Lancashire Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2018–19

Excellent care with compassion

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Lancashire Teaching Hospitals NHS Foundation Trust
Annual Report and Accounts 2018-19

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

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www.lancsteachinghospitals.nhs.uk

CHAIRMAN'S AND CHIEF EXECUTIVE'S WELCOME

Welcome to our annual report for the financial year 2018/19, 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.

Over the past year we have been really focusing on improving patient experience; making sure that our patients get the best care possible, in a timely way and in the right setting. We have made huge improvements to our emergency department at Preston, thanks to a £1.9m funding boost to improve facilities and increase capacity.

We have also started work to refurbish our critical care unit at Preston, as well as expand the space so that we can meet demand. The refurbishment will create a lighter and brighter unit, to provide a much better environment for patients and families and our staff.

We have introduced a new discharge process across our hospitals to make it quicker and easier to arrange for patients to be discharged from hospital. Standardising our discharge processes will enable us to reduce avoidable delays and help us to identify which patients can be discharged for assessments in another setting.

We have also been working hard to improve the experiences of patients with learning disabilities. Our new learning disability service aims to improve patient experience, safety and care through support, education and awareness amongst staff about how best to support and guide those with learning disabilities.

We have been looking ahead to the future and want to make sure we can attract and retain the very best staff to ensure that we can continue to provide excellent care for our patients. We're delighted to have been named within the Inclusive Top 50 UK Employers List 2018; this means we are recognised as an organisation that makes an outstanding effort to reinforce our commitment to attract and retain a diverse workforce.

We are extremely proud to see that our staff continue to be recognised for their outstanding achievements. Our maternity service has received an award for outstanding contributions to midwifery services. They have also received high praise in a national survey for offering a choice of where to give birth, the support provided by our midwives and partners being allowed to stay with mothers.

Our commitment to drive innovation through world-class research continues to go from strength to strength as we have been named the top performing site in the North West for recruitment onto clinical trials. We also recruited the highest number of patients in the UK onto an innovative kidney cancer trial which looks into whether immunotherapy treatment after surgery helps to reduce the risk of cancer returning.

Every year demand for care increases and last year was no different; As a result we have not achieved all the national performance standards this year. When wards are as busy as they have

been there are delays admitting patients from emergency departments, however we have made some significant improvements over the past year and our Emergency Department team has worked hard to improve ambulance handover times.

We continue to work in partnership with Lancashire Care, 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 programme.

Despite making £22.1m savings this year, the continued growth in demand along with rising costs and workforce shortages means our deficit has increased. 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 have launched Our Big Plan, which is our corporate strategy, our direction of travel, and sets out what we need to do to be successful, both now and for the future.

As ever our governors, volunteers and staff together with patients, carers, families and partner organisations continue to work with tremendous commitment and on behalf of the Board we thank them all for their passion and effort. Another tough year looms but we have made really exciting progress this year and have truly laid the foundations for our continous improvement journey.

Sue Musson
Chairman
24 May 2019

Karen Partington
Chief Executive
24 May 2019

Lancashire Teaching Hospitals NHS Foundation Trust

PERFORMANCE REPORT
2018/19

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 70 to 73.

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 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 Preston, South Ribble and Chorley and specialist care to 1.5 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

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. We have recently undertaken a service portfolio review to ensure that we can deliver sustainable services which have key interdependencies to our regional service provision.

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

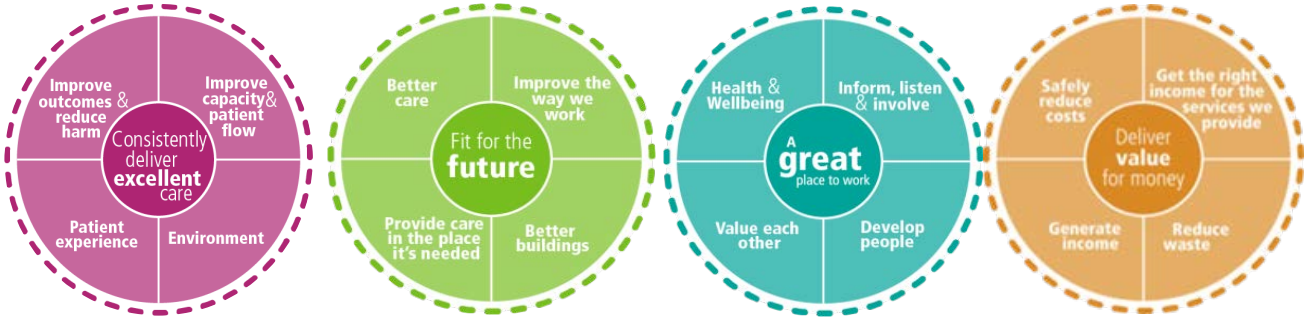
responsibilities. The board does, however, work closely with the council in formulating its forward plans. A schedule of matters reserved to the board is in place and this document details the matters reserved to the board, as well as providing more detailed information on the respective roles of the 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.

During 2018/19 we have been refreshing our corporate strategy and our strategy (our Big Plan) will be launched in April 2019.

The development of an Integrated Care Partnership (ICP) in Central Lancashire

A key development during 2018/19 is the progress we have made with our local partners to develop an Integrated Care Partnership for Central Lancashire. In March 2018 the Central Lancashire system agreed to come together to look at a radically different way of operating through an Integrated Care Partnership; to operate within the wider Integrated Care System for Lancashire and South Cumbria and be a connected planning, regulation and delivery system – with single place based leadership and a management infrastructure. The Partnership have developed, and begun the mobilisation of six strategic platforms of work for the medium term, and outlined the workstreams and activities that will sit within them. The work of the Our Health Our Care programme sits within the strategic platform focusing on acute sustainability. We want to move quickly and see progress towards a full partnership which includes integrated decision making, budgets, governance, workforce etc., within the next three years. Further details of the work of the ICP are included within the Accountability Report.

The development of an Integrated Care System (ICS) for Lancashire and South Cumbria

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 live longer, healthier lives. Work is ongoing to ensure that the developments within the central Lancashire Integrated Care Partnership (ICP) continue to align with the wider NHS planning context and the priorities of Healthier Lancashire and South Cumbria at an Integrated Care System (ICS) level. During 2018/19 the ICS has progressed work on the following areas:

- Out of Hospital
- Acute and Specialised
- Mental Health
- Pathology Collaboration
- Commissioning
- Urgent and Emergency
- Prevention and Population Health
- Digital
- Workforce

Further details of the work of the ICS are included within the Accountability Report.

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 for the Trust, as identified within the board assurance framework for 2018-19, related to:

1. high levels of bed escalation, occupancy and patient cancellation;
2. challenges associated with a financial deficit position;
3. availability of medical workforce and impact on sustainability of clinical services, particularly Emergency Medicine;
4. inability to recruit and retain the required number of nurses, midwives and AHPs;
5. system resilience;
6. non-delivery of the targets and indicators set within regulatory and compliance frameworks;
7. adherence to the agency ceiling set by the regulator;
8. weaknesses in corporate safety systems ;
9. the current configuration of our EPR system;
10. external cyber-attack impacting on Trust's business continuity; and
11. lack of availability of operational and strategic capital.

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.

Our performance

Overall during 2018-2019 the Trust achieved compliance against a range of measures identified in the NHS Improvement Compliance Framework and the Acute Services Contract such as four of the

eight cancer waiting times standards, and 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 during all quarters of 2018-19, the 18 week incomplete access target (though reduction in backlogs and long waiters has been made), and did not consistently achieve the 62 day cancer treatment. This was largely due to significant pressures within the emergency service throughout 2018-2019 that adversely impacted on access standards compliance and delivery of the Trust's elective care programme.

Going Concern

The financial statements are prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

For 2018/19 the Trust has a planned deficit of £46.441m excluding impairments and funding from the Provider Sustainability Fund which it did not qualify for. This plan was dependant on achieving a Performance Efficiency Target (PET) of £25m (5% of income). During the year the Trust benefited from enhanced support from NHSI and from a Financial Improvement Director. However the Trust has recorded a deficit in these accounts of £50.444 against this target mainly as a consequence of unachieved PET in the year. For 2019/20 the Trust is planning for a deficit of £37.050m excluding impairments and support funding, although this is again dependant on a PET of £25m. Working capital loans have been made available to support the deficit of the Trust, ensuring liabilities are met, and these are continuing to be available in 2019/20. The current working capital loan of £20.5m from the Department of Health has only been extended until March 2020, and the working capital facility of £30.4m falls due for repayment in April 2020. It has been indicated that these facilities will be extended further while the Trust remains in deficit. As with any trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they believe that it will do so.

The Trust's expectation is that services will continue to be provided from the existing hospital sites. However it recognises that sustainable financial balance needs to come through engagement with the wider health economy requiring not only the Trust to achieve service efficiencies but also for it to maximise the use of its assets and support the wider transformational change in service delivery. The Trust will work with NHS Improvement (NHSI) and its stakeholders to achieve this objective.

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

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.

PERFORMANCE ANALYSIS

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified in the NHS Improvement Compliance Framework and the Acute Services Contract.

During 2018-19 the Trust continued to experience significant operational pressures resulting in non-compliance in relation to key NHSI targets. 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. Alongside this during 2018-2019 the Trust set up a range continuous Improving and transformational work streams of which patient flow has a significant work plan attached to this. Significant work has been undertaken redesigning pathways around Urgent & Emergency Care settings, including Ambulatory Care at both sites, Emergency Observation Unit at RPH and Urgent & Emergency Care Value Stream Analysis work.

Overall during 2018-2019 the Trust achieved compliance against a range of measures within the Risk Assessment Framework including four of the eight cancer waiting times standards, and 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 did not consistently hit a number of cancer standards including 62 day cancer treatment. This was largely due to significant pressures within the emergency service throughout 2018-2019 that adversely impacted on access standards compliance and delivery of the trusts elective care programme. The summary position detailing performance against key targets 2018-19 is shown in the table below:

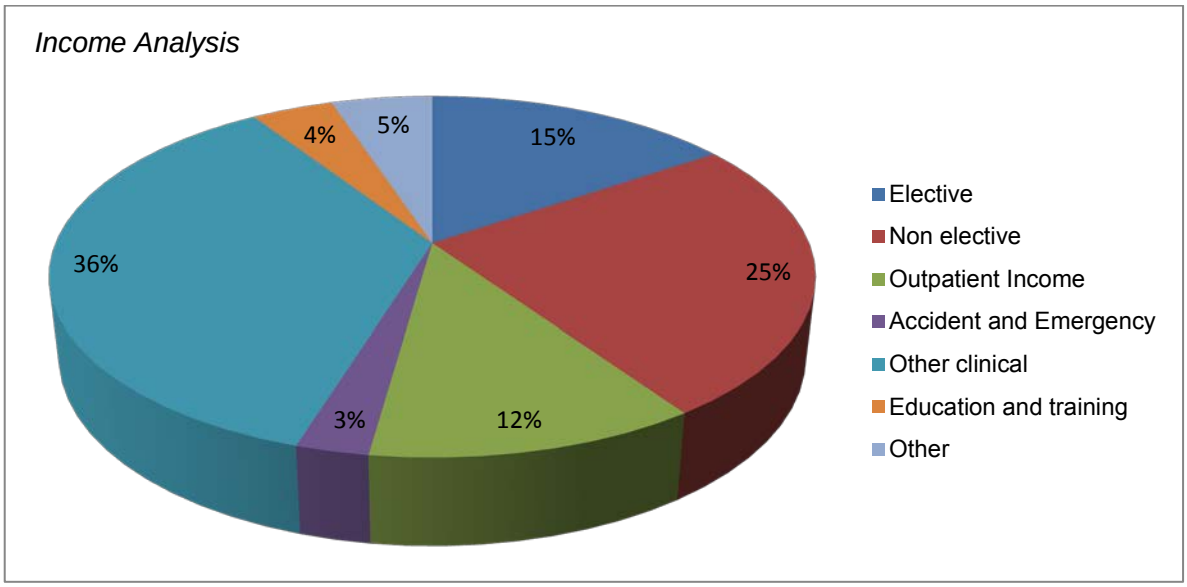
Indicator	National Target %	Cumulative Performance	Achieved	Current Period
A&E - 4 hour standard	90	82.67	Not Achieved	% - Cumulative to end March 2019 Position includes both ED and UCC locations. Target based on agreed Trajectory to March 2019
Cancer - 2 week rule (All Referrals) - New method	93	95.4	Achieved	% - Cumulative to end March 2019
Cancer - 2 week rule - Referrals with breast symptoms	93	91.3	Not Achieved	% - Cumulative to end March 2019
Cancer - 31 day target	96	94.6	Not Achieved	% - Cumulative to end March 2019
Cancer - 31 Day Target - Subsequent treatment – Surgery	94	92.5	Not Achieved	% - Cumulative to end March 2019
Cancer - 31 Day Target - Subsequent treatment – Drug	98	99.7	Achieved	% - Cumulative to end March 2019
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	94	98.5	Achieved	% - Cumulative to end March 2019
Cancer - 62 day target - total	85	79.6	Not Achieved	% - Cumulative to end March 2019
Cancer - 62 day target - Day 38 reallocations	85	81.2	Not Achieved	% - Cumulative to end March 2019
Cancer - 62 Day Target - Referrals from NSS (Summary)	90	91.0	Achieved	% - Cumulative to end March 2019
MRSA	0	0	NA	% - Cumulative to end March 2019
C.difficile Infections	<66	51	Achieved	Cumulative to end March 2019
C.difficile infection avoidable (Lapses in care)	<66	31	Achieved	Cumulative to end March 2019
18 weeks - Referral to Treatment - Incomplete Pathways	87	80.38	Not Achieved	% - sum of Apr-Mar in 2018-19 Target based on agreed Trajectory to March 2019

**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 2018/19 the Trust generated income of £440m from patient care, an increase of 4% from 2017/18. A further £45m 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.

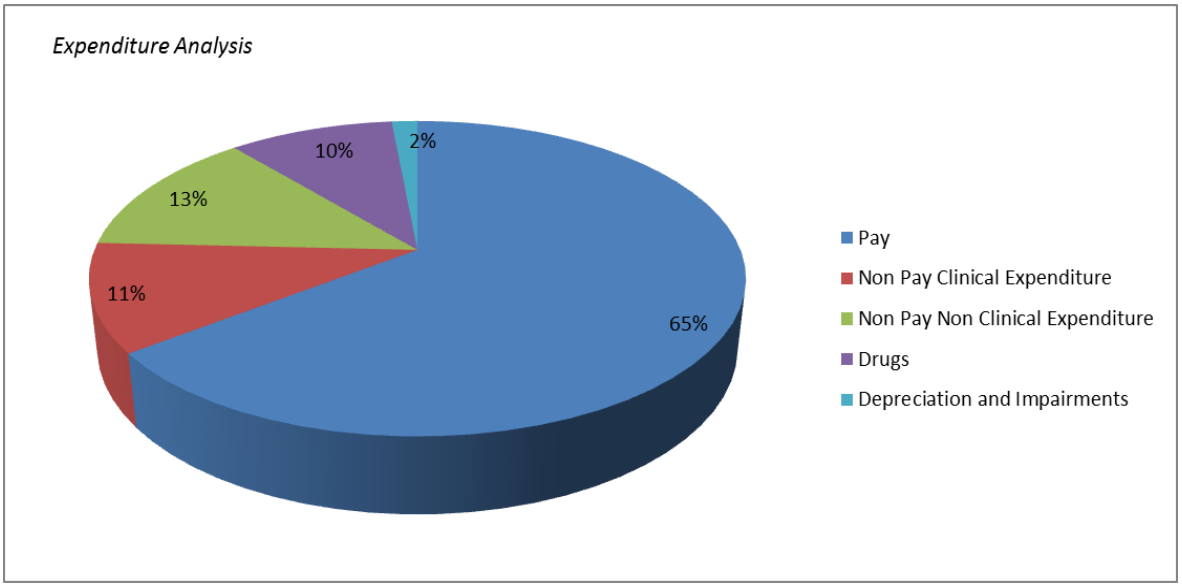


As the above chart demonstrates, income from health services is greater than income from any other sources.

Expenditure

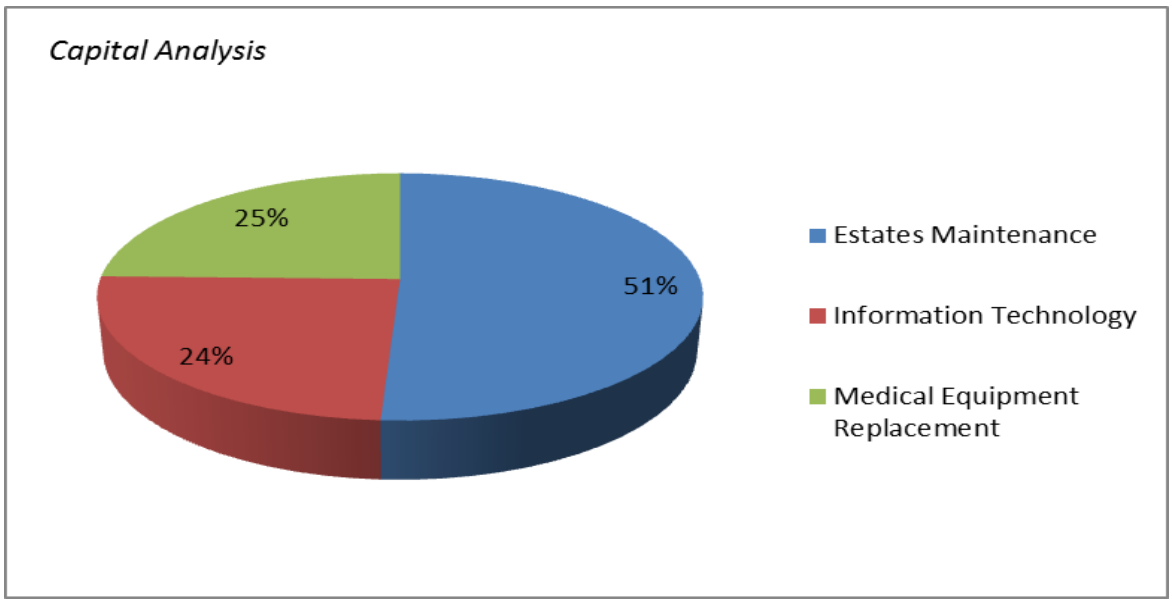
Operating expenditure (excluding impairments) for the year was £530m, the graph below shows the main categories of expenditure at the Trust. The main reason for the rise in costs can be attributed to staff costs and reflects the ongoing difficulties the Trust has experienced in recruiting substantive staff.

In 2018/19, the Trust achieved £22m, being 88%, of its challenging target for Performance and Efficiency savings of £25m.



Capital Investment

In 2018/19, £26m 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 2018/19 we paid 82% of invoices to this timescale.

	NHS		NON-NHS		TOTAL	
	No.	Value £	No.	Value £	No.	Value £
Invoices paid within 30 days	3,229	25,850,508.01	99,482	210,966,562.63	102,711	236,817,070.64
Invoices not paid within that 30 day period	1,314	9,212,225.81	30,260	42,801,526.75	31,574	52,013,752.56
Total Invoices	**4,543**	**35,062,733.82**	**129,742**	**253,768,089.38**	**134,285**	**288,830,823.20**
BPPC	**71.08%**	**76.27**	**76.68%**	**83.13%**	**76.49%**	**81.99%**
Total amount of any liability to pay interest	0	0	49	3,015.32	49	3,015.32

Being a Good Corporate Citizen

The Trust works in a number of ways to control the physical 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 being better than its peer group median for energy consumption and cost, which given the age of the estate is a positive reflection on past investment decisions.

During 2017/18 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 on the two sites. 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 continues to allow the Trust to reduce its energy bill by circa £ 1.1 million per year.

- Schemes to reduce water consumption across the Trust are providing financial benefits and reducing the Trust's carbon emissions.

- As part of our capital development programme we aim to construct new buildings in accordance with Building Research Establishment Environmental Assessment Method (BREEAM) standards.

- We invest in the use of LED lighting whenever possible and install LED as standard in any new developments or refurbishment schemes. During 2018/19 the Trust has also been successful in securing £294,000 from the NHS Energy Efficiency Fund (NEEF) and this funding will be used to install further replacement LED lighting within the estate during 2019/20.

- We continue to introduce other modern and more efficient technology which includes more efficient heating systems and reducing heat pump speeds to help reduce carbon emissions and lower costs.

- We continue to provide transport between our two hospital sites at a cost of around £100,000 per year, the purpose being to reduce the environmental impact of staff travel and single car usage.

- As part of our car parking strategy we have created an additional 120 parking spaces at the Royal Preston Hospital site. By relaxing visiting times we have significantly reduced site congestion at peak times and reduced traffic flow problems on Sharoe Green Lane. During 2018/19 we have also introduced a barrier-free automatic number-plate recognition (ANPR) system to manage our car parks, which has further reduced queueing and traffic congestion on site.

- The Trust is actively working with other health organisations in Lancashire and South Cumbria in an effort 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 10 years now. Students with learning difficulties from 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 prepare 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 390 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 young people across Chorley, Preston and South Ribble and over 550 individual placements have been organised over the last 12 months. We are also supporting college curriculum by providing students requiring work based hours as part of their study programme, in particular Health and Social Care students and those studying business and administration. Following the success of the Winter pressure pilot placement scheme last year we continued the offer this year and 136 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 getting fabulous feedback from both Staff and patients. With this in mind, Health Care Assistant bank positions have been offered to those who completed a successful placement with us.

Since 1st April 2018 the Trust has started 228 apprentices which is 2.75% of the workforce and combined with our 2.6% performance during 2017/18, puts us well ahead of the expected 2.3% Public Sector apprenticeship target. Recently published first year apprenticeship starts data puts us amongst the top performing Trusts in the North. We continue to offer a growing range of apprenticeships for both clinical and non-clinical roles in occupations from accountancy to pre-nursing. New apprenticeship programmes delivered during 2018 include:

- Nursing Associate
- Accountancy Taxation Professional
- Installation Electrician
- IS Business Analysist
- Customer Service - Preceptorship

Our long established apprenticeship programmes continue to be offered.

We have now been an approved apprenticeship training provider for 2 years and undergone full financial audit of year 1 data as well has having an Ofsted New Provider Monitoring visit which determined that we were making reasonable progress. We have started to see our first Level 2 Healthcare apprenticeship completers as well as some of our ILM Level 3 Team Leader/Supervisors and Level 5 Operations/Departmental Manager apprentices.

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 Preston's, Runshaw and Cardinal Newman Colleges. The programme runs for 7 weeks and includes a range of activities to help the students make informed choices about nursing careers. In addition to attending the course, the students commit to one shift a week as a 'buddy' to a health care assistant.

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 5th 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 Preston and Chorley sites where over 25 of our departments, both clinical and non-clinical, provided activities and gave 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 supported the pre-employment programme in partnership with Skills for Health (SFH) and Prestons' College in previous years however since the loss of service of SFH in 2017 we launched our own version of the programme in October 2018 and another in March 2019. Since the first programme back in 2013 the Trust has offered placements on the programme to 64 candidates, with 33 of the candidates gaining employment either with the Trust or externally as a direct result of the programme.

In April 2018 we launched the LIFE Centre (Learning Inspirations for Future Employment), our new building that will inspire the local community aged 5 years and upwards into NHS careers. The centre is a pan Lancashire facility which can be used by NHS organisations and public funded education providers to inspire NHS careers. LIFE is managed by the Widening Participation (WP) 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 nominated and shortlisted for a HSJ national award last year.

The Workforce and Organisational development (OD) strategy was refreshed and relaunched at the start of 2019, with over 500 staff contributing to the design of the priorities and approximately 300 staff and managers attending launch events to understand their role in making Lancashire Teaching Hospitals the best place to work in the whole NHS. The focus for the next 3 years is defined by the strategic aims which are to attract, recruit and resource – ensuring we plan our workforce for the future today whilst acquiring talented individuals to our current vacant posts. Further strategic aims

include to be inclusive and supportive - making each of our staff members feel valued for who they are and are well at work, to be well led – the focus of this aim is to continue to develop skilled, compassionate, inclusive and inspirational leaders and managers who focus on creating high performing teams. The final aims are to create a positive organisational culture which helps staff to flourish and to engage and retain existing staff members supporting them to reach their career aspirations and empowering them to feel able to make a difference for our patients so they have job satisfaction every day.

Health and safety performance

It is our policy to safeguard the health and safety of our employees, patients, visitors and anyone who may be affected by its activities. There are a number of committees that receive Health & Safety reports – those being:

Integrated Governance and Risk Group
The Integrated Governance and Risk Group is an operational group with cross-Divisional representation reporting into the Safety and Quality Committee (which is one of the board sub-committees). This committee receives all aspects of clinical and non-clinical risk, including health and safety information including risks associated with the physical environment.

Health and Safety Governance Committee
The health and safety governance committee has now been established. Over the past 12 months work has been done to better provide health and safety training for all members of staff. A blended learning package is now available via the Intranet. A specific Health and Safety Board workshop was delivered in February 2019.

The current focus of the committee is to complete the self-assessment against the Partnership of Occupational Safety and Health in Healthcare (POSHH) standards. Once this self-assessment has been completed an action plan will be prepared to address any identified weaknesses.

Each Division has a divisional safety and quality committee where divisional risks are managed and these divisional committees report into the new H&SGC on all aspects of operational H&S management. This has started to create better local ownership of H&S issues and risks, which continues to build capacity.

Security
The last 12 months have witnessed the merging of the old car parking team with the security team. Essentially we used to have only one security officer on duty at any one time at both our hospitals. This restructure means that we now have three on duty 24/7 at Preston and two at Chorley with a supervisor covering every shift. This has been largely possible because our ANPR installation has now provided a technological solution which means we were able to retrain and redeploy the car parking team to a new combined role. Notwithstanding this positive progress, the Trust still experiences more reported incidents of violence and aggression than our peer group trusts. Further work is planned for 2019/20 to further improve the situation using technology.

Fire Safety
Good progress has been made against the Fire Safety plans put in place two year ago. We now have over 140 Fire Wardens operating across the trust (previously we had none). During the year we had effected a significant upgrade to the fire alarm system t the Royal Preston hospital with 17 new fire alarm panel being installed and the whole system has now been networked.

Unfortunately the Trust's Fire Officer retired in March 2019 and recruitment of a suitable replacement is proving difficult. The Division is currently exploring alternative ways of delivering this essential service.

Health and Safety Joint Consultative Committee

The Health and Safety Joint Consultative Committee is now a well-established forum for staff sit engagement on safety matters. We are therefore 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 (as amended).

Safety and Quality Committee

This is a board committee, which has a wide agenda receiving all aspects of clinical health and safety information. The Committee has received positive reports on aspects such as:

- The People Led Assessment of the Clinical Environment (PLACE) with high/good scores ensuring the Trust sit in the upper quartile for most areas
- Strong results following the introduction of robust systems linked to the management of the Strategic Decontamination of medical equipment
- Ongoing strong results on monthly cleaning figures
- Successful external inspection of our catering environments by the Local Authority Environmental Health Officers resulting in the receipt of 5 * (highest) ratings in many of our environments

Emergency Preparedness

The terrorist attacks during 2017 led to a considerable reworking of mass casualty plans nationally. As part of that, we have completely rewritten our major accident plan. Additionally we have published revised plans for managing any type of incident and a new policy for emergency preparedness and business continuity.

We undertook a live exercise in March 2019 which was designed to test our new arrangements which all worked very well. The Trust continues to assess itself against the national core standards for emergency planning resilience and response (EPRR).

For 2018/19 we assessed ourselves as "Substantially Compliant". This is the same as we returned for 2017/18. The reason that there has been no change in our self-assessment is due to the ongoing requirement for staff training and the fact that we are not yet in a position to vouchsafe all individual business continuity plans through local divisional exercise. This work is planned for 2019/20.

The Trust has received no prohibition or enforcement notices from any of the regulating authorities.

Political Donations

The Trust has neither made nor received any political donations during 2018/19.

This Performance Report is signed on behalf of the board of directors by:

Karen Partington
Chief Executive
24 May 2019

ACCOUNTABILITY REPORT
2018/19

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 NHS Improvement in its Annual Reporting Manual 2017/18.

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, and education. The board believes that it 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.

Sue Musson, Chairman (I)
Appointment: 3 Jan 2017 to 2 Jan 2020
Sue's executive career has 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 has considerable experience of dealing with change management, strategic planning, research and building sustainable partnerships with agencies such as local authorities and universities. She is 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 is also the Independent Chair of 'Warrington Together', an integration programme to join up health and care in Warrington. Prior to joining the Trust, Sue was the Chair of Southport and Ormskirk NHS Foundation Trust; she has 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 has served as a Patient Representative for the National Joint Registry for five years, a role that keeps her close to the patient experience. Other than her involvement in Firecracker Projects Ltd, M&S Musson Partnership and Musson Projects LLP, Sue has no other significant commitments.

Tim Watkinson, Vice Chair (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 10 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 Chair 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.

Jeannette Newman, Senior Independent Director (I)

Appointment: 3 July 2017 to 2 July 2020

Jeannette was a non-executive director and later on Vice Chair 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 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 is the Senior Independent Director of the Trust and the Chair of the Trust's Finance and Performance Committee.

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, MoD, 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 Clinical Commissioning Groups 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 3 July 2020

James is an experienced executive currently working at BT Business, where he is Director of Project Management. During his career, James 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. James has worked with customers in many sectors including Government, Defence, Investment Banking and Retail. James 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 Chair 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 Clinical Commissioning Group. Kate was also the equality lead and the lead for deprivation, poverty and housing. From 2010 to 2019, she was an independent board member (latterly, the deputy chair) at Kirklees Neighbourhood Housing and the equality champion. She is currently a Lay Leader at Bradford Health Research Institute.

Paul O'Neill, non-executive 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 for 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.

Karen Partington, Chief Executive
Permanent post- appointment from 1 October 2011
Karen was appointed as Chief Operating Officer of Lancashire Teaching Hospitals NHS FT 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 A&E Delivery Board and co-chair of the Major Trauma and Critical Care ODN.

Paul Havey, Finance Director/Deputy Chief Executive
Permanent post - appointment from 6 March 2006
Having worked at Finance Director level within the NHS for 25 years, Paul is responsible for the strategic leadership and management of the Trust's finances. He is also the executive lead for Information Management and Technology and our senior information risk owner. Paul will be retiring in January 2020.

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.

Gail Naylor, Nursing, Midwifery and AHP Director
Permanent post – appointment from 1 April 2016
Gail has 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 will be retiring in July 2019 and will be succeeded by her Deputy, Sarah Cullen.

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, 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. Outside of the Trust she is the Chair and Trustee of Derian House Children's Hospice.

Adrian Griffiths, Interim Chief Operating Officer
Interim COO post – appointment from 2 July 2018 to 19 May 2019
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 10 years until 2011, and has held interim COO roles at Mid Yorkshire, South Manchester, and Great Western Hospital in Swindon, along with other senior management and consultancy roles. He has been interim COO at Lancashire Teaching Hospitals since July 2018. 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.

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/NHS Improvement. 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. She is a member of the Safety and Quality Committee and the Education, Workforce and Training committee.

Board members whose term of office ended during 2018/19

Suzanne Hargreaves, Operations Director
A nurse by background, Suzanne's career with us spanned 25 years during which time she has undertaken a variety of both clinical and managerial roles, including as an emergency department nurse. Prior to her role as Operations Director, Suzanne was our Divisional Director of Emergency

and General Medicine. Suzanne was Operations Directors for four years and stepped down from the role in October 2018.

Carole Spencer, Strategy and Development Director
Carole has more than 23 years' experience of working in the NHS and was involved in the development of the very first NHS trusts in the 1990s. She has held a number of directorships, including Director of Planning at Alder Hey, and prior to joining the Trust Carole was at Stepping Hill Hospital in Stockport. During 2018/19 Carole took on a substantive role within the Academic Health Science Network (AHSN) following her secondment to the AHSN in 2017/18.

Michael Welsh, Non-Executive Director (I)
Appointment: 1 May 2013 to 1 June 2018
After studying law at Oxford, Michael became an international marketing executive with British and American companies. From 1979 to 1994 he was Member of the European Parliament for Lancashire Central and then County Councillor for Preston North East from 1997 to 2013. He served as Chairman of Chorley NHS Trust from 1994 to 1998 when it merged with Preston to form Lancashire Teaching Hospitals and was an appointed governor of the combined Trust from 2009 to 2013. After five years of service, Michael stood down from his role as a non-executive director of the Trust with effect from 1 June 2018.

Tony Gatrell, non-executive director (I)
Appointment: 1 Feb 2014 to 31 December 2018
Tony is an academic who has worked at Lancaster University since 1984. From 2008 to 2014 he was Dean of the Faculty of Health and Medicine. He has a first class honours degree in Geography from Bristol University and a PhD from Pennsylvania State University. His research and teaching interests lie in epidemiology and the geography of health care provision, but with an underlying interest in health inequalities. He has published widely on these topics, with many health professionals. Tony is passionately committed to joint working across the University-NHS interface, with a particular focus on the innovation agenda. After four years of service, Tony stood down from his role as a non-executive director of the Trust with effect from 31 December 2018.

Alastair Campbell, non-executive director (I)
Appointment: 1 November 2015 to 31 December 2018
Alastair was a Consultant Paediatrician at Lancashire Teaching Hospitals NHS Foundation Trust from 1985 until his retirement in 2011, during which time he oversaw many developments in both the Paediatric and Neonatal Departments. He was also our Medical Director for four years from 2005. Alastair has held roles within the Royal College of Paediatrics and Child Health, the General Medical Council (revalidation and certification appeals), the Parliamentary and Health Service Ombudsman (Expert Clinical Advisor) and more recently the Care Quality Commission where he was a Paediatric Clinical Advisor on inspection teams. After three years of service, Alastair's term of office as a non-executive director came to an end on 31 December 2018.

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 chair 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 executives. 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. We are committed to ensuring that 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. Professor Tony Gatrell assumed this post in February 2014 and came to the end of his appointment on 31 December 2018. On 4 March 2019 Professor Paul O'Neill was appointed to this point for a three-year term.

Board meeting attendance summary 2018-19

PRESENT	05/04 /2018	03/05 /2018	07/06 /2018	05/07 /2018	02/08 /2018	06/09 /2018	04/10 /2018	01/11 /2018	06/12 /2018	07/02 /2019	A	B	Percentage of meetings attended
Sue Musson	P	Ab	P	P	P	P	P	P	P	P	10	9	90%
Ailsa Brotherton		P			P			P		P	4	4	100%
Alastair Campbell	P	P	P	P	P	P	P	Ab	P		9	8	89%
Tony Gatrell	P	P	P	P	P	P	P	P	P		9	9	100%
Adrian Griffiths				P	P	P	Ab	P	P	P	7	6	86%
Suzanne Hargreaves	P	Ab	Ab	Ab	Ab	Ab					6	1	17%*

PRESENT	05/04 /2018	03/05 /2018	07/06 /2018	05/07 /2018	02/08 /2018	06/09 /2018	04/10 /2018	01/11 /2018	06/12 /2018	07/02 /2019	A	B	Percentage of meetings attended
Paul Havey	P	P	P	P	P	Ab	P	P	P	P	10	9	90%
Gail Naylor	Ab	P	P	P	P	Ab	P	Ab	P	P	10	7	70%
Jeannette Newman	P	P	P	P	P	P	P	Ab	P	P	10	9	90%
Paul O'Neill (*appointed March 2019*)											-	-	-
Karen Partington	P	P	P	P	P	Ab	P	P	P	P	10	9	90%
Ann Pennell										P	1	1	100%
Geoff Rossington	P	P	P	Ab	Ab	Ab	Ab	P	P	P	10	6	60%*
Geraldine Skailes	P	P	P	P	P	P	P	P	Ab	P	10	9	90%
Kate Smyth										P	1	1	100%
Carole Spencer (*secondment*)											-	-	-
Karen Swindley	P	Ab	Ab	P	P	P	P	P	P	P	10	8	80%
Tim Watkinson	Ab	P	P	P	Ab	P	P	P	P	P	10	8	80%
Michael Welsh	P	P									2	2	100%
Jim Whitaker	P	P	P	P	Ab	P	P	P	P	P	10	9	90%

Ab = Absent **A** = maximum number of meetings the director could have attended
B = meetings attended **P** = Present
** Exceptional circumstances on the grounds of ill health*

Evaluating performance and effectiveness

The Trust commissioned an independent review in June 2018 against the new well led framework published by NHS Improvement in June 2017. This framework consists of 8 key lines of enquiry (KLOEs), which are shared with the Care Quality Commission, and details descriptions of good practice that organisations and reviewers can use to inform their judgements. The 8 KLOEs within the framework are as follows:

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

In preparation, we carried out a structured process to gather information, evidence and views from staff across the organisation and the Board of Directors to develop a formal self-assessment against the framework. The self-review process involved reflecting on current ways of working, potential development needs, and scoping areas for more detailed review by the independent reviewer. The Board's self-assessment highlighted that the key areas of development for the Trust mainly relate to KLOEs 1, 2 and 5.

The independent reviewer found that the Trust's self-assessment provided a good level of awareness around the strengths of the organisation, as well as reflecting areas where greater improvement is required. The independent reviewer also noted that there has been an ongoing focus on improving governance arrangements across the Trust throughout 2017/18 and 2018/19, 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, with the recruitment of a new team to lead this area and the recent approval of the continuous improvement strategy by the Board; and
- Continued emphasis on staff engagement, with a Staff Engagement Plan in place that aligns with the objectives in the Workforce and OD Strategy. A range of mechanisms for staff to have their voice heard are also in place, such as the Staff Survey, Big Conversation events, coffee catch ups, the 'Valuing Your Voice' approach and the Freedom to Speak Up team.

The independent reviewer concurred with our self-assessment ratings in six of the eight key lines of enquiry (KLOEs). Their ratings differed in the following two areas:

- KLOE 6: whilst the reviewer supported the work currently being undertaken in this area to strengthen board reporting, it was noted that further work is required to embed these changes, and that there is also scope for greater integration of the work of the BI, CI and Divisional leaderships teams. As such, the independent reviewer proposed a rating of amber/green in this area rather than green.
- KLOE 8: whilst the Trust proposed a rating of amber/red in this area, the independent reviewer considered this should be a rating of amber/green, recognising the progress being made in relation to delivering the Trust's continuous improvement strategy.

In July 2017 the Trust had its 'well- led' inspection by the Care Quality Commission. The findings of the independent review were shared with the CQC and there were no 'Must Do' actions stipulated by the CQC in relation to governance, which is testament to the ongoing focus of the Trust in improving governance arrangements. The areas of focus following the independent well led review and the CQC inspection have been: (i) to continue to strengthen risk management arrangements; (ii) to review the effectiveness of Board Committees; (iii) to continue to strengthen scrutiny of Trust performance; and (iv) to strengthen governance and leadership within Divisions.

During October – November 2018 the Board commissioned the Company Secretary and the Director of Governance to undertake a deep dive review specifically of the Board Committee governance arrangements (the 'Committee Review'). The purpose of the Committee Review was to:

- improve our governance structures and processes;
- achieve greater alignment of corporate and divisional reporting, outcomes and assurance;
- yield higher level of assurance to the Trust Board;
- ensure greater clarity of lines of accountability;
- ensure greater understanding and awareness of the Trust governance;
- ensure consistency of approach (unless explicable differences); and
- ensure efficiency of time.

The Committee Review gave rise to a series of recommendations, which were shared with the Board of Directors in December 2018. In February and March 2019 the Company Secretary and the Director of Governance developed a comprehensive 'Governance Maturity Plan' addressing each of the recommendations from the Committee Review as well as incorporating all of the recommendations arising out of the independent well led review and the CQC inspection.

The Integrated Governance and Risk Group is responsible for scrutinising and monitoring delivery against the Governance Maturity Plan and testing the impact of the actions on a quarterly basis. This group reports to the Safety and Quality Committee. An annual integrated governance report is presented to the Board of Directors along with a six monthly update that includes a report of progress against the Governance Maturity Plan. The Audit Committee also has a role in supporting the Board in monitoring the plan and providing assurance to the Board on its implementation.

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 board sub-committee level, we carry out annual effectiveness reviews and any improvement actions arising from the effectiveness reviews are captured within each Committee's development plan.

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 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 2018/19 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 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/governor development sessions, for example during 2018/19 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 Fridays.

The Modern Slavery Act 2015

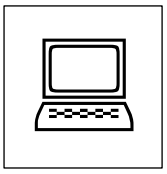
The Trust has zero tolerance to slavery and human trafficking and is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our service. The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community 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 113 and within our annual governance statement on page 80.

Major service developments

We have made huge improvements to our emergency department at Preston, thanks to a £1.9m funding boost to improve facilities and increase capacity. Improvements made include a new rapid assessment triage space to enable ambulances to handover patients without delay, extra cubicles to treat patients with serious conditions, upgraded high acuity cubicles, a new space for frail or elderly patients, extra surgical assessment capacity, a mobile x-ray, and IT systems to improve bed management.

These changes are part of a wider programme designed to improve flow throughout the hospitals, and ensure patients are transferred without delay to the most appropriate setting for their needs. The redesign has been led by our emergency department clinicians, to ensure that the changes work well in practice.

The emergency department team is delighted with the refurbishment

Work is underway to refurbish our critical care unit at Preston, as well as expand the space so that we can meet demand. The refurbishment will create a lighter and brighter unit, to provide a much better environment for patients, families and staff. A new reception area will provide a better welcome for families, and we are creating more rooms to maintain privacy during discussions.

We are also improving facilities for families including a new waiting area, kitchen, toilets, bathroom and locker room. There will be better facilities for visitors who are disabled and a new outside space for patients and families.

The refurbishment will also improve the working environment for staff; the refurbished facility will create more workspace around beds to enable better movement and flow, and the air conditioning will be improved. The staff room and rest facilities will be expanded, locker and changing rooms improved, and staff toilets moved to a more convenient location. There will also be a dedicated clinical skills and teaching room to support staff develop and keep up to date with training.

Visual plans for the Critical Care expansion

During 2018/19 other major service developments included:

- Introduced a new dedicated midwifery team to improve outcomes of maternity services and our maternity team has been honoured with a number of awards of the last year
- Selected to be a Health Foundation Flow Coaching Academy- an important step in our continuous improvement journey that will help us work towards delivering outstanding care for our patients
- Established a new discharge process to ensure patients can be discharged from hospital as quickly as possible
- Introduced new digital outpatient appointment letters via mobile phones
- Introduced a fully integrated pharmacy team within the emergency department
- Named within the Inclusive Top 50 UK Employers List 2018
- Chorley Hospital named as a National Joint Registry Quality Data Provider for commitment to patient safety
- Recruited first patient to be involved in an international clinic trial who has been treated by the cancer robot
- Received a nationally recognised accreditation for our commitment to the health and wellbeing of our staff
- Launched a new service to improve experience and support for patients with learning disabilities
- Introduced a dedicated sepsis team focused on developing sepsis screening
- Achieved the national target of 75% of our frontline staff vaccinated against flu

Research

In 2018/19 the Centre for Health Research and Innovation (R&I) has continued to grow and develop in line with the ambitious 3 year strategy 2016-2019. The financial year has been truly record-breaking and momentous, highlights include:

- The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 2822 (2832 in 2017/18).

- This year we have recruited a total of 2511 (2623 in 2017/18) participants, against a target of 2250, on to research studies on the National Institute of Health Research (NIHR) portfolio.

- We have opened 74 new studies (62 in 2017/18).

- We performed strongly against the Department of Health benchmarks for the set up and delivery of clinical research in the NHS. 71% of trials achieved the NHS 40 calendar day benchmark (69% 2017/18).

- The National Institute for Health Research (NIHR) Lancashire Clinical Research Facility (LCRF) for Experimental Medicine (EM) has completed its second operational year and we are delighted to report we have confirmed funding from the NIHR for a further 3 years until 2022, with a further £450,000 to be awarded. This was achieved on acceptance of a successful 2 year interim report and this consolidates the international position as a quality facility for delivering world class EM research.

- The average occupancy in the LCRF increased to 45% from 40% which is ahead of trajectory for Year 2. The LCRF has consolidated cross-sectoral funding to secure its sustainability and growth and is actively reviewing new partnerships, and ran in the financial year to a 'break-even' position.

- The LCRF, initially founded on an in-reach hotel model for studies from the Trust, Lancashire Care NHS Foundation Trust (LCFT) and Lancaster University research groups, has initiated and run 20 new studies in 2018/19 across the partnership, bringing genuine newness in EM to Lancashire and South Cumbria.

- Alison Swan, NIHR LCRF clinic sister has been shortlisted for a Trust 'Our People' Award.

- Dr Andrew Nixon, Renal Clinical Research Fellow, won the 'Rising Star' Award at the North West Coast Research and Innovation awards 2019.

- Dr Christian de Goede, Paediatric Neurologist and Multiple Principle Investigator, was shortlisted for 'Practitioner of the Year' at the North West Coast Research and Innovation awards 2019.

- One of our Oncology studies led by Dr Omi Parikh was one of the world's highest recruiting sites, and the only UK one to be in the top 7, along with centres in the USA, France, Mexico and Australia. We were also the first site to open in the UK.

- Our LCRF and Cancer teams successfully recruitment of our first randomised Phase 1 (B) patient. This is an historic moment in the history of EM at the Trust.

- Senior Research Nurse, Dr Chandbi Sange, has become a member of the first part of the Trust's Flow Coach Academy and will provide links from Research & Innovation into the Continuous Improvement team. The same nurse is also a named author on a Lancet journal article titled: Innovative smart insole system reduces diabetic foot ulcer recurrence: a prospective randomized, controlled trial.

- Nichola Verstraelen, Clinical Team Leader for Research and Innovation has been successful in her application to join 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.

- Stephanie Cornthwaite, one of our senior research nurses has been successful in joining the national Cancer Research UK Clinical Research Nurse Advisory Group. The group will be making sure 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. This programme is designed to support clinical research nurses working on cancer trials through the provision of relevant news and resources, facilitation of communication and collaboration, and increased awareness of clinical research nurses and their value.

- The Trust has continued to show an increase in the volume of commercially sponsored trials made available to patients accessing care through the Trust and utilising the NIHR LCRF. It has consolidated its Super-Site status with the Clinical Research Organisation (CRO) MedPace with 5 trials running in 2018/19.

- We have been the first UK site to open and recruit in 5 commercial studies and 1 non-commercial, over the last year.

- We are delighted that the updated R&I Strategy for 2019-22 has been endorsed by the Trust's Education, Training and Research Committee, and we will be delighted to report on the progress of this in future reports.

Patient care

We have continued our efforts to improve patient experience through a variety of methods, overarched by our Patient Experience and Involvement Strategy which is now in its second year of implementation. Further information on these areas can be found in the Quality Report.

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

- through our governors and 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 the national patient surveys
- through our "friends and family test" results

Our PALS team works 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 so 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

In 2018-19 over 2,500 concerns, raised by patients or their families/carers, were dealt with by the PALS team. This figure is an increase of 19% on 2017/18 performance which had also demonstrated a 12% increase when compared to the previous year.

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 now consider 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. In the future recordings will be available following meetings where all parties wish for this to take place. This ensures that the Trust is recognising the diversity of the population and avoids a 'one size fits all', demonstrating a commitment to engagement and involvement.

During 2018/19 the Trust received 710 formal complaints, an increase of 157 from 2016/17. This increase represents a percentage of 22%. In December 2018 the Trust introduced a new parking management system across the organisation, 83 out of the 157 increased complaints related directly to car parking.

Year	Complaints received	Increase/reduction
2012-13	593	
2013-14	582	-11
2014-15	579	-3
2015-16	575	-4
2016-17	595	+20
2017-18	553	-42
2018-19	710	+157

In 2018/19 the Trust received 1 formal complaint for every 1329 patient episodes compared to 1 in 1428 during 2017/18.

Year	No of complaints	Total episodes (IP/OP)	Ratio of complaints to episodes
2012-13	593	715670	1:1207
2013-14	582	718264	1:1234
2014-15	579	798490	1:1379
2015-16	575	808431	1:1406
2016-17	595	790696	1:1329
2017-18	553	789643	1:1428
2018-19	710	815607	0:9999

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In 2018-19, 100% of complainants received an acknowledgement within that timescale.

Of the 710 complaints received in 2018, 564 (79%) related to care or services provided at the Royal Preston Hospital (RPH), 140 (20%) to care or services provided at Chorley and South Ribble District General Hospital (CDH) and 5 (1%) to care or services provided offsite (by the Specialist Mobility Rehabilitation Centre, based at Preston Business Centre).

647 formal complaints were closed during 2018-19. 91% of all open complaints had been closed with 100% 35 day response compliance. By the end of 2018-19 there 89 complaints remain open and are being investigated, all of which are still within the required agreed timescales for completion.

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 2018-19, the Trust received 26 second letters, 14 less than the number received in the previous financial year.

Year	number of second letters	%age of second letters
2014-15	69	12%
2015-16	52	9%
2016-17	38	6.4%
2017-18	40	7.2%
2018-19	26	3.6%

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. During 2018-19, 16 complaints were referred to the PHSO. Of the complaints referred to the PHSO in 2018-19, 3 have been all of which were not upheld. Final reports received in a further 2 cases, both partly upheld and we are in the process of responding to the PHSO's recommendations. In this same period, the PHSO completed their investigations into 4 of the complaints that had been referred to them prior to April 2018. These cases have also been closed – 2 not upheld, 1 partly upheld, 1 upheld.

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

In response to feedback received in 2018 – 2019 the Trust has made changes in a number of areas to improve the quality of service provision. Some of these include:

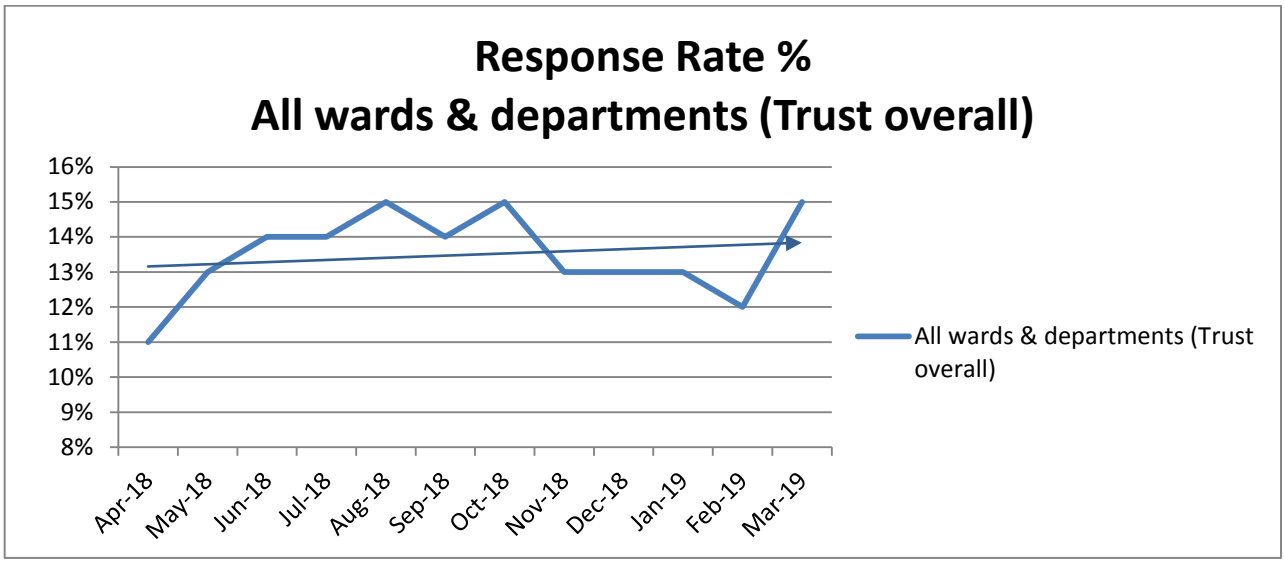
- The introduction of welcome boards to ward and departments, providing key information to patients and their carers
- Purple socks campaign to assist those patients who may be at risk of leaving the site
- Continuation of the Patient Experience Improvement Group, with representation from some patients who have complained to share their experiences
- Patient stories at Board to identify learning
- Introduction of patient boards for behind the bed to ensure that staff can, at a glance, be informed of their care needs
- Encouragement of patients to identify what matters most to them on any given day
- Continuation of the 'Hello My Name Is…' initiative across the organisation
- Increase in gathering Friends and Family feedback within departments who historically did not participate

In 2019-20 the Customer Care and PALS Team will be undertaking a review of the service overall. One of the key ambitions will be to ensure that a 'one team' principle is adopted. Currently this team is seen as two separate areas where 'formal' and 'informal' concerns and issues are raised. In order to support our patients, carers and service users more appropriately a change in service will

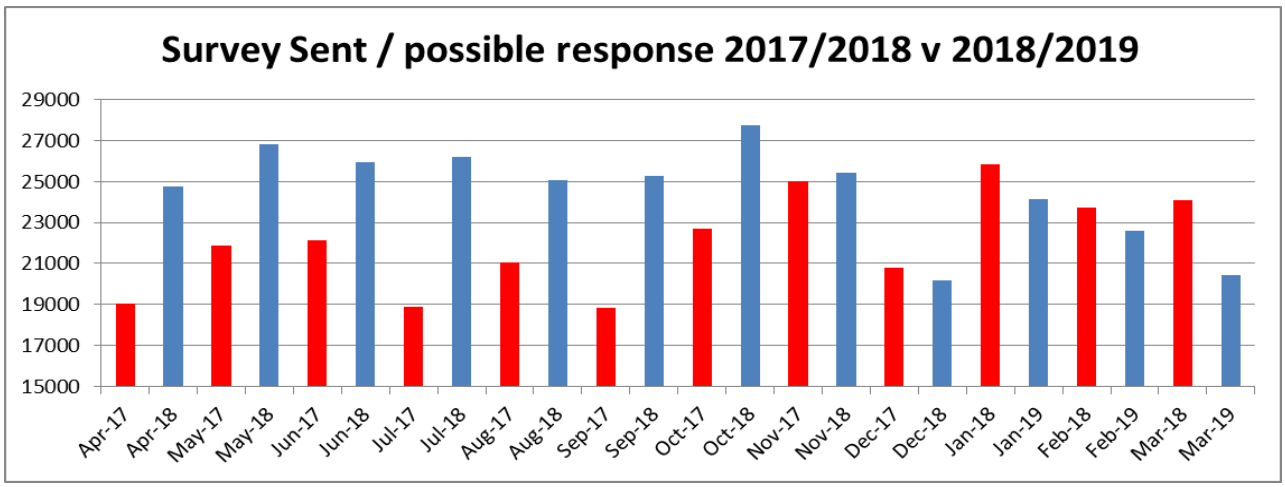
be required to ensure that all concerns are given a level of importance, where each one is considered important. This will link in with the 'What matters most to me' initiative.

Patient experience feedback

The Trust continues to gather patient experience feedback through using the Friends and Family Test (FFT) data. During 2018-19 there has been an increase of 3% in the response rate received, taking the overall response rate to 15%. The organisation continues to roll out FFT into areas where historically this information has not been gathered.



FFT feedback is gathered in a variety of ways including, SMS text message, postcards, voice message and online feedback.



Friends and Family test results and patient comments are available to wards and departments on a near real-time basis. Each ward area has a performance board displaying the feedback results and other quality indicators, and together they are used to identify areas for improvement within wards and across directorates. FFT informs assessment of ward performance that can result in the award of Beacon ward status for delivery of consistently high standards of care

As well as providing a good indicator of patient perception and experience, the results can also provide assurance around standards of care when analysed along with other data sources such as complaints and PALS activity. Reports capturing all these indicators are regularly reviewed by the board of directors.

The Trust identified that the response rate from our patients was below average compared to the national profile. One of the factors affecting this has been identified as where patients opt out of the text reminder service; this automatically removes the access for patients to provide FFT feedback. In order to address this and support the feedback process the Trust is reintroducing FFT cards into areas to gather information from patients, and to include them in the process, whilst respecting their view of not receiving a text reminder service.

National Adult Inpatient Survey

The survey was based on a sample of inpatients who received treatment at the Trust in July 2018. A total of 1207 were eligible following the survey, 397 inpatients responded to the questionnaire, providing a response rate of 32.1%. There has so far been no notification of the publication date.

The 2018 survey will not be published until after the publication of the 2018-19 Quality Account. 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

National Maternity Survey

Maternity services have received positive feedback in an annual, national survey for 2018; demonstrating significant improvements from the year prior.

The National Picker Maternity Survey 2018 is aimed at women, aged 16 years or over who gave birth at the hospitals in February 2018. The purpose of the survey is to understand what women think of the care they have received ranging from antenatal care, labour and birth, and postnatal care.

The results received demonstrate a significant improved position for maternity services compared to the last national Picker survey and also the one prior to that. Lancashire Teaching Hospitals ranked 12th out of 69 hospitals nationally. This is compared to the 2017 survey where the hospitals ranked 36th out of 68 surveyed; a huge improvement.

The maternity services ranked significantly better than the last survey on the following 3 statements in particular:

1. Treated with respect and dignity – 98%
2. Had confidence and trust in staff – 100%
3. Involved enough in decisions about their care – 96%

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

1. Found partner was able to stay with them as long as they wanted – 88%
2. Given a choice about where to have check-ups – 57%

3. Received support or advice about feeding their baby during evenings, nights or weekends – 87%

4. Saw the midwife as much as they wanted – 83%

5. Offered a choice of where to have baby – 97%

And when looking at the most improved areas from the previous 2017 survey; these were:

1. Offered a choice of where to have baby – 97%

2. Given the help needed by midwives – 99%

3. Felt that they were given appropriate advice and support at the start of labour – 95%

4. Had confidence and trust in staff – 100%

5. Found partner was able to stay with them as long as they wanted – 88%

A total of 300 mothers from our hospital were sent a questionnaire. Of these individuals; 292 mothers were eligible for the survey, of which 112 returned a completed questionnaire, giving a response rate of 38%. The average response rate for the 69 'Picker' organisations was 36%.

Notable positive feedback for the services included being offered a choice of where to have the baby, being given the help they needed by midwives, having their partner able to stay with them as long as they wanted, being able to see the midwife as much as they wanted, and receiving support or advice about feeding their baby during evenings and weekends.

Children and Young People's Survey

There national Children and Young People's survey was not carried out in 2017 as this is a bi-annual publication. The 2018 survey is currently being undertaken.

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2018-2019 (to February 2019) a total of 4699 compliments and thank you cards were received by wards, departments and through the Chief executive's office. The Patient Advice and Liaison Service have dealt with over 2033 issues which would have the potential to become formal complaints and resolved these with a reasonable outcome for patients.

Details of serious incidents

A serious incident is defined as a situation where one or more patients, staff members or contractors are involved in an incident which results in, or has the potential to result in, serious harm. It is important that organisations investigate and learn from such incidents, and that the board of directors is provided with an assurance that the circumstances are understood, corrective actions are taken and the likelihood of recurrence is reduced.

The board of directors monitors and reviews serious incident investigations and may commission high-level reviews of selected cases as necessary. This involves non-executive and executive directors working in conjunction with managers and clinicians to carry out a comprehensive review of events and formulating conclusions, recommendations and actions in response to the lessons learnt.

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 the key to delivery of high quality care and we will continue to ensure patients and the public are involved in major service changes and development. 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 a key priority being worked on to enhance communication with patients, carers, relatives and general visitors to our hospitals.

In January of 2018 the Trust launched two key strategies in support of communication and involvement in care, The Nursing, Midwifery, AHP and Care Givers Strategy and The Patient Experience and Involvement strategy. The continuation and momentum of these strategies 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 provision.

The Patient Experience Improvement group provides 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.

The NHS celebrated its 70th birthday year during the past 12 months, as part of this there was real engagement from service users in those celebrations with both Preston and Chorley Hospital holding a fun day in June to showcase services, seek views and generally hold up the NHS as a leader in world healthcare.

Our Trust has identified the LGBTQ+ population as requiring appropriate support. This year the organisation supported the Preston PRIDE initiative to gather feedback on how our services could be improved in the future. This demonstrated a real commitment to this group of underrepresented people in our community.

Volunteers

The contribution made by our 700+ volunteers, who cover many areas on the two hospital sites, cannot be underestimated. They give their time so generously to support patients and their families. In recognition of the need for them to have a voice in the way the Trust is run. We have a newly elected Volunteer Governor Shirley Murray, who currently volunteers with Babybeat, our last Governor Steve Mills stepped down at the end of his term in March. Steve was very active and supportive of the volunteers and was a member on several of the sub groups.

Volunteer Recruitment

- Over the last 12 months we have recruited 73 volunteers to the Trust in roles such as Ward Support, Paediatric ED, Research Unit and Chaplaincy.
- We are working hard to streamline our volunteer recruitment process 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 have been using our Trust recruitment system TRAC to manage and monitor all our volunteer recruitment. We are using social media more often to promote our volunteering

opportunities and we are linking in with all careers events attended by the Widening Participation Team. Our Volunteers can now access eLearning/on line Induction and this is speeding up our recruitment processes.

- A Volunteers Open Day was held during National Volunteers Week during summer 2018 which was well attended and coffee and cakes provided!
- A Careers event at UCLAN was also attended in November at which a number of students were recruited and several applications were received.
- We also attended Runshaw and Newman Colleges and the Sahara Community Centre Job Fare and several applications resulted from these events
- We have new volunteer promotional material and a video which we use on social media and at recruitment events. Our volunteer roles are promoted at Preston College, Newman College and Job Centres at Preston and Chorley.
- We are developing new Volunteers Handbook and we have also finalising a Manager's Toolkit for recruiting, supporting and training volunteers to improve the support we give our volunteers when joining the Trust.

Volunteer Management and Engagement

- We have introduced Volunteer 3 month checks at the start of their placement with us to ensure the placement is meeting their needs and to check if there are any issues or concerns. We have undertaken a number of verbal and face to face 3 month checks in the last 12 months and feedback has been very positive with volunteers seeming to be most content with their placement and support.
- We have introduced a new informal Volunteer Buddy system. All volunteers are placed with a Buddy for the first two weeks of the placement but will continue to have access to them for the remaining time for support and enquiries.
- We have also introduced Volunteer Exit interviews in the last 12 months to understand why our volunteers choose to leave us. We have undertaken 22 Exit interviews in the last 12 months and are using the feedback to inform our volunteer retention strategy.
- Last year during National Volunteers Week we held a drop in tea and cakes to thank the volunteers for all their hard work and their contribution to the Trust.
- A Christmas Lunch was held for all volunteers on both sites to celebrate the achievements and this included a presentation of long service awards for 10, 20 and 50 years' service.

- We asked our volunteers to tell us why they are proud to volunteer at the Trust during national volunteer's week. We are using the output of this for our promotional materials and social media to promote the benefits of volunteering.

- Following staff survey last year our Volunteers have been invited to attend our Big Conversation events. This year we will be running an engagement survey for our volunteers during the staff survey period and share the outcomes and any outcomes and actions.

- One of our volunteers has been nominated for the National Unsung Heroes Award. Lorraine Clucas, volunteer on the Help Desk and was presented her Certificate in January.

  Lorraine was nominated by her colleagues for her caring and conscientious manner in which she carries out her duties.

Identifying Volunteer Needs

- This year we have focused on the recruitment of **Pets as Therapy Dogs** to support our patients. We have recruited 3 additional Pets as Therapy Dogs (PAT) who give regular support to our wards.

- We are creating more **Meet and Greet** volunteer opportunities after feedback from wards that more volunteer support would be welcomed at visiting time.

- We have met 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 and ED, Palliative Care and Learning Disability.

- The volunteer manager is also a member of the Patient Experience Improvement Group, which meets monthly to plan actions from feedback received with focus on solutions and patient experience

- During the last 12 months the need for additional **Dining Companions** was highlighted. Several new Dining Companions have been recruited and trained in conjunction with the Clinical Education Team. Recruitment and training continues for wards where there is an identified need, the role of Ward Beverage Volunteer 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.

Priorities for 2019-20

Our Volunteer Strategy forms part of our Trust Workforce and OD Strategy 2019-2021

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

- Ensure 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, discharge.

- To raise the profile of how volunteers can proactively support service delivery ensuring our volunteers are embedded into clinical teams and pro-actively supported in the workplace.

- Launch the “What a Volunteer can do” campaign.

- Development and launch of new End of Life Care, Befriender and Discharge Support Volunteer Programmes as part of existing ward volunteer roles.

- Ensure clear action plans in place and are delivered for all aspects of volunteer compliance around recruitment checks, DBS and mandatory training.

- Improve positive celebration of volunteering through case studies, awards, tweets, posters, and communications for an immersive and uplifting culture of volunteering.

- Develop a volunteer action plan as a result of Big Conversation feedback. Conduct a bespoke volunteer engagement survey and implement actions as a result.

Stakeholder relations

Efforts continue to promote good working relationships with stakeholders, including strengthening partners such as the local authorities and the clinical commissioning groups. 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 A&E Delivery Board has representatives from the Trust, the local clinical commissioning groups, Lancashire Care NHS Foundation Trust, Primary Care, North West Ambulance Service, 111 Service, the Voluntary sector, Lancashire County Council, NHS Improvement and NHS England, 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 clinical commissioning groups, Lancashire Care NHS Foundation Trust, NHS Improvement and NHS England. 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.

Healthy relationships with the GP community are essential to the Trust and regular meetings are held with the chairs of the local clinical commissioning groups, 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 Our Health Our care programme. The overarching aim of the Our Health Our Care 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 Greater Preston, Chorley and South Ribble. The overarching aim of the Our Health Our Care 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 Clinical Commissioning Group, NHS Chorley and South Ribble Clinical Commissioning Group, Lancashire Care NHS Foundation Trust, the Trust, local councils, NHS England 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 & social care economy including Consultants, GP's, 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 over 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 workstreams, supported by specialist external advisers where required.

The development of an Integrated Care Partnership (ICP) in Central Lancashire

In March 2018 the Central Lancashire system agreed to come together to look at a radically different way of operating through an Integrated Care Partnership (ICP); to operate within the wider Integrated Care System (ICS) for Lancashire and South Cumbria and be a connected planning, regulation and delivery system – with single place based leadership and a management infrastructure. The shadow ICP Board came into being on the 1st April 2018, with the first Partnership Board taking place on 26th April 2018.

The focus of the ICP during 2018/19 has been on the establishment and development of a "shadow" Integrated Care Partnership Board and strategic platforms as a structure from which to develop and deliver the ambitions of the Partnership. A full ICP Annual Report for 2018/19 has been developed, which indicates the progress we have made in a short period of time.

The Board consists of senior colleagues from NHS Chorley and South Ribble and Greater Preston CCGs, Lancashire Teaching Hospitals NHS Foundation Trust, Lancashire Care NHS Foundation Trust, Lancashire County Council, and North West ambulance Service.

Lancashire County Council Elected Members are represented on the ICP Board via Councillor Shaun Turner, Cabinet Member for Health and Wellbeing. Our local District Councils have one representative, the Chief Executive of Chorley Council who links into other officers and members via the Central Lancashire Health and Wellbeing Partnership. The voluntary, community, faith and social enterprise sector (VCFSE) have one representative, the chair of the local VCFSE Leaders Network.

The Partnership Board has recruited an independent Chair, ICP Programme Director and ICP core team, during 2018/19.

We have also formed a Senior Leadership Team from existing Executive officers within the partner organisations and are developing a shared approach to programme management to monitor progress.

The Partnership have developed, and begun the mobilisation of six strategic platforms of work for the medium term, and outlined the workstreams and activities that will sit within them. The work of the Our Health Our Care programme sits within the strategic platform focusing on acute sustainability.

The strategic platforms are predicated on the agreed principles for transformation in Central Lancashire – that of developing person centred health and care, increasingly delivered within a community or home setting. Encouraging and enabling people to take responsibility for self-management of their health with co-ordinated support from services to improve their health, wellbeing and quality of life.

We will continue to build the partnership through a number of phases over the next few years. Unlike other NHS changes, the emphasis here is on finding local solutions that meet our particular communities and requirements – rather than implementing a top down restructure.

This means that we are working without any strict guidelines or requirements and the creation of a full partnership will be at our design and pace. However, we want to move quickly and see progress towards a full partnership which includes integrated decision making, budgets, governance, workforce etc., within the next three years. An annual ICP Business Plan has been approved which sets out what milestones we expect to achieve towards this within 2019/20.

The development of an Integrated Care System (ICS) for Lancashire and South Cumbria

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 live longer, healthier lives.

Central Lancashire is one of the five local integrated care partnerships across the Lancashire and South Cumbria ICS.

Work is ongoing to ensure that the developments within the Central Lancashire Integrated Care Partnership (ICP) continue to align with the wider NHS planning context and the priorities of Healthier Lancashire and South Cumbria at an Integrated Care System (ICS) level.

Partners across Lancashire and South Cumbria came together to develop priorities for 2018/19 which included those highlighted at national level and priorities driven by and based upon, the needs of the population it serves. A new commissioning framework agreed for Lancashire and South Cumbria has supported the development of this strong partnership working across the area.

During 2018/19 the ICS has progressed work on the following areas:

- Out of Hospital
- Acute and Specialised
- Mental Health
- Pathology Collaboration
- Commissioning
- Urgent and Emergency
- Prevention and Population Health
- Digital
- Workforce

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 NHS Improvement 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 Chair and other non-executive directors. The appointment, remuneration and terms of employment (ARTE) committee, a committee of the board, deals with the pay and conditions of senior executives.

Nominations committee

The committee comprises the chair (except where there is a conflict of interests in relation to the chair's role, when the vice-chair, 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

Name of committee member	A	B	Percentage of meetings attended (%)
Sue Musson, Chairman	4	3	75%
Nicola Leahey, public governor	4	4	100%
John Daglish, public governor	4	4	100%
Steve Heywood, public governor	4	3	75%
Alistair Bradley, appointed governor	4	3	75%
Substitutes			
Ken Jones, public governor (acted as substitute for Steve Heywood on 13th April 2018)	1	1	100%
Javed Iqbal, appointed governor (acted as substitute for Alastair Bradley on 21st May 2018)	2	2	100%
Tim Watkinson, acted as Chair for Sue Musson on 21st May 2018)	1	1	100%

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

Work of the committee

During 2018/19, the committee met on four occasions, with the main focus of the committee's work being the recruitment of new non-executive directors. The committee played a key role in the non-executive director selection process. An external recruitment agency was not used for these appointments.

Short listing of candidates involved (1) written report exercise, (2) governor/stakeholder group, (3) group exercise/interview, and (4) a panel interview. As part of the panel's assessment there was an evaluation of the following skills and competencies:

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

The panel met on 25 October 2018 and it comprised the Nominations Committee, the Chief Executive and the Workforce and Education Director, and was chaired by the Trust Chairman. The panel interviewed five candidates. Following evaluation of each candidate's performance, the nominations committee made appropriate recommendations to the Council to appoint Kate Smyth and Paul O'Neill as non-executive directors of the Trust, which was endorsed by the Council on 30 October 2018.

There were four longlisted candidates who did not attend the selection day on 25 October 2018. As such, the nominations committee agreed to run the same selection process again to fill the final Non-Executive Director vacancy. A further selection day was held on 4 December 2018, following which the nominations committee recommended to the Council that candidate, Ann Pennell, be appointed as the third new non-executive director of the Trust; this was endorsed by the Council on 13 December 2018.

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.

Appointments, remuneration and terms of employment committee attendance summary

Name of committee member	A	B	Percentage of meetings attended (%)
Sue Musson	5	5	100%
Tim Watkinson	5	5	100%
Alastair Campbell	2	2	100%
Tony Gatrell	2	1	50%
Michael Welsh	-	-	-
Geoff Rossington	5	3	60%
Jeannette Newman	5	2	40%
Jim Whitaker	5	4	80%
Ann Pennell *(appointed on 7 January 2019)*	3	0	0%*
Kate Smyth *(appointed on 4 February 2019)*	2	0	0%*
Paul O'Neill *(appointed on 4 March 2019)*	1	0	0%*

A = maximum number of meetings the member could have attended
B = number of meetings the member actually attended
**Undergoing induction into their new roles*

Work of the committee

During 2018/19, the committee met on five occasions which enabled it to:

- review and consider a retire and return request of the Finance Director
- review appraisal outcomes of senior executives
- review the remuneration of senior executives
- review the portfolio of the Strategy and Development Director post and approve the change in portfolio and title of the Workforce and Education Director to 'Strategy, Workforce and Education Director'
- review and approve the Director of Continuous Improvement post as a corporate, non-voting member of the Board
- review and approve the appointment to the Nursing, Midwifery and AHP Director post
- review and approve the appointment to the Chief Operating Officer post
- consider succession planning for the senior executives
- consider shared board-level objectives for the purposes of board appraisal processes

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.

As part of the Committee Review in 2018/19 (as detailed on pages 25 - 26), we undertook a review of the committee's effectiveness including its terms of reference, following which the Board agreed changes to the Committee's cycle of business and agreed that there would be two scheduled committee meetings per year.

During 2018-19 the committee approved the appointment of the Nursing, Midwifery and AHP Director and the Chief Operating Officer. 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 may be invited to deliver a presentation on a topic that is advised to them in advance. 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.

Sue Musson
Chair, 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

Other executives

- strategy, workforce and education director
- company secretary
- continuous improvement director

Details on membership of the appointments, remuneration and terms of employment committee and individual attendance can be found on pages 47-48 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 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. During 2018/19 the senior executive appraisal process was reviewed and a revised process will be implemented in 2019/2020.

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 (2017-18) are: ▪ £12,500 p.a. for non-executive directors ▪ £15,500 p.a. for the audit committee chair and vice-chair ▪ £43,000 p.a. for the chair
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.

ANNUAL REPORT ON REMUNERATION

Details of the total number of board members in post during 2018-19 are included on pages 19 to 23. Details of our Council of Governors are included on pages 96 to 100, together with information on expenses paid to them in 2018/19.

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:

	2017-18	2018-19
Total number of directors in office as at 31 March:	14	16
Number of directors receiving expenses:	4	7
Aggregate sum of expenses paid to directors (£00s):	£27	£18

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.

Income disclosures: senior executives

	2017-18				2018-19			
	Salary and fees (bands of £5,000) £'000	Taxable benefits (to nearest £100) £'00	Pension-related benefits (bands of £2,500) £'000	Total of all items (bands of £5,000) £'000	Salary and fees (bands of £5,000) £'000	Taxable benefits (to nearest £100) £'00	Pension-related benefits (bands of £2,500) £'000	Total of all items (bands of £5,000) £'000
Karen Partington Chief Executive	175-180	2	25.0-27.5	200-205	**180-185**	**7**	**5.0-7.5**	**185-190**
Suzanne Hargreaves Operations Director (Ended 16 October 2018)	125-130	0	17.5-20.0	145-150	**65-70**	**40**	**0.0-2.5**	**70-75**
Paul Havey Finance Director/Deputy Chief Executive	150-155	44	15.0-17.5	170-175	**145-150**	**75**	**0**	**155-160**
Geraldine Skailes* Medical Director (From 1 March 2018)	10-15	0	60.0-62.5	75-80	**170-175**	**18**	**5.0-7.5**	**175-180**
Gail Naylor Nursing and Midwifery Director	125-130	1	17.5 - 20.0	145-150	**125-130**	**3**	**0.0-2.5**	**125-130**
Karen Swindley Director of Workforce and Education	115-120	0	30.0-32.5	145-150	**115-120**	**0**	**0.0-2.5**	**115-120**
Phebe Hemmings Company Secretary	75-80	0	20.0-22.5	95-100	**75-80**	**0**	**0.0-2.5**	**75-80**

Adrian Griffiths Interim Chief Operating Officer (From 2 July 2018)	0	0	0	0	**110-115**	**0**	**0**	**110-115**
Ailsa Brotherton Director of Continuous Improvement (From 1 December 2018)	0	0	0	0	**35-40**	**0**	**0**	**35-40**
Mark Pugh** Medical Director (Ended 28 February 2018)	160-165	0	40.0-42.5	205-210	**0**	**0**	**0**	**0**
Sue Musson Chairman	40-45	34	0	47	**40-45**	**31**	**0**	**45-50**
Tim Watkinson Vice Chairman	15-20	3	0	16	**15-20**	**0**	**0**	**15-20**
Michael Welsh Non-Executive Director (Ended 1 June 2018)	10-15	0	0	13	**0-5**	**0**	**0**	**0-5**
Tony Gatrell Non-Executive Director (Ended 31 December 2018)	10-15	0	0	13	**5-10**	**0**	**0**	**5-10**
Alistair Campbell Non-Executive Director (Ended 31 December 2018)	10-15	0	0	13	**5-10**	**0**	**0**	**5-10**
Jeanette Newman Non-Executive Director (From 3rd July 2017)	5-10	0	0	9	**10-15**	**0**	**0**	**10-15**
James Whitaker Non-Executive Director (From 3rd July 2017)	5-10	0	0	9	**10-15**	**0**	**0**	**10-15**

Geoff Rossington Non-Executive Director (From 4th September 2017)	5-10	0	0	8	**10-15**	**10**	**0**	**10-15**
Ann Pennell Non-Executive Director (From 7 January 2019)	0	0	0	0	**0-5**	**0**	**0**	**0-5**
Kate Smyth Non-Executive Director (From 4 February 2019)	0	0	0	0	**0-5**	**0**	**0**	**0-5**
Paul O'Neill Non-Executive Director (From 4 March 2019)	0	0	0	0	**0**	**0**	**0**	**0**

***Professor Mark Pugh's remuneration includes £149k, (2016/17 £145k), which relates to his role as a consultant of the Trust.*

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Karen Partington Chief Executive	0.0-2.5	0.0-2.5	85.0-90.0	255-260	1,727	168	1,973	0
Suzanne Hargreaves Operations Director	0	0	45.0-50.0	145-150	934	43	1,040	0

Geraldine Skailes Medical Director	7.5-10.0	37.5-40.0	65.0-70.0	205-210	1,093	328	1,479	0
Gail Naylor Nursing and Midwifery Director	0.0-2.5	2.5-5.0	55.0-60.0	170-175	1,094	122	1,267	0
Ailsa Brotherton[(1)] Director of Continuous Improvement	0.0-2.5	0.0-2.5	40.0-45.0	0	0	19	592	0
Karen Swindley Director of Workforce and Education	0	0	30-0-35.0	90-95	629	0	630	0
Phebe Hemmings Company Secretary	0.0-2.5	0	5.0-10	0	24	9	46	0

(1) Ailsa Brotherton joined the board in December 2018, and her accrued pension benefits at that point are not available, therefore the increases in benefits cannot be calculated.
(2) Paul Havey retired in August 2018, and returned to his post. For this reason he is no longer 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 2018/19 was £180,000 - £185,000 (2017/18 was £175,000 - £180,000). This was 7.1 times (2017/18 - 7.8 times) the median remuneration of the workforce, which was £28,050 (2017/18 £22,683). In 2018/19, 2 employees (2017/18, one employee) received remuneration in excess of the highest-paid director. In 2018/19 remuneration ranged from £2,760 to £212,682 (2017/18 the range was £5,000 to £182,000). 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
24 May 2019

STAFF REPORT

Our people

As at 31 March 2019, we employed 8,103 substantive members of staff. This number is broken down as follows:

Staff Group	Headcount
Additional Professional, Scientific and Technical	263
Additional Clinical Services	1,790
Administrative and Clerical *(incl. NEDs)*	1,655
Allied Health Professionals	493
Estates and Ancillary	755
Healthcare Scientists	261
Medical and Dental *(excl. Pennine Doctors)*	613
Nursing and Midwifery Registered	2,273
Total	**8,103**

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

	2016/17 HC	% of Total HC	2017/18 HC	% of Total HC	2018/19 HC	% of Total
Age *(yrs)*						
Under 17	-	-	-	-	2	0.02%
17 – 21	148	1.91%	151	1.90%	158	1.95%
Over 21	7,593	98.09%	7,814	98.10%	7,943	98.03%
Ethnicity						
White	6,474	83.63%	6,591	82.75%	6,660	82.19%
Mixed	95	1.23%	99	1.24%	105	1.30%
Asian or Asian British	881	11.38%	969	12.17%	1,002	12.37%
Black or Black British	85	1.10%	106	1.33%	120	1.48%
Other	112	1.45%	119	1.49%	134	1.65%
Not Stated	94	1.21%	81	1.02%	82	1.01%
Gender						
Male	1,692	21.86%	1,739	21.83%	1,757	21.68%
Female	6,049	78.14%	6,226	78.17%	6,346	78.32%
Recorded Disability	204	2.64%	223	2.80%	242	2.99%

As at 31 March 2019, the gender split of our board of directors was six male and seven female. The gender split of our senior executives, as defined by the Appointment, Remuneration and Terms of

Employment Committee, was two male and six female. The gender split of our senior managers was seven male and thirteen female.

Attendance management

Sickness absence data reported on a calendar year basis (January 2018 to December 2018):

Figures Converted by Department of Health to Best Estimates of Required Data Items:	
Average FTE 2018	6,907
Adjusted FTE days lost *(to Cabinet Office definitions)*	79,864
Average sick days per FTE	11.6
Statistics published by NHS Digital from ESR Data Warehouse:	
FTE days available	2,527,940
FTE days recorded sickness absence	129,990

Source: *NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse*
Period covered: *01 January 2018 to 31 December 2018*

Sickness absence levels were a concern throughout the year with a rolling 12 month average rate of 5.17% for the period 1st January 2018 to 31st December 2018, compared to 4.92% in the previous year. In particular, mental health related absence has increased and a key focus of our health and wellbeing strategy has therefore been to proactively provide psychological wellbeing support. An incident support service was launched in April 2018, with a cohort of trained staff providing support and information to colleagues affected by incidents at work. We also made our employer pledge to the national 'Time to Change' campaign in September 2018, demonstrating our commitment to change perceptions about mental health in the workplace and ensure that staff feel supported.

The staff flu vaccination campaign ran from September 2018 to February 2019, with a total of 6256 staff accessing the vaccine and uptake of 75.2% amongst front-line health care workers. Although a direct correlation cannot be made, the prevalence of sickness due to cold, cough and flu during the winter months was lower than the previous year.

To support managers to reduce sickness absence, a dedicated Attendance Management team has been established within the Workforce Department. This team provide guidance to managers in proactively managing absence cases, ensuring a focus on early intervention; and they also work with managers from areas with persistently high absence to explore the underlying reasons and develop appropriate action plans.

The focus for the next year will be to take a more targeted approach to the prevention and management of sickness absence e.g. introducing pop up physio clinics in areas with high musculoskeletal absence and ensuring Mental Health First Aiders in teams with high mental health related absence. We will also be introducing a robust audit process to provide assurance that our Attendance Management policy is consistently applied; and there will be additional training for managers to support them in managing complex health conditions in the workplace.

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.

Activity has been focused on benchmarking where we are at as an organisation whilst simultaneously raising the profile of the inclusion agenda through trust wide communications and events in addition to the development of a short film which shows who 'we' are; a diverse team of people working together and respecting difference. This has been shared widely through social media internally and externally. From a workforce and organisational development perspective, achievements include the following:

- Undertaking our first Valuing Diversity Conference, this included a range of speakers sharing their lived experiences of discrimination in addition to a session on unconscious bias.
- 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 for the month of September which further demonstrated our support to our people and our wider community.
- We have incorporated diversity and inclusion into our people management programmes
- Following publication of our staff survey results, we have undertaken equality focused 'Big Conversations' to understand what is working well and where we still have work to do
- Development of a mandatory training module in respect of Equality, Diversity & Inclusion
- Launching staff ambassador forums to support BME colleagues, LGBTQ+, those who are Living with Disability and Multi Faith.
- Utilising our Equalities Champions, further raising their profile
- Achieving a top 50 ranking in the annual Inclusive Employers awards in our first year of entry
- Revising our workforce policy in support of colleagues who are living with disability which now includes the completion of a Supporting Disability Agreement, with an ongoing annual review. 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).

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 characteristic.
- 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 there 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.

- Annual report of levels and types of violence, aggression, harassment, bullying or abuse reported by staff from patients, their families and from other staff, this report and associated actions is presented at the Workforce Committee.
- Monthly reporting to Board on levels of violence and aggression reported by staff from patients, their families and from other staff.
- Proactively engaging with areas where informal concerns are raised in respect of discrimination
- Working with the partnership team/staff side representatives to communicate with staff around the importance of reporting incidents of bullying, harassment or abuse.
- The freedom to speak up champions continue to support colleagues who raise concerns from a range of professions and bands.

Plans for the next 12 months include a Call it Out campaign to support the Freedom to Speak up agenda, a Diversity and Inclusion festival which will include our first Living Library event enabling our people to share their lived experiences of discrimination, the introduction of a talent management programme focused on supporting the career development of colleagues from marginalised groups, growing our learning resources to increase awareness around diversity and inclusion (specifically as well as generally) and to challenge negative stereotypes and building on the staff ambassador forums.

Ensuring equality and diversity of services is a key undertaking of our organisation. The most significant achievement this year was the development and launch in January 2018 of the Patient Experience and Involvement Strategy. The strategy sets out the developments and improvements for our services in the next 3 years. 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. From the strategy a Patient Experience Improvement Group has been formed and is representative 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 include:

- Continued to work with Lancashire Deaf Rights Group and the wider deaf community to improve access to and delivery of services. There is now a facility available in the Emergency Department for virtual sign language, during core hours of service, enabling the deaf community to access interpreter services more timely.
- 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. This year’s theme focused on End of Life Care and Cancer Services at the request of this community.
- Continued to develop Learning Disability Champions across the Trust
- Continued to develop and implement the NHS England’s Accessible Information Standard
- ‘Browsealoud’ is available 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 are continued to be used in clinical settings, and as appropriate to the needs of people.
- Increased consultation has taken place in terms of estates and facilities to ensure access to services are equitable

- Continuation of the provision for deaf maternity parents in British sign language to enable them to gather information in relation to their care and treatment during pregnancy
- Consulted with patients who have hearing and sight problems in relation to how we can improve access and information
- Encouragement of Pets as Therapy (PAT) dogs invited in all areas across the organisation.
- Participated and provided an action plan for Healthwatch Lancashire to identify accessibility for patients with visual impairments
- Increased the number of Hearing Loops across the organisation, which now form part of the estates plan for improvements as a general requirement
- Identified the need for change to the Patient Advice and Liaison Service and access for our patients. This work is to be progressed within the next year.
- Implemented a Carers Charter to provide patients with the support they need.
- Developed a 'Helping Hands' symbol for patients who have learning disabilities.
- Provided training and awareness and engaged with the 'What Matters Most To Me' concept
- Adopted the 'Hello My Name Is…' ethos as a Trust standard

Future developments will be based on the Patient Experience Involvement Strategy, which highlights all areas of diversity and inclusion.

Staff engagement and consultation

Staff Engagement is essential to help us meet the current challenges the Trust faces including the need to deliver high quality and sustainable services, achieve financial plans, deliver organisational change and transform services. The Staff Engagement Plan focused on maintaining the engagement agenda within the organisation and 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 developing a whole systems approach to the staff survey, which includes communications, analysis, facilitation, and action planning. The aim was to create a culture that placed greater emphasis on staff engagement through organisation-wide plans and improving staff engagement at local level. In the last 12 months there have been a number of achievements including:

- Maintaining the systematic approach to the staff survey which has led to reduced variation in response rates across the organisation, in the 2018 survey 93% of areas achieved the minimum 40% response rate and therefore improved representation of staff voice has been achieved.
- Included bank staff in the staff survey, this provides bank staff with an opportunity to have their say and for us to measure bank staff experience.
- Increasing views of the successful, high profile "24 hours in Maternity" rising from 5,760 views to 7,322 views. This utilised multi-media to showcase the people behind the care, celebrate different roles, create a sense of team, and really show the kind of people we are by showing how we live our values through the way we work. The first series focused on Maternity services and has been successful in delivering improved staff and organisational outcomes. To date the mini-series has been viewed 7,332 times, the social media campaign has reached 90,393 people and has been viewed internationally helping to build our employer brand. Staff survey results in Maternity show improvements in staff recommending the organisation as a place to work, improvements in engagement levels and motivation levels. There has been a steady increase in Friends and Family test

results, a reduction in staff turnover, and an increase of 10 x more applications per post to work in Maternity. The project has won the national Haelo Film award for most innovative concept and is shortlisted for the national Healthcare People Management Award for Excellence in Organisational Development.

- Released series 2 of “24 hours in…Theatres” in June 2018. This series showcases the people behind the care in the theatre teams. To date the videos have been watched 12,000 times and have reached 102,000 people via the social media campaign, helping to build our employment brand. Staff survey results in Theatres show improvements in staff feeling they are recognised and staff feeling the organisation values their work, and staff intention to quite scores are better than the organisational average. Further evaluation is being carried out to determine the impact on other organisational measures.
- Supporting team engagement through the roll out of the Team Engagement and Development tool to a variety of clinical and non-clinical teams. The pilot phase in 2017 included 19 teams. Development of the online tool and resources has been completed to support organisation-wide roll out and since the launch in March 2018 a further 43 teams have engaged in their team development using TED. 6 TED team leader sessions have been delivered to support team leaders to lead and develop their own teams. Feedback from teams using TED is that it helps them identify areas to work on as a team and gives team leaders a framework to focus on.
- Re-introduced Fabulous Feedback Friday, an idea started on our wards which staff told us in the Big Conversations that we should replicate across the organisation. Since the launch in June 2018 17 teams have showcased their team by opening their doors to our senior leaders. It’s an opportunity for teams to show what they do and celebrate their achievements. Feedback from teams involved is that they’re now more aware of who our senior managers are, that those senior leaders showed interest in their work during the visit and are now more aware of what they do as a result of the visit, that taking part made them feel valued, proud and motivated, that it has raised their profile and they enjoyed taking part. There has been a positive impact on the staff survey results, for the majority of the teams who took part, on the following key areas: improved senior manager visibility, increased levels of staff saying they are recognised for good work, and increased levels of staff saying the organisation values their work.
- Thank You is an online peer-to-peer recognition tool which gives people the opportunity to say thank you and receive meaningful feedback. This idea came from staff during our Big Conversation focus groups where they said they wanted us to focus more on the positives and that saying thank you matters. The Thank Yous received sit within the online appraisal portfolio to support quality discussions and nurse revalidation. It was launched in July 2018 and to date 4168 thank yous have been received and this is evenly split between staff in clinical and non-clinical roles. Survey feedback against project objectives has been positive with staff saying: it made me feel valued and recognised, it’s a way to give meaningful feedback, it’s a way to give feedback to people I may not usual thank, it promote a sense of team, it’s helped me understand the difference I’m making and it’s helped me have a meaningful discussion around values. Positive improvements have been in the staff survey results: 46% of staff say the organisation values their work, up from 45% and 56% say they receive recognition for good work, up from 54%. Evaluation shows a positive trend with staff experience because areas with the highest amount of thank yous received have also seen improvements against the following staff experience measures in the staff survey: feeling satisfied with recognition for good work, feeling the organisation values their work, quality appraisal and recommendation of the organisation as a place to work.

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:

- 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 surveys
- staff engagement events
- staff suggestion scheme
- staff intranet
- 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.

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 our 2018 staff survey results largely remain stable and in line with the national average and trends. It is disappointing that the level of staff who would recommend us as a place to work and a place to receive care remains below the national average.

An area of strength remains staff involvement where 76% of staff say they can make suggestions to improve the work of their team / department and 74% say they are frequent opportunities for them to show initiative in their role. Whilst only 54% say they are able to make improvements happen, and so this remains an area of focus. The new 3 year staff engagement plans will continue their focus on embedding the staff survey as a whole systems approach to staff voice and measuring staff experience, improving team engagement through the TED programme, continuing to provide opportunities for Board engagement with the staff engagement agenda, building a sense of team and community, celebrating our achievements, and rewarding and valuing staff. We are committed to improving staff engagement because not only does it underpin quality care but by improving staff engagement we can improve organisational performance and effectiveness. 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

Following the publication of the 2018 staff survey results in March 2019 three Big Conversations focus groups have been held to explore the results as well as three further Equality, Diversity and Inclusion themed staff survey focus groups. These 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.

In March 2019 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 were held for a second year to further support managers to understand their data, identify trends and feel more able to hold conversations with their teams. The Core People Management Programme introduced in 2017 also supports managers to use the staff survey and engage their team. Each division is hosting Big Conversations focus groups at different levels to explore experience in their areas and identify local solutions to bring about improvements. Support has been provided by the Workforce and Organisational Development Team to facilitate the focus groups and formulate local action plans. The Head of Staff Engagement, Retention and Recognition, in partnership with the Strategic Workforce Leads will support directorates with the implementation and monitoring of progress against their individual plans.

The response rate is between 42% and 48%, the final figure is unknown due to reporting problems with the survey provider. Nonetheless the response rate is in line with the national average and is high enough for the data to be representative of the views or our staff.

The main indicators of staff experience are the staff engagement levels and whether staff would recommend the organisation as a place to work and receive care. Overall staff engagement has remained stable with a score of 6.9 / 10 and in line with the national average. An area of strength remains staff involvement where 76% of staff say they can make suggestions to improve the work of their team / department and 74% say they are frequent opportunities for them to show initiative in their role. Whilst only 54% say they are able to make improvements happen, and so this remains an area of focus.

59% of staff would recommend the organisation as a place to work, this remains unchanged and below the national average of 63%. Whilst, 65% of staff would recommend the care of the organisation, this remain unchanged and below the national average of 71%. These remain priority areas for improvement.

In the 2016 staff survey improvements were made against the majority of areas in the staff survey and in the 2017 and 2018 staff survey these results have largely been maintained and staff experience in our organisation is similar to the national average across the majority of questions. There have been some improvements to a small number of questions: staff reporting having an appraisal, satisfaction with pay, staff involved in errors being treated fairly, staff knowing who senior managers are and patient / service user feedback being collected.

There has been deterioration to 3 key themes: Equality, Diversity and Inclusion, Health and Wellbeing, and Bullying and Harassment. However it is important to note that Equality, diversity and inclusion is our second highest performing area, with Health and Wellbeing we perform better than the national average. Finally with Bullying and Harassment this is our third highest performing area and we perform better than the national average.

The three main negative changes:

1. **Equality, Diversity and Inclusion** is an area that needs to be improved. Across the Workforce Race and Equality Standard there has been a deterioration across all experience indicators for our BME staff, however, we generally still remain in a slightly better position than the national average. In relation to the Workforce Disability and Equality Standard our Disabled staff report a worse

experience than our non-Disabled staff across all the indicators, no national comparison data is available.

2. **Staff Health and Wellbeing** has declined most measures in the survey nationally and this trend is reflected in our organisation. Just 31% of staff feel the organisation takes positive action on health and wellbeing, which is a significant decrease from 38% in 2017. However this reflects the national trend and is slightly better than national average.

57% of staff say they have come to work despite not feeling well enough to perform their duties, an increase from 55% in 2017 and in line with the national average.

3. **Bullying and harassment** nationally remains a key theme and within our organisation more staff are saying they are experiencing bullying and harassment. This has increased in our organisation at a greater rate than the national trend, however we remain in line with the national average. 26% of staff say they have experienced harassment or bullying from patients, members of the public of their family members (23% in 2017). 14% of staff say they have experienced harassment, bullying or abuse at work from managers (12% in 2017) and 20% say they have experienced harassment, bullying or abuse from colleagues at work (16% in 2017).

The biggest improvements:

- More staff say the organisation treats **staff involved in errors fairl**y, increasing from 59% to 61%, this was a positive area of focus to improve in the 2017 staff survey action plan.
- More staff say they have had an **appraisal**, increasing from 79% in 2017 to 85% in 2018. This was a priority area for improvement for the organisation. However, the quality of appraisal remains the same at 5.4 /10, which is in line with the national average.
- More staff say they **know who senior managers are** rising from 81% in 2017 to 83% in 2018 and potentially reflects actions such as the re-introduction of Fab Feedback Friday and increased visibility of senior leaders in internal communications. However there has been a decline in perceptions of communication and involvement with senior managers; 37% of staff say communication with senior managers is effective compared to 40% in 201, 32% of staff say senior managers try to involve staff in important decisions compared to 35% in 2017. Whilst 32% of staff say senior managers act on staff feedback.
- **Satisfaction with pay** has noticeably increased from 34% in 2017 to 38% in 2018, potentially reflecting a positive initial impact of the three-year Agenda for Change pay rises.

Top performing areas compared to the national average:

- 50% of our staff say they **don't work any additional unpaid hours** per week for this organisation, over and above contracted hours, this is compared to 42% nationally.
- 56% of our staff say they are satisfied with **opportunities for flexible working** patterns, compared to 52% nationally.
- 57% say they have adequate materials, supplies and equipment to do their job compared to 54% nationally.

Priority areas to address are listed below and these are discussed during Big Conversation focus groups:

- Health and Wellbeing
- Quality Appraisals
- Equality, Diversity and Inclusion
- Safe environment – bullying and harassment
- Senior managers' involvement and communication
- Relationship with and support from immediate managers

A one year staff survey action plan will be developed and supported with “you said”, “we did” communications to respond to staff feedback. The new 3 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.

Learning and Development

The Workforce and Organisational Development team has continued to deliver a range of leadership and management development programmes. In 2018 over 1000 leaders and managers took part in a taught leadership or management development programme. The core people management skills programme continues to be effective with managers reporting feeling more confident and competent at managing staffing issues positively and in line with Workforce Policies. To build on the success of this programme and to ensure all managers are aware of their people management responsibilities this year saw the launch of the What Good Looks Like guidance for people managers, this is linked to appraisal process and supports managers understanding of the tasks and performance measures they are expected to achieve.

The Trust conducted its first succession planning exercise in the last year, which identified business critical roles and potential successors for all Executive level and Board member level roles. This is being rolled out across the Trust and is aligned to the well embedded talent management processes utilised in the organisation.

Compliance with our mandatory training target has increased by 2% (88% total) compared with 86% at March 2017. Mandatory training via e-learning offers staff a flexible and convenient way to complete their mandatory training. This channel is now well established with the majority of staff now opting to undertake their mandatory training using this method of delivery. The expansion of e-learning provision has continued throughout the year with Infection Control and Information Governance added to the portfolio of e-Learning courses.

Enhancements have also been made to the monthly training personalised emails. These list all employees training requirements and compliance against each required event. Categories have been introduced to identify ‘none role specific’ training that an individual may have undertaken. The emails have also been amended to advise employees of forthcoming changes to training requirements. Manager’s compliance reports continue to be circulated monthly to nominated managers. Real time training course flyers are now established which automatically show candidates how many places are available on each course advertised. These flyer update on a daily basis so the information displayed is current.

An e-mail confirmation facility has also been introduced. Once a member of staff books a place on a course, via training and booking, they automatically receive and email confirming their booking. This lists the details of the course including: time, date, venue, subject matter and duration. Additional functionality has been added this year which allows the automated production of course registers which are emailed to the nominated course trainers. Functionally now also exists which sends course completion certificates to all course attendees.

The Clinical 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:

- Delivered an additional 55 places compared to the previous year on 3 week Health Care Assistant (HCA) induction programme to support the target of 200 new HCA posts. Between April 2019 and March 2019 we achieved 234 new HCA starters.

- Current Year 2 NHS Careers Plus students from Cardinal Newman College have achieved places on nurse training, paramedic training (2nd year running) and a direct entry onto Midwifery training.
- Further increased Aseptic Non-Touch Technique compliance from 81% last year to 93%.
- Expanded our Doctor For a Day practical experience taster day for year 13 students to a further 2 schools, Clitheroe Grammar and Bolton Schools. Both visiting schools were very impressed and want to return in the future.
- Delivered our first Paramedic away day course using the new Simbulance for North West Ambulance Service NHS Trust.
- Increased Adult Basic Life Support compliance from 69% to 84% by delivering targeted sessions in clinical areas and additional drop in sessions.
- Taken over the delivery of the Sage & Thyme communications training and have commenced delivery.
- In March 2019, the external examiner from York University praised our running of OSCE exams as ”one of the best run OSCE’s that I have ever observed” in his report.
- We held a celebratory event for our Patients as Educators attended by around 60 patients.

The Placement 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 support them to access undergraduate training for their chosen profession. Some examples of the support offered by the team are:-

- 20 HCAs from within the Trust started a 2 year Nursing Associate Apprenticeship in June 2018 delivered by University of Central Lancashire, a further intake is planned for the end of 2019
- Pre-registration nurse training is delivered in partnership with the University of Bolton, there are now 3 intakes per year in January, May and September, there are currently 160 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.
- Students from 3 of our local colleges attend a Preparation for Nursing Programme to help them ensure they have chosen the correct profession for them and to help them develop their skills to enhance their performance at university interviews.
- A Registered Adaptation Nurse Programme is being delivered, 35 nurses have been recruited and will be supported to convert their international PIN numbers to a UK Nursing & Midwifery Council PIN number. The Trust has also pledged to recruit a further 50 overseas nurses over the next 12 months.
- 4 cohorts of Physicians Associate students are currently being supported by the team and the Trust has just successfully led on an apprenticeship trailblazer to develop the Physicians Associate as an Apprenticeship Standard.
- 11 Physicians Associate students have now been appointed to their first post as a Physicians Associate within the Trust.
- Over 40 inter-professional teaching sessions are offered to our learners annually to compliment 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, the team have supported the re-writing of the 3 years of programme delivered within the Trust.

- 12 new placement areas have been introduced for medical students within the population health module.
- Collaborative Learning in Practice (CLiP) is in place within the Trust across 11 placement areas with more to follow
- 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 and with the new junior doctor contract (2016) and the introduction of the new safe working rules and the national contract conditions (2002). Directorates continue to review the efficiency of rotas, whilst at the same time ensuring that training needs are appropriately delivered alongside service developments. Significant challenges remain in ensuring compliance with planned rotas for a number of reasons including vacant posts in a number of areas. 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 Trust Guardian of safe working. The number of exception reports submitted forms part of the quarterly Guardian of Safe working report which highlights any concerns raised related to hours worked and any concerns related to safe working. Doctors remaining on the national contract conditions (2002) are invited to monitor their working hours biannually however uptake to monitoring is low. The on-going medical workforce strategy will continue to address recruitment pressures.

Occupational health

Financial returns have again been strong in 2018/19 with new contracts to deliver support to Edge Hill University students and Bolton University. A contract for provision to UCLAN students has also been retained for another 4 years. A procurement process has been completed to upgrade the Occupational Health database software and the new system will be active by November 2019. A significant improvement for individual staff members will be the ability to print out their own vaccination history at any time. The system will also link to Electronic Staff Record. The service went through the annual external re-accreditation process in February 2019 with a successful outcome confirming provision of Safe, Effective, Quality, Occupational Health Services (SEQOHS). Feedback from service users also continues to be positive. There have been some challenges with staffing as Occupational Health nurses are in short supply. A new workforce plan has therefore been produced, with options for differing skill mix. A key focus for next year will be to ensure the resources to manage an increasing demand for psychological services, counselling and physiotherapy.

Staff costs

					2018/19		2017/18
	Permanent		Other		Total		Total
	£000		£000		£000		£000
Salaries and wages	247,377		-		**247,377**		257,314
Social security costs	25,863		-		**25,863**		24,743
Apprenticeship levy	1,275		-		**1,275**		1,222
Employer's contributions to NHS pensions	30,139		-		**30,139**		28,733
Pension cost - other	76		-		**76**		-
Other post employment benefits	-		-		**-**		-
Other employment benefits	-		-		**-**		-
Termination benefits	-		-		**-**		48

Temporary staff	-		37,715		**37,715**		12,239
NHS charitable funds staff	-		-		**-**		-
Total gross staff costs	**304,730**		**37,715**		**342,445**		**324,299**
Recoveries in respect of seconded staff	-		-		**-**		-
Total staff costs	**304,730**		**37,715**		**342,445**		**324,299**
Of which							
Costs capitalised as part of assets	-		-		**-**		-

Consultancy costs	
2018/19	2017/18
£000	£000
778	2,525

Average number of employees (WTE basis)

					2018/19		**2017/18**
	Permanent		**Other**		**Total**		**Total**
	Number		**Number**		**Number**		**Number**
Medical and dental	807		59		**866**		821
Ambulance staff	-		-		**-**		-
Administration and estates	616		52		**668**		676
Healthcare assistants and other support staff	2,824		278		**3,102**		3,077
Nursing, midwifery and health visiting staff	1,970		154		**2,124**		2,023
Nursing, midwifery and health visiting learners	-		-		**-**		-
Scientific, therapeutic and technical staff	647		9		**656**		658
Healthcare science staff	228		3		**231**		224
Social care staff	-		-		**-**		-
Other	-		-		**-**		-
Total average numbers	**7,092**		**555**		**7,647**		**7,479**
Of which:							
Number of employees (WTE) 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 53 – 56 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 the 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 2019, for more than £245 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2019	3
Of which:	
Number that have existed for less than one year at time of reporting	1

Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	2

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

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, 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 2018 and 31 March 2019	5
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	
Number for whom an IR35 was conducted	5
Of which:	
Deemed inside IR35	4
Deemed outside IR35	1

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

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.	7

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	1	1
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
Total number of exit packages by type	0	1	1
Total resource cost	£0	£30,000	£30,000

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

Values 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
59	50.7
Percentage of time spent on facility time	
Percentage of time spent on facility time during the relevant period	Number of employees
0%	10
1-50%	46
51-99%	0
100%	3
Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period	
Total pay bill	£312,012,000
Total cost of facility time	£89447.21
Percentage of pay spent on facility time	0.03%
Paid trade union activities	
Hours spent on paid facility time:	6331
Hours spent on paid trade union activities	594
Percentage of total paid facility time hours spent on paid TU activities	9.38%

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. NHS Improvement, 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

NHS Improvement 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.	5, 27, 96, 97
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.	19 – 22, 46 – 49, 106, 107

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.	96 – 100
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.	97 – 98
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.	19 – 21
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.	19 – 21
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	19 – 21
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.	46 – 49
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	47
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.	19
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.	27, 99
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.	25 - 27, 48, 50, 90, 91, 111

Code ref.	Summary of requirement	See page(s):
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.	25 - 26, 90
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, 85 – 86, 92 - 93
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.	25 - 27, 92 - 94
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.	110
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.	106 – 111
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
Code ref.	**Summary of requirement**	**See page(s):**
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	27, 28, 90, 91, 97, 105

	contact, surveys of members' opinions and consultations.	
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.	101 - 105
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.	29, 100
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.	101 – 105
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.	24, 97

"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;	62 – 64
The foundation trust's policies in relation to disabled employees and equal opportunities;	60 - 62, 89
Information on health and safety performance and occupational health;	15 – 16, 69
Information on policies and procedures with respect to countering fraud and corruption;	110
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	11
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;	33, 39, 61
Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas	42 - 45
Any other public and patient involvement activities.	39, 87 - 89, 103 - 105
The number of, and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Notes 5.2 and 5.3 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	11
Sickness absence data	59
Details of serious incidents involving data loss or confidentiality breach	91

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	12, 13
Equality reporting	60 - 62, 89
Slavery and human trafficking statement (Modern Slavery Act 2015)	28

NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

Single Oversight Framework

NHS Improvement'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

As at 24 May 2019 NHS Improvement has placed the Trust in segment 3. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website. During 2015/16 the Trust became in breach of its licence conditions and on 18 June 2015 NHS Improvement (formally Monitor) accepted enforcement undertakings given by the Trust pursuant to powers under section 106 of the Health and Social Care Act 2012. NHS Improvement (formally 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 17th May 2018 the Trust was issued a new set of enforcement undertakings which were formally accepted by the Trust on 29th May 2018. For details of the enforcement undertakings and the Trust's progress made against them, please see the Annual Governance Statement.

This segmentation information is the Trust's position as at 24 May 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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 that finance and use of resources is only one of the five 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	2018/19 scores				2017/18 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	I&E margin	4	4	4	4	4	4	4	4
Financial controls	Distance from financial plan	2	2	1	1	4	4	3	2
	Agency spend	2	2	1	1	2	2	2	2
Overall scoring		3	3	3	3	4	4	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 NHS Improvement.

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, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, 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 issued by NHS Improvement, 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.

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 her 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.

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
24 May 2019

ANNUAL GOVERNANCE STATEMENT 2018-19

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation 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 foundation 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 Foundation Trust Accounting 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 2019 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 quality. The Nursing, Midwifery and AHP Director, supported by the Medical Director and 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 staff all of whom are in post

to support the organisation and the Trust Board in meeting its governance responsibilities. The Governance Directorate 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 Integrated Governance and Risk Group for further consideration.

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. 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. Board committees 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 Board committees. During 2018/19 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 2018/19 and beyond. The effectiveness of the Trust's governance structures continued to be tested during 2018/19 via the Annual Internal Audit Programme.

Training

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 Risk Management team are responsible for undertaking training for all staff on Risk Management and Incident Reporting. A key priority for the Risk Management Team during 2018/19 was to review and improve the Trust's risk management training to ensure that it remains responsive to the needs of Trust staff. 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). The focus during 2018/19 has remained on ensuring compliance with mandatory training and appraisal requirements and the Trust has continued to demonstrate good levels of compliance. Monitoring and escalation arrangements are in place 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 Risk Management Group. Further mechanisms for ensuring the sharing of transferrable lessons – as well as good practice – will continue to be explored during 2018/19, including working with other organisations and learning from best practice elsewhere.

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

The Board considers at every board meeting whether there are issues or risks to be escalated to appropriate economy forums, such as the Central Lancashire Quality Improvement Board (CLQIB), the Central Lancashire A&E Delivery Board or the Integrated Care Partnership (ICP) Board. The Trust actively encourages networking and has strong links with relevant central bodies, e.g. National Health Service Resolution (NHSR), Health and Safety Executive (HSE), and acts on recommendations / alerts from these bodies as appropriate.

The Trust has established trusted relationship with the Care Quality Commission (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 and 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 the 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 Care Quality Commission (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 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 Integrated Governance and Risk Group scrutinises these reports, seeks clarification from divisional representatives and, where appropriate, requests more in depth reports and additional evidence. As part of this reporting process Divisions also highlight minor risks that have a maximum score of 5 in probability and consequence. In turn, The Integrated Governance and Risk 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 risk. Principal risks that impact on the Trust's ability to meet its strategic objectives are recorded on the BAF. During 2018-19, the Trust developed its "Big Plan", detailing what it's key priorities are over the next three years, key risks associated with achieving the "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 board committee, 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 2018/19 and this will continue into 2019/20 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.

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 board committee oversight of principal risks to the organisation's strategic aims and oversight by the risk management committee 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; and
- '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 2018/19 we have continued to strengthen our risk management arrangements, including through our monthly Integrated Governance and Risk Group (formally known as the Risk Management Committee) meetings, which is an operational committee reporting into the Safety and Quality Board Committee. Integrated Governance and Risk 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 2018/19 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 are monitored through the business planning and performance management frameworks. 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 for the Trust, as identified within the board assurance framework for 2018-19, related to:

1. high levels of bed escalation, occupancy and patient cancellation;
2. challenges associated with a financial deficit position;
3. availability of medical workforce and impact on sustainability of clinical services, particularly Emergency Medicine;

4. inability to recruit and retain the required number of nurses, midwives and AHPs;
5. system resilience;
6. non-delivery of the targets and indicators set within regulatory and compliance frameworks;
7. adherence to the agency ceiling set by the regulator;
8. weaknesses in corporate safety systems ;
9. the current configuration of our EPR system;
10. external cyber-attack impacting on Trust's business continuity; and
11. lack of availability of operational and strategic capital.

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.

Safety and Quality

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

- The Trust has in place 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 Trusts 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.
- The Trust has in place a Safety and Quality Committee (a committee of the Board) 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 Integrated Governance and Risk Group.
- The Trust publishes 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.
- The Trust has in place 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 chairs the Clinical Audit Committee. The Safety and Quality Committee retains a challenge and assurance role in respect of mortality and the Audit Committee has retains a challenge and assurance role in respect of clinical audit.
- STAR Quality Assurance Framework has been introduced into all ward and outpatient areas and is monitored via a programme of STAR visits.

- A programme of Board Visits is in place to all wards & departments – clinical and non-clinical – in order to ensure that there is 'Board to Ward' oversight and ownership of quality & 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.
- 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 & Public Involvement representatives, such as Health Watch and Trust Governors.
- Patient and Staff Stories are presented to the Trust Board monthly and actions and lessons learned are widely shared.
- Key risk issues are also discussed with governors at formal council meetings.
- Where appropriate, risk alerts are made to partner organisations in line with statutory responsibilities, such as for safeguarding purposes.
- The clinical commissioning group (CCG) systematically reviews Trust delivery of the contract and key risk issues are discussed through the contract process.
- The clinical commissioning group (CCG) undertake Quality Assurance visits at our Trust and provide feedback and recommendations.
- The Trust Board considers at every board meeting whether there are safety and quality issues that need to be escalated to the economy-wide Central Lancashire Quality Improvement Board, which was established during 2017. In addition, risks relating to emergency care and urgent care would be escalated to the Central Lancashire A&E Delivery Board for further discussion and resolution.

The effectiveness of the Trust's governance structures was externally tested during 2018/2019 via the CQC undertaking an inspection of the organisation during 2 unannounced 3 day inspections commencing on 12th June 2018 and 19th July 2018. 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 report in October 2018, with an overall view that the Trust 'Requires Improvement'. Although the Trust retained the same rating, 16 Core Domains and 4 Service Lines including Surgery, Maternity, Services for Children and Young People and Outpatients have moved to 'Good' from 'Requires Improvement'; however the existing challenges remain within the Responsive domain. The findings demonstrate the significant progress made since the last inspection, indicating the Trust have 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.

To deliver the recommendations in the CQC report 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.

Capacity and Flow

During 2018-19 the Trust has continued to experience significant operational pressures. The Trust has failed to achieve its objectives in relation to Accident and Emergency Waiting Times during Quarter 2, 3 and 4, 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 2018-2018 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:

- Intensive Support Team engaged by the Trust to offer advice and guidance.
- The Trust is working closely with the Emergency Care Improvement Programme (ECIP) team.
- Development of a Trust-wide Quality Improvement Plan and the establishment of an economy-wide Central Lancashire Quality Improvement Board to monitor delivery of the plan.
- 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 2018-2019 the Trust set up a range continuous Improving and transformational work streams of which patient flow has a significant work plan attached to this.
- Our Trust included as part of the Flow Coaching Academy.

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 2018-19.

Financial Sustainability

The Trust remains in breach of its NHS Improvement Licence conditions and has a single oversight framework segmentation of 3, 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 vacancy rate, and the need to insource additional expensive unplanned capacity to meet demand and improve flow.

The reported year-end operational deficit was £50.4m, £4m away from plan. Whilst the Trust achieved £22.1m savings in 2018/19, a considerable achievement, this was against a challenging savings target of £25m. At the end of 2018/19 there remained two outstanding areas in relation to our existing enforcement undertakings to the regulator:

i. *Liquidity:* For 2018/19 the Trust has a planned deficit of £46.441m excluding impairments and funding from the Provider Sustainability Fund which it did not qualify for. This plan was dependant on achieving a Performance Efficiency Target (PET) of £25m (5% of income). During the year the Trust benefited from enhanced support from NHS Improvement and from a Financial Improvement Director. However the Trust has recorded a deficit in these accounts of £50.444 against this target mainly as a consequence of unachieved PET in the year. For 2019/20 the Trust is planning for a deficit of £37.050m excluding impairments and support funding, although this is again dependant on a PET of £25m. Working capital loans have been made available to support the deficit of the Trust, ensuring liabilities are met, and these are continuing to be available in 2019/20. The current working capital loan of £20.5m from the Department of Health has only been extended until March 2020, and the working capital facility of £30.4m falls due for repayment in April 2020. It has been indicated that these facilities will be extended further while the Trust remains in deficit.

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 Our Health Our Care programme. The Joint Committee of CCGs met in March 2019 and approved a whole health economy model of care, from wellbeing and health, and primary care services through to acute services. This platform has now progressed onto the options development stage. 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 during 2019/20.

In Q4 2017/18 we were informed by NHS Improvement that they would be issuing a new set of enforcement undertakings to the Trust. On 17th May 2018 the Trust received from NHS Improvement the proposed new enforcement undertakings, which relate to: (i) taking all reasonable steps to improve our financial position, minimise our external funding requirement and to deliver our services on a financially sustainable basis, and (ii) complying with funding conditions and spending approvals. The Trust monitors its compliance against the enforcement undertakings via the Finance and Performance Committee on a quarterly basis.

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.
- establishing seven dedicated productivity and efficiency delivery groups which formally report into the Executive Committee;
- approval of the two year operational plan submission by the Board;
- approval of the annual budget by the Board;
- monthly Finance and Investment Committee meetings to ensure Directors meet their respective financial targets reporting to the Board;

- bi- monthly Divisional Performance Meetings attended by the Executive Team to ensure that Divisions meet the required level of performance for key areas;
- weekly Executive Committee meetings to review risks and issues escalated through the Financial Improvement governance structure;
- engaging a Finance Improvement Director;
- the Trust has continued to utilise its Transformation 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 CIP schemes.

Patient & 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 Health Watch.

The Our Health Our Care programme has provided significant opportunity during 2018/19 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 Greater Preston, Chorley and South Ribble. To date we have held eight Solution Design Events, which have brought together approximately 480 attendees, representatives from the whole health & social care economy including Consultants, GP's, 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 over 2000 clinical hours. During 2018/19 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, schools and so forth.

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 for members to inform the public of new developments and items of interest.

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 & 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.

Carbon Reduction

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Managing Conflicts of Interest

The Trust has published on its website its register of interests, gifts and hospitality for decision making staff as required by the 'Managing Conflicts of Interest in the NHS' national guidance.

Workforce Strategies and Staffing Systems

The Trust has a comprehensive Trust-wide workforce plan in place which is approved by the Board via the Workforce Committee on an annual basis. This identified the basis of workforce requirements in respect of all staff groups.

The Performance report presented at each board meeting contains reports on safe staffing for nursing in all ward areas and a guardian of safe working report is also presented to the Board quarterly in respect of non-consultant medical staffing. Further safe staffing reports are being introduced in 2019.

Review of board effectiveness

The Trust as a whole reviews its own leadership and governance arrangements periodically. In line with the requirements of NHS Improvement 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. Part of the review required the Trust to undertake a self-assessment. The self-assessment process involved reflecting on current ways of working, potential development needs, and scoping areas for more detailed review by the independent reviewer. The final self-assessment was congruent with 6 of the 8 indicators. For the remaining indicators one was deemed to be lower than our assessment in relation to the quality of data reviewed and was deemed to be higher than our assessment in relation to the learning and continuous improvement.

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 OD Strategy.

Deloitte highlighted 19 recommendations for improvement which the Trust has incorporated into the QIP 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 board sub-committee 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 2018/19 via the Annual Internal Audit Programme. Mersey Internal Audit Agency, the Trust's internal auditors, provided an overall opinion of moderate assurance, based on their work during 2018/19.

We continually strive to improve our governance structures and in April 2019 the Trust Board adopted a comprehensive Governance Maturity Plan and an integrated governance and risk handbook.

The Board also strives to improve its effective working relationship and engagement with the Council of Governors and, during 2018/19 reviewed and refreshed its Board and Council Engagement Policy and also held numerous joint development sessions with governors on topics of mutual interest and benefit.

Furthermore, the Trust's Governance Maturity Plan has a particular focus on improving the Board's engagement with, and visibility amongst, key stakeholders, such as the Council of Governors and staff throughout the organisation. For further details on the Board's engagement with governors please see pages 27-28 and pages 96 - 100.

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 (IG) assessment report overall score for 2018/19 was 81% and was graded as satisfactory (green) with Level 2 being achieved in 25 initiatives and level 3 in 19 initiatives. This demonstrates an achievement for the IG Team as the Trust remains consistent with the scores in accordance with last year's position of 81% being also being achieved.

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.

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 Integrated Governance and Risk Group and Board of Directors. 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 the Information Governance Toolkit assessment and by participation in the Information Governance Assurance Framework.

The Trust has completed the Information Governance Toolkit assessment for 2018/19 and Board of Directors has received a report regarding its system for control of Information Governance. The Trust is green rated on the Information Governance Toolkit. Internal assurance is also provided by the Trust's internal auditors to support the assessment provided by the Trust. Through 2018/19 the Trust has been working towards demonstrating compliance through the 'Data Security and Protection (DSP) Toolkit which requires organisations to demonstrate that they are implementing the ten data security standards recommended by the National Data Guardian Review as well as complying with the requirements of the General Data Protection Regulation (GDPR). During 2019/20 an area of continued focus for the Trust is to improve levels of compliance for mandatory Information Governance training for staff.

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. 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 in the NHS foundation trust annual reporting manual.

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

- Board and Safety and Quality Committee minutes and papers for the period April 2018 to March 2019
- Clinical Governance Committee minutes and papers for the period April 2018 to March 2019
- papers relating to quality reported to the board over the period April 2018 to March 2019
- the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
- the 2018 national inpatient survey (subject to publication)
- the 2018 staff survey

- friends and family test responses
- safety incidents, clinical audit and complaints data

As stipulated in the NHS foundation trust annual reporting manual 2018-19, 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, 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 tests, 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 clinical commissioning group 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, for example in respect of infection prevention and control and cancer services.

Systems & 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 2018/19 with the introduction of a revamped Integrated Performance Report which will bring information and risks together in one place. This will also be informed by learning from other Trusts.

People & 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 Use & Reporting to support delivery of the Annual Quality Account

- 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 every monthly 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 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. The external auditors have been engaged by the council of governors to perform an independent assurance engagement in respect of the content of the quality report.

Review of effectiveness

As Accounting 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 foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to 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 2018/19 is that moderate assurance can be given that there is an adequate system of internal control.
- 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 board committees 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 positive findings of the independent Well-Led Review carried out in 2018 which demonstrated the recent development of the revised approach to divisional governance and accountability arrangements to strengthen clarity of roles and expectations.
- The findings of the CQC Inspection Report that noted governance structures were working effectively in all but one core service.

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 2018/19. Where control issues have been identified, action has been taken or action/improvement plans are in place to address such issues. The Trust Board is satisfied that plans are adequate to ensure delivery of these targets or improvements during 2018/19. Where appropriate these action/improvement plans will be tested via relevant external scrutiny and review processes.

This Annual Governance Statement is signed on behalf of the board of directors by:

Karen Partington
Chief Executive
24 May 2019

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 2018/19, 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 Age UK Lancashire, 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 governor 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 2018, the terms of office of five public governors (3 posts for a three-year term period and 2 posts for a one-year term period) and one staff governor (representing doctors and dentists) came to an end. 1,420 votes were cast in the public election and 88 votes were cast in the election for staff governor representing doctors and dentists. This represents a turnout of 11.7% and 15.4% respectively. 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 12.0% and 15.5% respectively.

Ahead of this year's election process, we carried out various governor recruitment activities to promote the role of the governor, such as: the issuing of a 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 43. 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 meetings.

Board and council engagement

As the chairman chairs both the board of directors and the council of governors, she 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/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 the Big Plan at their quarterly Council of Governor meetings. We have also encouraged governor 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. We have also introduced a rota system for non-executive director attendance at council meetings; regular attendance by non-executive directors at council meetings provides governors with 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 2018/19 this was held by public governor, Nicola Leahey.

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 organised 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 six formal council meetings during 2018/19, four of which were quarterly meetings (April 2018, July 2018, October 2018 and January 2019) and a further two extraordinary council meetings held in December 2018 and March 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	6	6	100%
Rebecca Allcock	26/06/14 – 31/03/20	Staff: other healthcare professionals and healthcare scientists	6	6	100%
Frank Batin	01/04/17 – 31/03/20	Public	6	6	100%
Alistair Bradley	18/05/16 – 17/05/19	Appointed	6	3	50%
Helen Bradley	01/04/11 – 31/03/20	Staff: nurses and midwives	6	5	83%
Tricia Calderbank	01/04/13 – 31/03/19	Staff: non-clinical	6	2	33%
John Daglish	15/07/11 – 31/03/20	Public	6	6	100%
Margaret France	01/04/17 – 31/03/20	Public	6	5	83%
Michelle Hall*	01/04/16 – 31/03/19	Public	1	1	100%
Dylis Hayton	01/04/14 – 31/03/20	Public	6	4	67%
Anne Heywood	01/04/18 – 31/03/19	Public	6	5	83%
Steve Heywood	01/04/16 – 31/03/19	Public	6	6	100%
Javed Iqbal**	10/12/15 – 01/05/19	Appointed	6	2	33%
Mark Jarnell*	01/04/17 – 31/03/20	Public	1	1	100%
Ken Jones	01/04/11 – 31/03/20	Public	5	5	100%
Nicola Leahey	01/04/11 – 31/03/20	Public	6	6	100%
Karen Leckie	01/04/18 – 31/03/21	Public	6	5	83%
Lynne Lynch	01/04/15 – 31/03/21	Public	6	5	83%
Janet Miller	01/04/17 – 31/03/20	Public	6	6	100%
Steve Mills	01/04/18 – 31/03/19	Appointed	6	5	83%
Alan Morrow	01/04/10 – 31/03/19	Public	6	4	67%
Jacqueline Mort	15/06/17 – 14/06/18	Appointed	1	0	0%
Margaret Newsham*	01/04/17 – 31/03/20	Public	6	5	83%
Eddie Pope	15/06/17 – 11/07/21	Appointed	6	3	50%
Frank Robinson	01/05/18 – 31/03/19	Public	5	4	80%
Gurvinder Sahota	10/11/15 – 09/11/21	Appointed	6	3	50%
Michael Simpson	01/04/18 – 31/03/19	Public	6	5	83%
Teri Stephenson	18/10/18 – 17/10/21	Appointed	4	2	50%
Donna Studholme	06/11/17 - 17/10/18	Appointed	2	1	50%
Huw Twamley	01/04/18 – 31/03/21	Staff: doctors and dentists	6	3	50%
Karen Walton	03/07/18 – 02/07/19	Appointed	5	4	80%
No governor currently represented for the Universities of Central Lancashire, Lancaster or Manchester					
No governor currently represented for the Youth Forum					

A = maximum number of meetings the governor could have attended during 2018/19
B = number of meetings the governor actually attended during 2018/19
**Stood down as a governor during 2018/19*
***Exceptional circumstances due to ill health*

Director attendance at council of governors meetings

The following directors attended council meetings during 2018-19
Sue Musson, Chairman
Karen Partington, Chief Executive
Paul Havey, Finance Director / Deputy Chief Executive
Karen Swindley, Strategy, Workforce and Education Director
Ailsa Brotherton, Director of Continuous Improvement
Faith Button, Deputy Operations Director
Gail Naylor, Nursing, Midwifery and AHP Director
Tony Gatrell, non-executive director
Jim Whitaker, non-executive director
Alastair Campbell, non-executive director
Tim Watkinson, non-executive director
Geoff Rossington, non-executive director
Jeannette Newman, 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 2018/19, our governors have participated in a number of workshops, including the following topics:

- Continuous Improvement: this session provided governors with insight into the Trust's Continuous Improvement Strategy and its key priorities.
- Council of Governors annual effectiveness review: this session involved reviewing the themes and trends arising out of the Council's annual effectiveness review and agreement of development actions to be taken.
- Review of the Trust's Constitution and consideration of the Trust's code of conduct investigation process.

- The Trust's forward planning process: we held an interactive forward planning workshop with Board members and Governors to review, comment and provide feedback on the Trust's four key ambitions.
- Joint development session between the Board of Directors and the Council of Governors on 'Holding to Account' as facilitated by the Trust's internal auditors, MIAA.
- Joint development session between the Board of Directors and the Council of Governors on the Trust's key priorities for its End of Life Care Strategy, and for Mental Health and Learning Disabilities.
- Trust Appointment letters: the Clinical Business Manager for Patient Access and Patient Flow provided an update to governors on the ongoing project to review and improve the Trust's appointment letters, a project that governors have been closely involved in.
- An update on the Trust's AHP Workforce and their key contribution in delivering care.

Governors are encouraged to attend external education and training events. NHS Providers and Mersey Internal Audit Agency 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 2016/17 and 2017/18, the following expenses were claimed by our governors:

	2017-18	2018-19
Total number of governors in office (as at 31 March)	28*	29**
Total number claiming expenses:	10	13
Aggregate sum of expenses (£00):	£30	£51

Two vacant governor seats: vacant public governor seat and a vacant appointed governor seat for the Universities of Central Lancashire, Lancaster and Manchester

****Two vacant governor seats: vacant appointed governor seat for the Universities of Central Lancashire, Lancaster and Manchester and a vacant appointed governor seat for the Youth Forum***

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 of our Trust 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:

- are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least twelve (12) months, or
- have been continuously employed by the Trust for at least twelve (12) months, or
- are not so employed but who nevertheless exercise functions for the purposes of the Trust and who have exercised functions for the purposes of the Trust for a continuous period of at least twelve (12) months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis.

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 2019	31 March 2018	Difference	% Difference
Public	11,389	12,078	- 689	- 5.70%
Staff	7,773	7,509	+ 264	+ 3.51%
Total Membership	**19,162**	**19,587**	**- 425**	**- 2.17%**

During 2018/19 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 house and also ensuring that deceased members have been removed, minimising potential distress to relatives caused by sending out communications addressed to them. This has caused a 5.7% reduction in the number of public members during 2018/19 compared with membership figures for 2017/18. Recruitment activity has also 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

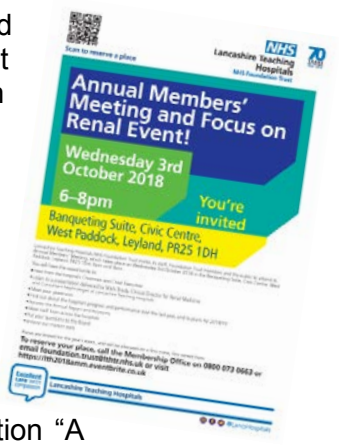
During 2018/19 we developed our Membership Management and Engagement Strategy 2019-2022, in consultation with governors, which was endorsed by the Council of Governors on 29 April 2019. Our vision for the Membership is to have an informed, engaged and involved membership which is able to fully represent the needs and experiences of its community by actively participating in influencing and shaping how the services are provided. The strategy outlines five objectives that are incorporated into the membership engagement plan for 2019/20; 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 2018/19

Members who have expressed a preference for a high and medium level of involvement (level three and level two) are contacted regularly to provide information about opportunities for engagement. We also issue Trust Matters, the membership magazine twice a year, with up to date information on service developments and delivery against strategic priorities. It also includes a dedicated governors' section featuring ways in which governors are representing members, engagement activities and how members have influenced decision-making and service development.

Our annual members' meeting was held in October 2018 and provided members with a summary of the highlights of our performance, and set out our plan for the year ahead. Furthermore the meeting was used as an opportunity to promote the renal services of the Trust and provide a platform for governors to discharge their statutory duties in representing the interests of trust members and the public.



Renal is one of the specialist services at Lancashire Teaching Hospitals and was selected in order to showcase and promote some of its amazing services and also to enable the team to highlight the critical shortage of organs in the UK. Delegates were able to meet and chat with governors and senior managers before visiting display stands themed around Renal Services. Attendees were able to observe a PowerPoint presentation "A Patient's Journey with Kidney Disease." The interesting and informative presentation was delivered by one of our senior clinicians with support from his colleagues. Following the presentations there was further time for members to visit the interactive display stands and learn more about the innovative services provided by our Renal Services.

In partnership with the communications department, social media has continued to prove a useful tool throughout the year to promote events, the opportunity to stand for election to the Council of Governors and to provide information to the public and members.

We have offered numerous and wide ranging opportunities for members to become involved in our work and directly affect the planning and development of our services during 2018/19:

- The 17th consecutive Health Meal was held in Preston at the University of Central Lancashire's Foster Building in April 2018. Many of our staff, along with governors supported the event in order to promote and share information about our services.

- We promoted a further local health meal event to our members; Leyland Health Meal in October 2018. Governors had a promotional display at the event which provided them with the opportunity to engage with the public and network with third sector organisations

staffing other promotional stands, listening to their views, raising the governor profile and informing them of the work of our Trust.

- In May 2018 we held a Listening Event; the aim was to provide an opportunity for governors to exercise one of their most important roles by gaining essential views and opinions from Foundation Trust members and the wider public. The event was a huge success with everyone attending giving meaningful input and feedback about their own experiences and concerns regarding the hospitals' services and environment. Many people commented that they felt that they had been listened to by senior and managers and clinicians. The outcome of the event was immensely useful and will help us to develop our future plans to continually improve the way we provide their care.

- The development of a youth forum established this year was promoted to our younger members. Youth Voice is aimed at ensuring children and young people have their voice heard within our hospitals.

- In July 2018, members were invited to family fun days as part of the celebrations of the NHS turning 70, it was the perfect opportunity for us to look back at our achievements and promote what we do; as well as look forward to the next 70 years.

- The Nursing Directorate introduced STAR a new quality assurance framework to governors and members in 2017. STAR (Safety Triangulation Accreditation Review) has been designed by staff, and will help us monitor, review and improve quality standards throughout our clinical areas. We continue to invite members to get involved through our dedicated members' magazine, Trust Matters.

- We continue to work collaboratively with our partners via Our Health Our Care, 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.

- Through the bi-annual members' magazine that we produce, we ask foundation trust members if they would like a visit from our governors in order to speak with their community groups, charities or any interested groups. Governors visited several community groups throughout 2018/19 in order to listen to their views and give feedback to senior management, recruit new members and raise the governor profile.

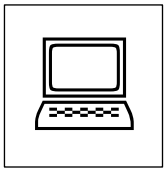
As evidenced in the engagement work outlined above, our governors gain the opinion of foundation trust members and the wider public at member events hosted by our hospitals and other external community organisations. Governors play a key role in seeking the views of members and the public on our services, and this information is in turn, used to inform governors' views in relation to our objectives, priorities and strategy. Governors can then ensure that these views are shared with the board of directors as part of joint planning work 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 adoption of the new 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.



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 2018-19. 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 health care and governance standards are accurate, robust and can be relied upon. I am very clear as chair 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. During 2018/19 the four members were: Jim Whitaker, Jeannette Newman, Ann Pennell and myself. Each member has been selected on the basis of their individual skills and attributes. Jeannette is a qualified accountant, with a range of relevant financial knowledge and experience and particular expertise in strategic communications and is also the Chair of the Trust's Finance and Performance Committee. Jim is a Chartered IT Professional with the British Computer Society and his areas of particular expertise are strategic planning, managing change, governance and risk management and is also the Chair of the Trust's Workforce Committee. Ann has had a long executive career in local government including senior roles in children's services, corporate improvement and housing, and has particular expertise in governance, strategic planning and quality and service improvement and is also the Chair of the Trust's Safety and Quality Committee. My background is as a qualified accountant with over 25 years' experience in senior audit positions in the public sector, including the roles as Group Chief Internal Auditor for the Ministry of Justice and District Auditor for the Audit Commission. I was previously a Chief Internal Auditor in the NHS.

The audit committee has met four times between 1 April 2018 and 31 March 2019 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 director and medical director, 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 levels of escalation; and
iv. recruitment and retention of clinical staff and managing the Pay bill.

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 these key issues.

Financial Reporting

The Audit Committee has reviewed the Trust's performance as outlined in the 2018/19 annual financial statements and has discussed with management the reasons for the main changes compared to the financial statements for 2017/18.

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 2018/19 highlighted as significant audit opinion risks:

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

The risk in relation to the valuation of land and buildings has been carried through from 2016/17 and 2017/18 however during 2018/19 the Trust commissioned a full revaluation of land and building assets by an external valuer for the purposes of the 2018/19 annual financial statements, in line with the Trust's policy of having a full revaluation every 5 years and annual desktop valuation between full valuations. In respect of this the external auditors: (i) assessed the competence, capability, objectivity and independence of the external valuer; (ii) agreed the information provided to the valuer by the Trust to underlying records of the estate held; (iii) reviewed the output of the revaluation and challenged management on key assumptions that were used in the valuation assessment for reasonableness; (iv) relating to those assets which were revalued during the year, they reviewed the accounting entries made to record the results of the revaluation in order to ensure that they were correct and appropriate; (v) held discussions with the valuer to fully understand and challenge the assumptions made during the course of their valuation; (vi) assessed the continued appropriateness of the 'alternative site' valuation methodology and the continued relevance of the theoretical alternative site for the purposes of valuation; (vii) critically assessed the Trust's formal consideration of other indications of impairment and surplus assets within its estate, including the process undertaken and the adequacy of the formal, written decision document used in the process; and (viii) considered the adequacy of the disclosures about the key judgements and degree of estimation involved in concluding whether there has been any material movement in the value of land and buildings since 31 March 2018.

The risk in relation to the recognition of NHS and non-NHS income has been carried through from 2017/18. The external auditor considered there to be a significant risk around revenue from patient care activities and other income (excluding education and training income which is largely recognised in line with pre-agreed contract values). In order to address this risk, the external auditors tested the recognition of NHS income through the Agreement of Balances exercise and tested non-NHS income by sample testing the balance and ensuring that amounts recognised had been classified correctly within income and had been appropriately recognised in year. They also performed sample testing over the accrued and deferred income balances to ensure that the amounts had been recognised appropriately and correctly classified in the financial statements.

They also adopted cut off procedures in order to gain assurance that income has been correctly recognised in the period.

The risk in relation to management override was considered to be a default significant risk. The external auditors' response included testing the operating effectiveness of controls over journal entries and post-closing adjustments, and assessing the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates.
During the year the audit committee received reports from internal audit on the Trust's financial systems and capital expenditure processes, the discussion of 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 General Ledger & Financial Reporting, Budgetary Control, Treasury Management, Income & Debtors and Accounts Payable.

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.

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.

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) Capital Scheme Review for Ophthalmology and Critical Care (a review of whether there were competitive processes in place for the procurement of those companies providing professional services to the Trust and that there were robust processes in place to approve proposed designs to ensure that that they delivered a fit for purpose, value for money scheme)
(ii) Critical Applications (a review of the Cancer Track system which facilitates the tracking of cancer patients through their care pathway, and a review of the DATIX system)
(iii) Financial Systems & Financial Integrity
(iv) Conflicts of Interest
(v) Data Protection and Security Toolkit and a 'GDPR Readiness Assessment'
(vi) Workforce reviews including Sickness Absence, Equality & Diversity Risk Impact Assessments, and ESR / HR Payroll Controls
(vii) Divisional Risk Maturity (an evaluation of the effectiveness of the current arrangements through the undertaking of a Risk Maturity review at Divisional level)

The organisation's systems for monitoring and managing the achievement of activity targets have been discussed by the committee at several meetings. Internal audit has conducted reviews into several areas and reviewed the resulting findings and where necessary the management action plans with the committee.

The committee receives all internal audit reports and pays particular attention to any 'Limited 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, two audits have provided High Assurance, four audits have provided Substantial Assurance, four audits have provided Moderate Assurance, two audits have provided Limited Assurance and none have provided No Assurance. The Assurance Framework Opinion met requirements. Additional support was provided by the internal auditors by way of a formal development session for the Board of Directors and the Council of Governors on 'Holding to Account'. (*Further details of the audits, particularly the Limited Assurance audits, are contained within the Audit Committee Report*).

The Director of internal audit has provided an overall opinion of Moderate Assurance based on their work during 2018-19.

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 'Significant Assurance' or some other positive assurance. However, the committee was concerned to receive two reports with Limited Assurance from the internal auditors in key risk areas for the Trust, namely the critical care/ophthalmology capital scheme and sickness management. The committee considered the underlying control weaknesses in these areas, referred the reports to the Board and other relevant committees and will continue to seek assurances regarding the required improvements. Additionally, the Trust has continued to experience some difficulty in achieving its financial plans and meeting its operational targets, and the committee will continue to seek assurance on the steps being taken to ensure improvements can be made in 2019/20 and beyond.

Compliance

With respect to regulatory compliance, towards the end of quarter 4 of the 2014/15 financial year NHS Improvement (formally Monitor) opened an investigation into the Trust's financial resilience. On 18 June 2015 NHS Improvement 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 17th May 2018 the Trust was issued a new set of enforcement undertakings, which were formally accepted by the Trust on 29th May 2018. For details of the enforcement undertakings and the Trust's progress made against them, please see the Annual Governance Statement. An internal audit in respect of the new enforcement undertakings is scheduled within the 2019/20 internal audit plan. The Trust's forward plan and its going concern status forms part of the external audit plan and opinion, from which the committee can take assurance.

The internal audit assurances sought by the committee on the achievements of activity targets detailed in the previous section are clearly linked to the Trust's ability to comply with its statutory requirements. The committee's activity plan for 2018/19 included internal audit work on the organisation's systems for achieving activity targets and regulatory compliance. During 2018/19 the board assurance framework was reviewed and a significant assurance given by the internal

auditors, and a review of the Information Governance Toolkit was undertaken during 2018/19 of which there were no significant issues reported.

Our external auditors

For the 2018/19 financial year KPMG LLP was paid £76,680 for statutory audit, as shown in note 3 to the accounts, which was slightly higher than the 2017/18 sum (£72,000) due to the group accounting element. KPMG were also paid £9,400 (excluding VAT) for the statutory quality report audit for the Trust during 2018/19, which was consistent with the 2017/18 sum.

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, with the support of the Audit Committee and formally ratified by the Council of Governors on 23rd April 2018.

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.

Oiur internal auditors

Our internal audit function is provided by Mersey Internal Audit Agency (MIAA). Our team at MIAA consists of a director and an assistant director of internal audit, along with a dedicated audit manager. The internal audit programme is risk-based and is aligned to our strategic risk assessment. MIAA attend our risk management committee meetings in order to inform their planning processes. 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.

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. Following a process agreed by the Audit Committee, bids were invited and interviews held with interested companies; the Audit Committee awarded the contract to MIAA who would be reappointed for a three-year term with effect from 1 April 2016, with the option to extend 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 Mersey Internal Audit Agency and they deliver the service in line with NHS Protect standards. In 2018/19 the anti-fraud specialist has carried out numerous anti-fraud awareness events across both hospital sites (including a MIAA cyber security event), an

online anti-fraud staff survey, anti-fraud training for staff and an anti-fraud benchmarking exercise which illustrated that the Trust's fraud referrals were at a comparable level.

Audit Committee attendance summary from 1 April 2017 to 31 March 2018

Name of Committee member	A	B	Percentage of meetings attended (%)
Tim Watkinson (Committee Chair)	4	4	100%
Jim Whitaker	4	3	75%
Jeannette Newman	4	3	75%
Ann Pennell	1	1	100%

A =maximum number of meetings the member could have attended during 2018/19
B = actual meetings attended during 2018/19

Audit Committee effectiveness

The committee undertakes a self-assessment on an annual basis, with the last self-assessment taking place on 23rd April 2019. A formal evaluation questionnaire was distributed to all attendees of the Audit Committee in advance of the meeting. The survey was designed based on the committee's current terms of reference and cycle of business; the committee's development plan; feedback from the CQC and Deloitte following the Trust's last well-led inspection; and my feedback as Committee Chair.

Through the survey, all attendees were invited to provide their comments and views on whether we are discharging our responsibilities as per the committee's terms of reference; what the committee's areas of strength and weaknesses are; how the committee interacts with other board committees and the board; and how we can improve.

The themes arising from the survey results were shared with all attendees for discussion in the form of a workshop facilitated by me as Committee Chair. A number of areas for action were highlighted during the course of the session and these build upon previous developments which have been implemented and are now reflected in the committee's development plan.
The overall conclusion of the review was that the committee considers it is delivering its core duties effectively, is appropriately served by the internal auditors, the external auditors and by the Trust management, and continues to address the challenges associated with its wider remit.

The committee's commitment to an annual effectiveness review reflects the committee's attentiveness to its responsibilities and its desire to operate effectively in light of its important role as part of the overall governance framework for the Trust.

Tim Watkinson
Audit Committee Chair
24 May 2019

This Accountability Report is signed on behalf of the board of directors by:

Karen Partington
Chief Executive
24 May 2019

Lancashire Teaching Hospitals NHS Foundation Trust

QUALITY REPORT
2018/19

PART 1

Chief Executive's Statement

This report provides an overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period April 2018 to March 2019.

The ongoing issues of an ever growing demand, more complex care requirements and finite resources means The National Health Service is facing an unprecedented challenge, and we face the same problems here a Lancashire Teaching Hospitals NHS Foundation Trust.

In 2018-2019 our performance against national targets has been mixed and we have not achieved the nationally set timescales in a number of areas, such as the Emergency Department Waiting Times and some cancer pathways. However, despite the operational and financial challenges we face, our staff continue to work hard to improve services for our patients. We are working in partnership with Lancashire Care, 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 programme*. You can find out more about this on the Lancashire Teaching Hospitals website.

The Care Quality Commission (CQC) carried out an inspection of our hospitals in July 2018, and we were given an overall rating of 'requires improvement.' Whilst the overall rating remains the same as last year, the majority of services at both hospitals have improved and are now rated as 'good' which is significant progression since the previous inspection in 2016. We're now working towards an overall 'good' status for our next inspection, and we have produced a detailed Quality Improvement Plan, which sets out everything we need to do to address all the issues identified by the CQC, to ensure we are providing the standards of care that our patients deserve.

We have recently published our *Big Plan* which sets out our direction of travel and goals for the next three years. The Big Plan outlines our overall mission, strategic aims and how every team and department contributes to it. Our *Continuous Improvement strategy* provides a framework for the development of a culture of ongoing improvements to our services.

We're extremely proud of the incredible achievements of our staff, with so many winning local and national awards for their innovative solutions to improving care and services. During 2018 - 2019 there were 141 shortlisted or winners of awards.

I would like to thank all our staff and local partners for their dedication and support in our ongoing ambition to continually deliver excellent care with compassion for our patients. In summary, I am pleased to present the 2018-19 Quality Account. The information provided represents an accurate account of progress and highlights achievements as well as areas for improvement.

I can confidently declare that, to the best of my knowledge, the information in this document is accurate. The Trust's external auditors will review the processes and mechanisms through which data is extracted and reported in the Quality Account Report 2018-2019 to provide further assurance.

Karen Partington

Chief Executive

PART 2

2.1 Priorities for Improvement

During 2018 -19 the Trust has undertaken extensive engagement with staff to develop priority strategies including a *Continuous Improvement Strategy* which outlines the continuous improvement methodology that is being adopted across the organisation and a *Big Plan* which outlines the strategic aims of the organisation and the specific objectives which will be achieved annually for the next three years.

This has been developed through engagement and prioritisation with the divisions. The Trust Board recognises our strategies are ambitious and have therefore also undertaken an engagement exercise to realign the divisions to ensure strong leadership teams are in place to lead the implementation of the strategies.

The Accountability Framework has also been updated to align to the strategic priorities. Further embedding of Trust values is a key priority as they are the foundation of the Trust and should constantly underpin all our efforts in providing excellent care with compassion. Trust values will be a fundamental and constant element of all staff training from induction throughout 2018/19 and beyond.

Trust values

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

Our 3-year Nursing, Midwifery, Allied Health Professional and Care Givers strategy which can be found at https://www.lancsteachinghospitals.nhs.uk/strategy was launched in 2018 and sets out a series of key commitments:

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

As part this strategy the trust has committed to delivering over a **3 year period**:

-  **A 10% reduction in the number of hospital acquired pressure ulcers**
  This has not been achieved due to a number of reasons. One of which is the increase in the number of patients admitted to hospital. As a result of this, this measure will now be measured in per 1000 head of population to ensure we can accurately understand the incidence of pressure ulcers. The pressure ulcer improvement project is now part of the continuous improvement patient safety collaborative supported by the Continuous improvement team

-  **A 10% reduction in patient falls**
  The number of falls has continued to reduce:
  - The end of year falls incident rate has decreased by 6.89% from 1234 falls in 2017-18 to 1149 falls in 2018-19

- The end of year falls with harm incident rate has decreased by 4.67% from 279 falls with harm in 2017-18 to 266 falls with harm in 2018-19

- **A 10% increase 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, 21525 have been reported. This represents a 11% increase.

- **A STAR status of 50% of wards and departments rated as silver by September 2018 with 25% of those rated as gold standard by February 2019**
  This goal has not been fully met during this reporting period however currently 23% of wards and departments have achieved a silver STAR rating. The STAR team have inspected all clinical departments with the exception of four departments which will be complete by the end of April 2019. The decision was made to focus on the re-inspection of the red rated areas to drive improvements in those departments and wards that were not at the minimum amber standard.

The trust priorities from 2018- 19 will continue for 2019-20, reflecting the 3 year performance objectives and aspirations of the Big Plan and associated strategies. These will continue to be monitored and managed through the arrangements described in the relevant documents.

In 2018 the Trust also launched a Patient Experience and Involvement Strategy. This strategy, which can be found at https://www.lancsteachinghospitals.nhs.uk/strategy has been developed with staff, governors and organisations throughout the local and wider community and aims to:

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

During 2018-2019, the patient experience and involvement group increased the size of its membership to more accurately reflect the community it represents. The group has successfully contributed towards the design of a number of patient information projects including:

- **Welcome boards**
- **Behind the beds boards**
  To ensure that staff can, at a glance, be informed of their care needs
- **Addressing environmental constraints to positive patient and carer experiences**
  A scoping exercise was undertaken by a group of governors to improve the facilities for patients and families through the provision of rest rooms at ward level.

- **Involvement of patients and family members in review of patient care pathways.**

  As part of listening to feedback, patients and their families have participated in the design of a new bathroom for disabled children on the children's ward, the use of lanyards for carers across the organisation and the design of the new Surgical Assessment Unit. Within the Maternity services, a maternity voices partnership meets regularly to improve the experiences of women and their partners. The group has specifically led to improvements in the experience of women in the antenatal period, in theatre and postnatally.

- **Addressing communication issues for patients and carers**

Improving access to high quality information has been addressed in a number of ways during 2018 -19 including:-

- The purchase of 100 hearing loops across the organisation
- Improved pictorial signage for use in ward areas
- An increase in the use of translation services for patients whose first language is not English
- Our Learning Disability team have worked alongside our Learning Disability community to create easy read resources
- Posters created to encourage parents to raise concerns under the title 'it's ok to ask'
- The use of a Values+ initiative to raise awareness of the importance of compassionate communication with patients and users of our services

Friends and family feedback is now available for all inpatient areas. During the reporting period 2018-19 this has increased in children and neonatal services and Allied Health Professional areas. The Trust has seen a continued improvement in all areas with the exception of the Emergency Department where patients reported adverse experiences over the winter period.

In 2018 the trust held the first support staff conference, where we delivered unconscious bias training to ward clerks, reception and support staff. The day included Values+ training.

During 2018-19 the Trust adopted a continuous improvement approach and appointed a Director of Continuous Improvement and a Head of Continuous Improvement. Initial work has been undertaken to ensure foundations are in place for the adoption of a Continuous Improvement (CI) approach, including the development and launch of the Continuous Improvement strategy and development of a web based CI toolkit.

Improvement programmes delivered have included the design, delivery and implementation of the system wide urgent and emergency care programme (following a Value Stream Analysis design event) and participation in national and regional external improvement programmes, including the NHS Improvement ECIST SAFER collaborative and the North West Ambulance Service 'Every minute matters' collaborative.

In order to adopt a robust approach to Continuous Improvement, the Trust has committed to delivering improvement programmes at a system (macro), pathway (meso) and local department and ward (micro) level. Each of the improvement programmes will commence with a diagnostic and review of baseline data.

The systems level improvement programmes are part of the Healthier Lancashire and South Cumbria Integrated Care System (ICS) and locally through the Central Lancashire Integrated Care Partnership (ICP). The detail of the partnership improvement programmes are presented in the Annual Report 2018-19 on pages 6, 7, 43, 44 and 88.

In January 2019 the Trust launched the Workforce and Organisational Development Strategy, the overarching aim of which is to make Lancashire Teaching Hospitals a *Great Place to Work* to work and the best place in the whole NHS. The strategy has six areas of priority which are:

1. To attract, recruit and resource
2. To be inclusive and supportive
3. To be well led
4. To be responsive and service focussed
5. To create a positive organisational culture
6. To engage and retain our staff

The priorities for the year ahead will be the implementation of a robust workforce planning process to drive proactive recruitment including the review of induction and on-boarding of new staff and succession planning to our business critical roles, bringing about further cultural change through ongoing measurement and delivery of change, supporting middle and senior leadership development, creating a truly inclusive workplace and identifying new ways to enable our staff to flourish and be well at work.

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 with the narrative which is mandated in the quality account regulations.

1.0 During 2018 - 19 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted forty six relevant health services.

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

1.2 The income generated by the relevant health services reviewed in 2018 - 19 represents 100 % of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2018 - 19.

Participation in Clinical Audits

2.0 During 2018-19 forty five 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 96%[2] national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

[1] List of national clinical audits as per specification provided by the DH cited on the HQIP website https://www.hqip.org.uk/wp-content/uploads/2018/05/NHSE-QA-List-2018-19-FINAL.pdf

2.2 The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2018 - 19 are as follows:

Clinical Audit
National Clinical Audit
Adult Community Acquired Pneumonia
BAUS Urology Audits – Cystectomy, Nephrectomy, Percutaneous Nephrolithotomy (PCNL) Radical Prostatectomy
Case Mix Programme (CMP)
Child Health Clinical Outcome Review Programme
Elective Surgery (National PROMs Programme)
Falls and Fragility Fractures Audit Programme (FFFAP)
Feverish Children (care in Emergency Departments)
Inflammatory Bowel Disease programme / IBD Registry
Learning Disability Mortality Review Programme (LeDeR)
Major Trauma Audit
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection
Maternal, Newborn and Infant Clinical Outcome Review Programme
Medical and Surgical Clinical Outcome Review Programme
Myocardial Ischaemia National Audit Project (MINAP)
National Asthma and COPD Audit Programme
National Audit of Care at the End of Life (NACEL)
National Audit of Dementia
National Audit of Seizures and Epilepsies in Children and Young People
National Bowel Cancer Audit (NBOCA)
National Cardiac Arrest Audit (NCAA)
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)
National Comparative Audit of Blood Transfusion programme
National Diabetes Audit – Adults
National Emergency Laparotomy Audit (NELA)
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Maternity and Perinatal Audit (NMPA)
National Mortality Case Record Review Programme
National Neonatal Audit Programme (NNAP)
National Oesophago-gastric Cancer (NAOGC)
National Ophthalmology Audit
National Paediatric Diabetes Audit (NPDA)
National Prostate Cancer Audit
National Vascular Registry
Neurosurgical National Audit Programme
Non-Invasive Ventilation - Adults
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)
Sentinel Stroke National Audit programme (SSNAP)
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance
Seven Day Hospital Services

[2] The Trust did not participate in the one national audit due to incompatibilities with IT systems (National Diabetes Audit). However the Trust fully participated in the Insulin Pump element of this audit programme. The remaining audit which the Trust did not participate in was the National Ophthalmology Audit due to software costs.

Surgical Site Infection Surveillance Service
UK Cystic Fibrosis Registry
Vital Signs in Adults (care in Emergency Departments)
VTE risk in lower limb immobilisation (care in Emergency Departments)

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 2018 – 2019
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Studies collecting data during 2018 – 2019 • Long-Term Ventilation Study 2018 • Acute Bowel Obstruction (2018) • Pulmonary Embolism Study (2018)

2.3 The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2018 - 19 are as follows:

Clinical Audit	**Trust Participated**
National Clinical Audit	
Adult Community Acquired Pneumonia	Yes
BAUS Urology Audits – Cystectomy, Nephrectomy, Percutaneous Nephrolithotomy (PCNL) Radical Prostatectomy	Yes
Case Mix Programme (CMP)	Yes
Child Health Clinical Outcome Review Programme	Yes
Elective Surgery (National PROMs Programme)	Yes
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes
Feverish Children (care in emergency departments)	Yes
Inflammatory Bowel Disease programme / IBD Registry	Yes
Learning Disability Mortality Review Programme(LeDeR)	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
Myocardial Ischaemia National Audit Project (MINAP)	Yes
National Asthma and COPD Audit Programme	Yes
National Audit of Care at the End of Life (NACEL)	Yes
National Audit of Dementia	Yes
National Audit of Seizures and Epilepsies in Children and Young People	Yes
National Bowel Cancer Audit (NBOCA)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Clinical Audit of Specialist Rehabilitation for Patients with	Yes

Complex Needs following Major Injury (NCASRI)	
National Comparative Audit of Blood Transfusion programme	Yes
National Diabetes Audit – Adults (National Diabetes Audit Insulin Pump audit)	Yes (part)
National Emergency Laparotomy Audit (NELA)	Yes
National Heart Failure Audit	Yes
National Joint Registry (NJR)	Yes
National Lung Cancer Audit (NLCA)	Yes
National Maternity and Perinatal Audit (NMPA)	Yes
National Mortality Case Record Review Programme	Yes
National Neonatal Audit Programme (NNAP)	Yes
National Oesophago-gastric Cancer (NAOGC)	Yes
National Ophthalmology Audit	No
National Paediatric Diabetes Audit (NPDA)	Yes
National Prostate Cancer Audit	Yes
National Vascular Registry	Yes
Neurosurgical National Audit Programme	Yes
Non-Invasive Ventilation - Adults	Yes
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes
Sentinel Stroke National Audit programme (SSNAP)	Yes
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes
Seven Day Hospital Services	Yes
Surgical Site Infection Surveillance Service	Yes
UK Cystic Fibrosis Registry	Yes
Vital Signs in Adults (care in emergency departments)	Yes
VTE risk in lower limb immobilisation (care in emergency departments)	Yes

National Confidential Enquiries	**Trust Participated**
Clinical outcome review programmes / National Confidential Enquiries	
Maternal, Infant and New-born Clinical Outcome Review Programme (MBRRACE-UK) Child Health Clinical Outcome Review Programme	Yes N/A
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Studies collecting data during 2018 – 2019 • Long-Term Ventilation Study (2018) • Acute Bowel Obstruction (2018) • Pulmonary Embolism Study (2018)	 Yes Yes 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 2018 – 2019, 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.

Clinical Audit	Clinical cases required	Actual number submitted
National Clinical Audit		
Adult Community Acquired Pneumonia	Data collection only just opened	
BAUS Urology Audits – Cystectomy, Nephrectomy, Percutaneous Nephrolithotomy (PCNL) Radical Prostatectomy	No set number, as met criteria	Latest HES data for 2015, 2016 and 2017 combined Cystectomy 87 % of the total of 103 cases Nephrectomy 92.19 % of the total of 269 cases expected PCNL 71 cases (total number of procedures performed) Radical Prostatectomy 83.2 % of the total of 245 cases expected
Case Mix Programme (CMP)	No set number, as met criteria	Data for 2017/18 1719 admissions both hospital sites
Elective Surgery (National PROMs Programme)	No set number of questionnaires for completion, as patients met criteria	Data for Hip replacement 1st April 2017 – 31st March 2018 (final). Published Feb 2019 data on Modelled records Hip replacement 139 Hip replacement primary 120 Revision 19
Falls and Fragility Fractures Audit Programme (FFFAP)	No set number of questionnaires for completion, as patients met criteria	Data collection for this audit has changed from a 1 week snapshot audit to a continuous audit where we are notified of cases to submit. One case identified to date
Feverish Children (care in emergency departments)	5 consecutive patients per week between 1st Aug 2018 – 31st Jan 2019	105
Inflammatory Bowel Disease programme / IBD Registry	Audit did not collect data during 2018. This has moved to a registry now	
Learning Disability Mortality Review Programme(LeDeR)	Review of patients who died in the Trust identified with a learning disability	1st April 2018 – 31st December 2018 total reviewed 9
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	Jan-Nov 2018 824 Case ascertainment percentage 92 =100%
Mandatory Surveillance of Bloodstream	No set number, as met criteria	Figures are from April 18 – January 19 E.coli 54 MSSA 15

Infections and Clostridium Difficile Infection		MRSA 0 Clostridium Difficile 37
Maternal, Newborn and Infant Clinical Outcome Review Programme	No set number, as met criteria	Neonatal deaths (April 2018 to February 2019) 12 Still birth 14 (2018)
Myocardial Ischaemia National Audit Project (MINAP)	No set number, as met criteria	CDH 84 RPH 191
National Asthma and COPD Audit Programme	Audit now moved to a continuous audit to form part of best practice tariff	COPD: CDH 213 RPH 268 Asthma CDH 45 RPH 73
National Audit of Care at the End of Life (NACEL)	No set number, as met criteria	Both sites 80
National Audit of Dementia	Minimum 50 cases (max 100)	CDH 56 RPH 56
National Audit of Seizures and Epilepsies in Children and Young People	No set number, as met criteria	44 are registered, (this does not include those screened and excluded), 7 are awaiting verification.
National Bowel Cancer Audit (NBOCA)	No set number, as met criteria	Latest figures 1st April 2015 – 31st March 2016 913 cases
National Cardiac Arrest Audit (NCAA)	No set number, as met criteria	1st April 2018 – 31st December 2018 CDH 20 RPH 65
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	NCASRI data collection finished in January 2018	NCASRI data collection finished in January 2018
National Comparative Audit of Blood Transfusion programme	No set number, as met criteria	Management of Maternal Anaemia – 20 patients Audit of the management of major haemorrhage – 10 patients Audit of the use of Fresh Frozen Plasma, Cryoprecipitate and of Transfusions for Bleeding in neonates and children - 2 neonate patients. 6 paediatric patients
National Diabetes Audit – Adults (National Diabetes	Organisation audit completed and returned. Trust is now eligible to take part in the Libre for which we have registered	

Audit Insulin Pump audit)		
National Emergency Laparotomy Audit (NELA)	Rolling - no set number, as met criteria HES recommends 120	31st March 2018 – 30th November 2018 196 cases
National Heart Failure Audit	No set number, as met criteria	CDH 186 RPH 124
National Joint Registry (NJR)	No set number, as met criteria	647 forms submitted
National Lung Cancer Audit (NLCA)	No set number, as met criteria	Latest data available 1st December 2015 – 31st December 2015:- 313 cases
National Maternity and Perinatal Audit (NMPA)	No set number of births at Trust	Latest data from April 1015 - March 2016:- 3838
National Mortality Case Record Review Programme	Trust deaths (1st April - 31st Oct 2018) 836* *Source Dr Foster Intelligence. Latest upload Oct 2018	1st April 2018 – 31st March 2019 total reviewed:- 609
National Neonatal Audit Programme (NNAP)	No set number, as met criteria	RPH NICU from 1st January 2017 to 31st December 2017 468 babies admitted; 7.6% missing data
National Oesophago-gastric Cancer (NAOGC)	No set number, as met criteria	Latest figures 1/4/16 – 31/3/17 185 cases
National Paediatric Diabetes Audit (NPDA)		204 cases
National Prostate Cancer Audit	No set number, as met criteria	Latest figures 1st April 2016 – 31st March 2017 292 cases
National Vascular Registry	No set number, as met criteria	AAA 73 Carotid 103 Angioplasty 371 Bypass 106 Amputation 58
Neurosurgical National Audit Programme	UK Shunt Registry	678 (draft report 2017)
Non-Invasive Ventilation - Adults	Data collection only just opened	
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	No set number, as met criteria (this is a CQUIN)	2a – 50 records per month 2b – 50 records per month 2c – 30 records per month (randomised from the 50 records above)
Sentinel Stroke National Audit programme (SSNAP)	No set number, as met criteria	CDH 14 RPH 537
Seven Day Hospital Services	No set number, as met criteria	For the mandated Spring report the Trust submitted 202 cases. For the Autumn return data collection for this is currently under review expecting to submit 80 cases

		across 4 Specialities (no national reporting structure)
Surgical Site Infection Surveillance Service	No set number, as met criteria. Mandatory for Hip and Knee ops under PHE for SSI	Oct 17 – Sept 18 Hip 217 cases, 0 SSI Knee 205 cases, 3 SSI
UK Cystic Fibrosis Registry	It is not an audit as such. It is a requirement to get Cystic Fibrosis tariff and the Trust is doing this	

2.5 The reports of 50 national clinical audits were reviewed by the provider in 2018 - 19 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

2.6 Table of intended actions

Title of Audit	Intended Actions
National Seven Day Services	A number of work streams are ongoing that will support achieving the 4 priority standards for 7/7 services, including: • Ambulatory Care Pathway development • CUR / SAFER / red2green • Bed reconfiguration • Discharge pathways Oversight of these work streams is provided through the Trust Non-Elective Programme Board. The Trust contributes to the 6 monthly national 7 day service data collection exercise, the results of which are reported through the Trust Clinical Governance Committee. Based on the last survey results, the Trust is currently achieving 3 of the 4 priority clinical standards. Achieving Clinical Standard 5: Access to Diagnostics Clinical Standard 6: Access to Consultant-directed Interventions and clinical standard 8: Ongoing daily review by a Consultant. The Trust did not meet Clinical Standard 2: Emergency admissions to have a Consultant review within 14 hours of admission, but the latest audit showed an improvement as follows: Weekday performance increased from 62% (Sept 2017) to 71% (May 2018) Weekend performance increased from 81% (Sept 2017) to 88% (May 2018) CS2 Overall performance increased from 67% (Sept 2017) to 76% (May 2018)
Mouth Care Matters - 6 Month Audit	• Increase staff awareness and support staff in delivering mouth care • Ensure suitable mouth care products are stocked on the wards • Develop a Trust Oral Hygiene & Mouth Care Guidelines for Hospital In-Patients
BTS National Adult Bronchiectasis Audit 2017 (CDH). Published March 2018	• A self-management plan leaflet was designed and is now available for patients
BTS National Adult	• All clinicians are now educating patients during their clinic

Bronchiectasis Audit 2017 (RPH). Published March 2018	consultations about the need to provide sputum samples prior to starting antibiotic therapy • Patient self-management plan leaflets have been completed and are now in use. Copies on the Trust Intranet
National Paediatric Diabetes Audit 2018. Published July 2018	• Complete contract agreement with Lancashire Care Foundation Trust and progress to advert for the post of a Clinical Psychologist • To monitor patients with high HbA1C through MDT meetings to assess and tailor management accordingly • To understand reasons behind high HbA1through a focussed audit project • Application submitted and approved to participate in a Quality Improvement collaborative programme
MBRRACE 2017 Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death. Published November 2017	• Adequate resource and training to be given to enable all intrapartum deaths to be systematically reviewed to facilitate organisational learning: a) Using a standardised tool/methodology and following the relevant national Serious Incident Frameworks, including review of the contributory factors b) By an appropriate multidisciplinary panel include obstetricians, midwives and pathologists and, as appropriate, a neonatologist and anaesthetist • Due to differing local circumstances maternity services should develop local guidance that clarifies the actions that should be undertaken when serious problems arise in a home birth, either planned or unplanned
National Pregnancy in Diabetes 2016 Published October 2017	• Improve communication with diabetic women to increase knowledge and uptake of preconception advice and preparation for pregnancy. Optimise HbA1c and folic acid 5mg dosage via leaflet given to all post-natal and post-miscarriage patients • Reduce mother and baby separation postnatally - new hypoglycaemia pathway introduced and new zero separation policy increasing skin to skin contact in theatre
The National Hip Fracture Database (NHFD) 2017	• A Business plan was submitted to apply for a 2nd theatre for hip fracture patients to avoid surgical delays
BTS Audit of Bronchoscopy 2017	• Provide patients with clear instructions about omitting anticoagulant and antiplatelet medication before their procedure • Give patient reminder calls to ensure they attend the list.
Peri-operative incidence of Anaphylaxis (NAP 6) Sixth National Audit Project of the Royal College of Anaesthetists	• Update preoperative assessment documentation to include questions regarding Penicillin allergy. Ensure there is clear documentation of anaphylaxis Y/N? or just a rash • Updated perioperative antibiotic prophylaxis guidelines to be displayed in all anaesthetic rooms. Also to be distributed via anaesthetic Team Leaders to all anaesthetic practitioners • Referral pack to be developed for referral to Immunology. This is to be communicated within department regarding the new referral process
BAD Audit of Psoriasis 2017	• Continue using current BAD & NICE standards for assessing and managing people with psoriasis • Patients with any type of psoriasis who do not have a diagnosis of psoriatic arthritis will be offered an annual assessment for psoriatic arthritis, and a validated tool should be used e.g. psoriasis epidemiology screening tool

Study Title	Study Period	Report Publication Date	Feedback Action To Date
NCEPOD Audit of patients presenting with mental health problems to the ED	All patients attending with mental health problems to ED. 01/06/2017 - 30/06/2017	Sept 2017	Education sessions on mental health aspects of emergency care have been delivered Introduction of Mental Health grab pack at CDH Review access to interpreting service for Mental Health patients Issue's raised with the Clinical Director and Clinical Business Manager for ED re issues with Urgent Care Centre referrals
NCEPOD Cancer in Children, Teens and Young Adults	The aims of this study are to study the process of children, teens and young adults under the age of 25 years who died/or had an unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy	Oct 2018	Although we sent an initial spreadsheet of data to NCEPOD, none of the patients met the criteria for this study, therefore NCEPOD did not request any further clinical data from the Trust
NCEPOD (Child Health Clinical Outcome review programme) - Chronic Neurodisability, focusing on cerebral palsy study (Report published in March 2018)	To identify the remediable factors in the quality of care provided to children and young people with chronic disabling conditions, focusing in particular on cerebral palsies. To examine the interface between different care settings and the transition of care	March 2018	An action plan is not appropriate at this time because of the implications for both the Trust and community services. This would involve health economy involvement which requires more time for consideration

2.7 The reports of 462 local clinical audits were reviewed by the provider in 2018 -19 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

2.8 Table of intended actions

Title of Audit	Resulting Actions
Re- audit of VTE Assessment and IPC Use of Ward 21	• To maintain the completion of VTE assessments. The consultants will allocate a doctor in each team on ward round to complete the VTE assessments and to ensure that it is documented on the prescription chart • There is now a Flowtron Chart on the ward that nursing staff should complete during each shift to confirm that patients have been assessed for Flowtrons

	• 100% of patients during this audit had a VTE assessment, compared to just 9% in the original audit. • 71% of eligible patients had Flowtrons on, compared to just 20% in the original audit
Compartment Syndrome Education	• A successful new teaching programme has been implemented within Ward 4, which nurses are actively encouraged to attend. There was, a consultant led teaching session directed at nursing staff • As a result of the teaching programme there is significant improvement in the knowledge of staff of compartment syndrome on the wards
Interval time of relapse to steroids. Compare practice against NICE guidelines.	• Regular bi-yearly educational sessions with the MAU team have been planned
Re-audit on Duration of corticosteroid treatment in COPD exacerbation	• Improved adherence to standard guidelines in prescribing the duration of corticosteroids for COPD exacerbation • All COPD patients admitted with exacerbation received corticosteroids
Audit of temperature management of major trauma patients	• Raise awareness of current practice in temperature management prehospital and highlight importance by liaison with prehospital teams/ NWAS/ Air ambulance • Ensure necessary resources for temperature control available in ED by: 1.Ensure thermometers available 2.Consider implementation of underbody Bair hugger to ease practical difficulties/ become part of process on arrival 3. consider updating trauma audit proforma to include temperature control
Unanticipated Difficult Airway Correspondence	• To write a guideline on when there should be correspondence between anaesthetists, GPs and patients regarding a difficult airway and draft a template for the correspondence
Reducing the time taken for death certificates to be completed	• Poster placed on all medical wards highlighting the GMC requirement and local targets for completion of MCCDs (Medical Certificate of Cause of Death) • A "Friday Deaths Protocol" has been developed and this has been emailed to medical wards and doctors and posters put up on the wards • A teaching session was delivered at FY1 teaching in order to educate the new FY1 doctors face-to-face about the importance of completing the MCCD in a timely manner • An email was sent to junior doctors in the medical division about the bereavement team including location, opening hours and contact number with a reminder to contact the team if they are struggling to attend to complete the MCCD within these hours
Physiotherapy Documentation Audit in MSK and Women's Health at CDH	• Each assessment form to be amended to include all relevant prompts/cribs to adhere to CSP (Chartered Society of Physiotherapist) guidelines • To arrange departmental training sessions on SOAP notes and legal issues (the SOAP note is a method of documentation employed by health care providers to write out notes in a patient's chart)

Diagnosis and management of delirium in ICU	• Add a checklist for delirium patients in Quadramed
NG Feeding in Critical Care: Aspiration for Glory	• The team writing the new protocol includes medical, dietetic, nursing and pharmacy input. Changing the Critical Care Unit NG Feeding Protocol to 24 hour volume based feeding would enable us to better meet our patients' nutritional requirements • A new method of checking NG tube position to be included
Critical Care Unit Activity Audit	• Based on the result some changes were incorporated in next rota, ensuring one airway competent doctor is always there in unit to deal with any crisis emerging even at the time of referral outside unit
Quality and Safety of Handover in intensive care	• All Doctors will be given a simulation training and introduced to a model video about an ideal handover and the appropriate use of SBAR for handover • Introduce a mandatory ward watcher update Consultant on call, for that day, will designate one person to handle the bleep during the handover • Consultant on call, for that day, will designate one person to handle the bleep during the handover
Pre-Treatment Dental Assessments (DA) and Extractions in Head & Neck Oncology Patients	• Restorative dentistry will introduce a new pilot scheme in conjunction with the Cancer services improvement facilitator, commissioners and Tier 2 Oral Surgery Providers. This scheme will allow for referrals for extractions to Tier 2 in primary care, reducing delays and streamlining the process further • To obtain patient feedback from patients regarding Tier 2 service
Ward storage of Insulin Products and Hypoglycaemia Treatments for Diabetic Emergencies	• "Hypo boxes" have now been introduced onto wards at Preston & Chorley to treat hypoglycaemia quickly
Shoulder Dislocation	• There was a teaching session on pain scoring and the use of sedation leaflets on 22nd June 2018 and there will be another session on 22nd September 2018.
Audit for Repeat OGD for Gastric Ulcers	• Endoscopists to be regularly encouraged to adhere to the guidelines • Unhealed benign ulcers should be referred to the upper GI MDT for advice • All referrals for patient surveillance/ fast tracks are now input on Quadramed and then exported on an electronic database so all endoscopists can ensure a follow up referral is completed or the patient will be missed off
Does the implementation of a ward round proforma in a medical ward improve adherence to best practice guidelines?	• A standardised pro-forma to document ward round notes has been provided to the doctors on the Gastroenterology ward
Assessing efficacy of outpatient Novasure and	• Analgesia regime to be revised by including analgesia in outpatient hysteroscopy with Novasure and Minitouch (theatre procedures)

Minitouch Endometrial Ablation	
Critical Care Rehabilitation guidelines audit including risk assessment, comprehensive clinical assessment and goal setting	• The dietetic assessment has now been re-labelled as goals. There are plans to build a form into Quadramed. Measuring dietetics outcomes is an ongoing process in the department. For critical care specifically there is work going into this on an national level
Outpatient SLT (Speech & Language Therapy) Voice Group Audit Pilot 2017	• Voice group to be arranged every 6 weeks for the patients currently on the ENT waiting list
An Audit to assess the number of failed appointments in OMFS Oral Maxillo Facial Service	• Text messages to be sent automatically 24-48hrs prior to appointment
Neonatal mortality 2017	• Joint bereavement visits to be offered by obstetrics and neonates teams
BCG (TB Vaccine) vaccine coverage	• Trust BCG (vaccine for tuberculosis) Guidelines updated • To continue with prospective monitoring of DNA rates on quarterly basis • SOP (standard Operating Procedure) for BCG referrals implemented
Re-audit of Smoking in Pregnancy	• Obtain sufficient CO monitors to equip midwives involved in antenatal care • Approach the blended learning team to see if VBA (very brief advice) in pregnancy can be added to the Trust blended learning site
Are we following the guidelines for Oncotype DX in Breast Cancer	• Oncologists to attend breast MDT to ensure patient suitable for chemotherapy prior to sending Oncotype • Re-audit in 2 years to see if TailorX data has made any impact on chemotherapy use
Case Note Documentation in Orthoptics	• Individual Orthoptists/Optometrists who do not currently have a stamp have been asked to order a stamp and use in all case notes. Replacement stamp pads will be ordered and stock held in the department • New Starter packs that are distributed to new team members will include a case note documentation section that will clearly state the minimum standard required • New starters induction will also include opportunity for discussion upon current proformas so that new members of the team are fully aware of the case note documentation requirements and to stipulate the importance of ensuring all details are filled
Spinal pre-operative assessment	• GP medication list to be available for all pre-op assessments (to reduce medication errors on admission) • Pre-op nurses have now access to smart cards so all the GP medication can be viewed on the system.
HbA1C in comparison to variable factors	• To appoint a Clinical Psychologist • Secure block contract for Insulin Pumps and CGMS • MDT meetings dedicated for patients with High HbA1c • Provision of more support for download of meters and pumps at home in order to make changes to insulin doses as

	required
Hospital Specialist Palliative Care Team (HSPCT) - Mortality review (March 2018)	• Disseminate medical and nursing care plans to support the care of dying adults by - Updating medical and nursing care plans and publishing on the palliative care intranet page - Face to face dissemination on all wards - Delivering sessions on doctors induction • Continue with education via TRANSFORM and doctors induction to improve recognition of deterioration and patients approaching the terminal phase, to improve timeliness of referrals
Blood monitoring of adult C1 inhibitor deficiency patients on acute and/or prophylactic treatment	• Build within Quadramed a Co-morbidities list which will be linked to outcomes and will have the ability to have order sets linked to it • The department has obtained blue postage to use so that blood samples can be posted to the Department • Arrange for the USS scans to coincide with clinic visits which is an option
Patient Feedback on the Process of Repatriation of Prescribing and Dispensing Renal Transplant Immunosuppression	• Include written information about how to obtain further supplies if patient runs out before next appointment or if clinic date changes
Oncology Psychology Service Annual Audit 2017-18	• Use the PHQ-9 and GAD-7 measures where possible and particularly in the last session (PHQ-9 and PHQ-8 for depressive symptom severity; GAD-7 for anxiety symptom severity) • Continue to record the ethnic group of all service users • Incorporate this issue into Level 2 staff training
Paediatric Micturating Cysto-urethrogram	• Implement a new standard set of images has been agreed to obtain when possible • Reports will in future always include details of bladder contour even if normal and residual contrast even when emptied fully
Accuracy of CXR (chest x-ray) reporting	• If a new, unexplained abnormality is identified on a CXR, cancer should be considered as POSSIBILITY - Urgent CT follow-up with an alert to referrer • If there are features of infection and the likelihood of cancer is low. 6 week follow-up CXR with alert to the clinician - If an abnormality persists on follow-up CXR, urgent CT follow-up with an alert to referrer
Rehabilitation prescription for Major Trauma patients	• Merge Critical Care RP (rehab prescription) with the Major Trauma RP for one "go to" RP document • Re-launch the new Rehabilitation Prescription once it has been merged • Undertake education and training so that staff are aware of the new RP
Evaluation of renal education sessions August 2018	• to invite a patient on in-centre HD to talk about their experience of this modality at next information day
Completion and maintenance	• Nursing and medical staff should be made aware that the

of DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decisions on Brindle Ward	first daily review should be signed by a consultant, if the order has been made by a middle-grade doctor • Remind medical staff about updating DNACPR forms and medical notes when discussions have been held with relatives • Remind staff that a review should be undertaken daily to check the validity of the decision, and the back of the form initialled to confirm that the daily review has taken place
Mimic Stroke Audit	• A pathway which guides the appropriate management of definite stroke, possible stroke and non-stroke (mimic) patients in ED is now available
Re-audit of Management of Pancreatitis: Are We Complying with NCEPOD Guidelines	• An Acute Pancreatitis Management pro-forma has been designed and is in use
Re-audit of Op-Notes for Major Urology operations	• Operation note now forms part of Quadramed (Quadramed op note)
Utilization of Hybrid Theatre in the Vascular Surgery	• The audit report was used to help in the re-configuration of vascular and endovascular services
CPEX (Cardiopulmonary exercise testing) and out-come of treatment of Abdominal Aortic Aneurysm	• Continue to use CPEX for patients who had AAA (abdominal aortic aneurysm) to predict peri-operative performance and requirement for a level 2 ITU bed

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 2018-19, that were recruited during that period to participate in research approved by a research ethics committee was 2822.

Research Recruitment

Lancashire Teaching Hospitals NHS Foundation Trust has recruited 2,511 patients to NIHR portfolio adopted studies in 2018-19. It granted NHS permission for 74 new portfolio studies to commence during that time. The Trust recruited a further 311 to non-portfolio studies. In total, there are currently 237 active research studies recruiting patients at the Trust.

Research Governance

In 2018-19 Lancashire Teaching Hospitals NHS Foundation Trust performed strongly against the Department of Health benchmarks for the set up and delivery of clinical research in the NHS. 71% of trials achieved the NHS 40 calendar day benchmark as compared to 73% average for the North West Coast region.

Commissioning for Quality & Innovation (CQUIN)

4.0 A proportion of Lancashire Teaching Hospitals NHS Foundation Trust income in 2018-19 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 payment framework.

Further details of the agreed goals for 2018-19 and for the following 12-month period are available electronically at http://www.lancsteachinghospitals.nhs.uk/cquin

Lancashire Teaching Hospitals NHS Foundation Trust will receive income of up to £8,700,000 in 2018-2019 for the achievement of quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. During 2017-18 Lancashire Teaching Hospitals NHS Foundation Trust received income of £7,368,047 on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

In 2018/19, the Trust agreed to deliver CQUINs in the following subject areas:-

- Preventing Ill Health Through Risky Behaviours
- Staff Health and Wellbeing
- Improving Services for People with Mental Health Needs who Present in A&E
- Offering Advice and Guidance
- Reducing the Impact of Serious Infections
- Clinical Utilisation Review (CUR)
- Medicines Optimisation
- Neonatal Community Outreach
- Adult Critical Care
- Spinal Surgery Multidisciplinary Team
- Activation System for People with Long Term Conditions
- Dose Banding for Intravenous SACT Drug List
- Enhanced Supportive Care for Advanced Cancer Patients
- STP Engagement

Two CQUINs finished partially complete during the 2018-19 financial year, namely the Risky Behaviours and Advice and Guidance CQUINs. In the case of Risky Behaviours, sufficient work was successfully carried out to enable the full mainstreaming of the support services at ward level moving forward into 2019-20. Advice and Guidance compliance took longer to achieve, but full achievement is anticipated by the end of the financial year.

Only one CQUIN has not been achieved at all, namely that associated with securing discharge from the Adult Critical Care units within four hours. The target of 64% of patients admitted has proved too challenging; although improvements in timely discharge have been achieved in year (current performance is 27%).

CQUINs have therefore again provided an incentive for the Trust to develop and improve its services and so gain income over and above its contracted baseline.

Registration with the Care Quality Commission

5.0 Lancashire Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is that the Care Quality Commission has registered and licensed Lancashire Teaching Hospitals NHS Foundation Trust to provide the following services;

Diagnostic and/or screening services

Maternity and midwifery services

Surgical procedures

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Termination of pregnancies

Treatment of disease, disorder or injury

Management of supply of blood and blood derived products

5.1 There are no conditions to this registration

a) The Care Quality Commission has not taken enforcement action against Lancashire Teaching Hospitals NHS Foundation Trust during 2018-19.

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 12 June and 19 July 2018.

Overall ratings for the Trust were as follows:

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?	**Requires improvement**

Results for each service across the two hospital sites are detailed below:

Ratings for Royal Preston Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018
Medical care (including older people's care)	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018
Surgery	Good ↑ Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Good ↑ Oct 2018	Good ↑ Oct 2018
Critical care	Requires improvement Apr 2017	Requires improvement Apr 2017	Good Apr 2017	Requires improvement Apr 2017	Good Apr 2017	Requires improvement Apr 2017
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 →← Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018

Ratings for Chorley and South Ribble Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Oct 2018	Good ↑ Oct 2018	Good →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018
Medical care (including older people's care)	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement ↓ Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018
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
Outpatients	Good Oct 2018	N/A	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Overall*	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Good →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018	Requires improvement →← Oct 2018

Although the Trust retained the same rating, sixteen Core Domains and four Service Lines including Surgery, Maternity, Services for Children and Young People and Outpatients moved to 'Good' from 'Requires Improvement'. 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. Despite some of the challenges, CQC found that staff were kind and compassionate and this was demonstrated through the rating of 'Good' across the Core Domain of Caring.

During the inspection, the CQC identified areas for improvement under the following regulations of the Health and Social Care Act 2008:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care.
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect.
- Regulation 11 HSCA (RA) Regulations 2014 Need for consent.
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.
- Regulation 17 HSCA (RA) Regulations 2014.Good governance.
- Regulation 18 HSCA (RA) Regulations 2014 Staffing.

In order to deliver the recommendations in the CQC report 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 recommendations is monitored through the Quality Improvement Plan which is reported to the Trust Board through Safety and Quality Committee and system partners through Central Lancashire Quality Improvement Board on a monthly basis.

Over the last 12 months, the Trust has further improved our established trusted relationships with the CQC by escalating 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 Trust 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 by the Trust as a result of changes that it has made.

8.0 Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2018-19 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
- 99.8% for outpatient care
- 98.8% for accident and emergency care

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

- 99.6% for admitted patient care
- 99.7% for outpatient care
- 99.4% for accident and emergency care

NHS Number coverage is better than then national average across all datasets, GP Practice coverage is slightly below the national average for 2018-19.

9.0 Lancashire Teaching Hospitals NHS Foundation Trust has utilised the new Information Governance (IG) Data Security and Protection toolkit. The data quality assertion 1.7 (Effective data quality controls are in place) has been completed and passed for both the 3 mandatory and 1 non-mandatory requirement. See below:

1. Personal Confidential Data

Met (8 / 8)
Not Met (0 / 8)
100 % complete

10.1 Lancashire Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018-19 by the Audit Commission

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

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

- Continued development of the Trust Integrated Performance Report aligned to Trust ambitions and CQC Domains including a Data Quality Marker across all data collections supporting key performance indicators.

- Rolling ward 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

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

Learning from Deaths Data

The nationally recommended approach to Mortality Review (MR) was implemented in the Trust during 2017-18 and is now embedded in practice. Further information regarding the Trust learning from deaths is presented on page 164.

27.1 During 2018-19 1,499 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:

- *376* in the first quarter
- *332* in the second quarter
- *396* in the third quarter
- *395* in the fourth quarter

Data source: Trust data warehouse (Adult deaths as required by 'Learning from Deaths')

27.2 By 31st March 2019 626 case record reviews using the Structured Judgement Review (SJR) and 9 investigations have been carried out in relation to the 1,499 of the deaths noted above. In four cases a death was subject to both a case record review and an investigation.

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

- In the first quarter there were 145 case reviews and 0 of these were subject to an investigation
- *In the second quarter there were 133* case reviews and 2 of these were subject to an investigation
- *In the third quarter there were 123* case reviews and 2 of these were subject to an investigation
- *In the fourth quarter there were 225 case reviews and 0 of these were subject to an investigation*

Data source: Trust MR database & Datix

27.3 Two, representing 0.13% of the patient deaths during the reporting period are judged to be more likely than not to be due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- *0* representing 0% for first quarter
- *0* representing 0% for second quarter
- *2* representing 0.50% for third quarter
- *0* representing 0% of deaths for fourth quarter

Data source: Trust MR database & Datix

27.4 Following secondary reviews the overarching key themes arising are that

- Patients are being appropriately managed
- Care provided did not impact on their death.

However there were some instances where issues have been raised around shared care and overall responsibility for the patient. Current work streams around patient flow and capacity are taking place which will help to address this issue. There have been some concerns over clear documentation in patient case notes. This area is subject to review with constant monitoring of performance at ward level.

Mortality reports are shared with the divisional Safety & Quality Committees focusing on any learning that has resulted from these reviews.

A project is currently underway to develop an enhanced Morbidity/Mortality software application that will house all Trust mortality reviews. The number of required reviews and the uptake of these will be displayed on a number of dashboards to enhance their completion. The software will allow direct patient level links into incidents and risk, work of the Bereavement team, Customer Care, the Coroner and eventually the wider Health Economy. This will enable a "learning bank" for required actions and the sharing of any learning.

2.3 Reporting Core Indicators

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified in the NHS Improvement (NHSi) Compliance Framework and the Acute Services Contract.

During 2018-19 the Trust continued to experience significant operational pressures resulting in non-compliance in relation to some key NHSi targets. 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 2018-19 the Trust has set up a range of 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 & Emergency Care settings, including Ambulatory Care at both sites and the Emergency Observation Unit at RPH. This has involved Urgent & Emergency Care Value Stream Analysis.

Overall during 2018-19 the Trust achieved compliance against a range of measures within the Risk Assessment Framework including four of the eight cancer waiting times standards, and 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 did not consistently hit the 62 day cancer treatment. This was largely due to significant pressures within the emergency service throughout 2018-19 that adversely impacted on access standards compliance and delivery of the Trust's elective care programme.

The summary position detailing performance against key targets 2018-19 is shown in the table below:

Indicator	National Target %	Cumulative Performance	Achieved	Current Period
A&E - 4 hour standard	90	82.67	Not Achieved	% - Cumulative to end March 2019 Position includes both ED and UCC locations. Target based on agreed Trajectory to March 2019
Cancer - 2 week rule (All Referrals) - New method	93	95.4	Achieved	% - Cumulative to end March 2019
Cancer - 2 week rule - Referrals with breast symptoms	93	91.3	Not Achieved	% - Cumulative to end March 2019
Cancer - 31 day target	96	94.6	Not Achieved	% - Cumulative to end March 2019
Cancer - 31 Day Target - Subsequent treatment – Surgery	94	92.5	Not Achieved	% - Cumulative to end March 2019
Cancer - 31 Day Target - Subsequent treatment – Drug	98	99.7	Achieved	% - Cumulative to end March 2019
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	94	98.5	Achieved	% - Cumulative to end March 2019
Cancer - 62 day target - total	85	79.6	Not Achieved	% - Cumulative to end March 2019
Cancer - 62 day target - Day 38 reallocations	85	81.2	Not Achieved	% - Cumulative to end March 2019
Cancer - 62 Day Target - Referrals from NSS (Summary)	90	91.0	Achieved	% - Cumulative to end March 2019
MRSA	0	0	NA	% - Cumulative to end March 2019
C.difficile Infections	<66	51	Achieved	Cumulative to end March 2019
C.difficile infection avoidable (Lapses in care)	<66	31	Achieved	Cumulative to end March 2019
18 weeks - Referral to Treatment - Incomplete Pathways	87	80.38	Not Achieved	% - sum of Apr-Mar in 2018-19 Target based on agreed Trajectory to March 2019
% of patients waiting over 6 weeks for a diagnostic test	<1	2.8	Not Achieved	% - Cumulative to end March 2019

Summary Table of Performance against Core Indicators

12. Summary Hospital-Level Mortality Indicator (SMHI)	October 2015 – September 2016	October 2016- September 2017	October 2017- September 2018
(a) the value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period	Trust = 1.0053	Trust = 1.0562	Trust = 0.9713
	National average = 1.0	National average = 1.0	National average = 1.0
	Low = 0.69	Low = 0.73	Low = 0.69
	High = 1.16	High = 1.25	High = 1.26
	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 = 36.5% National = 29.7% High = 56.3% Low = 0.4%	Trust = 38.8% National = 31.5% High = 59.8% Low = 11.5%	Trust = 46.3% National = 33.6% High = 59.5% Low = 14.2%

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

- The Trust remains within expected range due to a number of influencing activity which includes the improvement in palliative care coding due to the extensive work of the Palliative Care team

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

- Embedding the national Structured Judgement Review (SJR) process which promotes learning from deaths
- The Trust has an improved reporting process into the specialities and divisions in relation to their SJR performance which includes patient outcomes quality of care and avoidability scores.
- The quality of documentation and clinical coding continues to improve.
- The Trust has recently employed an Investigation and Learning Manager who will support the learning from deaths agenda.
- Implementation of the national Medical Examiner role also aims to continually improve the review of deaths and reduce the Trust mortality scores

18. PROMS; The Trust's patient reported outcome measure scores for:	**April 2015-March 2016**			**April 2016- March 2017**			**April 2017- March 2018**		
	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	NA	NA	NA	NA	NA	NA	Discontinued data collection nationally 1/10/17 Final data April 16 – March 17		
	National = 0.088 High = 0.157 Low = 0.021	NA	NA	National = 0.086 High =0.135 Low = 0.006	NA	NA			
(ii)varicose vein surgery	NA	NA	NA	NA	NA	NA			
	National = 0.095 High = 0.149 Low =0.018	NA	National =-8.252 High = 3.05 Low = -18.02	National =0.092 High = 0.155 Low =0.02	NA	National =-8.25 High = 2.1 Low =-18.1			
(iii)hip replacement surgery (Primary)	Health Gain = 0.408	Score = 20.906	NA	Health gain = 0.38	20.3	NA	Health gain = 0.45	21.9	NA
	National = 0.438 High =0.51 Low =0.32	National = 21.6 High = 24.97 Low =16.89	NA	National = 0.44 High =0.54 Low =0. 31	National = 21.7 High =25.1 Low = 16.4	NA	National = 0.46 High =0.56 Low =0. 40	National = 22.7 High =26.2 Low = 18.8	NA
(iv) knee replacement surgery	Health Gain = 0.276	Score = 15.731	NA	Health gain =0.28	Score = 14.8	NA	Health gain =0.33	Score = 16.9	NA

(Primary)	National = 0.32 High =0.398 Low =0.198	National = 16.4 High = 19.92 Low = 11.96	NA	National = 0.32 High = 0.4 Low =0.24	National = 16.5 High =19.9 Low =12.5	NA	National = 0.33 High = 0.41 Low =0.23	National = 17.3 High =20.6 Low =13.1	NA

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. This measures the impact of treatment on an individual patient. The higher the score, the greater the benefit experienced by the patient. The PROMS programme uses the following measures:

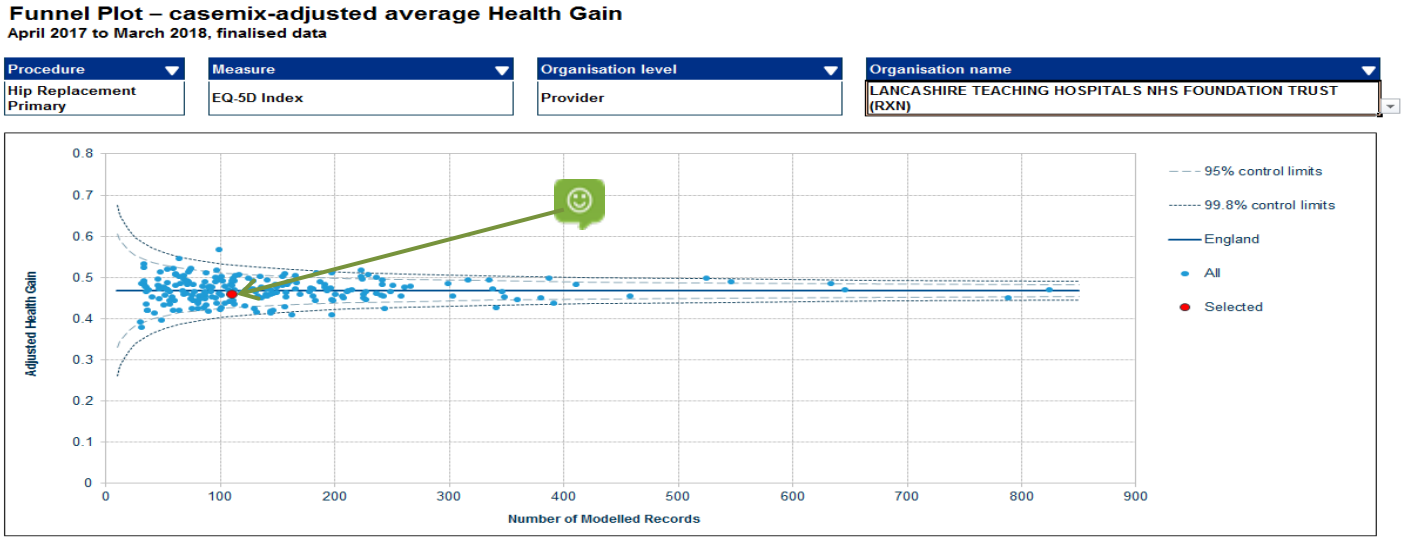
- The EQ5D tool provides a generic measure of quality of life.
- The Oxford score measures the impact of replacement surgery on quality of life

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

- EQ5D & Oxford scores for both hip and knee replacement have improved compared to prior periods and are within expected range in comparison with peers which is demonstrated in the embedded funnel plot graphs
- National PROMS data for groin and varicose vein surgery is no longer obtained, this ceased on 01/10/2017

The trust is the red dot in the graphs below and if it is within the two larger doted lines and close to the solid line the trust is within expected range

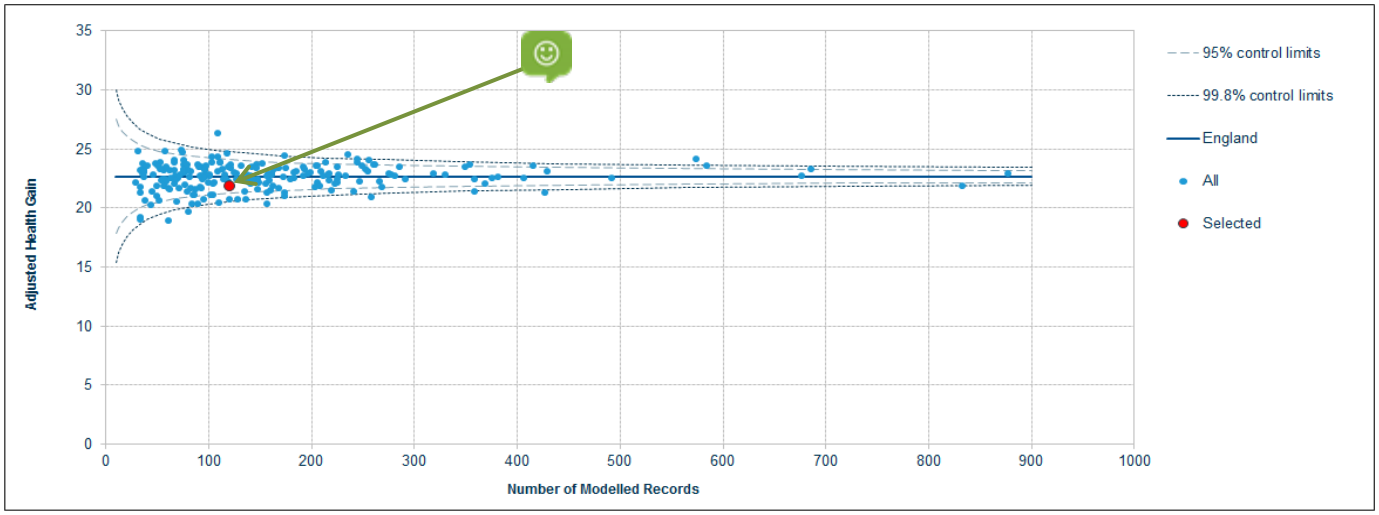
Hip Replacement funnel plot graphs demonstrating the Trust is comparable with national peers



Funnel Plot – casemix-adjusted average Health Gain

April 2017 to March 2018, finalised data

Procedure	Measure	Organisation level	Organisation name
Hip Replacement Primary	Oxford Hip Score	Provider	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST (RXN)

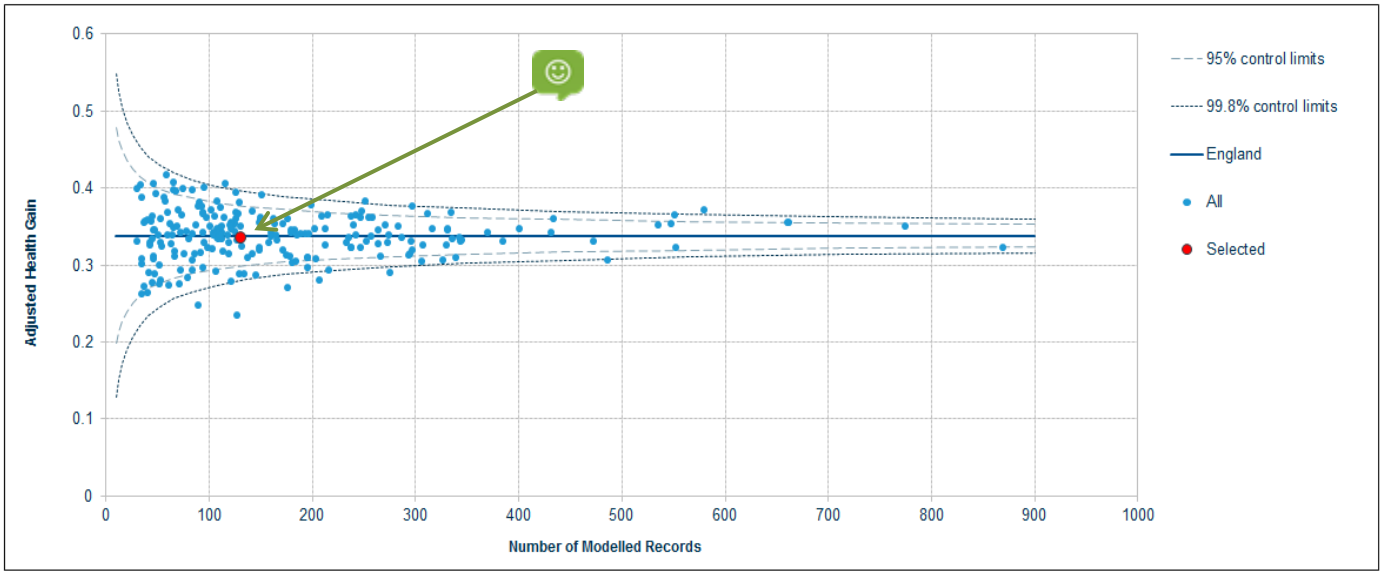


Knee Replacement funnel plot graphs demonstrating the Trust is comparable with national peers

Funnel Plot – casemix-adjusted average Health Gain

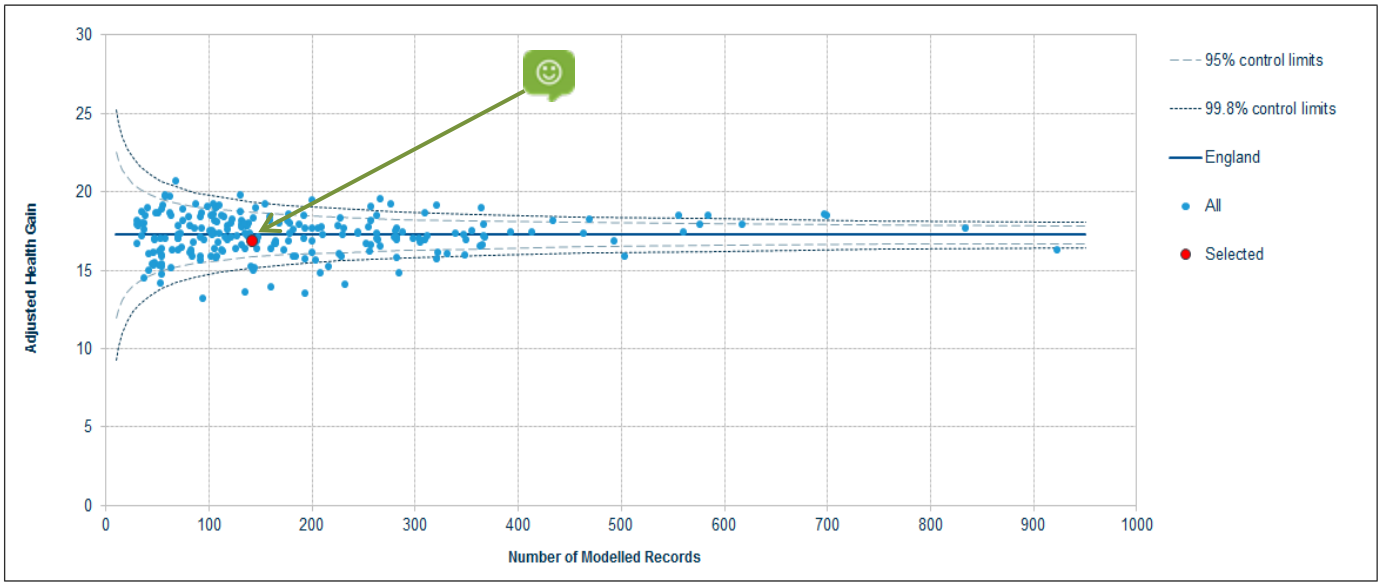
April 2017 to March 2018, finalised data

Procedure	Measure	Organisation level	Organisation name
Knee Replacement Primary	EQ-5D Index	Provider	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST (RXN)



Funnel Plot – casemix-adjusted average Health Gain
April 2017 to March 2018, finalised data

Procedure	Measure	Organisation level	Organisation name
Knee Replacement Primary	Oxford Knee Score	Provider	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST (RXN)



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

- Reviewing and responding to patient level data.
- Further increasing uptake of the PROMS questionnaire through review of points of access ensuring that they are provided with opportunity to complete initial assessments.

19. The percentage of patients aged: 0 to 15 and 16 or over Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	**2009/10**	**2010/11**	**2011/12 split under and over 16 years**
0-15 years	Trust = 11.94	Trust = 12.11	Trust = 11.71
	National = NA High = 14.02 Low = 0	National = NA High = 16.05 Low = 0	National = NA High = 14.94 Low = 0
16 years and over	Trust = 10.92	Trust = 10.87	Trust = 11.93
	National = 11.18 High=NA Low = NA	National = 11.42 High=24.84 Low =0	National = 11.45 High=13.11 Low =0

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

- Comparative national data for patients aged 0-15 years from the NHS information centre remains for the period 2011/12 as above– most recent data
- Performance in respect of patients aged 16 and over from the NHS information centre remains for the period 2011/12 as above – most recent data
- Readmissions 2017/18 for those aged 0-15 was 11.9% and only 7.0% for those aged 16 and above. The most current data April 18 – November 18 aged 0-15 10.5% and adults 7.8% (source: Dr Foster Intelligence).

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 review and monitor readmission rates and respond where improvements are required.

20. The Trusts responsiveness to the personal needs of its patients during the reporting period	**2015-16**	**2016-2017**	**2017-2018**
	Trust = 68.3	Trust = 64.1	Trust = 65.9
	National = 69.6 High=86.2 Low = 58.9	National = 68.1 High=85.2 Low = 60	National = 68.6 High=85.0 Low = 60.5

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

-  2017-18 performance data has improved in comparison to the previous period but recognises it remains below the national average.

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

- Reviewing the impact the patient experience and involvement strategy and nursing, midwifery, AHP and care givers strategy to continue to promote excellent care with compassion
- The STAR performance should also drive continuous improvement in our services being responsive to the personal needs of patients.
- The patient feedback is welcomed, monitored and action taken to respond to area requiring improvement.

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	**2016**	**2017**	**2018**
	Trust = 65	Trust = 67	Trust = 65
	National (Acute Trusts) = 70 High = 85 Low = 51	National (Acute Trusts) = 70 High = 84 Low = 47	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:

-  The trust has continued to invest in staffing and staff development but the impact has yet to translate into improving staff recommendations.

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 invest in staff recruitment and development
- Continue to implement the Workforce and Organisational Development strategy to make the organisation a great place to work which also provides excellent care.

23. %age of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period	**Q2 2017- 2018**	**Q3 2017- 2018**	**Q4 2017 -2018**
	Trust = 96.2%	Trust = 96.1%	Trust = 96.2%
	National = 95.3% High = 100% Low = 71.9%	National = 95.4% High = 100% Low = 76.1%	National = 95.2% High = 100% Low = 67%%

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

-  Effective systems and risk assessment processes leading to comparative % on an annual basis
- 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:

- Ongoing monitoring of data and the national Safety Thermometer point prevalence audit.

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	**2015-2016**	**2016-2017**	**2017-2018**
	Trust = 19.5	Trust = 18.9	Trust = 20.0
	National = 15.0 High = 67.2 Low = 0	National = 13.0 High = 82.6 Low = 0	National = 14.0 High = 91.0 Low = 0

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

- Patients continue to be admitted with community acquired *C Difficile*
- Hospital onset *C Difficile* continue to remain lower that the Trust annual objectives

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

- Implemented a Post Infection Review (PIR) which is a multidisciplinary approach to investigate each hospital onset CDI case
- To review and share lessons learned from PIR and implement quality improvement actions
- Continued focus on antimicrobial prescribing with community partners
- Continue to be responsive to the need for isolation
- Continuing to promote best practice around antimicrobial stewardship
- Promote hand hygiene and environmental cleaning
- Promote Infection Prevention and Control education Trust wide

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	**Oct 2016-March 2017**	**Apr 2017-Sep 2017**	**Oct 2017-March 2018**
(i)Rate of Patient Safety Incidents per 1000 Bed days	Number = 5925 Rate/1000 bed days = 39.2 National Rate/1000 bed days = NA High Rate/1000 bed days = 69 Low Rate/1000 bed days = 23.1	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
(ii) % of Above Patient Safety Incidents = Severe/Death	Severe harm or death	Severe harm or death	Severe harm or death
	Trust Number = 42 Percentage of all incidents= 0.28%	Trust Number = 39 Percentage of all incidents= 0.26%	Trust Number = 62 Percentage of all incidents= 0.42%
	National = NA	National = NA	National = NA

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

- The increase in reporting of incidents and corresponding increase in those cases reported as severe harm or death is as a result of continuing efforts to improve reporting systems, processes and tools.
- Ongoing organisational focus on the importance of incident reporting, including the reporting of Near Misses, and development of a positive safety culture with improved staff engagement in incident reporting

has also contributed to this increase.

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 the Trust's Datix system for improved incident reporting and management
- Review of the Trust's incident reporting and management policies and protocols to clearly define for staff what an incident is and to support timely investigation.
- Development and implementation of a Learning Bank and a framework for sharing learning across the Trust.

Achieving the NHSi 10 Clinical Standards for Seven Day Hospital Services

A key priority for the NHS is to develop 7 day services, with the initial focus being on achieving the 4 priority clinical standards for seven day services. NHSi issued a refreshed Board Assurance Framework in December 2018, which requires all Trusts to provide Board level assurance every 6 months through completion of a standardised template capturing performance against all 10 Clinical Standards.

The Board Assurance Framework was reviewed by the Trust Board on 7th February 2019, and was subsequently submitted to NHSi. The report captured good progress being made against the 4 priority clinical standards, with the key challenge being achievement of Standard 2 - Time to First Consultant Review. A number of actions to support improvements were captured in the Board paper, including:

- 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 7 days)
- Amendments to the Electronic Patient Record (EPR) to support more robust and automated data collection

The report also captured the progress being made towards achieving the '6 Continuous Improvement Standards'. This includes:

- Work being undertaken by the Customer Care Team to provide visibility of patient experience markers across 7 days
- Customer Care Team reviewing how patient experience data and feedback can be used to strengthen the evidence relating to the availability of 7 day clinical services (Standard 1).
- Clinical handover to be included in the audit plan for all specialities (Standard 4).
- Business Intelligence (BI) team to investigate if an automated report capturing performance relating to timely access to the Mental Health Liaison Team can be generated and included in the next Board assurance paper in the Summer 2019 (Standard 7).
- Clinical Effectiveness team and BI team to provide data relating to mortality, length of stay and readmissions (weekday vs weekend) for the next Board assurance paper in the summer 2019 (Standard 10).

A process has been agreed for the 7 day Services Board Assurance Framework to be reviewed by the Board every 6 months.

Freedom to Speak Up

Following publication of Sir Robert Francis' Freedom to Speak Up Review (2015), Lancashire Teaching Hospitals NHS Foundation Trust reviewed its processes and systems for inviting, listening and responding to concerns raised by staff. Further review and strengthening of arrangements subsequently took place in response the Gosport enquiry (2018).

The ability to raise concerns in a safe way is a key element of our workforce strategy, launched in 2019. This strategy will lead and support strengthening of our values and our just and compassionate culture.

Trust policy was reviewed in 2019 to ensure clearer understanding of means by which staff could raise concerns. First and foremost, 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. The Trust has an established 'Valuing your Voice' webpage on the intranet which allows staff to comment, make suggestions or raise concerns. Staff can to do this anonymously but are encouraged to confidentially provide contact details so that their concerns can be responded to in a more comprehensive manner.

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.

A new Freedom To Speak Up (FTSU) guardian was appointed in a substantive stand-alone post who, along with an executive and non-executive director lead and a growing network of champions, provide a safe and confidential route through which concerns can be raised. Union representatives and governors also provide opportunity for support when raising concerns.

Staff are guided by policy and protected in accordance with legislation at times when they decide to whistle blow to external organisation around their concern.

All concerns raised through Datix, via the 'Valuing your Voice' webpage, through the FTSU guardians, champions and any other routes are recorded and shared at a 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.

Medical and Dental Workforce Rota Gaps

The Trust recognises that Schedule 6. Paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires an annual report on rota gaps and plans for improvement.

The Trust monitors vacant posts monthly through a monthly vacancy gap analysis, an example of this can be found below (January 2019):

Count of Vacancy Reporting Status	Vacant	Filled	Grand Total	Grand Total
Deanery	**20**	**337**	**357**	**5.60 %**

Deanery Junior	**10**	**204**	**214**	**4.67 %**
FY1	1	53	54	1.85 %
FY2	4	51	55	7.27 %
ST1-2	5	100	105	4.76 %
Deanery Senior	**10**	**133**	**143**	6.99 %
ST3+	10	133	143	6.99 %
Trust	**84**	**530**	**614**	**13.68 %**
Trust Junior	**13**	**24**	**37**	**35.14 %**
Trust Senior	**34**	**114**	**148**	**22.97 %**
Senior Clinical Fellow	14	39	53	26.42 %
SAS	20	75	95	21.05 %
Trust Consultant	**37**	**392**	**429**	**8.62 %**
Consultant	37	392	429	8.62 %
Grand Total	**104**	**867**	**971**	**10.71 %**

Source: LTHTR data

This report can be broken down into specialty services to enable each department to fully understand their medical and dental staffing position monthly.

The medical workforce team use this information monthly to work closely with departmental managers/clinical directors to source vacancies and agree recruitment strategies for hard to fill posts. These strategies 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 of vacancies through social media, relevant journals and websites,
- Sourcing vacancies 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
- Implementation of the recruitment and retention premia policy to be applied with hard to fill posts and financially support international candidates with visa costs. This has been applied on a number of occasions
- Implementation of an Associate Consultant post to support retention of existing middle grade doctors by providing career progression. This only applies to middle grade doctors working in the Trust
- External review of junior doctor rotas and benchmarking numbers against other Trusts through Kendall-Bluck and plans to complete a capacity-demand modelling review of medicine junior medical cover
- Implementation of a Medicine division recruitment group aimed at working in partnership with business managers and clinicians to focus on recruitment strategies for hard to fill posts. This aims to ensure timely advertisement of vacancies.
- Focussing on job planning and ensuring the job plans are reflective of work carried out and demand
- Implementation of a medical bank to reduce reliance on agency workers and reduce cost. This has enabled the Trust to utilise our own doctors to work additional hours and therefore improves quality of care because doctors are familiar with patients and the hospital

- Implementation of F3 posts for August 2019 to help fill junior posts
- Working on a cost avoidance business case to introduce rotational junior clinical fellow posts over and above establishment to prevent the need for agency and bank staff
- 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

Lancashire Teaching Hospital NHS Foundation Trust considers the safety of patients to be our number one priority. To ensure the organisation is a safe place to receive care and treatment the Trust monitors performance against certain factors and continually aim to reduce and eliminate patient harm where possible.

The Trust Safety Triangulation Accreditation Review (STAR) framework assesses the standards of care that are delivered within clinical areas and promotes continual improvement.

The Trust also continues to maintain high levels of performance with all elements of the Safety Thermometer programme with a the 2018-19 performance at a level of 97.9% harm-free hospital care in respect of new harm events, compared to a target of 98%.

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 2018-19 the Trust reported 8 Never Events in the following categories:

Retained foreign object (1),

Wrong site surgery (4),

Misplaced nasogastric tube (2)

Wrong route of medication administration (1)

All Never Events are subject to a serious incident review and reported to the local Clinical Commissioning Groups as well as nationally to the Strategic Executive Information System (StEIS) and the National Reporting & Learning System (NRLS). Learning from both systems is shared nationally. The Trust shares the outcomes of the investigations and learning within the divisions along with actions undertaken in regard to the incident.

Lancashire Teaching Hospitals NHS Foundation Trust is committed to reducing Never Events and also other avoidable harms by:

- Reducing avoidable healthcare associated infections of MRSA and *Clostridium Difficile*
- Reducing avoidable falls with harm
- Improving incidence reporting and reduce medication errors
- Continuing to improve our culture of openness when incidents occur

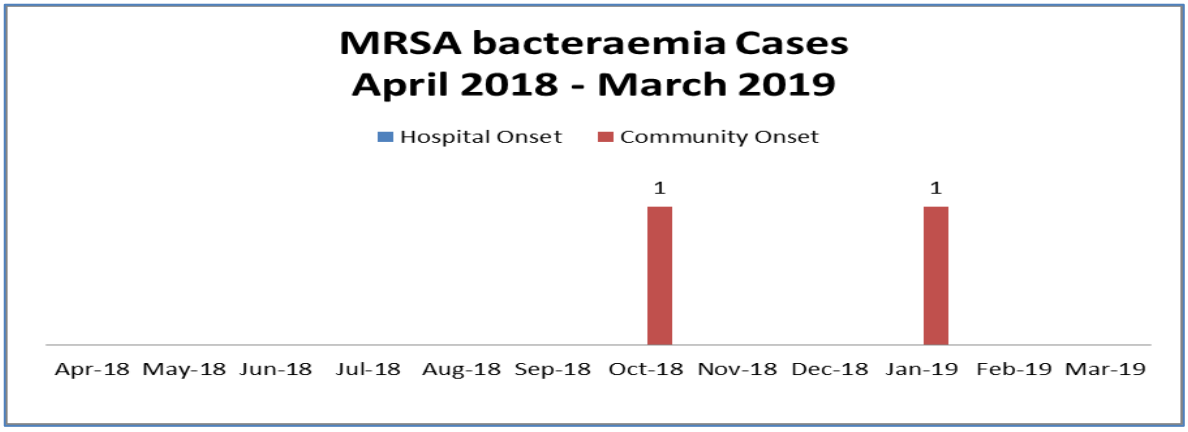
MRSA Bacteraemia

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 remains a key priority for the Trust which includes a focus on MRSA bacteraemia. In 2017-18 there was one incident of hospital onset MRSA bacteraemia and zero cases during 2018-19. There were however two community onset MRSA bacteraemia cases assigned to the Clinical Commissioning Group (CCG) with learning identified for both the CCG and the Trust.

The two cases were investigated by a multi-disciplinary team using the national post infection review tool. The post infection review findings were presented to the Director of Infection Prevention & Control to identify how each case may have occurred and to identify actions that will prevent similar cases reoccurring in the future.

The Trust remains committed to a zero tolerance on avoidable cases.



Source: LTHTR data

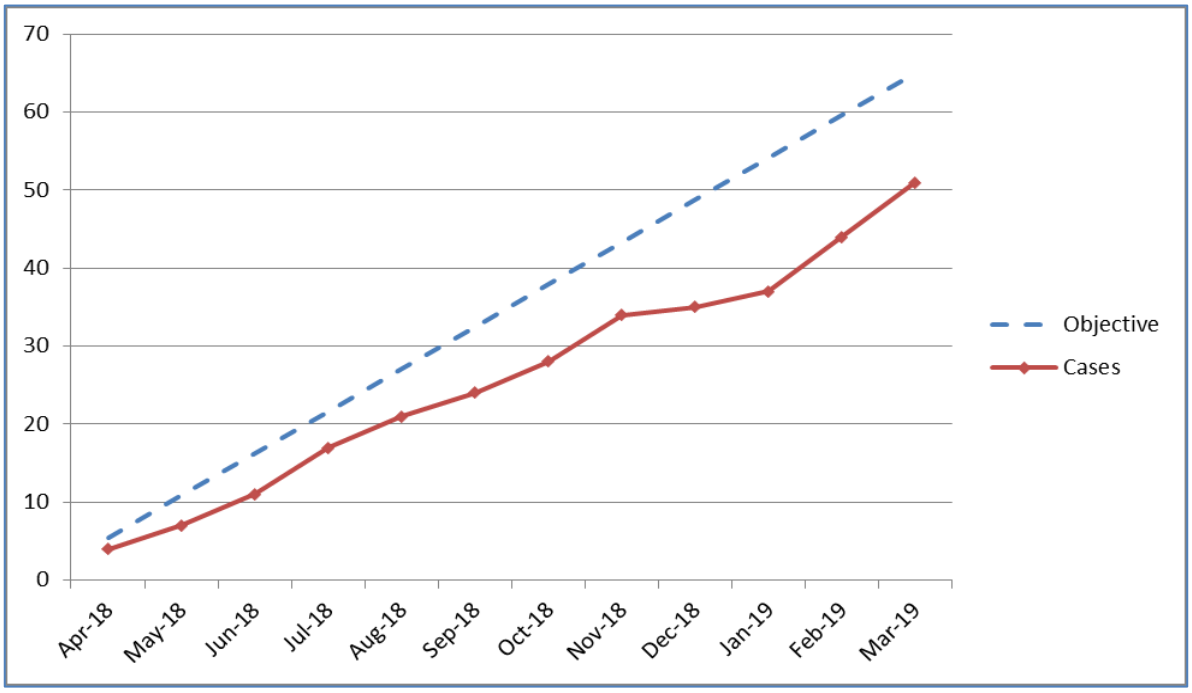
Clostridium Difficile Infection

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 antimicrobials or may have been exposed to *Clostridium difficile*.

The prevention of *Clostridium difficile* infection remains a key priority for the Trust which has been maintained with close monitoring of incidence.

There were 51 cases of C*lostridium difficile* in 2018-19 which is less than the 60 cases in the previous reporting period 2017- 18. This demonstrates and improving picture in comparison to the overall objective of not exceeding 65 cases a year for the organisation.

Clostridium difficile cases 2018 - 19



Source: LTHTR data

All hospital onset 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 patients care.

The review process facilitates a greater understanding of the individual causes 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 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.

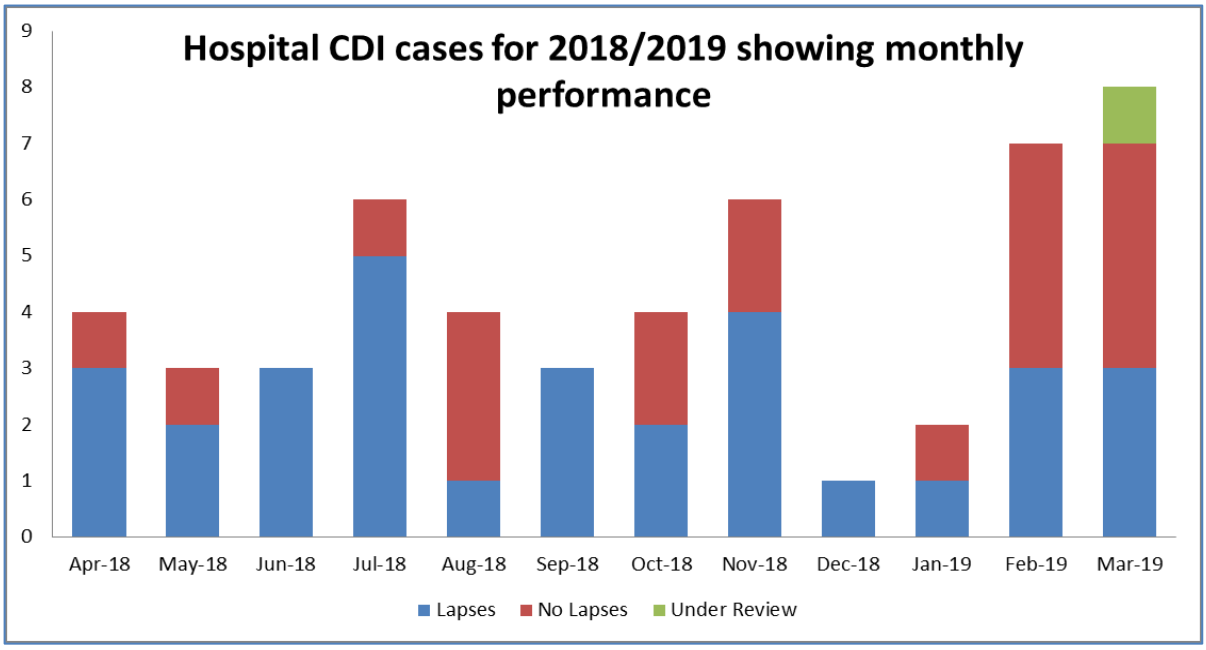
Of the 51 cases reviewed within the Trust during 2018-19, lapses of care were identified in 31 of these with 1 case currently under review at the end of March 2019.

Themes identified from those cases have included:

- Delays in sampling and isolation
- Improved compliance with antimicrobial prescribing in line with validated Trust guidance
- Improvements to environmental cleanliness

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 monthly meetings with the CCG leading to a health economy wide approach to learning.

Clostridium Difficile lapses in care 2018 - 19



Source: LTHTR data

Falls Prevention

Falls prevention remains a high priority for the Trust which is demonstrated by a continuous focus for improvement in falls prevention strategies. Falls prevention remains a complex challenge due to the large array 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.

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

The risk is also increased due to patients being acutely unwell, being frail and 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 5 years the Trust has 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 wards/divisions
- 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

During 2018-19 the Trust has implemented additional falls prevention improvements including:

- A falls prevention multidisciplinary team working group as part of the patient safety collaborative work streams. This aims to identify themes and trends and develop improvement strategies in falls prevention across the Trust
- A roll out across all in-patient areas the 'night time falls prevention action plan', which was developed as a result of a CQUIN project
- The development of the Enhanced Levels of Care (ELC) guidance, launched in June 2016 continues to form part of the patient safety collaborative group for improving risk assessments for confused patients

The Trust participated in the Royal College of Physicians National In-patient Falls Audit in 2017-18 which has resulted in on-going improvement actions. The falls plan has a number of key improvement actions which include:

- All patients above the age of 65 to have a lying and standing blood pressure
- All patients above the age of 65 to receive a medication review
- All patients over 65 years are assessed for visual impairment
- Walking aids to be available 7 days per week

The Trust is currently undertaking the 2018-19 National Falls Audit due to be completed June 2019.

The ambition is to reduce all inpatient falls by 10% within the Nursing, Midwifery AHP and Care Givers strategy 2018-21 which will require ongoing interventions which have been outlined previously as well as by:

- Continuing to maintain a focus on falls prevention measures through strengthened leadership, learning and feedback from falls
- Ongoing use of the guidance for assessing and Implementing Enhanced Level of Care

- Improving the care and management of confused patients
- Promoting staff awareness of the delirium policy
- Focusing on reducing night time and continence/toileting related falls
- Development of a falls improvement action plan as a result of the outcomes of the current national in-patient falls audit

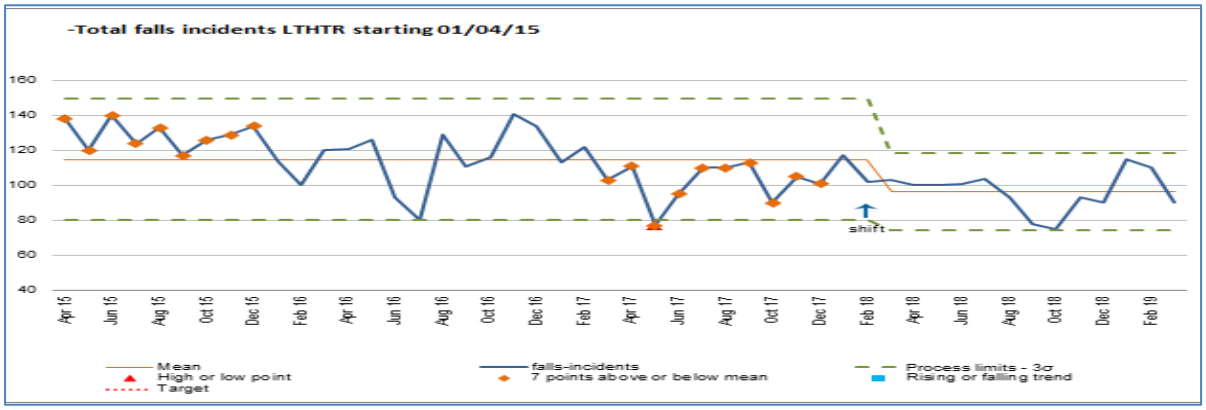
Number of falls incidents and falls with harm

Year	All Falls Incident	In-patient Falls with Harm
2014/2015	1736	344
2015/2016	1495	314
2016/2017	1389	309
2017/2018	1234	279
2018/2019	1149	266

Source: Datix LTHTR data

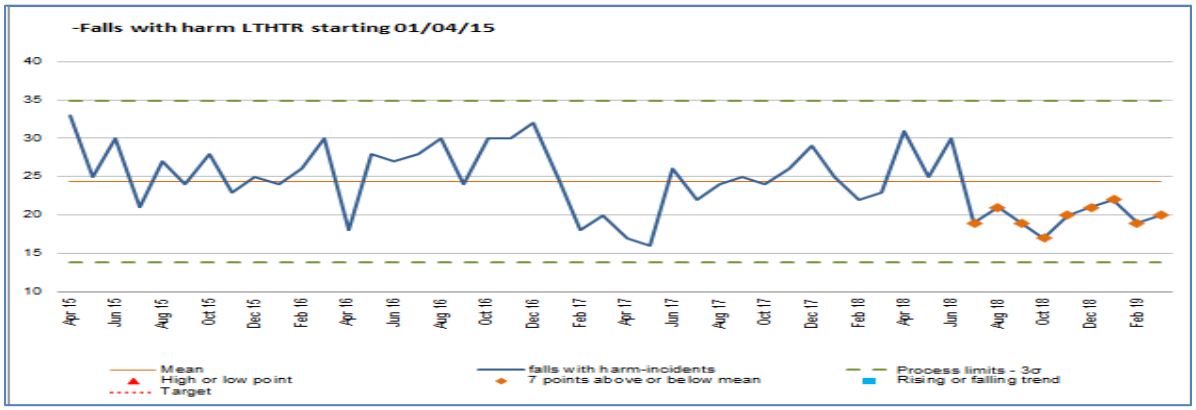
All falls incidents and falls with harm reported in the Trust since April 2015 are presented in the tables below.

Falls April 2015 - 19



Source: LTHTR data

Falls with harm 2015- 19



Source: LTHTR data

Analysis of the incident data:

- The end of year falls incident rate has decreased by 6.89% from 1234 falls in 2017-18 to 1149 falls in 2018-19
- Overall since 2014-15 the Trust has achieved a 33.81% reduction in total falls from 1736 to 1149
- The end of year falls with harm incident rate has decreased by 4.67% from 279 falls with harm in 2017-18 to 266 falls with harm in 2018-19
- Overall since 2014-15 the Trust has achieved a 22.67% reduction in falls with harm from 344 to 266

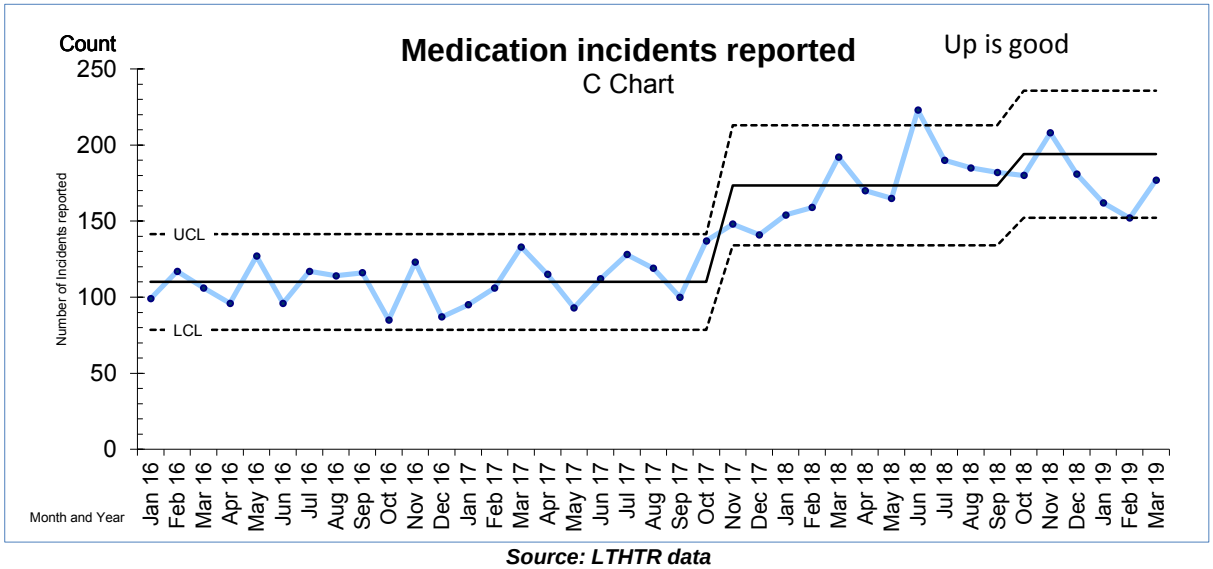
Through analysis of incident reporting and working with stakeholders, particularly within the falls collaborative, the Trust has built further on existing improvement work to identify reasons for falls and develop and implement additional falls prevention strategies.

Medication Errors

Medication errors have significant implications on patient safety. Error detection through an active management and effective reporting system 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.

Historically the Trust has been identified in the lower quartile (25%) for medication incident reporting nationally. Improving the reporting culture was objective of the Medicine Safety Officer (MSO) appointed in April 2017. As a result of focussed efforts on improving a reporting culture, the Trust has celebrated a 70% increase in reporting from the 2017 baseline. This increase has not yet filtered through to the Model Hospital where the Trust is still benchmarking in the lower half of all Trusts. The Model Hospital information is currently displaying data up to September 2017.

Medication incidents reported

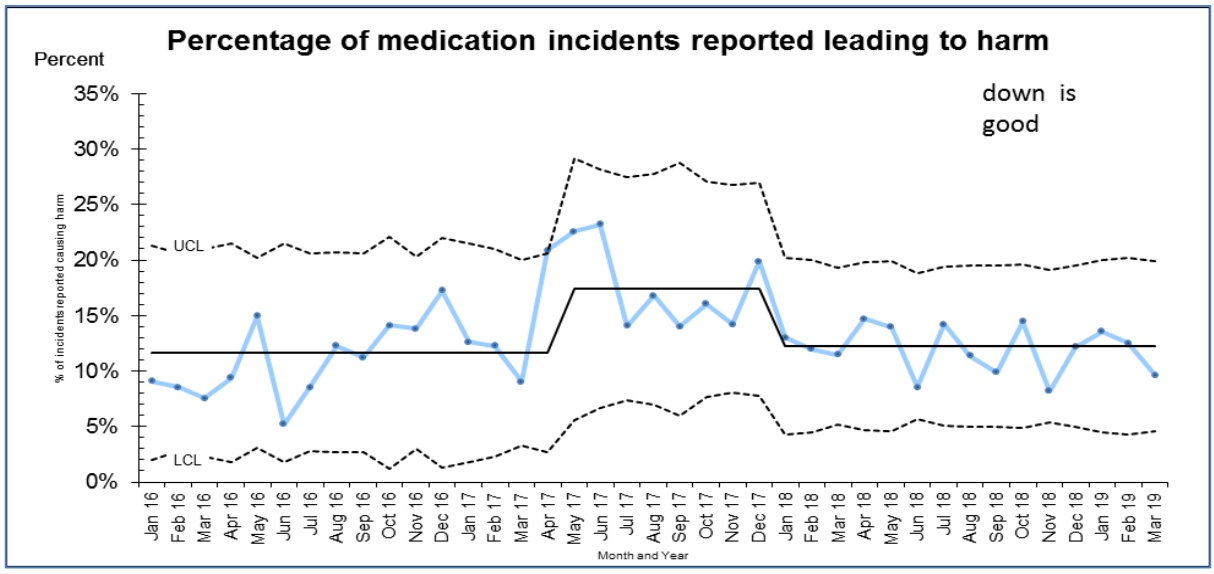


Source: LTHTR data

The MSO has established a network of medication safety champions (link nurses from each clinical area), who 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. The network has over 60 champions; around 50% attend all meetings. The MSO monthly update is also shared at Divisional Quality and Safety Committees and in harm free care and medicines governance meetings to support organisational learning.

The Trust reports around 20-25 medication harm events per 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 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 the Medicines Governance Committee on a monthly basis and is displayed in the graph below.

Medication incidents leading to harm



Source: LTHTR data

Other key priorities addressed during 2018/19 contributing to a reduction in harm include:

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 2018-19 shows improvement and is the best recorded. However, provision of opportunity for all patients to have medicines reconciliation during the first 24 hours is linked directly to implementation of plans around 7- day services (specifically pharmacy services). Following development of a successful business case and consultation with staff, this is due to be implemented in the summer of 2019. In addition a pharmacy service to the Emergency Department has been introduced in February 2019 with a clear remit to ensure the correct prescription is in place from the decision to admit.

Percentage of medicines reconciled within 24 hours of admission

	2015/16	2016/17	2017/18	2018/19 Q1	2018/19 Q2	2018/19 Q3
Percentage of medicines reconciled within 24 hrs of admission	66%	62%	73%	80%	72%	73%

Source: LTHTR data

Safe Storage of medication

Quarterly audits of all inpatient areas are carried out by the pharmacy department and assured via the STAR accreditation scheme. Improvements in meeting the medicines storage standards have been demonstrated in 2018-19, and the escalation process for those areas struggling to meet the standards 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 88% across all areas.

Antibiotic Prescription and administration

A range of metrics to demonstrate good antimicrobial stewardship were agreed as a part of the CQUIN for 2018-19. Improvement has been seen throughout the year with completion of the 72hr review now the remaining target which requires significant work.

Antimicrobial Compliance

	Q1 2018-19	Q2 2018-19	Q3 2018-19	Q4 2018-19
Antimicrobial compliance with formulary	88%	80%	88%	91%
Antimicrobial compliance with guidance/ microbiology recommended	91%	88%	90%	93%
Antimicrobial compliance with stop/review dates	74%	78%	90%	87%
Antimicrobial completion of 72hr review	30%	42%	56%	49%
Antimicrobial indication documented on chart	90%	88%	93%	92%

Addressing the World Health Organisation 3rd Patient Safety Challenge – Medication without harm

The World Health Organisation has launched its 3rd patient safety challenge to reduce the level of severe avoidable harm related incidents by 50% over 5 years globally. Three high priority areas for action have been identified which include: Polypharmacy, High Risk Situations and Transfers of Care.

Locally the Trust has started work on improving the discharge process, with a new Intermediate discharge letter soon to be launched. The Continuous Improvement and Nursing Directors recently dedicated a professional development day to improving the discharge process and a medication related work stream is planned.

Insulin safety is identified as a priority and a calendar of events are planned for Insulin Safety Week which occurs in May 2019. The Diabetes team has prepared a suite of new e-learning

material to include topics such as variable rate insulin, dealing with hypoglycaemia and the treatment of diabetic ketoacidosis, which will be launched during March 2019.

Duty of Candour

Duty of Candour requires, 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). Duty of Candour is a regulation that has been applicable to health service bodies since November 2014. It has been a further development of the "Being Open" process that was already followed in the Trust. The investigation of incidents 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 delivering excellent care with compassion.

Where incidents are reported as either 'moderate', 'severe' or 'death' harm categories within the Datix incident reporting system, the reviewer completes a mandatory field which triggers actions consistent with the guidance set out in the regulation. Compliance with Duty of Candour is monitored on a weekly basis through the Trust's Case Review Group.

The CQC highlighted during their inspection in 2018 that Duty of Candour was not always addressed in a timely way and consequently action has been undertaken to promote early identification of the need to apply Duty of Candour. In the year 2018-19 the Trust has applied Duty of Candour within the specified timescale on 155 occasions (64.8% compliance), which is a slight decrease in performance from 2017-18 when the Trust applied Duty of Candour within the specified timescale on 93 occasions (62% compliance). This was a significant improvement on the previous year 2016-17 where the Trust applied Duty of Candour within the specified timescales on 12 occasions (14.6% compliance). This provides further assurance that the application of Duty of Candour is embedded in the organisation.

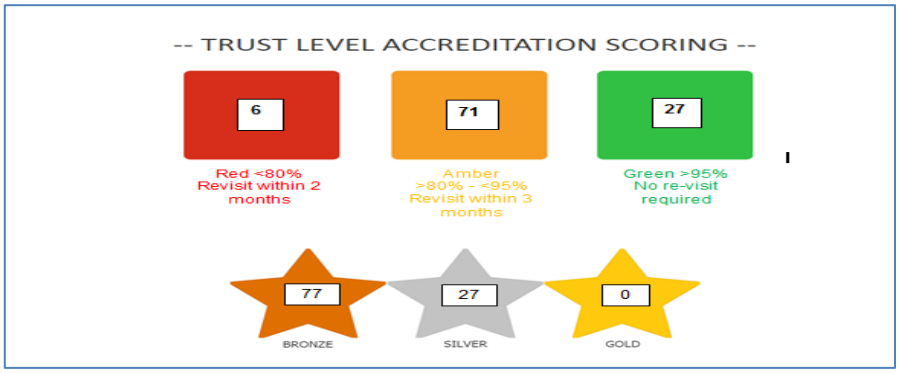
Safety Triangulation Accreditation Review (STAR)

The STAR Quality Assurance Framework has been designed 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 2 elements:

- STAR Monthly reviews – undertaken by the Matron or Professional Lead for each area
- STAR Accreditation Visits – undertaken by the Quality Assurance Team with support from staff, Governors and volunteers from across the Trust

STAR was launched in June 2017 and there are now 116 clinical areas registered on the Trust audit system AMaT and undertaking monthly reviews.

The visit results in a red, amber or green score depending on the level of assurance gained. The outcome of the visit will determine the revisit frequency. Up to end of March, 2019 total of 104 areas had STAR visits completed. These have resulted in the following scores:



Source: LTHTR data

As part of the STAR accreditation visit the 15 step challenge is undertaken by a member of the visit team, and usually a Governor or volunteer that 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/department manager and the Divisional Nursing or AHP Director to ensure immediate action on the areas of concern and implement recommendations in the report.

15 Step Challenge Outcome

	A Very confident	B Confident	C Not very confident	D Not confident at all
Trust Overall	62	40	1	0

Source: LTHTR data

Patient Safety – Birth Centre Closure

In response to feedback from Lancashire County Council Oversight & Scrutiny Committee (p.84)

In February 2019 during some planned building work asbestos was identified in the building that accommodates the birth centre at Chorley & South Ribble Hospital. Expert advice confirmed that removing the asbestos would not be possible whilst the building was occupied. As a result the birth centre is not currently available at Chorley, and the Trust has been working with pregnant women to review their birth plans, offering home births or access to the birth centre at Preston. The Trust is currently developing options to re-provide the birth centre at another area of Chorley & South Ribble Hospital.

Review of Quality Performance - Effective Care

The Trust aims to continually provide effective care and treatment by ensuring clinical practice is evidence based on 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. The Trust also learns from the deaths of patients and changes practice where required. These aspects of effective care are presented as well as 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

The Trust recognises the opportunities that the national GIRFT programme provides and the benefits it will bring to the services provided by the Trust. This quality improvement programme encompasses a wide range of clinical pathways in both surgery and medicine e.g., Emergency Medicine; Orthopaedic Surgery; Neurology

Currently the programme is clinically led and managed in the divisions, which promotes clinical ownership. To support the clinical leads and to have improved corporate coordination and oversight, the Trust is employing a full time programme manager in the immediate future.

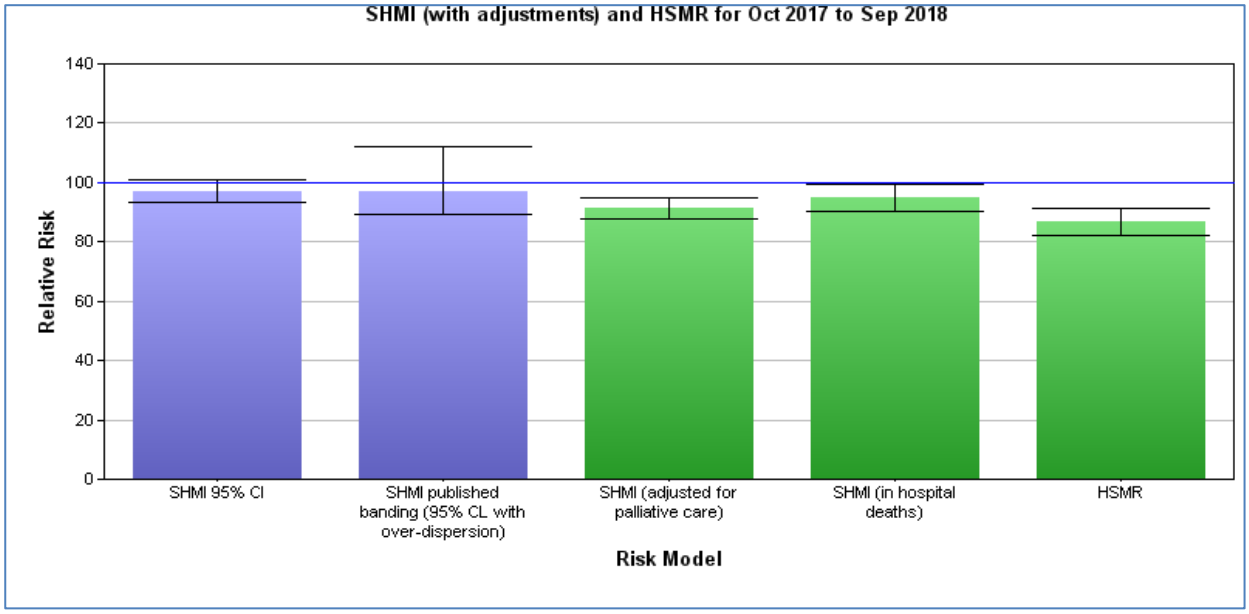
The GIRFT programme enables the organisation to benchmark with other similar hospital services and share learning. It will also be aligned with our Continuous Improvement and Financial strategies to ensure the Trust continues to provide efficient and cost effective care and treatment.

Mortality

The Trust recognises the importance of mortality rates as a key factor in promoting confidence in Trust services and an indicator of quality. The mortality intelligence relates to both the Summary Hospital Mortality indicator (SHMI) data and Hospital Standardised Mortality Rate (HSMR) data.

The Summary Hospital Mortality Indicator (SHMI) measures mortality in patients who die in hospital and at home within 30 days of discharge from hospital. In addition, 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 Trust SHMI for the most current period available 12 months October 2017 – September 2018 is 97.13 which is within expected range. The SHMI when adjusted for palliative care is 91.18 which is lower than expected. In comparison with the SHMI data submitted in the 2017-18 quality account this is an improved performance, the SHMI at that time for the period July 2016 – June 2017 was 105.25 which was higher than expected and 104.42 which was within normal range.

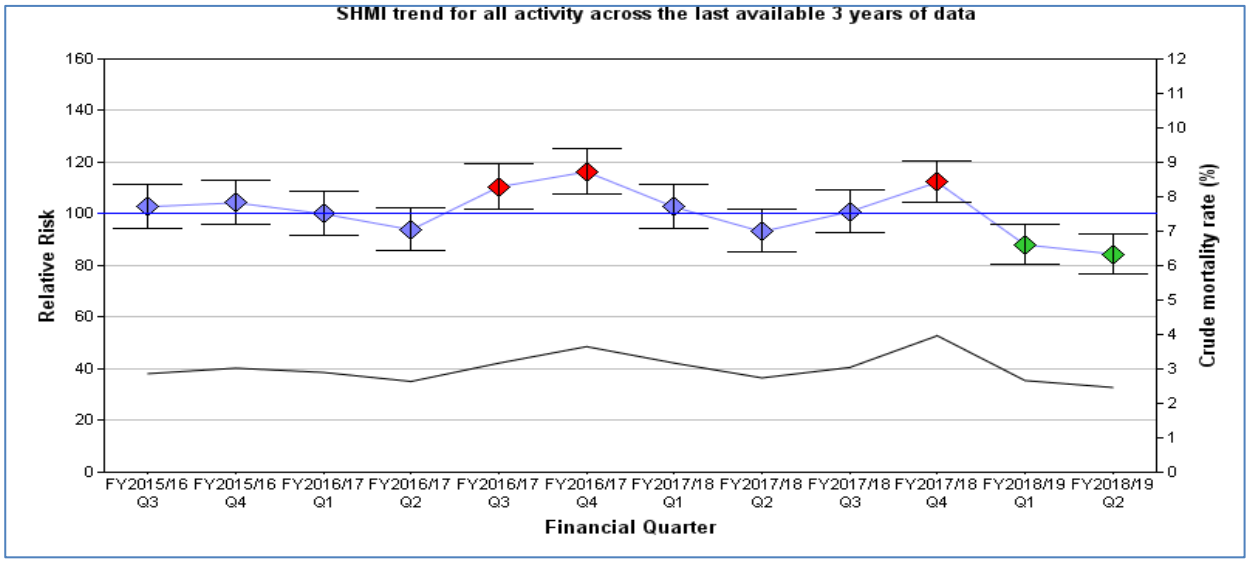


Source: Dr Foster Intelligence

SHMI (with adjustments) and HSMR for Oct 2017 to Sep 2018					
Model	**SHMI Spells**	**SHMI**	**Obs**	**Exp**	**95% CI**
SHMI 95% CI	78233	97.13	2370	2440.06	93.26-101.12
SHMI published banding (95% CL with over-dispersion)	78233	97.13	2370	2440.06	89.08-112.26
SHMI (adjusted for palliative care)	78233	91.18	2370	2599.36	87.54-94.92
SHMI (in hospital deaths)	78233	94.74	1679	1772.31	90.26-99.38
HSMR	39859	86.68	1467	1692.45	82.30-91.23

Source: Dr Foster Intelligence

The SHMI trend for the last 3 years is presented below which demonstrates the improving picture for Q1 & Q2 of 2018/19.



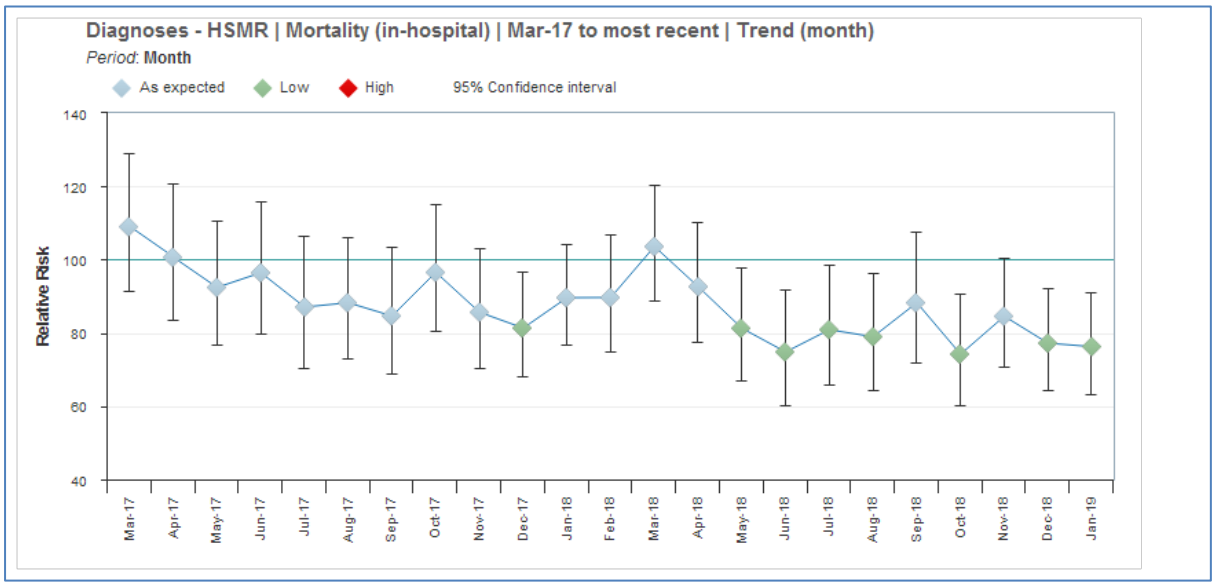
Source: Dr Foster Intelligence

The Trust also monitors 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 the direct control of the hospital 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 lower than 100

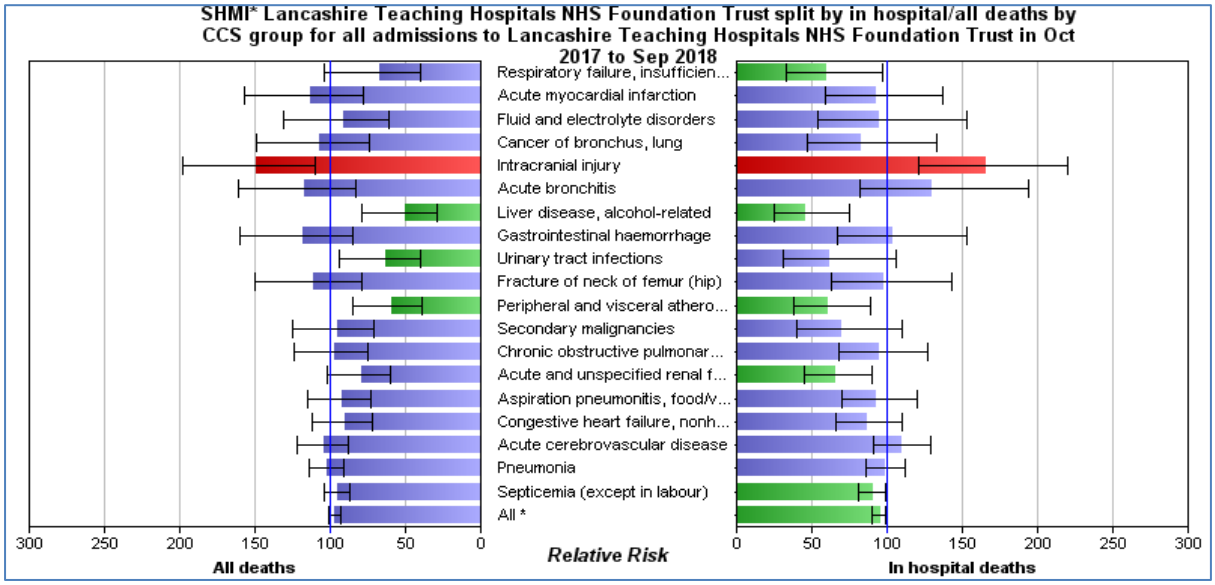
In the most current 12 month HSMR data (Dr Foster Intelligence) February 2018 – January 2019 the HSMR (basket of 56 diagnoses) is 83.8 and for all diagnoses (deaths) it is 85.0 both of which are better than the 'expected' range for the population of patients treated at Lancashire Teaching Hospitals NHS Foundation Trust.

The HSMR from March 2017 to January 2019 demonstrates the continued trend of mortality being either ‘within expected’ or ‘lower than expected’ range compared with the national picture.



Source: Dr Foster Intelligence

Although the overall mortality remains within expected range there have been intermittent periods of increased HSMR (Negative CUSUM alerts) in relation to intracranial injury during 2017 – 2018 which is also highlighted in the SHMI graph of deaths by group for the period October 2017 – September 2018 presented below.



Source: Dr Foster Intelligence

Case note reviews were undertaken during the alerting periods which 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. However, as mortality rates for this group of patients have remained elevated, a more detailed case note review was been requested by the CQC which was submitted in February 2019, which again highlighted no cause for concern.

In addition a period of raised HSMR was observed in relation to patients admitted with Abdominal Aortic Aneurysm. Detailed analysis of the cases found no cause for concern in relation to this group. The outcome of both reviews have been reported to the Trust Mortality Board

The Trust continually monitors both the SHMI and HSMR and where alerts are raised these are highlighted to the relevant clinical teams for a Structured Judgement Review of case notes. Relevant action would be taken where appropriate and learning from the deaths shared at a local level at Morbidity & Mortality meetings.

A comprehensive mortality report is presented to the bi-monthly Mortality Board which includes the SHMI & HSMR status and outcomes of the Trust SJR mortality reviews as well as avoidability of death and quality care scores.

Learning from Deaths

The Trust mortality review approach was changed in 2017 to reflect the national requirements of the National Quality Board and CQC report '*Learning Candour & Accountability*' (2016).

The mortality review process:-

- Is based on the recommended Structured Judgement Review methodology
- Involves bereaved families and carers into the review or investigation into the death
- Monitors quality care and avoidability of deaths scores and where there are concerns, these are raised for secondary review/serious incident investigation
- Shares outcomes of the reviews and investigations, which are raised within divisions through the monthly Clinical Effectiveness reports to speciality and divisional Safety & Quality meetings.
- Learning from deaths is also central to the speciality Morbidity & Mortality meetings
- A quarterly report is provided to the End of Life/Mortality Board which highlights

- Corporate & Divisional Mortality review participation
- Quality of End of Life Care
- Avoidability of Death Scoring
- Secondary Review Summary
- Serious Incident Level 3 /StEIS Reviews
- LeDeR reviews
- Doctor Foster Intelligence Mortality Alerts

The mortality review and investigations processes have both been recognised as needing changes to integrate them more effectively, which is planned for 2019-20. The aim of the review of policies, systems and processes is to reduce potential duplication of case note reviews, particularly with the implementation of the Medical Examiner role in 2019.

The ambition is that the Medical Examiner will review all deaths and signpost those additional to the statutory mortality review requirements for a primary SJR review or to the serious investigations/coroner cases. It is expected that the Medical Examiner/Medical Examiner Officers will have the opportunity to provide additional engagement with families in addition to that already offered by the bereavement services team.

The Learning Disabilities mortality process is also under internal and regional review. The Trust now has a Mental Health and Learning Disabilities team which will be improving the reviews and the approach to learning from the deaths of these patients

It has been recognised that there was a need to improve our approach to learning from deaths so the Trust now has made available additional resource to take forward changes, including the implementation of a “Learning Bank” to share the learning more widely and effectively.

The mortality data has been presented in this report on page 161.

Tissue Viability – Pressure Ulcer Incidence

National and Trust focus on the elimination of avoidable pressure ulcers in NHS provided care continues, with pressure ulcers one of the four indicators measured within the Safety Thermometer. The prevention of pressure ulcers continues to be a key focus of improvement for the Trust.

Pressure ulcers may be acquired in the community or in hospital, measurement systems therefore need to take account of the incidence or the number acquired in hospital and the prevalence which relate to the total number of patients with a pressure ulcer (a proportion of which will relate to acquisition in the community).

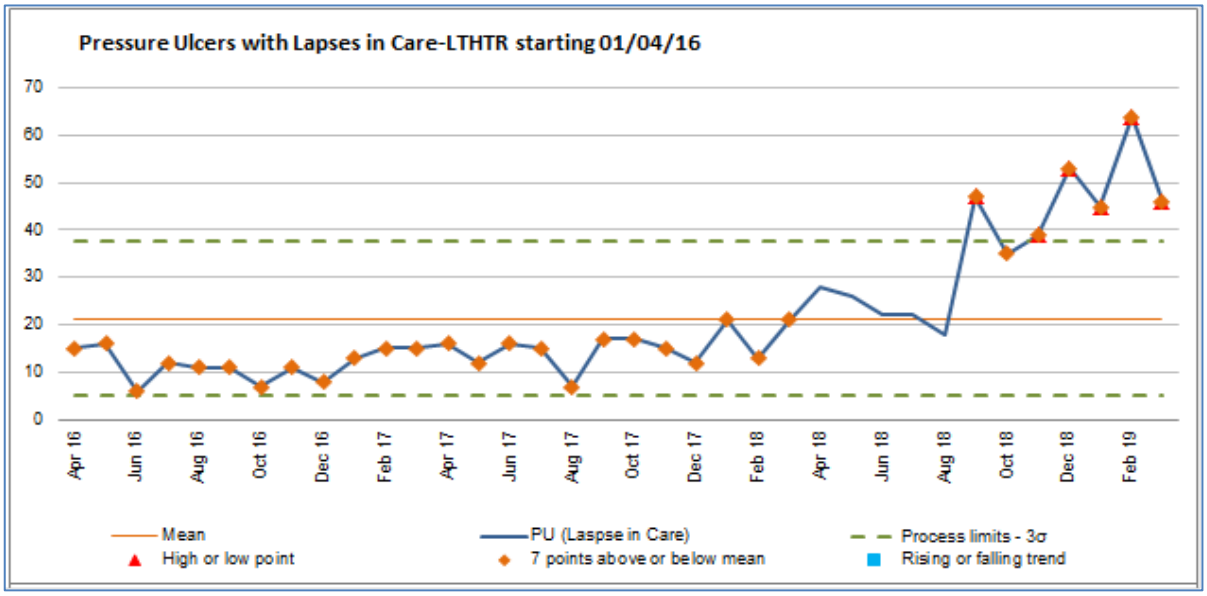
The Trust has an established programme focussing on prevention and management of pressure ulceration, which includes:

- 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 ED, airflow mattresses, electronic bed frames and protection aids.

- Use of technology, the Trust is currently working with the Academic Heath Science network to trial new technology to identify early indications of damage to enable us to be responsive to patient's needs.
- Registered Nurse staffing levels have a direct impact on the incidence of pressure ulcers, as such the Trust undertakes monthly staffing reports to identify early red flags in areas where additional support may be required to prevent harm occurring to patients.
- Specialist tissue viability teams work with staff in all areas to educate, respond to and support patients who are at risk of developing pressure ulcers.
- Collaborative working with community colleagues enacting the 'react to red' campaign in hospital and the community setting

Since September 2018, an identified increase in hospital acquired pressure ulcers has occurred. The reasons that underpin this increase are variable and as such the Continuous Improvement Team have commenced an improvement programme to recover this incidence.

The programme is focused on standardising practice, measuring performance of critical interventions and learning lessons from areas where lapses in care occur. The methodology used to review pressure ulcers is taken from the successful infection, prevention and control improvement programme, where all gaps in agreed processes are considered to be a lapse in care. This ensures the Trust is driving high standards of care and practice for all patients.



Source: LTHTR data

The graph above demonstrates the crude numbers of pressure ulcers, it should be noted that an increase in the overall number of patients has also occurred , however, even when considering this the increase is something that requires improvement.

Positively, the Trust has some wards and departments across the organisation such as Ward 14 that has achieved zero lapses in care for patients acquiring pressure ulcers for six months. Other wards including Ward 4 have significantly improved the number of pressure ulcers reported as avoidable. The focus for improvement is currently within the Division of Medicine and Ribblesdale Ward.

There is evidence of improved compliance with electronic risk assessments and overall documentation and as a result of this the ward teams have redesigned the documentation used to capture interventions with patients to support making doing the right thing as easy as possible.

A deep dive review of the detailed action has been presented to the Safety & Quality committee in August 2018 and then again in March 2019 to provide assurance regarding the progress of the actions.

Nutrition

The provision of high quality nutritional support is complemented by the Trust's 7-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 daycase 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. The services are designed to assess patients swiftly, make nutritional care plans, including feeding device selection, and appropriate follow up. The nursing seven day service provides a rapid access clinic which is an admission avoidance measure, and improves quality for patients as they have a dedicated telephone helpline to gain this expert advice.

The 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 sites all wards now 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 support the wards offering monthly 'tea parties' with the provision of home-made cakes. This is to be extended over the coming year to include non-alcoholic 'cocktails' on the Ribblesdale ward.

Another improvement is support from the dietetics team in nutritional analysis of patient recipes. The dietetic team also encourages 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.

The Trust is fully compliant with legislation relating to allergens. Catering services provide support with allergen information, should that be requested, by either the patient or the ward staff.

The Speech and Language Therapy department this year have implemented the new international dysphagia descriptors as part of nutrition and hydration week 2019. This also takes into account full compliance with national standards relating to soft, pureed and liquidized diets.

During 2018/19 the services key priorities were to:

- Ensure documentation relating to MUST assessment and discharge information is standardised

  The MUST assessment and discharge information is now standardised and hosted in the Electronic Patient Record

- Develop a competency framework for band 3 and band 5 nutritional staff

  This has been superseded by having food and hygiene learning for all

- Undertake a review of dietetic diagnostics and patient outcomes

  Reviews of diagnostics and patient outcomes is ongoing

- Establishment of parenteral feeding services for children at home across Lancashire

  This was a feeding service for children over 2 years, the Trust currently has a service for 0 -2 year olds

During 2019/20 the services key priorities are to:

- Ensure documentation relating to MUST assessment and discharge information is standardised
- Ensure compliance with the international dysphagia framework
- Undertake a review of dietetic diagnostics and patient outcomes
- Establishment of parenteral feeding services for adults at home across Lancashire and Merseyside

The Trust won prestigious Nursing Times award in 2018 for best safety initiative for the e-learning tool developed to support interpreting Chest X-Ray when looking at naso-gastric tube position.

This best practice safety imitative has been adopted by Health Education England, the Royal College of Radiographers and over 25 other NHS Trusts have adopted the programme, which has been offered as a free resource.

Review of Quality Performance - Experience of Care

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

Patient experience and feedback forms the bedrock of our service provision and provides opportunities for the organisation to reflect on practice to ensure developments are consistent and appropriate to meet the needs of our service users and carers.

During the reporting period 2018-19 the Trust has increased involvement and engagement with patients, carers and external organisations to foster our commitment to improve patient

experience. Our *Patient Experience and Involvement Strategy 2018-21* has provided a clear focus on what matters most to our community. The Trust has 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

Governance of the strategy is monitored through the Nursing Midwifery and Allied Health Professions Board and this is shared with the Trust governors, Healthwatch and members of external organisations.

This year the Trust has established a Youth Forum, made up of young people from the local community who wish to develop the Children and Young People's services to meet their needs and expectations, which in most instances are different from those of our adult population. This group is led by one of our young people formerly a member of the National NHS Youth Forum.

The organisation established a Patient Experience Improvement Group which continues to meet on a monthly basis to support the strategy. Key themes are selected from the strategy for discussion and experts across the Trust are invited to share new initiatives. The group suggests how these can be supported to ensure planned developments and implementation. The group consists of over 40 people from the local community, Governors, patient representatives, carer organisations and staff. The Patient Experience Improvement Group provides an opportunity for input from a fully diverse representation of the communities across Chorley and Preston. This gives is an open and honest reflection of the local community and will also oversee the feedback that the Trust receives from patient experience feedback in relation to several areas, including:

- Friends and Family Test Feedback
- PALS and complaints intelligence
- NHS Choices
- National Patient Surveys
- Patient Stories
- Patient and Public Involvement

Over the past year the Trust has engaged with several national Patient Surveys including:

- National inpatient Survey
- Emergency Department Survey
- National Maternity Survey
- Children and Young People's Survey

National Adult Inpatient Survey

The survey was based on a sample of inpatients who received treatment at the Trust in July 2018. A total of 1207 were eligible following the survey, 397 inpatients responded to the questionnaire, providing a response rate of 32.1%. There has so far been no notification of the publication date.

The 2018 survey will not be published until after the publication of the 2018-19 Quality Account. 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

National Maternity Survey

Maternity services have received positive feedback in the annual national survey for 2018 which demonstrated significant improvements from the previous year.

The National Picker Maternity Survey 2018 is aimed at women, aged 16 years or over who gave birth at the hospitals in February 2018. The purpose of the survey is to understand what women think of the care they have received ranging from antenatal care, labour and birth, and postnatal care.

The results received demonstrate a significant improved position for maternity services compared to the last national Picker survey and also the one prior to that. Lancashire Teaching Hospitals ranked 12th out of 69 hospitals nationally. This is compared to the 2017 survey where the hospitals ranked 36th out of 68 surveyed which is a huge improvement.

The maternity services ranked significantly better than the last survey on the following 3 statements in particular:

1. Treated with respect and dignity – 98%
2. Had confidence and trust in staff – 100%
3. Involved enough in decisions about their care – 96%

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

1. Found partner was able to stay with them as long as they wanted – 88%
2. Given a choice about where to have check-ups – 57%
3. Received support or advice about feeding their baby during evenings, nights or weekends – 87%
4. Saw the midwife as much as they wanted – 83%
5. Offered a choice of where to have baby – 97%

And when looking at the most improved areas from the previous 2017 survey; these were:

1. Offered a choice of where to have baby – 97%
2. Given the help needed by midwives – 99%
3. Felt that they were given appropriate advice and support at the start of labour – 95%
4. Had confidence and trust in staff – 100%
5. Found partner was able to stay with them as long as they wanted – 88%

A total of 300 mothers from our hospital were sent a questionnaire. Of these individuals; 292 mothers were eligible for the survey, of which 112 returned a completed questionnaire, giving a response rate of 38%. The average response rate for the 69 'Picker' organisations was 36%.

Notable positive feedback for the services included being offered a choice of where to have the baby, being given the help they needed by midwives, having their partner able to stay with them as long as they wanted, being able to see the midwife as much as they wanted, and receiving support or advice about feeding their baby during evenings and weekends.

Children and Young People's Survey

The National Children and Young People's survey was not carried out in 2017 as this is a bi-annual publication. The 2018-19 survey is currently being undertaken.

Friends and Family Test (FFT)

The Friends and Family Test is a key indicator of patient experience to gather information at the point of discharge and thereafter. This assists the Trust 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.

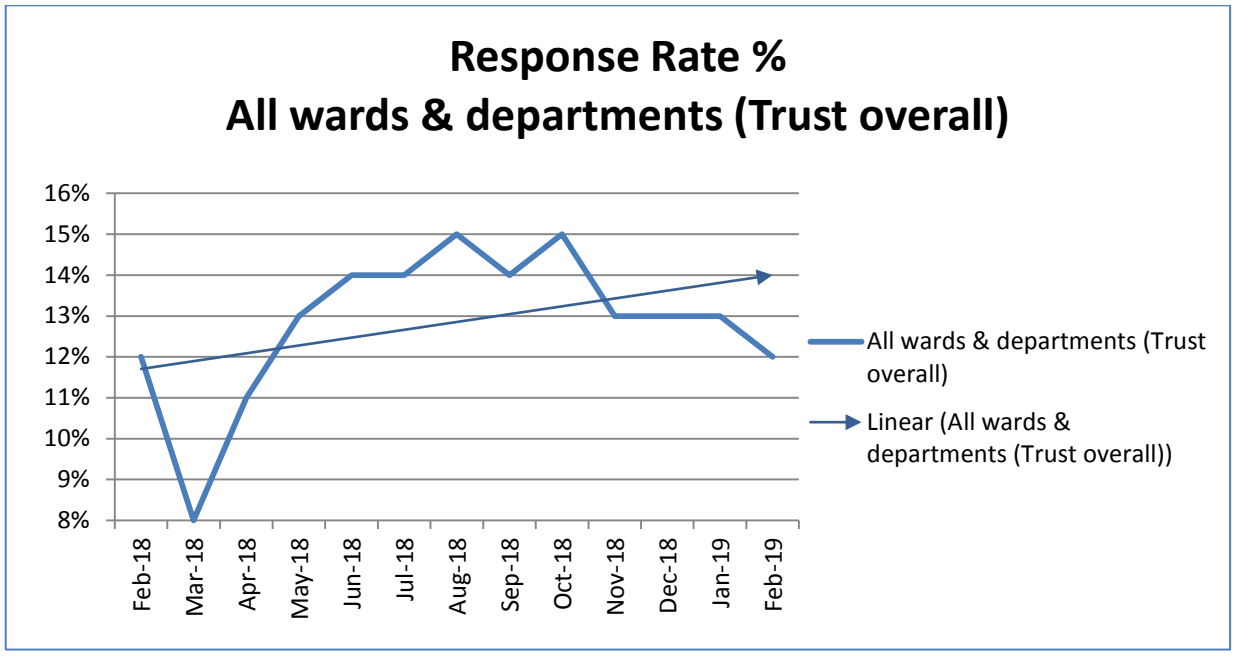
Historically information has been gathered from inpatients, outpatients, day case treatment and the emergency department services. However the Trust has recognised that there are a significant number of areas where key information has not been gathered. The Trust has started to gather information from Children and Young People's Services and has identified a number of areas where in the future information in relation to FFT will be collected. This will enable the Trust to triangulate all patient experience information to enable a balanced view of patient experience across all areas of the organisation. An additional question has been added to the FFT to ask patients how they would like to be involved in improving services. This provides a proactive and welcoming approach to involvement and a desire to engage with our patients to improve services. This has prompted people to get involved as part of the Patient Experience Improvement Group where the membership now consists of those who want to get involved.

Over the past year the Trust has been driving a communication campaign to ensure that as many areas as possible adopt the FFT. The reintroduction of FFT cards with recognisable branding has been introduced into all inpatient and outpatient areas, this includes specifically tailoring the FFT to Children and Young People's Services. The communication screens across the Trust raise awareness of the FFT with a poster and advertising campaign to support.

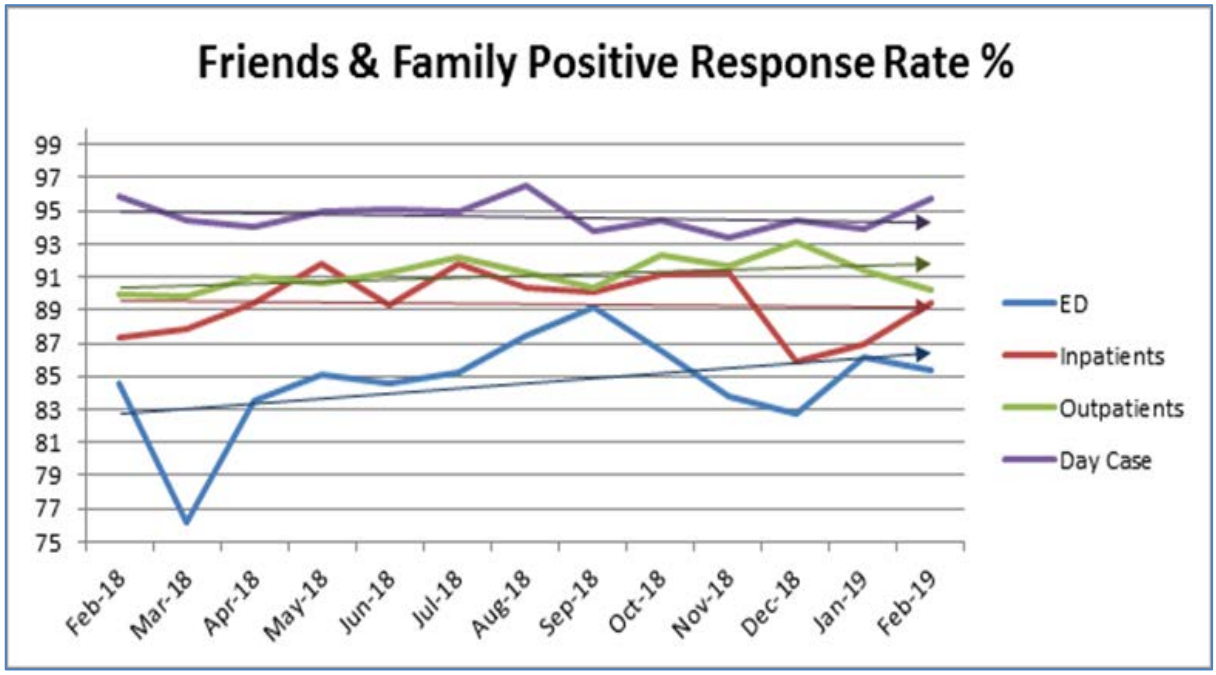
There has been an improvement in the response rate for the FFT within the past year, with more areas being more proactive to gather feedback. The advertising campaign has helped to support this. The text relay service continues to be problematic where some information is lost due to mobile phone numbers being rejected as incorrect. There continues to be awareness with teams to ask for patients attending to confirm their full mobile phone number, rather than the last 3 digits which had been asked for previously. This may be more successful to obtain in the future with the introduction of electronic patient appointment letters, which will be provided by the same company.

FFT performance is monitored on a monthly basis and is reported through the Trust Safety and Quality Committee. FFT information remains largely positive, however the Trust recognises that the response rate needs continuous improvement and has a plan in place to achieve this. One of the major considerations will be to continue to improve on the response rate from our patients to ensure a more reflective analysis of performance.

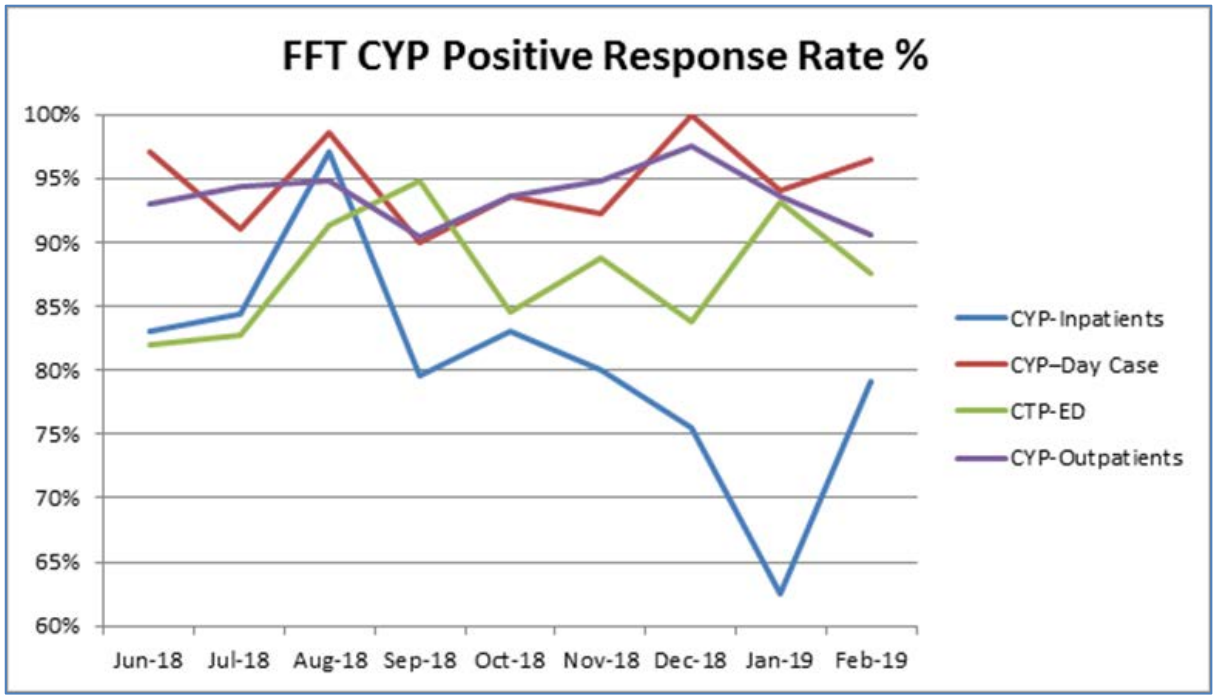
The maternity service will be introducing the FFT cards in the coming year on ward areas to increase the information currently gathered.



Source: LTHTR data



Source: LTHTR data



Source: LTHTR data

Complaints and Concerns

There has been a 22% increase in complaints since 2017-18. When considered in terms of the ratio of complaints to patient contact, the Trust received one complaint for every 1148 inpatient and outpatient episodes during 2017-18, (when activity increased from the previous year) compared to one complaint for every 1329 patient episodes during 2016-17. The trend in the ratio of complaints to patient contacts over the past four years is detailed below:

Year	No of complaints	Total episodes	Ratio of complaints to patient

		(IP/OP)	contacts
2015-16	575	808431	1:1406
2016-17	595	790696	1:1329
2017-18	553	789643	1:1428
2018-19	710	815607	0:9999

Source: Datix LTHTR

Of the 710 complaints received in 2018, 564 (79%) related to care or services provided at the Royal Preston Hospital (RPH), 140 (20%) to care or services provided at Chorley and South Ribble District General Hospital (CDH) and 5 (1%) to care or services provided offsite (by the Specialist Mobility Rehabilitation Centre, based at Preston Business Centre).

284 (40%) of the complaints received related to the care of inpatients, 228 (32%) to the care or services provided to those who were outpatients, 74 (10%) to patients attending the Emergency Department, 21 (3%) to patients attending Maternity Services, 20 (3%) to patients within the Children's and Young People's Services and the remaining, 83 (12%) complaints related to services offered to visitors to the Trust.

When considered in the context of the number of complaints per division, the information detailed below is reflective of the current divisional arrangements. 264 (37%) of the complaints received relate to directorates or departments that are now contained within the Medical Division, 291 (41%) to those within the Surgical Division and 62 (9%) to directorates and departments that sit within the Division of Diagnostics and Clinical Support, 88 (12%) relate to Facilities and Services with the remaining 5 (1%) complaints relate to corporate services.

647 formal complaints were closed during 2018-19. 91% of all open complaints had been closed with 100% 35 day response compliance. By the end of 2018-19 there were 89 complaints which remained open and are being investigated, all of which are still within the required agreed timescales for completion.

The investigations that were undertaken into those 647 closed complaints concluded that 147 (23%) of the complaints had been upheld, 230 (35%) were partly upheld and 190 (29%) had not been upheld. The 3 remaining records were cases that were withdrawn.

The percentage of complaints upheld or partly upheld decreased this year (from 61% in 2017-18 to 58%), perhaps reflecting the Trust's continuing ethos of being open, honest and non-defensive when care or services are suboptimal.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the last financial year, 100% of complainants received into the Customer Care Team have had an acknowledgement within that 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 2018-19, the Trust received 26 second letters, 5 more than the number received in the previous financial year.

During 2018-19, 16 complaints were referred to the PHSO. Of the complaints referred to the PHSO in 2018-19, 3 have been closed all of which were not upheld. Final reports have been received in a further 2 cases, both were partly upheld and the Trust is in the process of responding to the PHSO's recommendations. In this same period, the PHSO completed their

investigations into 4 of the complaints that had been referred to them prior to April 2018. These cases have also been closed of which 2 were not upheld, 1 partly upheld and 1 was upheld.

In response to feedback received in 2018 – 2019 the Trust has made changes in a number of areas to improve the quality of service provision. Some of these include:

- The continuation of a Carers Charter in recognition of how carers can support their loved ones whilst in hospital
- Resources to support patients who have dementia as a way of engaging in meaningful activities
- The development of patient boards for behind the bed to ensure that staff can, at a glance, be informed of their care needs, these have now been agreed and are being introduced into ward areas
- Welcome to the Ward boards to provide key information for visitors and carers of what to expect within areas, with photographs of the leaders within areas
- Encouragement of patients to identify what matters most to them on any given day
- Design of magnets to identify specific individualised needs of patients
- Continuation of the 'Hello My Name Is…' initiative across the organisation
- Introduction of 'ALWAYS' events developed in consultation with patients, carers and governors, in the Emergency Department and Children and Young People's Service
- Development of a Youth Forum for Children and Young People's Services
- Maternity Voices Partnership involvement
- Purple Socks campaign to support those patients who are at risk of wandering
- Refurbishment of the PALS Office on the Royal Preston Hospital site to ensure a safe, comfortable environment for patients to raise concerns
- An information desk at the Gordon Hesling Block to provide key information to patients and visitors to the organisation
- How Are We Doing campaign to support awareness for patients, carers and visitors who wish to provide feedback outside of the Friends and Family Test
- Introduction of ward cards with information of how to contact leaders of areas

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2018-2019 (to February 2019) a total of 4699 compliments and thank you cards were received by wards, departments and through the Chief executive's office. The Patient Advice and Liaison Service have dealt with over 2033 issues which would have the potential to become formal complaints and resolved these with a reasonable outcome for patients.

In 2018-2019 the Trust has consistently met the 35 day target of responding to complaints. There were 5 months where 100% was achieved, along with a further 6 months achievement of 94% to 97% providing an upward trajectory towards achieving 100%. There is currently a focus on the quality of complaint responses and the development, recording and validation of action plans associated with complaints.

A 3 year plan is in development that will provide clear objectives and key performance indicators for both the Customer Care and PALS Teams. One of the targets in the plan will be to ensure that the current teams work more closely, with the ultimate aim that they become one team to provide appropriate services in the future.

Patient Stories

The organisation welcomes feedback from many sources, and none more than those from real life experiences of the service. Formerly the Trust had patient stories delivered by the team

involved in a patients care at the Board. This has now progressed further, and patients, carers and relatives are invited to Board meetings to discuss the care given and received in order to share their experiences from the relative's perspective. This has demonstrated a clear impact in terms of the powerful messages portrayed by those who have been involved in patient experience.

Subsequent to the stories being presented at the Board they are cascaded through the organisation to promote discussion and where appropriate improvements can be made. Patient stories are provided through other forums such as the Nursing, Midwifery and Allied Health Professional Board.

Communication and involvement in care

Good communication is the basis of ensuring that effective patient experience is at the core of our services. To continually promote good communication the Trust is reviewing the current systems in place and engaging with service users to make improvements.

In January 2018 the Trust launched two key strategies in support of communication and involvement in care, The Nursing, Midwifery, AHP and Care Givers Strategy and The Patient Experience and Involvement Strategy. The continuation and momentum of these strategies 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 provision.

The Patient Experience Improvement group enables 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.

The NHS celebrated its 70th birthday year during the past 12 months. As part of this there was real engagement from service users in those celebrations with both Preston and Chorley Hospital holding a fun day in June to showcase services, seek views and generally hold up the NHS as a leader in world healthcare.

The Trust has identified the LGBTQ+ population as requiring appropriate support. This year the organisation supported the Preston PRIDE initiative to gather feedback on how our services could be improved in the future. This demonstrated a real commitment to this group of underrepresented people in our community.

Staff Survey

Improving staff experience is a priority for the Trust because we want to be a great place to work and we know as we continually improve staff experience we will improve the quality of care the Trust provides. Two key main indicators are firstly whether staff would recommend working here and secondly recommend our care. These scores have remained the same from last year and are still below the national average therefore the Trust recognises that there is more work to be done to improve staff experience.

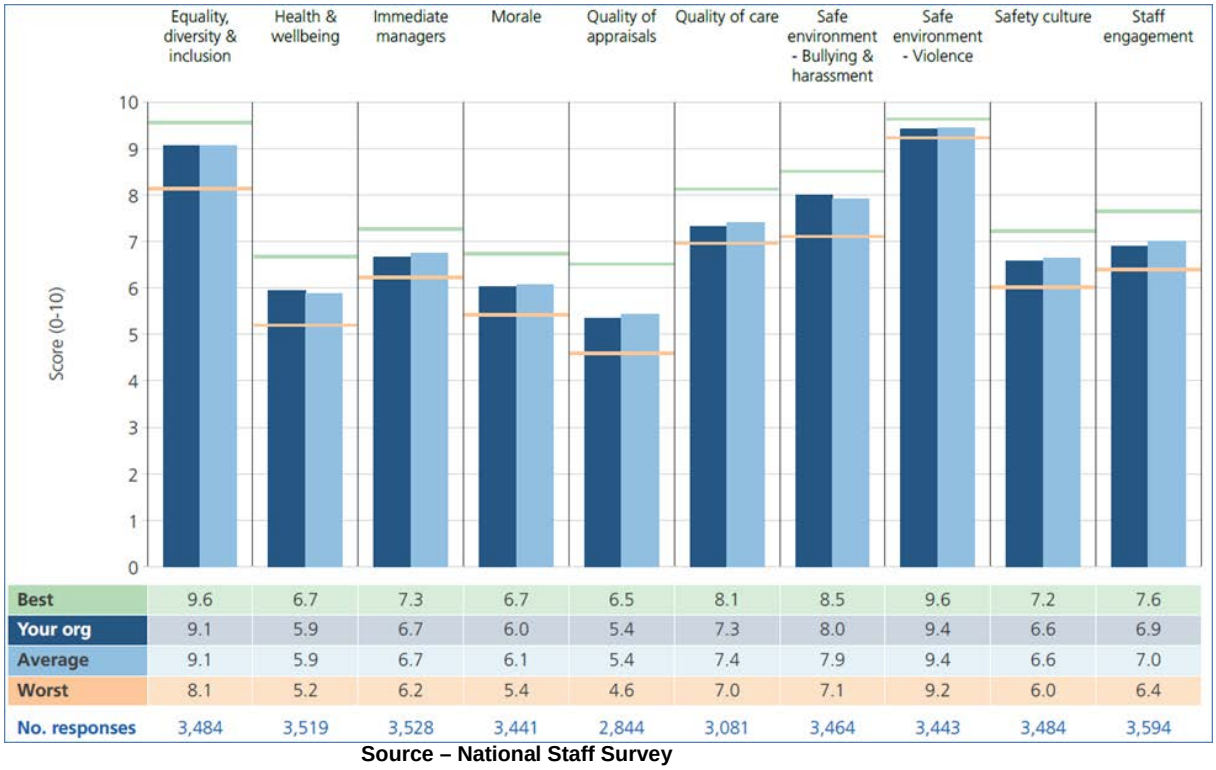
	LTHTR 2016	LTHTR 2017	LTHTR 2018	Movement from 2017	National average

	LTHTR 2016	LTHTR 2017	LTHTR 2018	Movement from 2017	National average
I would recommend my organisation as a place to work	59%	59.5%	**58.6%**	No significant change ⇔	62.6% ↓ Statistically significant
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	65.4%	66.3%	**65.4%**	No significant change ⇔	71.3% ↓ Statistically significant

Across the range of questions asked within the survey the results largely remain stable from the 2017 staff survey. There have been a few areas where experience has improved and a few where experience has deteriorated. Generally our staff experience is similar to the national average across the majority of the questions.

*Chart shows the number of questions that are better, worse, or show no significant difference

The results are now presented in key themes, which are shown in the table below. Our staff experience largely falls within the national average and the strongest performing area for our organisation relates to having a Safe Environment in relation to violence and Equality, Diversity and Inclusion.



	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
Best	9.6	6.7	7.3	6.7	6.5	8.1	8.5	9.6	7.2	7.6
Your org	9.1	5.9	6.7	6.0	5.4	7.3	8.0	9.4	6.6	6.9
Average	9.1	5.9	6.7	6.1	5.4	7.4	7.9	9.4	6.6	7.0
Worst	8.1	5.2	6.2	5.4	4.6	7.0	7.1	9.2	6.0	6.4
No. responses	3,484	3,519	3,528	3,441	2,844	3,081	3,464	3,443	3,484	3,594

Source – National Staff Survey

Key themes:

There has been deterioration in 3 key themes: Equality, Diversity and Inclusion, Health and Wellbeing, and Bullying and Harassment. It is important to note however that Equality, Diversity and Inclusion is the second highest performing area, with Health and Wellbeing better than the national average. Finally Bullying and Harassment this is the third highest performing area and better than the national average.

Overall staff engagement has remained stable with a score of 6.9 / 10 in line with the national average. An area of strength remains staff involvement where 76% of staff said they can make suggestions to improve the work of their team or department and 74% said that there are frequent opportunities for them to show initiative in their role. Whilst only 54% said they were able to make improvements happen and so this remains an area of focus for the Trust.

There have been some improvements to a small number of questions: staff reporting having an appraisal, satisfaction with pay, staff involved in errors being treated fairly, staff knowing who senior managers are and patient / service user feedback being collected.

'Big Conversation' focus groups and 'Equality, Diversity, and Inclusion Big Conversations' focus groups will take place in April 2019 to explore the staff survey results and consider additional actions which aim to improve further. An action plan will be created following the focus groups supported by "You Said We Did" communications to highlight the changes that will be implemented.

Quality Assurance

This Quality Account has presented the data, information and assurance required by NHSi. This has included reporting on core indicators and the quality of data. It has also highlighted the Trust priorities for improvement for 2019 – 20 which relate to our Big Plan and corporate strategies. The report has presented a review of performance in relation to patient safety, experience and effective care.

The Trust Safety and Quality Committee promotes and leads a safety and quality culture in which staff are supported and empowered to improve services and care. The committee provides the Board of Directors with assurance that the patient experience and outcomes of care are optimised 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, identifying and understanding significant variation and ensuring appropriate and effective response occur
- Monitoring performance and progress in respect 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 seeking and providing assurance by participating in STAR and other assessments. Governors also attend the Trust's Patient Safety Collaborative Group and Patient Experience Improvement as active members.

Governor involvement in the *Our Health Our Care* programme has been hugely valued and much appreciated by the Trust. The Governors patient experience group continues to offer valuable challenge and assurance, whilst they continue to contribute to significant environmental improvements for patients through use of their charitable fund.

This Quality Account has provided assurance of the performance and ongoing activity which promotes patient safety, effective care and excellent experience.

The organisation utilises nationally benchmarked data where possible, from such sources as the NHS Information Centre and Dr Foster Intelligence clinical benchmarking tools, and participation in peer review exercises.

Annex 1: Statements from External Stakeholders

Greater Preston Clinical Commissioning Group

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 CQC 'well led' inspection at the Trust in October 2018 resulted in an overall rating of 'requires improvement'. Whilst this was disappointing, the CCG notes that the Trust retained their 'good' rating across the board for 'caring', with three directorates moving to 'good' overall.

The CCG continues to be partners at the Central Lancashire Improvement Board and is pleased to note the continued progression against the CQC action plan, in particular noting the strengthened governance procedures that are now in place. The CCG also acknowledges that the Trust has implemented changes to urgent and emergency care services using a continuous improvement approach. It is, however, important to recognise the continued challenges the Trust faces in relation to internal flow and capacity issues and it would be useful to understand how the continuous improvement strategy can be utilised to positively affect these challenges. The CQC is due to carry out a further inspection at the Trust and the CCG looks forward to the outcome of this visit.

It is disappointing to note that eight Never Events were reported during 2018-19. The CCG would like to acknowledge that the Trust has participated in two round table events in relation to these incidents (in partnership with NHS England, NHS Improvement, the CQC and the CCG). This resulted in a thematic review in order to identify any immediate learning. Notably the Trust has received a Nursing Times award for the educational package produced in relation to check x-rays for nasogastric tube placement (which has been disseminated on a national level). Additionally, the Trust is currently participating in a clinical trial in relation to the standardisation of nasogastric tube aspiration. This has been presented at the NHSE Patient Safety Collaborative and highlights the work undertaken to address this patient safety issue.

The CCG also acknowledges the Trust's commitment to the CCG Serious Incident Review Panel whereby senior clinicians' present applicable learning and actions that have been implemented in practice.

Operational pressures have continued to affect performance against the NHS Constitutional targets. Whilst the Trust has implemented a range of improvement projects and submitted remedial action plans, these have not had the expected impact on performance targets. Achievement of the 18 week Referral to Treatment Time (RTT) target has remained problematic, which has resulted in a number of patients waiting longer than 52 weeks for surgery. The Trust has failed to achieve the 4 hour standard in A&E, with a significant increase noted in patients waiting for more than 12 hours on a trolley. Achievement of the 31 day and 62 day cancer standards has also been inconsistent throughout the year. The CCG would like to acknowledge the expansion of the ambulatory care pathways across both sites, along with the implementation of the Rapid Assessment and Treatment Service in the

A&E department. Both initiatives have had a positive impact on patient care, along with an associated reduction in ambulance handover times.

It is positive to note that Hospital Standardised Mortality Rates for all diagnoses remains below the required threshold. The CCG recognises that the Trust has embedded practice based on the recommended Structured Judgement Review methodology when carrying out case reviews. However, it is acknowledged that further improvement is required in order to increase the number of secondary reviews that are undertaken.

Staffing levels have remained challenging over the year, although the CCG recognises that this position is reflected nationally. Notably, the Trust undertakes monthly staffing reports to identify early red flags in areas where additional support may be required to prevent harm occurring to patients. It is positive to note the investment the Trust Board has agreed in order to enhance staffing levels, particularly within paediatrics, maternity and A&E. In addition, the development of the medical staffing model along with the introduction of the nursing associate, prescribing pharmacist and discharge facilitator roles will, hopefully, help to address this issue.

The results of the 2018 NHS staff survey have, in the main, remained stable when compared to the 2017 survey, with staff experience being similar to the national average. The CCG were concerned to note the deterioration in relation to the bullying and harassment indicator, however, recognise the positive work that the Trust has undertaken in relation to organisational culture and staff engagement in order to address this issue. It is encouraging to note the progress that has been made in relation to staff engagement, specifically the development of the 'Big Plan' which outlines the Trust's overall mission, strategic aims and how every team and department will contribute to delivery of the plan.

The CCG has undertaken a programme of announced and unannounced quality visits at the Trust throughout the year and would like to acknowledge that, on the whole, patients remain happy with the care that they are receiving. Staff have been welcoming, open and transparent in their discussions at these visits. The CCG recognises the ongoing commitment from the staff to improve patient care and would like to note the improvements the Trust has made in response to patient feedback. It is positive to note that patients have been involved in these improvements and have designed specific information projects.

In relation to the 2018-19 priorities for improvement; there has been a sustained reduction in the number of falls with harm at the Trust. There has been a recent increase in reported pressure ulcers; however, it is positive to note the immediate improvement actions that have been implemented as a result of this. Incident reporting has increased and the STAR accreditation process continues to drive improvements at ward level. There have been no reported cases of hospital acquired MRSA bacteraemia. In addition, the Trust has remained under trajectory for Clostridium Difficile cases. The Infection Prevention & Control Matron and Consultant Microbiologist are proactive members of the CCG's Health Care Acquired Infections Panel. It is very positive to note that the preliminary research work (in relation to understanding the causes of E.coli infections) that was undertaken by the Consultant Microbiologist has attracted national interest.

During 2018/2019, NHS England mandated the following CQUIN schemes:

Staff health and wellbeing.
Reducing the impact of serious infections (antimicrobial resistance and sepsis).
Improving services for people with mental health needs who present to A&E.
Offering advice and guidance.

Risky behaviours alcohol and tobacco screening, advice and referral.

The Trust has participated in all of the mandated schemes and achievement or partial achievement is expected in all schemes. The CCG would like to acknowledge the significant progress the Trust has made in relation to the implementation of the Advice and Guidance CQUIN indicator in 2018-19.

As the health economy moves towards their goal of an Integrated Care System (ICS) it will be essential to have strong leadership in place that promotes partnership working in order to ensure the delivery of quality services and the effective use of resources. The Trust has experienced continued financial pressures during 2018-19 and the CCG recognises the significant challenges that lie ahead for 2019-20. The CCG is also aware of a number of senior leadership changes that will occur during this financial year and will work to ensure that productive working relationships are maintained throughout this period.

The CCG looks forward to working in partnership with Lancashire Teaching Hospitals in 2019-20 in order to achieve our aims of safe, effective care that provides a positive experience for patients.

Yours sincerely

Denis Gizzi
Chief Officer

Lancashire County Councils Overview and Scrutiny Committee

The Lancashire Health Scrutiny function welcomes the opportunity to comment on the Lancashire Teaching Hospitals NHS Foundation Trust's Quality Accounts for 2018/19.

On priorities for improvement members welcomed the appointment of a Director of Continuous Improvement and Head of Continuous Improvement; the development of a Continuous Improvement Strategy and the Trust's Big Plan outlining the strategic aims of the organisation for the next three years. It was felt that future Quality Accounts should include relevant details of progression against specific objectives. On the STAR status of wards and departments it would have been useful to set out the capacity of those involved in the STAR team.

Information on participation in clinical audits was comprehensive. Although it was felt that the information contained in the tables could have been merged in order to remove the need to cross-reference.

Members commended the establishment of trusted relationships with the Care Quality Commission (CQC) as a mechanism to escalate risks and concerns in respect of patient safety and quality as they occur.

The Trust should be commended for reviewing its processes and systems for inviting, listening and responding to concerns raised by staff following the publication of Sir Robert Francis' Freedom to Speak Up Review (2015) and the additional work it has done to strengthen the arrangements in response to the Gosport Inquiry (2018).

There appears to be little reference to Chorley A&E unit and the services provided by GTD healthcare in the Urgent Care Centre. In addition there was no reference to the recent temporary closure (from 25 February 2019) of the Birth Centre at Chorley and South Ribble Hospital. The recent outcome in relation to the proposed Model of Care arising from the Our Health Our Care programme as agreed by the Joint Committee of Clinical Commissioning Groups for the programme at its meeting held on 13 March 2019, was also not referenced. It was felt that a link to this information should have been provided.

From the perspective of the general public, members felt the Account was a lengthy document and could be difficult to interpret in places particularly the use of funnel plots. Members would therefore be in favour of the production of a document, or easy read document that summarised the main content and findings of the Quality Account.

The Lancashire Health Scrutiny function would welcome early involvement with the planning process for the production of the Trust's 2019/20 Quality Account.

Healthwatch Lancashire

Healthwatch Lancashire is pleased to be able to submit the following considered response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts Report for 2018-19.

Part 1 Chief Executive's Statement:

This statement from the Chief Executive Officer acknowledges that performance has been mixed and whilst there have been improvements in some areas there is still more to do. The Trust has plans in place to address the issues raised by the Care Quality Commission (CQC) and The Big Plan outlines strategic aims and goals for the next three years. We note that the intention is to develop a culture of continuous improvement, an aspiration we fully support. The contribution of staff to the service improvements and innovative solutions is quite rightly recognised.

Part 2 Priorities for improvement and Mandatory Quality Indicators:

We are encouraged by the work that has been undertaken and the direction to develop a culture of improvement including the appointment of a Director and a Head of Continuous Improvement.

There are some notable successes reported in specific areas during 2018-19 and we hope these methodologies can be further developed and implemented more widely.

Healthwatch Cumbria particularly liked the Trust involvement in Clinical Audits, the value and impact of engagement in research is well described and demonstrates the improvement from learning approach that the Trust has adopted.

We commend the Trust for it's achievement of quality improvement and innovation goals through the Commissioning for Quality and innovation payment framework and the establishment of trusted relationships with the CQC in respect of patient safety and quality of care effected by regular relationship meetings.

In accordance with the current NHS reporting requirements and mandatory quality indicators requiring inclusion in the Quality Account the Trust appears to have fulfilled this requirement.

Information received by Healthwatch Lancashire (HWL) from service users and their families and carers regarding services provided by Lancashire Teaching Hospitals NHS Foundation Trust is consistent with the data, statements and comments contained in the Quality Account.

We are very pleased to see that the Trust has reviewed it's processes and systems in accordance with additional consideration (2) of the NHS Improvement letter 17th December 2018 Quality accounts: reporting arrangements 2019/19, ahead of legislation requested Trusts to provide details of ways that staff can speak up (including whistle-blowers) and how they ensure such staff do not suffer detriment as a result. An environment in which staff can voice concerns over quality of care, patient safety or bullying and harassment with the Trust is an enhancement which would further support the drive to increase recruitment, retention and morale of staff.

Suggestions for content 2019-20:

In respect of the 2019-20 Report we would suggest that the presentation could be enhanced in some areas to improve public accessibility including the format of charts and benchmarking. We liked the concept of links to further information however these did not connect from the Draft. Healthwatch Lancashire would be pleased to explore these issues with you.

Summary

Overall, we would say that this is a well-balanced document in that it acknowledges areas of improvement needed and the remedial measures being taken to address these. The emphasis on culture change, increased involvement of the public, staff and partner organisations to develop continuous improvement is integral to the document. We welcome, and would like to find ways of supporting, this in practice.

Sue Stevenson

Chief Operating Officer

Healthwatch Lancashire

Trust Governors

Feedback was provided by Governors on the content of the report including:

- Reference to the 23% achievement of the STAR silver against the target of 50% and queried the potential causes and highlighted the target may have been too ambitious. There was some concern at the number of red status results but encouragement that this gave a focus for rapid improvement
- Governor feedback suggested that the trust perhaps benchmark CQUIN achievements with peer organisations
- The Governors highlighted the continually improving relationship with the CQC
- The Governors commended the Freedom to Speak Up Guardian function and recommended that the increase in people speaking up through this service should be compared with the numbers from other available approaches for concerns to be raised
- It was also recognised that the Patient Safety Collaborative group met infrequently during this period

Annex 2:

Statement of directors' responsibilities for the quality report.

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 2018-19 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 2018 to March 2019
    - Papers relating to quality reported to the board over the period April 2018 to March 2019
    - Feedback from commissioners dated 00/05/2019
    - Feedback from governors dated 00/05/2019
    - Feedback from local Healthwatch 08/05/2019
    - Feedback from Overview and Scrutiny Committee 07/05/2019
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, went to Board 03/05/2018
    - The 2018 national patient survey undertaken in July 2018 remains under embargo until advised by CQC
    - The 2018 national staff survey 26/02/2019
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 17/05/2019 was presented to audit committee on 17/05/2019
    - CQC Inspection report dated 17/10/2018
- 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 and
- 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 24th May 2019

Chief Executive Date 24th May 2019

Glossary of Abbreviations

AHP	Allied Health Professionals
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach team
CDH	Chorley District Hospital
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
DNACPR	Do not attempt cardiopulmonary resuscitation
ECAP	Essentials of Care Audit Programme
EMB	Ethambutol endometrial biopsy
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
HDU	High Dependency Unit
HRA	Health Research Authority
HSMR	Hospital Standardised Mortality Ratio
IBD	Inflammatory Bowel Disease (Programme)
ICNARC	Intensive Care National Audit & Research Centre
ICU	Intensive Care Unit
IG	Information Governance
LeDeR	Learning Disability Mortality Review Programme
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MCCDs	Medical Certificate of Cause of Death
MDT	Multidisciplinary Team
MINAP	Myocardial Ischaemia National Audit Project
MRSA	Methicillin resistant staphylococcus aureus
NACEL	National Audit of Care at the End of Life
NAOGC	National Audit of Oesophago-gastric Cancer
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
NICE	National Institute for Health and Clinical Excellence
NJR	National joint registry
NLCA	National Lung Cancer Audit
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
PPH	Postpartum Haemorrhage
PREM	Patient Reported Experience Measure
PROMs	National Patient Reported Outcome Measures programme
RCOG	Royal College of Obstetricians and Gynaecologists
RPH	Royal Preston Hospital
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusions
SLT	Speech and Language Therapy
SSNAP	Sentinel Stroke National Audit Programme
TARN	Trauma Audit and Research Network
TIA	Transient Ischaemic Attack
VTE	Venous thromboembolism

INDEPENDENT AUDITORS' REPORT TO THE COUNCIL OF GOVERNORS ON THE QUALITY REPORT
2018/19

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Lancashire Teaching Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated May 2019;
- feedback from governors, dated May May 2019;
- feedback from local Healthwatch organisations, dated 8 May 2019;
- feedback from Overview and Scrutiny Committee, dated 7 May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3 May 2019;
- the 2018 national patient survey, not currently publicly available;
- the 2018 national staff survey, dated 26 February 2019;
- Care Quality Commission Inspection, dated 17 October 2018;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 17 May 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Lancashire Teaching Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Lancashire Teaching Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

24 May 2019

Lancashire Teaching Hospitals NHS Foundation Trust

FINANCIAL REVIEW
2018/19

Independent auditor's report

to the Council of Governors of Lancashire Teaching Hospitals NHS 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 2019 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 2019 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 2018-19 and the Department of Health and Social Care Group Accounting Manual 2018-19.

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	£9.0 million (2018:£6.0 million) 1.86% (2018: 1.27%) of total revenues	
Risks of material misstatement		**vs 2018**
Event driven	Material uncertainty related to going concern	◄►
Recurring risks	Valuation of land and building assets	◄►
	Revenue 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 of £37.1 million in 2019/20, excluding impairments and support funding, which is dependent also on the achievement of Productivity and Efficiency Target savings of £25.0 million. The Trust's financial plan for 2019/20 includes the receipt of additional working capital loan support of £20.0 million. As at 31 March 2019 the Trust has total borrowings from the Department of Health and Social Care (DHSC) of £166.5 million, of which £25.1 million is due for repayment in 2019/20. As of April 2019, existing loans of £30.4 million will become payable within 12 months, which will take total current borrowings payable within 12 months to £55.5 million. At present, there are no viable means for the Trust to repay its existing DHSC support loans, or any new ones which are received during 2019/20. 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** There is little judgement involved in the Accounting Officer's conclusion that the risks and circumstances described in note 1.3 to the financial statements represent a material uncertainty over the ability of the Trust to continue as a going concern for a period of at least a year from the date of approval of the financial statements. However, clear and full disclosure of the facts and the Accounting Officer's rationale for the use of the going concern basis of preparation, including that there is a related material uncertainty, is a key financial statement disclosure and so was the focus of our audit in this area. Auditing standards require that this reported as a key audit matter.	Our procedures included: — **Assessing transparency:** we assessed the completeness and accuracy of the matters covered in the going concern disclosure by: — Using our professional judgement to determine whether the basis of preparation note adequately describes the challenges facing the Trust; — Agreeing the financial balances disclosed back to the Trust's financial statements for 2018/19 and financial plan for 2019/20; — Agreeing the extent to which recurrent cost improvement schemes were achieved in 2018/19 and identified for 2019/20 to Board reporting and to the financial plan for 2019/20; — Reviewing the Trust's cash flow forecasts and the requirement of additional distress funding, including agreeing the balances drawn down in April 2019 and May 2019; — Confirming the terms of the loans from DHSC and considering the timing of future repayments and the availability of funding; and — Reviewing long-term forecasts to assess the cash and loan position in the Trust.

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 (unchanged from 2017/18):

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Valuation of Land and Buildings (£210.9 million; 201X: £196.7 million) *Refer to page 107 (Audit Committee Report), Note 1.11 (accounting policy) and Note 10 (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. There is significant judgment involved in determining the appropriate valuation basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. In 2018/19, the Trust commissioned a full valuation from an external valuer as at 31 March 2019, which included a physical inspection of all assets by the valuer. As a result, the value of land and building assets was increased by a net of £5.6 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	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 2018/19. — **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 2018/19.

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 (£440.0 million; 2017/18: £422.7 million) *Refer to page 107 (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.

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 (2017/18: £6.0 million), determined with reference to a benchmark of operating income (of which it represents approximately 1.86%; 2017/18: 1.27%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

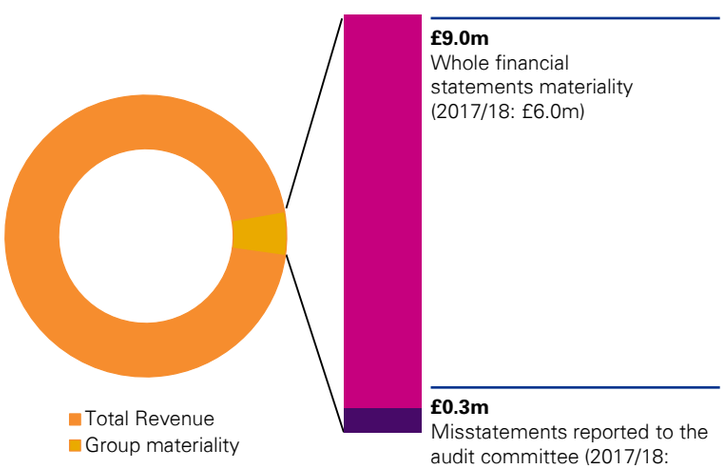
Materiality for the parent Trust's financial statements as a whole was set at £8.9 million (2017/18: N/A), determined with reference to a benchmark of operating income (of which it represents approximately 1.88%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2017/18:(£0.22 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the group's two (2017/18: one) reporting components, we subjected two (2017/18: one) 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.

Total revenue
£484.8m (2017/18: £470.9m)

Group Materiality
£9.0m (2017/18: £6.0m)



£9.0m
Whole financial statements materiality (2017/18: £6.0m)

£0.3m
Misstatements reported to the audit committee (2017/18: £0.22m)

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.

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KPMG

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 2018/19.

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 2018/19, 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 79, 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.

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 its 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 2018.

Basis for adverse conclusion

The Trust reported a deficit of £45.2 million for the year ended 31 March 2019, and is forecasting a deficit of £37.1m in 2019/20 (excluding impairment and non-recurrent support funding. The Trust has significant loan balances, including a loan of £25.1m due for repayment before the end of 2019/20. The current plans and forecasts do not demonstrate that the Trust will be able to repay this loan.

The requirement for external financial support has continued throughout 2018/19 and the Trust plans to access significant further working capital loan facilities of £20.0 million during 2019/20.

The Trust achieved Productivity and Efficiency Target (PET) savings delivery of £22.1m in the year, compared to a target of £25.0m. Of the total delivery, £13.3m represents non-recurrent savings achieved and places additional pressures on the 2019/20 savings targets.

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 the Trust's cash position and delivery of cost improvement programme	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. Monitoring progress and achievement of schemes that will generate recurring savings is a key part of the Trust's plans to achieve a sustainable medium and long term financial position.	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 around £22.1m of its required £25m cost improvement plan savings in 2018/19, with around £13m of the delivered savings being recurrent. This provides some assurance regarding the arrangements the Trust has in place to identify Productivity and Efficiency Target (PET) schemes, and for tracking and monitoring the achievement of these schemes through the year. However, the Trust's current 2019/20 financial plans show a forecast deficit of £37.1m (excluding receipt of non-recurrent support funding). Support funding is not guaranteed to be received in 2019/20 or in any given year. The Trust's plans also includes the assumption of further DHSC working capital cash support of £20m during the financial year. Without this cash support, the Trust simply would not be able to continue to operate. At present, there are no viable means for the Trust to repay its existing DHSC support loans which total £166.5m, or any new ones which are received during 2019/20. The Trust's operating performance and the outcome of its 2018 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 will 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 or an ability to repay the loans from the Department of Health. 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 – Response to Regulators	In May 2018, revised enforcement undertakings were put in place by NHS Improvement, which superseded those agreed in June 2015. The new undertakings relate principally to the financial sustainability of the Trust. The Trust CQC inspection in 2018/19 resulted in an overall rating of 'Requires improvement', including a 'Requires improvement' rating for use of resources.	Our work included assessing the adequacy of the Trust's arrangements for: — Monitoring progress against the recommendations and agreed actions in response to the 2018/19 CQC report and rating of 'Requires improvement', including a focus on the actions relating to the Use of Resources rating of 'Requires Improvement'; and — Monitoring progress against the undertakings agreed with NHS Improvement in May 2018. **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 are therefore satisfied that the Trust's arrangements in respect of Value for Money sub-criterion *Informed Decision Making* were adequate during 2018/19.

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 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 (Statutory Auditor)

Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

24 May 2019

KPMG

Foreword to the accounts

Lancashire Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 **24 May 2019**

Statement of Comprehensive Income

		Group	
		2018/19	2017/18
	Note	£000	£000
Operating income from patient care activities	2	440,040	422,698
Other operating income	2	44,754	48,232
Operating expenses	3	(524,552)	(498,937)
Operating deficit from continuing operations		**(39,758)**	**(28,007)**
Finance income	7	154	90
Finance expenses	7	(3,209)	(2,245)
PDC dividends payable		(2,484)	(3,736)
Net finance costs		**(5,539)**	**(5,891)**
Other gains	7	83	-
Deficit for the year		**(45,214)**	**(33,898)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	4	(7,755)	445
Revaluations		8,065	5,703
Total comprehensive expense for the period		**(44,904)**	**(27,750)**
Deficit for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(45,214)	(33,898)
TOTAL		**(45,214)**	**(33,898)**
Total comprehensive expense for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(44,904)	(27,750)
TOTAL		**(44,904)**	**(27,750)**

In accordance with Trust accounting policies the land and buildings of the Trust were revalued resulting in a reversal of previous impairments charged to expenditure. The Trust qualified for £4.4m of Sustainability and Transformation funding in 2017/18, although none in 2018/19, and also recieved a net income of £0.4m (2017/18 £1.6m) related to donated assets. Without these elements the deficit of the Trust would have been £50m (2017/18 £42m).

The notes form part of these accounts.

Statement of Financial Position

	Note	Group 31 March 2019 £000	Group 31 March 2018 £000	Trust 31 March 2019 £000	Trust 31 March 2018 £000
Non-current assets					
Intangible assets	8	3,702	4,735	3,702	4,735
Property, plant and equipment	9	254,807	235,580	254,798	235,580
Investment property		-	-	-	-
Investments in associates and joint ventures		-	-	-	-
Other investments / financial assets		-	-	-	-
Receivables	11	5,840	5,196	5,840	5,196
Total non-current assets		**264,349**	**245,511**	**264,340**	**245,511**
Current assets					
Inventories	10	14,111	11,845	13,161	11,845
Receivables	11	32,710	25,473	32,262	25,473
Cash and cash equivalents	12	2,981	6,874	2,376	6,874
Total current assets		**49,802**	**44,192**	**47,799**	**44,192**
Current liabilities					
Trade and other payables	13	(53,901)	(40,376)	(51,806)	(40,376)
Borrowings	15	(26,256)	(25,753)	(26,256)	(25,753)
Provisions	17	(791)	(521)	(791)	(521)
Other liabilities	14	(4,937)	(3,126)	(4,937)	(3,126)
Total current liabilities		**(85,885)**	**(69,776)**	**(83,790)**	**(69,776)**
Total assets less current liabilities		**228,266**	**219,927**	**228,349**	**219,927**
Non-current liabilities					
Borrowings	15	(142,584)	(91,904)	(142,584)	(91,904)
Provisions	17	(1,532)	(1,718)	(1,532)	(1,718)
Total non-current liabilities		**(144,116)**	**(93,622)**	**(144,116)**	**(93,622)**
Total assets employed		**84,150**	**126,305**	**84,233**	**126,305**
Financed by					
Public dividend capital		224,782	222,033	224,782	222,033
Revaluation reserve		46,450	46,914	46,450	46,914
Income and expenditure reserve		(187,082)	(142,642)	(186,999)	(142,642)
Total taxpayers' equity		**84,150**	**126,305**	**84,233**	**126,305**

The notes form part of these accounts.

Name
Position CHIEF EXECUTIVE
Date **24 May 2019**

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 - brought forward	**222,033**	**46,914**	**(142,642)**	**126,305**
Deficit for the year	-	-	(45,214)	**(45,214)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(774)	774	**-**
Impairments	-	(7,755)	-	**(7,755)**
Revaluations	-	8,065	-	**8,065**
Public dividend capital received	2,749	-	-	**2,749**
Taxpayers' and others' equity at 31 March 2019	**224,782**	**46,450**	**(187,082)**	**84,150**

Trust

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**222,033**	**46,914**	**(142,642)**	**126,305**
Deficit for the year	-	-	(45,131)	**(45,131)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(774)	774	**-**
Impairments	-	(7,755)	-	**(7,755)**
Revaluations	-	8,065	-	**8,065**
Public dividend capital received	2,749	-	-	**2,749**
Taxpayers' and others' equity at 31 March 2019	**224,782**	**46,450**	**(186,999)**	**84,233**

Statement of Changes in Equity for the year ended 31 March 2018

Group and Trust

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**220,609**	**42,987**	**(110,965)**	**152,631**
Deficit for the year	-	-	(33,898)	**(33,898)**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(2,221)	2,221	**-**
Impairments	-	445	-	**445**
Revaluations	-	5,703	-	**5,703**
Public dividend capital received	1,424	-	-	**1,424**
Taxpayers' and others' equity at 31 March 2018	**222,033**	**46,914**	**(142,642)**	**126,305**

Statement of Cash Flows

	Group		Trust	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Cash flows from operating activities				
Operating deficit	(39,758)	(28,007)	(39,675)	(28,007)
Non-cash income and expense:				
Depreciation and amortisation	13,236	13,317	13,236	13,317
Net impairments	(5,249)	(2,157)	(5,249)	(2,157)
Income recognised in respect of capital donations	(461)	(1,891)	(461)	(1,891)
(Increase) / decrease in receivables and other assets	(7,953)	3,170	(7,505)	3,170
Increase in inventories	(2,266)	(2,879)	(1,316)	(2,879)
Increase / (decrease) in payables and other liabilities	6,566	(5,164)	4,471	(5,164)
Increase / (decrease) in provisions	82	(9)	82	(9)
Net cash flows used in operating activities	**(35,803)**	**(23,620)**	**(36,417)**	**(23,620)**
Cash flows from investing activities				
Interest received	154	90	154	90
Purchase of intangible assets	(749)	(413)	(749)	(413)
Purchase of PPE and investment property	(16,143)	(11,955)	(16,134)	(11,955)
Proceeds from sales of PPE	89	-	89	-
Receipt of cash donations to purchase assets	442	773	442	773
Net cash flows used in investing activities	**(16,207)**	**(11,505)**	**(16,198)**	**(11,505)**
Cash flows from financing activities				
Public dividend capital received	2,749	1,424	2,749	1,424
Movement on loans from DHSC	51,325	39,745	51,325	39,745
Movement on other loans	89	(21)	89	(21)
Capital element of finance lease rental payments	(747)	(774)	(747)	(774)
Interest on loans	(2,791)	(1,886)	(2,791)	(1,886)
Interest paid on finance lease liabilities	(169)	(222)	(169)	(222)
PDC dividend paid	(2,339)	(3,606)	(2,339)	(3,606)
Net cash flows from financing activities	**48,117**	**34,660**	**48,117**	**34,660**
Decrease in cash and cash equivalents	**(3,893)**	**(465)**	**(4,498)**	**(465)**
Cash and cash equivalents at 1 April - brought forward	**6,874**	**7,339**	**6,874**	**7,339**
Cash and cash equivalents at 31 March 2019	**2,981**	**6,874**	**2,376**	**6,874**

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 2018/19 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

The financial statements are prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

For 2018/19 the Trust has a planned deficit of £46.441m excluding impairments and funding from the Provider Sustainability Fund which it did not qualify for. This plan was dependant on achieving a Performance Efficiency Target (PET) of £25m (5% of income). During the year the Trust benefited from enhanced support from NHSI and from a Financial Improvement Director. However the trust has recorded a deficit in these accounts of £50.444 against this target mainly as a consequence of unachieved PET in the year. For 2019/20 the trust is planning for a deficit of £37.050m excluding impairments and support funding, although this is again dependant on a PET of £25m. Working capital loans have been made available to support the deficit of the Trust, ensuring liabilities are met, and these are continuing to be available in 2019/20. The current working capital loan of £20.5m from DH has only been extended until March 2020, and the working capital facility of £30.4m falls due for repayment in April 2020. It has been indicated that these facilities will be extended further while the Trust remains in deficit. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have believe that it will do so.

The Trust's expectation is that services will continue to be provided from the existing hospital sites. However it recognises that sustainable financial balance needs to come through engagement with the wider health economy requiring not only the trust to achieve service efficiencies but also for it to maximise the use of its assets and support the wider transformational change in service delivery. The Trust will work with NHS Improvement (NHSI) and its stakeholders to achieve this objective.

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

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis. 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 a 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 charitable funds of Lancashire Teaching Hospitals NHS Foundation Trust are not material 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 was formed in August 2018 and commenced trading on 1st October 2018. As sole owner the company therefore constitutes a subsidiary of the Trust and the financial results of the company throughout its initial period of trading 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 Trust's other components.

The chief operating decision maker is the Board of Directors. The board receives the monthly financial statements 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 IFRS8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/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.

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.

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 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.

1.7 Revenue grants and other contributions to expenditure

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.

The value of the benefit received when accessing funds from the 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 NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, 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.

Employer's pension cost 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 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, eg, 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.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

As directed by HM Treasury, the Trust has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets. This approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design, with the same operational value as the existing asset. The modern equivalent may be smaller than the existing asset, for example, due to technological advances in plant and machinery or reduced operational use.

The land and buildings of the trust have been revalued as at 31st March 2019 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

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, borrowings 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 of property, plant and equipment is recognised as an increase in 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 and residual interests in off-Statement of Financial Position PFI contract assets 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 income.

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 ie:
- 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 at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other 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	83
Plant & machinery	-	15
Transport equipment	-	7
Information technology	-	10
Furniture & fittings	-	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, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the
• 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, eg 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, eg 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. Revaluations 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 IAS 40 of 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 useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life 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	5	5

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 asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for 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. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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 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

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 18 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 benefits 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:
• present 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 amounf 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 accounting judgements and key sources of estimation uncertainty

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 Key Sources of estimation uncertainty

The following are the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The revaluation of the hospital has been carried out by Cushman Wakefield, who have applied the modern equivalent asset valuation. 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 well be smaller than the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. The application and assessment of the valuation has been informed by Trust management in respect of the estimated requirements of a modern equivalent hospital.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. Outcomes within the next financial year that are different from the assumption around the valuation of our land or PPE could require a material adjustment to the carrying amount of the asset recorded in note 10

1.26 IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the DHSC, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £226k, and trade payables reduced by the same amount.

Reassessment of allowances for credit losses under the expected loss model did not result in a change in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £9,199k.

1.27 IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,563

No revenue was recognised in 2018/19 from performance obligations satisfied (or partially satisfied) in previous periods

Transaction price allocated to remaining performance obligations	**31 March**
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**2019**
	£000
within one year	4,443
after one year, not later than five years	494
Total revenue allocated to remainig performance obligations	**4,937**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii)

1.28 Early adoption of standards, amendments and interpretations

The DH GAM does not require recently published standards IFRS 16 - Leases, IFRS 17 - Insurance Contracts, or IFRIC 23 - Uncertainty over Income Tax Treatments to be adopted in the 2018/19 accounts as these have not been adopted within the FReM

2 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy

2.1 Income from patient care activities (by nature)

	2018/19 £000	2017/18 £000
Acute services		
Elective income	74,980	72,045
Non elective income	120,909	117,804
First outpatient income	24,424	23,493
Follow up outpatient income	32,783	32,077
A & E income	12,601	12,620
High cost drugs income from commissioners (excluding pass-through costs)	22,071	19,328
Other NHS clinical income	143,355	141,035
All services		
Private patient income	481	1,354
Agenda for Change pay award central funding	5,398	-
Other clinical income	3,038	2,942
Total income from activities	**440,040**	**422,698**

2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	151,146	142,307
Clinical commissioning groups	279,711	275,836
Department of Health and Social Care	5,475	-
Other NHS providers	213	228
Non-NHS: private patients	179	926
Non-NHS: overseas patients (chargeable to patient)	302	428
Injury cost recover scheme	2,843	2,877
Non NHS: other	171	96
Total income from activities	**440,040**	**422,698**
Of which:		
Related to continuing operations	440,040	422,698
Related to discontinued operations	-	-

2.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19 £000	2017/18 £000
Income recognised this year	302	428
Cash payments received in-year	33	83
Amounts added to provision for impairment of receivables	108	165
Amounts written off in-year	10	27

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 provided below:

	2018/19	2017/18
	£000	£000
Income from services designated as commssioner requested services	430,857	418,143

2.5 Other operating income (Group)

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	2,740	2,240
Education and training (excluding notional apprenticeship levy income)	20,009	20,338
Non-patient care services to other bodies	7,206	6,240
Provider sustainability / sustainability and transformation fund income (PSF / STF)	-	4,428
Other contract income*	14,338	13,095
Other non-contract operating income:		
Receipt of capital donations	461	1,891
Total other operating income	**44,754**	**48,232**
Of which:		
Related to continuing operations	44,754	48,232
Related to discontinued operations	-	-

* Items within other income that exceed £500,000 include:

	£000	£000
Pharmaceutical sales	2,543	2,108
Car Parking	2,590	2,351
Catering Income	1,365	1,497
Estates Recharges	764	664

3 Operating expenses (Group)

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	290	1,438
Purchase of healthcare from non-NHS and non-DHSC bodies	11,389	7,456
Staff and executive directors costs	342,862	324,280
Remuneration of non-executive directors	145	134
Supplies and services - clinical (excluding drugs costs)	46,672	42,031
Supplies and services - general	9,662	6,105
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	51,242	46,466
Inventories written down	9	-
Consultancy costs	778	2,525
Establishment	3,184	3,063
Premises	25,839	28,311
Transport (including patient travel)	2,091	1,876
Depreciation on property, plant and equipment	11,454	11,558
Amortisation on intangible assets	1,782	1,759
Net impairments	(5,249)	(2,157)
Movement in credit loss allowance: contract receivables / contract assets	(88)	-
Movement in credit loss allowance: all other receivables and investments	-	1,117
Increase in other provisions	130	-
Change in provisions discount rate	91	47
Audit fees payable to the external auditor		
audit services- statutory audit	77	71
other auditor remuneration (external auditor only)	11	11
Internal audit costs	120	138
Clinical negligence	19,452	19,196
Legal fees	571	822
Insurance	208	515
Research and development	151	-
Education and training	1,290	1,070
Rentals under operating leases	25	164
Redundancy	-	19
Losses, ex gratia & special payments	-	274
Other	364	648
Total	**524,552**	**498,937**
Of which:		
Related to continuing operations	524,469	498,937
Related to discontinued operations	-	-

3 Operating expenses (Trust)

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	290	1,438
Purchase of healthcare from non-NHS and non-DHSC bodies	11,815	7,456
Staff and executive directors costs	342,445	324,280
Remuneration of non-executive directors	145	134
Supplies and services - clinical (excluding drugs costs)	46,672	42,031
Supplies and services - general	9,652	6,105
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	51,242	46,466
Inventories written down	9	-
Consultancy costs	778	2,525
Establishment	3,184	3,063
Premises	25,820	28,311
Transport (including patient travel)	2,091	1,876
Depreciation on property, plant and equipment	11,454	11,558
Amortisation on intangible assets	1,782	1,759
Net impairments	(5,249)	(2,157)
Movement in credit loss allowance: contract receivables / contract assets	(88)	-
Movement in credit loss allowance: all other receivables and investments	-	1,117
Increase in other provisions	130	-
Change in provisions discount rate	91	47
Audit fees payable to the external auditor		
audit services- statutory audit	77	71
other auditor remuneration (external auditor only)	11	11
Internal audit costs	120	138
Clinical negligence	19,452	19,196
Legal fees	522	822
Insurance	196	515
Research and development	151	-
Education and training	1,290	1,070
Rentals under operating leases	25	164
Redundancy	-	19
Losses, ex gratia & special payments	-	274
Other	364	648
Total	**524,471**	**498,937**
Of which:		
Related to continuing operations	524,469	498,937
Related to discontinued operations	-	-

3.1 Other auditor remuneration (Group)

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	5	-
2. Audit-related assurance services	11	11
Total	**16**	**11**

3.2 Note 3.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

4 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(5,249)	(2,157)
Total net impairments charged to operating surplus / deficit	**(5,249)**	**(2,157)**
Reversals/(Impairments) charged to the revaluation reserve	7,755	(445)
Total net impairments	**2,506**	**(2,602)**

5.1 Employee benefits (Group)

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	247,572	257,314
Social security costs	25,863	24,743
Apprenticeship levy	1,275	1,222
Employer's contributions to NHS pensions	30,139	28,733
Pension cost - other	76	-
Termination benefits	-	48
Temporary staff (including agency)	37,937	12,239
NHS charitable funds staff	-	-
Total gross staff costs	**342,862**	**324,299**
Recoveries in respect of seconded staff	-	-
Total staff costs	**342,862**	**324,299**
Of which		
Costs capitalised as part of assets	-	-

5.2 Retirements due to ill-health (Group)

During 2018/19 there were 5 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £180k (£346k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

5.3 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting 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 the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from 01 April 2019. The DHSC have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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 judgment 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)

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	25	164
Contingent rents	-	-
Less sublease payments received	-	-
Total	**25**	**164**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	25	165
- later than one year and not later than five years;	-	417
- later than five years.	-	-
Total	**25**	**582**
Future minimum sublease payments to be received	-	-

7.1 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2018/19 £000	2017/18 £000
Interest on bank accounts	154	90
Total finance income	**154**	**90**

7.2 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	2,988	1,975
Other loans	50	42
Finance leases	169	223
Interest on late payment of commercial debt	-	3
Total interest expense	**3,207**	**2,243**
Unwinding of discount on provisions	2	2
Total finance costs	**3,209**	**2,245**

7.3 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2018/19 £000	2017/18 £000
Amounts included within interest payable arising from claims made under this legislation	-	3

7.4 Other gains and losses (Group)

	2018/19 £000	2017/18 £000
Gains on disposal of assets	83	-
Total gains on disposal of assets	**83**	**-**
Total other gains	**83**	**-**

7.5 Trust income statement and statement of comprehensive income

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 the period was £45.131million (2017/18 £33.898million). The trust's total comprehensive expense for the period was £44.821million (2017/18 £27.750million)

8 Intangible assets - 2018/19

Group & Trust	Software licences £000	Total £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

Intangible assets - 2017/18

Group & Trust	Software licences £000	Total £000
Gross cost at 1 April 2017 - brought forward	**14,407**	**14,407**
Additions	413	413
Gross cost at 31 March 2018	**14,820**	**14,820**
Amortisation at 1 April 2017 - brought forward	**8,326**	**8,326**
Provided during the year	1,759	1,759
Amortisation at 31 March 2018	**10,085**	**10,085**
Net book value at 31 March 2018	4,735	4,735
Net book value at 1 April 2017	6,081	6,081

9 Property, plant and equipment - 2018/19

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**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 - brought forward	**-**	**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 2019	**-**	**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**

9 Property, plant and equipment - 2018/19

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**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 - brought forward	**-**	**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 2019	**-**	**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**

9 Property, plant and equipment - 2017/18

Group & Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	**21,830**	**167,545**	**144**	**93,490**	**205**	**32,950**	**1,532**	**317,696**
Additions	-	3,628	57	6,252	-	1,984	6	**11,927**
Impairments	-	(97)	-	-	-	-	-	**(97)**
Reversals of impairments	-	542	-	-	-	-	-	**542**
Revaluations	-	4,921	-	-	-	-	-	**4,921**
Valuation/gross cost at 31 March 2018	**21,830**	**176,539**	**201**	**99,742**	**205**	**34,934**	**1,538**	**334,989**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**1,575**	**-**	**61,039**	**111**	**26,550**	**1,515**	**90,790**
Provided during the year	-	3,198	-	6,190	18	2,144	8	**11,558**
Impairments	-	1,323	-	-	-	-	-	**1,323**
Reversals of impairments	-	(3,480)	-	-	-	-	-	**(3,480)**
Revaluations	-	(782)	-	-	-	-	-	**(782)**
Accumulated depreciation at 31 March 2018	**-**	**1,834**	**-**	**67,229**	**129**	**28,694**	**1,523**	**99,409**
Net book value at 31 March 2018	**21,830**	**174,705**	**201**	**32,513**	**76**	**6,240**	**15**	**235,580**
Net book value at 1 April 2017	**21,830**	**165,970**	**144**	**32,451**	**94**	**6,400**	**17**	**226,906**

9 Property, plant and equipment financing - 2018/19

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019									
Owned - purchased	21,830	185,340	-	1,986	32,305	51	9,445	34	**250,991**
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**	**254,807**

Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
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**

Property, plant and equipment financing - 2017/18

Group & Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018									
Owned - purchased	21,830	172,981	-	201	30,199	67	6,240	15	**231,533**
Finance leased	-	992	-	-	-	-	-	-	**992**
Owned - donated	-	732	-	-	2,314	9	-	-	**3,055**
NBV total at 31 March 2018	**21,830**	**174,705**	**-**	**201**	**32,513**	**76**	**6,240**	**15**	**235,580**

10 Inventories

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Drugs	3,567	2,556	2,617	2,556
Consumables	10,422	9,163	10,422	9,163
Energy	122	126	122	126
Total inventories	**14,111**	**11,845**	**13,161**	**11,845**

Inventories recognised in expenses for the year were £63,428k (2017/18: £49,759k). Write-down of inventories recognised as expenses for the year were £9k (2017/18: £0k).

11 Receivables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Contract receivables*	19,276	-	18,828	-
Contract assets*	13,987	-	13,987	-
Trade receivables*	-	15,075	-	15,075
Accrued income*	-	10,869	-	10,869
Allowance for impaired contract receivables / assets*	(4,192)		(4,192)	
Allowance for other impaired receivables	-	(4,556)	-	(4,556)
Prepayments (non-PFI)	2,681	2,076	2,681	2,076
PDC dividend receivable	-	134	-	134
VAT receivable	732	710	732	710
Other receivables	226	1,165	226	1,165
Total current receivables	**32,710**	**25,473**	**32,262**	**25,473**
Non-current				
Contract receivables*	5,840	-	5,840	-
Accrued income*	-	5,196	-	5,196
Total non-current receivables	**5,840**	**5,196**	**5,840**	**5,196**
Of which receivable from NHS and DHSC group bodies:				
Current	23,224	18,422	23,224	18,422
Non-current	-	-	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

11.1 Allowances for credit losses - 2018/19

	Group & Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**4,556**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	4,280	(4,556)
Changes in existing allowances	(88)	-
Allowances as at 31 Mar 2019	**4,192**	**-**

Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period

	Group	Trust
	All receivables	All receivables
	£000	£000
Allowances as at 1 Apr 2017 - restated	**3,167**	**3,167**
Increase in provision	1,117	1,117
Amounts utilised	272	272
Allowances as at 31 Mar 2018	**4,556**	**4,556**

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

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
At 1 April	**6,874**	**7,339**	**6,874**	**7,339**
Net change in year	(3,893)	(465)	(4,498)	(465)
At 31 March	**2,981**	**6,874**	**2,376**	**6,874**
Broken down into:				
Cash at commercial banks and in hand	18	16	18	16
Service	2,963	6,858	2,358	6,858
Total cash and cash equivalents as in SoFP	**2,981**	**6,874**	**2,376**	**6,874**
Total cash and cash equivalents as in SoCF	**2,981**	**6,874**	**2,376**	**6,874**

13 Trade and other payables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Trade payables	18,254	17,712	16,168	17,712
Capital payables	11,064	2,079	11,064	2,079
Accruals	12,316	13,032	12,316	13,032
Receipts in advance and payments on account	-	-	-	-
Social security costs	3,692	3,509	3,685	3,509
Other taxes payable	3,408	3,071	3,408	3,071
PDC dividend payable	11	-	11	-
Accrued interest on loans*	-	226	-	226
Other payables	5,156	747	5,154	747
Total current trade and other payables	**53,901**	**40,376**	**51,806**	**40,376**
Of which payables from NHS and DHSC group bodies:				
Current	5,045	5,875	5,045	5,875
Non-current	-	-	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 15. IFRS 9 is applied without restatement therefore comparatives have not been restated.

14 Other liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Deferred income: contract liabilities	4,937	3,126	4,937	3,126
Total other current liabilities	**4,937**	**3,126**	**4,937**	**3,126**

15 Borrowings

	Group & Trust	
	31 March 2019	31 March 2018
Current	**£000**	**£000**
Loans from DHSC	25,129	24,732
Other loans	324	277
Obligations under finance leases	803	744
Total current borrowings	**26,256**	**25,753**
Non-current		
Loans from DHSC	141,325	89,885
Other loans	263	221
Obligations under finance leases	996	1,798
Total non-current borrowings	**142,584**	**91,904**

Reconciliation of liabilities arising from financing activities

Group & Trust	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£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:				**-**
Interest charge arising in year	2,988	50	169	**3,207**
Other changes	97	-	(54)	**43**
Impact of implementing IFRS 9 on 1 April 2018	168	-	58	**226**
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 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Gross lease liabilities	**1,938**	**2,738**	**1,938**	**2,738**
of which liabilities are due:				
- not later than one year;	880	913	880	913
- later than one year and not later than five years;	1,058	1,825	1,058	1,825
Finance charges allocated to future periods	(139)	(196)	(139)	(196)
Net lease liabilities	**1,799**	**2,542**	**1,799**	**2,542**
of which payable:				
- not later than one year;	803	744	803	744
- later than one year and not later than five years;	996	1,798	996	1,798

17 Provisions for liabilities and charges analysis - Group and Trust

	Other	Total
	£000	£000
At 1 April 2018	**2,239**	**2,239**
Change in the discount rate	91	**91**
Arising during the year	323	**323**
Utilised during the year	(139)	**(139)**
Reversed unused	(193)	**(193)**
Unwinding of discount	2	**2**
At 31 March 2019	**2,323**	**2,323**
Expected timing of cash flows:		
- not later than one year;	791	**791**
- later than one year and not later than five years;	393	**393**
- later than five years.	1,139	**1,139**
Total	**2,323**	**2,323**

Clinical negligence liabilities

At 31 March 2019, £345,689k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lancashire Teaching Hospitals NHS Foundation Trust (31 March 2018: £304,638k).

18 Contingent assets and liabilities

	Group & Trust	
	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(159)	(120)
Gross value of contingent liabilities	**(159)**	**(120)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(159)**	**(120)**
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 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Property, plant and equipment	10,100	5,863	10,100	5,863
Total	**10,100**	**5,863**	**10,100**	**5,863**

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 the 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)

transactions (and/or balances outstanding) in excess of £5m are summarised below:

	Income	Expenditure	Receivable	Payable
	£000	£000	£000	£000
NHS Blackburn with Darwen CCG	5,393	-	63	-
NHS Blackpool CCG	9,207	31	118	8
NHS Chorley and South Ribble CCG	101,579	184	3,370	486
NHS East Lancashire CCG	9,396	-	433	228
NHS England	151,069	(147)	8,524	21
NHS Fylde and Wyre CCG	19,274	-	364	-
NHS Greater Preston CCG	116,599	-	2,626	-
NHS Morecambe Bay CCG	12,116	-	-	169
Health Education England	20,528	-	280	149
NHS Resolution	-	19,780	-	-
NHS Pension Scheme	-	30,139	-	4,203
HM Revenue and Customs	-	27,138	-	7,093

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	
South Ribble Borough Council	7	27	-	18	Member of Council of Governors
Chorley Borough Council	10	684	63	4	Member of Council of Governors
Preston Council	-	1,983	171	4	Member of Council of Governors
Lancashire County Council	15	(72)	4	342	Member of Council of Governors
UCLAN	5	-	26	-	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 2019, 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 Foundation Trust Charity	1051194	316	154	13
The Rosemere Cancer Foundation Charity	1131583	287	54	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 loans and facilities through DH. The Trust largely finances its capital expenditure from internally generated cash, and funds made available by the Department of Health. 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 (Note 13).

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

22.1 Carrying values of financial assets

	Group		Trust	
	Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9				
Trade and other receivables excluding non financial assets	33,388	**33,388**	32,940	**32,940**
Cash and cash equivalents	2,981	**2,981**	2,376	**2,376**
Total at 31 March 2019	**36,369**	**36,369**	**35,316**	**35,316**

Group & Trust	Loans and receivables £000	Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39		
Trade and other receivables excluding non financial assets	25,015	**25,015**
Cash and cash equivalents	6,874	**6,874**
Total at 31 March 2018	**31,889**	**31,889**

22.2 Carrying values of financial liabilities

	Group		Trust	
	Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9				
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	46,797	**46,797**	44,702	**44,702**
Total at 31 March 2019	**215,637**	**215,637**	**213,542**	**213,542**

Group & Trust	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	114,617	**114,617**
Obligations under finance leases	2,542	**2,542**
Other borrowings	498	**498**
Trade and other payables excluding non financial liabilities	40,376	**40,376**
Provisions under contract	2,239	**2,239**
Total at 31 March 2018	**160,272**	**160,272**

22.3 Maturity of financial liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
In one year or less	73,053	66,650	70,958	66,650
In more than one year but not more than two years	75,809	36,589	75,809	36,589
In more than two years but not more than five years	50,286	49,833	50,286	49,833
In more than five years	16,489	7,200	16,489	7,200
Total	**215,637**	**160,272**	**213,542**	**160,272**

Fair Values of Financial Instruments
The carrying values of short term financial assets and financial liabilities are considered to approximate to fair value

23 Losses and special payments

	2018/19		2017/18	
Group and Trust	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	233	40	869	45
Total losses	**233**	**40**	**869**	**45**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	2	1
Ex-gratia payments	76	14	30	4
Total special payments	**76**	**14**	**32**	**5**
Total losses and special payments	**309**	**54**	**901**	**50**

24. Third Party Assets

The Trust held £4,400 cash at bank and in hand at 31 March 2019 (£4,000 at 31 March 2018) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts

25. Private Finance Inititative (PFI) Transactions

The Trust did not have any PFI arrangements during 2018/19 or at the balance sheet date

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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For more information about Lancashire Teaching Hospitals NHS Foundation Trust see:

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