Lancashire Teaching Hospitals
NHS Foundation Trust

70 YEARS OF THE NHS 1948 - 2018

Lancashire Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2017–18

Excellent care with compassion

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Annual Report and Accounts 2017-18

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

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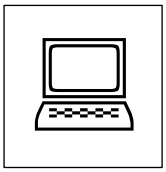


This symbol indicates that more information is available on our website:

www.lancsteachinghospitals.nhs.uk

CHAIRMAN'S AND CHIEF EXECUTIVE'S WELCOME

Welcome to our annual report for the financial year 2017/18, 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.

Our fantastic, state-of-the-art, cancer robot has been making a huge difference to Lancashire and South Cumbria cancer patients this year. The robot, purchased for us by the Rosemere Cancer Foundation, means we can operate with greater precision, and provide life saving treatment for many patients for whom conventional surgery isn't an option. Our commitment to developing the best cancer care for our communities was further reinforced with the opening of the chemotherapy unit at Chorley in 2017, so that local patients can receive treatment closer to home.

We have also continued to drive innovation through world-class research, education and training in the past year. We are delighted to have opened the Clinical Research Facility to support us to develop new drugs and treatment for this and future generations. We are very proud of Alison Birtle, Consultant Oncologist, who this year presented results of a groundbreaking trial that will improve survival rates for patients with upper urinary tract cancer. We also recruited our first ovarian cancer patient to the 100,000 genomes project – an ambitious programme that is sequencing the DNA of patients with rare conditions. As in previous years we recruited patients to national and international trials and studies, and are proud to have led a practice-changing trial for bladder cancer.

Every year demand for care increases and last year was no different. When wards are as busy as they have been there are delays admitting patients from emergency departments, and our ability to treat those waiting for planned operations is affected. As a result we have not achieved all the national performance standards this year. In November we began implementation of a continuous improvement plan, and have established 11 workstreams to improve patient flow in a systematic way so that change is embedded. We are confident this new approach will improve patient experience, quality and safety of care, and working lives. Despite making £20m 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.

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
25 May 2018

Karen Partington
Chief Executive
25 May 2018

Lancashire Teaching Hospitals NHS Foundation Trust

PERFORMANCE REPORT
2017/18

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 provide acute services to our local population of around 400,000 and provide a number of tertiary services to around 1.6 million people across Lancashire and South Cumbria. Most of our clinical services are provided on our two hospital sites – Chorley and South Ribble Hospital and Royal Preston Hospital. We also have a specialist mobility and rehabilitation service in Preston, the Broadoaks child development centre in Leyland and we provide dialysis units in various locations in Lancashire.

We provide the following general hospital services to our local population:

- 24-hour emergency department facilities
- intensive, high dependency and coronary care units
- general medicine, including elderly care
- general surgery and urology
- child health
- ear, nose and throat surgery
- orthopaedics
- maternity services
- gynaecology
- anaesthetics
- oral and maxilla-facial surgery
- ophthalmology
- support services for diagnosis and treatment, such as pathology, x-ray, physiotherapy, occupational therapy and specialist nurse
- rehabilitation services

People in Lancashire and South Cumbria also access the following specialist services:

- neurosurgery and neurology
- oncology (radiotherapy and chemotherapy) and complex cancer surgery
- elective and emergency vascular surgery
- renal and plastic surgery
- specialist mobility and rehabilitation services
- major trauma services

Our business model

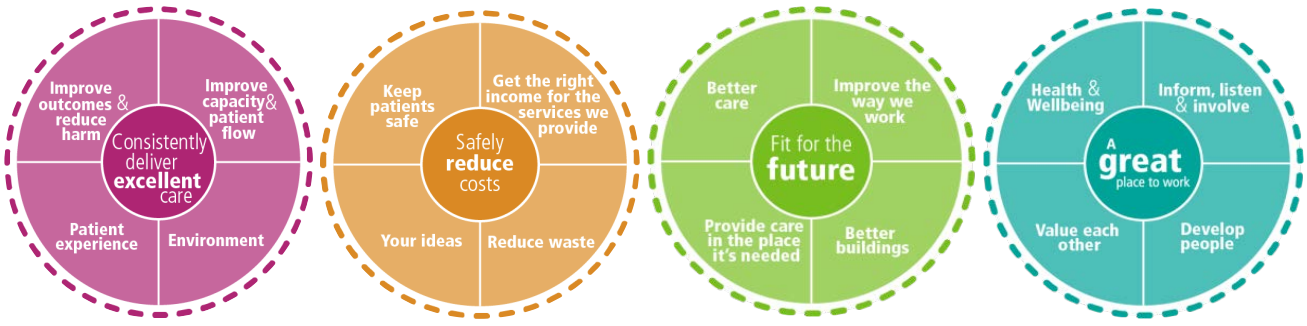
The governance structure of a foundation trust is prescribed through legislation, and is reflected within our constitution. All foundation trusts are required to have a board of directors and a council of governors as well as a membership scheme, which is open to members of the public and staff who work 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 aims and ambitions

We have three equally important strategic aims:

1. To offer excellent hospital care and treatment to our local communities
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria
3. To drive innovation through world-class education, training and research.

These strategic aims are underpinned by our four ambitions, which provide the framework for our business planning process, as well as our recruitment and appraisal processes:



Our strategic aims, 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 2017/18 the Trust committed to the adoption of a continuous improvement approach and has appointed a new Director of Continuous Improvement and a Head of Continuous Improvement. During the first three months of their appointment in Quarter 4, extensive staff engagement has been undertaken to identify the key priorities for improvement and these are informing the development of a system wide Continuous Improvement Strategy which will be delivered across the whole health economy. The strategy will be launched in May 2018 and will identify key priorities for 2018 and beyond.

The development of the 'Our Health Our Care programme

During 2017/18 we and our local partners continued to progress 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.

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, Lancashire Teaching Hospitals NHS Foundation Trust, local councils, NHS England and specialist commissioners. During 2018/19 we will be working towards producing a range of options for the future provision of services. The views shared by our local population have provided valuable insight to inform the development of options for the future.

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

During 2017/18 we have been working closely with our local partners to develop an Integrated Care Partnership for Central Lancashire which is aligned to and sits within the wider Integrated Care System. The Integrated Care Partnership for Central Lancashire will help us achieve a new approach to care, which includes the planning of total (health and social) care services, and the creation of a service delivery system that connects all services and providers together to ensure care is delivered in a seamless way. We and our local partners have formally established, in shadow form, an ICP Board and ICP governance arrangements from 1st April 2018.

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

The developments with the Our Health Our Care programme and the establishment of an ICP Board at the Central Lancashire level fits within a wider planning context for the NHS. At a Lancashire and South Cumbria level, we have an integrated care system, (formerly known as the Sustainability and Transformation Partnership) – made up of all commissioners and providers across Pennine Lancashire, Central Lancashire, West Lancashire, Fylde Coast and Bay Health and Care Partners. Lancashire and South Cumbria ICS has established formal governance arrangements, including an ICS Board, with agreed terms of reference comprising executive system leaders from each of our five Integrated Care Partnerships (formerly known as Local Delivery Partnerships (or LDPs)), non-executive directors from the same, chairs of each of the four Health and Well-being boards, a GP provider representative, ICS clinical leadership and ICS executive leaders including NHS England and NHS Improvement senior managers, as well as a 'Strategic Framework' that determines processes, design principles and criteria for ICS, ICP and neighbourhood level decision making.

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 board assurance framework is reviewed by the board and the executive team each month, and is presented to each board sub-committee at every meeting.

The principal risks and uncertainties that could affect our ability to deliver our strategic objectives include:

- challenges associated with the delivery of a sustainable financial plan
- high levels of bed escalation and increasing levels of demand for clinical activity across our two hospital sites
- delivery of the targets and indicators set within regulatory and compliance frameworks including provider licence
- reduced availability of consultants and doctors, particularly in Emergency Medicine
- continuing difficulties in recruiting and retaining the required number of nurses and midwives

Relevant controls and mitigation are included within our assurance framework, and these are monitored on a regular basis.

Our performance

Overall during 2017-2018 the Trust achieved compliance against a range of measures within the Risk Assessment Framework and Single Oversight Framework including access standards such as five of the eight cancer waiting times standards, infection prevention standards and diagnostic waits. 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 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 2017-2018 that adversely impacted on access standards compliance and delivery of the trusts 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 2017/18 the Trust planned a deficit of £19.2m before receipt of STF income and impairments, however this was dependent on achievement of a performance efficiency target of £34m (7% of income) which was extremely challenging. Despite the support of McKinsey and NHSI the Trust was unable to achieve this target, and suffered additional workload and staffing pressures during the year. As a result the operating deficit increased to £42m. Working Capital loans have been made available to support the deficit of the Trust, ensuring liabilities are met, and these have continued into 2018/19 when the deficit is expected to increase to £51m. Although the current Working Capital loan from DH has only been extended to March 2019, it has been indicated to the Trust that this will be extended further while the Trust remains in deficit.

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. However based on the indications below the Trust believe that it remains appropriate to prepare the financial statements on a going concern basis and therefore the financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

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.

PERFORMANCE ANALYSIS

Our performance

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified, since April 2017 in the NHS Improvement Compliance Framework and the Acute Services Contract.

During 2017-18 the Trust has continued to experience significant operational pressures due to patient flow. 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. Alongside this during 2017-2018 the Trust set up a range continuous Improving and transformational work streams of which patient flow has a significant work plan attached to this.

Overall during 2017-2018 the Trust achieved compliance against a range of measures within the Risk Assessment Framework and Single Oversight Framework including access standards including five of the eight cancer waiting times standards, and infection prevention standards and diagnostic waits. 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 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 2017-2018 that adversely impacted on access standards compliance and delivery of the Trust's elective care programme.

The summary position detailing performance against key targets 2017-18 is shown in the table below:

Indicator	Target %	Cumulative Performance	Achieved	Current Period
A&E - 4 hour standard	95	84.00	Not Achieved	% - Cumulative to end Mar 2018. Position includes both ED and UCC locations
Cancer - 2 week rule (All Referrals) - New method	93	98.2	Achieved	% - Cumulative to end Mar 2018
Cancer - 2 week rule - Referrals with breast symptoms	93	97.3	Achieved	% - Cumulative to end Mar 2018
Cancer - 31 day target	96	95.8	Not Achieved	% - Cumulative to end Mar 2018
Cancer - 31 Day Target - Subsequent treatment – Surgery	94	94.9	Achieved	% - Cumulative to end Mar 2018
Cancer - 31 Day Target - Subsequent treatment – Drug	98	99.9	Achieved	% - Cumulative to end Mar 2018
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	94	98.2	Achieved	% - Cumulative to end Mar 2018
Cancer - 62 day target - total	85	82	Not Achieved	% - Cumulative to end Mar 2018
Cancer - 62 Day Target - Referrals from NSS (Summary)	90	83.8	Not Achieved	% - Cumulative to end Mar 2018
MRSA	0	1	NA	Cumulative to end Mar 2018
C.difficile Infection- (Previous Monitor Indicator)	66	60	Achieved	Cumulative to end Mar 2018
C.difficile infection avoidable (Lapses in care) – (Revised Monitor Indicator)	66	35	Achieved	Cumulative to end Mar 2018
18 weeks - Referral to Treatment - Incomplete Pathways	92	83.88	Not Achieved	% - sum of Apr-Mar in 2017-18

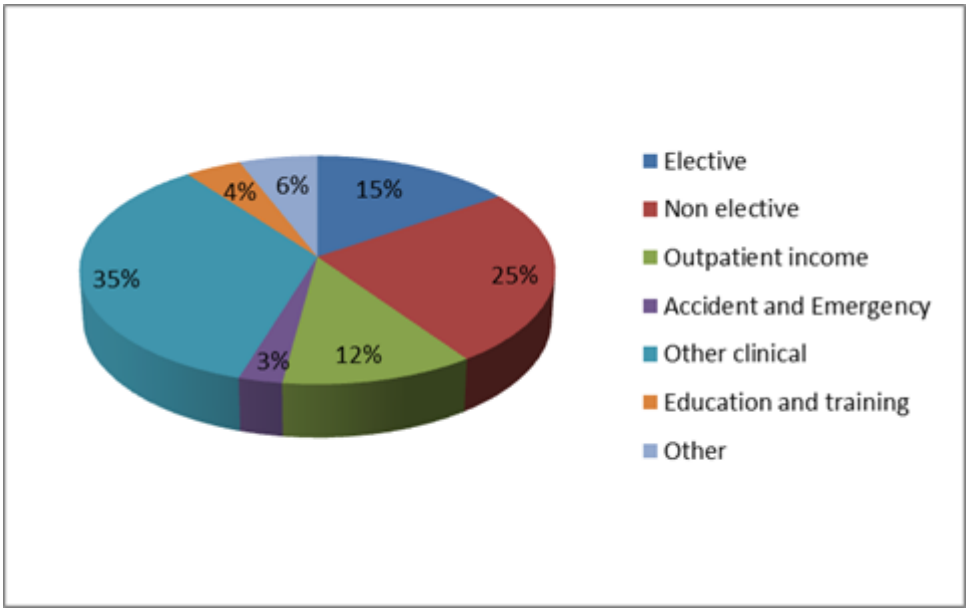
Our finances

Income Generation

During 2017/18 the Trust generated income of £423m from patient care, an increase of 3% from 2016/17. A further £48m 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.

Income Analysis

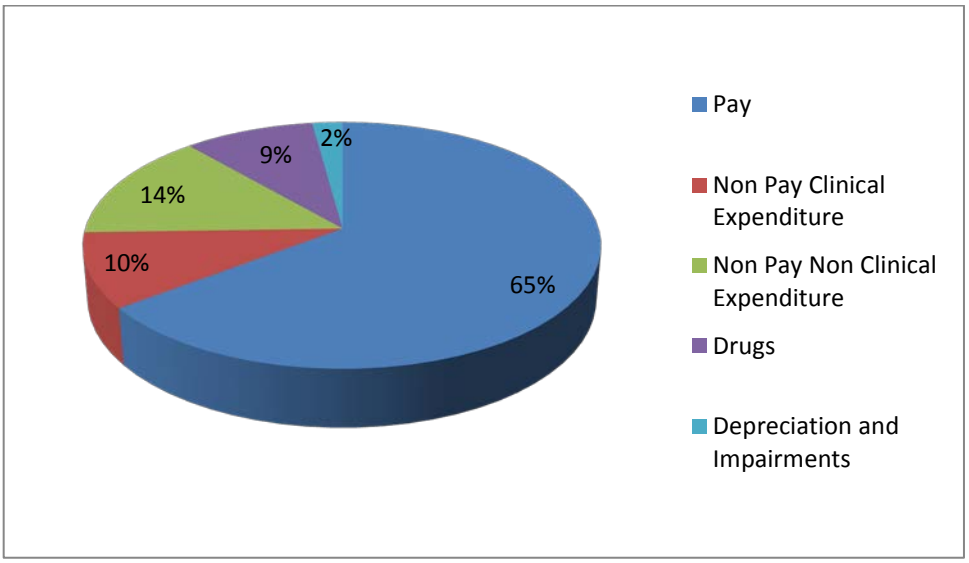


Expenditure

Operating expenditure (excluding impairments) for the year was £501m, the graph below shows the main categories of expenditure at the Trust. The largest element of cost at 65% and 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.

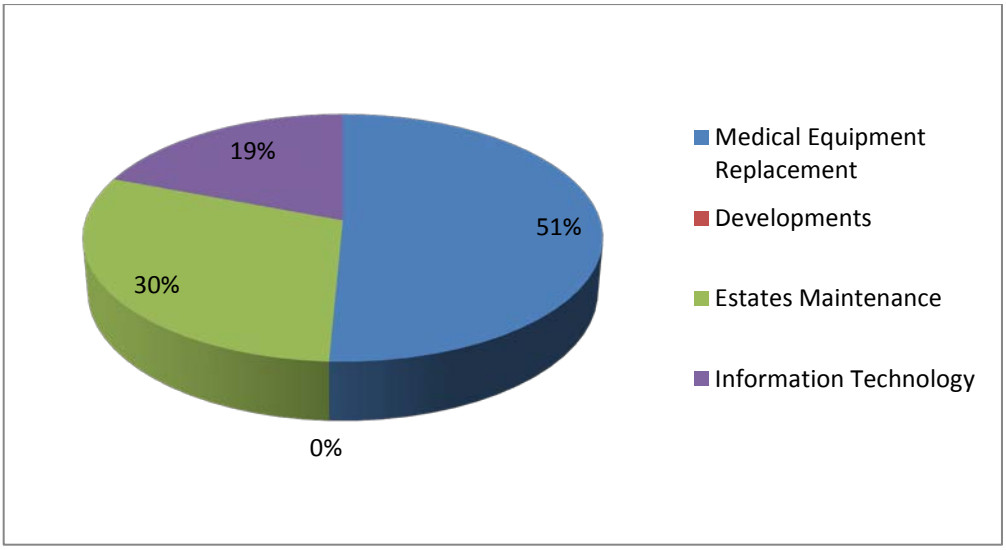
In 2017/18, the Trust achieved £20m, being 59%, of its challenging target for Performance and Efficiency savings of £34m.

Expenditure Analysis



Capital Investment

In 2017/18, £12m was invested in the Trust's capital programme to maintain the asset base of the Trust as illustrated in the chart below, with 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, which is later. For 2017/18 we paid 64.5% of invoices to this timescale.

	NHS		NON-NHS		TOTAL	
	No.	Value £	No.	Value £	No.	Value £
Invoices paid within 30 days	1,847	20,609,405.28	59,748	156,790,933.43	61,595	177,400,338.71
Invoices not paid within that 30 day period	1,878	11,296,019.78	82,684	86,215,302.02	84,562	97,511,321.80
Total Invoices	**3,725**	**31,905,425.03**	**142,432**	**243,006,235.45**	**146,157**	**274,911,660.51**
BPPC	**49.58%**	**64.60%**	**41.95%**	**64.52%**	**42.14%**	**64.53%**
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 aspect is through benchmarking as this helps to develop the direction for change and subsequent investment. The recent NHS Estates and Facilities dashboard released in January 2017 as part of the Carter review reports the Trust as being better than the equivalent Trust median for energy consumption and cost, which given the age of the estate is a positive reflection on past investment decisions.

With respect to the physical impact, over 2017/18 the Trust continues to:

- Maximise the benefits of the Combined Heat and Power plants on its two hospital sites. First installed circa 7 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 more subtle benefit is that the Trust reduces its impact on the local electrical infrastructure, releasing spare electrical capacity for the benefits of other developments within the surrounding areas.

- The use of CHP continues to allow the Trust to reduce its energy bill by circa £ 800k per year.

- Construct buildings to the highest Building Research Establishment Efficiency Assessment Methodology (BREEAM) possible.

- Invest in the use of LED lighting whenever possible as replacement or in any new developments.

- Start to introduce other modern and more efficient technology which includes more efficient electrical transformers and pumps to help reduce carbon emissions and lower costs.

- Continue to provide transport between our two sites at a cost of £ 100k per year – the purpose being to reduce the impact of travelling and single car usage.

- As part of our car parking strategy we have created an additional 40 patient parking spaces. 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 will be introducing ANPR to manage our car parks, which will remove the need for barriers and will further reduce congestion and improve the parking experience.

- The Trust is actively working with other Health organisations collaboratively in an effort to share working practices which will promote more efficiency and enhanced economic saving opportunities. This will offer a more regional strategic strategy approach to be developed.

Social, community and human rights issues

Many of our departments have supported our work familiarisation programme for 10 years now. Students with learning difficulties from Runshaw, 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 40 students complete every 12 months, totalling over 350 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 350 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. This year we piloted a 'winter pressure' placement programme where 50 Health care students from Prestons College and Cardinal Newman College fulfilled their work based hours over 10 weeks from January to March 2018. This mutually beneficial arrangement was a huge success for us all and will continue next year.

Since 1st April 2017 the Trust has started 251 apprentices which is an increase on the previous year of 132%. We continue to offer a growing range of apprenticeships both clinical and non-clinical roles in occupations from accountancy to pre-nursing. New subjects for 2017 include;

- Medical Engineering
- Pharmacy – Level 2
- IT – Business Analyst
- Healthcare Science - Level 6
- Assistant Practitioner
- Public Relations
- IT Application Specialist
- Operations & Department Manager

2017 has seen significant changes to apprenticeships with the introduction of the Apprenticeship Levy and the 2.3% Public Sector target for apprenticeship starts. For the Trust that meant we are expected to have at least 227 apprenticeship starts each and every year. We have far exceeded this expectation within our first year. We continue to embrace the opportunities these changes bring by recruiting apprentices as the next generation to careers in the NHS and also use apprenticeships to support our existing members of staff to develop new skills that will support them in their roles. We have now been a training provider for 12 months delivering level 2 and 3 apprenticeships in Healthcare and level 3 and 5 apprenticeships in Leadership and management. We also won the Regional award for 'National Apprenticeship service Macro employer of the year 2017'.

We are scoping further opportunities for apprenticeship delivery currently to include the preceptorship apprenticeship.

The preparation for nursing programme continues to grow from strength to strength. We had 2 students from the pilot programme and 3 students from PNP the following year now on our BNAP degree programme. 30 places are on offer each year via applications from students in their second year of the health and social care programmes at Preston, 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 healthcare 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. Since the pilot programme was launched in 2014 14 students are currently studying Medicine at Manchester University on the Preston Track. A further 27 have applied to Manchester this year and are awaiting conditional offers pending exam results.

In March 2017 we held a 'Careers in the NHS' event at Preston where over 25 of our departments both clinical and non-clinical provided activities and gave careers guidance to high school and college students. In September 2017 we also held the event at Chorley site with equally successful results. Over 600 students, parents and public members attended the event last year and we anticipate many more this year as word of our event spreads for the next event on Friday 20th April 2018. We also support careers events, provide careers advice, deliver assemblies and attend 'mock interview' days at local schools and colleges, since April 2017 we have attended over 30 such appointments.

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 last year we will be launching our own version of the programme later this year. Since the first programme back in 2013 our support services has offered placements to 40 candidates with 28 of these gaining employment either with the Trust or externally as a direct result of the programme. In June 2017 we launched a new similar programme aimed at 16 – 24 year olds who were Not in Employment or Educational Training (NEET). 7 candidates started the pilot programme, 5 completed successfully and gained apprenticeships with the Trust or another NHS organisation as a direct result of the programme.

Organisational development (OD) within the Trust continues to advance, with recognition being given to the value it can bring in helping to transform the culture of the organisation and ultimately inspire, engage, facilitate, motivate and develop staff. The Workforce and Organisational Development strategy is up for renewal in 2018, a coproduction approach to its development is underway with three large coproduction events already having been held where staff and managers from across the Trust have been invited to come along to share their views around their challenges and the actions they would like to see in place to support them to do their jobs effectively. The focus for the team going forward will include greater emphasis on reward, recognition and retention. We will invest more time and energy into equality and diversity and continue to support managers to manage positively through further role out of leadership and management development programmes. We will continue to build the capability and capacity of our staff by further developing talent management and succession planning processes to ensure the future success of the organisation.

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:

Risk Management Committee

The Risk Management Committee 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 primarily associated with the physical environment.

Health and Safety Governance Committee

During 2017/18 it became clear that the Risk Management Committee needed support to scrutinise and control the operational detail necessary to ensure effective health and safety governance. The Health and Safety Governance Committee, chaired by the Divisional Director of Governance has therefore been established in support of the RMC and to ensure that all H&S responsibilities are effectively addressed within each Division. The Health and Safety Governance Committee is accountable to the Safety and Quality Committee with the chair of the H&SGC being a member of the RMC.

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 is already starting to build capacity.

Fire Safety. The Grenfell Tower tragedy prompted a complete review of the Trusts fire safety arrangements. Whilst our buildings were deemed safe there were a number of related aspects, which were identified as offering scope for improvement. The Trust has therefore invested in additional evacuation equipment and instigated a revised training programme for staff. Additionally our fire alarm and detection systems have been upgraded so that we now have a fully networked system at Royal Preston Hospital and further improvements are planned for the coming year. Progress against the fire safety plan is monitored by the H&SGC.

Health and Safety Joint Consultative Committee

Providing a health and safety forum for staff to raise their concerns is a statutory requirement. This has been previously achieved via the Health and Safety Committee, which had been chaired by a senior Divisional Manager. The committee title has been changed to Health and Safety Joint Consultative Committee and it is now chaired by the Director of Workforce and Organisational Development. The purpose and role otherwise remain unchanged and is made up of both union and non-union health and safety representatives from departments throughout our organisation. The committee also continues to include advisors with expertise in health and safety, fire and security.

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 and the cyber-attack last May led to a complete review of our emergency plans. From the clinical experience gained by the Manchester and London Trusts our approach to the management of a mass casualty event has been completely revised with the learning from those attacks now incorporated into our plans. As the regional Major Trauma Centre these new arrangements were audited by NHSE in October 2017 and were approved.

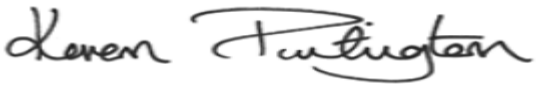
The cyber-attack had a significant impact on the Trust and our business continuity arrangements for IT have been completely revised. A mass casualty event is a totally different prospect to a cyber-attack (or any other type of major incident - fire, flood etc.) but whilst operational responses will differ, the Trusts command and control (C&C) arrangements remain the same. We have therefore developed a range of plans to deal with different types of external event but a single C&C procedure for managing all and any type of major incident.

The Trust continues to assess itself against the national core standards for emergency planning resilience and response (EPRR).

For 2017/18 we assessed ourselves as “Substantially Compliant” because the new plans and arrangements developed during the year need to be fully tested through exercising which are programmed for 2018/19.

The Trust has received no prohibition or enforcement notices from any of the regulating authorities but to consolidate our position and to ensure ongoing regulatory compliance an external H&S audit has been commissioned for delivery May 2018

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



Karen Partington
Chief Executive
25 May 2018

ACCOUNTABILITY REPORT
2017/18

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, healthcare 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 role of Managing Director of consultancy firm, Firecracker Projects Limited. She has considerable experience of dealing with change management, strategic planning, research and building sustainable partnerships with agencies such as local authorities and universities. Sue was the Chair of Southport and Ormskirk NHS Foundation Trust before joining us; 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 involvement in her consultancy firm, Firecracker Projects Ltd, Sue has no other significant commitments.

Tim Watkinson, Vice Chair (I)

Appointment: 1 April 2016 to 31 March 2019

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. Tim is the Chair of the Trust's Audit Committee and during 2017/18 was appointed as Vice Chair of the Trust.

Michael Welsh, Senior Independent Director (I)

Appointment: 1 May 2013 to 30 April 2019

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. Michael is the Senior Independent Director, the independent member of the Freedom to Speak Up Team and the Chair of the Trust's Finance and Investment Committee.

Tony Gatrell, non-executive director (I)

Appointment: 1 Feb 2014 to 31 Jan 2020

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. Tony is the Chair of the Trust's Education, Training and Research Committee.

Alastair Campbell, non-executive director (I)

Appointment: 1 November 2015 to 31 October 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. He is particularly interested in clinical governance and is the Chair of the Trust's Safety and Quality Committee.

Jeannette Newman, non-executive 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 Chair of the Trust's Workforce 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 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.

Karen Partington, Chief Executive
Permanent post
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 Risk Management Committee, the 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
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.

Gerry Skailes, Medical Director
Permanent post

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
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.

Carole Spencer, Strategy and Development Director
Permanent post
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 us Carole was at Stepping Hill Hospital in Stockport. Carole is currently on secondment to the Academic Health Science Network.

Karen Swindley, Director of Workforce and Education
Permanent post
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 23 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 strategic leadership and management of human resources, training and education, corporate communications and research.

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 appointment as Operations Director, Suzanne was our Divisional Director of Emergency and General Medicine. Suzanne was Operations Directors for four years and provided notice of her resignation from the role in April 2018.

Board members whose term of office has ended

Mark Pugh, Medical Director
Mark is an active clinician and continues to work as a Consultant in Intensive Care and Anaesthesia and joined us in 2002. He has been actively involved in teaching and education and was Hospital Dean from 2011 until his appointment as Medical Director in 2015. Mark stepped down from the role of Medical Director in March 2018 at the end of his three-year term.

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 was appointed to this post in February 2014. An added strength in understanding the need to remain independent was the fact that Professor Gatrell had prior experience as a foundation trust governor, allowing him to appreciate the need to remain independent.

Board meeting attendance summary

Name of director	A	B	Percentage of meetings attended
Sue Musson	12	11	91.66%
Alastair Campbell	12	12	100%
Tony Gatrell	12	12	100%

Name of director	A	B	Percentage of meetings attended
Suzanne Hargreaves	12	10	83.33%
Paul Havey	12	11	91.66%
Gail Naylor	12	8	66.66%
Jeannette Newman (from 3 July 2017)	9	7	77.77%
Karen Partington	12	10	83.33%
Mark Pugh (until 28 February 2018)*	11	5	45.45%
Geoff Rossington (from 4 September 2017)	7	5	71.42%
Geraldine Skailes (from 1 March 2018)	1	1	100%
Carole Spencer (on secondment from 30 September 2018)	6	6	100%
Tim Watkinson	12	11	91.66%
Michael Welsh	12	11	91.66%
Jim Whitaker (from 3 July 2017)	9	8	88.88%

A = maximum number of meetings the director could have attended
B- = meetings attended
* Exceptional circumstances on the grounds of ill health

Evaluating performance and effectiveness

In March 2014 the board commissioned Deloitte to undertake an independent review of its governance, using Monitor's consultation document on board governance reviews as the framework for this work. The findings of the 2014 review demonstrated the effectiveness of our governance arrangements and, where Deloitte highlighted areas for improvement, the Trust has since implemented actions to address them. In June 2017 NHS Improvement published a new framework for developmental reviews of leadership and governance. 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:

The Trust will be commissioning a further independent review in June 2018 against the new framework. In preparation, we have 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 final self-assessment will be formally approved by the Board on 7th June 2018 and will be shared with the independent reviewer as part of their review, which is due to commence on 8th June 2018. The key areas of development for the Trust, highlighted through our self-review process, mainly relate to KLOEs 1, 2 and 5. Following the independent review, we will be developing an action plan to implement any recommendations arising from the review, which we will share with both NHS Improvement and the Care Quality Commission.

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.

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 and council of governors meetings and linkages with the council sub-groups. During 2017/18 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) our 'Governor Brief' publication which provides details of recent governor activity and involvement is shared with board members so that board members are aware of governor involvement,

(iii) there is non-executive director representation at each of our core governor sub-group meetings,

(iv) board members are invited to every Council of Governors' meeting and non-executive directors in particular have a standing agenda item in which they are invited to comment on the Trust's performance and governors have the opportunity to ask them questions and seek assurances that non-executive directors are holding the executive team to account;

(v) 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;

(vi) there are joint board/governor development sessions, for example during 2017/18 we held a joint development session on Continuous Improvement and a Governance masterclass; and

(vii) there are joint visits and events around the hospital, such as the joint visit to the new chemotherapy unit at the Chorley site and the LIFE (simulated hospital) opening event.

The Modern Slavery Act 2015

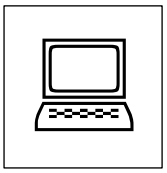
The Trust has zero tolerance to slavery and human trafficking and is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our service. The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community 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 110 and within our annual governance statement on page 77.

Major service developments

We are proud to have opened a new, innovative and inspirational educational facility, the LIFE Centre (Learning Inspirations for Future Employment). This is a flagship project which is set to inspire, educate and support a wide range of students from the age of five upwards to promote a career in healthcare with the NHS. The development of this facility has only been possible with funding support from Health Education England and the Cumbria and Lancashire Local Workforce Action Board.

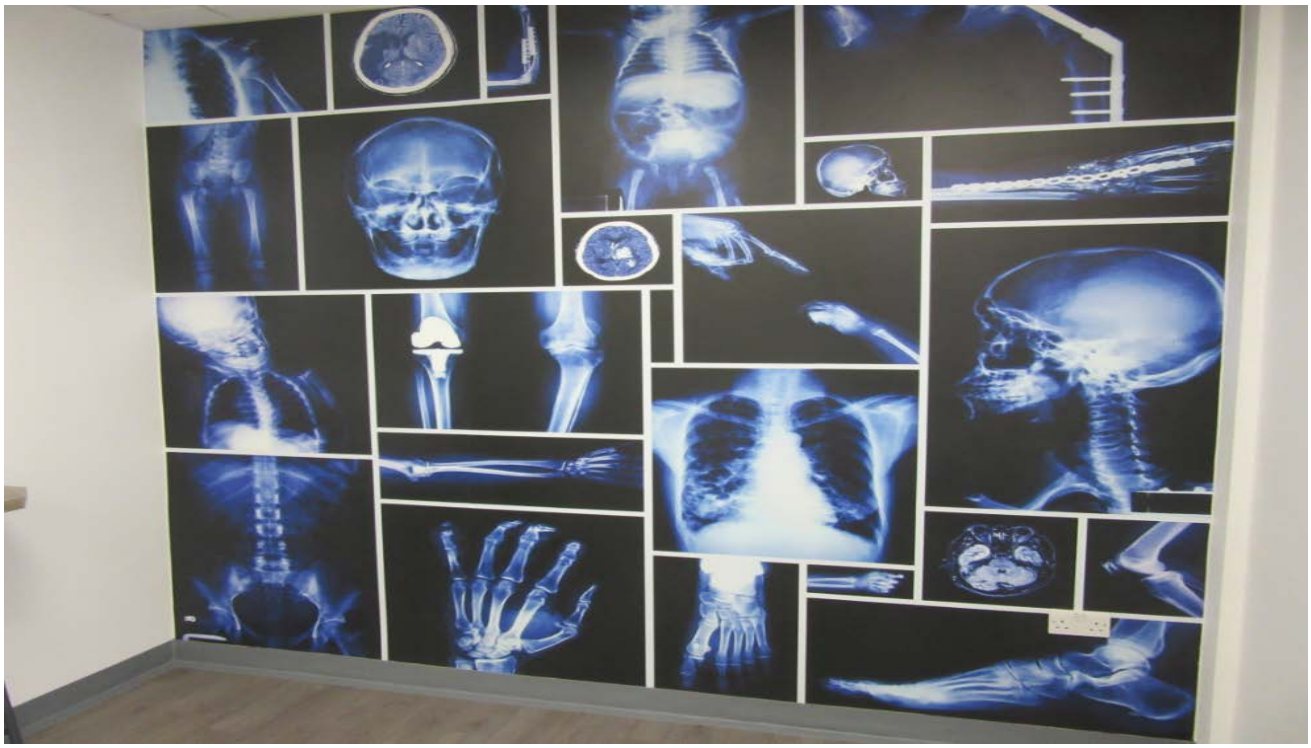
The LIFE Centre is situated at Chorley and South Ribble District Hospital and includes features such as mocked up ward areas, a mobile educational unit, augmented reality training and 360 degree virtual reality headsets in a cinema room. This community facility will be available to other Lancashire based hospital and community healthcare centres to use as part of our shared efforts to attract and develop a workforce who will help ensure Lancashire residents receive the type of care needed. The exciting new learning environment consists of several exciting and innovative features such as:

- Mocked up ward areas including an A&E department, triage room and x-ray room; which contain decommissioned hospital equipment to enable students to experience what it's really like to work in a variety of professional roles. All of these rooms contain cameras which link

up to education rooms in the facility where students can watch and learn from what is happening.

- A Mobile Education Unit, which will be available to visit local schools and colleges to provide easier and more flexible access to healthcare career and education opportunities.
- Virtual reality headsets in a 'cinema room' where you can view 360 degree videos and experience medical situations first hand such as going in an air ambulance, being inside a theatre or exploring anatomy.
- Whiteboard walls where ideas can be shared, as well as interactive TV boards where you can pause footage to draw on the screen e.g. circle an error when viewing the footage from the ward areas.
- Augmented reality training using iPads to view various human organs and learn how they work, and the use of QR codes to locate body parts around the centre and "build a body"; perfect for younger children.

We believe this new facility will make a real difference to the local community and NHS organisations more broadly. We and our local partners recognise the importance of actively reaching out and engaging the local community to help attract a local workforce.



Our fantastic, state-of-the-art, cancer robot has been making a huge difference to Lancashire and South Cumbria cancer patients this year. The robot, purchased for us by the Rosemere Cancer Foundation, means we can operate with greater precision, and provide life saving treatment for many patients for whom conventional surgery is not an option. Our commitment to developing the best cancer care for our communities was further reinforced with the opening of the chemotherapy unit at Chorley and South Ribble District Hospital. This facility means patients who live in the Chorley and South Ribble area can receive care closer to home, and provides us with extra capacity which will reduce waiting times. The nurse-led day case service will provide treatment to patients without the need for an overnight hospital stay. The new facility is partly funded by the Rosemere Cancer Foundation and The Witches of Adlington.

We believe this new service will make a real difference to patients with cancer living in the Chorley and South Ribble area and will enable us to continue to provide excellent care with compassion.

During 2017/18 other major service developments included:

- Introduced a new CT scanning facility at RPH for post mortems
- Introduced a new theatre management system
- Established 24-hour urgent care centres at both Preston and Chorley sites
- Established an ambulatory care pathway at Chorley
- Established the STAR quality assurance framework
- Awarded apprentice employer of the year
- PJ paralysis campaign
- Hosted Lord Carter for visit about OPAT
- Acquired a childbirth sim mannequin
- Introduced high resolution manometry service for colorectal and gastro patients
- Developed an e learning tool for nasogastric tube insertion
- Created a sensory garden for ward 2A
- Introduced “Fabulous Feedback Fridays”

A key service development planned for 2018/19 and beyond is the significant estates redevelopment for our Critical Care and Ophthalmology services.

Research

In 2017/18 Research has continued to grow and develop in line with the ambitious 3 year strategy 2016-2019. Highlights include:

- This year we have recruited a total of 2832 (2087 in 2016/17) participants on to research studies with 2623 (1931) being on the National Institute of Health Research (NIHR) portfolio.
- We have opened 62 new studies (41 in 2016/17).
- The proportion of studies achieving the NHS set-up within 40 calendar days (date site selected to date site confirmed) is 69%.
- The National Institute for Health Research Lancashire Clinical Research Facility (NIHR LCRF) for Experimental Medicine (EM) has completed its first operational year. The average occupancy increased to 40% from 31% which is ahead of trajectory for Year 2. The CRF has completed year 1 of 5 years of infrastructure funding and this consolidates the international position as a quality facility for delivering world class experimental medicine research.
- The CRF has consolidated cross-sectoral funding to secure its sustainability and growth and is actively reviewing new partnerships.
- The NIHR Lancashire CRF was a finalist in the North West Coast Research and Innovation awards 2018 for 'Clinical Research site of the year'.
- Dr Alison Birtle, Clinical Oncologist and Chief Investigator of the POUT Study, won 'Practitioner of the Year' at the North West Coast Research and Innovation awards 2018.
- Dr Birtle also presented the ground breaking results of the international practice changing trial at the American Society of Clinical Oncology Genito-Urinary Symposium, an international event with 4300 attendees. The POUT Trial was the largest and only large scale randomised trial within this patient group and looked at the impact of chemotherapy after surgery for cancer of the upper urinary tract. Lancashire Teaching Hospitals was the lead UK site for the study as well as the largest recruiting site.
- The Academic Faculty – a partnership between the Trust and the University of Central Lancashire (UCLAN) supporting the development of clinical academic careers for nurses and AHPs further developed the Research Development Group (RDG) and associated 'clinic' style meetings. The RGD is a collaboration of healthcare professionals, academics, clinical librarians and lay members at LTH and UCLAN providing advice on the design and development of research and improvement projects and facilitates the would-be-researcher in how to develop and carry out research.
- Writing4Publication - series to help people communicate and share their research, innovation and/or quality improvement activities to wider audiences. The Writing4Publication series helps people, who perhaps don't know where to start or lack the skills and confidence, as well as more experienced writers to communicate their research and innovation achievements to wider audiences. Participants from last year's series produced eleven communications (poster presentations, journal and newsletter articles, book chapters and blogs) with four are still works in progress.
- The Academic Faculty launched 6 Clinical Academic Trainee (CAT) posts combining clinical posts with protected academic time supporting nurses and AHPs, accessing a structured academic programme equipping them with the skills to conduct research and implement changes into practice. Areas covered are Nursing, radiology physiotherapy and midwifery.
- The Trust has consolidated its expanded tissue banking remit within the genito-urinary, neurodegenerative, gastrointestinal and neuro-oncology fields, maintaining challenging HTA regulatory standards in an extremely cost effective manner whilst working actively with

external research institutions to promote and engage in quality research throughout the region and country.

- The Trust has continued to show an increase in the volume of commercially sponsored trials made available to patients accessing care through Lancashire Teaching Hospitals and utilising the NIHR LCRF. It has consolidated its Super-Site status with the Clinical Research Organisation (CRO) MedPace with 6 new trials in 2017/18.
- We have been the first UK site to open and recruit in 8 commercial studies over the last year.

Patient care

We have continued our efforts to improve patient experience despite the significant pressures on services and healthcare targets. 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 received
- by listening to patient experience feedback from public websites, patient feedback devices, consultation and dedicated focus group events
- 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 2017-18 over 2,000 concerns, raised by patients or their families/carers, were dealt with by the PALS team. This figure is higher than in 2016/17 performance and maintained the increased level of performance demonstrated in 2016/17 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.

During 2017/18 the Trust received 553 formal complaints, forty two less than in 2016/17. This decrease represents a percentage decrease of 7.6%. In the context of the associated reduction in activity, the rate of complaints has decreased from 0.74/1000 patient contacts in 2016/17 to

0.7/1000 patient contacts in 2017/18. This figure represents the lowest number of complaints in the last six years.

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

In 2017/18 the Trust received 1 formal complaint for every 1428 patient episodes compared to 1 in 1406 during 2016/17.

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

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In 2017-18, 100% of complainants received an acknowledgement within that timescale.

Of the 553 complaints received in 2017-18, 435 (78%) related to care or services provided at the Royal Preston Hospital (RPH), 114 (21%) to care or services provided at Chorley and South Ribble District General Hospital (CDH) and 4 (1%) to care or services provided offsite (by the Specialist Mobility Rehabilitation Centre, based at Preston Business Centre).

590 formal complaints were closed during 2017-18. 84% of all complaints had been closed with 100% of complaints received in March closed within the timescales. By the end of 2017-18 only 2 complaint responses were still outstanding and outside of the required timescale of 35 working days. One of these was due to a planned meeting date with complaints and the other delayed the conclusion of a level three investigation.

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 2017-18, the Trust received 40 second letters, 2 more 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%

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 2017-18, 12 complaints were referred to the PHSO. Of the complaints referred to the PHSO in 2017-18, 4 have been closed with 2 not upheld and 2 partly upheld. Draft report received in one case – propose to partly uphold. In this same period, the PHSO

completed their investigations into 7 of the complaints that had been referred to them prior to April 2017. These cases have also been closed – 3 partly upheld, 4 not 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 2017 – 2018 the Trust has made changes in a number of areas to improve the quality of service provision. Some of these include:

- The introduction of a Carers Charter in recognition of how carers can support their loved ones whilst in hospital
- Lanyards to clearly identify who the 'shift leader' is in clinical areas
- Resources to support patients who have dementia as a way of engaging in meaningful activities
- Development of patient boards for behind the bed to ensure that staff can, at a glance, be informed of their care needs
- Ward boards to provide key information for visitors and carers of what to expect 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
- Introduction of the 'Hello My Name Is…' initiative across the organisation
- Introduction of 'ALWAYS' events developed in consultation with patients, carers and governors

The Trust has recently refocused on the importance of the complaints process and identified the need to respond to complaints in a timely manner. As part of this it was identified that clear leadership was required to answer complaints from patients, and a Head of Customer Care post has been introduced. Since this post has been created, the organisation has reduced a backlog of complaints that were outstanding and achieved a response to complaints within 35 days currently reporting 100% compliance within this area.

In the future clear objectives in terms of education and training and quality of responses will be an indicator that is monitored through the organisational governance reporting system.

Patient experience feedback

Since 2008, the Trust has invested in systems for the collection of patient feedback over and above that provided by the national patient survey programme, complaints and compliments. Initially Patient Experience Trackers (PET) were utilised, providing feedback on four key experience questions. As our need for further detail increased, the Trust invested in a more flexible and sophisticated platform to provide more detailed feedback from patients. Between 2011 and 2016, over 32000 questionnaires were completed through this platform by patients accessing services.

However, during 2013 NHS England introduced the Friends and Family Test (FFT), asking people if they would recommend the services they have used and, as a result and to avoid duplication, the PET scheme was decommissioned in favour of FFT. When combined with supplementary follow-up questions, the FFT is designed to provide a mechanism to highlight both good and poor patient experience. The FFT scheme currently applies to inpatients, outpatients, those using maternity services, ED attenders, day case patients and outpatients. The Trust currently generates over 4000 responses per month through the FFT programme, a response rate of around 17.5% of patients surveyed.

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.

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.

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.

Unfortunately the 2017 national inpatient and the national emergency department survey results have not been published in time for this report, and publication is not expected before June. A survey of children and young people undertaken in 2016 was published after publication of the 2017 annual report. The survey highlighted a number of areas for improvement that led to a number of actions initiated/completed during 2017-18 including:

- Establishment of friends and family test in all areas with regular review of feedback
- Establishment of a Twitter account to provide information to parents, children and young people
- Identification of 'young governors' ensuring opportunity for assurance and constructive feedback and criticism
- Establishment of a youth forum where views and feedback are sought and acted on
- Inclusion of young inspectors as part of the Trusts STAR accreditation process
- Recruitment of additional senior medical staff
- Recruitment of nursing staff
- Inclusion of young person's representative in recruitment processes
- Review of leadership structure with addition of a ward manager and requirement for Matron to seek views from parents and children on a regular basis
- Establishment of a 'safety huddle' ensuring that all important information/feedback is shared with all staff

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2017-18 a total of 5700 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 2000 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.

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. 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.

In January 2018 the Trust launched two key strategies in support of communication and involvement in care, The Nursing, Midwifery, Allied Health Professional and Care Givers Strategy and The Patient Experience and Involvement strategy. Both of these strategies identify and commit the organisation to achieve targets over the next 3 years and have been developed in consultation with our patient population, staff and partner organisations, such as Healthwatch Lancashire. The Patient Experience Improvement group was renewed and reformed to enable our patients to have a voice in relation to their healthcare and to contribute to the projects that are identified within the strategies.

This year the organisation has had a clear focus to support patients who are living with dementia. Several presentations and update days have taken place to highlight and identify how our care can support these patients. The days have included staff from all disciplines, in recognition that this illness has a potential impact on all staff and how patients and visitors should be treated appropriately.

In addition we have:

- Increased the areas for gathering Friends and Family Test Information
- Engaged with the learning disabilities community through our annual ‘Our Health Day’
- Engaging staff with the Tommy On Tour initiative
- Introduced more open visiting

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 Volunteer Governor, Elizabeth Carberry, who has been a chaplaincy volunteer for a number of years and we are currently actively recruiting our new Volunteer Governor to continue the good work and support Elizabeth has given the Trust in her role.

Volunteer Recruitment

- 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 are now using TRAC a new automated recruitment system 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 2017. A follow up event was held in the Health Academy in September 2017. We spoke to around 30 students who were interested in volunteering and received a number of applications as a result of the event.

- We now 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 a new Volunteers' Handbook and we have also developed 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 offered our volunteers free health checks and we are sharing and promoting all Trust Health and Wellbeing initiatives so our volunteers can access these. We are also working with the Library Services Team and Organisational Development teams to promote greater access to training and development for our volunteers and support them with their learning goals.

- During National Volunteers Week in June 2017 we held an afternoon in the Chaplaincy Centre and invited all our volunteers to attend as a thank you for their hard work and commitment to the Trust. 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 the results of our 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 with a view to sharing the outcomes with our volunteers and identifying any actions we can take to improve their experience of volunteering with the Trust.

- One of our volunteers has been named an unsung hero in the Lancashire Evening Post's Health Heroes awards. Mona Klavis volunteers in the Day Treatment centre at RPH and was recently presented with the award for her dedication and compassion.

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.

- 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.

- We continue to work in partnership with the Royal Voluntary Service to provide additional volunteer support for patients with dementia. Our Volunteer Manager is currently developing new roles and opportunities for volunteers across the Trust.

- We have also expanded the membership of our **Volunteer Strategy Group** which meets on a quarterly basis to develop and support the implementation of our Trust wide Volunteer strategy.

Our priorities for 2018-19 include updating our **Trust Volunteer Strategy for 2018-19** onwards. We are using the Health Education England Volunteering Strategy document to ensure we are current and up to date in all aspects of volunteering at the Trust.

The new strategy will have a clear focus on:

- Using volunteers to facilitate the release of additional nursing and clinical time and support the delivery of high quality care

- Increasing the diversity of our volunteers across the Trust with particular focus on creating opportunities for volunteering for 16-19 years olds linked with career pathways into the NHS and the employability skills programme. We are developing a volunteering/work experience programme which could support students with clear career pathways and links to the UCAS application process.

- Improving our conversion rate of expression of interest in volunteering to volunteer with the Trust, including further reduction in time to recruit. Creating career pathways for volunteers to encourage those with an interest in a career in health to volunteer and hopefully work for us in future.

- Educating and engaging wards and departments to increase the opportunities and support for volunteering across the Trust.

- Developing new ways to reward and engage with our volunteers and create further development opportunities for them whilst volunteering with us.

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, chaired by the Trust's Chief Executive, 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.

During 2017/18 we have continued to develop the Central Lancashire Quality Improvement Board (CLQIB), with representation 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 immediate Quality Improvement Plan for the Trust in response to the CQC Inspection report dated April 2017; (ii) to monitor and scrutinise the implementation of the Trust quality improvement and transformation agenda 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.

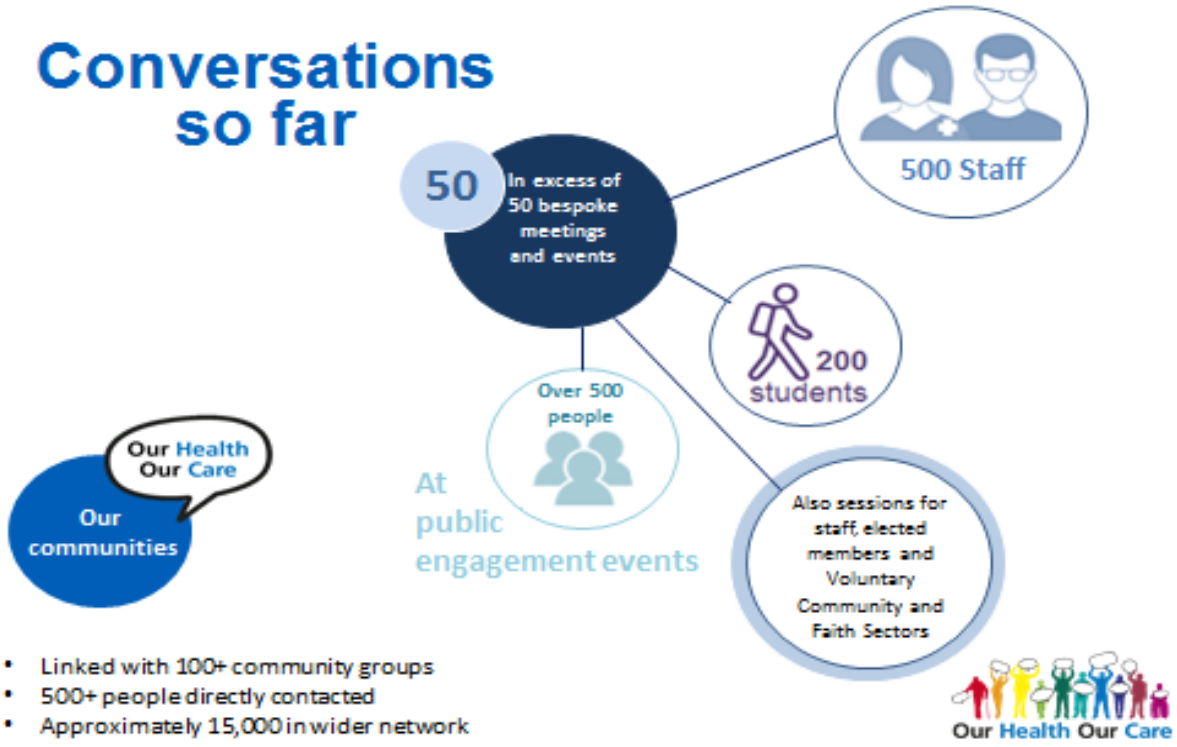
We have made some great strides this year with respect to working with our partners through the development of the Pathology Collaboration and the Lancashire Procurement Cluster. During 2018/19 we are committed to developing these programmes of work and scoping further areas of collaboration, such as 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. This significant programme of work has made great progress during 2017/18. 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, Lancashire Teaching Hospitals NHS Foundation 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 held eight Solution Design Events to date, 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. The Programme is supported by a central Programme Management Office (PMO), funded by the main partners, and located at Chorley House. This independent, dedicated team provide overall facilitation of the programme and its workstreams, supported by specialist external advisers where required.



The next steps for the programme in 2018/2019 include additional phases of public engagement to ensure a continuation of the dialogue with our communities. From this, we will be working towards producing a range of options for the future provision of services. The views shared by our local population have provided valuable insight to inform the development of options for the future. 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.

A key development during 2017/18 is the progress we have made with our local partners to develop an Integrated Care Partnership for Central Lancashire, which is aligned to and sits within the wider Integrated Care System. The Integrated Care Partnership for Central Lancashire will have the following;

- A new approach to care, which includes the planning of total (health and social) care services.
- The creation of a service delivery system that connects all services and providers together to ensure care is delivered in a seamless way.

- A single partnership arrangement that has care service planning, budget management and citizen engagement directly connected to the delivery of primary, community, mental health, acute and social care.
- A single leadership partnership board that is responsible and accountable to the population of Central Lancashire, and to regulatory bodies and, in the future, the developing Integrated Care System.

The Trust and our local partners formally established, in shadow form, an ICP Board and ICP governance arrangements from 1st April 2018.

The developments with the Our Health Our Care programme and the establishment of an ICP Board at the Central Lancashire level fits within a wider planning context for the NHS. At a Lancashire and South Cumbria level, we have an Integrated Care System (ICS), (formerly known as the Sustainability and Transformation Partnership) – made up of all commissioners and providers across Pennine Lancashire, Central Lancashire, West Lancashire, Fylde Coast and Bay Health and Care Partners.

Lancashire and South Cumbria ICS has already established the following arrangements to govern and assure whole system working:

- An established ICS Lead with executive and senior management support
- A dedicated ICS Board, with agreed terms of reference comprising executive system leaders from each of our five Integrated Care Partnership or ICP (formerly known as Local Delivery Partnerships (LDPs)), non-executive directors from the same, chairs of each of the four Health and Well-being boards, a GP provider representative, ICS clinical leadership and ICS executive leaders including NHS England and NHS Improvement senior managers
- A Joint Committee of Clinical Commissioning Groups (CCGs) with powers delegated from constituent CCGs to make legally binding decisions
- A wider Partnership Board, comprising senior representatives from a wide range of statutory and third sector organisations, primary care and Healthwatch
- A programme team to support ICS-wide workstreams, such as acute care, primary care, digital, workforce, Carter - resourced from contributions from the NHS organisations and also staffed by secondees from a range of organisations
- A ‘Strategic Framework’ that determines processes, design principles and criteria for ICS, ICP and neighbourhood level decision making
- A draft Memorandum of Understanding for the ICS working arrangements to be implemented once all parties are in full agreement

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 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	3	3	100%
Nicola Leahey, public governor	4	4	100%
John Daglish, public governor	4	3	75%
Sheen Keskin, public governor (member up to 31 October 2017)	3	3	100%
Alistair Bradley, appointed governor	4	4	100%
Steve Heywood, public governor (acted as substitute for John Daglish on 26th May 2017)	2	2	100%

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

Work of the committee

During 2017/18, 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, with the stakeholder event taking place on 28th April 2017, following which shortlisted candidates were invited through to formal interview on 12th May 2017 and 26th May 2017. On 26th May 2017 the committee resolved that a formal recommendation be made to the Council of Governors for Jeannette Newman, Jim Whitaker and Geoff Rossington be chosen as the successful candidates for the three vacant non-executive director posts. At an extraordinary Council of Governors meeting on 30th May 2017, the Council of Governors approved such appointments in light of the committee's recommendations. An external recruitment agency was not used for these appointments.

In December 2017 the committee met to consider the application of the 1% national pay award to non-executive directors' salaries from April 2017, in line with the national pay award for staff on Agenda for Change terms and conditions. The committee approved the uplift for 2017/18 and made appropriate recommendations to the council of governors who approved such uplift on 23rd January 2018.

In April 2018 the committee met to discuss the recruitment process for the two forthcoming vacant non-executive director posts and to receive a report from the Senior Independent Director on the outcome of the Chairman's 2017/18 appraisal and a report from the Chairman on the outcome of the 2017/18 non-executive director appraisals.

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 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	4	4	100%
Tim Watkinson	4	3	75%
Alastair Campbell	4	3	75%
Tony Gatrell	4	4	100%
Michael Welsh	4	3	75%
Geoff Rossington (from 4 September 2017)	3	3	100%
Jeannette Newman (from 3 July 2017)	4	4	100%
Jim Whitaker (from 3 July 2017)	4	4	100%

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

Work of the committee

During 2017/18, the committee met on four occasions which enabled it to:

- consider appraisal outcomes for the senior executives
- review the remuneration of senior executives
- review the committee's effectiveness
- review and approve a secondment arrangement for the Strategy and Development Director
- review and approve the new Director of Continuous Improvement post
- review and approve the appointment to the Medical Director post
- review and approve the new Managing Director post for the Pathology collaboration
- consider succession planning for the senior executives

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.

The committee undertook an effectiveness review on 2nd November 2017 whereat the committee's terms of reference were reviewed and updated. As with the Trust's other board committees, this committee effectiveness review (including the review and refresh of its terms of reference) forms part of the ARTE committee's annual cycle of business.

During 2017-18 the committee approved the appointment of the Medical Director and the Director of Continuous Improvement. 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.

In April 2016 the committee formally ratified the senior managers' remuneration policy to include the introduction of a floor and ceiling limit for each senior executive and the award to senior executives of national pay awards in line with the national pay award for staff on Agenda for Change terms and conditions, taking into account the fact that no changes were made to the remuneration of senior executives in 2015/16. In October 2016 the committee approved a pay increase for two senior executives (workforce and education director and the company secretary) following a rigorous process of benchmarking against other trusts and taking into account their additional responsibilities. During 2017/18 there were no changes to remuneration of senior executives, save for the application of the 1% national pay award in line with the national pay award for staff on Agenda for Change terms and conditions.

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
- operations director
- strategy and development director

Other executives

- 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 page 44 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 undertake 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 will be reviewed.

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 *During 2017/18 the council of governors approved the application of the 1% national pay award to non-executive directors' salaries from April 2017, in line with the national pay award for staff on Agenda for Change terms and conditions.*
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, however, the committee has approved a process, which provides for annual salary increases linked to performance as assessed during appraisal. The appraisal process rates each senior executive against the following leadership competencies:

- knowledge, skills and abilities
- quality of work
- quantity of work
- communication

The rating scale used is:

- ineffective
- developing
- capable
- strong
- outstanding

The ratings for each of these areas are used to calculate an overall rating that reflects the lowest rating given against any one of the criteria.

Any increase to salary will be based on the executive's overall rating, as shown in the table below:

Ineffective**	**Developing**	**Capable**	**Strong**	**Outstanding**
0% increase	0% increase	0.5% increase	1% increase	2% increase

** *Any staff member within this rating would be subject to formal performance review*

All senior executives are employed on permanent 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 2017-18 are included on pages 18 to 21. Details of our Council of Governors are included on pages 93 to 97, together with information on expenses paid to them in 2017/18.

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:

	2016-17	2017-18
Total number of directors in office as at 31 March:	11	14
Number of directors receiving expenses:	4	4
Aggregate sum of expenses paid to directors (£00s):	£22	£27

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: non-executive directors

	2016-17				2017-18			
	Salary and fees (bands of £5,000) £000	Taxable benefits (to nearest £100) £00	Pension-related benefits £00	Total of all items £000	Salary and fees (bands of £5,000) £000	Taxable benefits (to nearest £100) £00	Pension-related benefits £00	Total of all items £000
Sue Musson Chairman (from 3 Jan 2017)	10-15	4	0	11	40-45	34	0	47
Tim Watkinson Vice Chairman (from April 2016)	10-15	0	0	15	15-20	3	0	16
Michael Welsh Non-executive director	10-15	0	0	13	10-15	0	0	13
Tony Gatrell Non-executive director	10-15	0	0	13	10-15	0	0	13
Alastair Campbell Non-executive director	10-15	0	0	13	10-15	0	0	13
Jeannette Newman Non-executive director (From 3rd July 2017)	0	0	0	0	5-10	0	0	9
James Whitaker Non-executive director (From 3rd July 2017)	0	0	0	0	5-10	0	0	9
Geoff Rossington Non-executive director (From 4 September 2017)	0	0	0	0	5-10	10	0	8
NON-EXECUTIVE DIRECTORS NOT IN POST AS AT 31 MARCH 2018								
Shamim Mahomed Non-executive director (up to 31 March 2017)	10-15	0	0	13	0	0	0	0

Stuart Heys Chairman (up to 2 Jan 2017)	30-35	4	0	33	0	0	0	0
Stephen Ashley Vice Chair (up to 31 Dec 2016)	10-15	0	0	12	0	0	0	0
Robert Clarke (up to 29 February 2016) Vice-Chairman	0	0	0	0	0	0	0	0

Income disclosures: senior executives

	2016-17				2017-18			
	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	42.5-45.0	220-225	175-180	2	25.0-27.5	200-205
Suzanne Hargreaves Operations Director	125-130	0	27.5-30.0	150-155	125-130	0	17.5-20.0	145-150
Paul Havey Finance Director/Deputy Chief Executive	150-155	39	35.0-37.5	190-195	150-155	44	20.0-25.0	175-180
Phebe Hemmings Company Secretary	80-85	0	17.5-20.0	100-105	75-80	0	20.0-22.5	95-100
Gail Naylor Nursing and Midwifery Director	125-130	0	-17.5 – -15.0	105-110	125-130	1	17.5-20.0	145-150
Geraldine Skailes Medical Director (started 1 March 2018)	0	0	0	0	10-15	0	60.0-62.5	75-80
Carole Spencer** Strategy and Development Director	125-130	5	22.5-25.0	150-155	125-130	3	17.5-20.0	145-150

Karen Swindley Director of Workforce and Education	125-130	0	132.5-135.0	255-260	115-120	0	30.0-32.5	145-150
SENIOR EXECUTIVES NOT IN POST AS AT 31 MARCH 2018								
Mark Pugh* Medical Director (Ended 28 February 2018)	175-180	0	82.5-85.0	255-260	160-165	0	22.5-25.0	185-190

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

*** Carole Spencer is on secondment to the Academic Health Science Network.*

Taxable benefits include salary sacrifice schemes and lease car

Pension benefits

Non-executive director remuneration is not pensionable and therefore it is only the senior executives in the table above who are in receipt of pensionable remuneration 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 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Karen Partington Chief Executive	0.0-2.5	5.0-7.5	80.0-85.0	250-255	1,579	148	1,727	0
Suzanne Hargreaves Operations Director	0.0-2.5	2.5-5.0	45.0-50.0	145-150	844	90	934	0
Paul Havey Finance Director/Deputy CEO	0.0-2.5	5.0-7.5	65.0-70.0	200-205	1,444	128	1572	0

Geraldine Skailes Medical Director (started 1 March 2018)	0.0-2.5	2.5-5.0	55.0-60.0	155-160	1,051	42	1,093	0
Mark Pugh Medical Director (Ended 28 February 2018)	0.0-2.5	(2.5)-0.0	45.0-50.0	125-130	739	79	818	0
Gail Naylor Nursing and Midwifery Director	0.0-2.5	2.5-5.0	55.0-60.0	165-170	994	100	1,094	0
Carole Spencer Strategy and Development Director	0.0-2.5	5.0-7.5	30.0-35.0	100-105	667	79	746	0
Phebe Hemmings Company Secretary	0.0-2.5	0.0-2.5	0.0-5.0	0	14	11	25	0
Karen Swindley Director of Workforce and Education	0.0-2.5	0.0-2.5	35.0-40.0	85-90	563	66	629	0

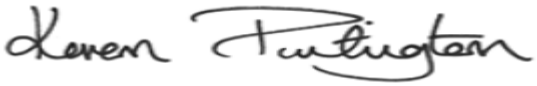
The “cash equivalent transfer value” (“CETV”) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment 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 2017/18 was £175,000 - £180,000 (2016/17 £175,000 - £180,000). This was 7.8 times (2016/17 - 7.5 times) the median remuneration of the workforce, which was £22,683 (2016/17 £23,679). In 2017/18, one employee (2016/17, nil) received remuneration in excess of the highest-paid director. In 2017/18 remuneration ranged from £5,000 to £182,000 (2016/17 £6,453 to £175,000). 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
25 May 2018

STAFF REPORT

Our people

As at 31 March 2018, we employed 7,965 substantive members of staff. This number is broken down as follows:

Staff Group	Headcount
Additional Professional, Scientific and Technical	251
Additional Clinical Services	1,594
Administrative and Clerical *(incl. NEDs)*	1,633
Allied Health Professionals	493
Estates and Ancillary	820
Healthcare Scientists	247
Medical and Dental *(excl. Pennine Doctors)*	627
Nursing and Midwifery Registered	2,254
Students	46
Total	**7,965**

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

	2015/16 HC	% of Total HC	2016/17 HC	% of Total HC	2017/18 HC	% of Total
Age *(yrs)*						
Under 17	-	-	-	-	-	-
17 – 21	105	1.42%	148	1.91%	151	1.90%
Over 21	7,285	98.58%	7,593	98.09%	7,814	98.10%
Ethnicity						
White	6,203	83.94%	6,474	83.63%	6,591	82.75%
Mixed	88	1.19%	95	1.23%	99	1.24%
Asian or Asian British	820	11.10%	881	11.38%	969	12.17%
Black or Black British	81	1.10%	85	1.10%	106	1.33%
Other	103	1.39%	112	1.45%	119	1.49%
Not Stated	95	1.29%	94	1.21%	81	1.02%
Gender						
Male	1,598	21.62%	1,692	21.86%	1,739	21.83%
Female	5,792	78.38%	6,049	78.14%	6,226	78.17%
Recorded Disability	199	2.69%	204	2.64%	223	2.80%

As at 31 March 2018, the gender split of our board of directors was seven male and seven female. The gender split of our senior executives, as defined by the Appointment, Remuneration and Terms of Employment Committee, was one male and seven female. The gender split of our senior managers was six male and fifteen female.

Attendance management

Sickness absence data reported on a calendar year basis (January 2017 to December 2017):

Figures Converted by Department of Health to Best Estimates of Required Data Items:	
Average FTE 2017	6,830
Adjusted FTE days lost *(to Cabinet Office definitions)*	75,595
Average sick days per FTE	11.1
Statistics published by NHS Digital from ESR Data Warehouse:	
FTE days available	2,495,330
FTE days recorded sickness absence	122,820

Source: *NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse*
Period covered: *01 January 2017 to 31 December 2017*

The rolling 12 month average sickness absence rate continued to reduce during the year, falling from 5.09% in January 2017 to 4.92% in December 2017. There was however a sharp increase in sickness absence from October 2017 which continued to rise throughout the winter months; and incidence of sickness due to cold, cough and flu was particularly high. This correlates with the high prevalence of flu like and respiratory illnesses reported by Public Health England for this period. Although the flu vaccine does not protect against every strain of flu or the common cold, in preparation for winter the flu jab was provided to over 6000 staff, achieving a vaccination rate in front-line health-care workers of 75.2%.

Recognising that mental health and musculo-skeletal conditions are consistently the highest known reasons for full time equivalent days lost, further proactive interventions have been implemented. Clinical psychology sessions for staff were introduced in July 2017 and a support service for staff affected by traumatic incidents at work will be launched in April 2018. Mindfulness and Mental Health First Aid programmes have also continued to run, with positive feedback from participants. There has been additional investment in physiotherapy for staff, with the establishment of a rotational post to support our Occupational Health physiotherapist. A poster campaign encouraging staff to 'Stop, Think' about effective moving handling techniques and good computer workstation posture has also been implemented and a back care awareness video has been introduced into moving and handling training.

As a result of the progress made in implementing the health and wellbeing strategy, the 2016/17 national Staff Health and Wellbeing Commissioning For Quality and Innovation (CQUIN) scheme was achieved in full and in March 2017 we were also awarded the nationally accredited Workplace Wellbeing Charter.

Work is currently ongoing to meet the 2017 to 2019 Staff Health and Wellbeing CQUIN requirements and achievements to date include:

- An agreement with our vending supplier, charity outlets and external retailers to reduce sales of sugar sweetened beverages to 10% or less by the end of March 2018

- A change of product lines in all of our internally and externally managed outlets to ensure lower calorific values of confectionary and reduced calorie and saturated fat content in sandwiches and other pre-packed savoury meals
- An improvement in our staff survey results for the question 'Does your organisation take positive action on health and wellbeing?' with respondents answering 'Yes. Definitely' rising from 31.88% in 2016 to 36.60% in 2017.

The focus for the next year will be to further develop our health and wellbeing plan to reduce sickness absence and particular priorities include the introduction of stress risk assessment tools for teams and workplace audits to prevent musculoskeletal injury at work.

Equality and diversity

Work has been ongoing throughout the year to progress implementation of the Equality Strategy action plan.

From a workforce and organisational development perspective, achievements include:

A review of talent management processes and talent opportunities has been conducted. The purpose of which was to understand if access to career development was inclusive for staff of all minority groups and to determine if new career development opportunities were needed to support specific groups of staff. As a result of the findings a series of improvements are to be introduced which will include a dedicated talent management programme for staff from minority groups.

Continuing to develop a culture which is centred around the values in order to ensure staff feel both physically and psychologically safe whilst at work. A number of work streams are currently being undertaken, these 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.
- A refresh of the Trust values, to further emphasise and strengthen the role all staff have in ensuring all staff regardless of background are treated with respect, in a fair and inclusive manner. As part of the refresh of the values, there will be greater focus placed on the culture and ethos of the organisation and how by living the values all staff can support the desired culture.
- 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.
- 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 be in place and have dealt with a number of concerns in the last 12 months raised by staff from a range of professions and bands.

Equality impact assessments of employee relations processes, recruitment and access to training, development and talent management have been undertaken and a Workforce group has been

established to ensure that equality, diversity and inclusion are central to all workforce and organisational development strategies.

Plans for the next 12 months include becoming a leading training provider of apprenticeships in health, leadership and management; and becoming registered as an independent end-point assessor for apprenticeships. The equality champion role will also be further developed and there will be a series of videos and materials launched to further embed Trust values and develop a culture where staff feel able to report concerns about bullying and/or harassment.

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 2016-2018 supports the overall delivery of the Workforce and Organisational Development Strategy. The 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:

- A strengthened approach to the staff survey which has led to an increased response rate for the organisation and has improved response rates in areas of the organisation that had previously low uptake.
- Successful delivery of the high profile project “24 hours in…” which 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 5,760 times, the social media campaign has reached 76,931 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.
- Supporting team engagement through the roll out of the Team Engagement and Development tool to a variety of clinical and non-clinical teams is in the pilot phase. Development of the online tool and resources has been completed to support organisation-wide roll out
- Developing a sense of “Team LTH” through corporate level engagement events including Coffee Catch up networking events, team development interventions and staff involvement events.
- Launched the refreshed annual awards called, “Our People Awards” to make them more inclusive
- Introduction of Staff Stories at Board to provide another opportunity to learn from staff experience and improve relationships between senior managers and staff.

Fabulous Feedback Friday celebrates the achievements of teams and shows our people their efforts are recognised. This remains popular and events continue to be held within teams. At a Corporate level the Trust Board and senior leaders embraced this initiative and introduced their own Fabulous Feedback Friday approach to visit different parts of the organisation and discuss with staff and teams the work they do and celebrate their achievements

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:

- 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 2017 staff survey results largely remain stable and show that more people would recommend this place as a place to work; 60% would recommend the organisation compared to 58% the previous year. However, this is below the national average of 61% and remains a priority for improvement.

It is disappointing that staff engagement levels have dipped slightly from 3.80 to 3.78 out of 5 and whilst this reflects the national trend within the NHS we remain committed to improving staff engagement levels and maintaining the staff engagement agenda.

Levels of staff involvement reported in the staff survey have been an area of strength for our organisation and previously placed us in the top 20% of Acute Trusts. Whilst this is still an area of strength the latest results indicate these levels have dropped in the last year. This is disappointing and we recognise this remains a priority for us in the refreshed Staff Engagement Plan because we are committed to the principles that if we improve staff engagement and involvement we will improve organisational performance and effectiveness during times of increased pressures and challenges.

Our approach to staff engagement is continually developing and we are currently refreshing our engagement plan and the 2018–2020 plan will be launched this year. The plan is being 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 2017 staff survey results in March 2018 three Big Conversations focus groups have been held to explore the results as well as two further Equality and Diversity themes staff survey focus groups. These are led by Board members and facilitated by the Leadership and Organisation Development team along with the Partnership Team and Equality Champions. 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.

In March 2018 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 introduced this 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 Staff Engagement Advisor in partnership with the Strategic Workforce Leads will support directorates with the implementation and monitoring of progress against their individual plans.

Response rates improved for a third successive year and 52% of staff completed the survey, this is an increase from 44% in 2016, above the national average of 44% and places the organisation in the top 20% of Trusts for response rates signalling the improved use of the survey as a mechanism for staff voice and understanding staff experience.

The results show our staff engagement levels are 3.78 out of 5 which is a slight decrease from 3.80 the previous year and reflects the national trend. The staff engagement measure is calculated using the results from questions relating to advocacy, involvement and motivation. Staff feeling involved and able to contribute to improvements has deteriorated slightly and accounts for the decrease in engagement levels, however the organisation is still better than national average for staff involvement. Levels of staff motivation and advocacy have remained stable. There has been a small increase in staff saying they would recommend the organisation as a place to work with 60% agreeing compared to 58% the previous year and is the highest level in three years. There has also been a small increase in staff stating that if a friend of relative needed treatment they would be happy with the standard of care provided by the organisation, with 66% agreeing compared to 65% the previous year. These remain priority areas for improvement.

In the 2016 staff survey improvements where made against the majority of areas in the staff survey and in the 2017 staff survey these results have largely been maintained. Whilst some areas have seen minor improvements or deterioration they are not classed as statistically significant shifts and represent stable results.

We have improved in 2 out of the 32 key findings and these relate to effective use of patient / service user feedback and staff feeling the organisation and management take interest in and action on staff health and wellbeing.

When compared against the national average for acute Trusts we are in the top 20% of Trusts in relation to 4 out of the 32 key findings, these are: % of staff experiencing discrimination at work in the last 12 months, satisfaction with opportunities for flexible working patters, % of staff working extra hours and staff experiencing harassment, bullying or abuse from staff in the last 12 months.

In 11 out of the 32 key findings our staff experience is better than the national average and these areas are: staff confidence and security in reporting unsafe clinical practice, % of staff attending work in the last 3 months despite feeling unwell because they felt pressure, organisation and

management interest in and action on health and wellbeing, staff feel able to contribute towards improvements at work, effective team working, staff satisfaction with resourcing and support, recognition and value of staff by managers and the organisation, effective use of patient / service user feedback, % of staff experiencing physical violence from staff in the last 12 months, % of staff reporting most recent experience of violence, and % of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

Areas which are below the national average include: % of staff appraised in the last 12 months, quality of non-mandatory training, learning or development, % of staff witnessing potentially harmful errors, near misses or incidents in the last month, staff recommendation of the organisation as a place to work or receive treatment, staff satisfaction with the quality of work and care they are able to deliver, staff agreeing their role makes a difference to patients / service users

The following tables present the national comparative highest and lowest ranking scores *by key finding* in relation to other acute trusts.

For each of the 32 Key Findings, the acute trusts in England were placed in order from 1 (the top ranking score) to 93 (the bottom ranking score). Lancashire Teaching Hospitals NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1.

	2017	
Top 5 Ranking Scores	**Trust**	**National Average**
FK 25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months *(the lower the score the better)*	**23%** ↓	28%
KF16 Percentage of staff working extra hours *(the lower the score the better)*	**68%** ↓	72%
KF15 Percentage of staff satisfied with the opportunities for flexible working patterns *(the higher the score the better)*	**54%** ↑	51%
KF 20. Percentage of staff experiencing discrimination at work in the last 12 months	**10%** ↓	12%
KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**22%** ↓	25%

	2017	
Bottom 5 Ranking Scores	**Trust**	**National Average**
KF11 Percentage of staff appraised in last 12 months *(the higher the score the better)*	**79%** ↓	87%
KF13. Quality of non-mandatory training, learning or development	4.01 (out of 5 and 5 is the best) ↓	4.05
KF3. Percentage of staff agreeing their role makes a difference to patients / service users	89% ↓	90%

KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	32% ↑	31%
KF1 Staff recommendation of the organisation as a place to work or receive treatment *(the higher the score the better)*	**3.70** ↓	3.75

Further analysis has been undertaken to identify the themes from the free-text comments. These themes combined with the highest and lowest scoring areas are going to be used to inform the focus of the Big Conversation discussions in which staff were invited to talk about what it is like to work here and what could improve their experience. The themes are:

Positive Themes	Improvement areas
1. Health and wellbeing 2. Feeling valued and recognised 3. Reporting errors and near misses 4. Equality and diversity: staff experiencing discrimination at work 5. Effective use of patient / service user feedback 6. Working patterns	1. Appraisals and quality of non-mandatory training, learning or development 2. Staff involvement 3. Staff satisfaction with the quality of care and feeling they make a difference 4. Physical violence and aggression from patients and public 5. Senior managers' involvement and communication

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 staff engagement plan 2018 – 2020 will present 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 organisational development team has continued to deliver a range of leadership and management development programmes. In 2017 the launch of core people management skills programme took place, this is a full blended and experiential training programme which is offer to all managers in Bands 4 – 8a and is designed to help support managers to manage effectively and to apply workforce policies positively.

The Trust continues to be leading the way with regards to Talent Management having been shortlisted in 2018 for a Health Services Journal Value Award. Support is being provided locally to teams across the Trust to enable them to develop and increase their way of working and team effectiveness. Coaching and mentoring training is providing to be successful, with middle and senior managers taking part in accredited training as a way to improve the quality of management conversations and create a culture of coaching conversations and empowerment.

Compliance with our mandatory training target has increased by 4% (86% total) compared with 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 67% of staff now opting to undertake their mandatory training using this method of delivery, this equates to a 13% e-Learning increase on last year. The expansion of E-learning provision continues to be utilised in various mandatory subjects eg Safeguarding and Prevent.

Staff members now receive monthly personalised emails which list all their training requirements and compliance against each required event. Manager's compliance reports are circulated monthly to nominated managers.

Real time training course flyers have also been introduced which automatically show candidates how many places are available on each course advertised. These flyer update in 'real time' so the information displayed is always 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.

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:

- Introduced the apprenticeship training programme for all new band 2 HCA's. As part of the 12 months apprenticeship the new HCA's complete the HCA Induction, achieve the care certificate and then attend a variety of training sessions to provide them with the skills and knowledge to provide good basic nursing care. By the end of the programme they are ready for progression to a band 3 HCA.
- The first cohort of the 2 years NHS Career Plus course in partnership with Newman College completes in May 2018. All the students have secured places either on nurse training or paramedic training. We currently have 16 new first years on the programme and will recruit again in June for our third cohort.
- Introduced Stroke Patient scenario sessions for year 4 and 5 medical students.
- Purchased Lucina birthing manikin which is one of the most advanced manikins of its kind. This has created the potential to offer realistic training for all stages of birth delivery for obstetricians, midwives, anaesthetics and theatre personnel and has a wide range of pre-programmed emergency obstetric complication scenarios. The purchase of Lucina was only possible due to a generous grant awarded by the Preston Postgraduate Medical Education Charity Trustee.
- Leased a 'Simbulance' to support the delivery of the Safe Critically Ill Transfer Training course to develop high-level of care in the transfer of a critically ill patient from one hospital through to another. This training can now take place whilst on the move and as it is rigged with 4G cameras this enables the training to be filmed and streamed live to an observing peer group back in the Education Centre. Increase of Y3 medical students to 96 (from usual intake of 85) giving us 257 in total for Y3, 4 & 5.
- Delivered all the initial clinical skills assessments (ANTT, Venepuncture & cannulation) within 3 weeks rather than the traditional 6 weeks allowed following a request from service.
- Recruited 72 new examiners to replace the 100 lost from withdrawal of support from East Lancashire NHS Trust.
- Recruited 78 new Patient as Educators from 3 recruitment events. Now have a live database of 152 PAE's.
- Increased involvement of Patient as Educators by an additional 243 PAE's over 32 more sessions than last year.
- Introduced new career events to attract young people into medicine.
- First team to introduce delivery of apprenticeships
- Increased ANTT compliance from 39% to 81%.

- Introduced 12 new communications sessions.
- Increased the return compliance of the 'green forms' following cardiac arrests from 33 to 100%
- Increased ABLS compliance from 45 to 69% by delivering locally based sessions.
- In addition to the 'Doctor for a day' career taster events for Schools, we introduced an enhanced work experience programme for 6th form students interested in a career in medicine. Students spend a week at the Trust attending clinical teaching sessions but also some sessions shadowing current medical students. We ran 33 sessions to support this new programme.
- The amount of communications teaching has increased over the past year from 111 to 123, which is an additional 12 sessions.
- New communications sessions introduced this year include:
  - Ethics for PWAP students
  - Communication for BNAP nursing students
  - Ethical clinical Debrief
  - 6 new Patient Centred Consultations
  - Long term conditions
  - Musculo- skeletal
  - Career Workshop 2
- Overall increased training delivery by additional 588 sessions

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:-

- The Placement and Student Support team work in partnership with several education providers to deliver the best training to our staff.
- 20 HCAs from within the Trust will start a 2 year Nursing Associate Apprenticeship in June 2018 delivered by UCLan
- Pre-registration nurse training is delivered in partnership with the University of Bolton, there are 2 intakes per year and the training is a three year programme.
- Pre Nursing Apprenticeship training is delivered within the Trust validated by Pearson. This is an 18 month programme to support healthcare assistants gain the qualifications needed to enter nurse training.
- Students from our 3 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 NMC PIN number.
- 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.
- 3 Physicians Associate students have 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.
- 4 cohorts of non-credit bearing Multi-professional Support for Learning and Assessment in Practice at level 5 are delivered annually ensuring there are sufficient qualified mentors to support our student nurses.
- A new link nurse role has been launched; the Learning Environment Manager is a crucial link between placement areas and the Placement and Student Support team.
- Collaborative Learning in Practice (CLiP) has been expanded across 10 placement areas within the Trust with more to follow shortly
- A new role of Clinical Placement Facilitator has been developed to support medical students whilst on placement to develop and enhance their skills.

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. Rotas are monitored biannually in line with the junior doctors in training national contract conditions (2002).

A trust guardian of safe working has been appointed in 2016 to oversee all exception reports raised by doctors engaged on the new junior doctor contract (2016) and will be reporting to board quarterly regarding any concerns raised related to hours worked and concerns related to safe working.

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.

The on-going medical workforce strategy will continue to address recruitment pressures.

Occupational health

Financial returns for the joint venture (Wellbeing Partners) over 2017/18 have continued to be positive. A new five-year strategic plan was agreed by the Governance Board to enhance the commercial potential for the joint-venture and this has started to show benefits with new contracts agreed with local organisations. A new marketing drive with enhancements of the website is planned for early 2018/19, underpinned by review of clinical and administration processes to improve efficiency and enhance the scope and potential to win new business.

A period of consolidation has led to improvements in IT functionality, full implementation of the online referral system and appointments to senior leadership positions. This has enabled enhanced reporting of service provision and performance against agreed key performance indicators has been scrutinised at local performance meetings with exception reporting to the Governance Board.

The service went through a robust national re-accreditation process with an on-site visit by the assessors in February 2018 and a successful outcome confirming provision of Safe, Effective, Quality Occupational Services (SEQOHS). The accreditation process provides independent assurance of the quality of service provided and in addition, feedback surveys from service users have consistently shown high levels of satisfaction.

Staff costs

	Permanent	Other	2017/18 Total	2016/17 Total
	£'000	£'000	£'000	£'000
Salaries and wages	257,285	0	257,285	233,153
Social security costs	24,743	0	24,743	22,606
Apprenticeship Levy	1,222	0	1,222	0
Employer's contributions to NHS pensions	28,733	0	28,733	26,984
Termination benefits	48	0	48	429
Temporary staff	0	12,239	12,339	18,653
Total gross staff costs	**312,031**	**12,239**	**324,270**	**301,825**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**312,031**	**12,239**	**324,270**	**301,825**
Of which				
Costs capitalised as part of assets	-	-	-	-

Average number of employees (WTE basis)

Average number of employees (WTE basis)	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	783	-	783	746
Administration and estates	625	-	625	607
Healthcare assistants and other support staff	2,812	-	2,812	2,651
Nursing, midwifery and health visiting staff	1,945	-	1,945	1,915
Nursing, midwifery and health visiting learners	-	-	0	40
Scientific, therapeutic and technical staff	646	-	646	620
Healthcare science staff	219	-	219	216
Agency and contract staff	-	315	315	165
Bank staff	-	134	134	282
Other	-	-	-	11
Total average numbers	**7,030**	**449**	**7,479**	**7,253**
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 49 - 53 of this report.

Off-payroll arrangements

We have a policy to ensure when the Trust enter 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 2018, for more than £245 per day and that last for longer than six months:

Number of existing engagements as of 31 March 2018	7
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	3
Number that have existed for between two and three years at time of reporting	4

We review our off-payroll engagements and where considered necessary we seek assurance as to whether the individual is paying the right amount of tax.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, 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 2017 and 31 March 2018	15
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	15
Number for whom assurance has been requested	15
Of which:	
Number for whom assurance has been received	15
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

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	1	1
£10,000 - £25,000	1	2	3
£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	1	4	5
Total resource cost	£19,167	£82,737	£19,167

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	1	£48,514
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	3	£34,223
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
TOTAL	4	£82,737

Values of special severance payments approved by NHS Improvement

Minimum value	£4,776
Maximum value	£48,514
Median value	£19,447

Also available on our website:
Further information on our research activities
Further information on our education activities
Details on how to make a complaint or to provide a compliment
Our publication scheme
Copies of our board papers

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.	4, 24, 93, 94
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.	18 – 21, 43 – 46, 103, 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.	93 – 97
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.	94 – 95
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.	18 – 20
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.	18 – 22
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	18 – 22
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.	43 – 45
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.	44
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.	18
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.	24, 96
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.	23, 24, 45, 78, 87, 107

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.	23, 87
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).	25, 81 – 82, 89 - 91
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.	23, 24, 78, 91, 92
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.	106 – 107
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.	103 – 108
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 contact, surveys of members' opinions and consultations.	24, 25, 94, 102
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.	98 - 102
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.	26, 97
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.	98 – 102
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.	22, 94

"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 unanimously 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;	59 – 60
The foundation trust's policies in relation to disabled employees and equal opportunities;	57, 58, 86
Information on health and safety performance and occupational health;	14 – 16, 66
Information on policies and procedures with respect to countering fraud and corruption;	107
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	10
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, 35, 41, 58, 81, 84, 86
Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas	39 - 42
Any other public and patient involvement activities.	35, 85, 100 - 102
The number of, and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Note 7.3 to the accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Note 3 to the accounts
A statement that the NHS foundation trust has complied with the cost allocation and charging guidance issued by HM Treasury	10
Sickness absence data	56, 57
Details of serious incidents involving data loss or confidentiality breach	88, 89

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 reporting	11
Equality reporting	57, 58, 86
Slavery and human trafficking statement (Modern Slavery Act 2015)	25

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 25 May 2018 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. For details of the enforcement undertakings and the Trust's significant progress made against them, please see the Annual Governance Statement.

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. Finance and use of resources is only one of the five themes feeding into the Single Oversight Framework.

Metric	2017/18 Q3 score	2017/18 Q4 score
Capital service cover	4	4
Liquidity	4	4
I&E margin	4	4
I&E variance from plan	4	4
Agency spend	2	2
Overall scoring	**4**	**4**

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 set out in the Accounts Direction. 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 NHS Foundation Trust Annual Reporting 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 have been followed, and disclose and explain any material departures in the financial statements;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

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. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

Karen Partington
Chief Executive
25 May 2018

ANNUAL GOVERNANCE STATEMENT 2017-18

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 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and Accountability

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.

The last CQC visit in September 2016 highlighted the need for strengthened risk management arrangements. During 2016/17 the Trust established a Directorate of Governance to support the organisation and the Trust Board in meeting its governance responsibilities and a key objective for the Directorate was to improve the Trust's risk management arrangements. The Directorate's other key responsibilities are to:

- 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 Risk Management Committee 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 will also take account of any recommendations arising from the external Well-Led Review being 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 2017/18 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 2017/18 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 2017/18 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 IT Risk Management System (Datix) 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 (which is also held on Datix). 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 Clinical Governance Committee and the Risk Management Committee. 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 SIs including lessons identified and learned, following which a monthly 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 continues to develop its relationship with the CQC - escalating risks / concerns in respect of patient safety / quality as they occur, together with the actions taken or proposed, and in order to provide assurance that the Trust Board has appropriate oversight of its quality governance / patient safety risks. Regular relationship meetings are held.

The Trust also routinely considers and acts upon the recommendations of relevant national high level enquiries through the use and monitoring of robust action plans.

The risk and control framework

The management of risk

The risk management strategy is critically important to the Trust and is reviewed by the 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 has its own local risk management strategy, which reflects that of the organisation. 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 Datix 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 Risk Management Committee 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 Risk Management Committee 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 Risk Management Committee may escalate a particular risk to the Safety and Quality board committee 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. 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 2017/18 and this will continue into 2018/19 in response to internal audit recommendations. A monthly 'deep dive' using the aviation industry's Bow-Tie model 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 2017/18 we have continued to strengthen our risk management arrangements, including through our monthly risk management committee meetings, which is an operational committee reporting into the Safety and Quality board committee. Risk management committee 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 2017/18 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 2017-18, 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 for fire safety auditing, fire safety training, health and safety auditing and Control of Substances Hazardous to health (COSHH);
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.

The board assurance framework includes further detail as to how these risks are being managed and mitigated, including how outcomes are assessed.

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 a dedicated Quality Delivery Group and a Clinical Governance Committee.
- The Trust publishes an Annual Quality Account.
- The integrated performance report 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 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 2016/17. 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 2016/17 via the CQC undertaking an inspection of the organisation in September 2016. The purpose of the inspection is 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 April 2017, with an overall view that the Trust 'Requires Improvement'. Whilst this was disappointing the Trust noted that the CQC saw that in terms of 'caring' the organisation was graded as 'good'. The Trust has developed a robust quality improvement programme, which addresses the issues raised by the CQC, alongside wider contextual challenges. The quality improvement programme is reviewed by the Trust Board and the Safety and Quality Committee on a monthly basis and is preparing the organisation for its journey towards 'Good'. Further details of the recommendations provided by the CQC can be found in the Quality Report.

Capacity and Flow

During 2017-18 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 2017-2018 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 2017-2018 the Trust set up a range continuous Improving and transformational work streams of which patient flow has a significant work plan attached to this.

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 operating deficit, before STF and technical items, is £42m. Whilst the Trust achieved £20m savings in 2017/18, a considerable achievement, this was 59% of our challenging savings target for the year (£34m) and, of the total delivery, £11m represents non-recurrent savings achieved and places additional pressures on the 2018/19 savings targets.

At the end of 2017/18 there remained two outstanding areas in relation to our existing enforcement undertakings to the regulator:

i. *Liquidity:* Due to deficits in the current and previous years the Trust's financial standing is based upon working capital facilities therefore we continued to be reliant on external financial support throughout 2017/18 and into 2018/19. We plan to access significant working capital loan facilities of £46m during 2018/19 and our term loan of £20.5m is due for repayment at the end of 2018/19. Whilst we have an expectation that this will be renegotiated before the expiry date, should this not be the case, the Trust will not have sufficient cash resources to repay the loan.

ii. *Long term sustainability:* With respect to the Trust's long term sustainability, both clinically and financially, we recognise that sustainable financial balance needs to come through engagement with the wider health economy; this requires not only the Trust to achieve service efficiencies but to maximise the use of its sites and support the wider transformational change in service delivery. We along with our local partners are together seeking sustainable solutions through the Our Health Our Care programme; in 2018/2019 we will be working towards producing a range of options for the future provision of services. We will then complete a pre-consultation business case containing evidence of the work undertaken through the solution design process, following which a formal public consultation may be required.

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 has arranged for an audit to be carried out within the 2018/19 internal audit programme in order to provide independent assurance to NHS Improvement as to the Trust's progress against the new undertakings.

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 2017/18 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 2017/18 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.

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

The Trust has robust arrangements in place for setting objectives and targets on a strategic and annual basis. These arrangements include ensuring that the budget is affordable, providing scrutiny of savings plans to ensure achievement and compliance with our sector control total and coordinating individual objectives with corporate objectives, as identified in our operational plan.

Performance against objectives is monitored and actions identified through a number of channels, including:

- approval of annual budgets by the Board of Directors;
- monthly reporting to the Board on key performance indicators covering finance, activity, quality and workforce targets;
- weekly reporting to the Executive Team on key influences on the Trust's financial position, including activity and other key performance indicators;
- monthly and weekly reporting to divisions through the budgetary control system and weekly benchmarking system;
- monthly performance management of divisions by the Executive Team covering performance on key areas;
- periodic reporting to NHS Improvement and compliance with the provider licence

The Trust also participates in initiatives to ensure value for money, including:

- review against the Lord Carter Review model hospital data sets to ensure that it continues to develop, it identify opportunities to improve efficiency and strengthen its financial position
- subscription to a national benchmarking organisation that provides comparative information analysis on patient activity and clinical indicators. This is used for the risk management process and to identify where improvements can be made;
- ensuring that value for money remains an important component of the internal and external audit plans that provide assurance to the Trust that processes are in place to ensure effective use of resources;
- in-year cost pressures are rigorously reviewed and challenged, and mitigating plans are considered; and

- The Trust has a standard assessment process for business cases and business plans to ensure value for money and to ensure that full appraisal processes are employed when considering the effect on the organisation.
- The Trust is currently preparing for its 'Use of Resources' assessment being undertaken by NHS Improvement on 18th June 2018.

Despite these arrangements during 2017-18 the Trust experienced deterioration in its financial performance, as a result of unprecedented operational pressure causing increased cancellations of elective activity thereby resulting in reduced income. The Trust 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 patient flow. During 2017-2018 the Trust set up a range Continuous Improvement and transformational work streams of which patient flow has a significant work plan attached to this, and during Q1 2018/19 we are starting to see a positive impact of such workstreams on key access standards.

Review of board effectiveness

The Trust as a whole reviews its own leadership and governance arrangements periodically. In March 2014 the board commissioned Deloitte to undertake an independent review of its governance, using Monitor's consultation document on board governance reviews as the framework for this work. The findings of the 2014 review demonstrated the effectiveness of our governance arrangements and, where Deloitte highlighted areas for improvement, the Trust has since implemented actions to address them. In June 2017 NHS Improvement published a new framework for developmental reviews of leadership and governance. The Trust will be commissioning a further independent review in June 2018 against the new framework. In preparation, we have 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 final self-assessment will be formally approved by the Board on 7th June 2018 and will be shared with the independent reviewer as part of their review, which is due to commence on 8th June 2018. The key areas of development for the Trust, highlighted through our self-review process, mainly relate to KLOEs 1, 2 and 5. Following the independent review, we will be developing an action plan to implement any recommendations arising from the review, which we will share with both NHS Improvement and the Care Quality Commission.

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 2017/18 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 2017/18.

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 2017/18 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 Risk Management Committee 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 2017/18 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 will work 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 2017/18 the Trust had 2 Level 2 confirmed Information Governance Serious Incidents which we reported to the Information Commissioner's Office. The Trust undertook investigations and strengthened controls. The Information Commissioner was satisfied with the actions taken on these incidents by the Trust and made no further recommendations.

The incidents were as follows:

1. A handover sheet was left in a day room (a side room on the ward area which is utilised by staff members for handover). The area was not normally available to patient's relatives but on this occasion the family were allowed to stay in this room as the family member was dying. The handover sheet contained details relating to four patients (including the family's

relative). The family subsequently submitted a complaint to the Trust. The IG Team, with the Caldicott Guardian, subsequently arrange for the documentation to be destroyed.

2. The Trust was affected by the Wannacry attack from 12 – 14 May 2017. Reports received centrally in the Trust through the IT Service Desk identified PCs which had been affected and patches as well as key technical fixes were applied to prevent further issues/attacks. A number of PCs throughout the organisation were not affected and there was no person identifiable information. From 12 May 2017 the Trust deployed its business continuity plans and there was minimal disruption to clinical services. By 15 May 2017 all clinical areas had access to a PC or Trolley to allow clinical services to function. Throughout this period the Trust complied with guidance issued by CareCERT and we have also received additional resources in the form of manpower to support the service restoration programme from NHS Digital and NHS England. A regional CIO and Technical task force was established within hours of the incident and this collaboration supported a common approach and coordinated response. The Trust also cooperated with the National Crime Agency Specialist Cyber Crime Unit.

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 2017 to March 2018
- Clinical Governance Committee minutes and papers for the period April 2017 to March 2018
- papers relating to quality reported to the board over the period April 2017 to March 2018
- the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
- the 2017 national inpatient survey (subject to publication)
- the 2017 staff survey
- friends and family test responses
- safety incidents, clinical audit and complaints data

As stipulated in the NHS foundation trust annual reporting manual 2017-18, 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:

Governance & Leadership

- The Trust has appointed a member of the Board, the Nursing, Midwifery and AHP Director, to lead on 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 the preparation of the Trust's annual Quality Account.

- The Director of Performance is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs the Annual Quality Account including external testing as appropriate. A Head of Performance, to whom this responsibility is delegated, is also in post.

Policies & Plans in ensuring quality of care provided

- 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

- 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

- 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

- 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 2017/18 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;

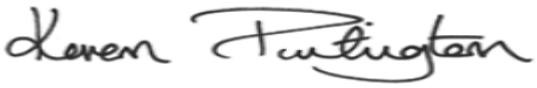
- The Board undertakes monthly reviews of the Assurance Framework and the board committees undertake detailed scrutiny of assurance received or gaps identified in relation to risks assigned to that particular committee;
- The audit committee reviews the establishment and maintenance of an effective system 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 2014, which demonstrated the effectiveness of our governance arrangements and all recommendations arising from the review have since been implemented. The Trust is preparing for our next independent Well-Led Review in June 2018 and the self-review process carried out by the Trust has been comprehensive and robust.

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 2017/18. 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
25 May 2018

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 2017/18, the council consisted of 30 governors, of which: 18 were elected governors who represent the public constituency; four were elected governors who represent the staff constituencies; four were appointed by our partnership organisations (our four partner organisations being Age UK Lancashire, Preston & Western Lancashire Racial Equality and Diversity Council, the Trust's Volunteers and the Universities of Central Lancashire, Lancaster and Manchester; and four were 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 2017, the terms of office nine public governors and one staff governor (representing nurses and midwives staff) came to an end. 1,720 votes were cast in the public election and 105 votes were cast in the staff election. This represents a turnout of 13.6% and 4.7% respectively. 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.

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. During 2017/18 we undertook reviews of the terms of reference of each of the three governor working groups.

Board and council communications

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 governor/non-executive director meetings, joint board/council workshops and written communications.

To help governors fulfil their important role of holding the board to account, governors routinely receive the corporate performance report, which provides information on key targets as presented to the board. 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. We have established a lead governor role, and during 2017/18 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 five formal council meetings during 2017/18, four of which were quarterly meetings (April 2017, July 2017, October 2017 and January 2018) and a further extraordinary council meeting was held in May 2017. 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 (%)
Rebecca Allcock**	26/06/14 – 31/03/20	Staff: other health professionals	5	3	100%
Brian Atkinson	01/04/12 – 31/03/18	Public	5	4	80%
Maureen Bamber*	01/04/13 – 31/03/19	Public	5	2	40%
Frank Batin	01/04/17 – 31/03/20	Public	5	4	80%
Alistair Bradley	18/05/16 – 17/05/17	Appointed	5	4	80%
Helen Bradley	01/04/11 – 31/03/20	Staff: nurses and midwives	5	3	60%

Name of governor	Term of office	Type of governor	A	B	Percentage of meetings attended (%)
Vanita Brookes	13/06/12 – 12/06/18	Staff: doctors and dentists	5	2	40%
Tricia Calderbank	01/04/13 – 31/03/19	Staff: administrative and clerical	5	3	60%
Liz Carberry	01/04/17 – 31/03/18	Appointed	5	4	80%
John Daglish	15/07/11 – 31/03/20	Public	5	4	80%
Margaret France	01/04/17 – 31/03/20	Public	5	4	80%
Michelle Hall	01/04/16 – 31/03/19	Public	5	5	100%
Hazel Hammond*	01/04/16 – 31/03/19	Public	4	0	0%
Dylis Hayton	01/04/14 – 31/03/20	Public	5	3	60%
Steve Heywood	01/04/16 – 31/03/19	Public	5	5	100%
Richard Hoyle*	01/04/16 – 31/03/19	Public	4	2	50%
Cliff Hughes	20/07/16 – 19/07/17	Appointed	2	0	0%
Javed Iqbal	10/12/15 – 09/12/17	Appointed	5	3	60%
Catherine Jackson*	04/08/15 – 31/05/18	Appointed	4	0	0%
Ken Jones	01/04/11 – 31/03/20	Public	5	5	100%
Sheena Keskin	01/04/15 – 31/03/18	Public	5	4	80%
Mark Jarnell	01/04/17 – 31/03/20	Public	5	3	60%
Nicola Leahey	01/04/11 – 31/03/20	Public	5	5	100%
Lynne Lynch	01/04/15 – 31/03/18	Public	5	4	80%
Margaret Newsham	01/04/17 – 31/03/20	Public	5	2	40%
Janet Miller	01/04/17 – 31/03/20	Public	5	5	100%
Alan Morrow	01/04/10 – 31/03/19	Public	5	3	60%
Gurvinder Sahota	10/11/15 – 09/11/18	Appointed	5	1	20%
Eddie Pope	15/06/17 – 14/06/18	Appointed	3	1	33.3%
Donna Studholme	06/11/17 05/11/18	Appointed	1	1	100%
Stephanie Tufft	12/08/15 – 11/08/18	Appointed	3	2	66.6%
Jacqueline Mort	15/06/17 – 14/06/18	Appointed	3	0	0%

A = maximum number of meetings the governor could have attended
B = number of meetings the governor actually attended
**Exceptional circumstances on the grounds of ill health*
***Exceptional circumstances on the grounds of maternity leave*

Director attendance at council of governors meetings

The following directors attended council meetings during 2017-18
Sue Musson, Chairman
Karen Partington, Chief Executive
Paul Havey, Finance Director / Deputy Chief Executive
Suzanne Hargreaves, Operations Director
Gail Naylor, Nursing and Midwifery Director
Tony Gatrell, non-executive director
Michael Welsh, 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 2017/18, our governors have participated in a number of workshops, including the following topics:

- 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.
- Managing Meetings: this session provided governors with training on effective chairing of meetings, effective participation of meetings and appropriate challenge and resolution of dispute/deadlock in meetings. This training forms part of the governor development programme.
- Role of the Audit Committee: briefing by the Trust Audit Committee Chair, Tim Watkinson, on the role of the Audit Committee and how it oversees the external auditors and internal auditors.
- Joint development sessions between the Board of Directors and the Council of Governors on (1) the Trust's Quality Improvement Plan and the Trust's Continuous Improvement approach, and (2) the Trust's Governance arrangements.
- 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.
- Trust Charities: this session provided governors with an overview of the Trust's charitable funds structure.
- Culture, communication and relationships: this developmental session was designed to encourage governors to focus on the importance of demonstrating the Trust's values in our behaviours, communications and relationships.
- Updates regarding the Trust's financial position, the Our Health Our Programme and the development of the Lancashire Procurement Cluster

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:

	2016-17	2017-18
Total number of governors in office (as at 31 March)	30	28*
Total number claiming expenses:	17	10
Aggregate sum of expenses (£00):	£53	£30

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

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:

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

Our Membership

We currently have one of the largest memberships in the North West region and the country. The table below shows member numbers by constituency including the year on year percentage change:

Constituency	31 March 2018	31 March 2017	Difference	% Difference
Public	12,078	12494	- 416	- 3.32%
Staff	7,509	7,142	+ 367	+ 5.13%
Total Membership	**19,587**	**19,636**	**- 49**	**- 0.24%**

During 2017/18 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 3.32% reduction in the number of public members during 2017/18 compared with membership figures for 2016/17. Recruitment activity has also been focused on targeting under-represented groups only.

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

Our strategy

Our Membership Engagement Strategy approved by the council of governors sets out how our membership community will remain involved and also develop, which is reinforced in our annual membership plan. The strategy outlines four aims that are incorporated into the membership engagement plan for 2017/18. The aims of the strategy are to:

- enable members to be actively involved in the planning and delivery of services so that they reflect the needs of patents and the local community
- communicate with members and provide information on developments, ensuring that information received is tailored to their selected level of involvement
- carry out targeted recruitment in order to ensure that our membership remains representatives of the community we serve
- encourage members to stand for election to the council of governors and to elect governor representatives

Our Membership Engagement Strategy will be reviewed during 2018/19 with input from members, the Council of Governors and the Board of Directors.

Review of 2017/18

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 during October 2017 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 cancer 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. Delegates were able to meet and chat with governors and senior managers before visiting various display stands themed around Cancer Services. Attendees were able to observe two short clinical presentations on the state of the art robotic surgery, cancer treatment that improve outcomes for patients with cancer and an introduction to electro chemotherapy. 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 Cancer 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 2017/18:

- The 16th consecutive Health Mela was held in Preston at the University of Central Lancashire's Foster Building in April 2017. Many of our staff, along with governors supported the event in order to promote and share information about our services.

- We promoted a further two local health mela events to our members, Chorley in September followed by the Leyland Health Mela in October 2017. 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 July 2017, the Nursing Directorate wanted to introduce STAR a new quality assurance framework to governors and members. STAR (Safety Triangulation Accreditation Review) has been designed by our staff, and will help us monitor, review and improve quality standards throughout our clinical areas. The team also used the event's opportunity to seek input on developing a process for patient and public involvement and how to increase involvement with local communities and to share and obtain feedback on the Nursing, Midwifery and Allied Health Professionals Strategy development.

- In partnership with the Clinical Commissioning group, members were invited to a free workshop in June 2017 that will help to support carers in understanding the law and their rights.

- We have been working collaboratively with our partners via Our Health Our Care, a transformation programme to improve the health and wellbeing of everyone in our communities. A schedule of events for 2017 was promoted to members whereby governors provided a huge support with their presence and listening to the views of members and the public. Governors were able to optimise their attendance at the college events and able to recruit new members in an under-represented area of our membership.

- Events were promoted to foundation trust members (public and staff) and the wider public via posters, flyers, social media, Trust Matters members' magazine and email communications.

- The promotion of the Our Health Our Care transformation programme continues to be one of the most critical priorities for the organisation. Throughout 2017 we offered numerous and wide ranging opportunities for members to directly affect the planning and development of our services.

- Using the bi-annual members' magazine we ask foundation trust members if they would like a visit from our governors in order to speak with community groups, charities or any interested groups. Several governors visited TOTS Community Group (Together on Thursdays) in September 2017 and an Osteoporosis Group in March 2018 and gave a short, informal presentation followed by a questions and answer session. Governors were able to recruit new members, listen to their views in addition to raising 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 Trust 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 2018/19 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 2018/19 and following the review of the Membership 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 2017-18. 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 three independent non-executive directors. During 2017/18 the three members were: Jim Whitaker, Jeannette Newman and myself (with non-executive director, Michael Welsh, standing in as a substitute member for the May 2017 and September 2017 meetings). 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. 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. 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 three times between 1 April 2017 and 31 March 2018 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 2017/18 annual financial statements and has discussed with management the reasons for the main changes compared to the financial statements for 2016/17.

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 2017/18 highlighted as significant audit opinion risks (i) the valuation of land and buildings and (ii) the valuation and existence of Income and Receivables. The risk in relation to the valuation of land and buildings has been carried through from 2015/16 and 2016/17 however a desktop revaluation has been carried out by an external valuer for the purposes of the 2017/18 annual financial statements, in line with the policy of having a full revaluation every 5 years and annual desktop valuation between full valuations. Given the recommendation relating to the revaluation reserve raised in the 2016-17 external audit, the external auditors also focused on the accounting for the valuation, and the new asset register the Trust implemented at the end of 2016-17. The risk in relation to the valuation and existence of Income and Receivables has been carried through from 2016/17. The external auditor considers there to be an increased risk of estimations of under or over activity against contracts and estimates of income due for delivering quality measures (CQUIN), in order to deliver control totals (from the perspectives of both the commissioner and the provider); as such there may be mismatches between NHS income/receivables in providers and NHS expenditure/creditors in commissioners.

During the year the audit committee has 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 Programme Management (to confirm whether the Capital Programme is managed effectively and the annual budgets are prepared based on a risk adjusted

assessment process and to give an assurance opinion on the budget being concentrated on high risk issues)

(ii) NHSI Reporting/Activity Targets (to ensure that there are adequate systems and controls in place including the accuracy, completeness and validation of information reported to the Board of the Trust's DTOCs).

(iii) Quality Spot Checks (to provide an assurance opinion on the effectiveness of the STAR Framework, reporting structure and interventional support methods).

(iv) Compliance with Human Tissue Act (to confirm the effectiveness of the Trust's adherence to the Human Tissue Authorities Code of Conduct A: Guiding principles and the fundamental principle of consent).

(v) Payroll/HR ESR (to provide an assessment of the effectiveness of the systems of control operating at the Trust to ensure that only employees of the organisation are paid, and only for work that they perform on behalf of the organisation).

(vi) Bank and Agency Staffing (to assess the overall arrangements, systems and processes for Bank, Agency & Locum staff).

(vii) Consent (to confirm the effectiveness of the Trust's consent policy and staff adherence to this).

(viii) Compliance with the Mental Health Act (to provide assurance of the Trust's compliance with the Mental Health Act (MHA) 1983 (and the amended 2007 Act)).

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, 1 has provided High Assurance, 8 have provided Significant Assurance, 1 has provided Limited Assurance and 1 has provided No Assurance. The Assurance Framework Opinion met requirements. Additional advisory support and guidance was provided by the internal auditors in relation to the Trust's Quality Improvement Plan, Cyber Security, Committee Standards and Risk Management Committee Effectiveness.

The Director of internal audit has provided an overall opinion of Moderate Assurance, based on their work during 2017-18. 'Moderate assurance' means that there is an adequate system of internal control, however, in some areas there are weaknesses in the design and/or inconsistent application of controls putting the achievement of some of the organisation's objectives at risk.

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 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 2018/19 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. During 2017/18 the audit committee was informed by management of NHS Improvement's intention to revise the Trust's enforcement undertakings and an internal audit in respect of the new enforcement undertakings is scheduled within the 2018/19 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 2017/18 included internal audit work on the organisation's systems for achieving activity targets and regulatory compliance. During 2017/18 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 2017/18 of which there were no significant issues reported.

Our external auditors

For the 2017/18 financial year KPMG LLP was paid £72,000 for statutory audit, as shown in note 4 to the accounts, which was consistent with the 2016/17 sum. KPMG were also paid £9,000 (excluding VAT) for the statutory quality report audit for the Trust during 2017/18, which was consistent with the 2016/17 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.

Our 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 2017/18 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)	3	3	100%
Jim Whitaker	2	2	100%
Jeannette Newman	2	0	0%
Michael Welsh (substitute member for May 2017 meeting and September 2017 meeting)	2	2	100%

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

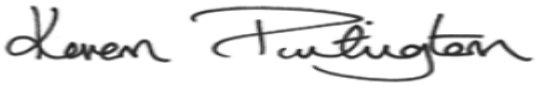
Audit Committee effectiveness

The committee undertakes a self-assessment on an annual basis, with the last self-assessment taking place on 12 April 2018 in the form of a 'symposium' style workshop facilitated by me as Audit Committee Chair. Committee members and attendees were invited to provide their comments and views on the effectiveness of the committee, taking into consideration the terms of reference and the committee's development plan. 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. 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.

Tim Watkinson
Audit Committee Chair
25 May 2018

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



Karen Partington
Chief Executive
25 May 2018

Lancashire Teaching Hospitals NHS Foundation Trust

QUALITY REPORT
2017/18

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 2017 to March 2018.

During 2017-18, The National Health Service has faced unprecedented challenge on its services and this has very much been the case for Lancashire Teaching Hospitals NHS Foundation Trust.

We have once again seen significant demands on both elective and emergency services over and above those faced in previous years, along with operational pressures due to patient flow. It is recognised that whilst we have responsibility for managing patient flow and ensuring as far as possible that patients receive the right care at the right time, long term sustainable solutions are not solely within our gift. Through active engagement with our partners, a health economy wide action plan has been developed to address the urgent care system pressures. Through a number of initiatives in both primary and secondary care we expect to deliver a level of sustainability across the health economy.

Overall during 2017-2018 the Trust achieved compliance against a range of measures within the Risk Assessment Framework and Single Oversight Framework, including access standards related to five of the eight cancer waiting times standards, infection prevention standards and diagnostic waits. In addition, the Trust has maintained performance against a range of other measures identified in the Acute Services Contract.

Due to significant pressures within the emergency service throughout the year, objectives in relation to Accident and Emergency Waiting Times during Quarter 2, 3 and 4, the 18 week access target and the 62-day cancer treatment target were not consistently achieved

Efforts to deliver excellent care with compassion have been compounded by the challenge of maintaining safe staffing levels. In this respect we have built and maintained ongoing efforts to recruit and, as importantly retain staff who have demonstrated admirable levels of resilience whilst striving to provide excellent, safe and compassionate care.

The Care Quality Commission (CQC) carried out an inspection of our hospitals in September 2016, and we were given an overall rating of 'requires improvement.' All of our services rated as 'good' for being caring, a rating of which I remain immensely proud. Nevertheless, we fully accept the CQC's findings, and are determined to improve the quality of services we provide, and deliver the outstanding care our patients deserve.

Since the inspection and continuing into 2017/18, the board and our senior clinical leaders have developed a trust-wide quality improvement plan which includes key changes needed to improve service delivery and care quality. This plan incorporates actions that are being undertaken in response to the CQC inspection; along with other improvements essential to ensuring services are safe, well-led, effective caring, responsive and sustainable. Consistent with the CQC schedule of reinspection the trust will be inspected again during either quarter one or early in quarter two of 2018-19

I continue to marvel at the ongoing passion and resilience of all those who continue to strive to deliver excellent care with compassion. I remain, as always, grateful for the continuing commitment and contribution of staff, patients, governors and members in supporting quality improvement activities at the Trust.

As in previous years, I remain thankful to our colleagues from the local area team, the Clinical Commissioning Groups and our community partners for the help and support they have given over the last year and will undoubtedly continue to give during 2017/18.

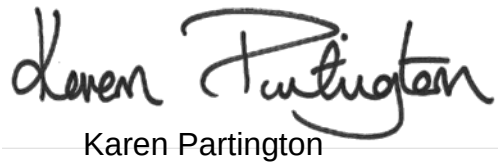
Our staff continue to receive national recognition for their efforts to provide high quality innovative care and treatment to our patients. The length of this list clearly demonstrates the breadth and depth of quality and commitment within our workforce. This year's awards include:

- Our finance team achieved level 3 accreditation from the NHS Finance Leadership Council.
- The leadership and organisational development team were shortlisted for the training and development award at the Health Service Journal (HSJ) awards for supporting rising stars to shine through talent management systems.
- Christina Moulding was shortlisted for the Rock FM radio stations 'Time to Shine' award for delivering 'Service with a Smile'.
- Alison Birtle won the Clinical Research Practitioner of the Year at the NW Coast Research and Innovation awards.
- Deborah Williamson, Rachael Moses and our Clinical Research Facility were finalists at the North West Coast Research and Innovation awards.
- Emily Hurt won the information literacy award from the CILIP Information Literacy Group.
- Tracy Earley was runner up for the Nutrition Nurse of the Year in the British Journal of Nursing awards.
- Rachael Moses was shortlisted for the Advancing Healthcare Awards, and for the Clinical Leader of the Year award in the HSJ awards.
- Emma Gornall won the Midwifery Leadership award in the British Journal of Midwifery (BJM) awards.
- Alison Birtle won a certificate of excellence from iwantgreatcare for patient feedback.

- The CLIP team were shortlisted for two awards at the Student Nursing Times awards.
- Vikki Lewis won a Health Tech Newspaper (HTN) award for Impact of the Year.
- The Blended Learning Team won 2 awards at the Haelo Film festival.
- Joanne White and Sean Jenkins were shortlisted for the GoToJobBoard's Unsung Hero award.
- Alison Birtle was nominated for the Kate Granger Compassionate Care award.
- Mona Klavis, Volunteer, won the LEP's unsung hero award.
- Patricia Leyland won a BJM Practice Award for her contribution to midwifery practice.
- Rachael Moses was named as a finalist in ITV GMB's Health Star awards.
- Kina Bennett won a Silver Innovation Award for her work in collaborating with Lancaster University to improve patient safety.

In summary, I am pleased to present the 2017-18 Quality Account. The information provided represents an accurate account of progress and highlights achievements as well as areas for improvement. More importantly it is an opportunity to reaffirm the Trust commitment to improving the patient experience and outcomes of care as a priority for all staff.

I can confidently declare that, to the best of my knowledge, the information in this document is accurate. The Trust's internal auditors will review the processes and mechanisms through which data is extracted and reported in the Quality Account Report 2017-2018 to provide further assurance.



Karen Partington

Chief Executive

PART 2

Priorities for Improvement

In previous years the priorities for improvement included:

- Achievement of 98% harm-free hospital care
- A reduction in the trust inpatient hospital standardised mortality ratio of 15% over the life of the safety and quality strategy *safe, Reliable and Compassionate*
- Achieving and sustaining 90% positive patient feedback relating to the overall experience of care and treatment within the Trust.

Outcomes and performance related to these priorities are reported in the *safe care*, *effective care* and *experience of care* sections within this report. New priorities for the Trust are derived from the strategy documents, published and in development, described below and whilst different, continue to reflect the Trusts commitment to delivery of safe, reliable and compassionate care and treatment.

In support of this commitment, a number of values based strategies have been developed.

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 we are committed to delivering:

- A 10% reduction in the number of hospital acquired pressure ulcers
- A 10% reduction in patient falls

- A 10% increase in the numbers of reported clinical incidents to reflect a safe organisation better able to learn and thereby improve care
- 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 (currently 10 wards out of 67 (12%) of wards/departments have achieved silver status with no gold status wards/departments yet) Further information about the STAR programme is available in the 'Assuring Quality' section of this report.

In 2018 we 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

During 2018-2019, particular areas of focus will be on:

- The provision of accessible information, supported by the creation of a patient reader group to review patient information, increasing access to information for people whose first language is not English.
- Create a forum for parents to discuss changes to the way we deliver child health services.
- Address environmental constraints to positive patient and carer experiences
- Include patients and family members in review of patient care pathways.
- Addressing communication issues for patients and carers.

The Trust has recently agreed to adopt a continuous improvement approach and has appointed a new Director of Continuous Improvement and a Head of Continuous Improvement. During the first three months extensive staff engagement has been undertaken to identify the key priorities for improvement and these are informing the development of a system wide Continuous Improvement Strategy which will be delivered across the whole health economy. The strategy will be launched in May 2018 and will identify key priorities for 2018 and beyond.

Statements of Assurance from the Board

During 2017-2018 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted forty six relevant health services.

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

The income generated by the relevant health services reviewed in 2017-2018 represents 100 per cent of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2017-2018.

PART 3

Participation in Clinical Audits

During 2017-2018 forty national clinical audits[1] and three national confidential enquiries covered relevant health services that Lancashire Teaching Hospitals NHS Foundation Trust provides.

During that period Lancashire Teaching Hospitals NHS Foundation Trust participated in 95%[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.

The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2017-2018 are as follows:

Clinical Audit
National Clinical Audit
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
Adult Asthma
BAUS Urology Audits
Bowel Cancer (NBOCAP)
Case Mix Programme (CMP)
Child Health Clinical Outcome Review Programme (NCEPOD)
Diabetes (Paediatric) (NPDA)
Endocrine and Thyroid National Audit
Elective Surgery (National PROMs Programme)
Falls and Fragility Fractures Audit Programme (FFFAP)
Head and Neck Cancer Audit (HANA)
Fractured Neck of Femur (RCEM)
Inflammatory Bowel Disease (IBD) Programme
Learning Disability Mortality Review Programme (LeDeR Programme)

[1] List of national clinical audits as per specification provided by the DH cited on the HQIP website (http://www.hqip.org.uk/national-programmes/quality-accounts/). Quality-accounts-2017-17-update. *Version 2 /13 February 2017*

[2] The Trust did not participate in the one national audit due to incompatibilities with IT systems (National Diabetes Audit). The Trust did not participate in the National Ophthalmology Audit due to software costs.

Major Trauma Audit
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
National Audit of Breast Cancer in Older Patients (NABCOP)
National Cardiac Arrest Audit (NCAA)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)
National Comparative Audit of Blood Transfusion
National Diabetes Audit
National Emergency Laparotomy Audit (NELA)
National End of Life Care Audit
National Heart Failure Audit
National Joint Registry (NJR)
National Lung Cancer Audit (NLCA)
National Maternal and Perinatal Audit (NMPA)
Neonatal Intensive and Special Care (NNAP)
National Ophthalmology Audit
National Vascular Registry
Neurosurgical National Audit Programme
Oesophago-gastric cancer (NAOGC)
Pain in Children (RCEM)
Procedural Sedation in Adults (RCEM)
Prostate Cancer Audit
Sentinel Stroke National Audit Programme (SSNAP)
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
UK Parkinson’s

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 Studies collecting data during 2017 – 2018 • Chronic Neurodisability • Young People's Mental Health study
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death NCEPOD: Studies collecting data during 2017 – 2018 • Cancer in Children and Young People • Perioperative diabetes • Heart Failure

The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2017-2018 are as follows:

Clinical Audit	Trust Participated
National Clinical Audit	
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes
Adult Asthma	Yes
BAUS Urology Audits	Yes
Bowel Cancer (NBOCAP)	Yes
Case Mix Programme (CMP)	Yes
Child Health Clinical Outcome Review Programme (NCEPOD)	Yes
Diabetes (Paediatric) (NPDA)	Yes
Endocrine and Thyroid National Audit	Yes
Elective Surgery (National PROMs Programme)	Yes
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes
Head and Neck Cancer Audit (HANA)	Yes
Fractured Neck of Femur (RCEM)	Yes
Inflammatory Bowel Disease (IBD) Programme	Yes
Learning Disability Mortality Review Programme (LeDeR	Yes

Programme)	
Major Trauma Audit	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Yes
National Comparative Audit of Blood Transfusion	Yes
National Diabetes Audit	No
National Emergency Laparotomy Audit (NELA)	Yes
National End of Life Care Audit	Yes
National Heart Failure Audit	Yes
National Joint Registry (NJR)	Yes
National Lung Cancer Audit (NLCA)	Yes
National Maternal and Perinatal Audit (NMPA)	Yes
Neonatal Intensive and Special Care (NNAP)	Yes
National Ophthalmology Audit	No
National Vascular Registry	Yes
Neurosurgical National Audit Programme	Yes
Oesophago-gastric cancer (NAOGC)	Yes
Pain in Children (RCEM)	Yes
Procedural Sedation in Adults (RCEM)	Yes
Prostate Cancer Audit	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes

UK Parkinson's	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 Studies collecting data during 2017 – 2018 • Chronic Neurodisability • Young People's Mental Health study	Yes Yes Yes Yes
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death NCEPOD: Studies collecting data during 2017 – 2018 • Cancer in Children and Young People • Perioperative diabetes • Heart Failure	Yes Yes Yes Yes

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 2017-2018, 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		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Rolling - no set number, as met criteria	228
Adult Asthma	No set number, as met criteria	18
Bowel Cancer (NBOCAP)	Rolling - no set number, as met criteria	335
Breast Cancer in Older Patients (NABCOP)	Rolling - no set number, as met criteria	308
Case Mix Programme (CMP)	Rolling - no set number, as met criteria	1604

Child Health Clinical Outcome Review Programme (NCEPOD)	No set number of questionnaires for completion, as patients met criteria	Chronic Neurodisability 8 Young People's Mental Health study 7
Diabetes (Paediatric) (NPDA)	No set number of questionnaires for completion, as patients met criteria	192
Falls and Fragility Fractures Audit Programme (FFFAP)	2 X 15 consecutive cases	30
Head and Neck Cancer Audit (HANA)	Rolling - no set number, as met criteria	275
Fractured Neck of Femur (RCEM)	Rolling - no set number, as met criteria	100
Learning Disability Mortality Review Programme (LeDeR Programme)	Rolling - no set number, as met criteria	See learning from deaths section of report
Major Trauma Audit	Rolling - no set number, as met criteria. Estimated 15 cases per month from HES figures	1067
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Rolling - no set number, as met criteria	Late fetal loss - 1 Still birth - 8 Early neonatal death - 4 Late neonatal death - 1
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	No set number, as met criteria	Cancer in Children and Young People (Still submitting data) Perioperative diabetes 8 (Still submitting data) Heart Failure 9
National Cardiac Arrest Audit (NCAA)	Rolling - no set number, as met criteria	116
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Audit now moved to a continuous audit to form part of best practice tariff	502

Programme		
National Comparative Audit of Blood Transfusion	No set number, as met criteria	Transfusion in Haematology Patients 27 Elective Surgery 16
National Emergency Laparotomy Audit (NELA)	Rolling - no set number, as met criteria	148
National Heart Failure Audit	Rolling - no set number, as met criteria	263
National Joint Registry (NJR)	Rolling - no set number, as met criteria	646
National Lung Cancer Audit (NLCA)	Rolling - no set number, as met criteria	292
National Maternal and Perinatal Audit (NMPA)	Rolling - no set number, as met criteria	Last audit published cover data period of April 2015 to March 2016 - Data extracted from HES, number of patients for each standard is different but of applicable deliveries during the period audited were 3846
Neonatal Intensive and Special Care (NNAP)	Rolling - no set number, as met criteria	For all first episode admissions there were 406 eligible episodes
Oesophago-gastric cancer (NAOGC)	Rolling - no set number, as met criteria	209
Pain in Children (RCEM)	No set number, as met criteria	87
Procedural Sedation in Adults (RCEM)	No set number, as met criteria	71
Prostate Cancer Audit	Rolling - no set number, as met criteria	486
Sentinel Stroke National Audit Programme (SSNAP)	Rolling - no set number, as met criteria	665
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	No set number, as met criteria	17

Scheme		
UK Parkinson's	No set number, as met criteria	21

The reports of nineteen national clinical audits were reviewed by the provider in 2017-2018 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Title of Audit	Intended Actions
National COPD Secondary Care Audit 2017/18	Due to participation in this continuous audit improvement has been noted in the Increase the number of specialist COPD nurses. Business case has now been approved. • Re-publicise the use of care bundles to appropriate staff
National Paediatric Diabetes Audit 2017 Data from 2015/16. (report published Feb 2017)	Since the previous audit Improvement in the reduction in mean HbA1c was noted – • There has been an increase in percentage of children with type I diabetes achieving good control (HbA1c levels <58mmol/mol from 23.5% (*17.6%)* in 2014/15 to 26.6% (*21.6%*) in 2015/16 • A corresponding reduction in the percentage of children with type I diabetes with poor control (HbA1c >80mmol/mol) was found from 21.3% (*23.4%*) in 2014/15 to 17.9% (*19.6%*) in 2015/16 • A little over third 35.5% (*53.7%)* of young people age 12 and above with type 1 diabetes completing a year of care received all key care processes recommended for this patient group in 2015/16 *(Note: Figures in italics, in brackets are Trust figures)*
National Pregnancy in Diabetes 2016. (report published Oct 2017)	Since the previous audit Improvement was noted in use of folic acid (5 mg dose) before conception. • Issue to 'Improve communication with diabetic women to increase knowledge and uptake of preconception advice and preparation for pregnancy. Optimise HbA1c and folic acid 5mg dosage' - Ongoing campaign to advertise/highlight preconception services in GP surgeries • Give out leaflets on preconception care to all post-natal and post-miscarriage patients • Issue to 'Reduce mother and baby separation postnatally' - New zero separation policy increasing skin to skin to skin contact in theatre & New hypoglycaemia pathway to be introduced this year
National Maternity	• Review data and establish why the department was unaware

Perinatal Audit (NMPA) Data April 2015 to March 2016 (report published November 2017)	of the outlier status from the unit dashboard. Clarify denominator figure for calculation. Assess whether our low episiotomy rate is related to third degree tear occurrence • Establish regular report via business intelligence for postnatal re-admissions.
The National Hip Fracture Database (NHFD) (report published Sept 2017)	Since the previous audit improvement was noted - Pre-op medical assessments and same day surgery or day after surgery have been addressed - business cases for second trauma theatre and another Geriatrician (SpR or Consultant)
NCABT Re- Audit of 2016 Red Cell & Platelet Transfusion in Adult Haematology Patients 2017	• Standard 1: Clinical staff should measure haemoglobin prior to transfusion of red cells in haematology patients (within 24 hours for inpatients and 72 hours for day patients) - We showed a high level of achievement in this standard. We are performing within the top 80% of hospitals nationally. We will conduct regular haematology audits to monitor our practice to ensure that we maintain our high level of achievement for this standard • Standard 2: Clinical staff should only transfuse red cells in normovolaemic haematology inpatients without additional risk factors (cardiovascular disease or signs or symptoms of cardiovascular compromise, severe sepsis or acute cerebral ischaemia) if their pre-transfusion Hb is less than 70g/L.- Our performance for this standard was outside of the top 5% of hospitals nationally. To improve the care we provide to our patients, we should prioritise this standard when planning our response to feedback. • Standard 7: Clinical staff should avoid routinely prescribing prophylactic platelet transfusions to patients with irreversible chronic bone marrow failure - We showed a high level of achievement in this standard. We are performing within the top quarter of hospitals nationally. This shows strong support for good transfusion practice in haematology patients within our hospital. However, there is room to further improve our practice. We should prepare an action plan that will recognise and build upon our existing good practice to further improve the service that we provide. • Standard 12: Hospital Transfusion Committees ensure that local written guidelines for the management of blood component transfusions are available to clinical staff via local procedures for dissemination - We will ensure that we have a process in place for developing or updating local transfusion guidelines as new national guidelines are published. We will review the content of our transfusion guidance to ensure that

	the transfusion thresholds and indications are consistent with guidance. We will check that any standard operating procedures are consistent with our local guideline Actions to undertake: • Roll out a single unit transfusion policy, which including the 70g/l threshold for transfusion (the main issue) • Issue to 'Avoid routine prophylactic platelets with irreversible chronic bone marrow failure' - Discuss with Haematologist correct indication for patients • Issue of 'Management of blood transfusions' - 1. To include grades of bleeding in description of patients presentation 2. Include in case notes 3. LIMS to record indication code
NCEPOD: Pancreatitis - Treating the Cause	• Create a Trust guideline for the Management of Pancreatitis • Undertake a local audit to see if we are following the recommendations from the national report
National Lung Cancer Audit (NLCA) 2016	• Issue of 'Patient contact with lung cancer Specialist Nurses has been marked low on NLCA'. - Certain cohort of tertiary patients attending for Oncology treatment are not in contact with local Specialist Nurses and therefore figures are not reflective. However, to improve our own practice there is a regular check on the data to ensure our patients are seen by the Specialist Nurse • Issue of 'Recording of performance status and staging has been rated slightly below the national average' - We have identified this as a documentation issue and MDT Co-ordinator has been proactive in documentation
National Paediatric Asthma Audit (report published May 2017)	• Issue of 'Improvement needed in area of providing asthma check list proposed in last audit to all patients presented with wheeze' - Ensure that asthma check list available on ward and PAU • Raise awareness of importance of monitoring some children using PEFR • Every child with asthma exacerbation to be seen by outreach nurse 1-2 weeks after discharge
National Audit of Dementia 2016-17 (report published July	• Ensure that we have robust mechanisms in place for assessing delirium in people with dementia • Audit implementation/use of personal information collected to

2017)	improve care for patients, and feedback results to dementia champions, dementia lead and ward staff • Promote the attendance of key carers to support care, but ensure that this is complementary to, and not instead of care delivered by staff • The level of input by carers and how carers feel about the level of input they have been asked to deliver should be monitored through carer feedback, complaints and PALS enquiries • There should be a dementia champion available to support staff 24 hours per day, 7 days per week • To confirm that we are continuing to provide good care for our dementia patients, we will participate in the 4th round of the National Audit of Dementia in 2018
National Emergency Laparotomy Audit (NELA) (report published May 2017)	An improvement has been noted regarding the issue of the 'Development of 'Surgo-Geriatician' post' - Now recruited • Issue of 'Improve Anaesthetic Consultant Presence' - Ensure escalation as per Landing Card. Change in Consultant On-call pattern • Issue of 'Improve Time From Decision To Operate To Theatre' - Requirement for 2nd Emergency Theatre. The Business Case has been Completed • Issue of 'Increase visibility of NELA' - Board Outside Theatre 9 to Share Run Charts and Key messages

The reports of over four hundred local clinical audits were reviewed by the provider in 2017-2018 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Speciality	Title of Audit	Improvements made
Palliative Care	Palliative care documentation on hospital discharge summaries (June - July 2017)	• Compared to Oct-Dec 16 the proportion of IHDIs with a completed palliative care IHDI section increased across both sites from 50% to 60% of all IHDIs. • Compared to Oct-Dec 16 an increase from 5% to 16% in the number of patients having an EPACS record created on discharge
Respiratory	Duration of corticosteroid treatment in COPD exacerbation	• We are prescribing 5-7 days of corticosteroids for majority of patients admitted with exacerbation of COPD as per guidelines
Emergency Departments	Audit of patients presenting with mental	• Improvement in documentation of consent to treatment from 66% to 81%

	health problems to the ED.	• Some improvement in risk assessment documentation 20 and 26% to 36% having grab pack completed
Paediatrics	Special Education Needs (SEN) audit	• 90% of reports were completed within 6 weeks as per the standard which is slight improvement in comparison to 2015 were 88% of reports were completed with 6 weeks
Elderly & Frail Patients	Re-audit of Advance care planning in elderly care	• The percentage of patients who had an MDT meeting for advanced care planning improved from 2% to 22% in the re-audit following the introduction of Friday MDT meetings with the Palliative Care Team.
ENT	Coding of ENT Procedures Performed in the Ward 3 Treatment Room	• Better documentation – ward attender sheets & coding table used for all patients seen • Has improved clinical coding ensuring the department receives the income it is due: Previous audit: Lost income - £1716.71 Re-audit: Gained income - £2532.60 • Reflects more accurately the procedures/workload done by the department
Orthopaedics & SMRC	Review current management of carpal tunnel syndrome in relation to the use of steroid injection in line with BOA commissioning guide recommendations and whether the prior approval form has affected this.	• Our concordance with BOA commissioning guidance has improved after the introduction of the prior approval form
Gynaecology	Colposcopy patient satisfaction survey 2017	• Significant improvement was noted in finding location of the clinic in this audit • 93% of patients said they received right amount of information which was higher than the last audit where 83% of patients said they received right amount of information
Colorectal	Re-audit of IV Fluid Prescription for Medical and Surgical Patients - 2017	• There was an improvement in fluid assessment on both medical and surgical wards following the introduction of the IV

		fluid reminder cards for junior doctors
Upper GI	An audit to assess complication rates for patients who underwent cholecystectomy between 01/04/16 and 31/03/17	• To confidently refer 'HOT gallbladder' patients to emergency theatre lists as complication rates in these patients are not significantly different to elective pts
Dental & Restorative Surgery	Re-audit of Quality of Extra-Oral Radiographs	• Achieved target of a 50% reduction year on year of unacceptable quality • Achieved target of no more than 10% of radiographs being of unacceptable quality
Dental & Restorative Surgery	A retrospective re-audit of bite-wing radiography for patients undergoing comprehensive dental care under general anaesthetic	• 100% of the patients had radiographs available which is higher than the previous audit (97.1%)
Breast Surgery	Re-audit(Audit loop closure), Feasibility of Early Discharge following Breast Reconstruction Surgery	• Decreased LOS for ADM and LD/TRAM flaps • Pre, per and post op pathways have been implemented by all Breast Consultants
Urology	Re-audit of Discharge Delays Due to Social Reasons on Ward 15	• Bed days have been reduced since the last audit • Residential/nursing home bed delays were reduced and there were no family or equipment delays • Increase in the use of community rehabilitation
Radiology	Healthcare Staff Awareness of Radiation Doses Incurred in Diagnostic Investigations	• Improvement was noted in knowledge and awareness of radiation dose in various radiological investigations
Radiology	Trauma re-audit	• 82% of out of hours scans were reported within one hour whereas 77% of in hour scans were reported within one hour. All out of hours reports were done by a consultant • More than 90% of scans initially reviewed by consultant were reported within one hour • two tail p value between initial reading by consultant vs registrar was 0.0002 which is statistically significant

Maxillo-Facial Surgery	A clinical re-audit of compliance to patient monitoring during Intravenous Sedation	• Pre-operative checks compliance: Initial audit (2015) 97%; Re-audit 98% • Intraoperative checks compliance: Initial audit (2015) 73%; Re-audit 93 • Post-operative checks compliance: Initial audit (2015) 97%; Re-audit 99%
Cardiology	Dual Antiplatelet Therapy (DAPT) for NSTEMI Patients on MAU at CDH	• Compliance with second standard "Ticagrelor should be given first line for all NSTEMI patients unless contraindicated or bleeding risk is high in medically managed patients" improved from 15% to 80% following presentation at meeting in MAU • Compliance with third standard "PPI should be prescribed in all patients receiving DAPT unless contraindicated" improved from 37% to 80% following presentation at meeting in MAU
Neonates	Prospective Audit of Central Line Associated Blood Stream Infections (CLABSI) in Neonates - 2017	• CLABSI numbers and rates have reduced by 58% and 56% respectively
Neonates	Re-audit of cardiac referrals	• Improvement in waiting time for babies with FH of CHD
Trust wide	National Audit on 7 day services (March 2017)	When the results from March 2017 are compared to September 2016: Standard 2 - Time from admission to 1st consultant review by day of the week (based on day of admission) • Total performance has improved from 66% to 70% • Weekday performance has improved from 68% to 75% • Weekend performance has improved from 57% to 59%

Research

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Lancashire Teaching Hospitals NHS Foundation Trust in 2017-2018 that were recruited during that period to participate in research approved by a research ethics committee was 2775.

Recruitment

Lancashire Teaching Hospitals NHS Foundation Trust has recruited 2,597 patients to NIHR portfolio adopted studies in 2017-2018. It granted NHS permission for 90 new portfolio studies to commence during that time. The Trust recruited a further 168 to non-portfolio studies. In total, there are currently 172 active research studies recruiting patients at the Trust.

Research Governance

In 2017-2018 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. 69% of trials achieved the NHS 40 calendar day benchmark as compared to 66% average for the North West Coast region.

Goals Agreed with Commissioners

Use of the CQUIN payment framework

A proportion of Lancashire Teaching Hospitals NHS Foundation Trust income in 2017-2018 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 2017-2018 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 £7,400,000 in 2017-2018 for the achievement of quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. During 2016-2017 Lancashire Teaching Hospitals NHS Foundation Trust received income of £8,860,640 on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework.

Registration with the Care Quality Commission

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

There are no conditions to this registration

The Care Quality Commission has not taken enforcement action against Lancashire Teaching Hospitals NHS Foundation Trust during 2017-2018

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 had a planned inspection on 27th-30th September 2016 as part of the NHS acute hospital inspection programme.

Overall ratings for the Trust were as follows:

Overall rating	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

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

Royal Preston Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Medical care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Maternity & gynaecology	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Children & young people	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients & diagnostic imaging	Requires Improvement	Not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement

Chorley and South Ribble Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Medical care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Requires Improvement	Good	Good	Good	Good
Maternity & gynaecology	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Outpatients & diagnostic imaging	Requires Improvement	Not rated	Good	Requires Improvement	Requires Improvement	Requires Improvement

There were 4 compliance actions:

Regulation 2010	Findings
Good governance	Governance processes needed to be strengthened. A significant gap was identified between the locally held risk registers and the directorate and corporate registers. Information is not well aligned and therefore does not provide assurance as to the escalation of risks or actions taken to mitigate those risks. Not all policies and procedures are current, up to date or appropriately reviewed. Duty of Candour regulations are not addressed in all cases in a timely way.
Safe care and treatment	The general physical environment is aged and worn. The discharge lounge at RPH is not conducive to promoting patient's privacy and dignity and does not have readily accessible means for calling for urgent assistance should it be required.
Staffing	Across the organisation nurse staffing was found to be an ongoing challenge to the trust. • There is a lack of assurance that the paediatric area is always appropriately staffed. • In neonatal services staffing levels were only compliant with BAPM standards 80% of the time. There is a need to review and improve the staffing levels to ensure safe care and treatment, particularly within maternity, children's and neonatal services and where patients require intensive nursing at either level 2 or Level 3. • Medical staffing was a significant challenge to the trust which was clearly recognised and plans were in place to improve the recruitment of relevant medical staff. The use of medical locums was most noticeable within medicine, neurosciences, accident and emergency and plastic surgery In addition there was an identified for improved performance in relation to mandatory training, including safeguarding training, in a number of areas.
Safeguarding	The safeguarding team was significantly understaffed due to sickness and vacancies affecting delivery. There were also concerns around the number of Deprivation of Liberty applications which were not responded to in a timely way by the local authorities.

Governance

Following a rapid improvement event, there is a programme in place to manage our corporate and departmental policies, procedures and clinical guidelines, The new approach will simplify all documents, making it easier to write and find and ensure that documents are accurate and current.

Risk registers – Education programmes have been rolled out to all -divisions advising them on how to link all of their risks to divisional risks and to the board assurance framework. Review of the risk register has indicated that performance has improved significantly.

Compliance with duty of candour regulations has improved across all three divisions in respect of delays in contacting patients affected by adverse incidents or occurrences

Safe care and treatment
A detailed plan for the construction of a new discharge lounge has been agreed with work to commence in June for completion in August.

Staffing
In paediatrics a business case has been developed to ensure a robust well led paediatric physiotherapy service that reflects the complexities and skill mix required to deliver a consistent highly specialised service to support acute paediatrics, the neuromuscular service, cystic fibrosis patients, neonatal level 3 care as well as general paediatric physiotherapy practice.

In respect of neonatal services, Registered Nurse and Midwife numbers are meeting the required demand against the planned establishment; BAPM compliance can fluctuate often on an hour by hour basis, depending on the needs of the baby. In response teams move flexibly within the service to respond to need. The last two months of 2017-18 saw the BAPM standard exceeded on the unit due to a decrease in acuity on the unit and a reduction on birth rate. Neonatal services is not currently experiencing difficulties in vacancy levels and BAPM levels are currently in excess of 100%. However, the service review undertaken in November 2017 identified the service achieves on average of 83% BAPM compliance. A neonatal dashboard has been developed to monitor standards and any impact on babies. Discussion at STP level aims to maximise the availability of neonatal specialty trained nurses and Intensive care bed availability. These discussions will continue to develop in 2018/19.

Safeguarding training compliance has improved as have mandatory training figures.

	April 17	March 18
Safeguarding children level 3	37%	71%
Safeguarding children level 2	30%	85%
Safeguarding adults level 3	70%	86%
Safeguarding adults level 2	68%	83%
All Core skills (mandatory)	55%	79%

Safeguarding

Staffing levels have improved in the safeguarding team. There has been significant focus on Deprivation of Liberty applications. This has been reviewed at Lancashire Safeguarding Board with the Trust recently requesting a review of a sample of cases to ensure that applications are being reviewed in accordance with guidance.

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.

Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2017-2018 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data, which included the patient's valid NHS number, was:

99.8% for admitted patient care
99.8% for outpatient care
98.9% for accident and emergency care

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

99.7% for admitted patient care
99.8% for outpatient care
99.4% for accident and emergency care

Both sets of indicators are consistent with the national average for 2017-2018.

Lancashire Teaching Hospitals NHS Foundation Trusts Information Governance (IG) Assessment Report overall score for 2017-2018 was 81% and was graded as Green. This demonstrates a position consistent with the previous year's submission demonstrating achievement of the minimum level two compliance in 25 out of 45 requirements, achievement of level three compliance in a further 19, with one requirement not relevant to the Trust.

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.

- Use of targeted Coding software to improve the depth and quality of clinically coded data.

The Trust has participated in on-going work in relation to a number of audits completed by Mersey Internal Audit Agency regarding quality assurance of specific board reporting areas.

Lancashire Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017-2018 by the Audit Commission. The Trust has completed an internal Information Governance clinical coding audit that resulted in Level 2 compliance, consistent with performance the previous year. The sample covered all specialties and reviewed both diagnostic and procedure coding completeness and quality levels.

Review of Quality Performance - Patient Safety

Within the Trust we consider the safety of patients to be our number one priority and as such we strive for a continual reduction in patient harm. Our ambition includes an explicit intention to not only reduce but also eliminate avoidable harm where possible.

The Trust has maintained high levels of engagement and performance with all elements of the Safety Thermometer programme with a year-end performance level of 98.3% 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 2017-18 the Trust reported 3 Never Events in the following categories:

- retained foreign object (1),
- wrong site surgery (1),
- misplaced nasogastric tube (1),

Robust action plans and improvement programmes were developed in response with progress monitored within the divisions and any incidence monitored via the Clinical Governance Committee. In specific response to the misplaced nasogastric tube, work undertaken by the Consultant Nutrition Nurse and team has been shared nationally to support the reduction in nasogastric associated never events.

The national ‘Sign up to Safety’ campaign aims to save 6000 lives over 3 years by reducing avoidable harm by 50%. Lancashire Teaching Hospitals NHS Foundation Trust has supported the campaign by committing to reduce avoidable harm with specific ambitions to:

- Reduce avoidable falls with harm. In 2017/2018 falls rates have continued to reduce and year-end figures show that there has been an overall reduction in in-patient falls of 7.43% and a 5.56% reduction in falls with harm compared to the previous 12 months.
- Reduce avoidable grade 3 hospital acquired pressure ulcers by 50% and eliminate grade 4 pressure ulcers. The trust has successfully achieved its target of eliminating grade 4 pressure ulcers, although three grade 3 pressure ulcers were recorded in 2017/2018.
- Increase screening of patients with suspected sepsis. Since July 2017, quarterly compliance for screening patients with suspected sepsis in admission areas has been consistently over 90%. This figure has been 100% for the last two quarters in in patient areas.
- Reduce avoidable healthcare associated infections. In 2017/2018, there was one incident of MRSA bacteraemia assigned to the organisation and 60 cases of Clostridium difficile against a trajectory of 66 cases.

Detailed information relating to key safety indicators and improvement programmes is presented below:

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 *S. 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.

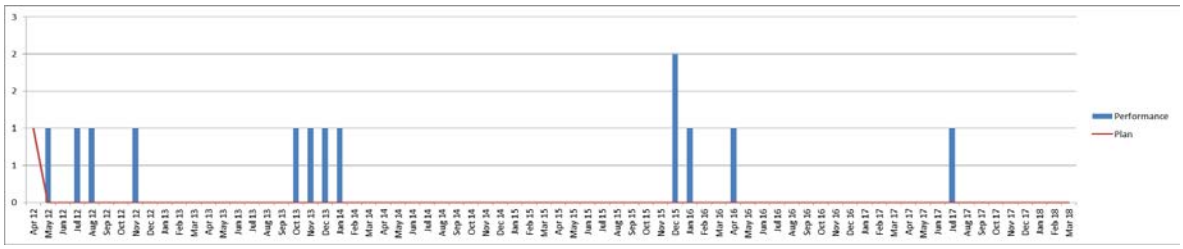
Infection prevention and control remains a key priority for the Trust, and the focus on MRSA bacteraemia (and *Clostridium difficile* infection) was maintained throughout the life of the trusts safety and quality strategy 2014-17 - *Safe, Reliable and Compassionate* - and has been reported in previous Quality Accounts. This focus will continue beyond the life of the strategy.

There was only one incident of MRSA bacteraemia assigned to the trust during 2017-2018. However, a further incident was assigned to the Clinical Commissioning Group with learning identified for the trust. The incidents 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 at dedicated meetings to identify how each case may have occurred and to identify actions that will prevent similar cases reoccurring in the future.

The post infection reviews identified a number of multifaceted clinical, social and behavioural complexities and the case was submitted for third party arbitration. Following review, a number of areas of learning were assigned to the trust. The focus for preventing further MRSA bacteraemia cases remains on;

- Best practice around peripheral and central line management.
- Antimicrobial stewardship.
- Urinary catheter care.
- MRSA screening, and decolonisation.
- Communication
- Safeguarding

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



Source: *LTHTR data*

C.difficile Infection

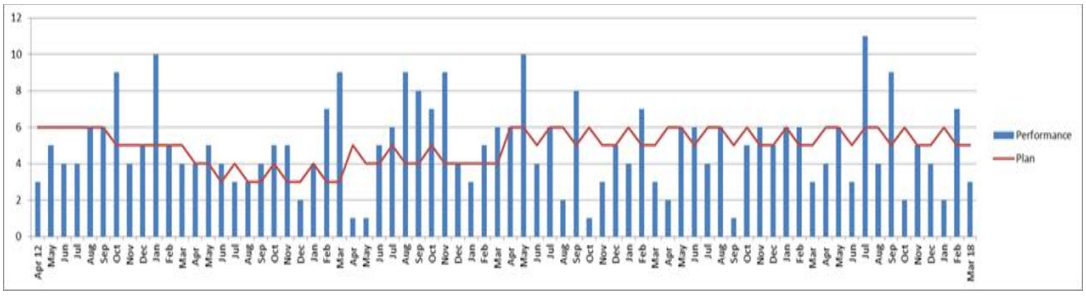
Clostridium difficile is an anaerobic bacterium that is present in the gut. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of infants). In some instances strains of *Clostridium difficile* can grow to unusually high levels and attack the intestines, causing 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*.

As stated above, infection prevention and control remains a key priority for the Trust. A strong focus on the prevention of *Clostridium difficile* infection has been maintained throughout the Trust with close monitoring of incidence

During 2017-2018 the Trust performance for *Clostridium difficile* cases was 60, not exceeding the overall objective of 66 for the organisation. All Trust apportioned cases are subject to a post infection review process which is reviewed by an expert group including the Director of Infection Prevention and Control / Infection Prevention and Control Doctor, Infection Prevention Matron, Antimicrobial Pharmacist/Specialist Antimicrobial Technician, Ward Manager, Ward Matron and Consultant in charge of the patients care. The process allows for a greater understanding of the individual causes of the *Clostridium difficile* cases, in order to determine if there were any lapses in the quality of care provided in each case and, if so, to take appropriate steps to address any problems identified and learning from this. A lapse in care is based on the checklist detailed in the national guidance and includes omissions which would not have contributed to the development of *C. difficile* infection. An action plan would be agreed for the learning needed. Of the 60 cases reviewed within the trust during 2017-18, lapses of care were identified in 35 of these.

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 cleaning.

Focus on learning from lapses in care are triangulated in the trust Antimicrobial Management Group and Divisional Infection Prevention and Control meetings and have focussed on antimicrobial stewardship, hand and environmental hygiene and timely isolation of patients with symptoms of diarrhoea. Further scrutiny of trust apportioned Clostridium difficile is undertaken during monthly meetings with the CCG leading to a health economy wide approach to learning.



Source: *LTHTR data*

Falls Prevention

Preventing patients from falling is a particular challenge in acute hospital settings. There will always be a risk of falls in hospital given the nature of the patients that are admitted, and the injuries that may be sustained are not always trivial. However, there is a lot that can be done to reduce the risk of falls and minimise harm, whilst at the same time allowing patient freedom and mobilisation during their stay.

Falls and falls related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling with 30% of people aged 65 and over and 50 % of people aged 80 and over falling at least once a year (NICE 2013).

The reasons why patients fall are complex and influenced by contributing factors such as physical illness, mental health, medication and age, as well as other environmental factors.

The Trust has a well-established programme of improvement activities and, to put this in real terms, since April 2014 the falls improvement programme has benefitted all in- patients and their families. The falls improvement programme has included:

- Sustained strong performance across the Trust in respect of risk assessment and response to risk, including enhanced supervision of ‘at risk’ patients
- Developed and implemented a new falls risk assessment and prevention care plan in line with NICE recommendations which incorporated a robust training programme
- Developed a falls prevention E-Learning package for all staff
- Implemented a visual system to remind and encourage patients to call for assistance - ‘Call Don’t Fall’
- Re-developed and re-launched Intentional rounding
- Production of quarterly falls information posters for ward staff
- Detailed analysis of falls data to identify themes and trends
- Working collaboratively with other Trusts (Aintree and as part of Quest)
- Post fall rapid review (Swarm)
- Falls executive reviews
- Harm Free care training
- Slips, trips and falls policy has been updated to reflect updated NICE guidance
- Development of guidance on the safe use of ultra-low beds
- Development of an adapted version of the falls assessment and prevention plan and post fall rapid review for paediatrics
- Continual embedding of all falls prevention interventions.
- Enhanced levels of care guidance for staff and developed and trialling new documentation to support implementation
- Implementation of an e-learning package

- As part of the CQUIN project we have developed a night time falls prevention package
- We have successfully trialled and introduced new anti-embolism stockings with sole grip to reduce fall due to slipping

During 2017 / 2018 we have implemented additional falls prevention improvements across the Trust:

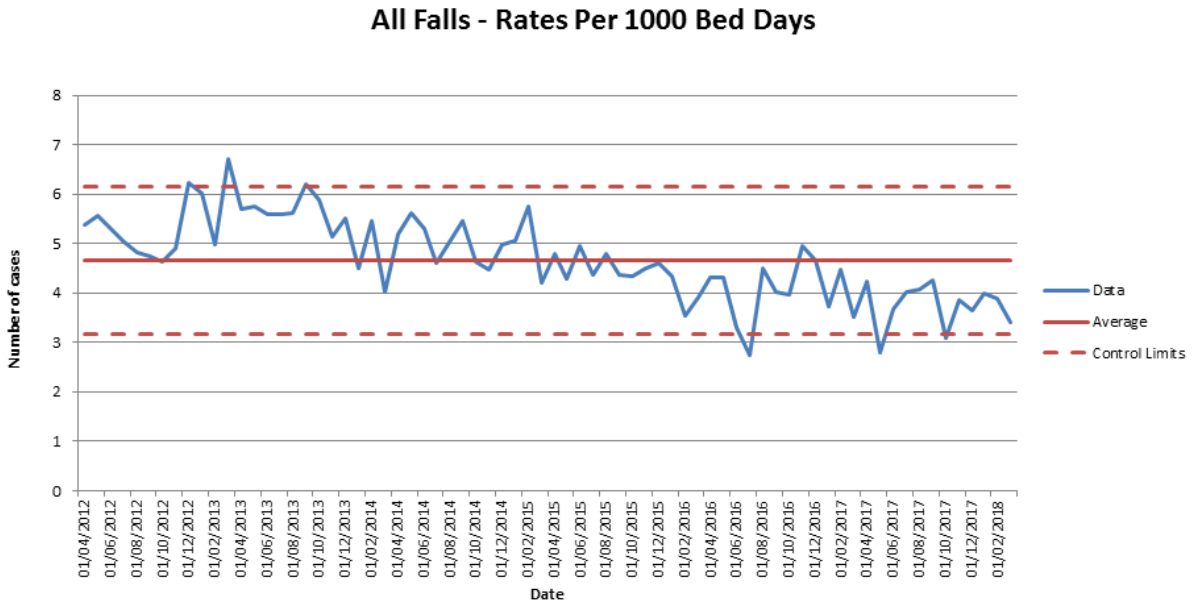
- We have developed and introduced enhanced levels of care documentation to support intentional rounding;
- The Trust continues to lead and co-ordinate the Central Lancashire Falls Collaborative involving partnership organisations and coordinating falls workshops across the health economy;
- As part of the patient safety work streams the Trust has introduced a falls prevention MDT working group who will identify themes and trends and develop improvement strategies in falls prevention across the Trust;
- We have rolled out across all in-patient areas the night time falls prevention package, including a night time falls prevention e-learning package that was developed as a result of a CQUIN project.

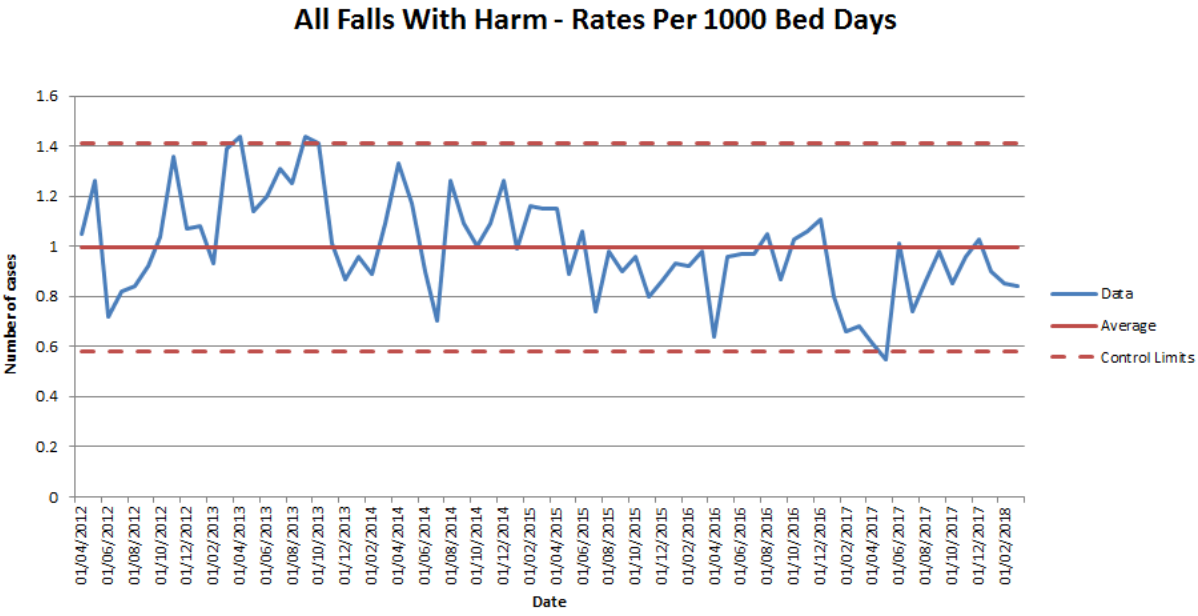
The Trust participated in the Royal College of Physicians National In-patient falls audit in May 2017.

Our monitoring continues to focus on the number of falls, on harm events associated with falls, and on staff compliance with expected standards of assessment and response, as evidenced through the Trusts STAR accreditation programme which led to the discontinuation of the previously used and reported Essentials of Care Audit Programme (ECAP)

The actual falls rate (incident/1000 bed days) fell from 4.04 in 2016/2017 to 3.74% in 2017 / 2018, a reduction of 7.43%. Overall, since 2013/2014 the Trust has achieved a falls reduction of 5.41 to 3.74 achieving a 30.87% reduction in in-patient falls.

Falls with harm rates (incident / 1000 bed days) fell from 0.9 in 2016/2017 to 0.85 in 2017/2018, a reduction of 5.56%. Overall, since 2013/2014 the Trust has achieved a falls reduction of 1.17 to 0.85 a reduction of 27.35% in falls with harm.





Source: Datix/LTHTR data

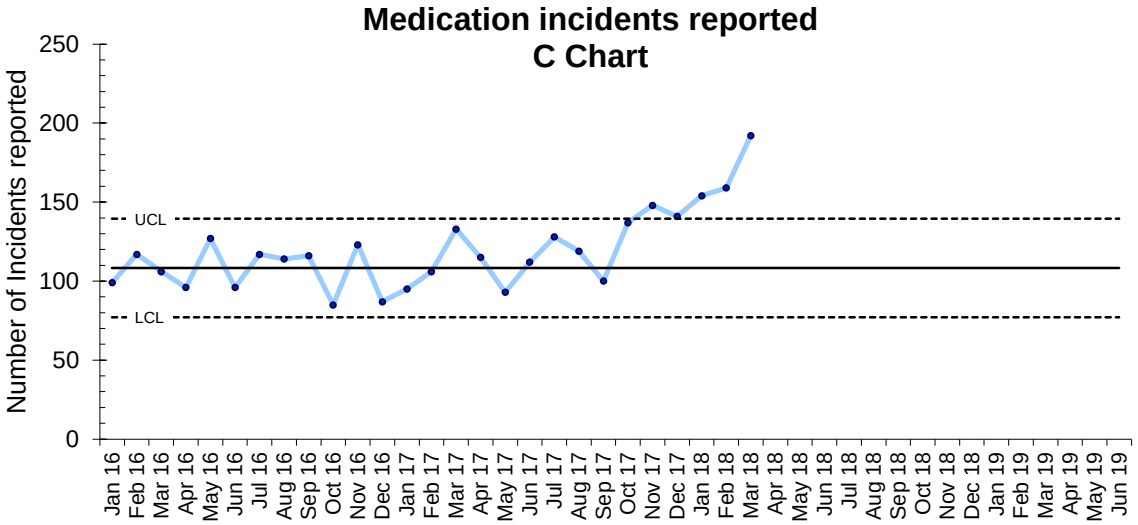
Year	All Falls Incident	In-patient Falls with Harm
2014/2015	1736	376
2015/2016	1512	320
2016/2017	1388	309
2017/2018	1226	282

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

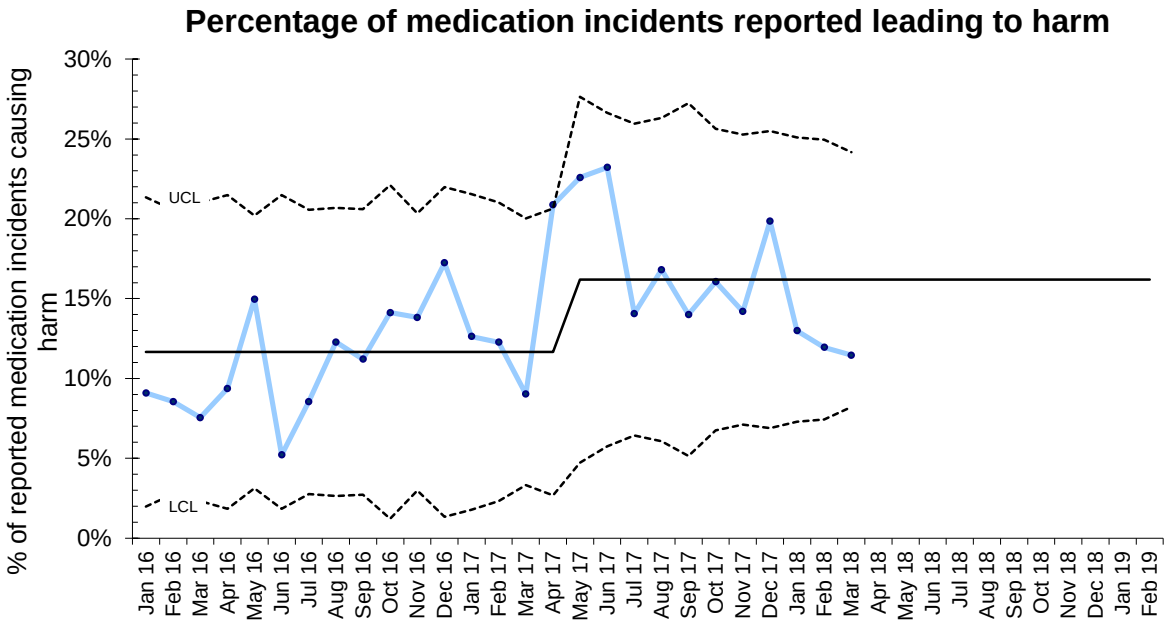
Medication Errors

Having a robust medication incident reporting culture is fundamental for the development and sustenance 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 has been a key objective of the new Medicine Safety Officer appointed in 2017/18.

Trust reporting systems have been improved with a focus on increasing reporting rates and as a result medication error reporting over the last 6 months has increased by 41% from the 2016/7 baseline. The medication safety officer now reports to each of the divisional governance committees, the matrons and professional leads group and is a key member of the patient safety collaborative. The officer is leading a medication safety work stream with focused efforts on omission of medications and improving the discharge process and high risk medications. Medication errors resulting in moderate harm are subject to a rapid review process and the Medication Safety Officer is now included in all reviews of this kind.



Medication incidents resulting in patient harm have increased as a result of robust application of definition of harm, for example, if a patient requires an additional set of observations as a result of a medication error, this is now classed as a low harm event. The graph below displays the proportion of medication incidents reported that are classified as harm events. The shift in the median correlates with the change in definition and process. However, it should be noted the proportion of incidents causing harm has reduced in recent months due to improvements in incident reporting rates.



Other key priorities addressed during 2017/18 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 2017/18 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) which are yet to come to full fruition.

	2015-16	2016-17	2017-18 Q1	2017-18 Q2	2017-18 Q3
percentage of medicines reconciled within 24 hrs of admission	66%	62%	74%	77%	71%

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 seen in 2017-18, and the escalation process for those areas struggling to meet the standards is in place to ensure additional support is given.

Antibiotic Prescription and administration

A range of metrics to demonstrate good antimicrobial stewardship were agreed as a part of the CQUIN for 2017-18. The Trust has implemented a number of improvement initiatives to good effect, and met the CQUIN targets for:

- Full review of antimicrobial formulary
- Antimicrobial formulary compliance
- Antimicrobial review within 72h
- Antimicrobial training
- Recording of indication

Duty of Candour

Lancashire Teaching Hospitals NHS Foundation Trust is strongly supportive of the principles of Duty of Candour. 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 and this is a key part of delivering excellent care with compassion. Duty of Candour is a regulation that has been applicable to health service bodies since 27th November 2014. It has been a further development of the "Being Open" process that was already followed in the Trust.

The 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).

Following the introduction of this regulation the Trust has included Duty of Candour in the being open policy, training and workshops have been provided for staff and this is now included in the incident reporting training. Where incidents are reported as moderate or severe harm within the Datix 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 Trusts case review group. The CQC highlighted during their inspection that Duty of Candour was not always addressed in a timely way. Since the inspection there has been increased focus on early identification of the need to apply Duty of Candour. In the last year we have applied Duty of Candour on 57 occasions, consistent with performance in 2016-17, providing further assurance that the application of Duty of Candour is embedded in the organisation.

Review of Quality Performance - Effective Care

We aim to provide effective care and treatment ensuring optimum clinical outcomes which is evidence-based and we remain committed to responding to identified areas for improvement. We continue to support the review of health economy-wide models and pathways of care to ensure consistency in all settings and effective transitions of care at the point of interface.

Our vision is to achieve the best clinical outcomes for our patients across all of the services we provide. We strive to achieve these outcomes by:

- Ensuring effective leadership and accountability
- Utilising best practice evidence and clinical research in defining clinical effectiveness
- Investing in the ongoing development of a skilled, competent workforce
- Supporting the development and implementation of improvements in operational infrastructure that ensures the delivery of the right care in the right place at the right time by the right people

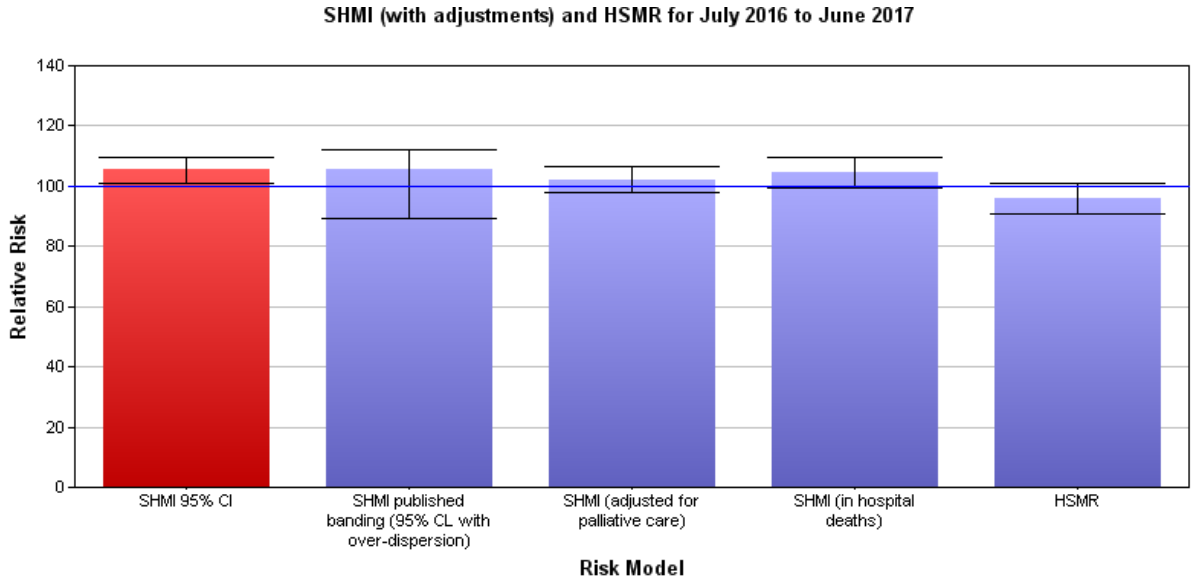
Leading improvements in healthcare through innovation, research and education is a key strategic priority for our Trust. We continue to offer our patients the opportunity to be involved in trials of new treatments as well as studies involving questions and interviews looking at their quality of life and service improvement.

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.

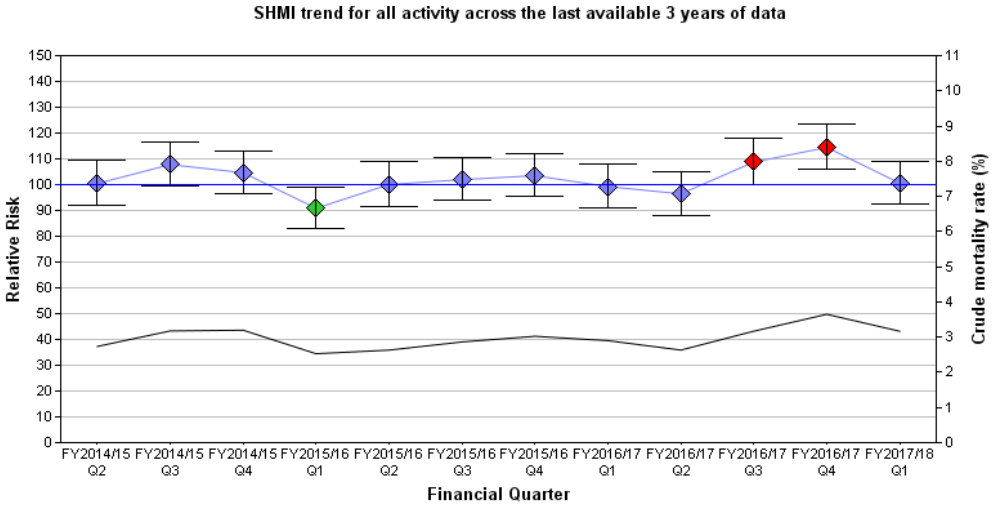
For the most current period available 12 months July 2016 – June 2017 the SHMI is 105.25 which is higher than expected however for both in hospital heads and when adjusted for palliate care the SHMI is within normal range of 104.42 and 102.18 respectively



SHMI (with adjustments) and HSMR for July 2016 to June 2017					
Model	**SHMI Spells**	**SHMI**	**Obs**	**Exp**	**95% CI**
SHMI 95% CI	74874	105.28	2357	2238.84	101.07-109.62
SHMI published banding (95% CL with over-dispersion)	74874	105.28	2357	2238.85	89.31-111.97
SHMI (adjusted for palliative care)	74874	102.18	2357	2306.72	98.10-106.39
SHMI (in hospital deaths)	74874	104.42	1684	1612.68	99.49-109.53
HSMR	37095	95.81	1438	1500.86	90.92-100.90

Source: *Dr Foster Intelligence*

The SHMI was higher than expected in Q3 & Q4 in 2017 and these peaks were reviewed and no risks were raised as outcomes.



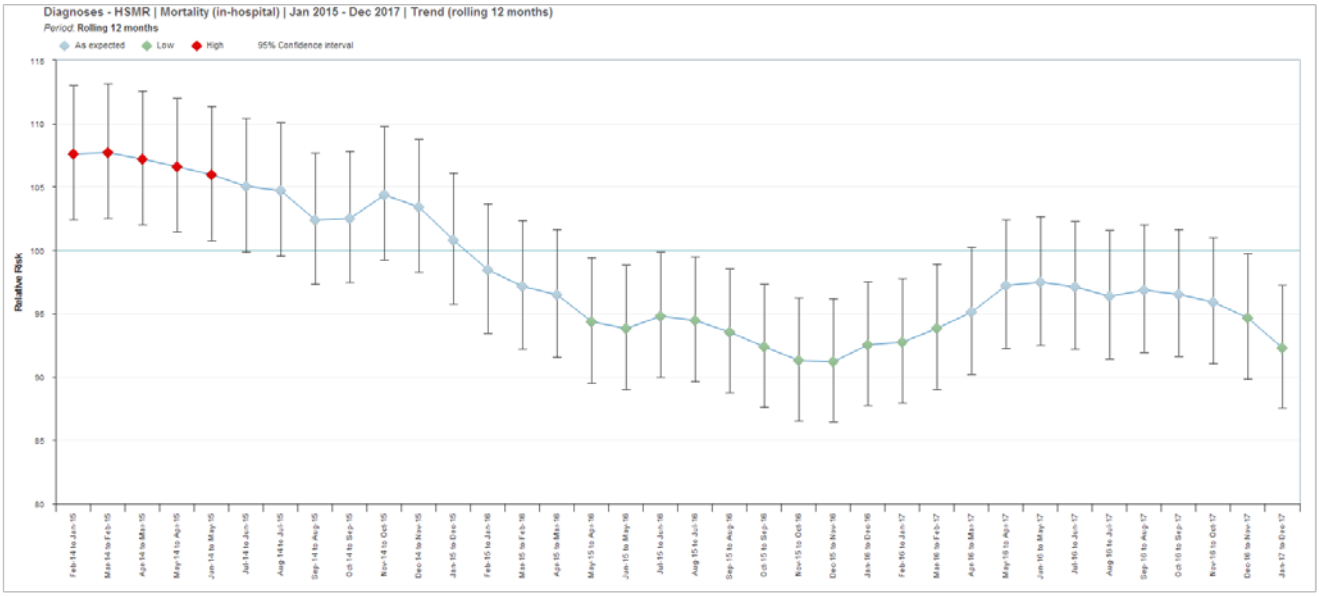
Source: *Dr Foster Intelligence*

The Hospital Standardised Mortality Rate (HSMR) is derived from routinely collected 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. Thus, a rate greater than 100 indicates a higher than expected mortality rate whilst a rate lower than 100

The most current HSMR data Jan 2017– Dec 2017 is 94.6 for all diagnoses and 92.3 for the 56 HSMR basket of 56 diagnoses. Both are better than the 'expected' range for the population of patients treated at Lancashire Teaching Hospitals NHS Foundation Trust. During 2016-17 a period of increased mortality was observed in relation to intracranial injury but an initial review 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 has been initiated. In addition a period of increased mortality compared to expected rates was observed in relation to patients admitted with intestinal obstruction without hernia. A further case note review of patient case notes has also been initiated in relation to this group. The outcome of both reviews will be reported to the Trust mortality Board

Monthly Hospital Standardised Mortality ratio 2015 – 2017



Source: Dr Foster Intelligence

The Board was established in 2015 and is chaired by the Medical Director and monitors mortality rates, themes and trends. Mortality rates are also reported to the board of directors on a monthly basis.

During 2017 the Trust reviewed the Mortality Review process based on the Royal College of Physicians Structure Judgement Review model which places an expectation that all deaths are reviewed and quarterly data on the level of care as well as avoidability of death is presented to the board in accordance with CQC guidance

Learning from Deaths

The new mortality review process was implemented during 2017-2018. Overall there has been a clear commitment from the Consultant body to undertake this work. There has been a proactive approach in many areas with collaborative working to share the cases fairly and to support colleagues. Many areas have adapted existing mortality review processes to fit in with the new system.

During 2017-2018 1699 of Lancashire Teaching Hospitals NHS Foundation Trusts patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- *442* in the first quarter
- *352* in the second quarter
- *417* in the third quarter
- *488* in the fourth quarter

By 31st March 2018, 261 case record reviews and investigations have been carried out in relation to the 1699 deaths included above.

In eleven cases a death was subjected 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:

- *29* in the first quarter
- *28* in the second quarter
- *2* in the third quarter
- *202* in the fourth quarter

(Note: In the third quarter the capability to undertake review was affected by the need to establish the new mortality review arrangements. As can be seen from the figures above there was a subsequent significant increase in reviews in the fourth quarter as a result of this endeavour)

Nine, representing 0.5% 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:

- *2* representing 0.45% for first quarter
- *1* representing 0.28% for second quarter
- *1* representing 0.23% for third quarter
- *4* representing 0.8% of deaths for fourth quarter

These numbers have been estimated using the principles of *learning, candour and accountability* and review tools developed by the Royal College of Physicians.

Cases identified for investigation in the fourth quarter are underway and any issues and learning will be reported to the Mortality Board. Individual learning points previously identified from reviews and investigations include:

- Frequency of consultant review
- Timeliness of discussion and decision-making regarding resuscitation

- Arrangements for the management of patients by two or more specialties
- Delays in internal transfers of care due to patient flow issues

Where these issues have been identified and where appropriate learning is shared with individuals, teams and services. Action in relation to consultant review and patient flow is being implemented across the Trust as part of the Trusts operational management strategy and implementation of clinical standards related to provision of seven day services as described below.

Implementation of Priority Clinical Standards Supporting Seven Day Hospital Services

A key priority for the NHS is to develop 7-day services. In 2014-15, NHS Improving Quality identified 10 clinical standards to support the development of 7-day services. The Government's Mandate to NHS England for 2016/17 set a priority to rollout 4 priority clinical standards in all relevant specialties to 25% of the population in 2016/17, and by 2020 to roll out 7-day hospital services to 100% of the population (with progress also made on the other six standards identified by the NHS Services Seven Days a Week Forum), so that patients receive the same standards of care in hospitals, seven days a week.

The 4 priority clinical standards, identified by Monitor, the Trust Development Authority and NHS England, together with the Academy of Medical Royal Colleges (identified as having the greatest impact on reducing weekend mortality) are:

Standard 2: Time to Consultant Review
Standard 5: Access to Diagnostics
Standard 6: Access to Consultant-directed Interventions
Standard 8: On-going Review

Acute Trusts were asked to complete a baseline assessment for these 4 standards in August 2015

A number of work streams are ongoing that will support achieving the 4 priority standards for 7/7 services, including:

- Ambulatory Care Pathway development
- Implementation of clinical utilisation review (CUR) – supporting processes to ensure that patients are receiving the right levels of care in the right settings at the right time
- Implementation of SAFER – a tool that contributes to the reduction of delays for patients in adult inpatient wards supporting improved patient flow
- Implementation of red2green
- Reconfiguration of beds demand to ensure that the distribution of beds is based on planned and emergency activity
- Review of and action around discharge pathways.

Oversight of these work streams is provided through the Trust Non-Elective Programme Board. The Trust contributes to the 6 monthly national 7/7 service data collection exercise, the results of which are reported through the Trust Clinical Governance Committee to the Board of Directors.

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 has been a key priority for the Trust throughout the life of Safe, Reliable and Compassionate and has been included in the Quality Accounts in recent years Pressure ulcers can occur in any patient but are more likely to occur in patients with underlying medical conditions, the elderly, the malnourished and those who are obese. 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 have in previous years included key features such as:

- Mattress, bed frame and seat cushion management. The contract with a commercial supplier allows for immediate availability of pressure relieving devices such as alternating pressure mattresses, for all patients in the Trust as the assessment of their risk dictates. The contract also allows for a yearly replacement programme for normal ward mattresses ensuring that mattress quality is maintained. There has been an increase in usage of specialist bariatric equipment; these patients are invariably at high risk of tissue damage due to pressure
- The availability of an electric bed frame for every patient enhancing the ability of patients to assist in pressure redistribution
- The use of a tissue viability risk assessment on admission and instigation of an appropriate care plan to prevent pressure ulcer formation
- Strengthening of validation processes, ensuring accurate classification, cause, and avoidability. All Grade 2, 3 and 4 pressure ulcers are subject to root cause analysis (RCA). This validation exercise undertaken by senior nurses provides assurance of the accuracy of reporting
- The practice of early and regular skin inspection practices and risk assessment of all patients is embedded across the Trust
- The Medical Illustration Department photograph all hospital acquired pressure ulcers which further informs and strengthens the investigation process
- An e-learning package workbook is available to all staff across the Trust.
- All staff are informed of the outcomes, learning and key actions from pressure ulcer review meetings through quarterly distribution of posters in clinical areas.

Pressure Ulcer grading posters have also been distributed to all clinical areas to ensure clear, consistent definitions and to improve the reliability of grading

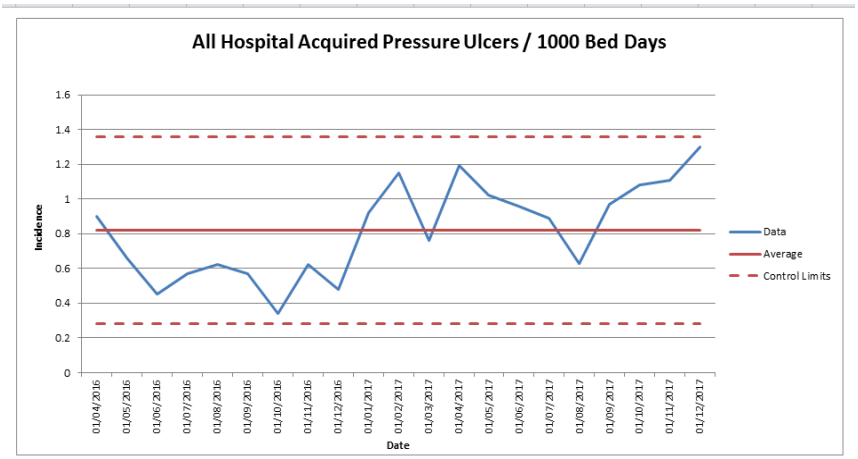
- There are now a range of options available for pressure ulcer prevention training to suit all staff learning styles – monthly taught sessions, an e-learning package and a recently developed pressure ulcer workbook
- A continued focus on reducing equipment related pressure ulcers resulting in the introduction gel sheets and change in practice within critical care to use different techniques to retain ET tubes as well as standardisation of pressure reducing oxygen products
- Involvement in the development of Lancashire wide best practice guidelines for safeguarding individuals with pressure ulcers
- Development of a new electronic pressure ulcer risk assessment which includes prompts regarding the risk of pressure ulcer development in diabetic feet
- Development and introduction of a repositioning chart which incorporates skin assessment
- The commercial contract has been reviewed to enable bariatric seating cushions to be made available for all patients who require them
- ECAP questions have been reviewed in line with NICE Quality standards to ensure that practice is accurately measured against existing standards
- Data is now shared with community teams providing geographical representation of where patients with pressure ulcers are admitted from
- All ward managers are able to view photographs of pressure ulcers relating to their ward
- Robust, consistent review of all grade 2 and above pressure ulcers with divisions and a senior nursing forum.
- Use of medical imaging communicating the impact of pressure ulcer and educating the workforce.
- Creation of patient and carer information resources
- Cascade of learning to all clinical areas.
- Standardisation of pressure relieving equipment
- Development of an e learning package for pressure ulcer prevention
- Participating in a ‘React to Red’ education programme in conjunction with the local CCG, community healthcare providers and nursing and care home staff to develop a health economy wide approach to pressure ulcer prevention.
- Celebration of achievements on wards

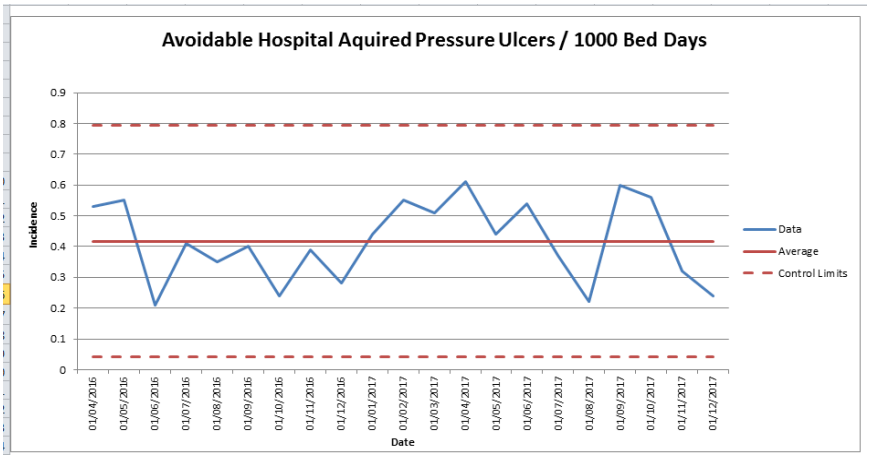
A Trust pressure ulcer improvement plan for 2017-2018 aimed to have no reported avoidable grade 4 pressure ulcers, reduce grade 3 pressure ulcers by 50% and reduce grade 2 pressure ulcers by 5%.

Currently all hospital acquired pressure ulcers grade 2 and above are reported on the Trust Datix incident reporting system. All incidents must have a root cause analysis to identify if accurate risk assessments and interventions have been implemented in line with national standards and Trust policy. Each case is reviewed

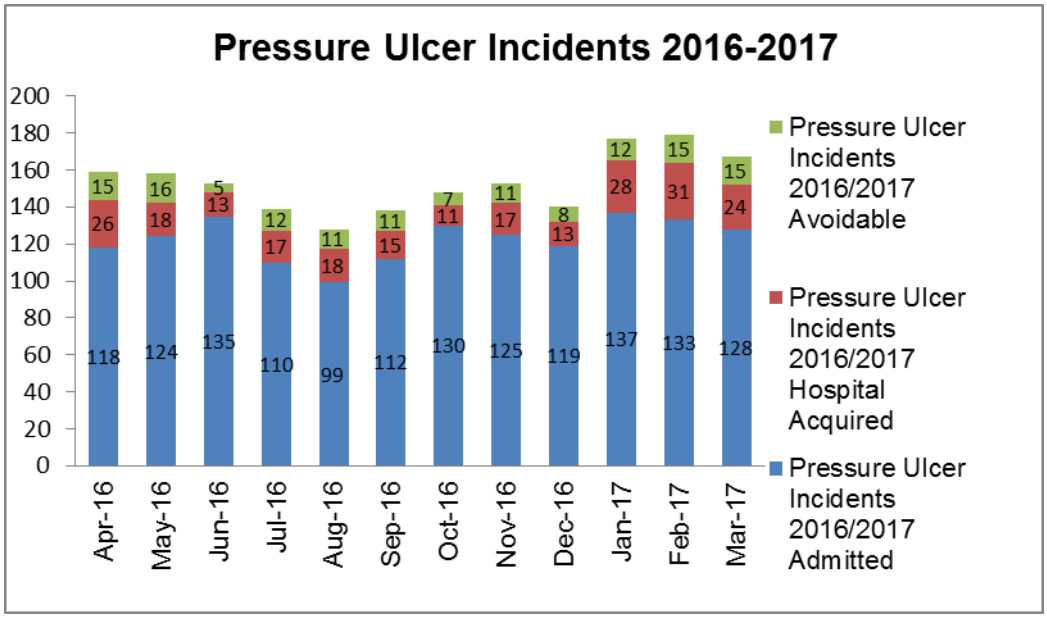
by the Divisional Nurse Directors to determine if the pressure ulcer is avoidable and what actions need to be put in place to ensure lessons are learned. This report aims to review the pressure ulcer incidence rates within Lancashire Teaching Hospitals, to analyse data "deep dive" and identify themes and trends that will influence the improvements required to reduce pressure ulcers.

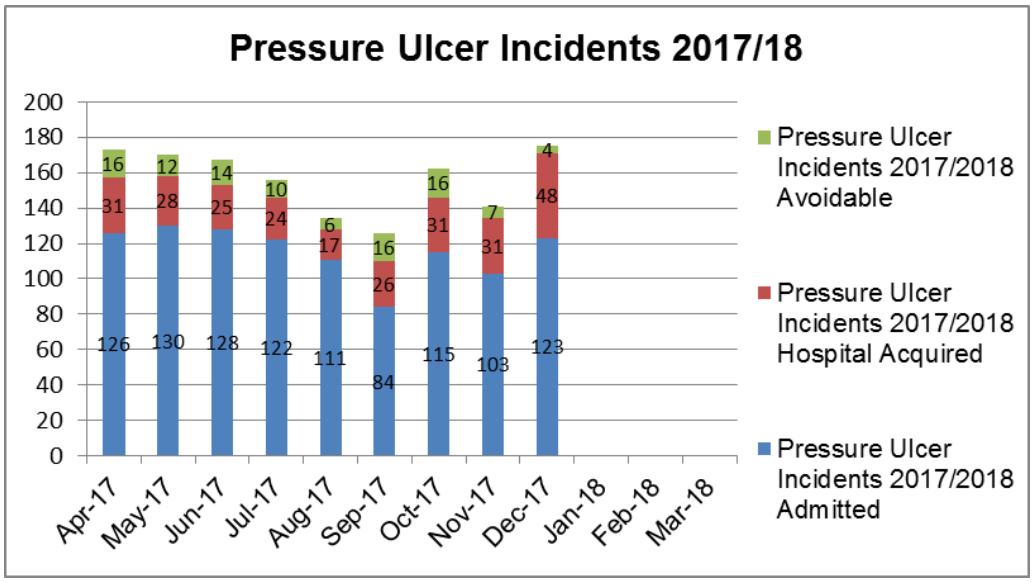
The charts 1 and 2 below show the rates per 1,000 bed days of all reported hospital acquired pressure ulcers and all avoidable hospital acquired pressure ulcers. The rates remain within normal variation, however the charts do show an increase in rates of total number of hospital acquired pressure ulcers and avoidable hospital acquired pressure ulcers since February 2017.





The tables below show comparison figures for 2016-17 and to date 2017-18. The Trust has reported no grade 4 pressure ulcers in this period. However there have been reported 2 avoidable grade 3 pressure ulcers in 2017-18. Current average monthly figures for avoidable grade 2 pressure ulcers reported in the tables below currently show a 13.4% reduction subject to further validation.





The following actions will form part of the 2018/19 pressure ulcer improvement plan with the aim of reducing the incidence further:

- Pressure ulcer validation within the month.
- Implementation of a standard pressure ulcer care plan.
- Review of intentional rounding and turn chart documentation.
- Purchase of high specification pressure reducing equipment within ED and EDU.
- Standardisation of access to snacks on all wards.
- Test and trial of hydration champion model.
- Monitoring of pressure ulcer education e learning package.
- Grade 1 reporting of pressure ulcer incidence.
- Review mattress contract.
- Improve registered nurse staffing.

- Reduce delayed transfer of care.
- Promoting the role of healthcare assistants as pressure ulcer prevention champions.
- Reviewing NHS England resources to promote the importance of nutrition and hydration in pressure ulcer prevention.
- Feedback mechanisms with Lancashire Care and CCG with details of patients admitted with pressure ulcers

Nutrition

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

The provision of high quality nutritional support is complemented by the Trusts 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:

- Improved access to support both in and out of hospital for patients with additional nutritional needs and those on parenteral nutritional support
- Effective crisis prevention with improved access to information and advice
- Standardisation of practice across the Trust in relation to tube insertion and feeding
- Improved monitoring of patients with feeding devices
- Introduction of bedside swallowing assessments using fibreoptic endoscopes, speeding up decision-making and provision of appropriate nutrition
- Increased follow up of patients at 28 days post discharge
- Development of a neonatal nutrition and therapy team.
- Support for the elderly care programme. Across both sites a number of wards receive a ‘snack tray’ that offers a range of snacks to support / encourage patients to eat, increase their nutritional intake. This is in addition to the snacks available on the evening menu
- Catering services support the wards offering monthly ‘tea parties’ with the provision of home-made cakes etc. This is to be extended over the coming year to include ‘cocktails’ on the Ribblesdale ward
- Nutritional analysis of patient recipes the dietetic team encourages a comprehensive balanced diet with increased choice of some items
- The provision of adaptive cutlery to support patient feeding where required

- A tick box on the menu prompts ward staff to identify the requirement for a ‘red plate’ to be used for dementia patients, indicating the need for additional support with feeding
- 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 of the ward staff
- Action taken to ensure full compliance with national standards relating to soft, pureed and liquidized diets
- Introduction of a range of finger foods on the menu.

The INCS has experienced some difficulties in recruiting to vacancies during the last year which has impacted on some of their activities but, during 2017-18, they have focussed on a number of key areas:

- Maintaining hydration levels for inpatients. Hydration stations have been established in a number of wards to encourage adequate fluid intake for patients
- Raising awareness of the importance of maintaining good nutrition
- Standardising snacks across the Trust in respect of nutritional values
- meeting nutritional needs in critical care services
- Assessment of nutritional risks in patients undergoing chemotherapy and immunotherapy
- Patients experiences of the nutritional rapid access service

During 2018/19 the services key priorities are to:

- Ensure documentation relating to MUST assessment and discharge information is standardised
- Develop a competency framework for band 3 and band 5 nutritional staff
- Undertake a review of dietetic diagnostics and patient outcomes
- Establishment of parenteral feeding services for children at home across Lancashire

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.

To support achievement of this priority, we have committed to increased patient involvement and engagement over the year, to ensure that the Trust understands and utilises the views and priorities for our patients in relation to their experiences whilst they are with us for care and treatment.

Patient experience and feedback has never been as important within the organisation and is at the core of our service delivery underpinning everything that we wish to achieve. We recognise that as well as healthcare, there are expectations from our patients, relatives, carers and loved ones that will ensure experiences are fit for purpose for our patients. With this in mind the Trust has launched a key strategy this year, The *Patient Experience and Involvement Strategy 2018 2021*, which provides a focus on a three year development plan to improve patient experiences across our hospitals. The strategy is aligned to the Trust Values to enable staff to understand the importance of its message.

During 2017-18 the strategy was developed over several months with engagement and consultation with over 3000 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:

1. To Deliver a positive patient experience
2. Improve outcomes and reduce harm
3. Create a good care environment
4. Improve capacity and patient flow

Implementation 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 organisation has an established Patient Experience Improvement Group that consists of over 40 people from the local community, Governors, patient representatives, carer organisations, carers and staff. These members will be the overseers of planned developments and implementation of the strategy. In the future focus groups will be formed to schedule key work streams to enhance the implementation of the strategy. The Patient Experience Improvement Group provides an opportunity for input from a fully diverse representation of the communities across

Chorley and Preston and is an open and honest reflection of the local community 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

Future developments for gathering feedback will include fostering a culture of welcoming information provided by patients, carers and service users and how the organisation wants to listen and act upon information provided.

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

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

National Adult Inpatient Survey 2017

The survey was based on a sample of inpatients who received treatment at the Trust in July 2017. A total of 1237 were sent a questionnaire. 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 2016 survey was not published until after publication of the 2016-17 Quality Account. Performance was about the same as most other Trusts who took part in the survey for nine of the eleven sections but for two sections, the trust did not perform as well for that particular question compared to most other trusts that took part in the survey:

- Operations and procedures
- Overall views of care and services

Specifically the questions where the trust did not perform as well for four questions compared to most other trusts that took part in the survey:

- Explanation of operation
- Answers to questions
- Expectations after the operation
- Patients' views

Responses to these questions clearly identified areas requiring improved communication. A review of patient information resources and staff reflection on feedback given has been undertaken during 2017-18, whilst posters highlighting how

patients can provide feedback or make complaints have been developed and displayed across the Trust.

Maternity Survey 2017

The survey was based on responses 115 patients who received antenatal care and/or attended the Maternity Departments at Preston and Chorley in 2017, comprising 38% of those surveyed. The survey comprised eight sections in total:

- the start of your care in pregnancy
- Antenatal check-ups
- During your pregnancy
- Labour and Birth
- Staff
- Care in hospital after the birth
- Feeding
- Care at home after birth

In respect of all sections and questions were about the same as most other Trusts who took part in the survey.

Children and Young People's Survey 2016

This survey was based on a sample of patients who attended from the Children and Young People's Inpatient and Day Case between the months of November and December 2016. A total of 1250 people were sent a questionnaire. 241 inpatients responded to the questionnaire, providing a response rate of 19.5%. The survey was not published until after the publication of the 2016 Quality Account.

There were a number of questions that suggested issues relating to information/communication and the availability of staff. In response a number of actions have been implemented:

- Establishment of friends and family test in all areas with regular review of feedback
- Establishment of a Twitter account to provide information to parents, children and young people
- Identification of 'young governors' ensuring opportunity for assurance and constructive feedback and criticism
- Establishment of a youth forum where views and feedback are sought and acted on
- Inclusion of young inspectors as part of the Trusts STAR accreditation process
- Recruitment of additional senior medical staff
- Recruitment of nursing staff
- Inclusion of young person's representative in recruitment processes
- Review of leadership structure with addition of a ward manager and requirement for Matron to seek views from parents and children on a regular basis

- Establishment of a 'safety huddle' ensuring that all important information/feedback is shared with all staff

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.

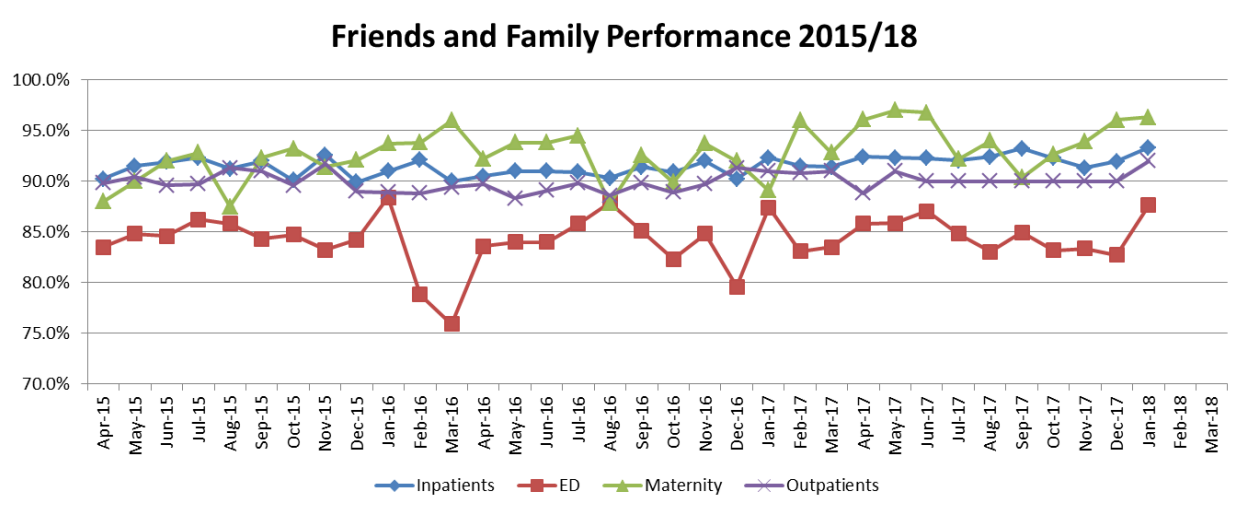
Historically information has been gathered from inpatients, outpatient, day case treatment and the emergency department services. However the Trust has recognised that there are significant number of areas where key information has not been gathered. As such the Trust has started to gather information from Children and Young People's Services and has identified a number of areas, where in 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.

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.

The organisation is currently working towards a communication campaign to ensure that patients are aware of the FFT process and to advertise that the organisation welcomes feedback in terms of what we do well and how we can improve. This will consist of advertising via our communication screens, pro-active information provided within departments and a poster and advertising campaign. It is hope that by doing these patients will want to be involved in decisions about the organisation, not just in relation to FFT but other patient experience engagement.

FFT performance is monitored on a monthly basis and in the future will be triangulated with the other sources of feedback to ensure that the real examples of effectiveness and improvement can be identified and acted upon. FFT information remains largely positive, however the Trust recognises that the response rate needs some improvement and has a plan in place to achieve this. One of the major

considerations will be to improve on the response rate from our patients to ensure a more reflective analysis of performance.



Complaints and Concerns

There has been a 7.6% decrease in complaints since 2016-17. When considered in terms of the ratio of complaints to patient contact, the Trust received one complaint for every 1428 inpatient and outpatient episodes during 2017-18, (when activity fell slightly) 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 (IP/OP)	Ratio of complaints to patient contacts
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

Source: Datix LTHTR

Of the 553 complaints received in 2017-18, 435 (78%) related to care or services provided at the Royal Preston Hospital (RPH), 114 (21%) to care or services provided at Chorley and South Ribble District General Hospital (CDH) and 4 (1%) to care or services provided offsite (by the Specialist Mobility Rehabilitation Centre, based at Preston Business Centre).

247 (45%) of the complaints received related to the care of inpatients, 215 (39%) to the care or services provided to those who were outpatients, 74 (13%) to patients attending the Emergency Department, 11 (2%) to patients attending Maternity Services, the remaining 6 (1%) 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. 227 (41%) of the complaints received relate to directorates or departments that are now contained within the Medical Division, 240 (43.5%) to those within the Surgical Division and 63 (11.5%) to directorates and departments that sit within the Division of Diagnostics and Clinical Support. 23 (4%) complaints relate to departments outside the three divisions detailed above (21 to Facilities, 1 to corporate services, 1 off site).

590 formal complaints were closed during 2017-18. 84% of all complaints had been closed with 100% of complaints received in March closed within the timescales. By the end of 2017-18 only 2 complaint responses were still outstanding and outside of the required timescale of 35 working days. One of these was due to a planned meeting date with complaints and the other delayed the conclusion of a level three investigation

The investigations that were undertaken into those closed complaints concluded that 147 (25%) of the complaints had been upheld, 210 (36%) were partly upheld and 229 (39%) had not been upheld. The 4 remaining records were cases that were withdrawn.

The percentage of complaints upheld or partly upheld decreased this year (from 72% in 2016-17 to 61%), 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 2017-18, the Trust received 40 second letters, 2 more than the number received in the previous financial year.

During 2017-18, 12 complaints were referred to the PHSO. Of the complaints referred to the PHSO in 2017-18, 4 have been closed with 2 not upheld and 2 partly upheld. Draft report received in one case – propose to partly uphold. In this same period, the PHSO completed their investigations into 7 of the complaints that had

been referred to them prior to April 2017. These cases have also been closed – 3 partly upheld, 4 not upheld.

In response to feedback received in 2017 – 2018 the Trust has made changes in a number of areas to improve the quality of service provision. Some of these include:

- The introduction of a Carers Charter in recognition of how carers can support their loved ones whilst in hospital
- Lanyards to clearly identify who the 'shift leader' is in clinical areas
- Resources to support patients who have dementia as a way of engaging in meaningful activities
- Development of patient boards for behind the bed to ensure that staff can, at a glance, be informed of their care needs
- Ward boards to provide key information for visitors and carers of what to expect 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
- Introduction of the 'Hello My Name Is…' initiative across the organisation
- Introduction of 'ALWAYS' events developed in consultation with patients, carers and governors

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2017-18 a total of 5700 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 2000 issues which would have the potential to become formal complaints and resolved these with a reasonable outcome for patients.

The Trust has recently refocused on the importance of the complaints process and identified the need to respond to complaints in a timely manner. As part of this it was identified that clear leadership was required to answer complaints from patients, and a Head of Customer Care post has been introduced. Since this post has been created, the organisation has reduced a backlog of complaints that were outstanding and achieved a response to complaints within 35 days currently reporting 100% compliance within this area.

In the future clear objectives in terms of education and training and quality of responses will be an indicator that is monitored through the organisational governance reporting system.

Patient Stories

The organisation welcomes feedback for many sources, and none more than those from real life experiences of the service. Formerly the Trust had in place where patient stories were 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 and to share their experiences from a real perspective. This has demonstrated a clear impact in terms of the powerful messages portrayed by those who have been involved in patient experience. A schedule for Divisions is available to identify patient experience stories. This information once it has been to Board is cascaded through to various other meetings across the organisation to share experiences and discuss, where appropriate improvements that may be made within area, and improvements that can be cascaded across other areas.

Communication and involvement in care

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. Both of these strategies identify and commit the organisation to achieve targets over the next 3 years and have been developed in consultation with our patient population, staff and partner organisations, such as Healthwatch Lancashire.

The Patient Experience Improvement group was renewed and reformed to enable our patients to have a voice in relation to their healthcare and to contribute to the projects that are identified within the strategies.

There has been considerable engagement across wards of all specialties, with the NHS ‘end pj paralysis programme, with a particular focus to get patients up, dressed and mobilising as well as they are able. These simple actions can prevent deconditioning and loss of independence, and reduce length of stay.

This year the organisation has had a clear focus to support patients who are living with dementia. Several presentations and update days have taken place to highlight and identify how our care can support these patients. The days have included staff from all disciplines, in recognition that this illness has a potential impact on all staff and how patients and visitors should be treated appropriately.

In addition we have:

- Increased the areas for gathering Friends and Family Test Information
- Engaged with the learning disabilities community through our annual ‘Our Health Day’
- Engaging staff with the Tommy On Tour initiative
- Introduced more open visiting

Staff Survey

We fully recognise the importance of valuing our staff in their efforts, and we are committed to promote recognition and celebration of excellence in patient care. We continually strive to develop well-structured and effectively led teams as these are fundamental to the development of an effective, valued workforce.

In the 2017 staff survey, performance significantly improved against 2016 results in three key areas relating to:

- Positive action by the Trust on staff health and well-being
- Training or development in the previous 12 months, and
- Regular updates on patient feedback in directorate/department

A number of areas for action and improvement were also identified, specifically:

- Staff satisfaction with the quality of care given to patients
- Awareness of who senior managers are
- Awareness of errors/near misses or incidents
- Experience of violence/abuse from patients, relatives or other members of the public
- Appraisals

Improvement plans have been identified and in process of implementation in response.

Assuring Quality

The availability of meaningful, relevant and timely information in relation to safety and quality is essential to monitor a range of clinical indicators that provide assurance and direction in the analysis of clinical outcomes and the identification of learning.

During 2017-18 we have significantly strengthened the quality and accessibility of information systems within the Trust, with:

- Increased accessibility and engagement with incident reporting systems providing meaningful information and performance reports
- Increased engagement with meaningful clinical audit through the Trusts electronic audit facility, developed to allow ease of access, reduce duplication and to ensure focus on priority audit and improvement as a result. All audit activity, local and national can now be accessed through the same process and the platform ensures that improvement actions are identified, completed and available to be shared with others within the Trust. We use a range of processes in order to monitor and assess safety and quality. We synthesize information from a range of sources including local and national audit, benchmarking, and feedback from patients (via surveys, friends and family tests and complaints/compliments).
- External accreditation visit reports are submitted on the Trust Datix system and any issues are reported through the Clinical Governance Committee to the Board of Directors

During 2016-17 we conducted a quality improvement event to develop a new quality assurance framework for wards and departments. Following on from this the safety triangulation accreditation and review (STAR) quality assurance framework was developed.

STAR is a formal process designed to support healthcare teams by measuring the safety and quality of patient care in clinical areas. This quality assurance framework is based on our approach to service delivery and combines key performance criteria which reflect regulatory standards for quality and safety. Launched in June 2017, the STAR process has enabled us to benchmark standards, ensure staff can evidence a baseline of compliance and promote a greater understanding of the standards we aims to achieve. Wards and departments receive a rating of white, bronze, silver and gold, depending on their level of performance. Gold standard wards are expected to support peer wards in improving performance and STAR accreditation status. The baseline has highlighted some themes which we have and continue to address and once the programme of re-visits are complete, progress and improvements will outline the level of success.

The assessment consists of standardised questions through monthly audits, and accreditation visits that include observations of care and the environment and asking

patients and staff relevant questions and receiving patient and staff feedback. The STAR framework monitors the quality of care provided and demonstrates which wards, departments and clinical areas are improving and maintaining best practice.

By the end of quarter 4 of 2017-18, the Trust demonstrated 88% compliance in respect of the standardised questions. Ten wards/departments achieved a level of performance consistent with silver rated performance following accreditation visits, with a further 57 achieving a level of performance consistent with bronze star status. All wards and departments will be revisited by the end of quarter 1 2018, following implementation of improvement plans.

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 is the assessor that the ward or department supports good care. Wards receive a confidence rating that contributes to the triangulation process of accreditation. Where confidence is low (Rated C or D) immediate corrective action is taken.

Performance during January and February 2018 was as follows:

	A Very confident	B Confident	C Not very confident	D Not confident at all
Trust Overall	30	33	3	1

All areas that have achieved an initial C or a D rating for the 15 Step Challenge have now been re-audited and all have achieved a B rating.

We utilise nationally benchmarked data where possible, from such sources as the NHS Information Centre and Dr Foster Intelligence clinical benchmarking tools, and have participated in peer review exercises e.g. in respect of infection prevention and control and cancer services.

Arrangements for the monitoring of safety and quality performance were revised during 2016-17. The 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;
- monitoring performance and progress in respect of CQUIN programmes and contractual quality schedule indicators; and
- ensuring compliance with Monitor and relevant Care Quality Commission standards

Trust Governors continue to be actively supportive of the Trusts quality improvement activities and continue to play a major part in seeking and providing assurance, participating in STAR and other assessments. Governors also attend the Trusts Patient Safety Collaborative Group, Patient Experience Improvement Group and Clinical Governance Committee as active members.

Governor involvement in the *Our Health Our Care* programme and local health melas 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.

In addition:

- Governors organise observational visits to gain first hand experience of the patients' journeys in both outpatient and inpatient areas. This also gives valuable opportunities to gather the views from patients of their experiences whilst in the care of the Trust.
- Governors attend local groups within the catchment area, to talk about the role of the governor but also gather views from the public, which is then fed back to the relevant Trust management team.
- The Governing Council Patient Experience Group has a strong working relationship with the Trust management with the Associate Director of Effectiveness and Experience and a non-Executive Directr part of the group membership.
- Governors are consulted on priorities for the coming year.

Performance against Key National Priorities

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified, since April 2017 in the NHS Improvement Compliance Framework and the Acute Services Contract.

During 2017-18 the Trust has continued to experience significant operational pressures due to patient flow. 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. Alongside this during 2017-2018 the Trust set up a range continuous Improving and transformational work streams of which patient flow has a significant work plan attached to this.

Overall during 2017-2018 the Trust achieved compliance against a range of measures within the Risk Assessment Framework and Single Oversight Framework including access standards including five of the eight cancer waiting times standards, and infection prevention standards and diagnostic waits. In respect of 6- week diagnostic waits, Trust performance stood at 0.36% by 2018 against a target of 1%, with a Q4 performance of 0.34%. This represents imperovement against Q3 performance of 0.46% - still below the target for this measure. 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 quarters 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 2017-2018 that adversely impacted on access standards compliance and delivery of the trusts elective care programme.

The summary position detailing performance against key targets 2017-18 is shown in the table overleaf:

Indicator	Target %	Cumulative Performance	Achieved	Current Period
A&E - 4 hour standard	95	85.03	Not Achieved	% - Cumulative to end Feb 2018. Position includes both ED and UCC locations
Cancer - 2 week rule (All Referrals) - New method	93	98.2	Achieved	% - Cumulative to end Feb 2018
Cancer - 2 week rule - Referrals with breast symptoms	93	97.5	Achieved	% - Cumulative to end Feb 2018
Cancer - 31 day target	96	95.9	Not Achieved	% - Cumulative to end Feb 2018
Cancer - 31 Day Target - Subsequent treatment – Surgery	94	94.9	Achieved	% - Cumulative to end Feb 2018
Cancer - 31 Day Target - Subsequent treatment – Drug	98	99.9	Achieved	% - Cumulative to end Feb 2018
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	94	98.1	Achieved	% - Cumulative to end Feb 2018
Cancer - 62 day target - total	85	81.5	Not Achieved	% - Cumulative to end Feb 2018
Cancer - 62 Day Target - Referrals from NSS (Summary)	90	82.5	Not Achieved	% - Cumulative to end Feb 2018
MRSA	0	1	NA	Cumulative to end Feb 2018
C.difficile Infection- (Previous Monitor Indicator)	66	57	Achieved	Cumulative to end Feb 2018
C.difficile infection avoidable (Lapses in care) – (Revised Monitor indicator)	66	28	Achieved	Cumulative to end Feb 2018
18 weeks - Referral to Treatment - Incomplete Pathways	92	84.1	Not Achieved	% - sum of Apr-Feb in 2017-18

Summary Table of Performance against Core Indicators

12. Summary Hospital-Level Mortality Indicator (SMHI)	April 2015-Mar2016	October 2015 – September 2016	October 2016-September 2017
(a) the value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period	Trust = 0.995	Trust = 1.0053	Trust = 1.0562
	National average = 1.0	National average = 1.0	National average = 1.0
	Low = 0.678	Low = 0.69	Low = 0.73
	High =1.178	High = 1.16	High = 1.25
	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 = 33% National = 28.5% High = 54.6% Low = 0.6%	Trust = 36.5% National = 29.7% High = 56.3% Low = 0.4%	Trust = 38.8% National = 31.5% High = 59.8% Low = 11.5%

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

- There has been increased focus on mortality across the organisation and improvements in the quality of documentation and clinical coding.

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 Learning from Deaths processes to ensure learning across the organisation
- Improved engagement with mortality reviews by clinical staff

18. PROMS; The Trust's patient reported outcome measure scores for:	April 2014 – March 2015			April 2015-March 2016			April 2016- March 2017		
	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	Health gain = 0.076	NA	NA	NA	NA	NA	NA	NA	NA
	National = 0.084 High = 0.154 Low = 0	NA	NA	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	NA	NA	NA
	National = 0.095 High = NA Low =NA	NA	National =-8.252 High = NA Low =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 = 0.418	Score = 19.79	NA	Health Gain = 0.408	Score = 20.906	NA	Health gain = 0.38	20.3	NA
	National = 0.437 High =0.517 Low =0. 331	National = 21.4 High =24.65 Low = 16.3	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
(iv) knee replacement surgery (Primary)	Health gain = 0.321	Score = 16.05	NA	Health Gain = 0.276	Score = 15.731	NA	Health gain =0.28	Score = 14.8	NA
	National = 0.315 High = 0.418 Low =0.204	National = 16.15 High =19.49 Low =11.48	NA	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

Patient Reported Outcome Measures (PROMS) is a survey through which patients are asked about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. In this way the impact of treatment on an individual patient can be measure. The higher the score, the greater the impact on the patient. The PROMS programme uses three measures:

- The EQ5D tool provides a generic measure of quality of life.
- The Oxford specifically measures the impact of knee replacement surgery on quality of life and is only used for patients undergoing knee surgery, whilst the Aberdeen score measures the impact of varicose vein surgery on quality of life and is only used for patients undergoing varicose vein surgery.

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

- Oxford scores for both hip and knee replacement have declined in comparison to previous reports. Patient level data is currently being reviewed to identify possible reasons for variance in performance and will inform development of improvement actions.
- For varicose vein surgery, performance cannot be accurately assessed due to the small numbers of procedures performed at the Trust.

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 by patients, particularly in respect of groin hernia repair and varicose vein surgery, 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 is not currently available from the NHS information centre
- Performance in respect of patients aged 16 and over was better than national performance during 2011/12 – the most recent available data

Performance during 2016/17 was 11.7% for those aged 0-15 and only 6.8% for those aged 16 and above (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 the impact of any significant shift in case mix on readmission rates and responding where areas of improvement are identified.

20. The Trusts responsiveness to the personal needs of its patients during the reporting period	**2014-2015**	**2015-16**	**2016-2017**
	Trust = 64.8	Trust = 68.3	Trust = 64.1
	National = 68.9 High= 86.1 Low = 59.1	National = 69.6 High=86.2 Low = 58.9	National = 68.1 High=85.2 Low = 60

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

- 2017-2018 performance data is not yet available pending publication (date to be confirmed)

- 2016/17 data demonstrates a worsened position, below but consistent with a corresponding decline nationally.

Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, through implementation of its patient experience and involvement strategy and nursing, midwifery, AHP and care givers strategy as described within this report, ensuring that excellent care with compassion, always events and trust values are fully embedded and by investing in leadership., training and development of staff.

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	**2015**	**2016**	**2017**
	Trust = 65	Trust = 65	Trust = 67
	National (Acute Trusts) = 70 High = 89 Low = 46	National (Acute Trusts) = 70 High = 85 Low = 51	National (Acute Trusts) = 70 High = 84 Low = 47

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

- Investment in staffing and staff development.
- Positive leadership at all levels.
- Embedding of positive organisational values from Board to ward.
- Focus on further improvement in mandatory training and appraisal rates.

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 development, exploring ways in which recruitment can be maximised and further improving appraisal and mandatory training rates.

23. %age of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period	**Q1 2017-2018**	**Q2 2017-2018**	**Q3 2017-2018**
	Trust = 96.2%	Trust = 96.2%	Trust = 96.1%
	National = 95.2% High = 100% Low = 51.4%	National = 95.3% High = 100% Low = 71.9%	National = 95.4% High = 100% Low = 76.1%

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

- Effective systems and risk assessment processes.
- Positive clinical leadership and response to lessons learned.

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

- Refining current processes, subject to ongoing satisfactory performance, by further encouraging local ownership of review and improvement actions

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	**2014-2015**	**2015-2016**	**2016-2017**
	Trust = 21.2	Trust = 19.4	Trust = 18.7
	National = 15.0 High = 62.6 Low = 0	National = 14.9 High = 66 Low = 0	National = 13.2 High = 82.2 Low = 0

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

- Case mix, including numerous specialties and admission from other hospitals (as explanation for relative position to national average)

- Increased focus on antimicrobial prescribing
- Improved responsiveness to need for isolation
- Engagement of antimicrobial pharmacist as a member of the infection control and prevention team

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

- Continuing to promote best practice around antimicrobial stewardship, hand and environmental hygiene. We have also invested in new technology to increase the availability of vaporised whole room decontamination equipment across the Trust to enable efficient and timely decontamination of isolation rooms as part of the Trusts ongoing commitment to reducing all avoidable cases of C.difficile infection.

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	**October 2015 - March 2016**	**Apr-Sep 2016**	**Oct 2016-March 2017**
(i)Rate of Patient Safety Incidents per 1000 Bed days	Number = 6097 Rate/1000 bed days = 40.2 National Rate/1000 bed days = NA <u>High</u> Rate/1000 bed days = 75.9 <u>Low</u> Rate/1000 bed days = 14.8	Number = 6256 Rate/1000 bed days = 39.2 National Rate/1000 bed days = NA <u>High</u> Rate/1000 bed days = 69 <u>Low</u> Rate/1000 bed days = 21.1	Number = 5925 Rate/1000 bed days = 41.5 National Rate/1000 bed days = NA <u>High</u> Rate/1000 bed days = 69 <u>Low</u> Rate/1000 bed days = 23.1
(ii) % of Above Patient Safety Incidents = Severe/Death	<u>Severe harm or death</u>	<u>Severe harm or death</u>	<u>Severe harm or death</u>
	<u>Trust</u> Number = 42 Percentage of all incidents= 0.69%	<u>Trust</u> Number = 32 Percentage of all incidents= 0.51%	<u>Trust</u> Number = 42 Percentage of all incidents= 0.71%
	National = NA	National = NA	National = NA

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 ongoing efforts to improve reporting systems, processes and tools.
- Ongoing organisational focus on the importance of incident reporting and development of a positive safety culture with improved staff engagement in incident reporting has also contributed to this increase.

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

- Further refinement of the Datix reporting system which enables closer monitoring of actions and provides feedback to the reporter

- Strengthening of Divisional Governance arrangements to ensure timely review and response to reported incidents and shared learning.
- Implementation of Learning from deaths processes and subsequent learning from casenote review and investigation

Source: NHS Digital

Annex 1: Statements from External Stakeholders

Greater Preston/Chorley and South Ribble 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.

In 2016 the CQC inspected the Trust and gave an overall rating of 'requires improvement'. Since this time the CCG has been partners on the Quality Improvement Board, which was implemented in order to monitor the resultant action plan. The CCG is keen to see the outcome of the CQC 'well-led' inspection, which is due to take place imminently, in order to understand the impact of the improvement work undertaken.

The launch of the Nursing Strategy in 2018 highlights the Trust's commitment to providing safe and effective care. It is positive to note the strategy includes a focus upon reducing pressure ulcers, reducing patient falls, improving incident reporting and improving the Safety Triangulation Accreditation Review status of wards.

The CCG is pleased to acknowledge the collaborative working that has taken place with the Trust during 2017-18. Staff have been very supportive in relation to driving the React to Red pressure ulcer initiative across the health economy and have also been instrumental in leading the improvement work for the Central Lancashire Falls Prevention Collaborative. Although there has been a rise in pressure ulcers noted recently, reductions have been noted in the number of falls with harm and the number of reported Cdifficile cases remains within trajectory. Notably Trust staff are also key members of the CCG Health Care Acquired Infection review panel.

Hospital mortality rates remain within the 'expected' range for SHMI and better than 'expected' for HSMR. The CCG notes the cases that are due to be reviewed by the Trust Mortality Board and look forward to receiving a copy of the subsequent outcome reports. The CCG would also expect additional learning to be shared as the 'Learning from Deaths' mortality review process becomes embedded across the organisation.

It is disappointing to note that three Never Events were reported in 2017-18. The Trust has put actions in place as a direct response to this issue and the CCG would like to acknowledge the improvement work that has been implemented. It is positive to note the introduction of 'safety champions' within theatres, along with the work undertaken by the Consultant Nutrition Nurse (which has been shared nationally) to support the reduction in nasogastric associated Never Events. In addition, the CCG attends the case review group at the Trust which encourages an open and honest reporting culture.

It has been another challenging year in relation to performance against NHS Constitutional targets, particularly in relation to achieving the 4 hour standard for A&E performance (resulting in a number of patients waiting more than 12 hours on a trolley in the emergency department), consistent achievement of the 62 day cancer standard, along with a deteriorating performance for 18 week Referral to Treatment time (which has resulted in a number of elective procedures being cancelled). It is also disappointing to note that a number of patients are waiting more than 52 weeks to be seen.

The CCG acknowledges that significant capacity and flow pressures within the Trust continue to affect performance, however, it is disappointing to note that the remedial action plans have not had the desired impact upon performance. The CCG would like to highlight that the implementation of the ambulatory care pathways service at Chorley District Hospital is a very positive development and would be keen to see this success replicated at the Royal Preston site.

The CCG has undertaken a number of quality visits throughout 2017-18 and is pleased to report that patient experience was, on the whole, very positive across the services that were visited. Members of staff did articulate a number of challenges but also identified numerous instances of their commitment to improving patient care on a daily basis. The NHS Staff Survey was comparable to 2016-17 and it is positive to note that there has not been any significant deterioration in these results. Notably, individual staff members have also continued to achieve national recognition for the work they have undertaken. The CCG would recommend that the senior management team ensure visibility and support for all sectors of the workforce in order to promote a timely response to any concerns and to ensure that any proposed improvements are encouraged.

Staffing remains a challenge at the Trust, both within nursing and medicine. The CCG acknowledges the recent in-depth nurse staffing review that has been undertaken, along with the proposed implementation plan for the review findings. The CCG recognises that staffing challenges are replicated on a national basis, however, is keen to understand any additional plans that will be implemented in order to maintain the quality and safety of patient care.

It is positive to note that Trust staff have worked collaboratively with the CCG to integrate the care home sector with the NHS. This has resulted in continued support for the CCG led Care Home Collaborative, along with the development of a ‘Buddy System’, which has resulted in a significant number of care homes ‘buddied’ with a Matron from the hospital.

During 2017/18, NHS England mandated the following CQUIN schemes: • Staff Health and Wellbeing.

- Supporting proactive and safe discharge.

- 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.
- NHS e-Referrals.

Unfortunately, the Trust did not achieve the Advice and Guidance CQUIN scheme during 2017-18 (at Q3 reconciliation), although the CCG is pleased to acknowledge achievement or partial achievement of the other mandated schemes.

The CCG recognises the significant financial challenge faced by the Trust and feel this will require strong leadership in order to ensure the delivery of quality services and make good use of resources. In order to achieve the requirements of the nationally mandated Integrated Care Partnership the CCG looks forward to a strengthened level of collaborative working and remains committed to working together in order to improve the health outcomes for the local population. The CCG is actively involved in the development of a Joint Continuous Improvement Strategy with the Trust and looks forward to the improvements that will be implemented throughout 2018-19 in relation to enhancing patient care.

Governors

Feedback was provided by Governors on the content of the report and suggestions for information to be appended in the report including:

- Reference to Governor involvement on the Patient Safety Collaborative Group, the Patient Experience Improvement Group and the Clinical Governance Committee
- Governors organise observational visits to gain first hand experience of the patients' journeys in both outpatient and inpatient areas. This also gives valuable opportunities to gather the views from patients of their experiences whilst in the care of the Trust.
- Governors attend local groups within the catchment area, to talk about the role of the governor but also gather views from the public, which is then fed back to the relevant Trust management team.
- The Governing Council Patient Experience Group has a strong working relationship with the Trust management with the Associate Director of Effectiveness and Experience and a non-Executive Directr part of the group membership.
- Governors are consulted on priorities for the coming year.

Feedback has been requested but not received from ***Lancashire County Councils Overview and Scrutiny*** or from ***HealthWatch***

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 2017-18 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 2017 to March 2018
    - Papers relating to quality reported to the board over the period April 2017 to March 2018
    - Feedback from commissioners dated 8th May 2018
    - Feedback from governors dated 29th April 2018
    - Feedback from local Healthwatch organisations requested on 25th April 2018 and not received
    - Feedback from Overview and Scrutiny Committee requested on 25th April 2018 and not received
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5th May 2018
    - Note - The 2017 national patient survey has not yet been published
    - The 2017 national staff survey, dated 7th March 2018
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated March 2018, was presented to audit committee on 18th May 2018
    - CQC Inspection report dated 21st April 2017

- 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

NB: sign and date in any colour ink except black

Chairman Date 25 May 2018

Chief Executive Date 25 May 2018

Glossary of Abbreviations

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
CS	Caesarean section
CRF	Clinical Research Facility
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
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MDT	Multidisciplinary Team
MINAP	Myocardial Ischaemia National Audit Project
MRSA	Methicillin resistant staphylococcus aureus

NAOGC	National Audit of Oesophago-gastric Cancer
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
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
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
SLT	Speech and Language Therapy
TARN	Trauma Audit and Research Network
TIA	Transient Ischaemic Attack
VTE	Venous thromboembolism

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 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;

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 2017/18* ('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 *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

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 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 8th May 2018;
- feedback from governors, dated 29th April 2018;
- feedback from local Healthwatch organisations, requested 25th April
- feedback from Overview and Scrutiny Committee, requested 25th April
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5th May 2018;
- the latest national patient survey, dated 8 June 2017;

- the latest national staff survey, dated 07 March 2018;
- Care Quality Commission Inspection, dated 21 April 2017;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 18 May 2018; 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 2018, 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 2018:

- 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
Manchester

25 May 2018

Lancashire Teaching Hospitals NHS Foundation Trust

FINANCIAL REVIEW
2017/18

KPMG

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 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity for the year and the Statement of Cash Flows, and the related notes, including the accounting policies in note [1].

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; 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 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Material uncertainty related to going concern

We draw attention to note 1.3 to the financial statements which indicates that The Trust has planned for a £49m deficit in 2018/19, and for working capital support loans of £46m in 2018/19. Although a significant term loan of £20.5m is due for repayment in March 2019 the Trust has an expectation that this will be renegotiated before the expiry date. Should this not prove to be the case, the Trust will not have sufficient cash resources to repay the loan.

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.

Overview	
Materiality: financial statements as a whole	£6m (2016/17:£4.5m) 1.3% (2016/17: 1%) of total revenue.

Risks of material misstatement		vs 2016/17
Recurring risks	Valuation of Land and Buildings	◀▶
	Valuation of NHS income and receivables	◀▶

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 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.

2. 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. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2017):

	The risk	Our response
NHS income and receivables NHS income £463 m; 2016/17: £453m)	**Subjective estimate** Of the Trust's reported total income of £471 m (2016/17£465m), £463m (2016/17, £453m) is from NHS sources. Of this total, £429 m (2016/17, £420m) came from Clinical Commissioning Groups (CCGs) and NHS England. The majority of this income is contracted on an annual basis, but actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then commissioners are able to impose fines. Disputes may also arise over the level of under or over-activity against contracted volume. This increases the risk of disagreements at year end between the Trust and its commissioners. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £300,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. Due to the issues highlighted above there is an increased risk that a material mismatch could arise and audit adjustments could impact on the Trust's performance against the planned deficit agreed with NHS Improvement.	— **Test of detail:** We compared the actual income from the Trust's most significant commissioners to the block contracts agreed at the start of the year. We agreed the validity of any significant variations between the actual income and the contracted income to appropriate third party confirmations. — **Data comparison:** We identified the mismatches arising from the agreement of balances exercise with CCGs and other NHS providers. For mismatches over £300K we challenged the directors' assessment of the level of income and receivables the Trust was entitled to and the receipts that could be collected. — **Test of detail**: We considered the impact of any identified audit adjustments on the delivery of the planned deficit that was agreed with NHS Improvement.

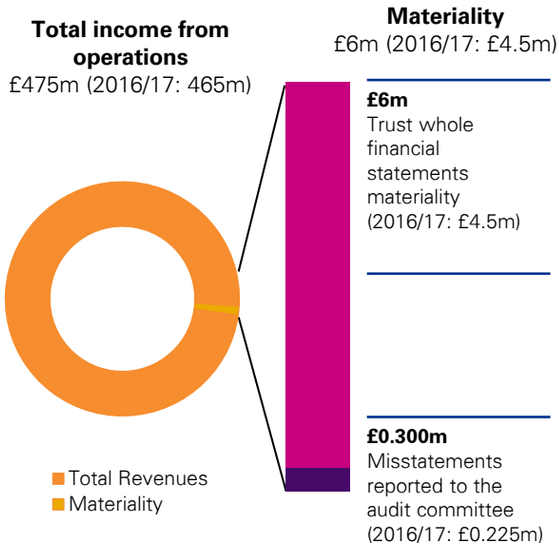
2. Our assessment of risks of material misstatement (continued)

	The risk	Our response
Valuation of Land and Buildings (£197 m 2016/17: £187.8m)	**Subjective valuation** Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property (MEAV). When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. The valuation is undertaken by an external expert engaged by the Trust, using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods. Valuations are inherently judgmental. There is a risk that the methodology, assumptions and underlying data, are not appropriate or correctly applied. The Trust last had a full valuation at 31 March 2014. An interim desktop valuation was performed at the 31 March 2018 resulting in a £8 m increase in the value of the property, plant and equipment balance **Accounting Treatment** There is a risk that the valuation is not applied to the financial statement balances appropriately to recognise the valuation gains and impairment losses in line with the requirements of the Department of Health Group Accounting Manual 2017/18.	— **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 2017/18. — **Test of detail:** We tested the accuracy of the estate base data provided to the valuer to complete the desktop valuation to ensure it accurately reflected the Trust's estate. — **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 considered how the Trust and the valuer had assessed the need for an impairment across its asset base either due to a loss of value or reduction in future service potential — **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 2017/18.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £6m (2016/17: £4.5m), determined with reference to a benchmark of total revenue (of which it represents approximately 1.3% (2016/17 1%)). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.300m (2016/17:(£220k), in addition to other identified misstatements that warranted reporting on qualitative grounds.



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.

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In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

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 Trust'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 2017/18, is misleading or is not consistent with our knowledge of the Trust 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 76, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; 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 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 Trust without the transfer of its 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

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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 £33.9m for 2017/18 and is budgeting for a deficit of £49.3m in 2018/19. The five year cumulative deficit position to 31 March 2018 is £92.8m

The Trust has significant loan balances, including a loan of £20.5m due for repayment at the end of 2018/19. 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 2017/18 and the Trust plans to access significant working capital loan facilities of £49m during 2018/19.

The Trust achieved Cost Improvement Plan (CIP) delivery of £20m in the year, compared to a target of £34m. Of the total delivery, £11m represents non-recurrent savings achieved and places additional pressures on the 2018/19 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 for securing 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 overleaf together with the findings from the work we carried out on each area.

Criteria	The risk	Our procedures and conclusion:
Sustainable Resource Deployment -Management of the Trust's cash position	There is a risk that the Trust will have insufficient cash to meet its working capital requirements in 2017/18 and over the medium term.	We assessed the adequacy of the Trust's arrangements to: —Access the cash support required from the Department of Health and Social Care; —Manage performance against any conditions attached to the support; and —Manage working capital, including the processes for forecasting and monitoring cash flows and delivering cash savings. We also reviewed the plan and cash flow projections for 2018/19. The Trust has adequate arrangements in place to identify and access the cash support required. However, in assessing the Trust's arrangements to manage working capital we considered that the Trust reported a significant deficit of £33.9m for 2017/18 and plans for a deficit of £49.3m in 2018/19. The Trust have submitted the 2018-19 plan in line with guidance and have accessed the facilities offered by NHSI to ensure the cash position of the Trust is maintained, however the Trust has significant loan balances, including a loan of £20.5m due for repayment at the end of 2018/19. The current plans and forecasts do not demonstrate that the Trust will be able to repay this loan. The requirement for external financial support continued throughout 2017/18 and the Trust plans to access significant working capital loan facilities of £46m during 2018/19. We concluded that this demonstrates weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and the maintenance of statutory functions
Sustainable Resource Deployment -Delivery of cost improvement plans	The Trust opted in to Financial Improvement Programme (FIP) phase 2, with ambitious savings targets of £34m to be delivered in 2017/18. 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 focused on the arrangements in place to: —Identify recurrent cost improvements; —Monitor progress against delivery; —Address slippage in CIP delivery; and —Develop a long-term financially sustainable plan for the Trust. The Trust achieved a Cost Improvement Plan (CIP) delivery of £20m in the year, which was less than the planned target of £34m. While arrangements to monitor progress in the delivery of the CIP are adequate, the Trust does not have adequate arrangements in place to return to a sustainable financial position. We concluded that this demonstrates weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and the maintenance of statutory functions.
Informed Decision Making – Response to regulators	The Trust continue to be listed as having additional licence conditions, although the work in 2016/17 demonstrated progress against these. The Trust CQC inspection in 2016/17 resulted in an overall rating of 'improvements required'.	We assessed the arrangements in place to: —Monitor progress against the response to the 2016-17 CQC report and rating of 'requires improvement'; —Monitor progress against the undertakings agreed with Monitor (operating as NHSI); —Satisfy NHSI on the progress made against the remaining enforcement undertakings; We concluded that arrangements are adequate..

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

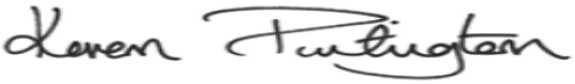
1 St Peters Square, Manchester, M2 3AE

25 May 2018

Foreword to the accounts

Lancashire Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2018, 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 **25-May-18**

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	2	422,698	409,483
Other operating income	3	48,232	55,384
Operating expenses	4	(498,937)	(471,794)
Operating deficit from continuing operations		**(28,007)**	**(6,927)**
Finance income	8	90	81
Finance expenses	8	(2,245)	(1,556)
PDC dividends payable		(3,736)	(4,430)
Net finance costs		**(5,891)**	**(5,905)**
Other gains		-	101
Deficit for the year from continuing operations		**(33,898)**	**(12,731)**
Deficit for the year		**(33,898)**	**(12,731)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments		445	(656)
Revaluations		5,703	7,254
Total comprehensive expense for the period		**(27,750)**	**(6,133)**

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 also qualified for £4.4m of Sustainability and Transformation funding in 2017/18, and also recieved a net income of £1.6m related to donated assets. Without these elements the deficit of the Trust would have been £42m (2016/17 £25.4m)

The notes form part of these accounts.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	9	4,735	6,081
Property, plant and equipment	10	235,580	226,906
Trade and other receivables	13	5,196	-
Total non-current assets		**245,511**	**232,987**
Current assets			
Inventories	12	11,845	8,966
Trade and other receivables	13	25,473	32,810
Cash and cash equivalents	14	6,874	7,339
Total current assets		**44,192**	**49,115**
Current liabilities			
Trade and other payables	15	(40,376)	(45,014)
Borrowings	17	(25,753)	(25,787)
Provisions	19	(521)	(485)
Other liabilities	16	(3,126)	(3,550)
Total current liabilities		**(69,776)**	**(74,836)**
Total assets less current liabilities		**219,927**	**207,266**
Non-current liabilities			
Borrowings	17	(91,904)	(52,874)
Provisions	19	(1,718)	(1,761)
Total non-current liabilities		**(93,622)**	**(54,635)**
Total assets employed		**126,305**	**152,631**
Financed by			
Public dividend capital		222,033	220,609
Revaluation reserve		46,914	42,987
Income and expenditure reserve		(142,642)	(110,965)
Total taxpayers' equity		**126,305**	**152,631**

The notes form part of these accounts.

Name KAREN PARTINGTON
Position CHIEF EXECUTIVE
Date 25 MAY 2018

Statement of Changes in Equity for the year

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' 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' equity at 31 March 2018	**222,033**	**46,914**	**(142,642)**	**126,305**

2016/17

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**218,529**	**37,036**	**(98,881)**	**156,684**
Surplus/(deficit) for the year	-	-	(12,731)	**(12,731)**
Other transfers between reserves	-	(561)	561	**-**
Impairments	-	(656)	-	**(656)**
Revaluations	-	7,254	-	**7,254**
Transfer to retained earnings on disposal of assets	-	(86)	86	**-**
Public dividend capital received	2,080	-	-	**2,080**
Taxpayers' equity at 31 March 2017	**220,609**	**42,987**	**(110,965)**	**152,631**

The notes form part of these accounts.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating deficit		(28,007)	(6,927)
Non-cash income and expense:			
Depreciation and amortisation		13,317	12,851
Net impairments		(2,157)	(1,977)
Income recognised in respect of capital donations		(1,891)	(82)
Decrease / (Increase) in receivables and other assets		3,170	(14,843)
Increase in inventories		(2,879)	(135)
(Decrease) / increase in payables and other liabilities		(5,164)	963
Decrease in provisions		(9)	(175)
Net cash generated used in operating activities		**(23,620)**	**(10,325)**
Cash flows from investing activities			
Interest received		90	81
Purchase of intangible assets		(413)	(814)
Purchase of property, plant, equipment and investment property		(11,955)	(9,207)
Sales of property, plant, equipment and investment property		-	446
Receipt of cash donations to purchase capital assets		773	25
Net cash generated used in investing activities		**(11,505)**	**(9,469)**
Cash flows from financing activities			
Public dividend capital received		1,424	2,080
Movement on loans from the Department of Health and Social Care		39,745	28,238
Movement on other loans		(21)	5
Capital element of finance lease rental payments		(774)	(899)
Interest paid on finance lease liabilities		(222)	(206)
Other interest paid		(1,886)	(1,243)
PDC dividend paid		(3,606)	(4,661)
Net cash generated from financing activities		**34,660**	**23,314**
(Decrease) / increase in cash and cash equivalents		**(465)**	**3,520**
Cash and cash equivalents at 1 April - brought forward		**7,339**	**3,819**
Cash and cash equivalents at 31 March		**6,874**	**7,339**

The notes form part of these accounts.

1 Notes to the Accounts

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 2017/18 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 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 2017/18 the Trust planned a deficit of £19m before receipt of STF income and impairments, however this was dependent on achievement of a performance efficiency target of £34m (7% of income) which was extremely challenging. Despite the support of McKinsey and NHSI the Trust was unable to achieve this target, and suffered additional workload and staffing pressures during the year. As a result the operating deficit increased to £42m. Working Capital loans have been made available to support the deficit of the Trust, ensuring liabilities are met, and these have continued into 2018/19 when the deficit is expected to increase to £51m. Although the current Working Capital loan from DH has only been extended to March 2019, it has been indicated to the trust that this will be extended further while the trust remains in deficit.

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. However based on the indications below the Trust believe that it remains appropriate to prepare the financial statements on a going concern basis and therefore the financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

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.

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 capital and reserves attributable to minority interests are included as a separate item in the statement of financial position.

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.

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 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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.

The Trust recognises the amount of income due as a result of care received by patients at the Statement of Financial Position date.

1.7 Expenditure

Short-term employee benefits

Salaries, wages and employment-related benefits 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

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. It is not possible for the NHS Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as 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.

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.

1.8 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 and
• the cost of the item can be measured reliably
• the item has a cost of at least £5,000, or
• collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic 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.

Land and Buildings used for the Trust's services or administrative purposes are measured subsequently at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses or current value in existing use. Revaluations are performed by external independent valuers with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the statement of financial position date. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS13, if it does not meet the requirements of IAS40 or IFRS5.

Fair values are determined as follows:
• Land and non-specialised buildings - market value for existing use
• Specialised buildings - depreciated replacement cost

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.

Where the asset life exceeds 15 years and its value is material, new fixtures and fittings are carried at depreciated historic cost with carrying values subject to review for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written out and charged to operating expenses.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic 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' ceases 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 reversed through operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

In accordance with the DH 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 imparment 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 income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where at the time of the original impairment a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed 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 dropped 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 economic 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.

1.9 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. 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 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.10 Government Grants

Government grants are grants from government bodies other than income from clinical commissioning groups or NHS Trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants as are grants from the Big Lottery fund

Where the government grant is used to fund revenue expenditure it is taken to the statement of comprehensive income to match that expenditure. Where the grant is used to fund capital expenditure the grant is taken to income, unless the grant is subject to conditions that the future economic benefits embodied in the grant are to be consumed in a specified manner, in which case the grant is held as deferred income and carried forward to future financial years to the extent that the conditions have not been met.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value

During the year the trust reviewed the application of its inventory policy and identified that instrument trays in theatres were not being accounted for in accordance with the policy. This has been amended during the financial year resulting in a one-off increase in the stock valuation to reflect these trays. The value of the trays that has been included is £2.95m

1.12 Financial Instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of though finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards or ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as Loans and receivables.

Financial liabilities are classified as other financial liabilities.

Loans and Receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash at bank and in hand, NHS receivables, accrued income and 'other' receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the statement of financial position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the statement of comprehensive income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the statement of comprehensive income.

Other Financial Liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
Fair value is the amount for which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arms length transaction. IAS39 provides a hierarchy to be used in determining the fair value for a financial instrument [IAS39 Appendix A, paragraphs AS69-82], and includes quoted market prices, independent appraisals, discounted cash flows.

Impairment of Financial Assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of the bad debt provision

The carrying amount of individual debts is written down directly where it is certain that the debt cannot be recovered. Where there is a level of uncertainty as to the recoverability of individual debts an appropriate provision is made.

1.13 Leases

Finance Leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation 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 as an item of property plant and equipment

The annual rental 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
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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. Leases of land are treated as operating leases

1.14 Provisions

Provisions are recognised where the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised is the best estimate of the resources required to settle the obligation at the Statement of Financial Position date, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using relevant rates issued by HM Treasury.

Clinical negligence costs
The NHS Litigation Authority (NHSLA), known as NHS Resolution from 1st April 2017, operates a risk pooling scheme under which the NHS 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.

Non-Clinical risk pooling
The NHS 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 the NHS Litigation Authority 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.

1.15 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.

1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS32.

A charge, reflecting the cost of capital utilised by the NHS Trust is paid over as public dividend capital dividend. The charge is calculated as the rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount is calculated as a simple average of opening and closing relevant net assets

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend 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 of the audit of the annual accounts.

1.17 Value Added Tax

Most of the activities of the NHS 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.

1.18 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.

1.19 Foreign exchange

The functional and presentational currencies of the Trust are 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 taken to the Statement of Comprehensive Income.

1.20 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS 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*.

1.21 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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). The losses and special payments note is compiled directly from the losses and compensations register which reports on an cash basis with the exception of provisions for future losses.

1.22 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.

1.23 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.

1.24 Early adoption of standards, amendments and interpretations

The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18, These standards are still subject to HM Treasury FreM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

IFRS 9 Financial Instruments - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM; early adoption is not therefore permitted.

IFRIC 22 Foreign Currency Transactions and Advance Consideration - Application required for accounting periods beginning on or after 1 January 2018. The Trust has very few transactions subject to this standard and so the effect of implementation is expected to be minimal.

2. Income from Activities (by type)

	2017/18 £000	2016/17 £000
Acute services		
Elective income	72,045	71,269
Non elective income	117,804	102,720
First outpatient income	23,493	22,710
Follow up outpatient income	32,077	35,751
A & E income	12,620	12,129
Other NHS clinical income	141,035	140,963
All services		
Private patient income	1,354	1,226
Other clinical income	2,942	2,820
Total income from activities	**403,370**	**389,588**

2.1 Income from Activities (by source)

Income from patient care activities received from:	**2017/18 £000**	**2016/17 £000**
NHS England	142,307	125,834
Clinical commissioning groups	275,836	279,349
Other NHS providers	228	254
Non-NHS: private patients	926	952
Non-NHS: overseas patients (chargeable to patient)	428	274
NHS injury scheme	2,877	2,683
Non NHS: other	96	137
Total income from activities	**422,698**	**409,483**
Of which:		
Related to continuing operations	422,698	409,483
Related to discontinued operations	-	-

Overseas Income	2017/18	2016/17
	£000	£000
Income recognised this year	428	274
Cash payments received in-year	83	30
Amounts added to provision for impairment of receivables	165	36
Amounts written off in-year	27	41

2.2 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 commissioners believe would need to be protected in the event of provider failure. This information is provided below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	418,143	405,183

3. Other Operating Income	2017/18	2016/17
	£000	£000
Research and development	2,240	2,696
Education and training	20,338	20,751
Receipt of capital grants and donations	1,891	82
Non-patient care services to other bodies	6,240	5,610
Sustainability and transformation fund income	4,428	10,671
Other income*	13,095	15,574
Total other operating income	**48,232**	**55,384**
Of which:		
Related to continuing operations	48,232	55,384
Related to discontinued operations	-	-

* Items within other Income that exceed £500,000 include:

	£000	£000
Pharmaceutical sales	2,108	3,585
Car Parking	2,351	2,263
Catering Income	1,497	1,601
Estates recharges	664	745

4 Operating Expenses	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	1,438	1,541
Purchase of healthcare from non-NHS and non-DHSC bodies	7,456	6,237
Staff and executive directors costs	324,280	301,825
Remuneration of non-executive directors	134	128
Supplies and services - clinical (excluding drugs costs)	42,031	46,207
Supplies and services - general	6,105	8,396
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	46,466	47,106
Consultancy costs	2,525	319
Establishment	3,063	2,695
Premises	28,311	24,572
Transport (including patient travel)	1,876	2,978
Depreciation on property, plant and equipment	11,558	11,100
Amortisation on intangible assets	1,759	1,751
Net impairments	(2,157)	(1,977)
Increase/(decrease) in provision for impairment of receivables	1,117	(98)
Change in provisions discount rate(s)	47	306
Audit fees payable to the external auditor		
audit services- statutory audit	71	71
other auditor remuneration (external auditor only)	11	87
Internal audit costs	138	143
Clinical negligence	19,196	15,603
Legal fees	822	640
Insurance	515	521
Education and training	1,070	1,020
Rentals under operating leases	164	154
Redundancy	19	20
Losses, ex gratia & special payments	274	6
Other	648	443
Total	**498,937**	**471,794**
Of which:		
Related to continuing operations	498,937	471,794
Related to discontinued operations	-	-

5. Impairments	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(2,157)	(2,619)
Other	-	642
Total net impairments charged to operating surplus / deficit	**(2,157)**	**(1,977)**
Impairments charged to the revaluation reserve	(445)	656
Total net impairments	**(2,602)**	**(1,321)**

6. Arrangements containing an operating lease

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	164	154
Total	**164**	**154**

	2018 £000	2017 £000
Future minimum lease payments due:		
- not later than one year;	165	155
- later than one year and not later than five years;	417	520
- later than five years.	-	20
Total	**582**	**695**

7.1 Staff costs

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	257,295	239,167
Social security costs	24,743	22,606
Apprenticeship levy	1,222	-
Employer's contributions to NHS pensions	28,733	26,984
Termination benefits	48	429
Temporary staff (including agency)	12,239	12,639
Total gross staff costs	**324,280**	**301,825**

7.2 Retirements due to ill-health

During 2017/18 there were 6 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £346k (£337k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

7.3 Pension Benefits

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 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation has been carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

8.1 Finance Income

	2017/18 £000	2016/17 £000
Interest on bank accounts	90	81
Total	**90**	**81**

8.2 Finance Costs - interest expense

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,975	1,248
Other loans	42	44
Finance leases	223	264
Interest on late payment of commercial debt	3	-
Total interest expense	**2,243**	**1,556**
Unwinding of discount on provisions	2	-
Total finance costs	**2,245**	**1,556**

8.3 The Late Payment of Commercial Debts (Interest) Act 1988

	2017/18 £000	2016/17 £000
Amounts included within interest payable arising from claims made under this legislation	3	-

8.4 Gains on disposal of non-current assets

	2017/18 £000	2016/17 £000
Gains on disposal of assets	-	101
Total gains on disposal of non-current assets	**-**	**101**

9 Intangible non-current assets	Software licences £000
Valuation / gross cost at 1 April 2017 - brought forward	**14,407**
Additions	413
Gross cost at 31 March 2018	**14,820**
Amortisation at 1 April 2017 - brought forward	**8,326**
Provided during the year	1,759
Amortisation at 31 March 2018	**10,085**
Net book value at 31 March 2018	**4,735**

	Software licences £000
Valuation / gross cost at 1 April 2016 - as previously stated	**13,593**
Additions	814
Valuation / gross cost at 31 March 2017	**14,407**
Amortisation at 1 April 2016 - as previously stated	**6,575**
Provided during the year	1,751
Amortisation at 31 March 2017	**8,326**
Net book value at 31 March 2017	**6,081**

10 Tangible non-current assets

	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 - brought forward	**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 - brought forward	**-**	**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**

	Land £000	Buildings excluding 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 Tangible non-current assets (previous year)	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
Valuation / gross cost at 1 April 2016 - as previously stated	**21,830**	**165,485**	**6**	**1,064**	**88,826**	**141**	**32,151**	**1,522**	**311,025**
Additions	-	2,554	-	144	4,664	64	799	10	**8,235**
Impairments	-	(656)	-	-	-	-	-	-	**(656)**
Revaluations	-	(902)	(6)	-	-	-	-	-	**(908)**
Reclassifications	-	1,064	-	(1,064)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**21,830**	**167,545**	**-**	**144**	**93,490**	**205**	**32,950**	**1,532**	**317,696**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**8,740**	**6**	**-**	**54,996**	**103**	**24,478**	**1,506**	**89,829**
Provided during the year	**-**	**2,968**	**-**	**-**	**6,043**	**8**	**2,072**	**9**	**11,100**
Impairments	-	4,637	-	-	-	-	-	-	**4,637**
Reversals of impairments	-	(6,614)	-	-	-	-	-	-	**(6,614)**
Revaluations	-	(8,156)	(6)	-	-	-	-	-	**(8,162)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2017	**-**	**1,575**	**-**	**-**	**61,039**	**111**	**26,550**	**1,515**	**90,790**

	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 2017									
Owned - purchased	21,830	164,073	-	144	31,663	83	6,400	17	**224,210**
Finance leased	-	1,225	-	-	-	-	-	-	**1,225**
Owned - donated	-	672	-	-	788	11	-	-	**1,471**
NBV total at 31 March 2017	**21,830**	**165,970**	**-**	**144**	**32,451**	**94**	**6,400**	**17**	**226,906**

10.2 Economic Life of property plant and equipment	Min Life Years	Max Life Years
Building excluding Dwellings	1	81
Plant and Machinery	5	15
Transport Equipment	7	7
Information Technology Hardware	5	8
Furniture and Fittings	10	10
Software Licences	1	3

11. Non-current Assets for sale and assets in disposal groups	Land £000	Dwellings £000	Total £000
Assets held for sale at 1 April 2016	150	195	345
Assets sold in year	(150)	(195)	(345)
Assets held for sale at 31 March 2017 and 2018	**-**	**-**	**-**

12. Inventories	31 March 2018 £000	31 March 2017 £000
Drugs	2,556	1,883
Work In progress	-	-
Consumables	9,163	6,947
Energy	126	136
Other	-	-
Total inventories	**11,845**	**8,966**

Inventories recognised in expenses for the year were £49,759k (2016/17: £45,134k).

13.1 Receivables	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	15,075	6,600
Accrued income	10,869	23,018
Provision for impaired receivables	(4,556)	(3,167)
Prepayments (non-PFI)	2,076	2,252
PDC dividend receivable	134	264
VAT receivable	710	354
Other receivables	1,165	3,489
Total current trade and other receivables	**25,473**	**32,810**
Non-current		
Accrued income	5,196	-
Total non-current trade and other receivables	**5,196**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	18,422	20,801
Non-current	-	-

The NHS Compensation Recovery Unit issued revised guidance in 2017/18 which required amounts owed under the compensation recovery scheme to be reported as non-current receivables where they met certain criteria. This is reflected in the figures above for the current year, but previous figures have not been restated as this guidance only took effect in 2017/18

13.2 Provision for impariment of receivables	2017/18 £000	2016/17 £000
At 1 April	**3,167**	**3,265**
Increase in provision	1,117	399
Amounts utilised	272	-
Unused amounts reversed	-	(497)
At 31 March	**4,556**	**3,167**

13.3 Analysis of impaired Receivables	31 March 2018 £000	31 March 2017 £000
Ageing of impaired financial assets		
0 - 30 days	1,030	35
30 - 60 Days	141	40
60 - 90 days	77	39
90 - 180 days	345	105
Over 180 days	2,963	2,948
Total	**4,556**	**3,167**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	6,358	1,447
30 - 60 Days	1,429	1,987
60 - 90 days	1,373	233
90 - 180 days	706	374
Over 180 days	1,410	546
Total	**11,276**	**4,587**

14. Cash and Cash Equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18 £000	2016/17 £000
At 1 April	**7,339**	**3,819**
At start of period for new FTs	**-**	**-**
Net change in year	(465)	3,520
At 31 March	**6,874**	**7,339**
Broken down into:		
Cash at commercial banks and in hand	16	24
Cash with the Government Banking Service	6,858	7,315
Total cash and cash equivalents as in SoFP	**6,874**	**7,339**
Bank overdrafts (GBS and commercial banks)	-	-
Total cash and cash equivalents as in SoCF	**6,874**	**7,339**

15. Payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	17,712	21,610
Capital payables	2,079	2,107
Accruals	13,032	15,162
Social security costs	3,509	3,135
Other taxes payable	3,071	2,605
Accrued interest on loans	226	96
Other payables	747	299
Total current trade and other payables	**40,376**	**45,014**
Of which payables from NHS and DHSC group bodies:		
Current	5,875	5,572
Non-current	-	-

16. Other Liabilities	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	3,126	3,550
Total other current liabilities	**3,126**	**3,550**

17. Borrowings	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Scoial Care	24,732	24,733
Other loans	277	327
Obligations under finance leases	744	727
Total current borrowings	**25,753**	**25,787**
Non-current		
Loans from the Department of Health and Scoial Care	89,885	50,140
Other loans	221	192
Obligations under finance leases	1,798	2,542
Total non-current borrowings	**91,904**	**52,874**

18. Finance Lease obligations	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**2,738**	**3,969**
of which liabilities are due:		
- not later than one year;	913	1,029
- later than one year and not later than five years;	1,825	2,845
- later than five years.	-	95
Finance charges allocated to future periods	(196)	(700)
Net lease liabilities	**2,542**	**3,269**
of which payable:		
- not later than one year;	744	727
- later than one year and not later than five years;	1,798	2,447
- later than five years.	-	95

19. Provisions	Other	Total
	£000	£000
At 1 April 2017	**2,246**	**2,246**
Change in the discount rate	47	**47**
Arising during the year	118	**118**
Utilised during the year	(174)	**(174)**
Unwinding of discount	2	**2**
At 31 March 2018	**2,239**	**2,239**
Expected timing of cash flows:		
- not later than one year;	521	**521**
- later than one year and not later than five years;	436	**436**
- later than five years.	1,282	**1,282**
Total	**2,239**	**2,239**

At 31 March 2018, £304,638k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lancashire Teaching Hospitals NHS Foundation Trust (31 March 2017: £205,902k).

20. Capital commitments	2018	2017
	£000	£000
Property, plant and equipment	5,863	5,580
Total	**5,863**	**5,580**

21. Post Balance Sheet Events

There are no post balance sheet events

22. Contingent Liabilities

	2018	2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(120)	(141)
Gross value of contingent liabilities	**(120)**	**(141)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(120)**	**(141)**
Net value of contingent assets	-	-

23. 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.

23. Related party transactions (continued)

The Trust had a significant number of transactions with other NHS or Government departments which are all classed as 'related parties' to the Trust. Material 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	5,926	-	366	-
NHS Blackpool CCG	8,917	-	507	6
NHS Chorley and South Ribble CCG	97,428	39	1,457	39
NHS East Lancashire CCG	9,610	-	430	-
NHS England	145,830	12	7,622	-
NHS Fylde and Wyre CCG	11,281	-	326	-
NHS Greater Preston CCG	113,437	-	1,674	-
NHS Morecambe Bay CCG	18,063	1	19	-
Health Education England	19,400	14	54	-
NHS Resolution	-	19,516	-	-
NHS Pension Scheme	-	28,733	-	4,028
National Insurance Fund	-	25,965	-	6,580

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	1	-	-	Member of Council of Governors
Chorley Borough Council	10	3	-	-	Member of Council of Governors
Preston Council	-	3	-	-	Member of Council of Governors
Lancashire County Council	-	95	-		Member of Council of Governors
UCLAN	71	147	18	6	Member of Council of Governors

23. 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 2018, 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	320	21	0
The Rosemere Cancer Foundation Charity	1131583	963	11	0

24. Financial Instruments

International Financial Reporting Standard 7 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).

24.1 Financial assets by category

	Loans and receivables £000	Total £000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	14,844	**14,844**
Cash and cash equivalents at bank and in hand	6,874	**6,874**
Total at 31 March 2018	**21,718**	**21,718**

	Loans and receivables £000	Total £000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	17,536	**17,536**
Cash and cash equivalents at bank and in hand	7,339	**7,339**
Total at 31 March 2017	**24,875**	**24,875**

24.2 Financial liabilities by category

	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	115,115	**115,115**
Obligations under finance leases	2,542	**2,542**
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**

	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	75,392	**75,392**
Obligations under finance leases	3,269	**3,269**
Trade and other payables excluding non financial liabilities	44,957	**44,957**
Provisions under contract	2,246	**2,246**
Total at 31 March 2017	**125,864**	**125,864**

24.3 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	66,650	71,228
years	36,589	5,255
years	49,833	41,350
In more than five years	7,200	8,031
Total	**160,272**	**125,864**

24.4 Fair values of financial instruments

The carrying values of short term financial assets and financial liabilities are considered to approximate to fair value.

25. Losses and special payments

	2017/18		2016/17	
	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	869	45	45	46
Total losses	**869**	**45**	**45**	**46**
Special payments				
Compensation payments	2	1	2	3
Ex-gratia payments	30	4	36	9
Total special payments	**32**	**5**	**38**	**12**
Total losses and special payments	**901**	**50**	**83**	**58**

Losses and special payments are reported on a cash basis.

26. Third party assets

The Trust held £4,000 cash at bank and in hand at 31 March 2018 (£6,000 at 31 March 2017) 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

27. Private Finance Initiative (PFI) transactions

The Trust did not have any PFI arrangements during 2017/18 or at the balance sheet date.

28. Limitation on auditor's liability

The auditors liability for losses in connection with the external audit is limited to £2m.

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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