Board of Directors

3 August 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	P O'Neill
2.	Apologies for absence	1.01pm	Verbal	Information	P O'Neill
3.	Declaration of interests	1.02pm	Verbal	Information	P O'Neill
4.	Minutes of the previous meeting held on 1 June 2023	1.03pm	✓	Decision	P O'Neill
5.	Matters arising and action log update	1.04pm	✓	Decision	P O'Neill
6.	Chair's opening remarks and report	1.05pm (5mins: Pres)	✓	Information	P O'Neill
7.	Chief Executive's report	1.10pm (15mins: Q&A)	✓	Information	K McGee
8.	Staff Story	1.25pm (10mins: Pres) (10mins: Q&A)	Pres	Assurance	S Kenny
9.	Board Assurance Framework	1.45pm (10mins: Disc)	✓	Decision	H Ugradar
10.	**FIT FOR THE FUTURE** (STRATEGY AND PLANNING)				
10.1	Finance Strategy *'Knowing the Business'* update	1.55pm (10mins: Q&A)	✓	Assurance	J Wood
11.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
11.1	Safety and Quality Committee Chair's Report	2.05pm (10mins: Q&A)	✓	Information	K Smyth
11.2	**Reports recommended for approval**: (a) Annual Nurse Staffing Review Report (b) Bi-annual Midwifery Staffing Report (c) Infection Prevention and Control Annual Report 2022-23	2.15pm (15mins: Q&A)	✓ ✓ ✓	Decision Decision Decision	S Cullen S Cullen D Orr
	Reports provided for assurance: (d) Patient Experience Annual Report 2022-23	2.30pm (5mins: Q&A)	✓	Assurance	S Cullen
11.3	Maternity and Neonatal Services report	2.35pm (10mins: Q&A)	✓	Assurance	E Ashton
11.4	Health Inequalities Delivery Plan	2.45pm (5mins: Pres) (5mins: Q&A)	✓	Assurance	S Cullen/ A Brotherton
12.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
12.1	Education, Training and Research Committee Chair's Report	2.55pm (10mins: Q&A)	✓	Information	P O'Neill
12.2	Workforce Committee Chair's Report	3.05pm (10mins: Q&A)	✓	Information	J Whitaker

№	Item	Time	Encl.	Purpose	Presenter
12.3	**Reports recommended for approval**: (a) Workforce Disability Equality Standard (b) Workforce Racial Equality Standard	3.15pm (10mins: Q&A)	✓	Decision	N Latham
	Report provided for assurance: (c) Guardian of Safe Working Annual Report 2022 (d) Guardian of Safe Working Quarterly Report (December 2022 to March 2023)	3.25pm (5mins: Q&A)	✓	Assurance	G Skailes
13. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE)					
13.1	Finance and Performance Committee Chair's Report	3.30pm (10mins: Q&A)	✓	Information	T Whiteside
13.2	Integrated Performance Report as at 30 June 2023 including Finance update *(considered by appropriate Committees of the Board)*	3.40pm (5mins: Pres) (10mins Q&A)	✓	Assurance	F Button
14. GOVERNANCE AND COMPLIANCE					
14.1	Audit Committee Chair's Report	3.55pm (10mins: Q&A)	✓	Assurance	T Watkinson
14.2	Standing Financial Instructions/Reservation of Powers to the Board and Scheme of Delegation	4.05pm (5mins: Q&A)	✓	Decision	J Foote
14.3	Board Effectiveness – Outcome of Review and Action Plan	4.10pm (5mins: Q&A)	✓	Decision	J Foote
15. ITEMS FOR INFORMATION					
15.1	Annual Report and Accounts 2022-23 (laid before Parliament)		✓		
15.2	Quality Account 2022-23		✓		
15.3	Safeguarding Annual Report 2022-23		✓		
15.4	Serious Case Thematic Review Annual Report 2022-23		✓		
15.5	Equality Quality Impact Assessment (EQIA) Policy		✓		
15.6	Date, time and venue of next meeting: *5 October 2023, 1.00pm, Microsoft Teams*	4.15pm	Verbal	Information	P O'Neill

Board of Directors

1 June 2023 | 1.00pm | Microsoft Teams

Part I

PRESENT	06/04/23	01/06/23	03/08/23	05/10/23	07/12/23	01/02/24
NON-EXECUTIVE DIRECTORS						
Professor P O'Neill (Interim Chair)	P	P				
Ms V Crorken	P	P				
Ms A Pennell *(until 31 May 2023)*	P					
Ms K Smyth	P	P				
Mr T Watkinson	P**	P				
Mr J Whitaker	P	P				
Mrs T Whiteside	P	P				
EXECUTIVE DIRECTORS						
Ms F Button Chief Operating Officer	P	P				
Ms S Cullen Chief Nursing, Midwifery and AHP Officer	P	P				
Professor N Latham Interim Chief People Officer *(from 1 June 2023)*		P				
Mr K McGee Chief Executive Officer	P	P				
Dr G Skailes Chief Medical Officer	P	P				
Mrs K Swindley Chief People Officer *(until 31 May 2023)*	P					
Mr J Wood Chief Finance Officer/Deputy Chief Executive	P	P				
IN ATTENDANCE						
Mrs K Brewin (minutes) Associate Company Secretary	P	P				
Mrs A Brotherton Director of Continuous Improvement	P	P**				
Mr S Dobson Chief Information Officer	A	A				
Mr G Doherty Director of Strategy and Planning	P	P				
Mrs N Duggan Director of Communications and Engagement	P	P				
Mrs J Foote MBE Company Secretary	P	P				
ASSOCIATE NON-EXECUTIVE DIRECTORS						
Mr M Wearden	A	A				
Mr P Wilson	A	P				

P – present | **A** – apologies | **D** – deputy | ** part meeting
***Quorum**: 4 Directors and must have at least 2 Executive Directors (one to be the Chief Executive or nominee) and 2 Non-Executive Directors (one to be Chair or Vice-Chair)*

Governors in attendance: P Akhtar, S Barnes, S Doran, J Miller, F Robinson, S Sarwar and P Spadlo

Observers in attendance: Paul Faulkner, Lancashire Post and Blackpool Gazette
Christine Morris, Associate Director of Safety and Learning

IN ATTENDANCE TO PRESENT THE BOARD ASSURANCE FRAMEWORK (Minute ref 100/23) AND CQC UPDATE (Minute ref 112/23)	
Hajara Ugradar	Deputy Director of Risk and Assurance

IN ATTENDANCE TO PRESENT THE PATIENT STORY (Minute ref 99/23)	
Kate Smith-Probert	Deputy Divisional Nursing Director for Medicine

92/23 Chair and quorum

Having noted that due notice of the meeting had been given to each member and that a quorum was present the meeting was declared duly convened and constituted.

93/23 Apologies for absence

Apologies for absence were received and recorded in the attendance matrix.

94/23 Declaration of interests

There were no conflicts of interest declared by the Board in respect of the business to be transacted during the meeting.

95/23 Minutes of the previous meeting

The minutes of the meeting held on 6 April 2023 were approved as a true and accurate record.

96/23 Matters arising and action log

There were no outstanding actions from previous Board meetings and all actions had been completed.

97/23 Chair's opening remarks and report

The report provided a summary of work and activities undertaken during April and May 2023 by the Interim Chair. Highlights from the report included an update on the Interim Chair and Acting Vice Chair arrangements, the resignation of a Non-Executive Director, and external meetings and events attended during the reporting period.

The Chair emphasised the difficult operating environment within the Integrated Care System (ICS) particularly due to financial constraints, and the work being undertaken to ensure services were equitable across the ICS. It was noted there would be a range of changes introduced which would support the financial improvement plan and the Provider Collaborative Board (PCB) and Integrated Care Board (ICB) were focused on delivering the best quality care for communities across the ICS.

Attention was drawn to the revised NHS Providers Code of Governance which came into effect from 1 April 2023 and compliance with the code would be scrutinised by the Audit Committee.

The structure for the Board Safety and Experience Visits was now in place. The visits enabled Non-Executive Directors to triangulate what was presented and discussed at formal Board meetings with the experience of Executive colleagues and staff within divisions. The most recent visit was undertaken to maternity services and discussions were held with staff to understand the operating environment. The structured approach to visiting targeted areas was positive and allowed feedback and discussion at Board Workshops to look at common strengths and challenges being faced by staff. It was noted that the teams visited to date had valued the time afforded by Board members with comments received that the Board not only considered patients but also views and experiences of staff.

98/23 Chief Executive's report

The report provided an update on key national, regional and local developments and highlighted a range of messages for information. Key highlights included:

- Step down of the national NHS incident level for Covid-19 from level 4 to level 3.
- Planned industrial action over the coming weeks including the 72-hour junior doctors' strike. Work was being undertaken on contingency and risk mitigation plans to ensure safe service provision. It was noted there would be a need to stand down significant tranches of activity during strike action.
- Information on key programmes being worked through by the PCB with a summary provided in appendix 1. A copy of the ICB Chair's report was included as appendix 2 and was now a key feature in the Chief Executive's report.
- Government approval of funding for new hospital facilities in Lancashire and South Cumbria with the announcement that two new hospitals would replace Royal Preston Hospital and Royal Lancaster Infirmary as part of the New Hospitals Programme. The physical build would commence in 2030 and further detailed work was underway including assessing the viability of potential locations. The Board recognised the exciting opportunities to develop services fit for the future and how they would be delivered to support the community. Work would also commence on clinical pathways and transformation of services in readiness for the new hospital.
- Investment in staff health and wellbeing and the opening of the refurbished Charter's Restaurant which provided a comfortable space to rest and recuperate and outstanding food for staff.
- Continued investment in the Chorley and South Ribble Hospital site with the opening of new study pods allowing clinical staff to study in an appropriate environment.
- Sir Lindsay Hoyle was welcomed to the LIFE Centre at Chorley and South Ribble Hospital and cut the ribbon to formally launch the expansion of Clinical Health Psychology Services with the opening of a new department at Royal Preston Hospital. The event included a presentation on the services provided recognising the support provided to both patients and staff who had experienced severe trauma, pain, and significant physical incidents.

Reference was made to the backlog of estates work which was increasing each year and whilst the announcement regarding the New Hospitals Programme was excellent, a question was raised regarding what could be done about the current physical environment in terms of the risk presented to both staff and patients. In response, the Board noted the Trust would continue to invest heavily in the Chorley site and in an appropriate way invest in the Preston site. Some additional capital had been obtained to support the front door to make it fit for purpose. Investment would continue on both hospital sites and the Trust would do its utmost to support backlog maintenance

although there would be choices moving to 2030 to ensure any investment was appropriately applied. During the next seven years some transformation work would need time to be worked through and embed. It would be essential that the Trust did not stand still and accelerated work and improvements that could be introduced prior to the new hospital facility coming online. Assumptions for the new hospital in terms of size and build would be predicated on reviewing clinical pathways particularly for people not requiring hospital admission to manage them close to home where safe and possible to so do and that work would need to be accelerated along with the outpatient programme. The Board recognised there was significant work to be undertaken and the recent announcement would provide the impetus to drive that work for completion over the coming years.

99/23 Patient Story: Mary's Story on Trauma Informed Care and Awareness

The patient story provided information from a trauma performance perspective around trauma informed care and awareness and had been developed in partnership with the patient, their advocate, and the safeguarding team. The story focused on understanding past traumas, how that influenced patient behaviours, interactions and experiences, and how a workforce was built that would be able to recognise the therapeutic interventions required to prevent adverse experiences for staff and patients. The Deputy Divisional Nursing Director for Medicine joined the meeting and delivered Mary's Story.

The Board asked for clarification on the hospital passport, how it was constructed, how much of the passport involved input from the patient/carer, the format in which it was produced, and whether the passport could be used in other organisations should the patient be admitted. It was explained that the hospital passport provided good information on what mattered to the patient. It provided a broad range of information on all aspects of the person's life, such as previous/current occupations, what they enjoyed, their mobility, and special dietary requirements, and was a good overview to provide the patient with individualised care. The passport was completed alongside the patient with the level of information they wanted to share. Some patients contribute well alongside family members, carers, and friends and the passport was updated by staff if the patient did not have a family member. It was noted that not all patients presented at the hospital with a passport and staff would support them to complete the document on admission. Patients admitted from nursing homes would present with a file produced by care home staff and the information would be scanned by hospital staff so there was access to papers notes for those patients.

In response to a question regarding the trauma informed approach, it was explained that trauma informed training was relatively new in the Trust and was being led by the Safeguarding team. The ambition was to introduce the training as a mandatory module although staff identified as safeguarding champions currently had more in-depth training which would then be cascaded until mandatory training was embedded. It was confirmed that trauma informed training would be incorporated into safeguarding training already in place as opposed to an add-on module.

Discussion was held regarding how support was provided to staff experiencing aggression. It was recognised that staff could be supporting patients with highly complex needs and the challenges could be significant. The Trust was trying to be proactive with staff, for example accessing psychological debriefs for patients with challenging behaviours. Information had also been shared on patients who may need additional support and pre-empting the effect it may have on staff members so the Trust

was being proactive. It was recognised that staff did experience patient assaults on occasion which was unacceptable, and a group was in place to debrief and review those incidents, look at whether there was a requirement for zero tolerance, and consider writing to staff to recognise the unacceptability of an assault. Feedback on the arrangements had been positive and staff had found the regular debrief sessions helpful.

The Chair asked whether there was anything in particular the Board should be considering or whether anything needed to be drawn out for the PCB and ICS in respect of joined up and integrated care. The Chief Medical Officer noted the earlier comment regarding portability of the hospital passport and referred to LPRES, a comprehensive shared care record which integrated health and social care organisations across Cumbria and Lancashire. LPRES sat on top of the Trust's current electronic systems which allowed access to some of the patient record although did not yet allow access to the hospital passport and this was the aspiration as it was important the patient did not repeat their story wherever they presented. Work was being undertaken to procure a single electronic patient record (EPR) across Lancashire and South Cumbria which would help with easy access to the whole patient record and was an ambition in all acute Trusts in the next five years. The introduction of a single EPR would mean more accessibility and exchange of patient information between health care professionals.

The Board thanked the Deputy Director of Nursing for Medicine for attending the meeting and presenting Mary's Story.

100/23 Board Assurance Framework

The report provided details of risks that may compromise the achievement of the Trust's high level strategic objectives, including full details of the controls, assurances, gaps and actions that were being taken to mitigate the strategic risks. The report also provided details of the outputs from the Board Workshop on 2 May 2023 where an annual review of the risk appetite statement and risk tolerance took place.

It was noted there had been no changes to risk scores since the previous report to the Board save for the risk relating to a Great Place to Work which had been increased from 12 to 16 at the Workforce Committee meeting on 9 May 2023 due to financial pressures, the retirement of the Chief People Officer, and ongoing industrial action. Three operational risks remained escalated to the Board relating to exit block (risk 23); elective restoration (risk 1125); and ongoing strike action (risk 1182).

Discussion was held regarding the gaps in Board membership and whether the risk of not yet having a permanent Chair in place, the reduction in the number of Non-Executive Directors, and the interim arrangements for the Chief People Officer had adequately been captured in the risk in terms of change and capacity. It was noted that the observations would be considered outside the meeting and be reflected across the operational risks. However, whilst some changes had been seen to Board-level posts, Board members recognised the need to balance risk and opportunities such changes brought, reflecting the Board was relatively stable, and the changes would allow additional skills and experience to be brought to the Board by the new appointees

Reference was made to the Equality Impact Assessment (EQIA) Policy. Clarification was requested on its scope and whether it involved looking at the quadruple aim along with the Trust's ability to adopt new ways of working rather than just in respect of the

ambition to Continuously Deliver Excellent Care. In addition, the current risk level in respect of specialist services appeared to be somewhat low (risk level 8) and it was queried whether that risk contained sufficient mitigations. In respect of EQIA it was confirmed that the policy had been approved by the Senior Leadership Team and would now include issues such as the cost improvement programme, establishment changes, unfunded posts, and transformation. The EQIA would also be incorporated in strategic risk reports presented to Committees of the Board, as appropriate.

The Board RESOLVED that:

1. **the updates to the Board Assurance Framework be noted.**
2. **the reviewed risk appetite statement and risk tolerances be approved.**
3. **through the revised Board Assurance Framework, assurance had been received that there continued to be an effective and comprehensive process in place to identify, understand, monitor, and address current and future risks in line with statutory requirements.**

101/23 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee meetings on 31 March and 28 April 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Robotic assisted surgery report and assurance of the procedures undertaken by the surgical team.
- A review of Never Events that had occurred at the Trust during the preceding 10 years which provided analysis of the themes and learning actions from incidents.
- The bi-annual update report providing an overview of progress with the CQC action plans and associate regulatory matters.
- The Always Safety First Strategy 2021-24 progress update on deliverables at the mid-point of year two.
- A report on outsourced contracts providing the Committee with an update on the ongoing contract management of the Trust's outsourced material sub-contracts for clinical healthcare.

Reference was made to the negative escalation on maternity leave within maternity services and clarification was requested on mitigation plans. The Board noted that ordinarily maternity leave would be managed through permanent recruitment and whilst the international recruitment campaign was underway the recruits would be unlikely to fully mitigate the gap therefore there would be reliance on agency staff. Local recruitment advertisements were being placed and the system had robust mutual aid arrangements in place for maternity services to allow staffing to be flexed daily according to demand and activity, with reciprocal arrangements across organisations.

Clarification was requested on the underlying cause for the dramatic increase above the trajectory in relation to *C.difficile* infection and whether the fundamentals driving the position were understood. It was explained that some of the underlying causes related to Covid-19 and increased antimicrobial prescribing practices which were being kept under review. The poor estate and operating environment also played a significant factor in increased infection levels as the ageing estate hampered the ability to clean effectively. However, the Trust had undergone an external infection prevention and control review towards the end of 2022, the outcome of which had been positive.

102/23 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee meeting on 11 April 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Core skills training report. The Trust had not met the 90% trajectory for core skills management training in five metrics or the 90% target for appraisals although had met the 80% overall interim target for medical devices training.
- The quality assurance report including the National Education and Training Survey and General Medical Council Training Survey results. It was noted that Health Education England would be visiting the Trust on 4 July 2023 to look at specific areas on both hospital sites.
- An update on Edovation was received.
- The annual Research Showcase evidenced the strong infrastructure and developments around research and highlighted a number of Trust staff who had received national and regional recognition for their work.
- Annual income and expenditure accounts (education and training). The Committee discussed the income and contracts and how things had moved forward with support from the Chief Finance Officer and both non-NHS and NHS funders. Discussions were also held regarding the difference in the reporting timescales for education and the NHS year-end deadlines and the need to ensure governance arrangements in this regard were robust.

Reference was made to the financial pressures on the Trust and the need to reduce costs and maximise income and clarification was requested on whether the Committee discussed the potential for increased income through research and education activity. It was explained that in terms of research, the Covid pandemic had changed everything for healthcare with focus redirected to research around Covid-19 therefore other studies had been paused. Having now re-commenced with normal business there were lots of studies coming through and whilst research was currently in deficit it was predicted a positive position would be seen over the next year. In terms of education, there were some issues around nurse training which involved seed set-up costs and the Committee was expecting to see finances move to a positive balance. The Chief Finance Officer referred to the Finance Strategy (Knowing the Business) and emphasised the importance of contributions from sources such as research and education income which was explicit in the strategy and some of those increases had been targeted this year. The Chief Nursing Officer advised that the challenge would be trying to manage finances from a Trust and education perspective and Universities were attempting to work in different ways to accommodate that. The longevity and funding for nursing qualifications tended to be provided in the shorter-term and that was felt to be a greater risk at the present time.

A question was raised regarding research and innovation and when looking to drive out opportunities for improvement whether there was any research where focus was directed to unlock opportunities in the medium to long-term. It was noted that research was focused in areas of strength although also had a regional and national reach. It was recognised that research studies would need to cover or exceed their overheads otherwise the activity would be undertaken at a loss. The Research team was mindful of the need to secure sufficient funding to cover those aspects and add to the Research

Strategy for the future. There was also awareness of the benefits of hospital research as there was evidence that safety benefits were better if patients were participating in research studies. Reference was also made to Edovation and the Board acknowledged that more could be undertaken in the field of commercial research which was high on the agenda and would help with the reputation of the Trust through use of Edovation as a research vehicle. It was also noted that the Deputy Director of Research and Innovation would in future be attending the monthly Divisional Improvement Forums with a dedicated item included on the agenda around research and innovation.

103/23 Workforce Committee Chair's report

The Chair's report from the Workforce Committee meeting on 9 May 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. In addition to the points raised earlier regarding the increase to the risk score (minute 100/23 refers), key highlights included:

- The workforce and organisational development performance report provided some positive points including a nil return for registered nurse vacancies. Save for the issues around maternity leave, there was good progress on recruiting registered nurses particularly through international recruitment. It was positive to note that 50% of international nurse recruits were now working independently.
- Health care assistant vacancy levels had improved having reduced several percentage points although there was more work to be done to improve overall vacancy levels for this cohort of staff.
- There was harmonisation of the agency rate card across the system which was welcomed in terms of avoiding movement of agency staff between different organisations through offers of higher pay.
- Review of the staff survey action plan. A key source of dissatisfaction for staff was the working environment and the amount of backlog maintenance which was increasing which was also reflected at the Finance and Performance Committee and remained a concern. However, the comments earlier in the meeting had been appreciated regarding plans to invest to improve the front door.
- Ongoing industrial action. It was recognised that the work undertaken with Staff Side to build positive relationships had been a key element in managing safe staffing levels during periods of industrial action.
- The employee services report was reviewed and it was noted the programmes being undertaken around centralisation of services would continue to be monitored by the Workforce Committee.

104/23 Freedom to Speak Up Annual Report 2022-23

The report provided an update on Freedom to Speak Up and whistleblowing activity, including responses to concerns raised and learning for 2022-23, and outlined priorities for 2023-24.

Attention was drawn to section 2(b) relating to whistleblowing activity with a number originating from the surgical division and clarification was requested on whether there was a particular problem in that area. It was explained there had been a series of concerns raised from one department and the series of interventions that had been introduced internally had not fully resolved the issues. Therefore, an external review had been commissioned where all individuals raising concerns would be interviewed to

articulate their concerns. It was expected the outcome report would be available in the next couple of weeks and appropriate recommendations would be adopted and improvement actions introduced.

Discussion was held regarding the open and honest culture within the organisation and whether there was balance and connection between equality, diversity, inclusion, culture and values meaning staff felt able to speak up and have more detailed conversations with their line manager without reverting to the Freedom to Speak Up Guardian. It was recognised that accessing the Freedom to Speak Up process could mean that local resolution has progressed as far as it could. It was right and proper that engagement between staff and line managers was used in the first instance to avoid a culture developing whereby colleagues were speaking up confidentially as they had nowhere else to go. It was recognised that there was always more that could be done and a meeting had been held with the Trust's Ethnicity Forum to celebrate International Nurses Day where discussions were held on the role those forums could play in delivering the strategies across the organisation. The Chief Nursing Officer confirmed that consideration would be given to whether anything further could be introduced.

The Board was reminded that there were Board-level Executive and Non-Executive Director Leads for Freedom to Speak Up and it was noted the Interim Chief People Officer had picked up the lead Executive role following the departure of the substantive Chief People Officer in May.

Attention was drawn to the third paragraph on page 2 where it was cited that of the staff who had responded to a request for feedback about the Freedom to Speak Up service, 91% reported that they would use the service again. Demographics of those staff who responded demonstrated a diverse range of staff positively comparable to the Trust population. In response to a question regarding whether those responding reflected the gender balance of staff and other characteristics described in appendix 2 to ensure one specific group was not showing a lower response, the Company Secretary confirmed the data would be reviewed and a response provided outside the meeting.

The Board RESOLVED that:

1. **the Mersey Internal Audit Agency report provided assurance relating to Freedom to Speak Up practices within the Trust including the introduction of e-learning programmes to support staff in speaking up, listening, and responding; and strengthening of governance arrangements in respect of triangulation and accountability.**
2. **learning and improvement resulting from speaking up including whistleblowing events be noted.**
3. **the experience of staff using the service be noted.**
4. **the priorities for 2023-24 outlined in the report be supported.**

105/23 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee meeting on 25 April 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- The Committee covered the operational performance on flow and access to services in the emergency department, financial information relating to Trust services, and

the transformation programme and key controls, all of which were standing items at every Committee meeting.

- The April meeting included year-end information and the Trust had landed on its financial deficit plan although some of the efficiencies were non-recurrent.
- The Committee looked at unwarranted variations relative to peer groups and a new programme of work on transformation would bring the Trust into parity with peers.
- The 2023-24 plans were reviewed particularly where significant challenges were faced in respect of finances and further assurance was being sought on the robustness of the plans.
- An update was received on the continuous improvement (CI) plan and the Trust continued to grow its CI capability with a range of programmes around incremental improvement, such as focus on the GEOFF initiative (streamlining process on admission and discharge).
- The Committee reviewed the risk appetite and tolerance and on balance agreed that the current arrangements remained appropriate. However, the position would continue to be reviewed throughout the year particularly when approaching the winter season.
- The Committee acknowledged the improvements on performance trajectories relating to six cancer tumour sites. Some external support around faster diagnosis of cancer had also been provided.
- The annual effectiveness review of the Committee's operational performance had been undertaken during the meeting and some areas for improvement had been identified which would feed into the wider Board effectiveness review.

The Chief Finance Officer noted that the financial improvement plan comprised two distinct sections – one relating to financial efficiencies; and the second relating to the reliance on partnership working particularly on urgent care pathways, which would need to be delivered as a system. Ultimately, as a Board, there would be a need to look at the plan as a whole bearing in mind the partnership work that would be required.

Reference was made to the month 1 financial position and it was noted the Trust had not achieved the target. Clarification was requested regarding whether the right financial controls and short-term plans were in place to drive predictable recovery. It was explained that the Trust reported on 23 May in terms of missing the target by circa £2m which included the industrial action in month although there may be a need for additional costs to be added during that period. The challenge was recognised, and the position would continue to be monitored through the Finance and Performance Committee. The Board acknowledged that April had been an exceptional month due to a range of factors and recognised the commitment to deliver the financial improvement plan over the next 11 months. Positively, the Trust was ahead in terms of its internal cost improvement programme when compared to previous years. In respect of the comment regarding controls, it was acknowledged that financial controls were stringent and the Trust was doing everything it possibly could and would continue to develop transformation and cost improvement. It was noted the financial improvement plan had only been signed off towards the end of May. Reference was made to the earlier point on the impact of industrial action and the Board noted that whilst needing to identify mitigation, strike action would add to the Trust's overall deficit position.

106/23 Integrated Performance Report as of 30 April 2023

The integrated performance report as of 30 April 2023 provided an overview of key performance indicators aligned to the Big Plan. Detailed scrutiny of the metrics aligned

to the four ambitions was undertaken by respective Committees of the Board. Key messages identified from the report included:

(a) ***Consistently Deliver Excellent Care*** – eradicating ambulance handover delays remained a high priority and a local improvement collaborative was in place. Positive work was being undertaken with Lancashire and South Cumbria NHS Foundation Trust (the local mental health provider) on admission avoidance with a coming together and co-location of the teams. A range of changes had been introduced to operational flow and services, including the Community Healthcare Hub, virtual wards, repurposing of some areas in the Emergency Department to create an Acute Assessment Unit, the creation of the new Williams Triage Unit in the Medical Assessment Unit at Chorley, and the revised Trust escalation plan. The improvements, together with the Urgent and Emergency Care Transformation Programme. were enabling withdrawal from escalated areas and the plans were on track for a second ward closure later in July all of which would help with financial and quality improvements. The Trust had been awarded capital for Medical and Surgical Assessment Units which would help with improving the patient pathway. In respect of urgent care, improvement work was ongoing and strong relationships were building around system working. Positive progress had been seen on cancer performance and the Trust had met new trajectories and diagnostic standards for month 1. It was positive to note that activity in respect of colorectal cancer had moved from the worst to the best. In respect of activity for patients waiting 65-weeks the Trust was on trajectory for month 1. For 78-week waiters there was a small number of patients scheduled for treatment in June who would be at risk of delayed treatment owing to the impact of ongoing industrial action. However, overall the backlog on the waiting list was starting to reduce.

With regard to safety and quality metrics, it was noted that pressure ulcers and *C.difficile* infection remained areas of concern and the position was being closely monitored by the Safety and Quality Committee.

(b) ***Great Place to Work*** – overall the Trust was now at a 0% vacancy rate for registered ward-based nursing. There continued to be some areas of over and under establishment whilst international nurses became fully competent and a reduction in registered nurse agency spend for vacancy cover should reduce further during the year as international nurses become fully competent. The health care support worker vacancy rate had also reduced during the month. The new ICS nursing agency rate card had been implemented in May and a de-escalation of the Emergency Department agency rate, both of which should start to see financial benefits and financial profiling was underway.

(c) ***Deliver Value for Money*** – the Trust was reporting a month 1 deficit position of £7.4m against a £5.1m deficit plan with the £2.3m variance attributable, in the main, to under-delivery of the cost improvement plan; the cost of supporting international nurses until fully competent; and a range of lost activity income due to the impact of strike action. An overview was provided of the capital and cash positions, cost improvement programme, and use of resources as outlined in the report.

Reference was made to the negative impact of strike action from a financial and performance perspective. Recognising the Trust attempted to mitigate as much as possible and manage competing demands on finance and performance, a question was raised regarding whether that challenge was recognised externally, as a system and nationally. It was noted that bodies such as NHS Providers and the NHS Confederation

continued to lobby strongly for HM Treasury to acknowledge the impact of strike action and the cumulative effect, such as preparation for strike action, the cost of staff acting up and down, and recalibrating the organisation following strikes. Trade bodies were also lobbying hard regarding the impact of the strikes. However, the view was about working with Trusts to ensure long-term delivery against performance and financial targets. Therefore, there was a need to gather the impact of the strikes to quantify the effect and relate that back to the Trust's overall finance and performance position. The challenge would escalate depending on the number of strikes through the summer into winter as a point would be reached where activity would not be recoverable. It was also noted the Trust was not in a unique position and all organisations were experiencing similar negative impacts. However, like-for-like comparison could not be made with other organisations as the Trust provided other tertiary services rather than solely general acute services. There were some mitigations in the financial mechanisms although the expectation was to hit the recovery plan.

The Board NOTED its assurance in respect of the actions being taken to improve performance.

107/23 Annual Plan 2023-24

The report summarised the Trust's annual planning processes for 2023-24 and presented the key elements within the 2023-24 Operational Plan for approval. An update was also provided on the enhanced oversight and monitoring arrangements.

An overview was provided of the process used to develop the plan and where the Trust expected to be on performance, workforce, and finance, strengthened risk management arrangements, and the internal governance process. The deficit plan had been agreed with the ICB and an ambitious target set to ensure best use of public money. The recovery plan post-pandemic was ambitious although challenging. Programmes were underway to improve services and enacting the plan would involve a significant amount of work for both the Trust and system.

It was noted that a significant amount of both the Annual Plan and the Financial Improvement Plan was contingent on system working and system-wide changes and a question was raised regarding whether a level of collaboration and cooperation was needed to deliver the plan. The Board was reminded that the ICB was a relatively new organisation with ultimate responsibility for financial balance therefore the Trust was working together with the ICB and broader partnership. There was a need to develop strategies at pace and work with the ICB to ensure realisation of the strategies, and urgent care pathways and pressures would need to be addressed in partnership.

Discussion was held regarding the multiple components and it was recognised to achieve the plan there was a need to reduce the prevalence of ill health in the community, reduce needless presentations at hospital, optimise performance, and discharge people back into the community or their place of residence. It was noted there were a range of national ambitions around primary, community and mental health services which it was suggested should be in the Fit for the Future ambition and consideration should be given to producing a suite of metrics. The Board would also be interested to understand how the plan would be sighted once all underpinning plans had come to fruition. It was agreed that the plan would be presented to the Board halfway through the year to show refinements, iterations and movement on the plan and would be scheduled on the December Board agenda.

The Board RESOLVED that the Annual Plan 2023-24 be approved.

108/23 Big Plan Metrics 2023-24

The report provided a reviewed and revised set of Big Plan metrics for 2023-24 for approval. It was noted that the existing Big Plan metrics had been set to cover the three-year period from 2021 to 2024 and the metrics were reviewed on an annual basis to take account of changing national policy, requirements, and local circumstances. As this was the last year of the three-year cycle, the next Big Plan metrics refresh would be a full review to set the next three years taking account of related key developments, such as the ICB forward plan and the development of Place, and the process would commence in September 2023.

It was noted the metrics were being tracked in appropriate forums and work was required to confirm some key deliverables this year, such as those relating to the New Hospitals Programme which would require input from the national NHP team. The metrics would develop and evolve in-year, similar to the Annual Plan, and following Board approval the information would be cascaded throughout the organisation. Work would then commence on the metrics for the three-year plan including opportunities versus uncertainties.

In response to a question regarding whether a look back exercise would be undertaken to show performance against the metrics at the end of the three-year period, it was confirmed that was part of the contents of the Annual Report and Accounts and Quality Accounts being produced. The refresh review in September would also include information on achievements over the last three years and in setting the metrics for this year Committees of the Board had reviewed the previous position and what had been achieved to date.

A lengthy discussion was held regarding refining the metrics to remove ambiguity, agree the approach and identify where system ownership was required, and lock down trajectories in the plan. A range of key metrics and immediate actions were proposed, and the Director of Strategy and Planning agreed to summarise the points from the discussion and circulate the information to Board members.

The Board RESOLVED that the final Big Plan metrics for 2023-24 be approved recognising the need to include additional key metrics and some additional information in the final plan.

109/23 Green Plan Update

The report provided a summary of progress against the Trust's three-year Green Plan approved by the Board on 3 February 2022. It was noted the update had been discussed at the Finance and Performance Committee meeting on 23 May 2023 during which a range of suggestions had been made to improve future updates which had been detailed in the report before the Board and would be actioned immediately or within the next annual update.

The Green Plan was part of the standard NHS Contract and there had been some changes nationally to what success would look like and broadening the Green agenda and once further information had been received the plan would be refreshed

accordingly. The Finance and Performance Committee had requested specific areas of the plan be reviewed and that information would be presented to the Committee once the work had been completed to ensure sharper focus on delivery of metrics and progress monitoring.

The Board commended the Trust on the positive progress that had been made around the Green agenda, given the context of the operational environment and additional pressures on the organisation.

The Board RECEIVED the report for information.

110/23 Engineering Better Care Update

The report provided an update on the work undertaken in the Engineering Better Care programme, which was the framework for delivering improvement at a system-level, from September 2022 to April 2023. The Director of Continuous Improvement and Transformation provided an overview of the contents for information.

The Board noted there was a large amount of Place-based activity and asked whether there was a danger of Place rather than the ICS driving that work. It was explained that system work was being co-designed by Place-based teams who worked together in the ICS therefore the work was happening in parallel. Place-based teams had been encouraged to deliver the plans they had in place in-year and there would then be a move to ensure system delivery.

The Chief Medical Officer observed that it was positive to see the unified approach and agreement across the ICS which was a significant step-change. There was a significant amount of enabling work to be undertaken before it would be possible to move to action. The Trust was moving into delivery stage and it would be useful to see the metrics that would be measured and clarity on what needed to be enacted through both the improvement and the operational approach as that differentiation had not been clear. It was acknowledged that some work must be delivered prior to winter outside of the more complex design and connections were being made with Primary Care Networks (PCNs) to ensure PCNs were undertaking what was needed to engineer the pathway correctly.

Clarification was requested on the definition of co-production rather than consultation. As an example, it was explained that Blackpool was working with Place teams and local Councils and engaging with local populations and staff in the system to design the work and fully understand the population and groups. In addition, there was good engagement with people attending local venues to ensure good representation of people using health and care services, and local demographics were being explored as it was recognised one size did not fit all. The ambition was to ensure gold standard co-production could be achieved.

Some general points were noted regarding delivering what was agreed in practice. Reference had been made during the presentation to this Trust linking into the Urgent and Emergency Care Programme Board and it was queried whether the same arrangement was in place for other organisations. It was explained that there was good practice with varying degrees of success and moving into test of change mode took time. There was a need to ensure it was not a distant programme and was connected into all organisations. In addition, the work of the Director of Continuous Improvement and Transformation was acknowledged particularly her contribution to the national

improvement strategy, which endorsed the methodology being used by the Trust. In response to reporting arrangements, it was noted that each Place-based team had reporting arrangements in place although further work was required to ensure a standardised approach. The ICB Chief Medical Officer would be updating the ICB Executive and actions to strengthen governance arrangements would be further explored.

The Board RESOLVED that:

1. **the report provided assurance of progress being made within the Engineering Better Care Programme and did not identify any areas that required strengthening.**
2. **the opportunities created by the launch of NHS Impact and further work to be undertaken to fully adopt NHS Impact and a programme of work developed for discussion in a Board Workshop be noted.**

111/23 Audit Committee Chair's Report

The Chair's report from the Audit Committee meeting on 20 April 2023 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- The annual internal audit plan had been completed in-year with positive assurance in a range of areas. There were some final audit reports providing high assurance at the end of the year.
- Positive assurance had also been received around the production of the annual accounts.
- Committee members had reviewed the accounts at a dedicated session with finance representatives and were confident everything was on track to meet the deadlines with delivery of the audited set of accounts.
- The only aspect of negative escalation related to the external auditors featuring financial sustainability in their risk assessment.

112/23 CQC Update

The report provided an update on progress against the Trust's Quality Improvement Plan (QIP) and the approach being taken to manage and deliver recommendations from previous inspections, an update on the forward plan for monitoring CQC recommendations, and the proposed merger of the outstanding recommendations in the 2018-19 QIP with the 2022 QIP. A high-level summary of the most recent regulatory updates to the Safety and Quality Committee had been included for information.

The Board was reminded of the CQC Inspection of the Emergency Department and Medicine which commenced on 31 May both of which had previously been rated as 'Requires Improvement'. The current inspection would be followed by a Well Led Inspection from 27 to 29 June. It was also anticipated that Maternity Services would be inspected as part of a wider programme of inspections by the CQC although timescales for that inspection had yet to be confirmed. The Chair would update the Board once feedback had been received from the CQC on the outcome of each inspection.

Reference was made to the action around theatre overruns and the dependency on the Theatre Management System. It was noted that historically there had been issues

around late starts in theatre and clarification was requested regarding whether the Theatre Management System would make the positive difference required. The Chief Operating Officer advised that the narrative was slightly misleading in terms of operational changes versus reporting and accurate data from system tools. It was explained that without the theatre system the Trust was reliant on manual paper-based systems therefore that was the link to reporting. The Theatre IT digital system would provide the ability to undertake sophisticated and intelligent scheduling to ensure the list was not overfilled.

The Board RESOLVED that the approach and arrangements in response to the CQC inspections provided assurance and the updates within the report be noted.

113/23 Items for information

The following report was received and noted for information:

(a) New Hospitals Programme (Q4) update

The Chair closed the meeting by thanking governors, members of the public and the press for attending the meeting.

114/23 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 3 August 2023 at 1.00pm using Microsoft Teams.

Signed: _____
Chair

Date: _____

Action log: Board of Directors (part I) – 1 June 2023

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	107/23	1 Jun 2023	*Annual Plan 2023-24* – the plan would be presented to the Board in six months to show refinements, iterations and movement on the plan.	Director of Strategy and Planning	7 Dec 2023	

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chair's Report			
Report to:	Board of Directors	**Date:**	3 August 2023
Report of:	Interim Chair of the Trust	**Prepared by:**	Professor Paul O'Neill
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide a summary of work and activities undertaken during June and July by the Interim Chair.

It is recommended that the Board receives the report and notes the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

None

Chair's Report

I am delighted to welcome Pete White as our new chair and, as Kevin describes in his report to Board, Pete will bring wide experience to the Trust and, I am sure, he will be an outstanding leader and I look forward to working closely with him. In our conversations so far, it is clear that we share a common purpose of providing the best health care to our communities

This means that this will be my last chair's report and it seems appropriate to reflect on the last 12 months and longer. It has been a challenging year for us with the winter, performance and now financial pressures. During all of this, the Board and senior management teams have worked well together and I am grateful for the support I have received from colleagues, particularly board and council members.

It has been a privilege to visit departments, services and clinical areas; staff are our (and the NHS) greatest asset, we must protect them as I sense increasing weariness and dissatisfaction in the NHS with strikes as a manifestation of these. Despite this national mood, it is noteworthy that our staff satisfaction survey results have improved and we must continue to focus on our staff as they do the work.

I started work in the NHS in 1979 and it has always been about change, but this is increasing. Given this context, the future is not simply about the new hospital programme and integrated care systems, it is about improving things through education and research and we must lead on this for the ICS.

As examples of improving care, when I started as a house officer 44yrs ago, patients with heart attacks were confined to bed for 6 weeks, there were no treatments for acute stroke, no brain imaging and stomach ulcers were treated by surgery. The treatment of all of these have been revolutionised by research.

Education of medical students was dominated by lectures and highly specialised teaching hospital attachments. There was no teaching of communication skills or ED&I and little primary care experience. Elderly care did not exist as a speciality; doctors were predominantly male and paternalistic in approach. There were no common standards for curricula, examinations and qualifying as a doctor.

This is why we should have a common vision of our new hospital being a health care campus acting as a beacon for the highest quality of care, research and education. We must lead this health care for the future.

In the final part of my report, I want to pay tribute both personally and on behalf of the board to Kevin for leading us in the last 2 years as Chief Executive Officer. He has been an outstanding CEO both internally and also within the developing ICS and PCB. He has combined an emphasis on staff and leading and developing the executive team with a strong focus on improving our performance, particularly during the very testing time last winter. He has always been clear that whatever the pressures, he will not compromise on patient safety and this is evident during our challenging discussions on our financial improvement plan.

He has achieved so much for the Trust in a short time, such as our Covid vaccination programme, the Nightingale Unit, Elective Care Centre at Chorley and, importantly, the new hospital that is crucial to the healthcare for our local population and a tertiary centre for the ICS populations.

I want to thank him personally for all his support, Kevin is a person of huge integrity and a good person and we wish him well in his new challenge in Gibraltar

Introduction

The purpose of this report is to provide an overview of the work and activities undertaken from 1 June to date.

1. Chair's attendance at meetings

a. Details below are the meetings attended and activities undertaken during June and July 2023.

Date	Activity
June 2023	
1 June	Board of Directors – Part 1 and Part 2
12 June	Board Feedback Session
13 June	NW System Leaders Call

	Education, Training and Research Committee
	Board Development Discussion
19 June	NED Catch Up Meeting
	1:1 – Non Executive Director
	1:1 – Chief Executive
20 June	Patient Experience Discussion
21 June	Introductory Meeting – Executive Director
	Chair Visit – Emergency Department, Royal Preston Hospital
	Provider Collaboration Board Meeting
22 June	Council Training Session
	Appraisal – Chief Executive
23 June	1:1 – Associate Non Executive Director
	CQC Prep
	1:1 – Executive Director
July 2023	
3 July	AAC Panel Interviews
	ARTE Committee
	Special Board – Part 2
4 July	1:1 – Company Secretary
5 July	1:1 – Non Executive Director
6 July	CQC Focus Group
	Agenda Setting – Board of Directors
	CQC Interview - Chair
	CQC Interview – Non Executive Directors and Chair
10 July	Non Executive Directors Catch Up
	1:1 – Company Secretary
17 July	1:1 – Executive Director
18 July	Provider Chairs Meeting
	2:1 – Non Executive Directors
19 July	1:1 – Executive Director
20 July	Provider Chair Pre Meet

	Provider Collaboration Board Meeting
	1:1 – Non Executive Director
24 July	ARTE Committee
	1:1 – Executive Director
	Education, Training and Research Agenda Setting
25 July	Council of Governors – Public Meeting
	Finance and Performance Committee
27 July	NHP Strategic Oversight Group
28 July	Safety and Quality Committee

2. Non-Executive Director Update

a. The chair meets regularly with the Non-Executive Directors on site to discuss a wide range of issues and challenges for the Trust and ICS as well as participating in structured visits to departments and clinical services.

b. We will be appointing a new non-executive director in the near future.

3. Financial implications

a. There are no financial implications associated with the recommendations in this report.

4. Legal implications

a. There are no legal implications associated with the recommendations in this report.

5. Risks

a. There are no risks associated with the recommendations in this report.

6. Impact on stakeholders

a. There is no impact on stakeholders associated with the recommendations in this report.

7. Recommendations

It is recommended that the Board received the report and notes the contents for information.

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	3 August 2023
Report of:	Chief Executive	**Prepared by:**	Naomi Duggan, Director of Communications and Engagement
Part I	✓	**Part II**	

Purpose of Report							
For approval	☐	**For noting**	☐	**For discussion**	☐	**For information**	☒

Executive Summary:

The Chief Executive's report provides an update to the Trust Board on key national, regional and local developments with a view to setting the context for the strategic and operational priorities for the Trust.

The Board is requested to receive the report and note its contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Not applicable

CHIEF EXECUTIVE'S REPORT

1. INTRODUCTION

a. The purpose of this report is to update the Trust Board on key national, regional and local developments with a view to setting the context for the strategic and operational priorities for the Trust.

2. UNDERSTANDING THE NATIONAL CONTEXT AND EXTERNAL ENVIRONMENT

a. National Headlines

i. Further strikes for NHS consultants and Junior Doctors

NHS consultants in England have announced a further two days of industrial action on 24th and 25th August 2023. This follows 48-hours of industrial action on 20th and 21st July which resulted in 65,557 rescheduled appointments and procedures nationally. The British Medical Association says consultants' take-home pay has fallen by 35% since 2008-09 and that the government must make an offer that addresses their pay erosion. It also wants a commitment to reform the pay review system and restore its independence from government.

The July Consultants' strike followed a five day strike by Junior Doctors which saw 101,977 cancellations of acute inpatient and outpatient appointments . At the peak of the action, there were 20,342 staff not at work due to industrial action. In the previous action by junior doctors over three days there were 106,120 cancellations. No new dates have yet been announced for industrial action by Junior Doctors.

The cumulative total of acute inpatient and outpatient appointments cancelled in eight months of industrial action now stands at 698,813.

ii. Progress on reducing longest waits continues

New data shows NHS staff are continuing to make significant progress in reducing the longest waits for treatment with 18 month waits down to 7,363 as of 2 July – a reduction of a third since April (10,979.)

More diagnostic tests and checks were delivered for patients than in any May on record (2,187,933), up more than 13% on pre-pandemic (1,929,255 in May 2019), with the average diagnostic waiting time reduced to three weeks.

In May, NHS staff carried out almost a quarter of a million checks for suspected cancer (245,595), up 13% on the month before (218,060) meaning in the last year around 2.9 million (2,893,037) people have now been checked for cancer. The number of patients starting cancer treatment is up almost a fifth on the month before to 28,453.

iii. Significant A&E demand continues for NHS amid increasing strike pressure

The hottest June on record saw heightened demand for urgent and emergency services, as staff nationally managed more A&E attendances and saw the second highest number of the most serious ambulance incidents (category 1) for any June.

Ambulance response times across all categories have seen improvements on last year, with paramedics reaching category 2 patients an average of 15 minutes faster than in June 2022. A&E four-hour performance has also improved compared to last year (73.3% vs 72.1%).

Local NHS teams continue to work to boost capacity and relieve pressure in line with the urgent and emergency care recovery plan launched earlier this year with thousands more beds, hundreds of new ambulances, and measures to better care for patients at home and in the community.

iv. NHS Celebrates 75th Birthday

On 5th July 2023, the NHS celebrated its 75th Birthday by showcasing its excellence from across the country. When it was founded in 1948, the NHS was the first universal health system to be available to all, free at the point of delivery. Today, nine in 10 people agree that healthcare should be free of charge, more than four in five agree that care should be available to everyone, and that the NHS makes them most proud to be British.

The NHS has delivered huge medical advances, including the world's first liver, heart and lung transplant in 1987, pioneering new treatments, such as bionic eyes and, in more recent times, the world's first rapid whole genome sequencing service for seriously ill babies and children.

The NHS is committed to transforming services, delivering for patients and better understanding the local population it serves. Through modernising outpatient services, rolling out new proactive and preventative models of care, and creating a sustainable system for the future, 'we' will ensure the NHS continues to be the healthcare envy of the world.

v. Report shows importance of tech on health at home

An NHS Assembly report has shown the importance of tech in helping people look after their health at home. According to the report, amid a post-pandemic drive to help people stay well, greater use of technology will put power into the hands of patients. The NHS Assembly consulted staff, patient groups, carers, charities, and partners in health and social care for the report launched ahead of the 75th anniversary of the NHS.

Analysis found that the NHS should focus on three key areas: preventing poor health, creating more personalised care that better responds to patients views and coordinated care closer to home, including by strengthening general practice. Integrated Care Systems (ICSs) allow the NHS to work with other bodies to find people at risk of conditions such as heart disease and tackle major causes of poor heath including obesity and smoking. ICS' should also use new technology to help people manage their health so they can monitor their conditions, receive advice remotely through virtual wards and make appointments or change prescriptions via the NHS App.

vi. NHS shingles vaccine will be offered to almost one million more people

Almost a million more people (900,000) will become eligible for a shingles vaccination from September, the NHS announced today.

Anyone who is severely immunosuppressed and over 50 will be able to get two doses of the Shingrix vaccine – currently the vaccine is only available to those over 70.

From 1 September 2023, those turning 65 and 70 will also be able to get the vaccine after their birthday, in addition to those already aged 70-80. Patients will be contacted by their GP practice when they become eligible.

Eligibility will then be expanded to include those 60 and up by September 2033.

vii. New Alzheimer's drug donanemab slows disease trial shows

Alzheimer's Research UK have confirmed that 'promising preliminary results from a trial of the Alzheimer's drug donanemab, first announced in May, have now been confirmed'. Although not a cure, the new drug is being seen as a turning point in the fight against Alzheimer's, after the global trial confirms it slows cognitive decline.

The antibody medicine helps in the early stages of the disease by clearing a protein that builds up in the brains of people with this type of dementia. The findings did, however, confirm the drug's side effects can be serious and require careful monitoring.

viii. NHS virtual ward expansion will see thousands of children treated at home

Tens of thousands of children will be able to receive hospital-level care at home thanks to an expansion of virtual wards.

The hospital at home service – already the largest of its kind in the world – will expand to cover children in every region of England from this month after successfully treating more than 6,400 children over the last year.

NHS chief executive Amanda Pritchard said the world-leading NHS virtual wards programme has "provided peace of mind" to parents who have used them during trials, including in Blackpool, Dudley and Dorset.

The services will treat a range of conditions like respiratory illness, such as asthma, and heart conditions, allowing kids to get the care they need from the comfort of their homes.

ix. Record recruitment and reform to boost patient care under first NHS Long Term Workforce Plan

Record numbers of doctors, nurses, dentists and other healthcare staff will be trained in England as part of the first ever Long Term Workforce Plan published by the NHS and backed by the Government in July.

Coming ahead of the health service's 75th anniversary, the NHS Long Term Workforce Plan sets out how the NHS will address existing vacancies and meet the challenges of a growing and ageing population by recruiting and retaining hundreds of thousands more staff over 15 years and working in new ways.

The NHS plan, a once in a generation opportunity to put staffing on a sustainable footing and improve patient care, focusses on retaining existing talent and making the best use of new technology alongside the biggest recruitment drive in health service history to address the gap.

It was commissioned and accepted by the Government, which has backed the plan with over £2.4 billion to fund additional education and training places over five years on top of existing funding commitments.

x. Reasons for hospital departure delays revealed

Hundreds of patients are taking up hospital beds across England every day despite being ready to leave, according to NHS data. Figures show the biggest obstacle to speedy discharge is lack of beds in other settings, such as care homes. Other reasons include hold-ups in sorting transport, medicines and paperwork. The government said it wanted to "ensure patients leave hospital as soon as they are medically fit". It is the first-time data has been published which breaks down the reasons for discharge delays.

The figures showed that, among patients in England in June who had been in hospital at least 14 days, an average of 1,791 a day were unable to be discharged due the lack of a bed in a residential or nursing home while 1,727 a day were waiting for a rehabilitation bed in a community hospital or a similar setting.

3. INFLUENCING THE LOCAL HEALTH AND SOCIAL CARE ECONOMY

a. Lancashire and South Cumbria Headlines

i. Chief Executive, Kevin McGee, is the lead for the Hospital Cell and Chief Executive for the Provider Collaborative. The list below highlight's Kevin's meetings in June and July 2023.

Date / Frequency	Meeting
Monthly – Monday	Central Lancashire Senior Leadership Team
Monthly - Wednesday	Formal Chairs and Chief Executive's Meeting
Monthly - Wednesday	Formal LSC Chief Executives Briefing
Monthly - Wednesday	North West Regional Leadership Group
Fortnightly - Monday	Lancashire & South Cumbria Joint Cell
Fortnightly - Wednesday	Optimising Urgent and Long Term Pathways Workshop
Weekly – Monday	North West Hospital Cell Gold Command Escalation
Weekly – Tuesday	David Flory, Independent Chair, (LSC) Integrated Care Board
Weekly - Wednesday	Executive Team Meeting
June 2023	
1 June	Board of Directors Public and Private Meeting
2 June	ED Safety Forum
5 June	1:1 – UHMB CEO
	1:1 – ICS CEO
6 June	Ethnicity Ambassador Forum
	Transformation and Recovery Board
7 June	Welcome Intro for Core20plus5 Accelerator Sites
	VoCL Meeting with LTHTR Executive Team and Clinical Directors
	Meeting with Provider CEOs regarding recovery programmes
8 June	Provider Chair and CEO session re Recovery Programme Governance Structure
9 June	PCB Coordination Group Meeting
	New Hospitals Programme Meeting
12 June	New Hospitals Programme Meeting
	Clinical Strategy Meeting
	Board Feedback Session – Maternity and Neonatal Services

13 June	Provider Collaborative Meeting
	NHS ConfedExpo 2023
14 June	NHS ConfedExpo 2023
15 June	NHS ConfedExpo 2023
16 June	1:1 – ICS Chair
19 June	Executive Team Catch Up
	1:1 – Interim Chair
20 June	Health Day for Learning Disabilities – Chorley & South Ribble Hospital
	Filming – International Nurses Event
	Workstream Stock Take – Shared Bank and Agency
21 June	Extraordinary ICB Board Meeting
	ICB Board Development Session
	Provider Collaboration Board Meeting
22 June	CEO Visit – Fr Neil Kelley – St Laurence's Church, Chorley
	CQC Well Led Prep Meeting
23 June	Meeting regarding Neuro beds
	Catch up meeting regarding Pathology
26 June	CQC Presentation Prep
27 June	CQC Well Led
	Board of Directors – part 2 meeting
28 June	1:1 – ICS Chair
	Call regarding Chief People Officer Role
	Tier 1 Meeting
29 June	ITV Interview – NHS75
	CQC Interview – CEO
	CQC High Level Feedback Session
30 June	L&SC Pathology Service Board
	The Health Academy Education Awards
July 2023	
3 July	1:1 – UHMB CEO
	NHS Long Term Workforce Plan
	Meeting with Secretary of State
4 July	Convenzis Event – The Patient Flow Conference
5 July	L&SC ICB Board Meeting – part 1 and part 2
6 July	NHP Catch Up
	1:1 – ICB Chair
	1:1 – Pathology Lead
17 July	MSAC Meeting
	Pre Meet – Expressions of Interest
	Expression of Interest Meeting
	Surgical Hub Strategic Intentions and Plan
	Pathology Investment Meeting
18 July	1:1 – ICS Chair
	x3 Media Interviews
	Research and Innovation Catch Up
19 July	Central Lancashire Executive Oversight Group Meeting
	FSD Level 3 Reaccreditation Interview
20 July	Provider Collaboration Board
	Media Interview
	Patient Experience Meeting
	CQC Update Meeting
21 July	1:1 – Pathology Lead
	1:1 – PCB Director
24 July	Digital and Data Strategy Interview – Provider Collaborative

	1:1 – Chair of Patient Voices
25 July	Nominations Committee
	1:1 – ICS Chair
	Council of Governors Part 1 and 2
	1:1 – UHMB Chair
	ICB trust partner member event
26 July	UEC Strategic Redesign and Improvement Programme
	Ethnicity Ambassador Forum
27 July	LTHTR/Beamtree Steering Group
	JNCC Meeting
	NHP Strategic Oversight Group
28 July	Welcome Event – Vinrod Bawak
	1:1 – UHMB CEO
	Long Service Celebration Event
31 July	Monthly Executive Q&A Session
	Interview on the National Strategy

ii. Personal news about my retirement from the NHS

I have recently announced that I will be retiring from the NHS after 38 years of service, so this will be my last Board meeting. This has been a very difficult decision as I have thoroughly enjoyed my time at the Trust and indeed all the roles that I have undertaken, and there is never a perfect time to move on either personally or professionally. However, at age 62, I have been considering when the right time would be for a little while and having now had confirmation that we are to receive the funding for a brand new hospital on a new site as part of the New Hospitals Programme, it feels like the right time to hand over to someone who can see this through to fruition. Health Care is a life long passion so I am pleased that when I leave the Trust at the end of September to take up the role of Director General for Health Care for the Gibraltar Health Authority, I will still be able to make a difference to people's health outcomes with the added advantage of some sunshine!

I would just like to take a moment to thank all my fellow Board members, staff, governors, partners and our communities for their support since I joined the Trust and to wish you all well for the future.

The post of Chief Executive Officer will now be advertised and go through a competitive process with interviews scheduled to take place in September 2023. Lancashire Teaching Hospitals is a fantastic Trust with a bright future and I am sure this will be much sought after position.

An internal process to agree interim arrangements is underway.

iii. New Chair appointed to Lancashire Teaching Hospitals

I am delighted to confirm that Peter White has been appointed as our new Chair of the Trust Board. He is currently Chair of North West Ambulance Service (NWAS), will be taking up his new position with effect from 1 August 2023.

Peter brings with him a breadth of experience having held senior roles with Lancashire Police during a career spanning over thirty years culminating in the role of Assistant Chief Constable before he retired. He has also held a number of non-Executive roles including that of Deputy Chair for a community interest company delivering social care,

before joining NWAS in 2014 as a Non-Executive Director and becoming Chair in February 2019.

Peter will be retaining his role as Chair at NWAS alongside his new responsibilities until his term ends in January 2025.

Peter has an excellent track record of improving performance within the NHS and the synergy with his current role at NWAS will be a huge benefit to our Trust. His appointment was unanimous and the Board are looking forward to working with him.

I would like to take a moment to acknowledge the significant contribution of Professor Paul O'Neill who has fulfilled the role of Interim Chair since Professor Ebrahim Adia left the Trust in September 2022. I am delighted that once Peter is in post, Paul will be taking up his previous role as a Non-Executive Director and Vice Chair.

Talking about his appointment, Peter said: "I am delighted to have been appointed as Chair for Lancashire Teaching Hospitals NHS Foundation Trust and I look forward to working with the Board of Directors and Council of Governors to help deliver the excellence in health care that our communities rightly deserve. As a long-time resident of the area covered by the Trust, I, my family, and friends have relied upon the care and treatment provided by the staff at the Trust - this role for me is therefore a very personal one and it is a great privilege to serve in this way.

"I have been a Non-Executive at North West Ambulance Service for nearly 10 years and have seen the great work that NWAS staff do day in day out for the communities we serve. It has been, and continues to be, a source of great personal pride to work with NWAS and I look forward to the developments in system wide urgent and emergency care that will help ensure we are with patients when they need us most."

iv. Provider Collaboration Board – 20 July 2023

The Provider Collaboration Board (PCB) met on 20 July 2023. As this was a day of Industrial Action by Consultants the meeting was kept brief. It received updates on the following standing items: system pressures and performance updates within urgent/emergency care and elective care; mental health and learning disabilities, and finances.

Performance management continues to be the responsibility of Trust Boards, with the PCB using performance data to inform wider strategic discussions on system transformation.

The Joint Committee has been established to give the PCB a mechanism via which to make decisions on key programmes of work as agreed with Trust Boards. Updates on central services, clinical services and progress on Elective Recovery were discussed under Joint Committee working items. An item on Developing Provider Led Population Health Management was deferred.

You can view the full report in Appendix I.

You can also view the latest edition of the One LSC Newsletter here.

v. Integrated Care Board, Chief Executive's Report – 5th July

The Integrated Care Board's Chief Executive, Kevin Lavery, provided his report to Board on 5th July which provides an opportunity to reflect on a year since the establishment of the ICB, focusing on the importance of strong leadership that will be required to lead the organisation through a challenging recovery and transformation programme.

A key part of ensuring the ICB's success is to achieve the right balance between what happens at place and what happens across the system, and the report introduces the proposal for a place integration deal and the opportunities that are opened up by delegating to our places. The report also provides an update on the Integrated Care Strategy and specialised commissioning.

The report is available on the ICB website and also available in Appendix II.

vi. Care Quality Commission (CQC) Inspections

a) Unannounced Inspections

The CQC carried out an unannounced visit to Royal Preston Hospital beginning 31 May which focused on the emergency department and medical pathways. As part of each of the inspections the CQC met with leaders in the medical and emergency department and focus groups were held with staff. The CQC also requested significant numbers of supporting documents. A further unannounced inspection of the emergency department at Chorley took place on 26th June.

The initial high-level feedback noted many positives, such as the welcoming and transparent attitudes of staff, caring interactions with patients, good team working, and positive collaboration with mental health colleagues. However, the assessment and management of risk relating to mental health and the environment within the acute assessment unit at RPH was an area of concern identified as requiring additional assurance. The CQC have been provided with assurances on this topic, which is an identified risk within the Emergency Department and medical division, and we will continue to monitor this area.

In a small number of areas the CQC identified that they observed inconsistent hand hygiene practices and routine equipment checks, as these fall within the "brilliant basics" that we want to get right every time. An intensive communications campaign has subsequently been launched with a particular emphasis on bare below the elbows and we are asking our teams to role model exemplary practice in this area.

A further unannounced inspection, this time focusing on our Surgery services at Royal Preston took place on 12 and 13 June. Once again, we have received very encouraging verbal feedback from the team of inspectors including references to our positive culture, well led services and caring and compassionate staff.

b. Well Led Review

The planned CQC Well Led review took place 27th - 29th June. This was an assessment of leadership at all levels of the organisation which involved interviews, focus groups and a review of data and information. We had a feedback meeting with inspectors on 14 July.

They noted that we had a transparent, innovative and positive culture which was reflected by staff at all levels as well as in the staff survey results where the trust scored above the benchmark for all nine people promise elements. Inspectors witnessed a strong commitment to quality improvement methodology with continuous improvement starting to flourish and embed across the organisation with evidence of positive outcomes.

They found that the board worked well together and were focused on safety, quality and staff, directors were more outward facing and partnerships were beginning to be embedded and strengthened with the ICS and other national work programmes. There was recognition of the need to strengthen effective working with the Council of Governors. A plan to do this was discussed with the Council of Governors meeting on 25 July 2023.

It was noted and acknowledged by the Trust that the ethnic diversity of the board is not representative of the staff as a whole or the local population. This is an issue that we continue to seek to address during our recruitment processes and a number of other actions including close working relationships with our Ethnic and Minority Ambassador Forum, reverse mentoring programme and shadow Board programmes, however we will continue to seek to address this.

Our finance and performance challenges around elective recovery were recognised and further clarity was sought on how the financial plan would be delivered.

Inspectors found appropriate arrangements were in place relating to the identification, recording, and management of risks, but felt the articulation of these could have been more clearly articulated through the organisation.

The three never events reported, relating to oxygen and airports were identified as an opportunity for further learning across the organisation.

Finally, the CQC, understood recruitment to the chair position was underway and will be kept informed of the process for recruiting the new CEO and interim arrangements.

c. Review of Maternity Services

The CQC carried out an inspection of the Trust's Maternity Service across both Royal Preston and Chorley and South Ribble Hospitals on 3 and 4 July 2023. This is part of a national maternity inspection programme the CQC are undertaking to provide an up-to-date view of the quality of hospital maternity care across the country, and to gain a better understanding of what is working well to support learning and improvement at a local and national level. You can read more about this work on the CQC website.

We are currently undergoing the review process for this inspection and a more detailed update will be provided to the next Board meeting.

This has been a very intense period of visits, interviews and data collection and I would like to thank all colleagues, governors and board members for their input during the backdrop of ongoing Industrial Action and ongoing pressures. There has been much to be proud of in the feedback so far, and we are already acting on identified areas of concern to date. The written CQC reports will provide a more detailed understanding of the inspector's findings. Following receipt of these a comprehensive action plan will be developed and monitored by our Safety and Quality Committee and reported to Board. The final reports are expected between August and September 2023.

VII. Sexual safety of NHS staff and patients

On 23rd June, Steve Russell, Chief Delivery Officer, NHS England wrote to all Trusts and Integrated Care Boards in relation to the sexual safety of staff and patients, outlining a range of initiatives that are taking place to ensure that the NHS has a zero tolerance approach to sexual misconduct, violence, harassment or abuse and is a place of safety, offering a safe space for victims of abuse to seek support. As part of this work, Chief Executives have been asked to nominate an Executive to lead this work on domestic violence and abuse both internally and with the Integrated Care Board (ICB) and I can confirm that for our Trust this is Sarah Cullen, Chief Nursing Officer. As part of this work, we will be reviewing our policies, data collection, reporting and analysis and will of course continue to support any staff and patients who experience such crimes in the course of contact with our

Trust. This will be managed through the Safeguarding portfolio and actions contained within this will be reported through the Safeguarding Board and through to the Safety and Quality Committee

The letter can be viewed in full here. We take this matter extremely seriously within our Trust and would urge any member of the public who experiences any incidence of this nature at one of our facilities to report this immediately to the ward or department manager or our Patient Advice and Liaison service PALS@LTHTR.nhs.uk so that appropriate action can be taken and support put in place as quickly as possible. In the case of staff, concerns should also be reported immediately to managers, or if they wish for confidentiality via our Freedom to Speak up channels which are regularly publicised.

VIII. Local NHS welcomes government announcement of national funding, paving the way for new hospital facilities in Lancashire and South Cumbria

On 25 May 2023, the Government announced a record investment of more than £20 billion, ring-fenced for the next phase of the national New Hospital Programme, which brings proposals for new cutting-edge hospital facilities for Lancashire and South Cumbria a step closer.

In September 2022, the NHS in Lancashire and South Cumbria stated its preference for new hospitals on new sites for both Royal Preston Hospital and Royal Lancaster Infirmary as part of the New Hospitals Programme, alongside alternative partial rebuild options. This followed a comprehensive assessment for deliverability, affordability, value for money, and viability, considering feedback from thousands of patients, local people and staff.

Following the statement to the House of Commons from the Secretary of State for Health and Social Care, the local NHS welcomed the announcement of two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary as part of a rolling programme of national investment in capital infrastructure beyond 2030. This will also include investment in improvements to Furness General Hospital. Read more on the New Hospitals Programme website.

IX. Pill-sized cameras set to help cut patient waiting lists

Cameras that people can swallow to check for bowel cancer are now being trialled in Lancashire as part of a national pilot.

The new colon capsule endoscopy (CCE) features an easy-to-swallow pill with two cameras inside that provide clear images to help clinicians detect polyps (small growths that can progress to bowel cancer) and determine if a colonoscopy is necessary.

Traditional colonoscopies involve inserting a tube into the patient's large intestine, which can be an invasive procedure.

The PillCam capsule is the size of a large vitamin pill. Once the patient has taken the capsule and has the receiver in place to capture the images, they are free to go home. The camera takes thousands of pictures as it travels along the patient's gut, which takes about eight hours. Read the full story on the ICB website.

X. New partnership deal puts NHS decision-making at the heart of communities

The NHS in Lancashire and South Cumbria has announced plans to delegate decision-making down to the four 'place-based partnerships', which will improve outcomes for patients and help tackle health inequalities across the region.

The Place Integration Deal – announced at the Lancashire and South Cumbria Integrated Care Board (ICB) July formal business meeting – moves resources and decision-making closer to our local communities, and recognises the critical role of all organisations that support people to live healthier lives.

The partnerships cover Blackburn with Darwen, Blackpool, Lancashire and South Cumbria, largely aligning with the region's four upper-tier councils to boost integration between health and wellbeing services, local authorities, Voluntary, Community, Faith and Social Enterprise (VCFSE) and partners in each of the places.

The ICB, which has responsibility for NHS spend and performance, set out its aim to delegate services such as general practice, community pharmacy, dental services and eye health, as well as a range of community-based services like district nursing, occupational therapy, and bed-based community rehabilitation, to all four partnerships in the future, giving communities in each area greater involvement in decision-making and planning.

XI. New dads can download DadPad for advice and support

Dads-to-be in Lancashire and South Cumbria are set to benefit from the DadPad app - an easy-to-use resource, developed with the NHS to provide support and guidance.

The DadPad app is a useful resource before baby arrives and after baby is born, and is designed to be used as a quick, on-the-go reference tool, allowing new dads to enjoy their babies and feel more confident about fatherhood.

Written by health professionals, DadPad is already up and running in other areas of the UK, and each area has content edited and amended to be bespoke to local needs, including details of nearby support groups and services.

Read more on the ICB website.

XII. New campaign encourages young people to speak about mental health worries

NHS Lancashire and South Cumbria Integrated Care Board (ICB) has launched a new campaign aimed specifically at 11 to 18-year-olds.

The campaign, which will mainly been seen on Snapchat, TikTok and Instagram, encourages young people who may be feeling anxious about school or exams, finding it hard to fit in, or having negative thoughts about how they look, to find help and support on the Healthy Young Minds website.

This website was developed as part of a redesign of children's mental health services – creating a one-stop shop for emotional and mental wellbeing support resources. It was co-produced by children and young people, parents and carers, and health and care organisations across Lancashire and South Cumbria. Read more on the ICB website.

XIII. The NHS Smokefree Pledge

I am pleased to confirm that with effect from today's Board meeting, the Trust has signed up to the NHS Smokefree Pledge which acknowledges the harm caused by smoking and gives a series of commitments in support of a smoke free future.

You can read the attached Pledge at Appendix III.

4.

Consistently deliver excellent care

a) Royal Preston Renal Team nominated as NHS Heroes

The Royal Preston Hospital's renal team were nominated as #NHSHeroes by kidney patient Fez Awan, for Kidney Research UK as part of the NHS 75 celebrations.

Patient volunteers were invited to nominate members of NHS staff who've made a difference to them, and Fez, a fantastic and dedicated volunteer for Kidney Research UK, nominated the entire team and explained why he wanted to highlight the work of so many brilliant NHS England staff:

"These teams have changed my life. I'm a human being to them, and no words I can fully express can ever really be a big enough thank you. I understand this is many people from two main hospitals but if these teams, at the right times, did not do all they could for me, I genuinely may not be here today."

b) Lancashire Teaching Hospitals earns NHS Pastoral Care Quality Award

The Trust has been awarded the NHS Pastoral Care Quality Award, recognising the quality and delivery of pastoral care for internationally educated nurses and midwives.

Launched in March 2022, the award scheme is also an opportunity for Trusts to recognise their work in international recruitment and demonstrate their commitment to staff wellbeing both to potential, and existing employees.

Once Trusts have achieved the award, it demonstrates a commitment to supporting internationally educated nurses and midwives at every stage of their recruitment and beyond.

The NHS has always benefited from overseas recruitment, since the outset of the service, coinciding with the arrival of the Windrush generation, and recruitment from outside the UK continues to feature as an important part of the workforce supply strategy of NHS organisations, in line with the NHS People Plan. You can read more here.

c) Consultant Nephrologist helping educate and train around developing world

A former International Society of Nephrology (ISN) fellow, Aimun Ahmed – a Consultant Nephrologist with Lancashire Teaching Hospitals – has been helping to educate and train on kidney disease in developing countries across the world, in his role as an ISN Renal Ambassador. One of the ISN's aims is to promote nephrology and kidney disease in developing countries, by training young nephrologists or sending experts out to educate, teach and exchange experiences, and Dr Ahmed has visited Egypt, Bosnia and Herzegovina, Kazakhstan and Uzbekistan.

The society also allows sponsored fellows to come to well-known centres for excellence around the world – of which Royal Preston Hospital is one – to be trained, before returning to their countries to apply the knowledge they have gained. Delegates from around 48 different countries have been to Preston on international courses in renal, like the kidney biopsy course and the peritoneal dialysis catheter insertion course, with fellows from approximately 15 nations also coming here to train and observe, spending time in Preston for up to one year.

Dr Ahmed is the lead for these international links, with a place on the UK Renal Association International Committee. You can read more here.

d) Lancashire Teaching Hospitals Charity secures one of 600 LEGO MRI scanners to help children prepare for scans

Thanks to a successful application from Lancashire Teaching Hospitals Charity, the amazing patients and staff of Ward 8 at Royal Preston Hospital are among 600 lucky recipients worldwide of a special LEGO MRI scanner.

The charity submitted an application to receive one of the sets, designed to help children cope with MRI scans, and make them less scary.

A team at Odense University Hospital and volunteer LEGO employees teamed up to make MRIs more playful and less stressful, designing a LEGO brick model of an MRI scanner, in the hope that by playing with it before their scans, guided by hospital staff, children get a feel for the room they'll be in and the machine they'll face.

And, by putting a LEGO minifigure through the model scanner first, children can take control and learn what to expect at the same time. You can read more here.

5. A great place to work

a) NHS75 celebrations

As part of the NHS' 75th Birthday celebrations, colleagues across the Trust joined together to host 'Big Tea Parties' as well as enjoy a special afternoon tea put on by our catering team. As well as celebrations across our sites, a video was produced to showcase some of the fantastic work that takes place each and every day across Lancashire and South Cumbria within our National Health Services. You can watch it here or watch a Trust specific video here.

b) Chorley memorial garden is lasting tribute to organ donors

As a lasting tribute to organ donors and those who lost their lives in the Covid-19 pandemic, Lancashire Teaching Hospitals Charity has been able to create a Memorial Garden at Chorley and South Ribble Hospital, thanks to a generous grant from NHS Charities Together, as well as other donations from public, staff and local businesses.

The project was designed to remember not only those who were sadly lost during the pandemic, but also those who have given the precious gift of life, highlighting the importance of organ and tissue donation across the region.

The tranquil space will also serve as an extra place on site for quiet contemplation and reflection to be used for the benefit of all staff, patients, and visitors. The garden will be dementia-friendly - featuring a circular path - and will include a memorial sculpture, seating, and a selection of trees, wildflowers, and plants with interest and sensory features.

The memorial garden was funded by a grant from NHS Charities Together who helped fund two memorial gardens at both Chorley and South Ribble Hospital and Royal Preston Hospital at a total cost of £100,000, while the Harold and Alice Bridges Charity donated £2,000 towards the project, and the Warburtons Foundation £400.

Special thank you also to Service Care Solutions and Home Instead, who have sponsored benches for the garden, as well as Hardscape, who donated the stone obelisk. Darwin Group kindly donated a gift voucher for £450 of plants, while Brian Jolly from Frank Whittle Partnership gave his time free of charge. You can read more here.

6. 

Deliver value for money

a) Exciting new children's service at Chorley and South Ribble Hospital

In June we saw the exciting start to a new service for children based at Chorley and South Ribble Hospital.

After many months of planning, everything was ready for the first "children's surgery day" with children being admitted to Rawcliffe Ward for day surgery procedures. The ward became a "pop up" children's ward, with posters and toys and a vast team of professionals - surgeons, anaesthetists, nurses, HCAs and play specialist - were ready to greet the children as they arrived.

This project was created with an aim to improve efficiency in the pathway, reduce the number of waiting children and improve patient experience.

The children's surgery GIRFT (get it right first time) report had indicated an opportunity to look for an alternative model of surgery for children, and the NW Region Operational Delivery Network and National Clinical Director for Children Simon Kenny have supported the move.

This development has also been supported by Professor Tim Briggs during the accreditation of the Chorley Elective Surgical Hub.

A total of five lists were running including ENT, dental, maxillofacial, plastic surgery and ophthalmology. The plan now is to have a "children's day" at Chorley once a fortnight.

You can [read more here.]

7. 

Fit for the future

a) UK-first for Lancashire Teaching Hospitals as charity raises funds for cutting-edge LungVision Bronchoscopic Navigation System

Lancashire Teaching Hospitals has become the first centre in the UK – and the third in Europe – to utilise the cutting-edge LungVision Bronchoscopic Navigation System at Royal Preston Hospital.

The technology has been available for little over a year, with the Trust's Consultant Respiratory Physician and Interventional Pulmonologist, Professor Mohammed Munavvar, monitoring its progress and applying to Rosemere Cancer Foundation charity for the funding.

Rosemere raised the £237,500 to purchase LungVision, and although two centres in Italy – in Milan and Bologna – became the first in Europe to use the equipment, Professor Munavvar was able to break new ground in this country.

LungVision allows doctors to use a bronchoscope (a thin tube-like instrument with a light and a lens for viewing) to examine inside a patient's lungs in real time, penetrating deeper and with more accuracy than before.

The technology will now be used to see between 2-4 patients a week, with the procedure – which takes approximately an hour – hopefully leading to an accurate diagnosis within a few days.

In an exciting development, the NHS Confederation will feature the new technology in an upcoming Insight Report, which is sent to acute Trusts across the NHS to demonstrate good practice and improvements for patients. You can read more here.

b) New Regional Hyper-Acute Stroke Unit (HASU) is 'big step forward'

A new Regional Hyper-Acute Stroke Unit (HASU) was opened at Lancashire Teaching Hospitals in June, bringing experts and equipment under one roof to help reduce death rates in stroke patients.

The new unit, based at Royal Preston Hospital, is led by stroke specialist consultants, supported by a multidisciplinary team including specialist nurses, occupational therapists, physiotherapists and speech and language therapists, who are able to closely monitor and stabilise patients newly diagnosed with a stroke with world-class treatment for the first 72-hours following their diagnosis. You can read more here.

c) Lancashire Teaching Hospital hosts two-day workshop with focus on reducing healthcare inequalities

Lancashire Teaching Hospitals hosted a two-day workshop earlier this month with the NHS England and Institute for Healthcare Improvement (IHI) Core20PLUS5 accelerator sites, focusing on reducing healthcare inequalities in our communities.

The international IHI team and colleagues from the National Healthcare Inequalities Improvement Programme at NHS England joined the learning session, as well as LTH Chief Executive Kevin McGee, with other executives and speakers contributing to the event from the seven accelerator sites from each region of England - Lancashire and South Cumbria ICS, Cornwall and Isles of Scilly ICS, Humber and North Yorkshire ICS, Nottingham and Nottinghamshire ICS, Surrey Heartlands ICS, Mid and South Essex ICS and North Central London ICS.

The vision for Core20PLUS5 is to achieve exceptional quality healthcare for all, through equitable access, excellent experience and optimal outcomes. The main approach is to work with the local community, to listen to their thoughts and concerns, to co-produce the improvement work and strategy, and learn together with other like-minded systems as innovative approaches are tested. You can read more here.

d) LTH are first Trust to host NHS England for showcase pilot

Lancashire Teaching Hospitals held a pilot for the Specialised Foundation Programme Showcase – the first Trust to host NHS England in this capacity.

NHS England want to use the Trusts in the network as bases so that doctors and trainees are able to access these events and make them more local.

Held in the Education Centre 1 at Royal Preston Hospital, the Specialised Foundation Programme provides a fabulous opportunity for foundation doctors to develop research, teaching and leadership/management skills in addition to the competences outlined in the Foundation Programme Curriculum. The day consisted of over 50 abstracts of posters being presented and around 40 oral presentations, and there were also a number of keynote speeches.

e) Group B Step research trials helping to detect serious health problems in women and babies

July was International Group B Streptococcus (GBS) awareness month, raising awareness of a type of bacteria which is one of the most serious infections that causes newborn illness and death worldwide.

Lancashire Teaching Hospitals are working on two important research studies about GBS – helping to investigate testing strategies for the bacteria as well as support the global development of a maternal vaccination.

Most women carrying GBS will have no symptoms, but GBS can occasionally cause serious infection in young babies and, very rarely, in babies before they are born. Carrying GBS can also rarely lead to serious infections for pregnant and recently postnatal women.

The GBS3 trial is a national study which aims to investigate two different testing strategies to help reduce the risk of undetected GBS infection, versus the current ‘risk factor based’ strategy.

The ‘risk factor based’ strategy offers antibiotics during labour to women who are considered at risk of their baby developing GBS - and the trials team pull anonymised data from the maternity unit, as a comparison for other sites.

The iGBS3 trial is a large study aiming to support the global development of a maternal vaccination for GBS, by finding out how much antibody a woman needs in her blood to protect her baby from getting GBS. This study asks mothers if they are happy to donate a small sample of cord blood after the birth of their baby – which would usually be disposed of.

f) ‘Our Health Day’ makes health services more accessible to people with autism

A specialist Health Day event for people with a learning disability or autism has been held at Chorley and South Ribble Hospital to help patients feel less anxious ahead of their hospital appointment.

'Our Health Day' was set up by the Lancashire Teaching Hospitals Learning Disabilities team to make it easier for people with a learning disability or autism to understand their patient journey and know what to expect when they attend an appointment in our outpatient department, visit our emergency department or when they're admitted to a ward in one of our hospitals.

The event was supported by local partners from Lancashire Learning Disability Partnership Board, Healthwatch, Lancashire Care NHS FT and the Learning Disability Mortality Review (LeDeR) team and attendees were invited to visit a range of interactive stalls and chat to teams, enjoy some chair-based exercises with our physio team and listen to special talks from teams including the PALS team. You can read more here.

8. AWARDS, ACHIEVEMENTS AND OTHER NEWS

a) Gemma is double winner at Apprenticeship awards

Gemma Abbott, a staff nurse in the Neurosurgery Unit at Lancashire Teaching Hospitals, was a double winner at the Lancashire and South Cumbria NHS apprenticeship awards at the Imperial Banqueting Suite in Preston.

The event recognised the outstanding contribution and achievements apprentices from the area have made over the last year. Gemma was a very worthy winner of the Equality and Diversity award, and then went on to take the Excellence Award – as the overall Champion Apprentice of the year.

Gemma gained the highest grade of distinction on her apprenticeship, received fantastic feedback throughout, and she is a champion for health and safety, using her platform to advocate apprenticeships and life-long learning.

Gemma was not the only success story on the night for the Trust, who were runners-up in the Employer of the year, highly commended behind Lancashire & South Cumbria NHS Foundation Trust. Rebecca Pattman was also highly commended as a runner-up in the Perseverance category, and Tanya Marlow was again highly commended, a runner-up in the Promotion award.

Find out more here.

b) Lancashire Teaching Hospitals shortlisted for five 2023 HSJ Patient Safety Awards

Five initiatives across Lancashire Teaching Hospitals NHS Trust have been shortlisted for awards in this year's HSJ Patient Safety Awards, which recognises safety, culture and positive experience in patient care, celebrating its worthy finalists on a national scale.

The Trust was named in five categories:

- Community Care Initiative of the Year - Lancashire Community Healthcare Hub - Finney House
- Developing a Positive Safety Culture Award - Always Safety First
- Improving Medicines Safety Award - Reducing Medication Omissions
- Patient Safety in Elective Recovery Award - Tell People Quickly that They Don't Have Cancer
- Quality Improvement Initiative of the Year - Microsystem Coaching to Improve Patient Safety

The HSJ Patient Safety Awards acknowledges the hard-working teams and individuals across the UK who are continually striving to deliver improved patient care. The judging panel was made up of a diverse range of highly influential and respected figures within the healthcare community.

The official awards ceremony will be held later this year in Manchester (September 18). The Awards are a highlight of the HSJ's annual 2-day Patient Safety Congress (taking place on 18 & 19 September), where delegates working at the forefront of safety, quality and clinical excellence will come together to join in with open and honest discussions about the current reality of safety. Find out more here.

c) Retired Consultant in Special Care Dentistry is awarded MBE

Vanita Brookes, Retired Consultant in Special Care Dentistry with Lancashire Teaching Hospitals, was awarded an MBE in the King's Birthday Honours List for services to improving the oral health of patients with disabilities.

In 2008, LTH became the first Trust in the North of England to employ a consultant in Special Care Dentistry, in Vanita, who was a real pioneer of the specialty.

A fellow in dental surgery of both the Royal College of Surgeons of England and Edinburgh, she was also an elected board member of the Faculty of Dental Surgery of the Royal College of England from 2015-2021.

Fifteen years ago, the General Dental Council ratified the decision to recognise Special Care Dentistry – which provides dental services for patients with a variety of disabilities and impairments, such as those with severe learning difficulties and complex medical problems – as a new dental specialty.

Vanita was instrumental in advancing Special Care Dentistry nationally and was elected as the consultant representative on the Specialty Advisory Committee at the Royal College of Surgeons. Find out more here.

d) Colleagues enjoy a special day at Westminster Abbey

Four colleagues from Lancashire Teaching Hospitals enjoyed a special celebration ceremony at Westminster Abbey on Wednesday, 5 July, the 75th birthday of the NHS.

Professor Mohammed Munavvar (Consultant Chest Physician/Interventional Pulmonologist), Naeem Toorawa (Imam), Khalid Ibrahim (Imam) and Simon Gilbertson (Reverend/Chaplain) were honoured to represent the Trust following a rigorous nationwide selection process.

They joined other NHS workers from across the country to mark the anniversary in at the historic venue, location of the coronations of 40 English and British monarchs, and several Royal weddings - including that of Prince William and Kate Middleton - since 1100.

Find out more here.

e) Trust Lead Chaplain ordained as an Anglican Priest

Lancashire Teaching Hospitals Lead Chaplain Martin McDonald had the privilege of being ordained as an Anglican Priest in July.

One of 24 new Priests and Deacons ordained across Lancashire, to serve in The Church of England in Lancashire (Blackburn Diocese) to support its ongoing work across the County, Martin's service was held at St John the Baptist, Broughton, by Bishop of Lancaster, the Right Reverend Dr Jill Duff.

He said: "It was a beautiful and joyful service, full of deep spirituality. A friend commented that it was ancient, timeless and deeply moving.

"After serving a year as a deacon within the church, priesthood marks a turning point in my (very long) journey. I am delighted to continue to serve the patients, staff and visitors of Lancashire Teaching Hospitals as we continue to journey together." Find out more here.

f) Trust shortlisted in two BIBA Awards

Lancashire Teaching Hospitals NHS Foundation Trust has been shortlisted in two categories in this year's **BIBA Awards**, Lancashire's most prestigious and longest running business awards programme.

The BIBAs celebrate Lancashire's success stories, in the form of some of the most exciting companies and entrepreneurs in the county and are run by the North & Western Lancashire Chamber of Commerce. The Trust has been shortlisted in two categories – Apprentice Team of the Year and Education Establishment of the Year.

The awards will be held on 15 September 2023, in the Blackpool Tower Ballroom, with the Trust hoping some stellar achievements will impress the judges. Find out more here.

9. RECOMMENDATIONS

It is recommended that:

I. The Board receive the report and note its contents for information.

Lancashire and South Cumbria Provider Collaborative

NHS

Appendix I

Provider Collaboration Board – 20 July 2023

- The Provider Collaboration Board (PCB) met on 20 July 2023. As this was a day of Industrial Action by Consultants the meeting was kept brief.

- It received updates on the following standing items: system pressures and performance updates within urgent/emergency care and elective care; mental health and learning disabilities, and finances.

- Performance management continues to be the responsibility of Trust Boards, with the PCB using performance data to inform wider strategic discussions on system transformation.

- The Joint Committee has been established to give the PCB a mechanism via which to make decisions on key programmes of work as agreed with Trust Boards. Updates on central services, clinical services and progress on Elective Recovery were discussed under Joint Committee working items. An item on Developing Provider Led Population Health Management was deferred.

System pressures – acute

- The implications and costs of the ongoing Industrial Action was the most pressing issue for the system and needed to be reviewed including the increase in costs of those who were acting up into more senior roles; the income lost as a result of having to stand activity down and the premium costs of reclaiming the lost activity. It was not yet clear how this would be managed at a national level and given that more Industrial Action was planned this is an ongoing issue for the system in terms of both performance and finances. It was agreed that local Trusts should take a joint approach until the national approach was clear.

- The PCB acknowledged the ongoing hard work of staff across the system.

System pressures – mental health, autism and learning disabilities

- The Care Quality Commission had been at Lancashire and South Cumbria NHS Foundation Trust (LSCFT) for the last two weeks undertaking a review of adult services. Feedback had been positive.

- The Trust Medical Director was due to meet the Integrated Care Board (ICB) Medical Director to discuss a strategy for moving from NHS system oversight framework (SOF) segment 3 to SOF 2, looking at the evidence in relation to the encouraging progress made to date.

Financial Update

- Month three year-to-date is a deficit of £72.9m versus a plan of £65.3m, with three Trusts currently off plan.

- The impact of Industrial Action up to month three is £4.1m - £2.6m of which are additional costs and £1.5 which is lost income.

- The recent pay award for 23/24 has created a net pressure for providers, with the year-to-date pressure at £0.9m, and the full year at £3.6m. Further work is underway to ensure consistent impact assessment given the variation.

Central Services Transformation Update

- The half-day workshop on 18 July had been a productive session with 40 plus central services leadership colleagues which discussed the mandate from the Joint Committee for the development of the Target Operating Model and was the final planning session for the prioritisation of the D1-D4 services as we move towards a Central Services Delivery Model. A further session would be held in around 4 weeks' time to look at the HR and comms interdependencies to ensure messages are aligned. There are clear functional delivery plans, but as the transformation opportunities are cross functional we will now spend some time considering this.

- There was a very clear discussion with each of the leads that the development of the Operating Model for Central Services will now have an Executive lead from each of the providers who will be part of an Executive Delivery Board chaired by Aaron Cummins as CEO and Senior Responsible Officer (SRO) for the programme. The Professional leads would still be involved in the design and delivery.

- Good work has taken place on developing engagement toolkits and other engagement mechanisms and infrastructure were now mobilising. All Providers were asked to dovetail this with activity undertaken by local communications leads to ensure appropriate cascade and usage of these within their own organisations. The PCB SRO for Governance was working with local teams to ensure Trust leadership and assurance processes were aligned with the Central Services programme so there were no surprises when decisions came out of Joint Committee meetings.

- The Central Services Interim Managing Director role had gone out for expressions of interest and interviews were due to take place shortly. An appointment should be made by the end of July. The role will then start to fill the operating model leadership team, up to a point where we will want to go out for permanent appointment for that new structure.

- It is expected that there would be a financial benefit to the system this financial year as a result of the Central Services work. There would be an intense focus on delivering savings from procurement, bank and agency, and individual Cost Improvement Plan (CIP) performance from management of vacancies in in-scope services. There has been some good early progress at Q1 but there was still much more to do and plenty of risk. There would be further discussion on this over the next month.

- The PCB have previously agreed that transactional operational central services will be brought together into one 'umbrella' service hosted by one of our NHS Trusts, known as a 'Host Trust Model'. Organisations are being asked for formal expressions of interest to host this – there will be clear criteria and this should be resolved over the summer period.

Clinical Programme Board Update

- The PCB supports the discussions that were held on 19 July around unsustainable services, encouraging their teams to be bold and ambitious in thinking through solutions. Good work has taken place in specialities where alternative models of care are being delivered and will provide support for these in both development and implementation phases. The ICB will be standing up a commissioning group to support the clinical programme in decision making and implementing new care models that are now being agreed, and community transformation groups have been set up to look at working with alternative models, particularly for the winter period and into next year.

- Notable updates included; the implementation of a system-wide networked service model for Cardiology; the establishment of the Lancashire and South Cumbria (LSC) vascular network with a single inpatient unit at Royal Preston Hospital (RPH); the development of a networked service model for Urology that meets the

national service specifications for cancer surgery but also delivers a more robust service; development of networked services in Musculoskeletal (MSK) Trauma and Orthopaedic (T&O); pathway improvement in Dermatology with the establishment of training and education workstreams; GIRFT implementation in Ophthalmology; and a Business Case that is being developed for Integrated Mental and Physical Health that will implement a new model for early assessment and treatment of mental health issues in Emergency Departments.

Elective Recovery Programme Group Update

- This was the second programme update to the PCB since the refresh of the programme was approved in Q4 of 2022/23. It set out key highlights and risks, providing a high-level update of each of the six transformation programmes within the Elective Recovery Portfolio including an overview of the programme's financial benefits.

- The update intentionally focused on the Surgical Hub programme given the priority currently being given to this programme. The work to co-create a strategic plan for Surgical Hubs in LSC has now concluded, with this report setting out the strategic priorities and objectives proposed by stakeholders across the system, the scale of the opportunities to be released and immediate next steps. Members of the PCB were asked to support the strategic intentions set out for surgical hubs and provide organisational commitment to working collaboratively in delivering the immediate next steps and actions.

- The Lancashire and South Cumbria Elective Recovery Programme continues to perform and benchmark well across a range of key metrics on both a regional and national footprint, with Day case rates at 83.1%, maintaining LSC's position within the top quartile. As at the 4 July, 1,893 patients were waiting over 65 weeks. This is ahead of the end of July trajectory by 583, with the 65-week cohort reducing by 31% in the first three months of 2023/24. The Surgical Hub programme has made excellent progress in creating a LSC strategic plan, setting out an agreed vision and strategic priorities and also forecasting the scale of the opportunity to accelerate elective recovery and repatriate activity, and LSC is pursuing the opportunity to become the first system in the country to implement the nationally developed Patient Treatment List (PTL) tool. This is a key enabler to delivering the collective ambition of managing our waiting lists and capacity 'as one.'

- Programme highlights discussed included; referral optimisation, waiting list management, outpatient transformation, theatre transformation, surgical hubs and use of the independent sector.

- One strategic risk was brought to the Board this month, stating that the ongoing impact of industrial action is impeding the system's ability to fully eliminate 78-week waits, impacting on productivity and activity, whilst also reducing our operational and clinical leaders' capacity for system-wide transformation programmes.

- The Surgical Hubs programme was also discussed in detail, confirming opportunities and challenges on how the Hubs are helping to address the elective backlog. There is significant opportunity to increase activity levels within LSC's surgical hubs through both improving utilisation of current capacity and expanding the hours surgical hubs are staffed and operational in line with Get It Right First Time (GIRFT) expectations. Our existing hubs cover 16 specialities. The total LSC admitted waiting list for these specialities has grown by 7% in the last 12 months, with this growth highest in Trusts with existing surgical hubs. Expanding Surgical Hub capacity would provide the opportunity to repatriate activity currently being undertaken by the independent sector.

- Next steps will be to develop the delivery plan and taking forward technical solutions for managing waiting lists across the system.

- PCB members stressed the importance of appropriate public and stakeholder engagement and agreed the direction of travel of the programme.

Interim PCB arrangements

It was agreed that Aaron Cummins would take up the role of lead Chief Executive for the Provider Collaborative following Kevin McGee's departure in the autumn and discussions around handover are taking place. Kevin's last meeting would be in September, as the August meeting has been cancelled due to a number of apologies.

Appendix II

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	5 July 2023
Title of paper	Report of the Chief Executive
Presented by	Kevin Lavery, Chief Executive
Author	Hannah Brooks, communications and engagement manager and executive team lead contributors
Agenda item	5
Confidential	No

Executive summary

This report provides an opportunity to reflect on a year since the establishment of the ICB, focusing on the importance of strong leadership that will be required to lead the organisation through a challenging recovery and transformation programme.

A key part of ensuring the ICB's success is to achieve the right balance between what happens at place and what happens across the system, and this report introduces the proposal for a place integration deal and the opportunities that are opened up by delegating to our places. The report also provides an update on the Integrated Care Strategy and specialised commissioning.

Recommendations

The Lancashire and South Cumbria Integrated Care Board are requested to note the updates provided.

Which Strategic Objective/s does the report contribute to		**Tick**
1	Improve quality, including safety, clinical outcomes, and patient experience	✓
2	To equalise opportunities and clinical outcomes across the area	✓
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	✓
4	Meet financial targets and deliver improved productivity	✓
5	Meet national and locally determined performance standards and targets	✓
6	To develop and implement ambitious, deliverable strategies	✓

Implications

	Yes	**No**	**N/A**	**Comments**
Associated risks			✓	
Are associated risks detailed on the ICB Risk Register?			✓	
Financial Implications			✓	

Where paper has been discussed (list other committees/forums that have discussed this paper)

Meeting	Date	Outcomes
n/a	n/a	n/a

Conflicts of interest associated with this report
Not applicable

Impact assessments				
	Yes	**No**	**N/A**	**Comments**
Quality impact assessment completed			✓	
Equality impact assessment completed			✓	
Data privacy impact assessment completed			✓	

Report authorised by:	Kevin Lavery, Chief Executive

Integrated Care Board – 5 July 2023

Report of the Chief Executive

1. Introduction

"Rough waters are truer tests of leadership. In calm water, every ship has a good captain." - Swedish proverb

1.1 As we reflect on one year since the establishment of the ICB, there are three key areas to focus on:

1. Leadership is about facing up to challenges.
2. Improvement is a constant process.
3. Delivery is key.

1.2 Being a leader is not easy. Of course, working within a challenged health organisation, decision making comes with the territory. However, it goes beyond that; it should not be easy to be a good leader. It is about facing up to challenges, getting out of your comfort zone, recognising that something is not working and having the courage to change it.

1.3 It is too easy to avoid the difficult decisions and just enjoy the trappings of power. I saw that clearly in local government during the austerity crisis. Some leaders stood up and faced up to the issues, whilst others did not – and instead hoped they would go away. This had real impact on local communities and some suffered more than they needed to as a result of a lack of leadership.

1.4 We face major challenges in health and care on a similar scale to those faced by local government in austerity. The challenge is not going to go away, and as leaders we will need to be brave in the difficult decisions that we will face over the coming years. It will be an uncomfortable experience if we are going to achieve a real step change across the system.

1.5 We also cannot take our eye off the ball. Focusing on a small number of priorities and getting them right is vital to our success but we also have to be on a continuous journey of making sure that what we are doing is making a difference.

1.6 To make progress, as leaders we have to make the most of the opportunities we have now and in doing so, we will reach a point where we can go even further.

1.7 We need to continually review the good, the bad and the ugly; reset and identify the opportunities to improve. An essential part of leadership is setting and managing expectations. Transformation programmes can often be oversold and do not meet the original expectations which can lead to a perception of failure, despite the improvements that have been made. In this context it is important

that we under-promise and over-deliver.

1.8 Which brings me to the final point that delivering improvements, consistently, is the real goal in all of this. As an organisation that enables change and supports system-thinking, our ICB must still focus on the delivery. As a board we have a duty to make sure that our priorities are met and our communities are served.

2. Integration at place

2.1 If there is one difficult decision that we made in the last year that we should commend, it was the decision that we took as a board in our first business meeting to realign the place boundaries.

2.2 Before our ICB was established, we had eight Clinical Commissioning Groups (CCGs) working across five places based on hospital catchments, and those places were not coterminous with our principle local authorities, so it would have been nigh impossible to integrate health and care. Lancashire County Council for example were in five place-based partnerships. Integration would have been too hard.

2.3 It was a tough decision to make so early in the establishment of a new organisation with a newly-formed board, but recognising the need and having the courage to make the change has built a strong foundation for much of the integration work that has taken place since.

2.4 We knew it was the right thing to do and that we would never be able to truly integrate without this step. But it was not easy. We knew it would affect our ability to make fast progress with the places. We had challenges from our colleagues in primary care. Those that had been working in the former place footprints felt a connection to those places that was hard to shift away from.

2.5 It did slow us down initially; it took until December to get our full leadership team in place. Since then, we have begun to move forward and we are now really gathering pace.

2.6 It is because of the brave decision that we made in July last year that we have been able to make two other significant decisions already at our board meetings; the transaction between Lancashire and South Cumbria NHS Foundation Trust (LSCFT) and East Lancashire Hospitals NHS Trust (ELHT) for community services in Blackburn with Darwen; and the roll out of integrated neighbourhood teams over the next two years.

2.7 As part of today's papers, there is another big decision around the place integration deal. We are presented with a major delegation programme over a two-to-three-year period, and the decision opens up the opportunity to go even further.

2.8 This moves us towards the idea of a small, slim, strategic centre with most of the action happening in place and with our providers, and most people working in the ICB at those more local levels. As the delegation programme develops,

we will need to revisit that vision of a small, slim, strategic centre and make sure that what remains at the centre of the ICB is fit for purpose.

2.9 As a board, we need to appreciate that this is a huge change for the ICB. It will be a major challenge in terms of financial delegation, and in terms of leadership and culture for our staff. The other challenge is that we have a number of services that are fragile and fragmented, with significant variation in delivery arrangements, funding levels and service standards across Lancashire and South Cumbria. This is not going to be for the faint hearted and it certainly will not be plain sailing.

2.10 The place integration deal is one of the enablers for us to achieve greater integration with our local authority partners and has the full support of our local authority chief executives, who we brought together for a half day workshop in early June to look at the proposed arrangements for place integration and the opportunities to go further and faster.

2.11 The workshop was a great opportunity to reset our intentions to integrate further and for me there are three big things to consider here.

2.12 Firstly, how we can remotely monitor patients, in ‘virtual’ beds. We have done well as a system in this, and we have plans in place for rapid expansion of our virtual wards. The important part about this is not the expansion of beds. It is how we make sure that the people in those beds are the ones that need it the most. We must carefully target patients who are at risk of going into hospital, or those that are currently in hospital with moderate health needs that could be managed at home. We also have a low technology offer across the four hospital virtual ward systems. Increasing the level of technology, for example with wearable technology, could help us to move further and faster on this too.

2.13 Secondly, the Jean Bishop Integrated Care Centre in Hull is a great model of admission avoidance, providing a central hub for NHS, social care, voluntary, fire and rescue services to work collaboratively to keep thousands of frail and elderly people fit, out of hospital and living independently at home or in their care setting.

2.14 Following an initial assessment in their own home or care setting, each patient is seen at the Jean Bishop centre by a clinician (either a GP with an extended role in frailty, a consultant community geriatrician or an advanced nurse practitioner), a physiotherapist, social worker, voluntary services worker and other specialists. There are also diagnostics facilities, which enable healthcare staff to carry out blood tests, x-rays and in the near future CT scans as required.

2.15 At the end of their visit, each patient receives their care plan, knowing they have been listened to by healthcare professionals who have the time to listen and identify what is important to each patient, and reassured their plan will be implemented and monitored.

2.16 Between April 2019 and September 2022, the Jean Bishop Integrated Care Centre contributed to a 13.6% reduction in emergency hospital attendances for patients aged over 80. Over the same period there was a 17.6% reduction in emergency department attendances for patients in care homes. Following its success, the service has now been rolled out to cover the East Riding of Yorkshire.

2.17 It is a fully integrated centre and, rightly so, has received national attention as an example of good practice, not least from the Secretary of State for Health and Social Care in his keynote speech at the NHS ConfedExpo. We are just starting to look at whether we can do something similar in our patch, and one area in particular that we are looking at is Cumbria.

2.18 The third area was the opportunity to use NHS and local authority resources better between us. We already have the Better Care Fund, so why do we not utilise that more to target the right priorities within that fund, to receive a maximum return for minimum investment? Using our shared resources as efficiently as possible gives us the opportunity to free up some of our capital spend to be used on frontline services. The possibilities are impressive, and exciting if we get this right.

3. System transformation and recovery

3.1 We are one of 14 systems in England that has confirmed that we will end the year with a budget deficit, having been one of the original five ICBs that had forecasted this outcome. We are grateful to NHS England for recognising our circumstances and the work that we have been doing, with the approval of a multi-year approach to tackling our financial deficit.

3.2 However, we know that finance is just the symptom of an underlying issue; in this case it is how we are configured and how we do things round here. As I have said before, we are in a crisis, but there are some amazing opportunities that we need to take advantage of.

3.3 If we had a blank sheet of paper, we would not plan to have seven elective care centres, six A&Es, five separate and expensive sets of support services. We would not plan to spend over £300 million on temporary staff at premium rates and spend two thirds of our money on treating illness, and one third on care and community.

3.4 The solutions are pretty obvious; we need a major clinical productivity and reconfiguration programme with single clinical networks, increasingly moving to single sites so that ultimately we have two or three elective sites. We need major non-clinical reconfiguration with a single platform for shared services and the collaboration bank.

3.5 Although the answers are obvious, they are not easy to do. Again, this links back to strong leadership and making difficult decisions. In recognition of the importance and enormity of the system recovery and transformation work,

Maggie Oldham is taking the lead on this portfolio.

3.6 To free Maggie up to focus fully on recovery and transformation, we have made some changes to the portfolios of other members of our executive team. Chief nurse, Sarah O'Brien, and medical director, David Levy, will also be freed up to support as clinical leads, which will be a vital part of the clinical productivity and reconfiguration.

3.7 Most of Maggie's functions, along with some of David's and Sarah's, will move to Craig Harris, who will be responsible for urgent and emergency care, mental health, primary care and emergency preparedness, resilience and response (EPRR). The expectation is that with these new functions, Craig will play a much bigger role in consolidating commissioning, which has been fragmented due to legacy arrangements from the eight CCGs.

3.8 We have embarked on a month of intensive work to kickstart the recovery and transformation programme and the paper in part two of the board meeting presents the results of this intense review and provides a baseline for the programme.

3.9 We also launched a second mutually agreed resignation scheme for ICB staff. Feedback from staff side representatives has identified a small number of staff that did not feel they were well enough informed of the future of the organisation to make a decision about the scheme during the first round. We are not expecting large numbers of applications and the approvals process will be carefully managed to ensure that we retain the stability of our teams.

3.10 We need to recognise that we have a very challenging agenda here, reconfiguration is not for faint hearted and will be high risk, which again links back to the need for robust leadership. That is why we need a dedicated team for this. We are going to keep this at the forefront of our decision-making; it is going to be biggest issue that dominates our agenda in the coming years.

4. Lancashire and South Cumbria Integrated Care Partnership (ICP)

4.1 The ICP continues to support the development and maturity of our place-based partnerships, which are often best placed to act on the wider determinants of health. The ICP has made good progress in building a shared purpose across the whole system; to support people to live healthier and more independent lives longer, through our Integrated Care Strategy.

4.2 We must tackle the most complicated issues affecting people's health and wellbeing together, we know that many of these problems can only be solved through better integration and working together with our communities. ICB board members endorsed the draft strategy at the 29 March meeting and can now find the full strategy document on the ICP's website.

4.3 It is intended for use by the public, partners, our places and wider organisations within the Lancashire and South Cumbria system. Both the full strategy and summary version were approved by the Lancashire and South Cumbria

Integrated Care Partnership on 17 April 2023 and can now be formally adopted by the ICB board.

4.4 The partnership itself also continues to develop, since it formed in the summer of 2022, so the Terms of Reference (ToR) have also been updated to reflect the move to a more formal and established stage in the partnership's existence. Board members are also asked to endorse the updated ToR, which can be found on the Lancashire County Council website.

5. Specialised commissioning transfer

5.1 NHS England will be delegating a major portion of specialised commissioning to ICBs from next year. The new arrangements will be set up in shadow form during 2023-24, scheduled to go live on 1 April 2024.

5.2 It has been agreed that Lancashire and South Cumbria ICB will host the North West specialist commissioning hub.

5.3 The inaugural meeting of the North West Specialised Services Committee (NWSSC) met on 1 June 2023. The purpose of this committee is to provide a forum for NHS England and the three North West ICBs (Greater Manchester, Cheshire and Merseyside and Lancashire and South Cumbria) to collaboratively make decisions on the planning and delivery of the joint specialised services, to improve health and care outcomes and reduce health inequalities. The draft ToR for the committee were received and endorsed by the board in May and the final version can now be found on the ICB website.

5.4 This joint committee will support ICBs taking on full delegated commissioning responsibility and will provide Lancashire and South Cumbria ICB a greater level of involvement in the commissioning of specialised services to better align and transform pathways of care around the needs of local populations. Future meetings will focus on the identified transformation priorities as well as the financial plan.

5.5 It is important to note here that we do not want to simply devolve the hub to the three ICBs and then do everything in the same way it had been done by NHS England. The rationale behind this transfer is to do things differently and better. One of the big opportunities will be further devolution of specialised commissioning and integration with the work of the ICBs. There will be opportunities to move work upstream and reduce the demand for specialised commissioning and this is best done at ICB level, rather than at a national level.

5.6 There are also substantial risks in making this change, looking at the transformation agenda. We must recognise that this is a significant change; funding is currently directed to specialist institutions, for example Liverpool University Hospitals NHS Foundation Trust (LUHFT) and Manchester University NHS Foundation Trust (MFT).

5.7 From 2024, funding will be population-based through ICBs. A careful balance will therefore need to be struck between progressing the transformation agenda

and transitioning safely from the current arrangements. Further work will need to take place to understand the full financial risks and opportunities.

5.8 The added complication in the North West is that we have a number of specialist institutions in Greater Manchester and Merseyside that provide services to patients well beyond the North West. That is another significant risk that we will need to keep an eye on.

6. Hewitt review: government response

6.1 Following on from the Hewitt report published in April 2023, the government provided a response to the report within their response to the House of Commons Health and Social Care Committee's report on 'Integrated care systems: autonomy and accountability'.

6.2 The response is generally supportive of Hewitt, and there is a lot of overlap between Hewitt's report and that of the Health and Social Care Committee's, with regards to ICS oversight, national targets and the role of the Care Quality Commission (CQC).

6.3 One of the areas that was perhaps not responded to as fulsomely as I might have expected was prevention. The budget for prevention is one of the things that has been left to ICB discretion. Hewitt had recommended a one per cent real terms increase annually, but this does not feel like it goes far enough.

6.4 We need to go further and invest more, whilst recognising that this will be challenging with the financial constraints within which we are working.

6.5 Prevention is a local priority, for us as an ICB and as an Integrated Care Partnership, and we are one of a small number of ICBs that commissioned Professor Sir Michael Marmot to do a report on the issue of inequalities, who called for an increase in public health funding and increased focus on prevention from the NHS.

6.6 However, not everything requires significant extra investment. One simple area is the campaign to reduce smoking. I have agreed with the chair that we will commit to the NHS Smokefree Pledge. In signing the NHS Smokefree Pledge, organisations commit to reduce the harm caused by tobacco through implementing comprehensive smokefree policies.

6.7 To support our work in this area, the ICB is working with key partners to develop a refreshed Tobacco Free strategy for Lancashire and South Cumbria which will be presented to the board during the autumn.

6.8 The pledge document will be signed by the chair, chief executive and medical director of the ICB.

7. New Hospitals Programme

7.1 At the end of May, there was a national funding announcement which confirmed that Lancashire and South Cumbria will receive funding for two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary.

7.2 We are in the second tranche of funding, which on the face of it seems like a delay from 2030 to 2035. However, if we are realistic about the delivery, this involves two huge and complex projects, and there will be a lot of groundwork to complete between now and then, which we would have been unlikely to achieve within six or seven years.

7.3 The timescales will allow the necessary time for securing the land, getting the consent, carrying out a comprehensive consultation and engagement process with our staff, patients and communities, undertaking significant enabling works, working closely with local authority partners, as well as undertaking the construction of the project. This is a huge project that will take eight to ten years from start to finish. There is a long way to go; the critical issue is to secure the land. We are not in a position to be able to discuss sites as that is commercially sensitive, but we do need to secure the land as a priority.

7.4 We have also had confirmation of the budget envelopes, and that both hospitals will be new builds. This is significant as it really does allow us to build hospitals of the future, which will be premised on transforming our community services to result in a community centric health and care system, rather than being set up purely to tackle illness.

7.5 Our prime objective is that most people get care living independently at home and only go into hospital when they really have to. One of the differences we might therefore expect to see would be fewer beds.

8. NHS Parliamentary Awards

8.1 We have been shortlisted for three NHS Parliamentary Awards; improving the care and detection of oesophageal cancer in patients with Barrett's oesophagus (cytoprime); Lancashire and South Cumbria Reproductive Trauma Service (our maternal mental health service) and tackling COVID-19 vaccination hesitancy and health inequalities in underserved and seldomly heard communities. The awards ceremony take place on the same day as board, Wednesday 5 July.

8.2 The recognition that we received from 11 MPs across our patch helps to highlight the work of our staff and partners and shows appreciation from our MPs for a number of projects that are making a difference to the lives of our communities. Being nominated for awards such as these helps to demonstrate the impact that colleagues working in the ICB have for our patients and communities on a daily basis and I am keen to see more recognition for our organisation as we develop.

9. Recommendations

9.1 The Lancashire and South Cumbria Integrated Care Board is requested to note the updates provided.

Kevin Lavery

26 June 2023

The NHS Smokefree Pledge

As local health leaders we acknowledge that:

- Smoking is the leading cause of premature death, disease, and disability in our communities
- Smoking places a significant additional burden on health and social care services and undermines the future sustainability of the NHS
- Healthcare professionals have a key role to play in motivating smokers to try to quit and offering them further support to quit successfully
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities
- Smoking is an addiction starting in childhood with two thirds of smokers starting before the age of 18
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the tens of thousands of people its products kill in England every year

We welcome:

- The Government's ambition to make England smokefree by 2030 and tackle health inequalities in smoking prevalence
- The NHS Long Term Plan's commitment for all smokers in hospital, pregnant women, and long-term users of mental health services to be offered NHS funded tobacco dependence treatment by 2023-24
- NICE public health guidance on tobacco

In support of a smokefree future, Lancashire Teaching Hospitals commits from 3rd August 2023 to 3rd August 2024

- Treat tobacco dependency among patients and staff who smoke in line with commitments in the NHS Long Term Plan and Tobacco Control Plan for England
- Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care
- Create environments that support quitting through implementing smokefree policies as recommended by NICE
- Deliver consistent messages about harms from smoking and the opportunities and support available to quit in line with NICE guidance
- Actively work with local authorities and other stakeholders to reduce smoking prevalence and health inequalities
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Support Government action at national level
- Publicise this commitment to reducing smoking in our communities and join the Smokefree Action Coalition (SFAC), the alliance of organisations working to reduce the harm caused by tobacco

Signed by:

Chair

Chief Executive

Medical/Clinical Director

Endorsed by:

Amanda Pritchard, Chief Executive, NHS England

Prof Dame Helen Stokes-Lampard, Chair, Academy of Medical Royal Colleges

Prof Jim McManus, President, Association of Directors of Public Health

Prof Maggie Rae, President, Faculty of Public Health

Dr David Strain, Chair, BMA Board of Science

Gill Walton, Chief Executive, Royal College of Midwives

NHS England · Academy of Medical Royal Colleges · Association of Directors of Public Health · Faculty of Public Health · BMA · Royal College of Midwives

9th March 2022

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Board Assurance Framework (BAF) Risk Report							
Report to:	Board of Directors			**Date:**	3rd August 2023		
Report of:	Associate Director of Risk and Assurance			**Prepared by:**	K Clay		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☒	**For information**	☐		

Executive Summary:

The Well Led Framework by NHS Improvement and the Care Quality Commission (CQC) require Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. This includes a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of its high level strategic objectives.

The purpose of this paper is to provide the Board of Directors with details of those risks that may compromise the achievement of the Trust's high level strategic objectives.

Strategic Risks

A copy of the Trust's BAF can be found in Appendix 1, whilst Appendix 2 provides the Strategic Risks with full details of the controls, assurances, any gaps and actions that are being undertaken to mitigate the strategic risks. Due to scheduling of committees, the strategic risks that are detailed in Appendix 2 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

The BAF in Appendix 1 identifies the strategic risks that threaten the delivery of the strategic aims and ambitions of the Trust. There has been no change in score for the strategic risks since the last report. Any changes to the content of the Strategic Risks since the previous update to Board are highlighted in yellow within the strategic risk template.

Operational High Risks for Escalation to Board

There are three operational high risks that continue to be escalated to the Board within the BAF this month. These are:

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to the recovery of cancer, and non-cancer backlogs.

- Risk ID 1182 (scoring 20) Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, which has been escalated to Board since October 2022.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.

Appendix 1 – Board Assurance Framework
Appendix 2 – Strategic Risks

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Committees of the Board in line with cycles of business and a Board Workshop in May 2023.

1. Background

1.1 The Well Led Framework by NHS Improvement and the Care Quality Commission (CQC) require Boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. It extends to include a Board Assurance Framework (BAF) which provides a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives.

1.2 This paper provides the Board of Directors with details of those risks that may compromise the achievement of the Trust's high level strategic objectives.

2. Discussion

2.1 Board Assurance Framework (BAF)

2.1.1 The BAF in Appendix 1 identifies the strategic risks that threaten the delivery of the strategic aims and ambitions of the Trust.

2.2 Strategic Risk Register

2.2.1 There has been no change in score for the strategic risks since the last report.

2.2.2 Any changes to the content of the Strategic Risks since the previous update to Board are highlighted in yellow within the strategic risk template in Appendix 2.

2.2.3 It should be noted due to scheduling of committees, the strategic risks detailed in Appendix 2 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper.

2.3 Operational Risk Register

2.3.1 There are 3 previously escalated operational high risks that remain escalated to the Board within the BAF this month. These are:

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to recovery of cancer, and non-cancer backlogs.
- Risk ID 1182 (scoring 20), Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, which has been escalated to Board since October 2022.

2.3.2 Risk ID 1182, Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, saw an increase in score from 16 to 20 at the end of June 2023 due to the increased length of the strike periods and the possibility of the different unions/staff groups striking at similar times and the impact this could have in staffing level. At the time of the score increase junior doctors strike action for 13th – 18th July 2023 had been announced (and has since taken place) and Consultants were balloting for strike action, which took place 20th – 21st July 2023. In June 2023, the Royal College of Nursing did not meet the required number of votes to implement further strike action.

UNITE are also balloting the Porters at LTH to strike. This risk is further compounded by the future inability to use agency staff during strike action. The Strike Group continues to meet when needed (when new action is announced) to ensuring staffing is discussed and rotas are covered and any concerns are escalated at the earliest opportunity.

2.3.3 Further details on the operational high risks escalated to Board can be found in the BAF in Appendix 1.

3. Financial implications

3.1 Any financial implications are captured within the Risk Register records and managed accordingly.

4 Legal implications

4.1 Any legal implications are captured within the Risk Register records and managed accordingly.

5. Risks

5.1 The paper identifies Strategic and Operational Risks that may compromise the achievement of the Trust's high level strategic objectives and therefore, the entirety of the paper is risk focused.

6. Impact on stakeholders

6.1 A robust and well managed BAF reduces the negative impact on patients and staff and the reputation of the organisation and its purpose is to mitigate and reduce, as far as is reasonably practical, the level of risk to that identified in the trust risk appetite statement.

6.2 All risk records impact upon patient experience, staff experience, Integrated Care System and cross divisional work. This is captured within individual risk register entries on Datix.

7. Recommendations

7.1 **It is recommended that Board of Directors:**

i. Note and approve the updates to the BAF.

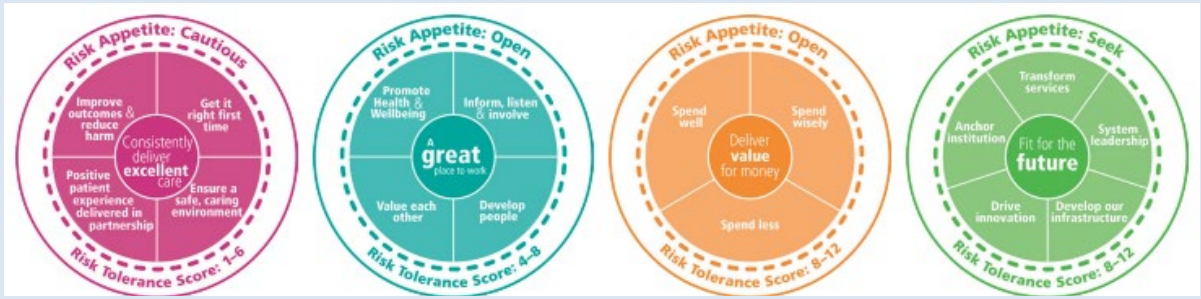
Appendix 1 - Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Trust Aims

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

Trust Ambitions



Current principal risks on the Strategic Risk Register – August 2023

Following a review of the Board Assurance Framework, the following Strategic Risks were identified in June 2020. These are detailed below:

Strategic Risks		Risk ID	Initial Score	Risk Appetite	Risk Tolerance	June 2022 Score	Aug 2022 Score	Oct 2022 Score	Dec 2022 Score	Feb 2023 Score	Apr 2023 Score	June 2023 Score	Aug 2023 Score	Change
Risk to delivery of Strategic Aim to offer a range of high quality specialist services to patients in Lancashire and South Cumbria		859	8	Open	6-9	8	8	8	8	8	8	8	8	→
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		860	6	Seek	9-12	16	12	12	12	20	20	20	20	→
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &...	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	855	20	Cautious	1-6	20	20	20	20	20	20	20	20	→
	Risk to delivery of Strategic Ambition: A Great Place to Work	856	20	Open	4-8	12	12	12	12	12	12	16	16	→
	Risk to delivery of Strategic Ambition: Deliver Value for Money	857	20	Open	8-12	20	20	20	20	20	20	20	20	→
	Risk to delivery of Strategic Ambition: Fit for the Future	858	20	Seek	8-12	15	15	15	15	15	15	15	15	→

Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Strategic Risk Summary

Risk		Risk ID	Risk Summary
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research.		860	There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.
Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service		859	There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients.
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities	**Risk to delivery of Strategic Ambitions.. Consistently Delivering Excellent Care**	855	There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to: a) Availability of staff b) High Occupancy levels c) Fluctuating ability to consistently meet the constitutional and specialty standards d) Constrained financial resources impacting on the wider system, the deficit position facing the Trust and the significant costs of operating the current configuration of services. e) Health inequalities across the system.
	Risk to delivery of Strategic Ambitions.. Great Place to Work	856	There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development. This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care.
	Risk to delivery of Strategic Ambitions.. Deliver Value for Money	857	There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection.
	Risk to delivery of Strategic Ambitions.. Fit For the Future	858	There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

See next slide for key operational risks that are for escalation to Board.

Board Assurance Framework 2023/2024 – Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Key Operational Risk Summary for Escalation to the Boards

This details those operational risks that pose a significant threat to achieving organisational objectives

- **Impact of Emergency Department Block on Patient Safety (Risk ID 25 – Initial Score 20, Current Score 20)** – The data measured through the ED Dashboard continues to demonstrate a department under significant pressure with sustained attendances and high numbers of patients waiting over 12 hours to be admitted to a ward or mental health facility. In July 2022, a 24 bedded medical ward opened on the CDH site, whilst this has increased the number of beds on the CDH site, analysis demonstrates that at the same time there was an increase in attends through the ED at CDH site, resulting in the additional beds preventing a further escalation of risk rather than reducing the risk overall. Further actions to address the risk include:
  - Converting the former ED COVID Majors space into a new 20 bedded Acute Assessment Unit
  - 64 beds now open in the Community Health Care Hub to reduce the number of patients in acute beds who no longer meet the criteria to reside in hospital.
  - Continued development of virtual wards to reduce length of stay and avoid admission.
  - Strengthened site management arrangements with 8a Tactical Operational Officers now in place 7.30am – 10.00pm 7 days a week.
  - Joint bid in place with Lancashire South Cumbria Foundation Trust to implement a Mental Health Urgent Assessment Centre co-located to the ED to reduce the number of patients with mental health needs in the ED.
  - Urgent and Emergency Care Transformation Board established with Executive level leadership which will focus on delivering:
    - Newly developed Urgent Emergency Care strategy
    - Therapy admission avoidance 7/7 team ED and MAU/SAU
    - 40% reduction in ambulance conveyances to the ED
    - 10% reduction in length of stay for inpatients.
    - 5% reduction in the patients not meeting the criteria to reside in hospital.

  Assumptions in the Urgent and Emergency Care Transformation Plan indicate material improvements are expected to be seen in Quarter 2 of 2023/2024 and therefore this risk remains escalated to Board

- **Elective restoration (Risk ID 1125 – Initial Score 20, Current Score 20**) - Patients continue to wait for a significant amount of time to receive non-urgent surgery. The plan to eliminate 104+ week waits has been achieved, with the exception of those patients that are unavailable for treatment and have chosen to wait longer. The plan to eliminate 78 week waits by March 2023 has not been achieved due to the displacement of activity during industrial action, however the Trust is now working towards elimination of 78 week waits by the end of July 2023 (extended from May 2023 due to industrial action), subject to ongoing industrial action. Achievement of the plan and performance against the trajectory is reviewed weekly. All specialties have target plans to work to and are being supported through divisional meetings and the wider Performance Recovery Group. In addition to this there is an Elective Care Transformation Board established with Executive level leadership which will focus on delivering:
  - Repatriation of services
  - Diagnostic efficiency
  - Sustainable workforce models
  - Theatre productivity
  - Streamlining elective pathways

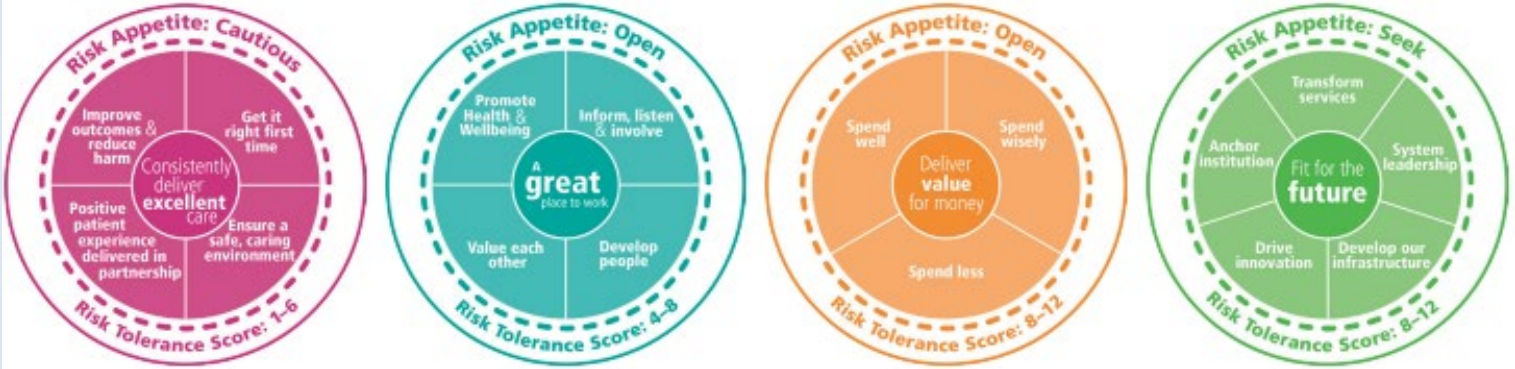
- **Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award (Risk ID 1182 – Initial score 16, Current Score 20) -** Strikes have taken place for nursing, ambulance, physiotherapists, junior doctors and consultant. In May 2023, a National Pay deal was signed off at a meeting between the government and 14 health unions representing all NHS staff apart from doctors and dentists. In June 2023 the Royal College of Nursing did not meet the required number of votes to implement further strike action, however the British Medical Association (BMA) continued to ballot and strike action took place for junior doctors and consultants in July 2023. The Unite Union (on behalf of hospital porters) are also currently undertaking strike ballots. The risks associated with this are being managed in partnership with staff side, workforce, and clinical leaders at the Strike Action Emergency Planning Group. The risk score was reduced in March 2023 from 20 to 16 based on multiple strikes having taken place and these having been managed effectively due to the significant planning undertaken in preparation. In June 2023, however, the score was increased back to 20 in reflection of the ongoing industrial action amongst junior doctors and consultants which is having an impact on the hospital's activity. This risk is further compounded by the future inability to use agency staff during strike action.

Appendix 1 - Board Assurance Framework 2023/2024 – Details of Risk Appetite and Risk Tolerance alignment with Strategic Risks

Lancashire Teaching Hospitals NHS Foundation Trust

- **Risk Appetite**: is the decision about the level of risk that the Trust is prepared to accept, after balancing the potential opportunities and threats a situation presents. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings.
- **Risk Tolerance**: is the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives in accordance with the Trust's Strategy and Risk Appetite.

Trust aim: To provide outstanding and sustainable healthcare to our local communities



Trust aim: To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

Risk Appetite: Open — **Risk Tolerance Score 6–9**

Trust aim: To drive health innovation through world class education, training and research

Risk Appetite: Seek — **Risk Tolerance Score 9–12**

Appendix 1 - Board Assurance Framework 2023/2024 – Risk Appetite Statement

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Trust Risk Appetite Statement

Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **Consistently Provide Excellent Care**, we recognise that, in pursuit of this overriding objective, we may need to take other types of risk which impact on different organisational aims. Overall, our risk appetite in relation to consistently providing excellent care is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.

We have an open appetite for those risks which we need to take in pursuit of our commitment to create a **Great Place to Work**. By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce this tolerance does not extend to risks which compromise the safety of staff members or undermine our trust values.

We also have an open appetite for risk in relation to our strategic ambition to **Deliver Value for Money** and our strategic aim **to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria**, maintaining and strengthening our position as the leading tertiary care provider in the local system, where we can demonstrate quality improvements and economic benefits. However, we will not compromise patient safety whilst innovating in service delivery. We are also committed to work within our statutory financial duties, regulatory undertakings, and our own financial procedures which exist to ensure probity and economy in the trust's use of public funds.

We seek to be **Fit for the Future** through our commitment to working with partner organisations in the local health and social care system to make current services sustainable and develop new ones. We also seek to lead in **driving health innovation through world class Education, Training & Research** by employing innovative approaches in the way we provide services. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

Risk Title: Risk to delivery of the Trust's Strategic Objective to Consistently Deliver Excellent Care

Risk ID: 855
Risk owner: Chief Nursing Officer
Date last reviewed: 10th July 2023

Risk

There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to:
a) Availability of staff
b) High Occupancy levels
c) Fluctuating ability to consistently meet the constitutional and specialty standards
d) Constrained financial resources impacting on the wider system, the deficit position facing the Trust and the significant costs of operating the current configuration of services.
e) Health inequalities across the system

This may, result in adverse patient outcomes and experiences.

Risk Appetite:

Cautious to Risk – Willing to accept some low risk, whilst maintaining an overall preference of safe delivery options.

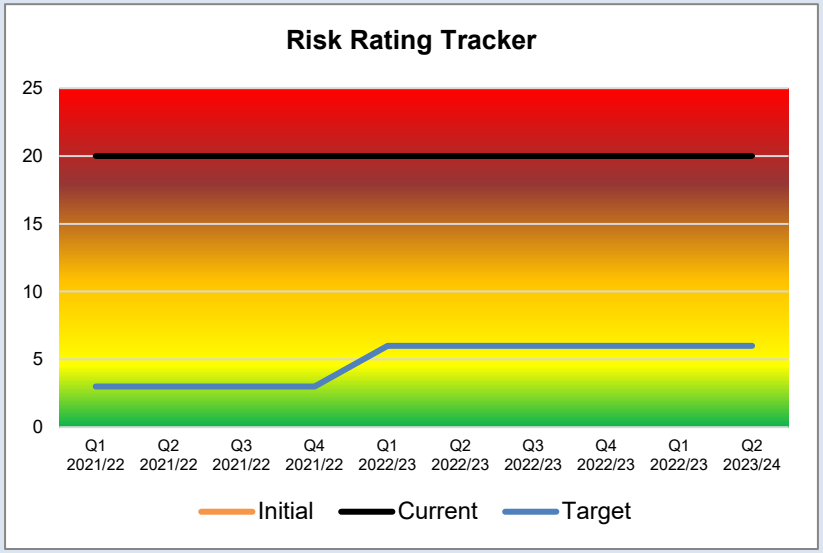
Risk Tolerance

1-6

Rationale for Current Score

- There is currently a reliance on temporary workforce due to sickness levels in excess of 4% and greater than 5% vacancy levels resulting in variation in care delivery.
- The requirement to deliver a Cost Improvement Programme of 5.5% and an overall Financial Improvement Plan of 8.5%.
- Continued deterioration in the backlog maintenance position and the impact on both buildings and equipment.
- Estate does not meet HTN standards, limiting consistent adherence to safety and aesthetic estate standards.
- Excess waiting times in elective services remain evident for patients.
- Occupancy levels are in excess of 95%.
- Patients are routinely waiting longer than some national standards for treatments and in the Emergency Department.
- Adult inpatient experience feedback is identifying room for improvement.
- There is national acknowledgement that health inequalities exist in all heath and care systems and contribute to poorer outcomes of citizens.
- The ability to live within the resources available is dependent upon scalable system wide transformation. The foundations for this work remain formative.
- C.*Difficile* rates exceed expected rates and allocated trajectory (managed through Risk ID 1157 – Increased C. Difficile Infection)

Risk Rating Tracker * (Likelihood x Consequence)
Initial: 4x5 = 20 Current: 4x5 = 20 Target: 1-6



*Initial score also 20 throughout but covered by current score line on above graph

Future Risks

- Risk of New Hospital Programme not progressing.
- Risk that the backlog maintenance of the estate may reach a point where closures of departments is required due to unsatisfactory estate conditions.
- Failure to improve existing operational flow arrangements.
- Failure to address system health inequalities.
- Failure to progress with transformation at scale to live within resources available to us.

Future Opportunities

- ICS networks and collaboration leading to reconfiguration of vulnerable services.
- New Hospital Programme delivery.
- Reduction in vacancy and sickness levels will present an increase likelihood of improved outcomes and experiences for patients and staff.
- Closer working relationship across the health and care system in partnership with public health presents opportunities to level up access to services and design out system inequalities.
- Mobilisation of transformation at scale across the system.

Controls

- Workstream related strategies and plans in place
  - Always Safety First
  - Clinical Strategy

Gaps in Control

- Equitable access to health and care is disproportionately more challenging for

Assurances

Internal

- STAR Assurance Framework
- Always Safety First Group
- Safety and Learning Group

Gaps in Assurances

- Gaps identified within the revised IPC BAF version 1.11. ***(Ref CDEC 013)***

○ STAR Quality Assurance Framework ○ Patient Experience and Involvement Strategy ○ Risk Management Policy ○ Our Big Plan ○ Continuous Improvement Strategy ○ Equality, Diversity and Inclusion Strategy ○ Workforce and OD Strategy ○ Education, Training and Research Strategy ○ Financial Strategy ○ Health and Wellbeing Strategy ○ Communication Strategy ○ Targeted recruitment & plans and temporary staffing arrangements (inc international and healthcare support workers) ○ Safety and Quality Policies and Procedures ○ Workforce Policies and Procedures ○ Health & Safety Plan ○ Operational Plan ○ Restoration and Recovery Plan ○ Safe staffing reviews ○ Safeguarding Board • Accountability Framework • Freedom to Speak Up, Guardian of Safe Working and Person in Position of Trust (PIPOT) arrangements • Safety Forums • GIRFT programme of work. • Capital planning process • Medical device process • EQIA policy and procedures • Transformation programme • Integration of services and pathways and effective system-based working • Confirmation received of progression to the next stage of the NHP in May 2023 • Capital investment case created expand the MAU and SAU.	citizens with protected characteristic or those living in deprived areas. ***(Ref CDEC 007)*** • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection. ***(Ref CDEC 008)*** • The demand for medical device replacement exceeds available capital. ***(Ref CDEC 009)*** • Lack of available capital funds to support all medical device requirements. ***(Ref CDEC 009)*** • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. ***(Ref CDEC 012)*** • The current environment within medical and surgical assessment units does not meet demand. ***(CDEC 014)***	• Divisional Governance Structures and arrangements • Divisional Improvement Forums • Safety and Quality Committee • Workforce Committee • Finance and Performance Committee • Education, Training and Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system • CNST internal assurance reporting • Medical Staffing Review Plan in place to strengthen assurance of testing safe medical staffing • Equality Quality Impact Assessment (EQIA) procedure and reporting in place. • Transformation programme Board **External** • National Surveys • Clinical Negligence Schemes for Trust • External regulators and benchmarking • Medical Examiner's Office, Perinatal Mortality Tool • Internal Audit • External system assurances, PLACE based arrangements, ICB and PCB • NHS England performance monitoring • Independent Support Team (IST) review	

• Local plan to respond to the national Core20PLUS5 approach to equitable healthcare for adults and children in place			

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 002	Create a Long term Urgent and Emergency Care Strategy	Chief Nurse/Director of Continuous Improvement	30 June 2023	10 June 2023	Completed	Control	• Integration of services and pathways and effective Place and system-based working
CDEC 007	Create a local plan to respond to the national Core20PLUS5 approach to equitable healthcare for adults and children.	Chief Nursing Officer	~~30 June 2023~~ 31 July 2023	31 July 2023	Completed	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristic or those living in deprived areas.
CDEC 008	Progress to the next stage of the New Hospitals Programme.	Chief Medical Officer/Chief Financial Officer	30 June 2023	31 May 2023	Completed	Control	• The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection.
CDEC 009	Increase oversight of medical device replacement programme and process through Finance and Performance Committee.	Chief Financial Officer	31 August 2023		Ongoing	Control	• The demand for medical device replacement exceeds available capital. • Lack of available capital funds to support all medical device requirements
CDEC 010	Review of EQIA policy to extend to wider change and transformation programmes.	Chief Nursing Officer	31 May 2023	31 May 2023	Completed	Assurance	• EQIA policy requires extending to wider programmes of change and not exclusively Cost Improvement programmes.
CDEC 011	Development of a capital investment case to right size the medical and surgical assessment unit.	Director of Strategy	30 June 2023	30 June 2023	Completed	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 012	Development of an ED capital investment case to improve the environment until NHP is delivered.	Chief Operating Officer	31 December 2023		Ongoing	Control	• The current environment within the ED requires upgrading to reduce the risk of environmental decontamination.
CDEC 013	Weekly executive oversight of progress against updated IPC BAF v 1.11.	Chief Nursing Officer	30 September 2023		Ongoing	Assurance	• Gaps identified within the revised IPC BAF version 1.11.
CDEC 014	Completion of planned expansion of MAU and SAU	Chief Nursing Officer	31 July 2024		Ongoing	Control	• The current environment within medical and surgical assessment units does not meet demand.

Summary of review – June and July 2023

- Action CDEC 002 completed leading to new control identified - Unable to secure a place strategy at this time whilst place approach to this is refined. LTH strategy approved.
- Action CDEC 007 completed leading to an LTHTR plan to respond to CORE20PLUS5. This will require continued refinement as the year progresses and more is understood on how to tackle health inequalities effectively, which is why the gap in control remains documented on the risk.
- Action CDEC 008 completed leading to new control identified - Confirmation received of progression to the next stage of the NHP.
- Action CDEC 010 completed and removal of gap in assurance - EQIA policy reviewed and expanded to provide greater breadth of change projects alongside CIP.
- Action CDEC 011 completed leading to a planned expansion of MAU and SAU due for completion July 2024.
- Action CDEC 012 created in response to a review of the ED environment and acknowledgement that it requires upgrading whilst the NHP develops and is implemented.
- Action CDEC 013 created in response to national revised IPC BAF v1.11 and gaps identified. Weekly executive oversight of this is in place in response to continued elevated rates of C. difficile. Safety and Quality committee have in place monthly reporting relating to C. difficile and 6 monthly deep dives scheduled.
- Action CDEC 014 created in response to ongoing planned work to expand MAU and SAU.
- New gap in control identified which is supported by action CDEC 009 - Lack of available capital funds to support all medical device requirements
- Risk Rating Tracker redesigned to a graph format instead of table.
- Updates to narrative in Rationale for Current Score

Risk Title: Risk to delivery of the Trust's Strategic Objective of Delivering Value for Money

Risk ID: 857

Risk owner: Chief Finance Officer (Update provided by Operational Director of Finance in July 2023)

Date last reviewed: 12th July 2023

Risk

There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection

Risk Appetite:

Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Tolerance

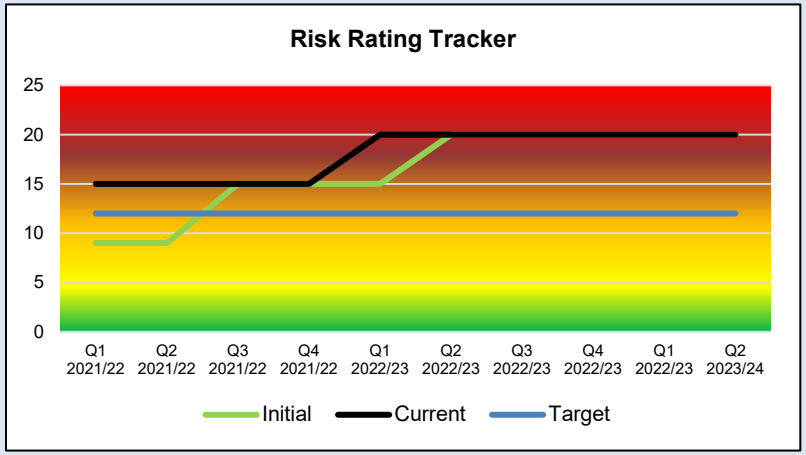
8-12

Rationale for Current Score

- **Undertakings** The Trust is in segment three for the System Oversight Framework (SOF). Undertakings applied by NHSE to the Trust include the need for the Trust to agree its financial plans with the Integrated Care Board, a requirement to deliver that plan and a supporting need to deliver the associated cost improvement plan. The Trust must deliver a challenging costing improvement target of 5.5% in 2023-24. In addition, unless a solution can be found to offset the cost of excess unfunded capacity (c3% of operational expenditure), the Trust will fail to meet its financial plan. The Trust has enforcement undertakings relating to its financial position. This may result in a move to SOF four.
- **Excess urgent care demand** – Excess flow related demand on the non-elective pathways have resulted in additional unfunded beds being opened. Despite this additional capacity, the Trust's performance standards are being impacted negatively due mainly to the excess patient demand for hospital beds.
- **Industrial relations** – Increased industrial tension is giving rise to additional financial and performance pressures which will further hamper the delivery of VFM. The Trusts ability to mitigate the impact of these tensions is limited, without some further consequence.
- **Financial recovery (Trust)** – The Trust is unable to deliver a balanced plan for 2023-24 and will aim to rebalance its finances over a three-year period. The Trust has set a challenging financial improvement target for 2023-24 and it needs to ensure that the associated change is managed through an effective equality and quality impact assessment process.
- **Financial Recovery (system)** – In setting plans for 2023-24 all NHS organisations in Lancashire and South Cumbria will be challenged to deliver their financial trajectories. To do so will inevitably lead to changes in the commissioning and provision of services. Some of these changes will inevitably impact on arrangements with partners which may impact further on delivering value for money.
- **Dependencies** – Whilst there are many improvements to be driven internally, to further improve value for money there are many dependencies on partners, e.g. to develop a clear out of hospital strategy, to help tackle not-meeting criteria to reside, to support the reorganisation of services or to fund the alternatives to hospitalised care.

Risk Rating Tracker (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x5 = 20 Target: 8-12



The score of 20 reflects the underlying financial position of the Trust.

	Future and Escalating Risks • **Investment** – The Trust in the meantime has an underlying overspend which will need to be addressed. The failure to improve financial performance is likely to impact on future major investment decisions facing the Trust. • **Placed based leadership** – The place-based roles are continuing to form and are considered to be pivotal in the optimisation of the health and care 'eco-system'. There is a risk that the evolution of these arrangements do not sufficiently impact on the optimisation processes and that leadership arrangements between sub place, place and system are confusing with unclear accountability. • **Rising demand** – Failure to develop a credible and meaningful urgent and emergency care strategy at system and place to respond to a growing population with increased complexity/comorbidity will result in residents accessing inappropriate services which could impact detrimentally on value for money for public services as a whole. • The failure to reorganise planed care across the system will result in waste and unwarranted variation, resulting in impact on overall value for money.	**Future Opportunities** • Benchmarking indicates opportunities remain to reduce waste and the underlying overspend. • There is an opportunity to reduce financial risk through reorganisation, adoption of technologies, automation and the removal of unnecessary duplication and waste. • There remains an opportunity to increase margins through non-NHS activities. • There remains opportunity through the ICS and the place-based arrangements to reduce the unnecessary duplication of NHS services. • There is an opportunity to work with the Provider Collaboration Board to identify and pursue collaboration opportunities at scale. • There remains an opportunity to commission more effective services to mitigate hospital attendances. • There remains a partnership opportunity at system and place to better manage patient pathways and reduce inappropriate demand and unnecessary cost escalation. • There remains an opportunity for partners to support more timely discharge from hospital, reducing the overall cost to the taxpayer and improve outcomes.

Controls	**Gaps in Control**	**Assurances** **Internal**	**Gaps in Assurance**

• Workstream related strategies in place
  ○ Workforce and OD Strategy,
  ○ Continuous Improvement Strategy
  ○ Clinical Strategy
  ○ Financial Strategy
  ○ IM&T Strategy,
  ○ Estates Strategy,
  ○ Our Big Plan, Annual Business Plan Planning framework established to track delivery of schemes.
  ○ Always safety first
• Scheme of delegation/Standing Financial Instruction
• Accountability Framework
• Long term case for change the New Hospitals Programme
• CCG funding for additional plans in Stroke and Palliative care
• Contract management and activity under regular monitoring
• National Planning Framework and Capital now given to ICS areas.
	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs.
	• Service disruption due to ongoing industrial tensions (Managed through operational risk ID 1182 (probability of strike action) escalated to Board)
	• Inability to sufficiently influence externally impacting directly on services provided by LTH (e.g., partner organisation strategies and decision taking, financial rules for NHS services, NHS wide workforce development and investment and some processes and decision making at system and PLACE such as priority setting in development and deployment of system and PLACE Urgent and Emergency Care Strategy)
		• Specialty Performance meetings
		• Divisional Improvement Forums
		• Integrated Performance reporting at Finance and Performance Committee and Board
		• Audit Committee assurance processes to test effectiveness of financial infrastructure and internal control system
		• Temporary monitoring of undertakings internally (The Trust has been placed in segment three for the System Oversight Framework (SOF)).
		• Use of Resources assessments now reported through Finance & Performance Committee.
		• Regular embedded cycle of sharing information relating to the wider programme of change in place
		• Report on elective productivity and plans for improvement completed to better understand the impact on elective productivity together with movements in the underlying drivers together with plans for improvement
			• The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding. (***DVFM 010)***
			• The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better. ***(DVFM 015, DVFM 016, DVFM 017 and DVFM 018)***
			• To support the drive for improved delivery the governance arrangements require some amendment. ***(DVFM 019 and DVFM 020)***
			• The trust has an opportunity to improve the rigour and robustness of its decision-making processes. ***(DVFM 021)***
			• There is an opportunity to better describe how partnering/collaborative arrangements, e.g. through the Provider Collaborative Board, can help to improve value for money ***(DVFM 022)***

• Planning guidance now reflective of current operational pressures secondary to Covid-19 with revised Big Plan and annual business plans in place • Stocktake of senior leadership engagement in place or system decision making processes • Clear and regular updates to/discussions at Board Subcommittees and Board meetings to ensure robust assumptions underpin our planning returns/templates • Vacancy freeze for non-essential posts now in place • Virement policy revised and in place. • Role of the vacancy control process extended to put greater challenge into replacement posts.		**External** • Head of Internal Audit Opinion/Going concern review • Benchmarking model hospital/GIRFT • External Auditor review • External system assurances, PLACE, ICB and PCB • Contract monitoring report to provide stronger assurances on the underlying trading position and associated activity now reintroduced. • Considering the deteriorating financial position faced by NHS providers, NHS England have issued a series of checklist with an updated protocol for a deterioration in financial forecast. Now complete and submitted.	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 010	Develop a medium-term plan with a supporting financial model to outline the route to recovery	Chief Financial Officer and Director of Strategy and Planning	~~30.06.23~~ 30.09.23		Ongoing	Assurance	The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding.
DVFM 014	Clinical strategy (urgent care)	Director of Transformation & Chief Nursing Officer	~~31.05.23~~ 31.07.23	10.07.23	Complete	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 015	Clinical strategy (scheduled care)	Chief of Operations	~~31.05.23~~ 31.07.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 016	Clinical strategy (provision)	Director of Strategy and Planning	~~31.07.23~~ 30.09.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 017	Income strategy	Chief Financial Officer	~~31.07.23~~ 30.09.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 018	Digital strategy	Chief Information Officer	~~31.07.23~~ 30.09.23		Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.

DVFM 019	Strengthen executive oversight of transformation and subsequent reporting to Committee	Director of Transformation	31.05.23	31.05.23	Complete	Assurance	To support the drive for improved deliver the governance arrangement require some amendment.
DVFM 020	Evolve performance accountability framework		~~31.07.23~~ 30.09.23		Ongoing	Assurance	To support the drive for improved deliver the governance arrangement require some amendment.
DVFM 021	Develop a set of strategic decision-making criteria	Director of Strategy and Planning	31.05.23	31.05.23	New - Complete (STA)	Assurance	The trust has an opportunity to improve the rigour and robustness of its decision-making processes
DVFM 022	Develop a 'value add' reporting for collaborative arrangements	Chief Financial Officer	~~31.07.23~~ 30.09.23		Ongoing	Assurance	There is an opportunity to better describe how partnering/ collaborative arrangements e.g. through the Provider Collaborative Board can help to improve value for money

Summary of updates to risk – June and July 2023

- Risk Rating Tracker redesigned to a graph format instead of table
- Deadline for DVFM 010 extended to end of September as the medium term financial plan is to be completed in line with the national and ICB timetable.
- Action DVFM 014 completed
- Action DVFM 015 remains on track for completion by the end of July 2023.
- Action DVFM 016, Action DVFM 020 and Action DVFM 022 due dates extended as work remains ongoing
- Action DVFM 017 due date extended as work remains ongoing. An action plan has been devised to address the development of Trust Income strategy in Q2 2023/24 and includes analysing and understanding sources of Trust income and current financial status, refreshing all trading accounts, completing the income strategy to be presented to FPC, developing SOPs for ongoing monitoring of all sources of Trust income and adding an identified improvement opportunities to the CIP plan/financial recovery plans.
- Action DVFM 018 due date extended as work remains ongoing. The digital program is successfully overseeing numerous large initiatives with a primary emphasis on collaborative efforts across the Integrated Care System (ICS). Particularly noteworthy are the ongoing procurement of an ICS-wide shared Electronic Patient Record (EPR), the establishment of a secure data environment across the Northwest region, supported by a funding award of 14 million, the development of an ICS-wide patient engagement portal, the migration to SharePoint and OneDrive for improved working practices and corporate collaboration. While most programs are progressing as planned, challenges such as funding constraints, workforce shortages, and mounting pressures are increasingly apparent.
- Deadlines for DVFM 020 and DVFM 022 all extended to end of Sept as work continues on these actions.

Risk Title: Risk to delivery of the Trust's Strategic Objective to be a Great Place to Work

Risk ID: 856
Risk owner: Chief People Officer
Date last reviewed: 29th June 2023

Risk

There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development.

This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care.

Risk Appetite:

Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

Risk Tolerance

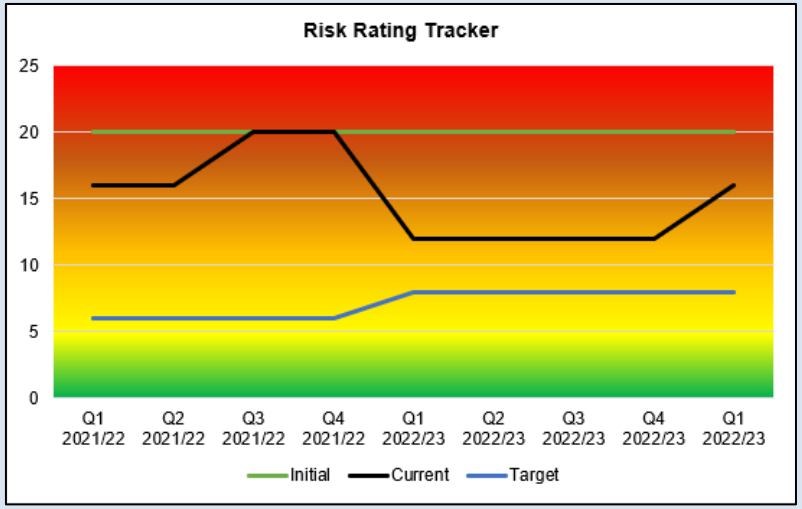
4-8

Rationale for Current Score

- Workforce shortages in some key professional groups, which creates vacancies and creates pressure on existing staff in particular registered nurses and some medical specialties.
- High turnover of less than 12 months in some staff groups particularly support workers and ability to recruit from local labour market.
- Staff engagement score is currently at the national average and has reduced in year.
- Staff advocacy scores currently below the national average and have deteriorated over the last four quarters.
- Physical environment, colleague facilities (catering) and car parking cited as a concern by departments and teams for having an impact on morale, wellbeing and ability to work effectively.
- Leadership ability and capacity impacting on levels of staff satisfaction, cultural transformation and workforce metrics in a number of areas.
- High levels of sickness absence related to mental health issues and musculoskeletal injuries and lack of capacity in health and wellbeing service to respond to needs in a timely way.
- Increase pressure from restoration leading to staff burn out post COVID and ability to participate in wider engagement and development activities.
- Gap between the desired and the current culture indicates improvements are needed.
- Staff not feeling valued due to inconsistency in employment offers internally and across the region.
- Impact of cost of living pressures on staff which are further compounded in some grades by implications from pension scheme as a result of levels of contribution levels and tax implications.
- The impact of uncertainty and clear direction from PCB plans is leading to higher levels of turnover, inability to recruit to vacancies, reduced engagement and morale levels in teams potentially affected by the changes, making it difficult to deliver on strategic plans described in Our People Plan.
- Insufficient resource within the Workforce and OD team to deliver change programmes at pace and respond to changing directions from the PCB.
- Vacancy freeze for all non-clinical roles along with a competitive recruitment market will mean vacant posts will be unable to be filled, leading to non-delivery of core objectives and business as usual.
- 3% reduction in establishment is likely to create additional pressures on existing staff impacting on sickness, well being and morale

Risk Rating Tracker (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x4 = 16 Target: 4-8



	• Local onboarding processes do not consistently provide new recruits with a positive employment experience. • National unrest regarding cost of living and national pay deals leading to strike action taking place in most professional groups. • National pay and reward contract negotiations outcomes not seen as favourable by Unions leading to continuing strike action taking place. • The junior doctor strike action will have an impact on the delivery of planned activity due to consultants required to act down to provide strike cover. • The British Medical Association (BMA) rate card challenge will have a significant impact on the overall pay bill if implemented. If not implemented this could create a significant resourcing challenges and inability to deliver on planned activity and restoration plans as it is likely Consultants will withdraw from supporting waiting list initiatives. • Due to the BMA rate card challenge we are seeing an increased appetite for the establishment of Limited Liability Partnership (LLPs) by our Consultant workforce, at present there is limited governance in place to ensure adequate controls and regulation.	
	Future Risks • Ageing workforce profile in some services, leading to significant gaps post retirements. • Development of new roles may be hindered by inability to fund training posts and service posts simultaneously. • Impact of training and support for international new recruits on current staff and the retention of the new recruits. • Inability to source additional temporary workforce to support restoration and recovery plans • Further reduction in staff morale given focus on need to deliver financial turnaround • Non-delivery of New Hospital Programme impacting on ability to utilise available workforce effectively. • ICS transformations on corporate services benchmarking identified significant opportunity for saving in HR/OD workforce which is in direct contrast to the significant service pressures on the teams and ability to deliver transformational culture and OD programmes • Continued deterioration of the working environment and hygiene factors impacting on staff satisfaction	**Future Opportunities** • There are opportunities to work across the ICS to support workforce supply, i.e., international recruitment, creation of new roles. • Changes to models of care present opportunities to remodel workforce. • Continued opportunity to use the multi professional skills of our workforce in different ways to help tackle specific workforce shortages. • Opportunity to adequately resource an OD programme to increase staff engagement and cultural transformation at pace. • Create a first-class working environment as part of the New Hospitals Programme • Redesign and implementation of more effective and consistent off boarding processes in order to retain a positive perception of leavers with regards to their employment experience.

Controls	Gaps in Control	Assurances	Gaps in Assurances

• Workforce and OD strategy related strategies and plans in place
  ○ Trust Values
  ○ Workforce Plan
  ○ Targeted recruitment & plans (international and
	• Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking and action plans to reduce unwanted	**Internal**
		• Divisional Governance Structure and Arrangements
		• Divisional Improvement Forums (including Part II process to address cultural concerns)
		• Raising Concerns Group
			[None]

healthcare support workers) ○ Workforce policies with EIA embedded ○ Health and Wellbeing strategy ○ Just culture ○ Regular temperature checks in place for staff satisfaction, culture, with action plans e.g., Staff Survey, NQPS, HWB, TED, Cultural survey ○ Leadership and Management Programmes ○ Appraisal and mentoring process ○ Workforce business partner model and advice line in place ○ Staff representatives in place, including union representatives, staff governors ○ Vacancy control panel in place and meeting weekly ○ Strike Action Emergency Planning Group weekly meeting • Equality, Diversity, and Inclusion strategy • Freedom to Speak Up and Guardian of Safe working arrangements • Education & Training strategy • Risk Management Strategy • Health and Safety Plan • Always Safety Strategy • Safe staffing reviews • Our Big Plan • Communications strategy • Accountability Framework • Safety Forums	variation in existing strategies. ***(GPTW001/DVFM002)*** • Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design. ***(GPTW002)*** • Ability to influence the direction of the Provider Collaborative Board with regards to programmes of work, desired impact measures and methods for achieving aims. • Sufficient staffing within workforce and OD to support work required to deliver transformation and deliver of the Trust's People Plan	• Workforce Committee • Education Training and Research Committee • Safety and Quality Committee • Audit Committee assurance processes. • Regular schedule of reporting arrangements for cultural risks at Committees of the Board and Board now in place and covered within the Risk Management Policy **<u>External</u>** • National Surveys and benchmarking including staff satisfaction survey, workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) • Internal audit and external reviews e.g. • External regulatory oversight e.g., Re-accreditation of Workplace wellbeing charter (5 out of 8 domains sitting as excellent) • rostering review by NHSI indicating excellence in rostering practice	

• New Hospitals Programme • Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision included within the revised People Plan launched in April 2023			

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
GPTW001	Review strategies considering financial pressures and delivering value for money as part of committee cycles of business.	Executive Leads	31st March 2023	1st April 2023	Complete	Control	• Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking and action plans to reduce unwanted variation in existing strategies. • Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision.
GPTW002	Incorporate transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	Director of Strategy and Planning	~~31st May 2023~~ 31st May 2024		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.

Risk updates – June 2023

- Current score increased from 12 to 16 following recommendation from Workforce Committee in May 2023 and Risk Grading Tracker updated to graphical heat map format from tabular format.
- Actions completed in the previous financial year archived from this document and remain captured within the risk record on the Datix system.
- Due date for Action GPTW 002 extended by 12 months – A workforce plan was submitted to Workforce Committee in May 2023. Some actions within that plan sit within the Divisional Transformational Programmes of Work which are ongoing and workforce efficiencies and transformation are still to be formulated. The Workforce team is actively engaged in the Transformation Schemes however this is a longer-term ongoing piece of work. Divisions are also rescoping their service delivery models to determine workforce changes that need to take place.

Risk Title: Risk to delivery of the Trust's Strategic Objective of Fit for the Future

Risk ID: 858
Risk owner: Director of Strategy and Planning/Chief Medical Officer
Date last reviewed: 19th July 2023

Risk

There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

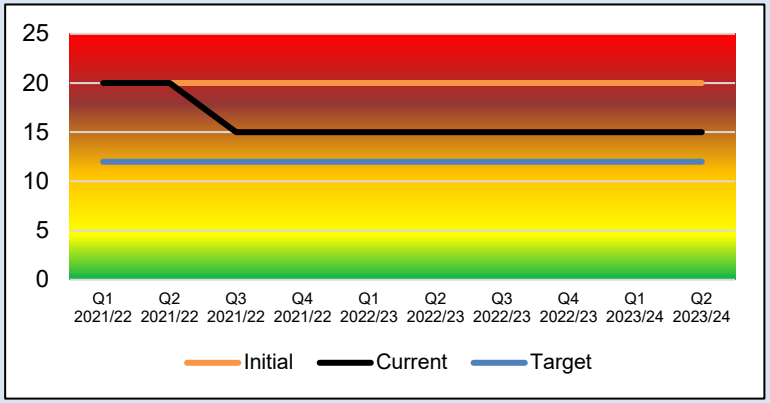
Risk Appetite: Seek – Eager to be innovative and to choose options offering higher rewards, despite inherent business risk.

Risk Tolerance 8-12

Rationale for Current Score

- Place and System based working are developing both in terms of personnel, roles, governance, strategies, and plans and within this context LTH has reputational/performance challenges that are challenges to our ability to work effectively at both levels. System working has progressed to a clearer position though there is still a need for greater clarity particularly in relation to driving benefit across the quadruple aim. Place Based working is still being established though a helpful update was given to the 10th May Senior Leaders Team meeting by the Integration Place Leader for Central Lancashire
- The Clinical Programme Board (CPB) is established, meeting regularly to oversee the PCB clinical transformation programme with a range of Programme plans, Trackers and Toolkits in place. The Benefit Tracker for the CPB is shared with the Trust's Finance & Performance Committee – progress is being made but there remains work to be done to show clear contribution against all the quadruple aims.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- Digital transformation will be a major enabler for partnership working, pathway/service integration and ensuring we are fit for future. We have an ambitious Digital Northern Star strategy but delivering this will be a major challenge in terms of resources, organisational change and system working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to meet delivery of the services our partners rightly expect and our staff will be focused on immediate operational challenges rather than service and pathway integration. The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- Delivering the above will be a major challenge which will require the highest levels of staff engagement and communication, areas where the Trust scores relatively well compared to our peers but we will need significant improvement in future to deliver our ambitions
- Delivering the above will require the Trust to develop its capacity, capability and governance to robustly deliver major change programmes

Risk Rating Tracker (Likelihood x Consequence)
Initial: 4x5 = 20 Current: 3x5 = 15 Target: 8-12



Future Risks

- Demographic pressures
- Population health and Health inequalities challenges
- Estates challenges/backlog maintenance
- Workforce gaps/challenges

Future Opportunities

- System and Place working
- Service transformation/integration
- Digital
- New Hospitals Programme

Controls	Gaps in Control	Assurances	Gaps in Assurances

• Workstream related strategies in place
  ○ Clinical Strategy
  ○ Digital Strategy,
  ○ Estates Strategy, including New Hospital Programme
  ○ Comms and engagement
• New Hospitals Programme operational groups established and named executive lead.
• Place and system delivery boards established, where LTHTR continue to link own strategies with Place and System plans.
• LTHTR executive leads with Place/ICS responsibilities.
• Director of Communications & Engagement and Head of Communications in roles of SRO and Chairs of professional networks and providing significant contribution to the Provider Collaborative
• Clinical Programme Board (CPB) in place meeting monthly overseeing the PCB clinical transformation programme
• ICB has published 5 Year Joint Forward Plan
• Transformation Programmes developed and being led by Executive Team
• Transformation & Recovery Board in place chaired by CEO, strengthening oversight of delivery of transformation programmes against agreed trajectories and addressing barriers for progress.
• Digital Northern Star working groups in place to deliver the Digital Northern Star programme
• Organisations within Digital Northern Star are sharing information regarding infrastructure digital contracts for a collaborative approach to networking and data centres.
• Improved communications Trustwide and External – HeaLTH matters, In Case You Missed It and Exec Q&A session all put in place to enhance staff engagement and External newsletter reinstated for key stakeholders across our communities.
	• Integration of services and pathways. ***(FFTF 001, FFTF 003, FFTF 004, FFTF 005, FFTF 006, FFTF 008)***
	• Effective Place and system based working. ***(FFTF 001, FFTF 005, FFTF 007, FFTF 008)***
		Internal
		• Executive Transformation Group
		• Planning Framework updates to Finance and Performance Committee.
		• New Hospitals Programme assurance to Board
		• Audit Committee assurance processes to test effectiveness of infrastructure and internal control system.
		• Strategic element of Board discussions has been strengthened with dedicated sessions to focus on specific strategies
		• Northern Star Programme shared approaches developed leading to £1M in cash realising or cost avoidance savings
		• Online presence seen to increase over the period March 2023 – May 2023 with 23,000 new users to the Trust website in that period demonstrating continuing upward trend of engagement with the local population. Increase in Twitter and Facebook interaction and internal intranet interaction also.
		
		External
		• New Hospitals Programme Oversight Group
		• ICS Digital Board
		• Clinical Programme Board
		• Central Services Board
			• Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim ***(FFTF 001, FFTF 003, FFTF 004, FFTF 008)***
			• The Board requires dedicated time to fully discuss the wide range of system issues/changes that will be a key element in our being Fit for the Future ***(FFTF002)***
			• Gaps in Clinical Programme Board Benefit Tracker to show clear contribution against all the quadruple aims ***(FFTF 001)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
FFTF 001	Link LTHTR strategies with Place, Provider Collaborative and ICS Strategies	Executive Leads	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system-based working. • Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim • Gaps in Clinical Programme Board Benefit Tracker to show clear contribution against all the quadruple aims
FFTF 002	Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters	Director of Strategy and Planning	31st March 2024		Ongoing	Assurance	• The Board requires dedicated time to fully discuss the wide range of system issues/changes that will be a key element in our being Fit for the Future
FFTF 003	Ensure maximum LTH influence on/contribution to Place and System working	Executive Leads	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system-based working. • Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim
FFTF 004	Develop and deliver Digital Northern Star strategy	Chief Information Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways • Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim
FFTF 005	Deliver staff engagement/comms strategy (including reputation monitoring/management)	Director of Communication & Engagement and Chief People Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system-based working.
FFTF 006	Deliver New Hospitals Programme	Chief Finance Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways
FFTF 007	Deliver our Social Value Strategy	Director of Strategy & Planning,	31st March 2024		Ongoing	Control	• Effective Place and system-based working.
FFTF 008	Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change	Director of Strategy & Planning, Director of Continuous Improvement & Transformation	31st March 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system-based working. • Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim

Updates – July 2023

- FFTF 001 Link LTHTR strategies with wider Place, Provider Collaborative and ICS Strategies and FFTF 002 Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters: the ICB Director of Planning met with the Board to discuss the Joint Forward Plan 2023 onwards. The Plan has now been agreed by the ICB and will be used to review/update our Clinical Services Strategy.
- FFTF 003 Ensure maximum LTH influence on/contribution to Place and System working: LTH continue to deliver a very substantial commitment/contribution to system working both at Place and System level eg taking on formal system roles, leading on System/Place projects etc
- FFTF 004 Develop and deliver Digital Northern Star strategy: Scoring for ICS wide EPR is 60% complete and likely to finalise in September post moderation. Treasury has provisionally approved a further ~£11M of funding for the North West secure data environment and the team are working closely with all three ICB's for approval to spend while local governance is being prepared ready for implementation of a proposed ICS centralised information architecture. ICS wide patient engagement portal and collaborative working through the central services portfolio are both accelerating.
- FFTF 005 Deliver staff engagement/comms strategy. The Communications team have continued to support the work of the Lancashire and South Cumbria Provider Collaborative by running the virtual colleague briefing session held in May for all colleagues across the system, as well as producing two newsletters, and are actively involved in the set-up of the soon to be launched Engagement Hub. The Trust also participated in a cross-system celebratory video which highlights the breadth of work taking place across Lancashire and South Cumbria. The department continue to lead the way on fulfilling pro-active and reactive media requests on behalf of the Integrated Care Board and NHS England, particularly in relation to Industrial Action and an ITV Special Report on the NHS' 75th Birthday. Other items included a BBC NW Tonight report on the Trust becoming the first in the country to benefit from the Lung Vision Navigation system. Internally, the Trust has continued with its cycle of regular communications, supporting with key messaging for the visit of the Care Quality Commission (CQC), industrial action and the announcements surrounding the future of Chief Executive, Kevin McGee. Externally, the Trust continues to feature positive news stories including colleague recognition, research developments, award shortlists, unit openings and much more. Digitally, the overall traffic to the Trust website has increased by 7.6%, which in numbers means 30,000 more visitors. Equally, the average engagement time has increase by 3.6%, meaning users are actively spending longer on the website. The Trust has also been making significant improvements to its website accessibility following an inspection from the Cabinet Office's Accessibility Monitoring Team. Areas identified, which have not yet been corrected, will be made available on the Accessibility Statement with a timeframe for them being rectified. On the social media front, all our platforms have experienced growth with Facebook seeing a 6.7% increase in its reach with Instagram improving by 13% on the same metric. On Twitter the Trust has received 112,000 Tweet impressions and 5,374 profile visits during June, a significant increase versus previous months.
- FFTF 006 Deliver New Hospitals Programme: On the 26th May the Secretary of State for Health announced confirmation of two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary as part of a rolling programme of national investment in capital infrastructure beyond 2030.
- FFTF 007 Deliver our Social Value Strategy: Working well with all partners. On track to submit level 2 accreditation application by April 2024
- FFTF 008 Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change: Progress continues to be made to develop and strengthen our governance and processes. In 2023/24 the transformation programmes are being further strengthened, maximising the focus on delivery and recovery.

Risk Title: Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service

Risk ID: 859
Risk owner: Chief Medical Officer
Date last reviewed: 18th July 2023

Risk Description:
There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients.

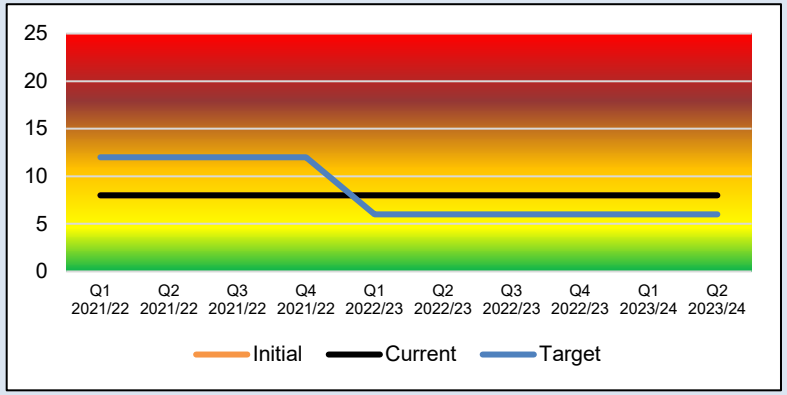
Risk Appetite: Open to Risk - prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

Risk Tolerance
6-9

Rationale for Current Score

- Place and System based working are developing both in terms of personnel, roles, governance, strategies, and plans.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to meet deliver the services our partners rightly expect, and our staff will be focused on immediate operational challenges rather than service and pathway integration. The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- ICS and LTH Clinical Strategy developed.
- Provider Collaborative Board Clinical Strategy requires development.
- Limited availability of NHS capital prevents further rationalisation of the estate to more effectively provide specialist services (i.e. Neurosciences, Trauma Services, Stroke Services, and Vascular Services).
- Aging estate with significant backlog of maintenance will produce ongoing limitations with implementing options for service developments in the interim before the new hospitals programme.
- Geography and mutually dependent infrastructure.
- With the transition to the new year the financial rules which apply resource allocation within the NHS in England have transitioned. These rules give some clarity in the allocations awarded to Integrated Care Systems but not to how allocations will be distributed across those systems

Risk Rating Tracker * (Likelihood x consequence)
Initial: 2x4 = 8 Current: 2x4 = 8 Target 6-9



*Initial score also 8 throughout but covered by current score line on above graph

	Future Risks • Risk of New Hospital Programme not progressing. • Commissioning risks to lower volume/low priority services.	**Future Opportunities** • ICS networks and collaboration leading to reconfiguration of services. • New Hospitals Programme investment leading to establishment of Lancashire Specialist Hospital which may include additional specialist services. • Increasing research and innovation profile of specialist services. • Harnessing innovative ways of working using technology

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurances**
• Workstream related strategies in place - LTHTR Clinical Strategy - ICS Clinical Strategy - Estates Strategy - Finance Strategy and Plans • New Hospitals Programme • LTHTR Executive leads with Place/ICS responsibilities e.g. Chief Medical Officer located on a number of network bodies e.g. Chair of Cancer Alliance, Chair of Clinical Oversight Group for New Hospitals Programme, Lead Medical Director for the PCB • Quality and safety controls support the retention of specialist services. *Full details of controls associated with quality and safety of specialist services will be noted in the Strategic Risk associated with the Strategic Ambition to provide Consistently Delivering Excellent Care. • ICS Speciality Boards in place for a number of specialist services • Statutory development of the ICS into. • Capital Planning Group arrangements in place to provide structure and organised approach to capital investment. • Specialist services included within the planning framework.	• Integration of services and pathway and effective Place and system-based working ***(SPEC 001)***	**Internal** • Speciality Boards • Divisional Governance Structures and Arrangements • Divisional Improvement Forums • Safety and Quality Committee • Finance and Performance Committee • Strengthened updates to Board and Audit Committee regarding Specialised Services risk **External** • Scheduled contractual reviews with Specialised Commissioners including Executive Management Team forums to progress and resolve issues. • New Hospitals Programme Oversight Group • ICS and ICB system delivery Boards	• None documented.

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
SPEC 001	Link LTHTR and ICB Clinical strategies with PCB Clinical Strategy	Chief Medical Officer	30th September 2023		Ongoing	Control	• Integration of services and pathway and effective Place and system-based working • PCB clinical strategy still in development

Updates to risk – July 2023

- Risk reviewed with no significant changes to note.

Risk Title: Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research

Risk ID: 860
Risk owner: Chief People Officer
Date last reviewed: 24th July 2023

Risk

There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.

Risk Appetite:

Seek – Eager to be innovative and to choose options offering higher rewards despite inherent business risks.

Risk Tolerance

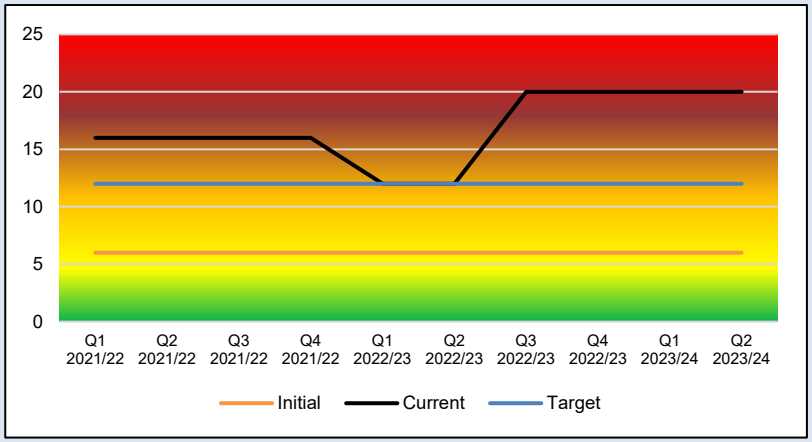
9-12

Rationale for Current Score

- Inability to invest educational income in capital development programmes to expand our education infrastructure.
- NHS Education Contract Tariff changes effective from September 2022 resulting in a review and removal of roles previously funded through education income.
- Ongoing capacity challenges to support education activity.
- Workforce shortages impacting on capacity and educational quality.
- Increasing evidence of health and wellbeing concerns in student and learner community.
- Ongoing challenges to achieve optimum faculty for specialist teaching requirements.
- Impact of economic climate/loss of work due to diagnostic backlogs on commercial research income.
- Not meeting compliance in all training subjects and medical device competencies.
- While being managed by NIHR, ongoing backlog in research study start-up due to 2-year Covid disruption (Covid studies vs re-start vs new) and significant impact on commercial research portfolio, investigator time to dedicate and set-up. Therefore, NIHR guidance changes to re-prioritise studies and rectify necessitates revision of the portfolio. As a result of these R&I running at reducing loss, last Q at breakeven.
- There are opportunities to lead on education, innovation and research programmes in NHP and ICB programmes of work. Presentation of present work has commenced in the PCB.
- Inability to influence essential release of staff for education activity due to service pressures.
- Audit requirements for management of educational income limit flexibility to deliver educational activity which is based on academic years or to support innovative developments funded through income generation

Risk Rating Tracker (Likelihood x Consequence)

Initial: 2x3= 6 Current: 5x4 = 20 Target: 9-12



Future Risks

- Capacity for effective marketing and communications.
- Impact of the New Hospitals Programme on Education estate
- Impact of the increased allowance for simulated placements for nursing students delivered by HEIs – this could result in a reduction in NMET tariff income.

Future Opportunities

- Continued participation and development of funded COVID/respiratory/UKCRF Network sourced related research activities.
- Expansion of undergraduate programmes.
- Increase in the use of advanced digital/AI solutions to provide education and research programmes.
- Launch of Trust innovation hub and external funding opportunity.
- Development of hi-tech education programmes including robotics and simulation learning.
- Development of joint appointments with HEIs.

	• Impact of place-based placement allocation systems (currently emerging) – this could result in a reduction in NMET tariff income. • UK becoming less competitive/losing commercial research trials • Impact of UGME capacity scoping exercise being undertaken by HEE • Potential income deficit position for education as a result of tariff changes and audit requirements for income deferral • Innovation opportunities may be stifled due to reluctance to accept in-year funding developments where income cannot be flexibly utilised across multiple financial years • Potential impact of shared service development across ICS • Potential reduction in CPD/Workforce Development funding and/or potential bid income	• Re-focus of research activity on key national clinical priorities. • Opportunity to bid for capital to update Health Academies to provide hi tech simulation and education. • Opportunity for LTH to become apprentice provider for ICS • Opportunity to manage income generation via Edovation • Potential to expand student placement offer to HEIs within and outside region. • Provision of a range of educational services to primary care • Potential to lead a range of education activity as part of ICS shared service development

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurances**

• Workstream related strategies in place:
  ○ Education & Training Strategy
  ○ Apprenticeship Strategy
  ○ Digital Education Strategy
  ○ Research Strategy
  ○ Our Big Plan, Annual Business Plan Planning framework
  ○ Workforce & OD Strategy
• Ring-fencing of education and research funding.
• Divisional education contracts.
• NHS Education Contract with HEE.
• Policies in place with review cycle.
• Business continuity plans in place.
• Head of R&I now part of New Hospitals Programme and ICB programme working parties.
• Enhanced plans identified within Research & Innovation Strategy to leverage more opportunity to increase funding and assist recovery processes.
• Full review of deferred income has been conducted by finance evidencing and ensuring drawdown of income from deferred position/reserves is matched in line with expenditure and the Education Contract on an ongoing basis.
• Categorised investment requirements for education infrastructure now in place, which is being worked through with Capital Investment Team
	• Lack of research personnel embedded in divisions ***(ETR 007)***
	• No mechanism to utilise educational income to support capital developments ***(ETR 004)***.
		Internal
		• Sub-committees for education, training and research incorporating risk reviews.
		• Quality assurance and performance management of education activity.
		• Learner improvement forum.
		• Monthly training compliance reports.
		• Divisional performance reviews
		• Monthly finance reviews.
		• Education, Training & Research Committee
		• Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system.
		• Board.
		
		External
		• Full OFSTED inspection completed August 2022 with 'Good' rating achieved.
		• ESFA audits
		• HEE self-assessment return.
		• Matrix accreditation.
		• Annual performance reviews with Manchester Medical School
		• National Student Surveys.
		• National Education Trainee Surveys.
		• STAR accreditation for Clinical Research Facility.
		• Engagement in range of external forums and committees.
		• Quarterly strategy meetings with local HEIs
		• Trust Involvement/leadership in ICS discussions re education and R&I
			• None currently identified.

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
ETR 001	Reset research provision to develop an affordable portfolio and refer to this in the refreshed Research and Innovation Strategy.	Head of Research & Innovation	30.04.23	30.04.23	Complete	Control	• Ongoing losses in research income which necessitate a recovery plan.
ETR 004	Include development of international education programmes post-Covid in Education and Training Strategy.	Deputy Director of Education	31.12.23		Ongoing	Control	• No mechanism to utilise educational income to support capital developments
ETR 005	Identify solutions to facilitate and support creation and delivery of a capital programme for education.	Chief Finance Officer, Associate Director of Education	30.07.23	25.07.23	Complete	Control	• No mechanism to utilise educational income to support capital developments. • Ability to income generate in current economic climate
ETR 006	Identify a plan to mitigate identified risks associated with change in deferred income	Chief People Officer/Chief Finance Officer	30.04.23	30.04.23	Complete	Control	• Control of in-year adjustments relating to income deferral
ETR 007	Have Research roles in place within 2 Divisions	Head of Research & Innovation	31.08.23		Ongoing	Control	• Lack of research personnel embedded in divisions.

Summary of Updates – July 2023

- From a research perspective the risk content remains the same as previously documented.
- Action ETR 005 – Action completed. There is now a collated list of investment required in our education infrastructure. This has been split into three categories, education funded, maintenance (should be undertaken by estates) and capital investment. With regards to capital investment, this covers building upgrades such as windows, toilets, air conditioning, heating etc. Education team is currently working with capital investment team to progress further.

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Trust Headquarters

Lancashire Teaching Hospitals Refreshed Financial Strategy– Knowing the Business (2023)– Actions update			
Report to:	Board of Directors	**Date:**	3rd August 2023
Report of:	J Wood, Chief Finance Officer	**Prepared by:**	S Naylor, Senior Assistant Finance Director
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this paper is to provide the Board of Directors with an update on the progress of the refreshed '*Knowing the Business'* medium term finance strategy, presented to FPC on 28 March 2023 and BOD in April 2023.

The original Knowing the Business finance strategy was first launched in October 2021. The core ethos of the strategy was '**financial sustainability'** supported through a number of enabling programmes to drive improvement in the financial sustainability our services and ultimately reduce waste and any unwarranted variation. The original strategy set out the local and national factors influencing the Trusts financial sustainability agenda, recognising the roles from ward to board in ensuring the best use of public resources, understanding the services we provide ensuring they are financially sustainable along with the importance of using our capital resources to sustain existing activity and transforming for the future.

The refreshed strategy (March 2023) retained the core ethos of the original strategy and associated enabling programmes with a renewed focus on delivering recurrent efficiencies. The refreshed strategy included a new enabling programme of work, **'strategies',** reflecting the importance of other organisational strategies in the delivery of financial sustainability.

Good progress has been made against the actions contained within the refreshed strategy with summary highlights contained in the main body of the report and commentary against individual actions included in appendix A.

Recommendation

It is recommended the Board of Directors:

I. Note the updates to the actions contained within the refreshed finance strategy

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☐	Consistently Deliver Excellent Care	☐
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐
Previous consideration			
FPC March 2023, BOD April 2023			

Introduction

1. This report provides an update on the actions contained within the Lancashire Teaching Hospitals NHS Foundation Trust refreshed finance strategy '*Knowing the Business* (KTB)' (March 2023).

Background

2. The Trusts financial strategy was approved in October 2021. The core focus of the strategy was on financial sustainability driven by a number of key enabling programmes[1] with the aim to drive improvement in our services, reduce waste and any unwarranted variation. The original strategy set out the local and national factors influencing the Trusts financial sustainability agenda, recognising the roles from ward to board in ensuring the best use of public resources, understanding the services we provide, ensuring they are financially sustainable along with the importance of using our capital resources to sustain existing activity and transforming for the future.

3. The refreshed finance strategy (March 2023) retains the core ethos of the original strategy and enabling programme's structure, with the exception of a new enabling programme, **'strategies'** reflecting the importance of those other organisational strategies such as workforce, clinical, digital that have an enabling role to play in the delivery of the Trust and system financial sustainability. A renewed set of actions were included to which this report provides an update on.

Enabling Programmes Progress update

4. Progress against the actions set out in the refreshed strategy are contained in appendix A to this report and summarised below:

- **Governance and communications**

  A series of communications around the Trust financial position has been provided over the last six months included in the Chief Executive communications and Trust wide online Q & A

[1] Governance and communications, Operational capacity planning, Knowing the Business, System engagement, Enabling waste reduction and Capital Investment.

briefings including the need to focus on financial sustainability providing a contextual overview of the financial challenges.

The Trust has implemented enhanced governance controls such as no PO no Pay, virement policy and bi daily discretionary payment reviews as part of the focus on grip and control to support the financial improvement plan. As the financial environment continues to be challenged across the LSC system the Trust will continue to engage with staff and provide updates on the financial improvement agenda, internally and system wide.

- **Operational capacity planning**

  As part of the 23/24 planning process operational plans including activity were agreed with the LSC ICB triangulated with finance and workforce assumptions. Monitoring of activity is undertaken against both operational SLAM plans on weekly and monthly basis which supports early warning of any mitigating steps required.

- **Knowing the Business**

  A key success for 23/24 has been the introduction of the unwarranted variation transformation programme. Although still in the early stages of implementation across all divisions, the methodology and framework to understand our data and our opportunities is welcomed from our clinical teams and there is triumvirate engagement in the process.

  Since March the Trust has worked collaboratively in the development of a LSC system wide Patient Level Information and Costing System (PLICS) dashboard which recently won the Northwest (NW) HFMA Finance award. The use of the patient level dashboards will be rolled out during the year to support the forensic analysis of speciality data to help inform efficient and improved patient pathways where required.

  The Trust has also been pivotal in driving forward the population health agenda across the NW and ICB. LTH are hosting the secure data environment on behalf of the NW that will support the research capabilities with our local academia to investigate key drivers of population health and to inform future commissioning intentions.

- **System engagement**

  The Trust is working closely with its system colleagues as the ICB matures and the realignment in the commissioning of services is embedded. Weekly meetings are held with ICB colleagues and biweekly with specialised commissioning to discuss contractual matters and work collectively to progress future workflows including setting the planning agenda for 24/25 and lodging those services that require investment/ disinvestment.

  The ICB provider collaborative has started to take shape since the refreshed strategy update and Target Operating Model together with a roadmap for the way shared services will work in the future is being developed. LTH are a key player in this PCB with our Chief Finance Officer, Jonathan Wood as the finance lead. Regular PCB meeting are held to share progress and keep all staff across the system on priorities areas for shared services.

- **Workforce**

The Trust is work collaboratively with our system colleagues and there is agency rate card reduction model across the ICS that is already making saving £300k included in the Trust overall FIP plan. There is an agency rate card for medical staffing internally and there are plans in train for this as an ICB wide programme of work.

Since March the lead employer model for bank staff has been developed with the contract due to be finalised imminently. This will ensure there is consistency across the system in the payment of bank staff and will allow the passporting of staff across the system.

- **Enabling waste reduction and efficiency**

  There has been an amendment to the action of the digital strategy as this was a duplicate within the 'strategies' programme of work and therefore removed from the updated action plan.

  In respect of the '**effective use of medicines'** action the ICB ascetics group has been established and ongoing work with the ICB is continuing. A gain share agreement on the use of biosimilars has been agreed across the ICB.

  A focus on non-pay expenditure is in place with bi daily reviews internally and through this process areas of priority such use of/ purchasing of paper is being explored with our procurement colleagues as an ICB wide approach.

- **Capital Investment**

  The Trust agreed the three-year capital plan with the ICB as part of the 2023/24 planning process.

- **Strategies**

  There has been good progress on the development of digital, Urgent care, Procurement and Estates strategies. There is slippage to the timescales of the Social Value, Income and clinical scheduled care strategies as they are in development with revised timescale of Q2. Updates on progress are contained within appendix A.

In progress actions

5. A number of actions remain outstanding mainly around the 'strategies' enabling programme. Continued focus on the development of these strategies during the course of quarter 2.

Risks

6. No new risks have been identified.

Impact on stakeholders

7. There is a positive impact on stakeholders through implementation of the refreshed finance strategy. The actions specifically around capacity planning, establishing relationships with the independent sector, understanding population health dynamics and working in collaboration with the LSC ICB will

allow the Trust to shape, influence and lead the way in reducing health inequalities for the people of Lancashire and South Cumbria.

Recommendations

8. It is recommended the Board of Directors:

    - Note the progress of the actions outlined in the Financial Strategy, '*Knowing the Business' (March 2023)*

Appendix A Action plan update

Programme	Objective	Action	Action Lead	Action Due Date	RAG status - July 2023	Comments as at July 23
Governance and Communication						
Creating the conditions for success	Put in place and communicate the financial strategy internally and externally	1 Refresh the finance intranet page	Senior Assistant Finance Director	Q1 23/24	Green	New digital front door for all internal customers to access FAQ and chat bot in place for any direct queries. Any communications relating to finance are held on this page. There is also a link to allows staff to share any savings ideas. A structured plan of regular communications across different staff groups has been agreed.
		2 Develop programme of communication and engagement	Director of Operational Finance (DoF)	Q1 23/24	Green	
		3. Implement engagement plan – spend wisely/ bridging the gap	Director of Communications	Q1 23/24	Green	
		4 Refresh the finance training to make more accessible via digital ebooks	Senior Assistant Finance Director	Q1 23/24	Green	
		5 Roll out of No PO no Pay	Assistant Finance Director - Financial Services	Q4 22/23	Green	
		6 Implement virement policy	Assistant Finance Director - Financial Management	Q1 23/24	Green	
		7 Ensure all budget holders sign off 23/24 budgets	Assistant Finance Director - Financial Management	Q1 23/24	Green	
		8 Implement process for managing discretionary spend	Assistant Finance Director - Financial Services	Q4 22/23	Green	

Operational Capacity Planning						
Improving Productivity	To ensure the Trust meets waiting time targets and delivery of agreed 23/24 activity levels	1. Establish process to review all continuing covid related costs identifying •Whats here to stay? •What can be removed/reduced and when?	DoF/COO	Q4 22-23	Green	
		2 Agree 23/24 activity levels with the need to meet system agreed activity totals.	Director of Strategy /COO	Q4 22-23	Green	
		3 Put in place systems to monitor elective recovery performance and generate income to offset costs ensuring timely information.	CIO/ Director of Operational Finance	Q1 23-24	Green	
		4 Continue to implement plans to de-escalate Covid costs	DoF/COO/ Director of Strategy	Q4 22-23	Green	Continuing plans presented to Executive team for those areas funded by Covid , including patient transport, use of redirooms, use of masks and Trust wide approach to covid absence. As part of 24/25 planning it is planned all covid funding to cease, actions being developed to safely reduce funding.
Integrated approach to planning	Develop a set of tools to support operational teams to model and optimise capacity and pathways	1 Develop capacity model to match demand with supply (consultants, theatres and beds) to model backlog wait clearance and increased referrals	Chief Information Officer/COO	Q1 23-24	Green	
		2 Use capacity model to identify and agree plans to overcome constraints	Chief Operating Officer /Director of Service Development	Q1 23-24	Green	
		3 Create a clear planning timetable for the 23-24 planning round resulting in the production of a business plan for approval by the Board in April 2024	Chief Operating Officer /Director of Service Development	Ongoing	Green	

Knowing the Business						
Portfolio service review	•Use available data to identify opportunities for performance improvement, efficiency and waste reduction, including options for pathway redesign •Use clinical and economic criteria to assess the sustainability of key services and develop forward plans to inform future service models •Inform if services part of core business to grow/ develop/ exit	1 Agree outline of approach with Exec Team as part of annual planning cycles	Director of Service Development	Q1 23-24	Green	Approach agreed - to be address via establishment of Unwarranted Variation Board, reporting into Transformation and Recovery Board
		2 Develop programme of reviews to cover circa services within a 24-month period (4 cohorts, one per quarter) informed by model health/ GIRFT/ PLICS/ SLR data	Director of Strategy / Director of Continuous Improvement & Transformation	Q1 23-24	Green	Programme of Tranche 1 and Tranche 2 Specialties agreed
		3 Prepare data packs for each division's first cohort (Q1 2023/24) spanning clinical, operational, workforce and financial metrics and benchmarks to inform initial discussions	Head of Planning/ Finance Service Improvement/ Head OF Contracting/ Head of Business Intelligence / Head of workforce planning	Q1 23-24	Green	PLICS/ SLR data packs and Unwarranted Variation action logs have been completed for Tranche 1 and Tranche 2 specialties. The workstream is being actively embedded into a cycle of business with clinical and operational leads with the ultimate aim of understanding and validating identified variation for improvement across the full scope of the Trusts operations.
		4 Findings shared with executive team and shared with divisions incorporate action plans into divisional objectives as part of performance and planning process	Divisional Director/ COO	Q3 23-24	Q3 23/24 action	
		5 Formally report summary of actions to be taken to Finance committee/Board as part of planning cycle of the outcome.	Director of Strategy	Q3 23-24	Q3 23/24 action	
Understanding population health dynamics	Identify and use data to model health needs and trends to support allocation of resources	1 Engage director of public health to understand ICS approach to population health analytics	Chief Information Officer/Medical Director	Q1 23-24	Green	The NHS Secure data environment is a collaboration across the northwest bringing data together for secondary uses and research. LTHTR is hosting the programme on behalf of the Northwest. Approximately 14M has been awarded by NHSE.
		2 Review approach to population health being taken by providers locally, regionally and nationally	Chief Information Officer/Medical Director	Q1 23-24	Green	The NHS Secure data environment is a collaboration across the northwest bringing data together for secondary uses and research. LTHTR is hosting the programme on behalf of the Northwest. Approximately 14M has been awarded by NHSE.
		3 Develop plan for LTH to use existing data, or support the development of additional information sets to model health and prevention needs	Chief Information Officer/Medical Director	Q1 23-24	Green	The NHS Secure data environment is a collaboration across the northwest bringing data together for secondary uses and research. LTHTR is hosting the programme on behalf of the Northwest. Approximately 14M has been awarded by NHSE. This is part of the research capabilities that will benefit from enhanced collaboration with Universities
		4 Use the above data to benchmark resource need versus allocation and share findings	Chief Information Officer/Director of Finance	Q2 23-24	Green	The NHS Secure data environment is a collaboration across the northwest bringing data together for secondary uses and research. LTHTR is hosting the programme on behalf of the Northwest. Approximately 14M has been awarded by NHSE. This is part of the research capabilities that will benefit from enhanced collaboration with Universities
Patient level information	Use existing internal and external data sources to understand service and patient level costs and performance metrics, to inform service line review and commissioner discussions	1 Take stock of progress with PLICS internally and re-clarify objectives to complement financial strategy (post PBR)	Head of costing	Q4 22-23	Amber	The Trust Costing Strategy was approved in May 22, this was summarised into the Costing Plan on a page in March 23. Data packs have been provided to the top 10 loss-making service lines highlighting potential unwarranted variation, and detailing breakdown of costs for high cost patients. A PLICS dashboard has been developed that can be utilised by the costing team to drill down to see patient level cost data. The roll-out of this dashboard to services is planned for Q2 23/24.
		2 Develop a plan to roll out PLICS to service lines in support of the service line review process (above)	Head of costing	Q4 22-23	Amber	

System Engagement						
Commissioning Approach	Prepare the Trust for the anticipated changes in the commissioning landscape, so we are ready to act and influence the ICS approach	1 Identify and develop relationships with local authority, community and third sector and Primary Care Network representatives, focusing on how future service models can be developed as part of the planning cycle.	Director of Strategy	Q1 23-24	Green	Significant, effective engagement has taken place with colleagues within Place, Primary Care, Local Authorities and the 3rd sector and good progress has been made on discussions regarding new service models.
		2 Discuss and negotiate with the ICB contracting approach in line with national contracting guidance.	Director of Operational Finance/ Assistant Finance Director Contracting, Income and Costing	Q3 23-24	Q3 23/24 action	Regular (weekly) Contracts meetings are held with ICB colleagues and bi-weekly with NHSE SpecCom to discuss and progress matters as they arise. Trust issues are also discussed and consolidated at the monthly finance Activity Management Group (AMG), which is chaired by the Deputy Finance Director and attended by finance, planning and contracting teams, for onward progression with system partners as appropriate. Planning and Contracting leads from LTH attend the weekly system EACT group, which discusses and progresses related matters from a system perspective.
		3 Review the current specialised commissioning arrangements, and work with ICS to plan the pace of transfer to local arrangements whilst flagging any historic funding issues.	Director of Operational Finance/ Assistant Finance Director Contracting, Income and Costing	Q3 23-24	Q3 23/24 action	Roadmap for delegation of specialised services has been deferred to 24/25 and beyond. LTH representatives attend bi-weekly contracts meetings with NHSE colleagues where related matters are discussed for progression. There is a quarterly Exec to Exec meeting held between NHSE SpecCom and LTH where strategic workflows are considered in detail.
Provider collaboration	Prepare for taking a lead role in shaping and delivering provider collaboration	1 Carry out a systematic appraisal of all support functions and establish strengths and weaknesses, opportunities and threats	CFO	Q1 23-24	Green	This approach has been superseded by the agreed PCB Central Service Collaboration Programme which has identified a set of priority services to be provided at scale and has established a Target Operating Model to take the programme forward at pace from September
		2 Use the outcome from the above review to inform Exec Team in formulating obvious “make vs buy” preferences for all or parts of support functions	Director of Service Development	Q1 23-24	Green	See above
		3 Use the Exec Team discussion to help determine LTH approach to provider collaboration and a set of objective criteria that can be used to evaluate each collaboration opportunity on its merits as they are developed	Director of Service Development	Q1 23-24	Green	See above
		4 Engage with and influence the emerging ICS strategy for provider collaboration to ensure those areas with the greatest potential for improvement are progressed	DoF	ongoing		The Trust is a key player in the ICS collaboration strategy. The Provider collaboration board is established and chaired by Aaron Cummins (CE Morecambe Bay). There is continuing dialogue with the ICB in the development of plans and the introduction of the ICB transformation and recovery board. Priority schemes are being identifed through the Provider Collaborative Board

Workforce						
Develop Workforce Information	Proactively reduce the use and associated cost of workforce models that rely on overtime, bank, agency and waiting list arrangements	1. Work as a system to reduce agency costs to scope out programme of work	Chief People Officer	Q1 23-24	Green / Amber	There is a Trust action plan in place for the reduction of agency usage. The Trust work collaboratibely with our system colleagues and there is agency rate card reduction model across the ICS that is already making saving £300k included in the Trust overall FIP plan. There is an agency rate card for medical staffing internally. This is a programme of work across the ICS to which the Trust will be part of.
		2 Work with LSC provider collaborative to standardise approach to bank staff	Chief People Officer	Q1 23-24	Amber	Led employer model in place but contract yet to be awarded. Steering group and project group in place
Reducing the cost of premium rate pay	Proactively make better use of administrative staff	1. Identify areas where data from intra/inter systems automated using RPA	CIO	Q1 23-24	Amber	Several workforce processes in place. The RPA team is not yet cost neutral as processes are reducing workload but are not resulting in cash releasing removal of WTE. This has forced the RPA team to remain running on Capital in 23/24 until additional processes can be implemented. This is not sustainable in the long run.

Enabling Waste Reduction and Efficiency						
~~Technology led productivity and waste reduction~~	~~Identify and ready for implementation opportunities to deploy technology to improve productivity or reduce waste.~~	~~1. Update Digital IT strategy develop VFM~~	~~Chief Information Officer~~	~~Q1 23-24~~		~~RPA, Paper light, Reduction in Scanning~~
		~~2. Support divisions and departments in implementing the prioritised improvements in RPA~~	~~Chief Information Officer~~	~~Q1 23-24~~		
Effective use of medicines	Collaborate with partners across the ICS to identify opportunities to improve the use of medicines and reduce costs	1. Annual ICS strategy on medicines management to support the delivery of financial sustainability.	Chief Pharmacist	Q1 23-24 - revised Q2 23/24 & ongoing	Amber	ICB Aseptics Group established. LTH successfully gained access to £600K Research monies to support refurbishing our old aseptic unit. Acute Hospital Collaboration group established. Project 1 underway - joint venture re outsourced outpatient dispensing service. Project 2 - up-take of biosimilar medicines (50:50 gainshare agreed with ICB).
Effective management of non-pay expenditure	Build on Trust procurement strategy to ensure the benefits of collaboration with partners across the ICS is maximized	1. Procurement strategy to be finalised and reviewed annually	Director of Procurement	Q4 23-24	Green	Approved March FPC

Capital Investment						
Investment strategy	Develop strategic prioritisation plan for capital investment	1 Agree approach to capital 2022-23 allocation with the Executive team, including •Indicative budgets for each type of investment (Strategic, backlog, IT, med equipment) •Priority and reserve schemes (for when additional funds get announced) •3 year rolling programme	Director of Finance	Q4 22-23	Green	Capital programme approved as part of 23/24 financial plan.

Strategies						
Refresh of all Trust strategies	Ensure all strategies focus on delivering value for money and reducing financial run	1. Digital strategy to focus on greater automation and a removal of unnecessary administrative processes	CIO	Q1 23-24	Green	Strategy in place period 2021- 2026. Updated to FPC 27th June.
		2. Clinical strategies refresh	Director of Strategy/ Chief Medical Officer	Q2 23-24	Not required Q2 action	The Clinical Services Strategy will be refreshed by the end of September 23.
		3. Clinical strategy (Urgent and Emergency care) to be rewritten to tackle rising demand and current sustainability challenge.	Chief Nursing Officer/ Director of Continuous Improvement	Q1 23-24	Green	Interim UEC strategy developed.
		4. Clinical strategy (Scheduled care) to be rewritten to tackle productivity and a resetting of scheduled care including repatriation of Independent sector activity (to be negotiated & agreed with the ICB)	Director of Continuous Improvement & Transformation / Chief Operating Officer	Q1 23-24	Red	
		5. Workforce strategy – To evolve and consider the alternative to a workforce which does not exist (service reconfiguration, skills profiles etc).	Chief People Officer	Q2 23-24	Amber	Workforce & OD strategy refreshed and launched June 23. Further work on developing alternative models of delivery around patient pathways are being worked on with division in supported by the divisional HR business partners.
		6. Procurement strategy to FPC March 2023	Director of Procurement	Q4 22-23	Green	
		7. Social value strategy to be developed to include green plan	Director of Strategy	Q1 23-24 - revised Q2 23/24	Amber	Draft social value framework approved at board. Draft strategy in development due end of September.
		8. Income strategy to be developed to focus on maximising clinical and commercial income including Research & Development and Education income.	Director of Operational Finance	Q1 23-24 - revised Q2 23/24	Amber	Action plan has been worked up to address the development of Trust Income Strategy in Q2 23/34; as follows: (1) Analyse and understand all sources of Trust income, current financial status and any risks and/or opportunities. (2) Refresh all trading accounts (applying a consistent costing methodology and reporting format). (3) Complete Income Strategy paper and submit for approval to FPC. (4) Develop SOPs for ongoing monitoring of all sources of Trust income. (5) Add any identified improvement opportunities to the CIP plan and/or financial recovery plans.
		9. Estates strategy refresh	Director of Estates and Facilities	Q1 23-24 - revised Q2	Amber	The NHS New Hospitals Programme announced on 25 May 2023 that the Royal Preston Hospital would be replaced with a new hospital on a new site, but capital funding to commence the scheme would not be made available before 2030. An updated site strategy is therefore currently being commissioned to create a detailed investment / rationalisation plan for the RPH site to ensure its continued safe operation through to circa 2035, being the earliest likely delivery date of a new hospital.

Chair's Report

Committee:	Safety and Quality Committee
Chairperson and role:	Kate Smyth, Non-Executive Director
Date(s) of Committee meeting(s):	26 May 2023 and 30 June 2023
Purpose of report:	To update the Board on the business discussed by the Safety and Quality Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

26 May 2023

Following the meeting held on the 26 May 2023, the Committee conducted a comprehensive review of the scheduled items on the agenda.

The Committee approved the following items:

- Minutes and actions
- Strategic risk register
- Exception Report from Divisional Improvement Forums

The Committee received presentations and reports and discussed the position on the following:

- Safety and Quality Dashboard including Nursing and Midwifery staffing reports for adult inpatients (including the Emergency Department); maternity; and neonatal and children and young people services.
- Bi-annual Maternity Safe Staffing Report.
- Annual Safe Staffing Report.
- Quarterly Serious Case Thematic Review and Learning Report.
- Annual Patient Experience and Involvement Strategy report including the Annual Patient Experience Report.
- Infection, Prevention and Control Annual Plan Report.

30 June 2023

Following the meeting held on the 30 June 2023, the Committee conducted a comprehensive review of the scheduled items on the agenda.

The Committee approved the following items:

- Minutes and actions
- Strategic risk register
- Exception Report from Divisional Improvement Forums

The Committee received presentations and reports and discussed the position on the following:

- Safety and Quality Dashboard including Nursing and Midwifery staffing reports for adult inpatients (including the Emergency Department and Finney House); maternity; and neonatal and children and young people services.
- Maternity Safe Staffing Report.
- Annual STAR Report.
- HSMR/SHMI Data Deep Dive.
- Bi-annual Mortality Update including LEDER.
- Annual Serious Case Thematic Review.
- Annual Safeguarding Report.
- Elective Patients Delayed due to Covid 19.
- Radiopharmacy Report.

- Annual Sepsis Report. - Annual Pathology Report. - The Equality Quality Impact Assessment Policy. - Human Tissue Authority Postmortem Inspection Report. - Annual Quality Account. - Clinical Audit Report. - Terms of Reference for the Always Safety First Committee.	- Bi-annual Medicines Governance Report.
Items for the Board's attention	
The Committee received the bi-annual maternity safe staffing review that triangulated workforce information with safety, patient experience and clinical effectiveness indicators to provide assurance of safe staffing levels. The Safety and Quality Committee received the Annual Adult Safe Staffing Report Implementation Proposal with details of the recommended staffing levels following a revised review of the November 2022 safe staffing review. Both safe staffing reports would be presented to Board August 2023 in line with guidance. It was important to note the committee approved the professional judgements and recommendations. The financial approval was required through the Board and ICB. The Annual Patient Experience and Involvement Strategy report including the Annual Patient Experience Report was presented to the Committee. The report provided an update for the outcomes associated with the patient experience and involvement strategy 2022 to 2025 and demonstrated what progress had been achieved over the last 12 months. The committee approved the updated Equality Quality Impact Assessment (EQIA) Policy. The policy extends the scope of the current policy to a broader scope to include all decisions related to service changes and Cost Improvement Projects undertaken ensuring that any change that may impact on patients or staff are fully assessed and any risk associated with this is managed. The Safety and Quality committee receive a quarterly report of any schemes that score 15 or above and assurance on the scoring attached to change projects. The report as approved by Safety	The Committee were provided assurance of the safety and quality standards within the maternity services. Risks were being regularly reviewed, monitored, and mitigated where possible. A concern around the expected number of staff that would be taking maternity leave would be escalated to the Board. A plan for managing that was included within the bi annual maternity staffing report and would be included for the attention of the Board in August 2022. The CQC wrote to the trust outlining concerns relating to the management of mental health patients in the Emergency Department. A response had been provided to the CQC and the committee was assured of the actions in place to respond to these concerns.

and Quality committee is on the agenda for Board in the section for information only.	
Positive escalation	
26 May 2023	**30 June 2023**
- The outcomes associated with the patient experience and involvement strategy and the focus to capture the patient voice were noted by the Committee. It was advised that each clinical area now had patient experience champions following their recruitment. - The Committee were assured of the actions being taken to improve the quality and safety of care provided to patients with sepsis.	- Quarterly Sentinel stroke National audit programme (SNNAP) - Cleaning standards - E. Coli rate - Staffing registered nurse fill rate - Friends and Family Test (FFT) Emergency Department (ED - Patient Advice and Liaison Service (PALS) requests.
Negative escalation	
26 May 2023	**30 June 2023**
- The rate per 100,00 bed days of C.*difficile* was identified as high when compared to peers nationally. The committee had increased scrutiny in this area, received an external report in this regard and the annual plan outlined the actions being taken to respond to this. - The Human Tissue Authority Postmortem Inspection Report had identified a number of improvements required. These were discussed in detail and assurance gained on the plan to address these. The Human Tissue Authority had confirmed they were content with the action plan that had been submitted by the Trust to address the findings of the report.	- C. Difficile infection rate – Weekly Executive oversight commenced. - Pressure ulcers – Improvement programme in place demonstrating early progress. - The CQC findings relating to management of mental health patients in the Emergency Department.
Committee to Committee referral	
26 May 2023	**30 June 2023**
No referrals.	The Committee received a referral from the Finance and Performance Committee to consider the health and safety risks, due to impact of the financial constraints for Estates. Assurance was provided in the advice that the overview of backlog maintenance was managed through Finance and Performance Committee on a rolling cycle and that information had been triangulated on Datix. The Safety and Quality Committee would continue to monitor the Health and Safety risks on a bi-annual basis.
Items recommended to the Board for approval	

26 May 2023	30 June 2023
- Bi-Annual Safe Staffing Report. - Bi-annual Maternity Safe Staffing Report. - Annual Infection Prevention and Control Report and plan.	- Maternity Safe Staffing Report.
Committee Chairs reports received	
26 May 2023	**30 June 2023**
(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Medicines Governance Committee (e) Safety and Learning Group (f) Patient Experience and Involvement	(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Mortality and End of Life Committee (d) Always Safety First Committee (e) Medicines Governance Committee (f) Safety and Learning Group (g) Patient Experience and Involvement (h) Health and Safety Governance
Items where assurance was provided and/or for information	
26 May 2023	**30 June 2023**
The Committee received the Safety and Quality dashboard and was assured of the actions being taken to address areas for negative escalation. Assurance was provided of the progress against the 2022/23 Infection, Prevention and Control Annual Plan, Patient Experience Annual Report 2022-23 and the Serious Case Thematic Review Annual Report 2022-23.	The Committee were assured of the rigor of the Safety Triangulation Accreditation System (STAR) improvement actions and learning from the quality assurance process. Assurance was provided of safe staffing and the safety and quality of Children and Young People services and that the risks were being regularly reviewed, monitored, and mitigated where possible. The Committee were provided with assurance of the deep dive into the mortality data and an explanation of the Summary Mortality Indicators. The report also provided assurance of the accuracy of mortality data included in the Commissioning Data Sets submissions.
Progress against the Committee's cycle of business	
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 28 July 2023 using Microsoft Teams.	

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Safety and Quality Committee agenda (26 May 2023)

Appendix 2 – Safety and Quality Committee agenda (30 June 2023)

Safety and Quality Committee

26 May 2023 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Noting	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Noting	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Noting	K Smyth
4.	Minutes of the previous meeting held on 28 April 2023	12.33pm	✓	Approval	K Smyth
5.	Matters arising and action log	12.35pm	✓	Approval	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Approval	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Discussion	C Gregory
7.2	Bi-annual Maternity Safe Staffing Review	12.55pm	✓	Approval	E Ashton
7.3	Neonatal, Children and Young People Staffing Report	1.05pm	✓	Approval	C Gregory
7.4	Annual Adult Safe Staffing Report Implementation Proposal	1.10pm	✓	Approval	C Gregory
7.5	Quarterly Serious Case Thematic Review and Learning Report	1.20pm	✓	Discussion	C Morris
7.6	Annual Patient Experience and Involvement Strategy report including the Annual Patient Experience Report	1.30pm	✓	Approval	C Gregory
7.7	Infection, Prevention and Control Annual Plan Report	1.40pm	✓	Approval	D Orr
7.8	Annual Sepsis Report	1.50pm	✓	Noting	C Roberts
8.	GOVERNANCE AND COMPLIANCE				
8.1	Annual Pathology Report	2.00pm	✓	Noting	R Dineley
8.2	The EQIA Policy	2.10pm	✓	Approval	C Gregory

№	Item	Time	Encl.	Purpose	Presenter
8.3	Human Tissue Authority Postmortem Inspection Report	2.20pm	✓	Noting	R Dineley
8.4	Annual Quality Account	2.30pm	✓ Pres	Approval	C Morris
8.5	Strategic risk register review	2.45pm	Verbal	Approval	K Smyth
8.5	Items for referral to the Board or to/from other Committees	2.50pm	Verbal	Noting	K Smyth
8.7	Reflections on the meeting and adherence to the Board Compact	2.55pm	✓	Discussion	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Clinical Audit Report		✓		
9.2	Terms of Reference – Always Safety First Committee		✓		
9.3	Exception report from Divisional Improvement Forums		✓		
9.4	**Chairs' reports from feeder groups**: (a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Medicines Governance Committee (e) Safety and Learning Group (f) Patient Experience and Involvement		✓		
9.5	Date, time and venue of next meeting: *30 June 2023, 12.30pm, Microsoft Teams*	3.00pm	Verbal	Noting	K Smyth

Safety and Quality Committee

30 June 2023 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 26 May 2023	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard including Adult Safe Staffing Report	12.50pm	✓	Assurance	C Gregory
7.2	Annual STAR Report	1.00pm	✓	Assurance	C Gregory
7.3	Maternity Safe Staffing Report	1.10pm	✓	Assurance	E Ashton
7.4	Children and Young People Staffing Report	1.15pm	✓	Assurance	S Cullen
7.5	HSMR/SHMI Data Deep Dive	1.20pm	✓	Assurance	A Gale
7.6	Bi-annual Mortality Update including LEDER	1.25pm	✓	Assurance	A Gale
7.7	Annual Serious Case Thematic Review	1.35pm	✓	Assurance	C Morris
7.8	Annual Safeguarding Report	1.50pm	✓	Assurance	C Gregory
7.9	Elective Patients Delayed due to Covid 19	2.00pm	✓	Assurance	S Cullen
8.	GOVERNANCE AND COMPLIANCE				
8.1	CQC ED/Medicine Inspection Response	2.10pm	✓	Assurance	S Cullen
8.2	Radiopharmacy Report	2.20pm	✓	Assurance	G Price

№	Item	Time	Encl.	Purpose	Presenter
8.3	Bi-annual Medicines Governance Report	2.30pm	✓	Assurance	G Price
8.4	Strategic risk register review	2.40pm	Verbal	Decision	K Smyth
8.5	Items for referral to the Board or to/from other Committees a) FPC referral for health and safety risks due to constrained investment to estates.	2.45pm	Verbal	Information	K Smyth
8.6	Reflections on the meeting and adherence to the Board Compact	2.50pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Cycle of Business		✓		
9.2	Exception report from Divisional Improvement Forums		✓		
9.3	**Chairs' reports from feeder groups**: (a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Mortality and End of Life Committee (d) Always Safety First Committee (e) Medicines Governance Committee – **no meeting** (f) Safety and Learning Group (g) Patient Experience and Involvement (h) Health and Safety		✓		
9.4	Date, time and venue of next meeting: *28 July 2023, 12.30pm, Microsoft Teams*	3.00pm	Verbal	Information	K Smyth

Board of Directors

Annual Safe Staffing Review – Nursing 2022/2023 Revised proposal

Report to:	Board of Directors	**Date:**	3 August 2023
Report of:	Chief Nursing Officer	**Prepared by:**	S. Cullen, C. Gregory, N. Ross
Part I	✓	**Part II**	

Purpose of Report

For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary

The purpose of this report is to present the outcome of the annual safe staffing review undertaken in November 2022. The report has been revised following presentation at the Safety and Quality committee in February and May 2023 due to the financial implications associated with the original review, ongoing transformation work and the current levels of vacancy within the HealthCare Assistant workforce (HCA) of 180WTE.

The review has included 38 recurrently funded clinical areas which include assessment areas, adult inpatient areas, neonates and children and young people areas. This revised review excluded all non-recurrently funded areas, Critical Care, Surgical Enhance Care Unit and ED as the first version of the review established staffing levels were considered safe in these areas and they are subject to transformation programmes in 2023/24.

The recommendations for 2023/24 implementation include;

- Correction made for the previous review not enacted to sustain increase in ward manager leadership in the large wards with 28 or more beds.
- Increase in leadership for gynaecology services following review of themes identified within patient experience, safety metrics and a 47% increase in the number of patients in the gynaecology assessment area.
- Standardisation of Registered Nurse staffing on the surgical wards in response to an increase in occupancy rates from 68% in June 2020 to 96% in April 2023.
- Increase and skill mix change in HCA in response to increase in occupancy and the number of acutely unwell/1:1 patients in Medical Assessment Units at RPH and CDH.
- Conversion of consistent bank spend to substantive staff in neurorehabilitation to provide 1:1.

The Board is required to approve the annual safe staffing review. Given the financial position of the organisation, the Integrated Care Board (ICB) and NHS England are now responsible for approving investments. The impact of the acuity review is a proposed recurrent budgetary increase of £1.08m. The source of the funding required is yet to be determined. This has been discussed with Chief Finance Officer and Integrated Care Board (ICB) Finance Director. Following this, a request for the ICB Chief Nurse to review the safe staffing recommendation has been accepted.

It is noteworthy, the withdrawal of agency HCA usage is evaluating effectively to date and has so far delivered savings of circa £340k per month. The reduction of Registered Nurse agency is also in line with the planned reduction.

Overall, the revised establishments recommended by the Chief Nursing Officer have considered the availability of resources and the inability to recruit substantively at the required rate to close the existing gap of HCA vacancies. This risk is mitigated through the use of bank and fill rates monitored through month staffing reviews.

The revised recommendations have prioritised the essential posts that impact on safety, considering the current financial position, whilst not compromising the ability to deliver safe, effective, and sustainable staffing levels for the organisation and meets the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board (NQB) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016).

It is recommended the Board of Directors:

I. Approve the contents of the revised annual staffing review 2022/23, note the further requirement to agree an approach to funding with the ICB following a review with the ICB Chief Nurse.
II. Agree to receive an update on the outcome of this review.
III. Note, in line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Chief Nursing officer confirms they are satisfied with the outcome of the revised annual safe staffing assessment and that whilst risks remain present staffing is safe, effective and sustainable.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Safety and Quality Committee - February 2023
Safety and Quality Committee – May 2023

1.0 Background

Following the Annual Safe Staffing review in November 2023, a report was considered by the Safety and Quality Committee in February and was approved. However, given the current financial considerations, the need to undertake a further risk assessment of the safe staffing review has been undertaken. This has been presented to the Safety and Quality committee in May 2023. Whilst the professional judgement of the Chief Nursing Officer has been accepted and approved. The Board is required to approve the annual safe staffing review. Given the financial position of the organisation, the Integrated Care Board (ICB) and NHS England are now responsible for approving investments.

This process has been led by the Chief Nursing Officer and deputy. The purpose of the nursing safe staffing review is to set an appropriate staffing resource, to deliver safe care within the inpatient bed base, using a robust, systematic process. This report excludes escalation areas and clinical areas that are not recurrently funded including ED.

Prior to the pandemic, the integrity of the Chief Nursing Officers approach to undertake appropriate and proportionate safe staffing reviews was tested by a Nurse lead at NHS Improvement and found to be valid.

The report fulfils the requirement outlined in the National Quality Board (NQB) staffing guidance, supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time and uses further sector specific evidence-based improvement resources published by NHS Improvement.

2.0 Scope

This risk assessed review considered the safe staffing requirements 38 clinical areas with recurrent funding which include assessment areas, adult inpatient areas, neonates and children and young people areas.

Critical Care and the Surgical Enhance Care Unit (SECU) and ED have not been included as part of this report as a separate work through of the staffing needs in these areas are being undertaken and will be presented in due course.

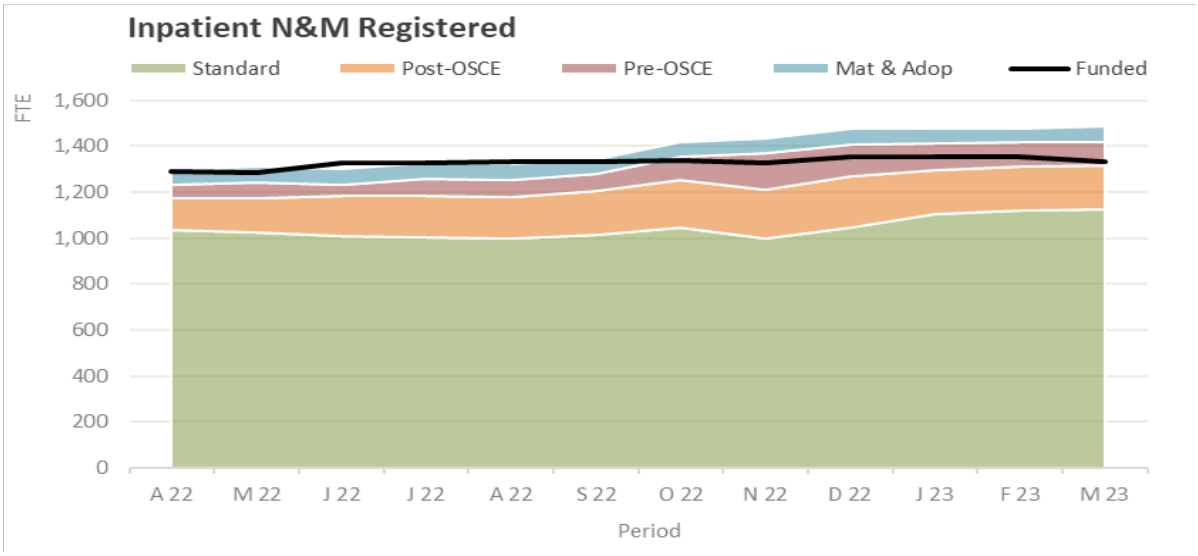
3.0 Context

The establishments are set at ward level with ward manager permission to:

- Recruit substantively to maternity leave for registered (RN) and health care assistants (HCA). (Maternity leave is not included in the headroom allowance)
- Request immediate bank in response to changes in patient acuity or dependency (e.g patient may require 1:1 care).
- Request an establishment review at any time if the assessment by the ward manager, matron and Divisional Nurse Director (DND) is that the current establishment is not meeting the needs of the patients.

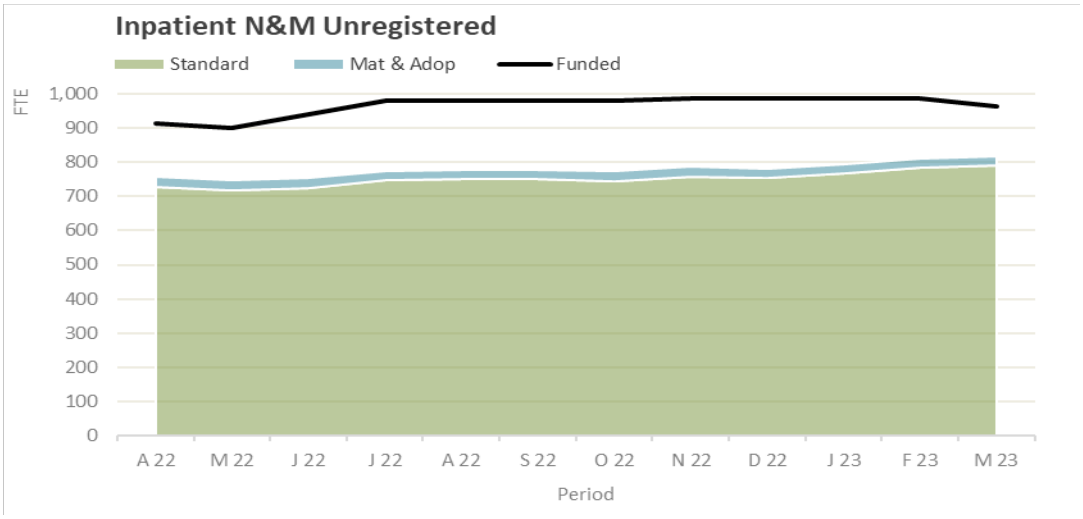
Graphs 1 and 2 below demonstrate the RN and HCA establishment versus actual staff in post. Retention continues to be a key priority. This is integrated into the Big Plan with specific plans in place to reduce the turnover of staff.

Graph 1 – Registered nurse and midwife establishment breakdown



Registered Nursing and Midwifery inpatient staffing has reached zero vacancies overall, however, as a result of the international nurse recruitment there is a clinical practice gap of 80 FTE as at 31 March 2023 leading to reliance on agency until the remaining international recruits become independent in practice.

Graph 2 – Unregistered nurse and midwife establishment breakdown



Vacancy rate for Band 2 and 3 HCA remains high at 12.3% (c. 180.89 FTE), recruitment and retention continues to be an area of focus. Based on the Trust HCA vacancy position, the revised staffing proposal for 2023/24 will not include the previous HCA recommendations as recruitment to the volume of posts will not be possible and bank fill rate is meeting the current requirements, considering a risk mitigated position. The 2023 biannual review will consider any safety implications of this and a further position considered in 2023/24 review.

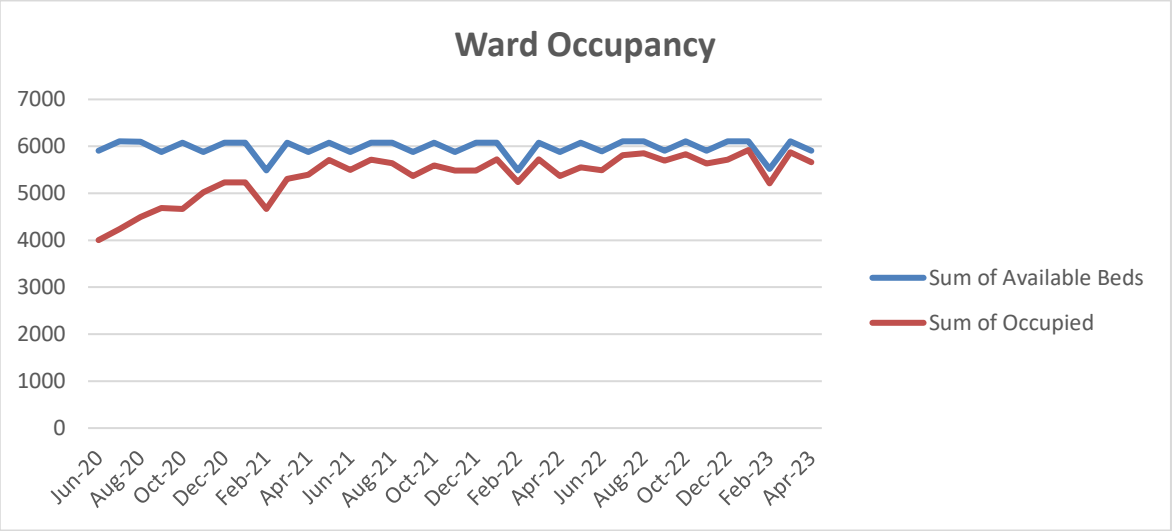
4.0 Leadership

The report presented in February 2023 outlined the pivotal role of the ward manager. The decision to proceed with an increase ward manager for larger wards (equal to and >28 beds) was evaluated and the conclusion to move to a substantive arrangement remains within the revised templates. The requirement for a second band 7 to manage the assessment areas with Gynaecology is also included based on the increased activity in the GAU of 47% over the last 2 years and the requirement to improve patient experience and outcomes in this area.

Surgical Occupancy

Historically within the surgical wards the staffing requirements differed due to activity and capacity at the weekend. Occupancy levels have consistently increased within the surgical wards since 2020 and therefore there is now a requirement to consistently staff the weekends in line with weekdays and full occupancy requirements. In June 2020 the surgical wards capacity was 68% compared to 96% in April-23.

Graph 3 – Occupancy June-20 – April-23 (wards 4,10,11,12,14,15,16 & MTW)



5.0 Financial implications

The impact of the acuity review is a proposed recurrent budgetary increase of £1.08m. The source of the funding required is yet to be determined. This has been discussed with Chief Finance Officer and Integrated Care Board (ICB) Finance Director. Following this, a request for the ICB Chief Nurse to review the safe staffing recommendation has been accepted. It is noteworthy, the withdrawal of agency HCA usage is evaluating effectively to date and has so far delivered savings of circa £340k per month. The reduction of Registered Nurse agency is also in line with the planned reduction.

The original recommendation made to Safety and Quality committee in February 2023 contained a whole skill mix recommendation, this was revised further given the financial position of the organisation and the vacant HCA posts. The second proposal presented to Safety and Quality in May has required a slight revision, as the skill mix changes suggested that would deliver savings were required on the HCA element being funded. Therefore, with the removal of this part of the review at this time the funding required is £1.08m.

6. Changes to Establishment

Appendix 1 outlines the overall changes made due to the revised safe staffing recommendations 2022/23 annual review. The recommendations for 2023/24 implementation include;

- Correction made for the previous review not enacted to sustain increase in ward manager leadership in the large wards with 28 or more beds.
- Increase in leadership for gynaecology services following review of themes identified within patient experience, safety metrics and a 47% increase in the number of patients in the gynaecology assessment area.
- Standardisation of Registered Nurse staffing on the surgical wards in response to an increase in occupancy rates from 68% in June 2020 to 96% in April 2023.
- Increase in HCA skill mix in response to increase in occupancy and the number of acutely unwell/1:1 patients in Medical Assessment Units at RPH and CDH.

- Skill mix adjustments in line with professional judgement.
- Conversion of consistent bank spend to substantive staff in neurorehabilitation to provide 1:1.

7.0 Conclusion

The staffing reviews for 2022/23 complies with the requirements of the NQB guidance. As part of this review the Chief Nursing Officer confirms they are satisfied with the outcome of the revised annual safe staffing assessment and that whilst risks remain present, staffing is safe, effective and sustainable.

The impact of the safe staffing recommendations is a budgetary increase of £1.08m. Recognising that most of the implications for this review are aligned to the fixed element of the contract and the ICB and NHS England are now responsible for approving investments, the Trust has initiated discussion with the ICB and agreed a review of the CNO staffing recommendations by the ICB CNO. In the meantime, the Trust will continue to mitigate the risks associated with staffing through the use of bank and agency. The Trust continues to work to transform its services, seeking to release or transfer funds where appropriate.

8.0 Recommendations

It is recommended the Board of Directors:

I. Approve the contents of the revised annual staffing review 2022/23, note the further requirement to agree an approach to funding with the ICB following a review with the ICB Chief Nurse.
II. Agree to receive an update on the outcome of this review.
III. Note, in line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Chief Nursing officer confirms they are satisfied with the outcome of the revised annual safe staffing assessment and that whilst risks remain present staffing is safe, effective and sustainable.

Appendix 1 Staffing Establishment - recurrently funded wards analysis Beds, WTE and financial impact.

		Beds				WTE		Financial impact	
Division	Ward	Beds 2021	Beds 2022	Difference	Recurrently funded beds	Professional Judgement Nov22	Sum of Proposed change to Recurrent Funded WTE	Proposed incr/(dec) Recurrent budget £	Reasons for change
W&C's	Gynaecology Ward (RPH)	14	14	0	18	41.64	2.19	117,423	Currently established for 14 beds however continually escalated to 18 beds for some time, so professional judgement uplifted to support this. 47% increase in GAU activity over the last 2 years - Ward manager added to GAU, band 6 head room added as band 6 24/7 for pregnancy loss. Additional band 3 added following 12month trial, current band/agency spend 77k.
	Neo Natal Unit (RPH)	28	28	0	28	83.61	0.08	(3,933)	BAPM compliant. Net impact 0.08 WTE, savings due to skill mix of ETE changes.
	Paediatric Assessment Unit	10	10	0	10	22.46	(1.17)	(53,437)	Ward manager clinical time adjusted, 1 clinical shift as ward manager covers Paediatric Day case also. 1wte reduction due to headroom adjustment. Savings reinvested in to paeds outreach clinical educator
	Paediatrics Ward 8 (RPH)	30	30	0	30	71.33	(1.72)	(42,403)	Ward manager clinical time adjusted. Head room removed from band 7 time as per nursing principles on this review. Savings reinvested to Paeds outreach CE roles
W&C's Total						219.04	(0.62)	17,650	
Surgery	ENT Ward 3 (RPH)	14	14	0	14	31.12	(0.23)	(8,209)	Standardised 2wte band 6, as per revised principles.
	Gen Surgery Ward 10 (RPH)	29	29	0	29	44.38	0.71	47,456	1 additional B2 HCA on 12hr shift Friday - Sunday. Headroom allocated to B6s, in-line with principles for 28 beds and above. Hospital occupancy levels are now consistantly above 95%, 7 days per week.
	Gen Surgery Ward 12 (RPH)	33	33	0	33	47.14	0.42	30,943	Headroom allocated to B6s, in-line with principles for 28 beds and above. Hospital occupancy levels are now consistantly above 95%, 7 days per week.
	Leyland Wd (CDH)	25	15	-10	15	24.41	(1.04)	(35,432)	Removal of B5 short shift Monday - Wednesday (7.5hrs), and 0.79wte B2 HCA vacant post.
	Major Trauma Ward	10	10	0	10	29.68	(1.58)	(40,304)	Removal of 2 x B3 short shifts Monday - Sunday, partly offset by creation of 1 x B4 Monday - Friday long day shifts and B3 additional weekend long day shifts. Headroom allocated to B6s, in-line with revised principles for high-care areas.
	Neurosurgery Ward 2a(RPH)	17	17	0	17	35.83	6.76	205,106	Wards split into 4 areas - 2a, 2b, 2c, NHC. 2a, b, c standardised staffing model. Neuro wards should be considered as a whole, the changes are cost neutral across the 4 areas.
	Neurosurgery Ward 2b(RPH)	27	17	-10	17	35.83	(8.33)	(269,280)	Wards split into 4 areas - 2a, 2b, 2c, NHC. 2a, b, c standardised staffing model. Neuro wards should be considered as a whole, the changes are cost neutral across the 4 areas.
	Neurosurgery Ward 2c(RPH)	17	17	0	17	35.83	2.26	91,666	Wards split into 4 areas - 2a, 2b, 2c, NHC. 2a, b, c standardised staffing model. Neuro wards should be considered as a whole, the changes are cost neutral across the 4 areas.
	Orthopaedics Ward 14(RPH)	24	24	0	24	45.46	0.26	5,582	Additional HCA B2 on Short Saturday and Sunday shifts, and standardised 2wte band 6 for ward size, ward manager clinical time adjusted. Hospital occupancy levels are now consistantly above 95% 7 days
	Orthopaedics Ward 16(RPH)	24	24	0	24	46.46	0.26	3,427	Additional HCA B2 on Short Saturday and Sunday shifts, and standardised 2wte band 6 for ward size, ward manager clinical time adjusted. Hospital occupancy levels are now consistantly above 95% 7 days
	Plastics Ward 4 (RPH)	22	22	0	22	41.94	(0.20)	(3,078)	Skill mix between B3 and B4 levels due to increased theatre lists and the needs for specialised post operative care. RN added to Sunday to standardised staffing 7 days per week.
	Ribblesdale Unit	28	24	-4	24	45.81	2.09	75,970	Skill mix between B2 and B4 levels on night shifts (no wte impact). Reduction of 1 x B6 weekend long day shifts offset by headroom added as per change in principles. Additional band 5 during the day due to nursing time needed for chemotherapy administration, additional duty now added to safecare to allow accurate capture of this additional need.
	Surg Ambulatory Care Unit	10	10	0	10	53.27	(0.24)	27,374	Surgical Ambulatory Care Unit is actually the Surgcal Assessment Unit (cost centre name updated in the ledger effective M10 22/23). Headroom changes between B5 and B6 levels, in-line with
	Surgical Unit	16	16	0	16	35.05	(0.05)	5,435	Reduction in B2 A&C Ward Manager support.
	Upper GI Ward 11 (RPH)	22	22	0	22	38.58	0.81	39,253	Head room for band 6 added to band 5 for Longton Day Case staffing template.
	Vascular Ward	33	33	0	33	59.94	(1.81)	(34,605)	Headroom allocated to B6s, in-line with principles for 28 beds and above. Reduction in 1 x B3 short shift Monday - Thursday and at weekends, and B4 short shift Tuesday - Thursday.
	Neuro Enhanced High Care	0	10	10	10	30.83	(0.01)	(187)	Wards split into 4 areas - 2a, 2b, 2c, NHC. 2a, b, c Staffing set as per high care prinicples. Neuro wards should be considered as a whole, the changes are cost neutral across the 4 areas.
Surgery Total						681.56	0.08	141,118	

Medicine	Bleasdale Ward (RPH)	20	21	1	20	41.34	(0.24)	(18,165)	Time adjusted for ward managers clinical time.
	Brindle Ward - Gastro	30	30	0	30	49.89	(1.39)	(54,464)	B5 adjusted for Ward Manager undertaking clinical shifts. Headroom allocated for B6, in-line with principles for 28 beds and above.
	Cardiac Unit CDH	10	10	0	10	20.41	(0.05)	18,791	B5/B6 skill mix for headroom and clinical shifts undertaken by the ward manager.
	Cardiology Ward 18 (RPH)	28	28	0	28	53.65	(4.58)	(158,872)	Time adjusted for clinical shifts undertaken by the ward manager. Headroom allocated for B6, in-line with principles for 28 beds and above.
	Coronary Care Unit (RPH)	6	6	0	6	17.14	0.64	112,284	Added band 6 overnight - high care area + head room.
	Elderly Rookwood A (CDH)	24	24	0	24	49.60	(0.91)	(30,638)	Skill mix enacted for B2 / B3. Standardised 2wte band 6, as per revised principles. Increased patient complexity.
	Elderly Rookwood B (CDH)	24	24	0	24	44.09	2.19	108,226	B3's moved to long days. Additional RN on days to support acuity and complex patient needs. Standardised 2wte band 6, as per revised principles.
	Gastro Ward 24	32	32	0	32	63.67	0.27	30,153	B2 / B3 skill mix adjusted, high spend on bank/adgency due to patient complex needs. Headroom allocated for B6, in-line with principles for 28 beds and above.
	Gen/Med Elderly Ward 17	32	32	0	32	52.65	0.58	65,023	Headroom allocated for B6, in-line with principles for 28 beds and above. Average bank and agency spend for April - December'22 is £35k/month.
	Hazelwood	19	19	0	19	35.83	(1.03)	(66,148)	Ward manager clinical time adjusted. Skill mix enacted between B2 / B3 colleagues. Standardised 2wte band 6, as per revised principles.
	MAU (CDH)	29	29	0	29	65.58	7.12	377,988	Headroom added to templates, skill mix reviewed for GP lounge cover. Bed days increase from 503 in 2020 - 859 in 2022. Average bank and agency spend for April - December'22 is £60k/month.
	MAU RPH	29	34	5	29	66.83	4.45	252,595	B3's adjusted as moved from short days to long days and night cover. Staffing for additional 'fit to sit' area. Bed days increase from 778 in 2020 - 912 in 2022. Average bank and agency spend for April - December'22 is £69k/month.
	Neurorehabilitation (SGH)	13	16	3	13	35.37	4.59	146,876	B4 extended to cover 7 days. Average bank and agency spend for April - December'22 is £38k/month.
	Renal Ward 25 (RPH)	23	23	0	23	41.34	0.89	34,582	Standardised 2wte band 6, as per revised principles.
	Respiratory Ward 23 (RPH)	34	34	0	34	59.27	(0.73)	(2,312)	Headroom allocated for B6, in-line with principles for 28 beds and above. Skill mix altered between B2 / B3. Time adjusted for ward manager clinical shifts.
	Stroke Ward 21 (RPH)	24	24	0	24	61.02	(2.35)	(48,103)	Headroom allocated to B6. Additional funding provided to facilitate the creation of 5 enhanced high care beds. Average bank and agency spend for April - December'22 is £46k/month.
	Respiratory Enhanced High Care	11	11	0	22	42.34	(1.04)	66,325	
Medicine Total						**800.02**	**8.41**	**834,140**	
Grand Total						**1,700.63**	**7.88**	**992,908**	
					Add back W&C PAU/Ward 8 savings			95,840	
					Total Impact			**1,088,748**	

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity Service Bi-annual Staffing Review					
Report to:	Board of Directors		**Date:**	3rd August 2023	
Report of:	Chief Nursing Officer		**Prepared by:**	Jo Lambert	
Part I	✓		**Part II**		
Purpose of Report					
For Assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The purpose of this report is to detail the findings of the Lancashire Teaching Hospitals NHS Foundation Trust bi-annual maternity staffing review to provide assurance to the Board of Directors of safe staffing levels within the maternity service. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators to provide assurance of safe staffing levels.

BirthRate plus is a national midwifery acuity tool that is mandated for use every three years in maternity services. The outcome of BirthRate plus, as undertaken by an independent staffing expert, is considered robust by NHS England, as such, compliance with BirthRate plus staffing recommendations is identified as a key deliverable with the national planning guidance. The current service establishment is based on the assessment undertaken in 2019. This has been repeated and a draft report was made available at the end of 2022.

The findings of the most recent Birth Rate Plus assessment has been reviewed by the service. A significant increase in complexity of caseload was noted and this triangulates with local analysis. The findings of the assessment have been accepted by the Divisional Midwifery and Nursing Director and this indicates that an uplift to the funded establishment of 29.73WTE at a cost of £1,392,845 will be required to meet the recommended safe staffing levels. The findings of the assessment are summarised within the report and are detailed in Appendix 1. The services assessment of staffing levels based upon the Birth Rate Plus assessment and professional judgement have been discussed with the Integrated Care Board Associate Director of Midwifery to enable a funding approach to be considered by the Integrated Care System (ICS).

The service highlights that the whilst the registered midwifery staff in post has improved since the last biannual review, a significant vacancy gap is anticipated, totalling 29.47WTE midwives by August 2023 because of maternity leave, leavers and reduction in hours. International recruitment of midwives is progressing well with three new recruits now at LTHTR, this represents a viable option to mitigate future workforce planning.

A breakdown of obstetric staffing levels is included in the report and recruitment is ongoing to fill the vacant consultant positions.

The service confirms that the current level of midwifery continuity of carer (MCoC) (31% April 2023) can continue to be delivered safely without impacting on one-to-one care in labour. However, with a significant projected staffing establishment gap anticipated by August 2023, there will be no further expansion of CoC. This will continue to be reviewed monthly.

Within this reporting period there have been no whistleblowing CQC enquiries relating to staffing levels.

The National Single Delivery Plan (SDP) for maternity and neonatal services was published at the end of March 2023. This aligns the key priorities and national actions following the East Kent report, the Ockenden reports, the NHS Long-Term Plan and Maternity Transformation Programme. A technical specification for the report is expected to be released shortly and will include specific actions required.

The maternity dashboard metrics are not identifying any serious safety concerns, however, there are times when the service is required to use local escalation procedures to divert women and babies to maintain safety in the unit. It is anticipated that there may be a period where these pressures intensify coinciding with the reduction in midwifery staffing levels from July 2023.

It is recommended that the Board of Directors:

i. Receives and approve the maternity staffing review.
ii. Note that investment is requested following the 2022 Birth Rate+ report and the plan to work with the ICB to agree the approach to funding this.

Appendices attached:

Appendix 1 – Detailed review of new BirthRate Plus assessment.
Appendix 2 – Divisional Leadership Structure
Appendix 3 – Breakdown of Specialist Midwifery Roles as defined by Birth Rate Plus 2019
Appendix 4 – Midwifery specific training compliance matrix November 2022 until April 2023
Appendix 5 – Maternity Red Flag data
Appendix 6 – Midwifery Staffing action plan

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

None

1.0 INTRODUCTION

The report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust April 2023 bi-annual maternity staffing review. The review triangulates workforce information with safety, patient experience and clinical effectiveness indicators to provide assurance of safe staffing levels within the maternity service.

The report fulfils the requirement outlined in the National Quality Board (NQB) staffing guidance for maternity services (NQB 2018) and the Clinical Negligence Scheme for Trusts (CNST). The Incentive Scheme guidance (CNST 2021 Year 4) recommends maternity services should undertake a bi-annual safe staffing review to demonstrate an effective system of midwifery workforce planning.

The bi-annual review continues to be collated using the three National Quality Board expectations for safe, sustainable, and productive staffing levels adapted for maternity services namely right staff, right skills and right place and time.

2.0 SCOPE

This report details the arrangements for midwifery staffing provision across all inpatient, community, and specialist midwifery services and is the first bi-annual report of 2023.

It is acknowledged that a safe and effective workforce planning for maternity services must include core obstetrics and gynaecology medical services. Some detail will be provided in relation to medical staffing within the narrative of this report for triangulation and evidence of the continued effective co-production and forward planning of the midwifery and obstetric workforce.

3.0 METHODOLOGY

A triangulated approach to the planned safe staffing reviews is undertaken by the Chief Nursing Officer, Divisional Midwifery and Nursing Director, Finance Business Partner and Midwifery Matrons. Findings of the review continue to be cross checked using professional judgement and benchmarked data where appropriate.

The review incorporates all national guidance relating to the provision of safe staffing levels within maternity services; Royal College of Obstetrician and Gynaecologists (RCOG) 2021), National Institute for Clinical Excellence (NICE) 2016, National Quality Board (NQB) 2018), The Single Delivery Plan (2023) as well as workforce indicators, clinical outcome and activity measures, outcome measures reported by women, incident reports and the latest findings of the Birth Rate Plus (BR+) assessment (2022).

4.0 MATERNITY SPECIFIC SAFETY AND QUALITY

Maternity staffing metrics are displayed on the maternity dashboard each month as part of the safe staffing report submitted to Safety and Quality Committee for oversight and assurance. The metrics collated are triangulated (Table 1) and the service continues to respond to professional judgement, safety intelligence and external reports. Additional local metrics provide greater oversight of clinical outcomes which may be affected by staffing levels within the service.

Most recently, the maternity service has moved from using a traditional RAG rated maternity dashboard to statistical process control (SPC) analysis. Moving the maternity safety dashboard to SPC analysis aligns the speciality with the approach adopted by the Safety and Quality Committee and with best practice and provides

the opportunity to fully understand performance over time. A move to SPC analysis for the wider Maternity specific safety and quality matrix (Table 1) is being considered for future reports.

Table 1 – Maternity specific safety and quality matrix table

Metric	Red flag		Green flag		May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23	April 23
CNST 10 Key safety actions (Year 4 scheme updated in October 2022)					**80%**	**80%**	**80%**	**80%**	**80%**	**80%**	**80%**	**80%**	**100%**	**100%**	**100%**	**100%**
Births					356	369	373	348	362	354	354	318	350	304	376	298
Total stillbirth rate (per 1,000 births)	>	4.9	≤	4.9	0	8.1	8.0	11.5	2.8	8.5	2.9	6.3	5.7	0.0	5.3	3.4
Stillbirth rate excluding termination for fetal abnormality					****	****	****	****	****	****	****	3.1	2.9	0.0	5.3	3.4
Examination of the newborn completed within 72 hours	<	95 %	≥	95%	94%	96%	95%	98%	95.9%	97.7%	95.9%	96.5%	95.1%	95.7%	94.7%	95.6%
Breastfeeding initiation	<	70 %	≥	70%	76%	78%	78%	77%	76.0%	60.1%	76.0%	75.9%	73.9%	76.3%	82.9%	79.8%
Births per Funded clinical midwife WTE (Staff in post)	>	28	≤	26	21	25	25	23	25	24	24	21	23	22	25	21
Booked by 9+6	<	50 %	≥	50%	48%	36%	32%	38%	39.3%	49.4%	51.0%	45.8%	32.6%	38.7%	47.3%	42.2%
Booked by 12+6	<	90 %	≥	90%	90%	85%	85%	86%	87.1%	90.1%	93.1%	90.7%	88.0%	90.8%	88.9%	83.3%
Women giving birth in a midwife-led setting	<	25 %	≥	30%	21%	25%	21%	21%	18.1%	19.2%	20.0%	18.0%	17.5%	16.6%	15.1%	16.6 %
Continuity of carer Removed target range (Sept 22)					27%	28%	28%	32%	28%	28%	28%	28%	26%	30%	32%	31%
Home birth	<	1.7 %	≥	2.0 %	1.3%	4.7%	4.1%	3.5%	2.2%	3.7%	2.0%	1.9%	2.3%	3.3%	2.1%	3.7%
Incidence of severe tears grade 3 and above	≥	2.4 %	<	2.4 %	3.0%	2.5%	3.0%	2.6%	2.7%	4.5%	1.6%	4.2%	2.4%	2.1%	2.8%	2.7%
One-to-one care in labour in Delivery Suite	<	95 %	=	100 %	97%	99%	97%	97%	95.2%	98.2%	98.9%	97.7%	99.6%	98.4%	99.7%[$]	99.2%
One-to-one care in labour in Preston Birth Centre	<	95 %	=	100 %	98%	100 %	100 %	100 %	97.2%	100%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Chorley Birth Centre	<	95 %	=	100 %	100 %	100 %	97%	100 %	100%	100%	100%	92.9%	100%	100%	100%	100%
One-to-one care in labour overall	<	95 %	=	100 %	97%	100 %	100 %	97.6 %	95.9%	98.5%	99.1%	97.7%	99.7%	98.6%	99.7%[$]	99.4%
Supernumerary status of DS coordinator	<	95 %	=	100 %	100%**	100%**	100%**	100%**	100%**	100%**	100%	100%	100%	100% **	100%	100%
CTG update training	<	90 %	≥	90%	92%	89%	92%	92%	95%	97%	95%	94%	92%	93%	94%	96%
Annual competency (K2 Training Package)	<	90 %	≥	90%	91%	90%	92%	91%	97%	98%	99%	98%	99%	99%	99%	97%
Antenatal CTG	<	90 %	≥	90%	94%	93%	94%	94%	98%	***	***	***	***	***	***	***
Intrapartum CTG	<	90 %	≥	90%	92%	91%	93%	92%	97%	***	***	***	***	***	***	***
Intrapartum IA	<	90 %	≥	90%	96%	94%	95%	94%	97%	***	***	***	***	***	***	***
GAP/GROW (Growth Assessment Protocol Training)	<	90 %	≥	90%	89%	83%	83%	81%	84%	82%	87%	87%	82%	82%	87%	83%
Emergency skills Training (PROMPT – Practical Obstetric Multi-Professional Training)	<	90 %	≥	90%	87%	86%	89%	89%	90%	97%	97%	98%	93%	93%	94%	93%
Staff sickness rate					8%	10%	9.8%	10.7%	7.43%	7.2%	7.6%	11.15	8.7%	8.6%	8.6%	7.9%
Incidents of moderate harm and above					1	2	1	0	2	0	4	3	1	2	2	0
HSIB referrals					0	1	1	0	2	0	0	2	0	2	1	0

Prevention of future deaths regulation 28			0	0	0	0	0	0	0	0	0	0	0	0
Number of Consultant hours on obstetric unit	<70 hrs	=/> 96.5hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5% hrs	76.6% hrs	76.5 hrs	76.5 hrs	76.5 hrs
RCOG obstetric benchmarking compliance			97%	98%	*94%	100%	100%	100%	100%	100%	93%	95%	94%	100%
24-hour Acute obstetric medical staffing fill rate		100%				100%	100%	100%	100%	100%	100%	100%	100%	100%
Complaints			3	4	1	2	2	2	1	2	2	3	2	2
Maternal Death	> 1	<1	0	0	0	0	0	1 (late)	0	0	0	0	0	0
Fill rate RM Day	<85%	>85%	89%	81%	71%	71%	81%	82%	78%	73%	82%	81%	81%	82%
Fill rate MSW Day	<85%	>85%	68%	70%	68%	68%	67%	70%	77%	67%	77%	72%	71%	73%
Fill rate RM Night	<85%	>85%	93%	90%	81%	87%	82%	90%	88%	89%	95%	94%	90%	97%
Fill rate MSW Night	<85%	>85%	95%	115 %	108 %	100 %	97%	98%	95%	89%	95%	94%	95%	100%
Red flags			4	5	7	6	38	78	12	2	5	12	126	44
Maternity Diverts	> 1	<1	0	0	1	0	0	1	0	0	0	0	0	0
In- utero transfers declined from other units (maternity)			4^	4	4	10	2^	2	0	4	1	2^	2	0
In- utero transfers declined from other units (NICU)			1	0	0	0	2	0	0	0	0	4	0	2
In- utero transfers to another Trust			0	0	0	0	2	0	0	0	0	0	0	0
NICU Closure			0	0	0	0	2	0	0	0	0	3	2	5
Registered Midwife shifts sent to agency per month. (New Jan 23)											122	143	152	107
Registered Midwife Agency shifts filled. (New Jan 23)											71	73	77	51
Registered Midwife Agency hour fill rate percentage. New Jan 23.											58%	51%	51%	51%

* Amended rate following further case review from 92% to 94% after data validation. ** Data amended following publication of new guidance which clarified definition of supernumerary status (based upon deep dive results) *** Recording methodology changed and now reported as overall compliance following roll out of full day training. $ Adjusted 1:1 care rate following review of cases. ^ Rates adjusted in months where previously both maternity and neonatal declined IUT were recorded cumulatively.

4.1 ANALYSIS OF THE DASHBOARD

Still Birth

The stillbirth rate is monitored monthly by maternity Safety and Quality Committee. In April 2023, the stillbirth rate (3.4 per 1000) was below the national average of 4.9 per 1000 births. The SPC analysis shows variation of the stillbirth rate that is within the expected range with no cause for concern identified. The maternity service continues to closely monitor the incidence of stillbirth and the MBRRACE real time monitoring tool is utilised to track cases.

A cluster of stillbirths were identified in quarter three of 2022-2023. Local review of the cases did not identify any thematic learning or concerning features however, an external review of the cases by the regional chief obstetrician was requested for assurance. The written outcome of the review is awaited, verbal feedback has not identified any concerns.

Booked by 9+6

Performance in this area has been below expected standard for the previous 12 months. Recent interventions have led to improvements in this area, and it is expected the service will demonstrate an improved position by

June 2023 and will then be able to sustain the 50% compliance standard for antenatal booking by 9+6 weeks. A weekly performance tracker is maintained and there is close monitoring by the operational and digital teams.

Birth in a midwife led setting

Birth in a midwife led setting rate has been consistently below the service target of 25%. There is no national target for this metric. In April 2023, the rate was 16.6%. The BirthRate Plus assessment undertaken last year (2022) identified an increasing complexity of cases by around 10-11% and an increase in both emergency and elective caesarean section rates by around 10%. This explains the decrease in the number of women who are assessed as suitable to give birth in a midwife led setting. The service will conduct an in-depth review of the risk assessments for place of birth at the end of pregnancy and will continue to monitor the rates of birth in midwifery led settings.

Severe tears

Whilst the maternity specific safety and quality matrix shows that the 3rd and 4th degree tear rates for April 2023 was slightly higher than the target range, when this data is viewed as an SPC chart, it demonstrates that this is a normal fluctuation and is not a statistical cause for concern. In addition, the review of the North West Coast (NWC) regional dashboard shows that the service is not an outlier in comparison to regional peers.

GAP and GROW

The service has remained consistently just below the target of 90% for Gap and Grow training. At present this training is delivered by e-learning for health and relies on self-declaration of training being undertaken. This means that tracking performance can be challenging. Discussions are ongoing within the service to consider whether an in-house training package, undertaken as part of PROMPT would be better placed to ensure that compliance is achieved and accurately recorded.

Fill Rates

The fill rates for Registered Midwives (RM) and Maternity Support Workers (MSW) demonstrates a stable but sustained, lower than planned fill rate. A deep dive review of the roster templates and fill rate data will be undertaken to ensure that these correctly reflect the staffing requirements and provide accurate information about unfilled shifts.

The service has a current Registered Midwifery vacancy rate of 10.6 WTE, with a further 18.8 WTE (leavers and maternity leave) from June 2023, totalling 29.47WTE staffing gap by August 2023.

A recurrent advert to fill all vacancies is ongoing with 8 prospective midwives (in training currently) recruited on condition of qualification. There are 19 further student midwives shortlisted for interview in the next few weeks.

Introducing department specific roles is one way the service is attempting to retain and attract new staff. This recruitment has predominantly been filled by internal candidates and internal recruitment to core roles correlates with feedback received that some colleagues want consistency of department. These department specific roles have been received positively by staff.

International recruitment continues with three new colleagues having now joined the organisation and a plan for 13 further midwives to join later this year.

The service has a predicted MSW vacancy of 4.41 WTE (Maternity leave and vacancy) by August 2023.

A work force plan for 2023 has been collated by the service in collaboration with the workforce business partners to detail the actions taken to mitigate the staffing risk (Appendix 6).

Agency fill rates are now included in the maternity specific safety and quality Matrix. All shifts are initially offered as bank and are then converted to agency after 2 weeks of not being filled. This demonstrates the commitment of the service to fill all vacant shifts. Consistently the service fills between 50-60% of all unfilled agency shifts.

Sickness

The sickness levels within the service have been significantly above the Trust target for over 12 months. Long covid has been a key factor affecting absence within the service. The staff survey indicates there is work to do to improve the way that some staff feel about work. Several steps have been taken to improve colleague experience such as strengthened leadership, core roles, reward and recognition activity and improvement work and this will continue throughout the year. However, given the sustained high sickness rates, the division has requested additional scrutiny and support to explore if anything further could be done to improve the position.

Red Flags

Midwifery red flags highlight potential areas of staffing concern within the service. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing levels. If a midwifery red flag event occurs, the Delivery Suite Coordinator should be notified and determine whether midwifery staffing is the cause, and the action that is needed.

The dashboard records the number of flags reported, and a detailed breakdown of each category is detailed in Appendix 5. There was an expected significant increase in red flag reporting in the month of March 2023. A change in methodology and intensive education increased the number of incident reports submitted from 12 in February 2023 to 126 in March 2023. The service is now more accurately reporting against the delays in maternity triage, time critical activity and induction of labour, with individual incident reports being submitted for each case rather than overarching incident reports listing several patients who have been affected. A reduction in reporting in April 2023 can be attributed to lower acuity overall.

Diverts

Maternity Diverts are not currently classified as a national red flag event, however the service continues to monitor capacity issues that have resulted in a request to divert. Since May 2022, there have been 2 instances where the maternity unit was placed on divert as the acuity exceeded the staffing levels. The last occasion was in October 2022.

The service collects data related to inability to accept intrauterine transfers. The decision to decline Northwest Connect requests for a level 3 neonatal cot is undertaken using a multi-disciplinary approach. The on-call consultant, delivery suite coordinator and maternity matrons (in hours) review the acuity, induction of labour activity, delays, planned elective work and staffing and when required the decision to prioritise safety on the unit is taken.

To provide wider triangulation of operational pressures on the maternity and neonatal service, for the first time, the maternity specific safety and quality matrix includes a separate breakdown of all Intra uterine transfers (IUT's) declined by maternity and those declined by the neonatal unit. It also details instances when antenatal IUT's are requested by the neonatal service because of staffing, capacity, or closure of the neonatal unit. Finally, the matrix details when the neonatal unit has been closed.

Continuity of carer

The three-year single delivery plan for maternity and neonatal services asked that services continue to consider the roll out of MCoC in line with the principles around safe staffing. The service continues to monitor the level of MCoC. The DMND and leadership team regularly reviews the service provision and confirms that 3 continuity models can be continued without impacting on the safety of the service. (31% of women in April 23 were booked onto a MCoC pathway).

The service is considering how to expand the provision of MCoC so that priority can be given to those most likely to experience poorer outcomes first, including women from Black, Asian and mixed ethnicity backgrounds and those living in the lowest decile of deprivation. Further roll out will be dependent on safe staffing levels.

The home birth rate has been over the national average of 2% for over 12 months and reflects the positive outcomes related to the continuity modelling. In the month of April 2.9% of births were at home with a mean rate of 3.5% year to date.

The continuity of care teams were also the most positively performing midwifery team in the 2022 staff survey results, scoring 100% for; enthusiasm about their job, knowing what their work responsibilities are, feeling trusted to do their job and indicating that their role made a difference to service users.

5.0 LEADERSHIP

The Board level safety champions are the Chief Nursing Officer and the Non-Executive Director with responsibility for women, children and safeguarding. The post has its own specific job description and recognition of the additional responsibility reflected. The Chief Nursing Officer chairs the bi monthly safety champions forum. The Divisional Midwifery and Nursing Director (DMND) is the senior lead within the midwifery team, reporting professionally to the Chief Nursing Officer and provides clinical leadership and strategic direction to the maternity service in addition to the Breast, Gynaecology and Sexual Assault Forensic Examination (SAFE)/Sexual Assault Referral Centre (SARC) Services. The DMND is part of a divisional leadership quad that includes a Divisional Director, Medical Director and Divisional Nurse Director for Children and Neonates.

Additionally, the Matron for Safety and Quality is now included in the leadership structure to strengthen safety outcomes and speciality governance arrangements in line with national reporting recommendations. The updated QUAD, midwifery and governance structures are included in appendix 2. The leadership within the birth centres has been strengthened increasing the management establishment from 1 WTE to 2 WTE band 7 roles. This means that both the free standing and alongside birth centres have a lead midwife which enables dedicated leadership and increases staff engagement with the aim of improving satisfaction and retention.

5.1 BOARD VISIBILITY

A Board visibility visit was undertaken within maternity and neonatal services on the 2nd of May 2023. The Board Safety and Experience Programme was received positively by the service and demonstrated the interaction that exists between the Board, staff colleagues and families. The visit provided an opportunity for members of the Board to explore whether safety intelligence presented at Trust Board triangulates with the ‘work as done’ in practice. The service will receive a letter summarising the visit outcomes and thanking the staff for their time.

5.2 GOVERNANCE PROCESS

Improving governance rigour and risk maturity remains an ongoing action for the service. The addition of a Matron for Quality and Safety and an adjustment to the structure of several specialist posts within the current establishment has enabled essential requirements within the Ockenden report to be realised. The service has taken precursory steps to prepare for the Patient Safety Incident Response Framework (PSIRF). This includes joint terms of reference setting with families, allocation of a family liaison contacts and reviewing low level incidents thematically.

This work is supported by the Maternity Governance Manager with oversight from the Divisional Governance Lead. A Consultant Obstetrician has dedicated governance time allocated within their job plan to support the governance agenda.

5.3 OCKENDEN ASSURANCE

The second ICB Ockenden assurance visit was undertaken on the 28th April 2023. The purpose of the visit was to review the progress made from the initial insight visit and to review the status of the recommendations from the final report. The visit was led by the Associate Director of Midwifery for the Local Maternity and Neonatal System and Integrated Care Board (ICB), supported by the Maternity & Newborn Alliance- (ICB) and the Maternity and Neonatal Voice Partnership (MNVP) Chair Pennine in the absence of the MVP Chair for Central which is currently vacant.

Feedback from the visit was positive with the service commended for the open and honest approach to the visit, and for its evident drive and passion for continuous improvement for the benefit of women and families. The positive impact of the role of the safety champions in their ability to understand the challenges and drive improvements was noted. The visit included areas of focus such as induction of labour and the maternity triage pathways and the review team noted good progress within these work streams.

The new governance structure which continues to drive the safety and quality agenda was considered a positive escalation. Specifically, the way in which the service heard the voice of women and families through the investigation process was highly praised.

The area that requires progress is in relation to the recruitment to the Maternity Neonatal Maternity Voices Chair, the previous chair has stepped down and recruitment to the new role will be undertaken by Health Watch once the workforce processes have been agreed with the ICB.

5.4 THREE YEAR DELIVERY PLAN FOR MATERNITY AND NEONATAL SERVICES

The National Single Delivery Plan (SDP) for maternity and neonatal services was published at the end of March 2023. This aligns the key priorities and national actions following the East Kent report, the Ockenden reports, the NHS Long-Term Plan and Maternity Transformation Programme. A technical specification to the report is expected to be published, detailing the actions required.

6.0 RIGHT STAFF

6.1 BIRTH RATE PLUS - EVIDENCE BASED WORKFORCE PLANNING

The recently published Three-Year Delivery Plan for maternity and neonatal services (March 2023) states that services should undertake regular workforce planning and where they do not meet the staffing establishment levels set by Birth Rate Plus to do so and achieve fill rates by 2027/28. This includes developing and implementing local plans to fill vacancies. It is also likely that CNST Year 5 will state that Trusts must have a

funded establishment based upon Birth Rate Plus calculations or an agreed plan which includes the timescale for achieving an appropriate uplift in funded establishment, which includes mitigation to cover any shortfalls. BirthRate Plus is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. The calculation used to determine safe staffing levels is based upon traditional models of care and includes the Trusts 23% uplift for annual, sickness and study leave, and 15% community travel uplift but does not include modifications for the implementation of continuity models of care.

The current service establishment is based on the assessment undertaken in 2019. This has been repeated and a draft report was made available at the end of 2022, which has been reviewed and accepted as correct in May 2023.

The number of births is similar to the last assessment carried out in 2019, however there have been changes in the following areas, which account for the recommendation to uplift staffing:

- A significant change in the case mix, with an increase of 10/11% in Category IV and Vs (the most complex care categories)
- An increase in both emergency and elective caesarean section rates from 13.2% to 22.3% (Emergency) and 11.9% to 19.6% (Elective).
- An increase in the number of Outpatient Clinics
- Staffing requirements for Triage to meet the nationally recommended BSOTS model.
- Additional safeguarding built into the community.
- Staffing requirements for the Homebirth team to cover 24/7 on call.

The development of the maternal medicine centre is likely to further increase the acuity associated with complexity of cases.

Appendix 1 details the analysis of the Birth Rate Plus assessment and includes a breakdown of the staffing uplift requirements for each clinical area and staff group with the financial breakdown.

The most recent assessment recommends an uplift to the current the funded establishment of 16.67WTE registered midwives, 5.93WTE Midwifery Support Workers and 5.53WTE Health Care Assistants. This comes at a total cost of £1,392,845.

6.2 SPECIALIST MIDWIFERY ROLES

Birth Rate Plus advises that the additional workforce should equate to approximately 10% of the funded clinical midwifery establishment to enable specialist support for the provision of a safe service. Specialist midwives provide expert guidance and specialist support.

The total clinical establishment as produced from BR+ with 23% uplift of 190.10 WTE (excludes the non-clinical midwifery roles). BR+ recommends 10% of the workforce should be specialist roles. This equates to 19.01 WTE specialist midwifery posts, however this can be set by the service depending upon specialist midwifery need requirements. Currently the service has 16.70 WTE this leaves a deficit of 2.31WTE specialist midwife funding. The service request is to fund a 1.0WTE Band 8a Advanced Midwifery Practitioner to support the obstetric team in maternity triage and the maternity ward. This would reduce the current pressure and the risk currently being experienced in these areas. In addition, the service requires a 1.0WTE Band 7 Specialist Midwife for Multiple Pregnancy which is a national recommendation from NICE, MBRRACE and Ockenden. The remaining 0.31WTE hours would be for Bereavement Midwifery hours to contribute to the provision of a 7 day per week bereavement service which is an Ockenden recommendation.

The breakdown of WTE specialist midwives and the distribution of clinical and non-clinical work is detailed in Appendix 3.

6.3 OBSTETRIC MEDICAL STAFFING

Acute obstetric unit medical staffing and consultant availability (daytime labour ward cover and out of hours/on call) has been included and is monitored on the maternity specific safety and quality dashboard from August 2022. The data submission reflects the actual medical staffing for the acute obstetric service, in relation to the planned staffing levels.

The provision of acute obstetrics takes priority over all other planned medical obstetric and benign gynaecology workload. Since August 2022 (when the data collection commenced) 100% cover was achieved for all tiers of the acute obstetric rota (consultant, middle grade, and junior tier). However, it should be acknowledged that gaps continue to be realised in the planned consultant and middle grade workforce. Parental leave, vacant posts, and acting down resulted in consultants altering rosters to prioritise the acute obstetric service. This impacts on the ability of the consultant to consistently be available for their usual day time clinical sessions, other planned clinical work, or professional activity. Table 3 provides a breakdown of the work force establishment for information and details the progress to increase funding and fill all positions.

Table 3 Obstetric Medical workforce

Workforce plan			
	WTEs		
Name	Funded	Contract	Official vacancy
Consultant Total	21.71	18.15	3.56
Middle grade Medics Total	14.99	10.77	4.22
Clinical Fellow	0.00	3.00	-3.00
Junior Medics Total	11.00	15.47	-4.47
Trainee Medics Total	1.00	1.00	0.00
TOTAL	**48.70**	**45.39**	**3.31**

Actions
Establishment increased to 22 Consultants and 14 Middle grades (Previous 17 consultants 11 middle grades)
Against the 3.56 consultant vacancy: • 1x Consultant Obstetrician recruited • 2 x Obstetrics and Gynaecology Consultants out to advert.
3 x Clinical Fellows recruited as Junior Doctors to progress into the middle grade rota this is due to challenges in recruitment, this will then support a 2 tier rota once they move to the middle grade rota
Once all the Consultants are recruited the on-call rota will be reviewed to increase the predicated-on call hours for obstetric cover. (currently at 76.5hrs)

6.4 SAFE STAFFING MITIGATING ACTIONS

The Northwest Maternity Escalation Policy including Maternity Operational Pressures Escalation Levels (OPEL) has unified the procedures for the Northwest region to manage significant surges in demand. The escalation policy enables standardised oversight of the maternity status at Trust and regional level to be operationalised. In addition, the daily GOLD call provides prompt system response and mutual aid in the event of high activity, or the requirement for deflection of work or emergency divert.

Daily staffing figures and acuity levels within the maternity intrapartum areas are captured in an electronic Birth Rate Plus acuity tool and weekly a summary of compliance is reported and shared. The app-based Birth Rate

Plus acuity tool is utilised across all 4 local maternity and Neonatal system (LMNS) providers to give greater oversight of the intrapartum areas to enable more efficient management of workload and staffing.

The addition of a ward-based acuity tool is anticipated to be introduced to provide wider insight into all operational pressures and training planned for June 2023.

A review of all staffing levels is also undertaken at twice daily huddle meetings and any actions taken to redeploy staff are documented for future reference. Oversight of acuity and demand is undertaken by the Matron during working hours and the Delivery Suite Co-ordinator out of hours. The safety and quality dashboard now includes decisions to divert to ensure the broader context and experiences of women and families is understood.

7.0 RIGHT SKILLS

7.1 TRAINING

The service reports positive compliance to the essential midwifery training related to fetal monitoring and PROMPT. Compliance with emergency skills training and fetal monitoring has been maintained consistently with 90% compliance achieved in all staff groups. Fetal monitoring has been over 90% since July 2022 and PROMPT been over 90% since September 2022.

As a result of historic ongoing staffing deficits in 2022 related to non-filled vacancies and higher sickness rates, compliance to infant feeding training compliance was reduced. A restoration plan to improve compliance is ongoing, however further staffing establishment gaps is expected to further impact on the ability to fully recover all training. The service will continue to prioritise fetal monitoring and PROMPT. The last 6-month overview of essential training compliance is detailed in appendix 4 for information.

7.2 RESTORATIVE SUPERVISION

In January 2020 the Professional Midwifery Advocate role was relaunched to deliver the Advocating for Education and Quality Improvement (A-EQUIP) model of restorative support for registered midwifery staff. The A-EQUIP model of restorative support aims to build personal and professional resilience, enhance quality of care, and support professional revalidation and the expectation for Trusts.

Six staff members have undertaken the PMA training and provide restorative supervision within maternity service, with a further 3 in training. It is anticipated that more staff will be trained until the recommended ratio of one PMA to every 20 registered staff is achieved. There is also a dedicated email for staff to seek one to one support as required. Following a review of supervision, the Nursing, Midwifery and AHP Board has agreed to allocate specific time on the rota of 8 hours per month to drive improved engagement for this important part of the health and wellbeing offer. To date, available hours for supervision have been dependent upon acuity, activity and competing clinical priorities and there is a plan to review the PMA service in the next 2 months to devise a programme of work.

7.3 TRAUMA INFORMED WORK

Petals is a Baby Loss Counselling Charity that is available to support Healthcare Professionals experiencing trauma and/or loss from pregnancy and/or birth experiences. Through the HART project, Petals is being funded to offer specialist counselling and support to staff who require psychological support. This service has been positively evaluated by staff members who have already accessed this service for support and is a welcome additional for psychological trauma support.

7.4 ENHANCED SUPPORT MIDWIFERY TEAM SAFEGUARDING SUPERVISION

Safeguarding supervision is facilitated by the enhanced support midwifery team to the maternity and corporate specialities. Regular supervision sessions for midwifery staff are provided as part of planned team meetings, daily safety huddles and during 1:1's. The team also continue to be visible in the maternity unit and provide ongoing supervision during evolving cases. In the last 3 months the team have provided clinical supervision to 103 staff over 29 sessions.

8.0 RIGHT PLACE AND TIME

8.1 SUPERNUMERARY STATUS

CNST Standard 5 Element C *The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.*

The supernumerary status of the coordinator and compliance is monitored within the service monthly and reported to Trust Safety and Quality Committee. 100% compliance has consistently been achieved each month.

8.2 ONE TO ONE CARE

The ability to provide one to one care in labour is monitored each month and provides a reference point from which safe staffing levels can be confirmed. The birth centre locations continue to consistently achieve a 100% compliance rate. Delivery Suite is being closely monitored as the Maternity Information System (MIS) is reporting (97-99.7%). On any occasion when 100% is not achieved, the cases continue to be reviewed.

8.3 RCOG ATTENDENCE

Ongoing monitoring of compliance related to consultant attendance for the clinical situations listed in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' continues. This is an important metric to sense check the system pressures and track the clinical impact of gaps within the obstetric workforce. In April 2023 100% compliance was achieved.

9.0 STAFFING RELATED RISKS

Detailed below (Table 4) are the open risks on the women's health register that are associated with the ability to maintain safe staffing levels.

Table 4

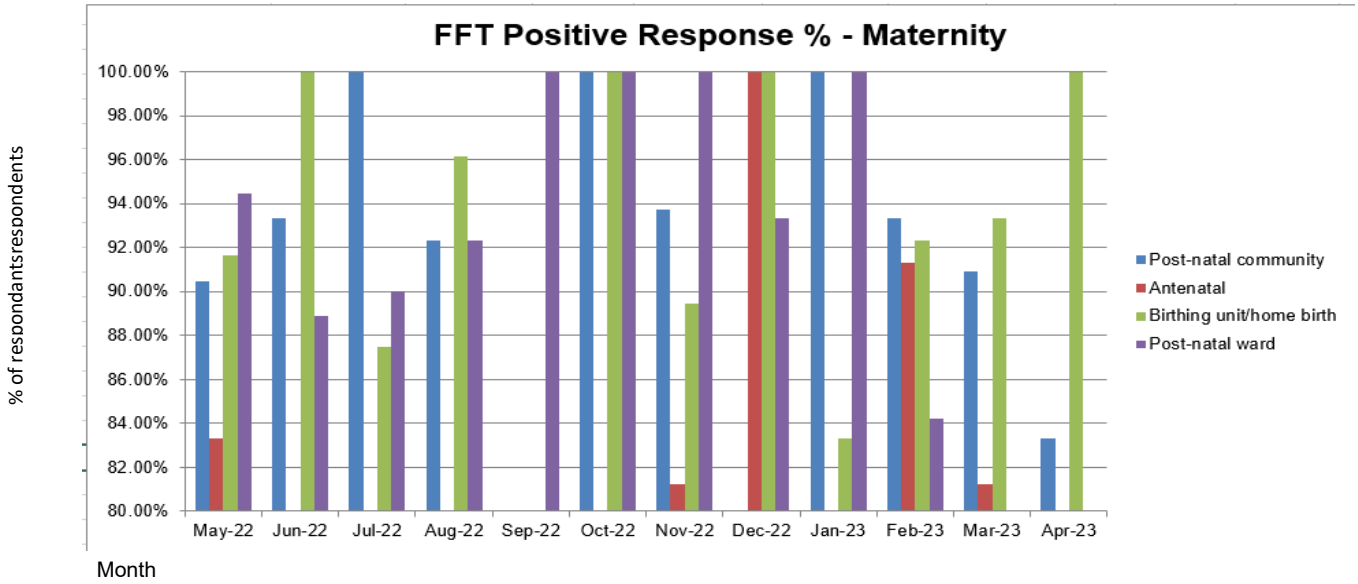
Risk ID	Title	Current risk rating
581	Maternity staffing deficit	15 (Active risk)
1592	Delays in induction of labour process	15 (Active risk)
1292	Inability to accept intra-uterine transfers from other organisations	15 (Active risk)
569	Elective caesarean sections list over running	15 (Active risk)
1708	Deferring and rearranging planned consultations in midwifery led services	15 (Active risk)
1688	Maternity Assessment Suite (MAS) – partial implementation of the Birmingham symptom specific obstetric triage (BSOTS) system.	12 (Active risk)
1154	Multi-professional maternity AIMS training not provided within national Ockenden core competency framework	12 (Active risk)

570	Inability to provide one to one care in labour in birth settings at RPH 100% of the time.	3 (Controlled risk)

10.0 PATIENT EXPERIENCE

The maternity service continues to actively seek feedback from service users to continuously improve the experience of women and families. The maternity CQC survey, complaints triangulation, lived experience feedback, maternity and neonatal voices partnership and the friends and family response rates provide a wide platform of intelligence in relation to how we are performing. Table 5 details the maternity friends and family survey finding from May 2022 to April 2023.

Table 5: Maternity friends and family survey responses May 2022- April 2023



The Friends and Family feedback test for antenatal care and postnatal has not recorded responses consistently. Work is ongoing within the service to review reporting methods and ensure that the right pathways are in place for collecting responses. The service is also considering the use of the Badger Net electronic record for collation of additional feedback.

10.1 MATERNITY SURVEY 2022

The 9th CQC maternity survey was undertaken between the 1st February and the 28th February 2022 and feedback was obtained from the antenatal care, labour and birth and postnatal continuum. 312 mothers were invited to take part in the study. All women invited to responded had birthed in February 2022. 135 mothers responded to the invitation giving an overall response rate of 44%, it was noted that there was a decrease in the overall response rate when compared to the 2021 data where the response rate was 59%.

The survey results, highlight areas of exemplary practice whilst also identifying the areas of further improvement required within the service. The survey compared the LTHTR Trust responses with those from 121 other Trusts and highlighted that 3 of the responses were better than expected and 44 of the responses were about the same as other Trusts. Two responses were noted to be worse than expected. The first of these was related to whether midwives or doctors were aware of medical history during antenatal check-ups. The second was around the number of contacts with a midwife at home after birth and lack of signposting information in relation to mental health and wellbeing.

The maternity service implemented the BadgerNet digital maternity record system in August 2021. At the time of the survey the team were learning the functionality of this system and making local adaptions where necessary and this is likely to have impacted on experience of care.

During the timeframe of the survey some restrictions were still in place because of the Covid 19 pandemic and modifications to service including rationalising home visits may have impacted on the number of contacts women received. Since this time, full-service restoration has been completed, however the service recognises the ongoing risk of cancelling community work in response to current staffing pressures and as such this is reflected on the risk register and an action plan is in place attached to this risk.

The better-than-expected performance related to the involvement of partners in care and demonstrated the importance of unrestricted access for families during pregnancy and birth. Since the survey was completed in February 2022, the service and LMNS have invested in additional recliner chairs for each bedspace across the maternity wards to improve the facilities for support person to stay overnight which includes during the induction of labour process.

The maternity service remains committed to listening and learning from service user feedback to continuously improve services for women and families. A detailed speciality report has been collated with an associated action plan has been produced in response to the findings.

10.2 COMPLAINTS

Quarterly thematic analysis of all complaints is undertaken by the Matron for Safety and Quality to identify trends and actions to be undertaken.

The number of complaints as well as the clinical themes has been included below to aid further triangulation of experience against clinical outcome measures. Table 6 details the number of complaints received from April 2022 until March 2023.

Table 6: Number of complaints received from April 2022- March 2023

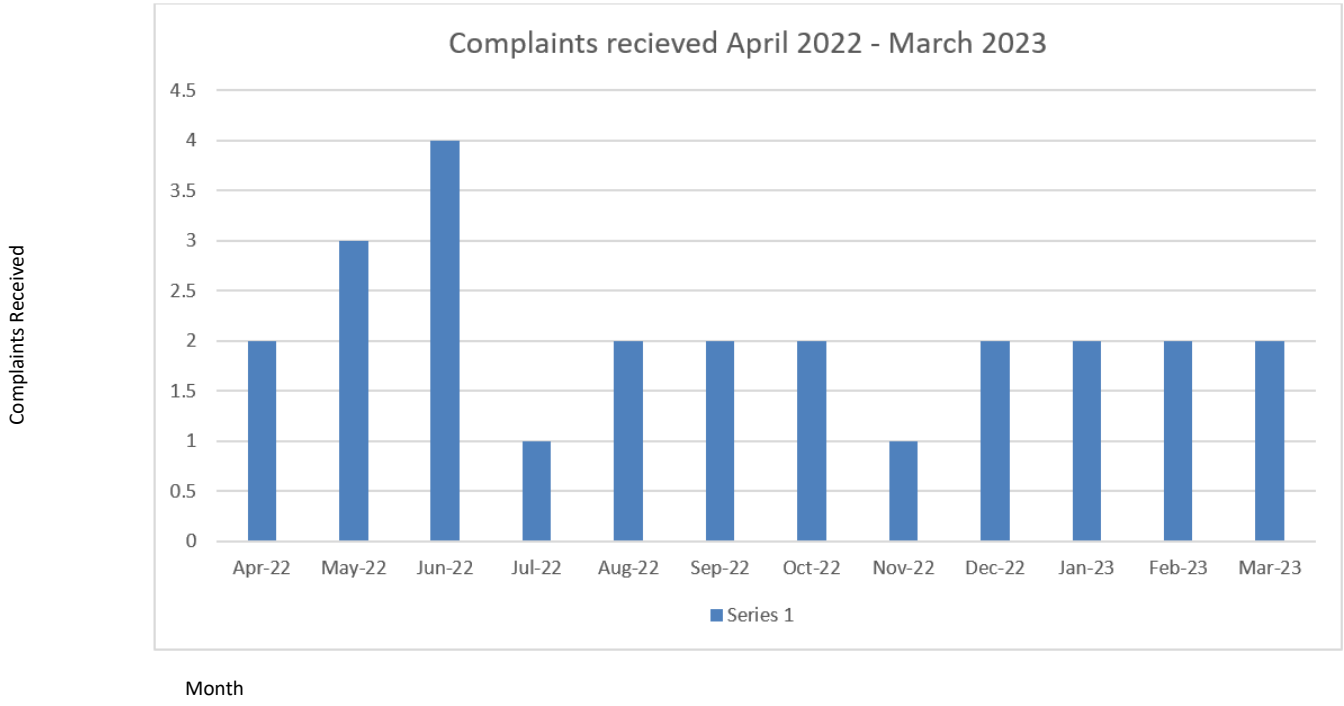
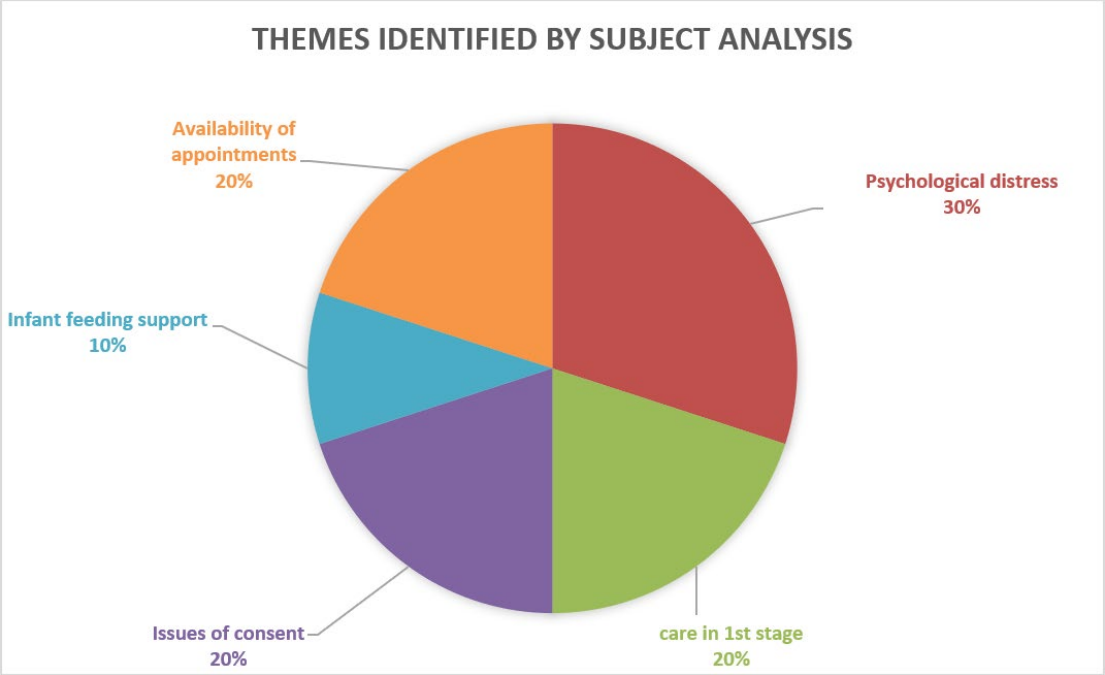


Table 7: Themes by subject



Actions taken in response to complaints

Actions have already been implemented by the maternity service to learn from the triangulated themes/trends identified within the new referrals to NHS resolution, the new letters of claim/ claims being considered, the claim score card, patient complaints and the concluded StEIS investigation reports. All StEIS investigations (including HSIB investigated incidents) are subject to detailed actions plans. Compliance with action plans is monitored through both Datix and the maternity Safety and Quality Committee. The service offers women and families the opportunity to meet the team discuss the care and share their lived experience for learning when appropriate. An early pregnancy experience story is going to be scheduled to be presented at the Maternity & Newborn Alliance Board later in the year to demonstrate the ongoing improvement work and development of the early pregnancy service. All women who report emotional trauma or distress from their experience are offered referral to the Reproductive Trauma Service.

11.0 STAR ACCREDITATION

Findings from the recent STAR Quality Assurance accreditation visits are highlighted in the table 5 below.

Table 5 – STAR accreditation awards April 2023.

Area	Star Rating	1st Visit Score	2nd Visit Score	3rd Visit Score	4th Visit Score	5th Visit Score	6th Visit Score
Antenatal Clinic RPH	Silver	89% A 02/05/18	89% B 24/06/19	88% A 07/07/20	95% A 18/05/21	95% A 15/09/22	
Birth Centre RPH	Gold	95% A 04/04/18	96% A 17/06/19	100% A 25/02/20	97% A 27/10/20	94% A 10/5/23	
Birth Centre CDH	Silver	89% A 10/02/21	94% A 24/06/21	91% A 03/02/23			
Delivery Suite	Gold	90% A	92% B	92% A	94% A	94% A	95% A

		06/11/17	01/02/19	06/02/20	09/11/20	21/06/22	14/04/23
Maternity A	Silver	96% B 18/12/18	95% A 11/03/19	87% A 10/02/20	93% A 28/02/20	92% B 14/10/22	
Maternity B	Bronze	85% B 11/09/17	96% A 05/09/18	96% A 21/2/20	96% A 03/09/20	88% B 08/09/22	89% A 28/02/23
Maternity Day Case RPH	Silver	85% A 30/08/18	94% A 07/10/19	91% B 12/05/21			

Performance against the STAR accreditation assessment has been consistently good within maternity services.1/7 has achieved a bronze star. 4/7 have achieved a silver rating with 3/7 on track to attain gold status at the next inspection. 2/7 has a gold star. There has been a reduction in performance on maternity ward B and this has resulted in the loss of gold star accreditation to bronze in February 2023. A detailed action plan for improvement is ongoing with oversight from the matron.

12.0 STAFF ENGAGEMENT

There have been no whistleblowing internal or external activity within maternity and neonatal service in the last 6 months. Monthly maternity and neonatal engagement forum are held by the Divisional Midwifery and Nursing Director, the Chief Nursing Officer and the Non-Executive Director who all hold a responsibility as named Safety Champions. This forum is a valuable opportunity for staff to escalate any concerns impacting upon the maternity team or service and receive feedback actions taken in response their concerns. Feedback is included in the bi monthly Board reports.

12.1 STAFF SURVEY RESULTS

The most recent staff survey was made available to the service in April 2023. Maternity A, Maternity B and Delivery Suite were identified as areas of particular concern and focused work with the HR Business Partners is ongoing. Midwifery Led Services, Continuity of Care and Specialist Midwives reported the highest satisfaction overall reporting that they felt that the organisation ensures that incidents do not repeat, they felt secure about raising concerns about unsafe practices and felt confident that the organisation would address safety concerns. Work is ongoing with area leads and the Trust Organisational Development team to formulate team action plans for improvement.

13.0 CELEBRATING SUCCESS

A successful workforce, which is derived on the principles of continuous improvement is a key enabler to safer maternity care. The NHS Long Term Plan recognises creating a high performing system is dependent on our people and our workforce. The team is encouraged to contribute and celebrate when things go well and connecting and networking is instrumental in midwifery leadership.

The service continues to promote the organisation at regional and national events and celebrate positive achievements. Recently the service was runner up at the National Maternity and Neonatal Summit for the poster presentation of the preceptorship programme. The Safety and Quality Matron and the Deputy DMND presented the work around family involvement in incident review and the safety II principles at the Regional International Day of the Midwife Celebration event. The specialist Midwife for Bereavement was nominated for a Mariposa Award and several of the speciality have been shortlisted for Our Peoples Awards.

A maternity conference has been arranged in June 2023 to highlight national and regional developments within maternity services and to show case the work being done. This is an opportunity for staff to engage on a more strategic level and will contribute to their continuing professional development.

14.0 CONCLUSION

This report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust first bi-annual maternity staffing review of 2023 to provide assurance to the Board of Directors of safe staffing levels within the maternity service and identify future requirements to maintain safety.

The Board receives a bi monthly update report on CNST and maternity and neonatal services. The Divisional Midwifery and Nurse Director attends Safety and Quality Committee and The Board of Directors to ensure the profile of maternity and neonatal services is high within the organisation.

Maternity is a stable service, however, is experiencing increases in acuity and staffing vacancies that at times are affecting the ability to sustain delivery of services. Colleagues work flexibly across several areas as required to ensure safety is maintained. Deflection and divert procedures are utilised to maintain safety in line with the Regional Escalation Policy. The impact on families should not be underestimated when they have to receive care from unfamiliar services that are further away from home.

Positive steps are being taken in response to the Ockenden Report to increase medical staffing and explore several new strategies to improve midwifery staffing. This includes international midwifery recruitment to ensure a sustainable, high functioning service is provided to women and families.

It is expected the predicted high levels of maternity leave will require an increase in mutual aid provision during quarter 2 and 3 of 2023 to maintain safety. Work is underway to minimise the impact of this, including permanent recruitment to maternity leave, specialist roles, core team roles, enhanced leadership provision and bank and agency use.

The outcome of the most recent Birth Rate Plus assessment and professional judgment identifies the need to increase establishment by 29.73WTE because of an increase in complexity of cases. This has a cost pressure of £1,392,845.

It should be noted that in line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Chief Nursing Officer confirms they are satisfied with the outcome of the bi-annual safe staffing assessment and that whilst risks remain present staffing is safe, effective and sustainable.

This bi-annual safe staffing review complies with NHS Improvement and the National Quality Board requirements and requirements of the Clinical Negligence Scheme for Trusts.

15.0 RECOMMENDATIONS

It is recommended that the Board of Directors:

i. Receives and approve the maternity staffing review.
ii. Note that investment is requested following the 2022 Birth Rate Plus report and the plan to work with the ICB to agree the approach to funding this.

Appendix 1: Detailed Birth Rate + (BR+) staffing summary (2022)

Background

The Three-Year Delivery Plan for maternity and neonatal services (March 2023) states that:
It is the responsibility of Trusts to:

- Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where Trusts do not yet meet the staffing establishment levels set by Birth Rate Plus (BR+) or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

It is the responsibility of ICBs to:

- Commission and fund safe staffing across their system.
- Agree staffing levels with Trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).

It is likely that CNST Year 5 will state that Trusts have to have a funded establishment based upon BR+ calculations or an agreed plan which includes the timescale for achieving an appropriate uplift in funded establishment, which includes mitigation to cover any shortfalls.

BR+ is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour.

The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives and have been endorsed by the Royal College of Midwives (RCM) and Royal College of Obstetricians and Gynaecologists (RCOG). The RCM strongly recommends using BR+ to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels.

Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. It takes into account changes in government policies on maternity services and clinical practices, and local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. BR+ is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide care.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff to provide elements of postnatal care is included. Other support staff roles are based upon professional judgement of safe staffing levels. The

recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local 23% uplift for annual, sick & study leave allowance and for travel in community.

Factors which influence the BR+ assessment include transitional care which is provided on the ward rather than in neonatal units, and safeguarding needs which require significant input putting higher demand on the workload. Shorter postnatal stays before transfer home requires sufficient midwifery input to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided. Community based care is expanding with the emphasis being placed on care being provided in community venues by midwives and midwifery support roles. Women and babies are often seen more in a clinic environment with less contacts at home. However, reduced antenatal admissions and shorter postnatal stays result in an increase in community care.

Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home. Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. Equally, there are women who birth in a particular hospital but from out of area so are 'exported' to their local community service. Adjustments are made to midwifery establishments to accommodate these community flows. The NICE guideline on Antenatal Care recommends that all women be 'booked' by 10 weeks' gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal.

<u>The assessment</u>

The maternity service last undertook a BR+ assessment in 2019. A new assessment was commissioned in 2022 and the report was made available in draft form. The service has now reviewed this for accuracy and agreed the contents of this report as of May 2023.

The results of the most recent BR+ assessment are based on three months case mix data obtained for the months of December – February 2021/22. Annual activity is based on the Financial Year 2021/2022 and total births of 4219. The Trust agreed uplift of 23% for annual, sick and study leave is included, however it is acknowledged that the Local Maternity and Neonatal System (LMNS) recommend a 25% uplift for midwifery staff to accommodate the increased levels of training that are now required following the publication of the recent national reports therefore a 25% uplift figure has also been included in the report for consideration. 15% community travel is included in the staffing figures and time to lead is included for Band 7 Coordinators, Ward and Department Managers, and Team Leaders to cover the day-to-day management and coordination of all areas.

The number of births is similar to the last assessment carried out in 2019, however there have been changes in the following areas, which account for the recommendation to uplift staffing:

- A significant change in the case mix, with an increase of 10/11% in Category IV and Vs (the most complex care categories)
- An increase in both emergency and elective caesarean section rates from 13.2% to 22.3% (Emergency) and 11.9% to 19.6% (Elective).
- An increase in the number of Outpatient Clinics
- Staffing requirements for Triage to meet the nationally recommended BSOTS model.
- Additional safeguarding built into the community.
- Staffing requirements for the Homebirth team to cover 24/7 on call.

The development of the maternal medicine centre is likely to further increase the complexity of cases, and this must be considered.

Table 1 shows the recommended BR+ staffing levels for clinical midwives and Maternity Support Workers (providing postnatal care) in each clinical area including 23% uplift.

Table 1 – BR+ recommended establishment

Birthrate Plus® Staffing: inclusive of 23% uplift

Clinical WTE required	
Delivery Suite: • Births • A/N cases • Postnatal Readmissions • Non-viable pregnancies • Induction of labour	45.90wte RMs
Triage - BSOTS Model	14.69wte RMs
Preston Birth Centre • Births & postnatal care • Births only • Transfers to Delivery Suite	21.36wte RMs
Antenatal Ward • A/N Admissions • Inductions of Labour Postnatal Ward • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions • Postnatal ward attenders	11.02wte RMs *min staffing 2 RMs per shift)* *38.38wte* *(Includes B3 MSWs for postnatal care)*
Outpatients Services • midwife led clinics • Obstetric/Specialist clinics • Fetal medicine • CDH clinics • Maternity Day Care Unit	11.43wte RMs 1.84wte MWs
Community Services: • Home births • Community cases • Attrition • Additional safeguarding	37.44wte RMs and B3 MSWs *(Includes 6.00wte for Homebirth Team, and MSWs -postnatal care)*
Chorley Birth Centre • Births/Triage cases	8.04wte RMs
Total Clinical WTE	**190.10wte RMs & PN MSWs**

Table 2 shows a breakdown of current clinical midwifery establishment in each clinical area.

Table 2 – current midwifery establishment

Area	Current Midwifery Establishment (WTE) not including Band 3 PN MSW
Delivery Suite	35.46
Maternity Triage	11.56
Preston Birth Centre (PBC)	41.38
Community Services	
Antenatal Ward	8.71
Postnatal Ward	25.69
Outpatient Services	7.17
Continuity teams	25.42

(Includes Homebirth team and CBC team, Tulip team works across antenatal clinic, Delivery Suite and community)	
Contribution from Specialist Midwives	5.54
Total	**160.93**

Table 3 compares the current establishment with the BR+ recommended establishment for each area. It is evident that all areas have a midwifery staffing deficit. Within the table there is the addition of the continuity teams. BR+ does not have the ability to calculate staffing requirements based upon continuity team models, however the national ask is that whilst migration towards continuity models is paused until all the building blocks are in place to do this safely, services should continue to plan towards migration. The service currently has 3 teams one covering women with diabetes in pregnancy (Tulip Team), one covering homebirths (Ivy Team) and one covering Chorley Birth Centre (CBC Team). The funding for these teams is shown in the continuity cost centre and these midwives work across different areas of the service therefore this has been added/subtracted from the totals at the bottom of the table.

Table 3 – Comparison of current midwifery establishment and BR+ recommended establishment

Area	Current Midwifery Establishment (WTE)	BR+ recommended Establishment (WTE)	Number of WTE midwives required
Delivery Suite	35.46	**45.90**	10.44
Maternity Triage	11.56	**14.69**	3.13
Preston Birth Centre (PBC)	41.38 (this includes staffing for PBC and community services and not CBC which is counted in continuity teams)	21.36 (PBC)	16.09
Chorley Birth centre (CBC)		8.04 (CBC)	
Community Services		37.44 includes PN MSW so with these removed (9.37) = 28.07 community **(Total of PBC+ CBC+ Community = 57.47)**	
Antenatal Ward	8.71	**11.02**	2.31
Postnatal Ward	25.69	38.38 includes PN MSW so with these removed (9.64) = **28.74** midwives	3.05
Outpatient Services	7.17	11.43 +1.84 = **13.27**	6.10
Subtotal	128.97	171.09	41.12
Continuity teams (work across all areas of the service)	25.42 (this includes 8.04WTE at CBC)		-25.42 from total
Contribution from Specialist Midwives	5.54		-5.54
Total	160.93	171.09	**=10.16**

Specialist midwives

The total clinical establishment as produced from BR+ with 23% uplift of 190.10wte excludes the non-clinical midwifery roles needed to provide maternity services the RCM Staffing Guidance support 9-11% and BR+ is NICE endorsed hence being applied in maternity services. 10% of the workforce would give 19.01WTE specialist midwifery posts, however this can be increased by the service depending upon specialist midwifery need requirements. Currently the service has funded 12.90WTE band 7 Specialist Midwives and 3.80WTE funded

band 6 midwives working to support the specialist midwifery teams (16.70 WTE in total) this leaves a deficit of 2.31WTE specialist midwife posts. The plan would be to fund a 1.0WTE Band 8a Advanced Midwifery Practitioner to support the obstetric team in maternity triage and the maternity ward. This would reduce the current pressure and risk currently being experienced in these areas. In addition, the service requires a 1.0WTE Band 7 Specialist Midwife for Multiple Pregnancy which is a national recommendation from NICE, MBRRACE and Ockenden. The remaining 0.31WTE hours would be for Bereavement Midwifery hours to contribute to the provision of a 7 day per week bereavement service which is an Ockenden recommendation.

Support staff

The total clinical establishment contains the contribution from Band 3 Maternity Support Workers (MSWs) in hospital and community postnatal services. It is recommended that maternity units work with a minimum of 90/10% skill mix split of the clinical total whole-time equivalents (WTE). The current skill mix is based on 87% of RMs, and 13% Band 3 Midwifery support workers on the Postnatal Ward/Community. In addition, there is a need to have support staff usually at Band 2 working on delivery suite, maternity wards and in outpatient clinics. These roles are essential to the service but are not included in the midwifery ratio. To calculate the requirement for these support staff, professional judgement of the numbers per shift is used rather than a clinical dependency method.

There is a significant shortfall of Band 2s on the ward and a staffing deficit for Band 2 and Band 3 workers in other areas of the service. The requirement is to have at least one Band 2 per shift on the wards and Delivery Suite to carry out the housekeeping duties and assist in general care. The MSWs focus on other tasks that would otherwise be completed by the midwives. The lack of support staff hinders the midwives' ability to focus on clinical care because they are picking up tasks usually performed by health care assistants or clerical staff. Recruiting to these posts in the short term will see significant benefit whilst recruitment to midwifery posts, which is challenging across the UK at present, is ongoing.

Table 4 shows the current and recommended establishments for Band 2 and band 3 workers within the service. The total uplift required equates to 5.53WTE Band 2 HCA and 5.93WTE band 3 MSW (this includes the recommended 1.42WTE uplift for PN work)

Table 4

Area	Band 2 (Current WTE)	Band 2 (Recommended WTE)	Difference WTE Band 2	Band 3 (Current WTE)	Band 3 (Recommended WTE)	Difference WTE Band 3
Delivery Suite	5.90 (includes 0.6WTE housekeeper)	5.51 (1 per shift includes housekeeper responsibilities)	-0.39	0	0	0
Maternity Triage	1.0	Not required	-1.0	1.0	5.51	4.51
Preston Birth Centre (PBC)	0	0	0	12.80	5.51 (1 per shift to support PN work)	2.08
Chorley Birth centre (CBC)		0	0		5.51 (1 per shift to support birth)	
Community Services		0	0		3.86 (for PN work in community)	

Antenatal Ward	3.50 (includes 1.0WTE housekeeper)	5.51 (1 per shift includes housekeeper responsibilities)	2.01	0	0	0
Postnatal Ward	0	5.51 (1 per shift)	5.51	10.30	9.64 (2 long shifts and 1 short shift during day and 1 at night)	-0.66
Outpatient Services	0.6	Not required	-0.6	4.02	4.02	0
Total required			**5.53**			**5.93**

Staffing uplift required

Based on 2021/22 activity, a 23% uplift the clinical total recommended for Lancashire Hospitals NHS Trust is 190.10wte. To align the workforce to a 90/10 skill mix split for postnatal and community work 171.09WTE should be Registered Midwives and 19.01WTE MSW to provide postnatal care. The clinical deficit would then be 10.16WTE midwives, and 1.42WTE MSWs for the postnatal and community areas. Based upon professional judgement as recommended in the BR+ paper the total uplift of Band 2 and 3 workers required by the service is 5.53WTE Band 2 HCA and 5.93WTE band 3 MSW (this includes the recommended 1.42WTE uplift for PN work)

The current calculations are based upon a 23% uplift for the midwifery staff; however, it is recognised that this does not accommodate the increased training requirements that have been applied since the publication of the recent national safety reports. The Local Maternity and Neonatal System (LMNS) undertook a piece of work to collate all the training required and calculate the number of hours this would take. As a result, their recommendation is that midwifery services should have a 25% uplift. Without this uplift the service will continue to rely on bank and agency shifts to support completion of essential training. Calculations based on 25% uplift would require an additional 4.2WTE midwives.

Table 5 and 6 are the financial breakdown of this staffing uplift.

Table 5 – Financial implications

Staff group (Working 24/7 shifts unless stated otherwise)	WTE required	Costs
Midwives (Band 6)	10.16	£596,167
Staffing uplift of 25% for midwives (Band 6)	4.20	£245,647
MSW (Band 3)	5.93	£218,844
HCA (Band 2)	5.53	£195,769
Specialist Midwives (Mon-Fri 9-5)	2.31	£136,418
Total	29.73	£1,392,845

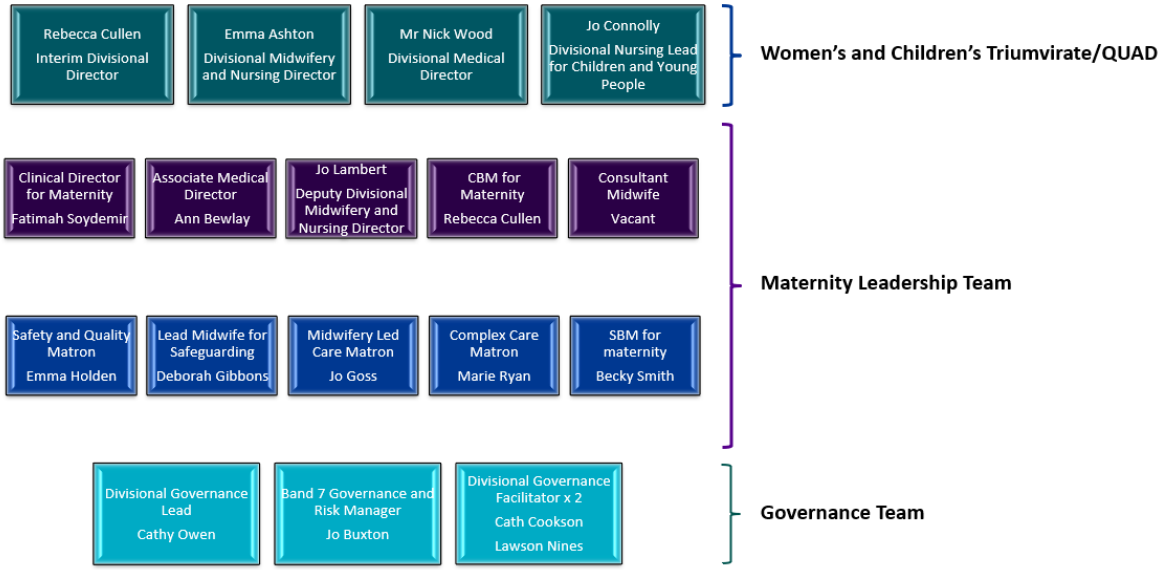
Table 6 – Financial breakdown

Required input Department / Ward Staff Group	Pay Band (Select)	Scale Position (Select)	Shift Req't (Select)	Hours per Week	WTE per Week	Req'd Hours	Req'd WTE	Salary Cost	Enh't Cost	Net Cost	N.I. Class 1 13.8 Nov 22 rate	N.I. Class 1 Upper Earning	Super 14.38% 2223 rate	Annual Cost £
Staff group (Working 24/7 shifts unless stated otherwise)														
Midwives (Band 6)	Band 6	Mid Point	Rotational	37.50	1.00	37.50	10.16	379,838	86,327	466,165	62,967	0	67,035	**596,167**
Staffing uplift of 25% for midwives (Band 6)	Band 6	Mid Point	Rotational	37.50	1.00	37.50	4.20	157,020	35,686	192,706	25,230	0	27,711	**245,647**
MSW (Band 3)	Band 3	Mid Point	Rotational	37.50	1.00	37.50	5.93	134,982	36,813	171,795	22,344	0	24,704	**218,844**
HCA (Band 2)	Band 2	Mid Point	Rotational	37.50	1.00	37.50	5.53	116,147	37,647	153,793	19,860	0	22,115	**195,769**
Specialist Midwives (Band 7) (Mon-Fri 9-5)	Band 7	Mid Point	Days (Only)	37.50	1.00	37.50	1.31	59,012	0	59,012	6,780	0	8,486	**74,279**
Specialist Midwives (Band 8a) (Mon-Fri 9-5)	Band 8a	Mid Point	Days (Only)	37.50	1.00	37.50	1.00	49,542	0	49,542	5,473	0	7,124	**62,139**
Department Total							**28.13**							**1,392,845**

Appendix 2 - Divisional Leadership Structure

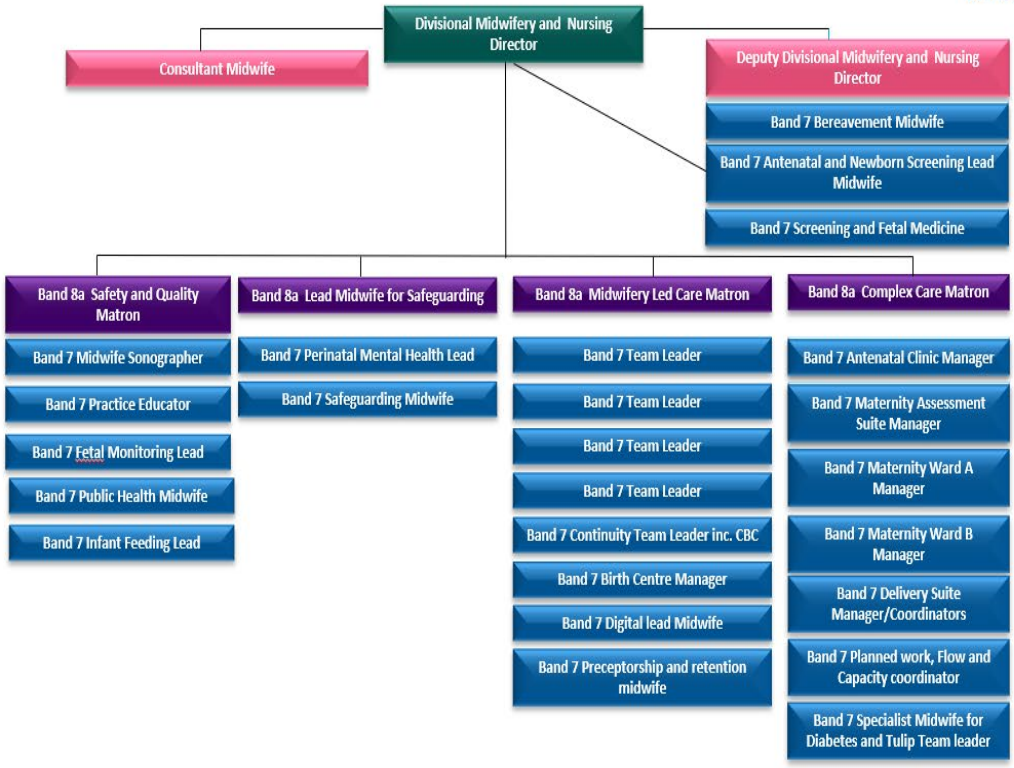
Maternity Leadership Team

Lancashire Teaching Hospitals NHS Foundation Trust



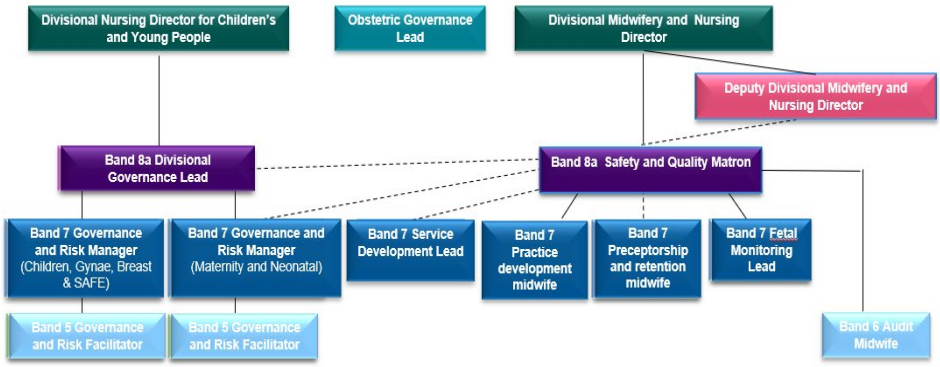
Maternity Midwifery Leadership Structure

Lancashire Teaching Hospitals NHS Foundation Trust



Women's and Children's Governance Structure including Ockenden requirements

Lancashire Teaching Hospitals NHS Foundation Trust



Appendix 3 Breakdown of Specialist Midwifery Roles

Specialist Midwifery Roles (Current funded establishment 16.70 WTE)	WTE	Clinical WTE	Non clinical WTE
Consultant Midwife	1.0	0.2	0.8
Antenatal & Newborn Screening Lead Band 7	1.0	0.8	0.2
Antenatal & Newborn Screening/Fetal Medicine Lead	1.0	0.8	0.2
Digital Midwife Band 7	1.0	-	1.0
Capacity and Flow Coordinator	1.0	0.8	0.2
Named Midwife for Safeguarding Band 8a	1.0	-	1.0
Safeguarding Lead Band 7	1.0	-	1.0
Specialist Perinatal Mental Health – Band 7	1.0	0.5	0.5
Infant Feeding Coordinator Band 7	0.8	0.2	0.6
Specialist Diabetes Band 7	1.0	0.6	0.4
Public Health Midwife Band 7	1.0	0.6	0.4
Practice Education and Development Midwife Band 7	0.8	-	0.8
Bereavement Specialist Midwife Band 7	0.8	0.6	0.2
Bereavement Midwife Band 6	0.4	0.4	-
Service Improvement Midwife Band 7	1.0	-	1.0
Information Technology Midwife Band 6	1.0	-	1.0
Clinical Audit Midwife Band 6	1.0	-	1.0
Governance and Risk Midwife – Band 7	1.0	-	1.0
Fetal Monitoring Lead Midwife Band 7	0.6	-	0.6
Preceptorship Lead Midwife (Funded by NHS E)**	0.8	-	0.8
Total (WTE)	**17.2**	**5.5**	**11.7**
Adjusted figure	**16.4**		

Appendix 4 Midwifery specific training compliance matrix from November 2022 until April 2023

Metric	Red flag	Green flag	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	April 23	Narrative
Emergency skills Training (PROMPT – Practical Obstetric Multi-Professional Training)	< 90%	> 90%	97%	96%	94%	93%	90%	94%	
Antenatal Screening	< 90%	> 90%	79%*	79%*	79%	92%	92%	93%	*Training suspended through summer 2023
Infant Feeding	< 90%	> 90%	33*	33%*	31%	40%	45%	63%	*Training suspended through summer 2023
Mental Health Training	< 90%	> 90%		100%	100%	94%	93%	76%	
CTG Update (taught)	< 90%	> 90%	97%	95%	93%	92%	94%	94%	
CTG Competency Assessment – K2 training package	< 90%	> 90%	98%	99%	97%	99%	99%	99%	
Adult Basic Life Support	< 90%	> 90%	91%	94%	94%	95%	91%	95%	
Aseptic Non-Touch Technique	< 90%	> 90%	89%	87%	90%	90%	90%	90%	
Safeguarding Level 2 - Adult	< 90%	> 90%	99%	99%	98%	100%	99%	98%	
Safeguarding Level 3 - Adult	< 90%	> 90%	97%	95%	94%	98%	96%	100%	
Safeguarding Level 2 - Children	< 90%	> 90%	100%	100%	100%	100%	100%	100%	
Safeguarding Level 3 - Children	< 90%	> 90%	98%	98%	89%	94%	92%	96%	
Moving and Handling	< 90%	> 90%	84%	88%	87%	92%	94%	97%	
Modified Early Warning Score	< 90%	> 90%	99%	98%	98%	98%	96%	96%	
Prevent	< 90%	> 90%	97.5%	95%	90%	96%	96%	100%	
Medical Device Training	< 80%	> 85%	82%	87%	79%	75%	91%	TBC	

Appendix 5: Maternity red flag data

Maternity Red Flag Data: 2022 - 2023													
Red flag Reporting Metrics	**Apr -22**	**May -22**	**Jun -22**	**Jul -22**	**Aug -22**	**Sept -22**	**Oct -22**	**Nov -22**	**Dec -22**	**Jan -23**	**Feb -23**	**Mar -23**	**Apr-22**
Delay in time critical activity	0	0	1	1	25	11	16	2	1	2	13	54	22
Missed or delayed care> 60 mins in washing or suturing	0	0	0	0	1	0	2	0	0	0	0	1	0
Failure for women to receive the medication required	2	0	0	1	6	2	3	2	0	0	0	1	0
>30-minute wait for pain relief.	0	0	1	0	0	2	1	0	0	0	0	1	0
Lack of full examination when woman presents in labour.	0	0	0	0	0	0	1	0	0	0	0	1	0
>2-hour delay in induction?	12	2	3	2	27	15	19	3	1	1	0	10	1
Delay in recognition of and action of abnormal signs.	2	2	0	0	0	1	1	0	0	0	0	2	2
Inability to provide one to one care in labour?	0	0	1	2	5	4	5	0	0	0	0	2	0
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS	0	0	0	0	0	1							
>30-minute wait for triage.	0	0	0	1	2	2	1	1	0	1	1	40	15
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)							1	0	0	0	0	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)							13	3	0	1	0	7	3
Was there a delay in transfer once labour was established? (New parameter Oct 22)							3	0	0	0	0	1	0
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)							1	0	0	0	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)							1	1	0	0	0	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)							9	0	0	0	0	2	0
Has there been any cancelled or delayed community work? (New parameter Oct 22)							1	0	0	0	1	4	1
Total numbers of red flags	**16**	**4**	**5**	**7**	**66**	**38**	**78**	**12**	**2**	**5**	**15**	**126**	**44**

Appendix 6

Version	Date
V1	17.04.2023
V2	24.04.2023
V3	15.05.2023
V4	03.07.2023

Action Plan: Workforce Improvement Plan

Organisation:	LTHTR
Lead Officer:	Emma Ashton
Position:	Divisional Midwifery and Nursing Director
Tel:	01772 524293
Email:	Emma.ashton@lthtr.nhs.uk
Address:	Royal Preston Hospital

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update	Current Status (1 2 3 4)
1	**Review temporary staffing solutions.**	Introduce Thursday 11am weekly operational planning meeting between the ward managers and matrons. Sickness absence should also be discussed during the meetings.	Matrons	~~01.05.2023~~ ~~01.06.2023~~ 01.08.2023	24.04.2023 To commence week beginning 15.05.2023. 15.05.2023 First meeting planned. 03.07.2023 First meeting held. Template to be revised and the regular meetings to be set up.	
		Develop a midwifery staffing team's channel.	Matron for complex midwifery care	01.05.2023	24.04.2023 JG to provide MR with a list of people to be added to the team's channel. 15.05.23 List collated and teams' channel open.	
		Develop a weekly staffing meeting template to record meetings and actions.	Matron for complex midwifery care	~~01.05.2023~~ ~~07.07.23~~ 01.08.2023	24.04.2023 Draft template to be updated by MR 03.07.2023 Template trialled and to be revised.	
		Consideration of an on-call system for the unit.	Matrons	~~30.06.2023~~ 01.09.2023	24.04.2023 Offer on-call shifts as a volunteer temporary arrangement to staff. Draft an expression of interest for staff. Considered and excluded	
		Consult summer leavers to understand if they will consider deferring end date.	Matron for midwifery led services	30.06.2023	24.04.2023 Staff have been consulted and majority are going to new positions. Action closed.	
		Request 10WTE agency midwives block booking for 6-month period.	Chief Nursing Officer	06.07.23	03.07.23 - Request made through temporary staffing and agency recruitment for block booking ongoing based on unfilled shifts through top October 2023.	
		Explore use of registered Nurses from critical care within maternity services.	Chief Nursing Officer	31.07.23	03.07.23 -Request made of critical care team for nursing staff to support when appropriate and in line with "Safe practice principles for adult nurses working as part of multidisciplinary	

					teams (MDT) in Maternity Services" published by NHS England on 25th May 2023. Options for other nurse roles within maternity services to be explored.	
		Publicise bank shifts within and external to the unit	Recruitment team	06.07.23	03.07.23 -Request made of recruitment	
		Additional shifts created for band 2 and 3 shifts to provide support on reduced fill rate shifts.	Deputy Midwifery and Nursing Director	ongoing	03.07.23 - In place	
		Bank midwifery advert agreed with Chief Nursing Officer	Chief Nursing Officer	ongoing	3.07.2023 Advert for bank midwives published.	
2	**Utilisation next 3 months**	Review Newly Qualified Midwife (NQM) preceptorship clinical rotation plan to identify any possible rotations which could be better utilised within the service.	Team leaders	~~30.04.2023~~ 31.05.2023	24.04.2023 Shifts have potentially been identified in ANC – assessment to be completed to identify prioritisation of the clinical areas to receive the additional staffing. 15.05.2023 Scoping of hours undertaken. Unable to progress at this time as movement of NQM from ANC will potentially impact on essential planned work re-organisation. Action closed.	
		Review of the birth centre staffing models because of the current birth rates within midwifery led services.	Matron for midwifery led services	30.06.2023	24.04.2023 review is ongoing. Potential for the third person to be a "floating midwife". 15.05.2023- Matron for MLS reviewed percentage of births in co-located birth centre. Plan to reduce staffing to 2 per shift from 3 per shift from the 10th of June 2023. Action closed.	
		Identify and consider potential withdrawal of non-essential services.	Divisional midwifery and nursing director.	30.05.2023	24.04.2023 identify the non-essential services. 15.05.2023 Unable to identify any non-essential services at present. Non-viable option. Action closed.	
		Identify areas of the service that could be distributed to other staff groups.	Public Health Midwife	~~30.06.2023~~ 31.07.23	15.05.2023 To explore vaccination services. Potential for a nurse to administer vaccines. Public health midwife liaising with LMNS to consider wider system options.	
		Telephone consultation/ virtual services for differed visits.	Matron for midwifery led services	30.05.2023	24.04.2023 Scoped whether there is appetite for a leaver to stay and complete hybrid virtual working. Non-viable option. Action closed.	
		Determine which specialist midwives can be utilised to work clinical shifts during anticipated summer pressures.	Senior management team	~~30.04.2023~~ 30.05.2023	24.04.2023 Specialist midwives identified: screening midwives, midwifery practice educator, preceptorship and retention lead, public health midwife, infant feeding and potentially service development midwife. 15.05.2023 8 specialists will contribute 1 day a week to ANC, Maternity A, B and DS from the 10.06.2023 Action Closed.	
		Consult specialist midwives regarding the preferrable pattern of clinical working (i.e.) 2 days per week or one block week.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting 25.04.2023. 15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	

		All managers to have time to lead reduced to days per week during anticipated summer pressures.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting. 15.05.2023. All managers and team leaders to increase clinical shifts from 1 day per week to 2 days per week from 10.06.2023.	
		Consult team leaders and ward managers regarding the preferrable pattern of clinical working.	Matrons	30.06.2023	15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		Consider rationalisation of meeting schedule.	Deputy DMND	~~30.06.2023~~ 01.08.2023	15.05.2023 Review speciality meetings to consider rationalisation and defined attendance over months of June, July, August and September 23.	
3	**Birth rate plus data utilisation**	Review the latest birth rate plus data and complete a paper for board.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 Paper to be shared with chief nurse and then presented to board for review. 15.05.2023 Paper to be presented as part of bi-annual staffing review in May 2023 26.05.23 Biannual staffing report presented to S&Q. Action closed	
		Complete the training for the ward acuity tool.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.23	24.04.2023 date agreed for training with the external providers. Staff to attend currently being agreed. 15.05.2023 Ward managers assigned to attend, and additional staff released if possible. Session will be recorded for use later. App not working at this time action paused	
		Launch the acuity tool across the ward areas.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.2023	24.04.2023 to be launched in June 2023 following completion of training. Action paused as above.	
4	**Roster management**	Meet with the health roster term to specify supernumerary tiles which will not be included in the unfilled rate.	Matron for complex midwifery care	30.06.2023	24.04.2023 MR has met with health roster team. Health roster team to review request and feedback. 15.05.2023 Email request for speciality meeting. 30.06.2023 Supernumerary tiles now in place. Action closed	
		Matron review of roster templates to ensure that templates reflect the establishment for each area.	Matrons	01.07.2023	15.05.23 Meeting to be arranged with e-roster team to confirm templates reflect staffing requirements. Awaiting update that all areas reviewed.	
		Meet with team leaders/ ward managers regarding summer annual leave planning. Reiteration that maximum allowance is 17%.	Matron for complex midwifery care	30.04.2023	24.04.2023 MR has pulled the roster reports and confirmed that the annual leave is booked and does not exceed the maximum requirement. Action closed	
		Creating a new cost centre for preceptees or team midwives	Finance BP	31.07.23	15.05.2023 Finance BP to create new cost centre. Update awaited.	
		Unused roster hours to be reviewed by the matrons at sign off.	Matrons	30.04.2023	24.04.2023 Healthroster to be reviewed as part of monthly sign off with each area to utilise un-filled shifts. Action closed	

		Maternity ward B roster to be reviewed for balance. Review MSW staffing ratios across day and night.	Matron for complex midwifery care	30.05.2023	24.04.2023 MR to discuss with HA. 15.05.2023 Staffing gaps have been reviewed to reflect the service requirement. Action closed	
		Consider options for assessing and balancing staff numbers across whole service and develop plan for June-October 2023.	Matrons	30.05.2023	15.05.2023 Matrons to meet to review establishments and confirm plan for distribution of staff across the areas with highest establishment gaps. 03.07.23 – This is now done on a weekly basis. Action closed	
5	**Recruitment**	Continuation of the preceptorship lead midwife post for further 11 months.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 awaiting confirmation from finance. JG has completed the workforce form for the extension. Action closed	
		Recruit up to 16 international recruits.	Preceptorship and retention leader midwife	~~30.07.2023~~ 31.12.2023	24.04.2023 – 3 currently in post, 2 coming to the testing centre in May 2023. Awaiting further information. Recruitment ongoing. 15.05.2023 Deadline date extended to reflect ongoing recruitment plan. 01.07.23 – 4 RM in post. Action ongoing.	
		Vacancy and maternity leave tracker to be overseen workforce committee.	Matrons	~~30.05.2023~~ 30.06.23	24.04.2023 – two external recruits successfully made week commencing 17.04.2023. 15.05.2023 Deadline date extended to reflect ongoing and continuous monitoring of vacancies. 30.06.2023 Item to be added to workforce committee in July 2023.	
		Recruitment to delivery suite core team.	Matron for complex midwifery care	30.05.2023	24.04.2023 – shortlisting has been completed awaiting date for interview. 15.05.2023 Core team recruited. Action closed	
		Recruitment to the birth centre core team.	Matron for midwifery led services.	30.05.2023	24.04.2023 – successfully completed	
		Recruitment to the Mat A/B ward core team.	Matron for midwifery led services.	31.08.23	01.07.23 - Advert out currently	
		Recruitment to the caesarean section team as core (1.6 WTE).	Matron for complex midwifery care	~~30.05.2023~~ 30.06.2023	24.04.2023 – advert for the team has been completed and approved by EA. Advert to go to vacancy control this week. 15.05.2023 Shortlisting outcome awaited. Deadline extended. 01.7.23 – recruited to successfully.	
		Associate leader positions to be considered.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – stand down as non-viable at present time.	
		Band 5 advertisement to be released.	Matron for midwifery led services	~~30.04.2023~~ ~~30.06.2023~~ 01.09.2023	24.04.2023 – advert has been approved by EA and RC. Currently with vacancy control anticipated release 28.04.2023. 15.05.2023 Shortlisting in progress. Deadline extended. 01.07.23 – continuous adverts out.	
		Recruitment open day for band 5 midwives.	Matrons	~~30.05.2023~~ 31.07.2023	24.04.2023 – to be organised once the vacancy is released. 15.05.2023 Consider whether open day or engagement of new	

					starters required. 01.07.23 – ongoing next recruitment event to be confirmed.	
		Consider recruitment to the band 4 practice development post once the funding becomes available.	Divisional midwifery and nursing director	~~30.05.2023~~ 01.09.2023	24.04.2023 – awaiting outcome of funding. 15.05.2023 Update awaited. 01.07.23 – paper to LMNS submitted and awaiting final approval to recruit.	
		Band 3 allocation to be reviewed across the service.	Divisional midwifery and nursing director	~~30.05.2023~~ 01.09.2023	24.04.2023 – needs finance review. Long term funding of the roles needs to be reviewed. 01.07.23 – Birth rate plus report taken to Board May 2023.	
		Increase consultant obstetricians by 3 WTE to support demand and capacity and increase in complexity	Divisional Director and Deputy Medical Director	01.01.2024	03.07.23 Demand and capacity assessment has taken place and business case has been created to discuss with finance. Business case will support 98 hours obstetric cover, antenatal clinics, caesarean section list, induction of labour and maternity triage	
6	**Retention Flexible working**	Line manager to have conversations with all staff about flexible working opportunities. Flexible Working Toolkit available	All Managers	1.11.2023	30.06.2023 Flexible working conversations to be included in appraisals and as part of team meetings.	
7	**Retention Seeking Feedback**	To seek feedback from staff via TED surveys, listening events, team meetings	All Managers	31.09.2023	30.06.2023 All areas to undertake a TED survey and develop local ways to seek feedback from teams.	
8	**Retention Retain, Reward and Recognise – Staff Satisfaction**	Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.03.2023	30.06.2023 Monthly thank you awards nominated by the band 5 team for a team member who offering supportive mentorship and professional support.	
		Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.10.2023	17.04.2023 Shining Star award. A monthly award for outstanding kindness and team work continues	
		Engage in Microsystems Coaching Programme via CI team.	Divisional midwifery and nursing director	31.10.2023	17.04.2023 Divisional Engagement with flow and micro coaching programmes	
		Opportunities for development and career progression available via CPD funding work streams	Divisional midwifery and nursing director	31.10.2023	30.03.2023 CPD requests submitted. HDU courses, NIPE, PMA, Fetal monitoring speciality training, maternal medicine. ANNB ARC.	
9	**Retention Engagement**	Alternate month mobile coffee catch up with leadership team visiting clinical areas scheduled for 12 months.	Leadership Team	31.03.2024	30.06.2023 Mobile coffee catch up sessions ongoing.	
8	**Retention of Students**	Link with the LMNS 2-day course to be facilitated by university to link with colleges for perspective midwives.	Divisional midwifery and nursing director	~~30.06.2023~~ 01.01.2024	24.04.2023 – awaiting further information. 15.05.2023 Action ongoing.	
		Explore continuation of funding for midwifery clinical placement facilitator.	Divisional midwifery and nursing	30.05.2023	24.04.2023 – awaiting further information to meet. 15.05.2023 Meeting arranged for 19.05.23 to discuss PEF funding.	

			director		03.07.23 – Meeting held and funding continued for PEF with other funding streams being explored therefore action closed	
9	**Retention Health and wellbeing**	Maternity conference to be organised for 15/06/2023 for current midwives and maternity support workers.	Matron for midwifery led care	30.06.2023	24.04.2023 – progressing well. Agenda in development. 15.05.2023 Planning on track 15.06.2023 – Maternity conference delivered as planned	
		Establish and agree the PMA offer.	Divisional midwifery and nursing director	~~30.05.2023~~ 01.09.2023	24.04.2023 – date to meet with PMA's to be arranged. 15.05.2023- Meeting with DMND to be confirmed. 01.07.23 – Trust structure agreed for PNA/PMAs. 5 PMA trained. Staffing limiting activity. To remain on workplan and meeting to be arranged with PMAs to agree development of this service.	
		International day of the midwife – cups and biscuits for the clinical areas/ teams.	Deputy divisional nursing and midwifery director.	30.05.2023	24.04.2023 – Cup designs have been developed and order placed. 15.05.2023 Mugs and biscuits distributed to all areas. Celebrated IDM 2023. Action closed	
		Expansion of the unit coordinator role to include ward and area managers.	Matrons	~~30.05.2023~~ 30.06.2023	24.04.2023 – to discuss with ward managers. Action deadline extended. No further progress. Action stood down	
		Introduce de-brief tool to support hot de-briefing.	S&Q matron	~~30.05.2023~~ 31.08.2023	24.04.2023 – EH to explore hot debrief tool and feedback at the next meeting. 15.05.2023- Options for debrief ongoing. Deadline extended.	
		OD department to develop division wide action plan with ideas for action which are specific to each area	OD leads	01.09.2023	03.07.23 – Meeting held with OD lead for division and area action plans to be developed.	
10	**Correlation between staffing and safety intelligence**	Monitor safety data daily, including red flags, BR plus acuity, coordinator feedback at safety huddles, PALS, service user feedback, governance systems.	Divisional midwifery and nursing director	Ongoing	Systems in place. Daily monitoring	
		Monthly oversight of safety and quality metrics through the maternity safety dashboard to safety and Quality group in division and Board.	Divisional midwifery and nursing director	Ongoing	Systems in place	
11	**Well Led**	Trust development programme based on ward manager and matron handbook to develop leadership capability and capacity.	Chief Nursing Officer	30.09.23	Chief Nurse leading	
		To undertake a training needs analysis of the leaders and managers within the Division, understanding who has completed which development programme, where additional tailored support can be provided and who may need performance management intervention.	OD and Divisional Board to commit & enable attendance	1.11.2023	30.06.2023 Scoping work to understanding of level of capability and confidence in department. What development support is needed, how expectations are communicated and reinforced to improve management effectiveness across the Division.	
		To set up a Band 7 Action Learning set where leaders come together monthly to have the headspace, facilitated support,	OD and Divisional Board to	31.10.2023	30.06.2023 Action Learning groups to be set up from October 2023 after new recruits in post.	

		consultancy support to identify how to make improvements in team engagement and staff satisfaction, enabling them to develop actions plans which improve colleague experience	commit & enable attendance			
		Based on the findings of the training needs analysis consider the delivery of a series of bespoke leadership 'away days.	OD and Divisional Board to commit & enable attendance	30.09.2023	30.06.2023 Agree bespoke series of meetings following review of leadership TNA and from listening to feedback from the team.	
		To improve the quality of appraisal conversations/paperwork, objective and development planning in appraisal. This will be achieved by all appraisers attending the Appraisal Masterclass.	OD and Divisional Board to commit & enable attendance	31.03.2024	30.06.2023 Improved appraisal quality audit rating. Increased use of 360 feedback in appraisal. Increased number of appraisals with objectives and personal development plan completed. Increased scores benchmarked against the 2022 National Staff Survey for questions relating to having a quality appraisal.	
		Increased capacity within senior midwifery team through creation of: - Deputy Divisional midwifery and Nursing Director - Creation of Safety and Quality matrons - Creation of the Specialist Midwife for maternal medicine - Creation of the Planned work, capacity, and flow co-ordinator - Enhanced antenatal and newborn screening leadership capacity	Chief Nursing Officer	~~31.04.23~~ 01.09.23	03.07.23 – All posts recruited.	

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Infection Prevention and Control Annual Report 2022/2023

Report to:	Board of Directors	**Date:**	3rd August 2023
Report of:	Chief Nursing Officer	**Prepared by:**	Dr D Orr Matron S Marsh

Purpose of Report

For approval	☒	**For noting**	☐	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this paper is to provide an overview of the progress made against the annual Infection Prevention and Control plan for 2022/2023 and update the Board of Directors on the Trust's performance against key areas of Infection Prevention and Control (IPC).

During the period 2022/2023 there has been an increase in subsequent infections including MPox and Influenza, with the National Health Service (NHS) operating under significant pressure during the recovery of the COVID-19 pandemic.

In 2022/23 the summary points of the IPC specialty include.

- Four waves (increase incidences) of COVID-19 in the hospital leading to 2878 COVID-19 positive patients in the Trust.
- 1 hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteraemia case.
- The Clostridioides difficile (C. *difficile*) objective was exceeded by 74 cases despite the measures put in place to reduce. There has been a national increase in cases following the COVID-19 pandemic. Faecal testing has been continued to accurately identify the source of infection, identify and isolate C. *difficile* earlier in the patient's journey. Following an NHS England review increased oversight of improvement actions is included in this report. (Appendix 3)
- Assurance received in relation to water safety compliance.
- Decontamination – the water testing company SGS annual external Audit took place January 2023 on Standard ISO 13485: 2016 certificate and audit passed with 100% compliances on standards.
- The new build decontamination unit at Preston Endoscopy is now operational with full compliance with HTM01-06 standards.
- Additional actions continued to manage the risk of the age of estate in relation to ventilation.
- Achieved the NHS standard contract for 2022-23 requirement of a 4.5% reduction in use of antimicrobials which fall into 'Watch' and 'Reserve' categories (as defined by the World Health Organisation) from 2018 baseline.

The report contains an update on the actions delivered in the 2022/23 IPC plan, the majority of which were completed but where a delay has occurred the reason for this is given alongside the plan for how this is being addressed. This closes the IPC plan for 2022/23 and presents the 2023/2024 IPC plan for approval.

It is recommended that:

1. The Board of Directors note the contents of the Annual report and confirm that it is assured of progress against the 2022/23 Annual Plan (Appendix 1).
2. Approve the IPC Annual Plan 2023/2024 (Appendix 2).

Appendix 1 – IPC 2022/23 Annual plan
Appendix 2 – IPC 2023/23 Annual plan
Appendix 3 – C. *difficile* improvement plan

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Infection Prevention and Control Committee, 17/05/2023

1. Introduction

The purpose of this paper is to provide an overview of the progress made against the annual Infection Prevention and Control annual plan for 2022/2023 and update the Safety and Quality committee on the Trust's performance against the annual objectives for Methicillin-Resistant *Staphylococcus aureus* (MRSA) bloodstream infection and *Clostridioides difficile* infection (C. *difficile*).

Infection Prevention and Control (IPC) remains a key priority for Lancashire Teaching Hospitals (LTHTR). The IPC team continues to work closely with other providers across the health economy. Dr David Orr, a Consultant Microbiologist, currently holds the Director of Infection Prevention and Control (DIPC) role and the Deputy Chief Nursing Officer, Catherine Gregory, is the senior nursing lead for IPC. The DIPC is supported by a team of senior nurses and doctors. The Associate Director of Infection Prevention Control (ADIPC) is currently vacant.

Hospitals across the UK were challenged in 2022/23 by the COVID-19 pandemic; however, LTHTR was particularly challenged due to the high community prevalence and its poor estate, evidenced by the Trusts participation in the New Hospitals programme. This results in proportionally lower levels of side-rooms that do not meet the demands of the patient population who require them, poor ventilation in a large number of clinical areas and lack of space for separation between bed spaces. As identified in the report the infection control team responded to a rise in nosocomial cases in a proactive way to implement measures to reduce hospital-acquired infection. The data supplied from Information Technology and Business Intelligence colleagues was invaluable to identify problem areas and assess the response to Infection control initiatives.

Multidisciplinary Post Infection Reviews (PIRs) continue to be a key strategy for learning and improvement. The PIR process promotes a culture of learning and openness rather than blame.

This report presents the details of IPC performance of Lancashire Teaching Hospitals Trust (LTHTR) in 2022/2023 with the focus on key IPC issues and includes the 2022/2023 programme which details the completion of improvement actions in line with the ten domains of the Hygiene Code which accompanies the Health and Social Care Act 2022.

The Infection Prevention and Control Annual Plan 2022/2023 is attached for information and closure. The 2022/23 IPC Annual Plan was ambitious and the majority of actions have been delivered, however, as a result of unprecedented demand, multiple infections and staffing levels there have been some which have been delayed and are carried over to the annual plan 2023/2024.

The 2023/2024 Annual Plan is attached for approval. This will expand and build on improvements made in 2022/2023.

2. Discussion

TRUST PERFORMANCE RELATED TO ORGANISMS OF CONCERN

2.1 Methicillin resistant Staphylococcus Aureus (MRSA) Bacteraemia

Staphylococcus aureus is a bacterium that commonly colonises human skin and mucosa. Most strains of S. *aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. However, some S. *aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant S. *aureus* (MRSA). Bacteraemia occurs when bacteria get into the bloodstream.

Infection Prevention and Control continues to be a key priority for us, and the incidence of MRSA is outlined below:

- In 2021-22 there has been 1 incident of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.
- In 2022-23 there has been 1 incident of hospital onset MRSA bacteraemia and 5 cases of community onset MRSA.

Cases are investigated by a multi-disciplinary team using the national post infection review tool and discussed with the Director of Infection Prevention & Control to identify causes and actions for future prevention. The Hospital associated case identified in January 2023 was reviewed with no key contributing factor identified. There was however learning identified to strengthen systems and processes moving forward.

***2.2 Clostridioides difficile* Infection**

Clostridioides difficile (C. *difficile*) is an anaerobic bacterium that is present in the gut. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of infants). In some instances, strains of *C. difficile* can grow to unusually high levels and attack the intestines, causing mild to severe diarrhoea. Patients who are commonly affected are elderly and/or immunocompromised; exposed to antibiotics and *C. difficile* from spores from the environment.

The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2022/23, the national objective set by NHSE for the trust was no more than 122 hospital associated cases. There was an increase in hospital associated cases during 2022-23 in comparison to previous years with a total of 196 cases. This was a 48% increase from 2021/22 which had a total of 132 hospital associated cases.

The national and regional picture

There has been a national increase in *C. difficile* infection and a significant proportion of Trusts nationally are above trajectory. NHS England (NHSE) completed an Infection Prevention Control review due to the national increase in Healthcare Associated Infections in September 2022 at LTHTr. Following this visit an action plan was completed (Appendix 3).

There is UK Health Security Agency (UKHSA) /NHSE study in progress to understand the reasons for this national increase, but likely contributors include:

- Increased susceptibility of patients to infection due to an ageing population with multiple co-morbidities
- The potential impact of the COVID-19 pandemic on population health
- High antibiotic-use due to the COVID-19 pandemic and particularly broad-spectrum antibiotics that place patients at higher risk of *C. difficile* infection
- Overcrowding of patients on hospital sites because of increased demand
- Insufficient decant facilities for more intensive decontamination of the environment (“Fogging” or Ultraviolet technology)
- Sub-standard estate due to reduced funding for repairs and insufficient decant to perform repairs
- Insufficient side-room capacity worsened by COVID-19 numbers
- Understaffing and its impact on IPC practice

In the Northwest 12/24 trusts (50%) were over their objectives in February 2023, however, Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) ranks highest of major trusts in terms of *C. difficile* rate per 100,000 bed days.

Table 1 C.*difficile* incidence and rate per 100,00 bed days - North West hospitals

Organisation Name	April 2022 to March 2023	Rate per 100,000 bed days	Significance
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1	1.2	Low (0.001)
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	91	29.0	
BOLTON NHS FOUNDATION TRUST	128	47.7	High (0.001)
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	80	41.8	High (0.001)
EAST CHESHIRE NHS TRUST	19	12.7	Low (0.001)
EAST LANCASHIRE HOSPITALS NHS TRUST	65	16.3	Low (0.001)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	196	50.4	High (0.001)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2	3.1	Low (0.001)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0.0	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	182	27.0	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	202	21.1	Low (0.001)
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	39	16.3	Low (0.001)
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	46	17.6	Low (0.001)
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	130	18.1	Low (0.001)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	47	26.2	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	57	16.7	Low (0.001)
STOCKPORT NHS FOUNDATION TRUST	76	27.0	
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	59	32.0	
THE CHRISTIE NHS FOUNDATION TRUST	51	74.2	High (0.001)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	13	34.2	
THE WALTON CENTRE NHS FOUNDATION TRUST	7	12.4	Low (0.025)
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	99	36.1	High (0.025)
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	55	22.5	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	142	43.0	High (0.001)
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	70	31.2	
North West	1857	26.7	

The impact of a change in definition of diarrhoea

The increase at LTHTr was also compounded by a change in the definition of diarrhoea (as recommended by NHS England. Prior to June 2022, only type 6/7 stools were treated as diarrhoeal. NHS England recommended that we also include type 5 stools, which resulted in increased testing and the inclusion of patients with mild *C. difficile* infection in our figures.

Figure 1 Inpatient laboratory test numbers for *C. difficile*

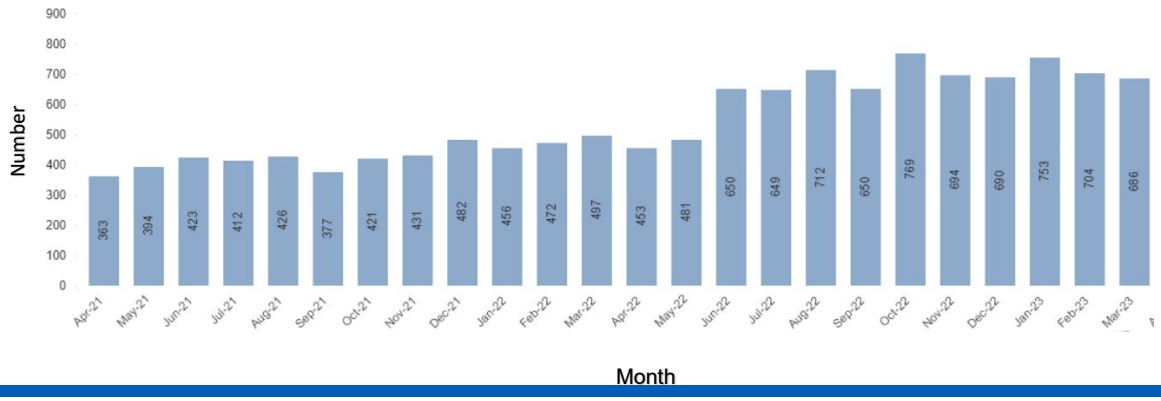
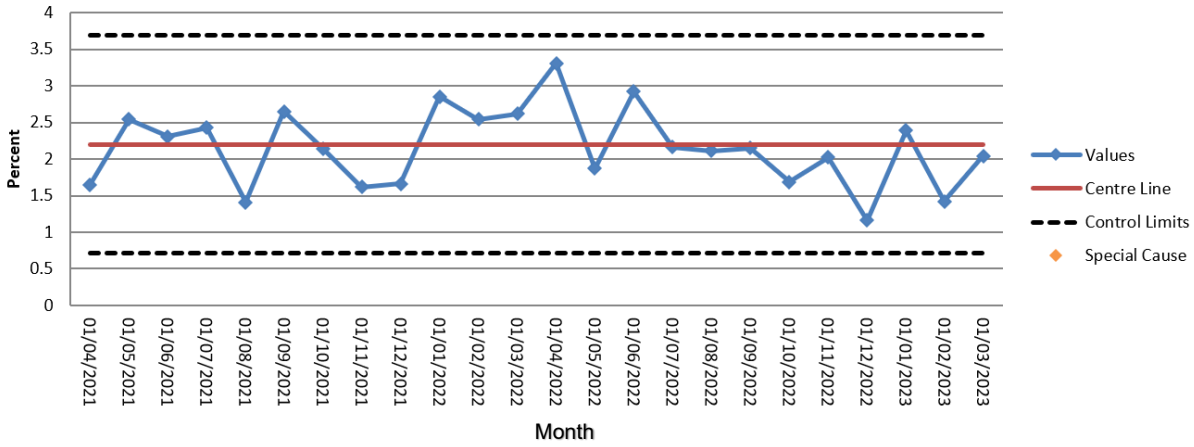


Figure 2. represents an attempt to account for the change in testing, by assessing *C. difficile* test positivity (HOHA cases), as a proportion of inpatient tests. This proportion has decreased since June 2023.

Figure 2 HOHA cases as a proportion of total Inpatient tests



Lapses in care

All hospital cases are reviewed by an expert group including the Director of Infection Prevention and Control, Infection Prevention and Control Matron or Infection Prevention and Control Nurse, Antimicrobial Pharmacist or Specialist Antimicrobial Technician, Governance representative, Ward Manager, Ward Matron and Consultant in charge of the patients care.

The review process facilitates a greater understanding of the individual cause of the C. *difficile* cases to determine whether there were any lapses in the quality of care provided. This is so that we can develop an appropriate plan of action to address any problems identified and to promote learning and best practice. 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. The information in terms of lapses in care are now logged in Datix, making the process for monitoring themes and trends easier than previous years.

Common themes in terms of lapses in care included:

- Missing doses of *C. difficile* treatment
- Poor or no documented risk assessment of loose stools on the day that diarrhoea began
- Delay in sampling
- Poor hand-hygiene audit results
- Delay in isolation
- Non-complaint antimicrobials

These lapses encompassed approximately 75% of all lapses of care identified in PIR meetings and will be a focus of improvement works for the coming year. Focus on learning from lapses in care are triangulated in our Antimicrobial Management Group (AMG) and Divisional Infection Prevention and Control meetings and we have focused on antimicrobial stewardship, hand hygiene, environmental cleanliness, and timely isolation of patients with symptoms of diarrhoea. Hospital onset *C. difficile* review is undertaken during the monthly CDI Panel meeting with the Clinical Commissioning Group (CCG) leading to a Health economy wide approach to learning and reduction.

Rapid Intestinal Test

Only approximately 20% of beds at Lancashire Teaching hospitals are in side rooms, which is one of the lowest isolation capacities in the country. The inclusion of type 5 stools as diarrhoeal, which was part of UKHSA guidance and advocated by NHS Improvement leads, has also led to a doubling of the number of patients diagnosed as having diarrhoea, further exacerbating the problem. Typically, at any time, there are 100 patients who have had type 5, 6, or 7 stools in the last 48 hours.

Since April 2022, to improve the efficiency of side room utilisation, a rapid intestinal screening test was trialled via the point of care team. When this test is negative (typically a rectal swab), which happens in 77% of diarrhoeal cases, the patient does not require a side room or redi-room. The results of the trial are expected in the coming weeks.

Summary

For the reasons described above there has been a national and local increase in *C. difficile* infection, however, LTHTr has particularly high rates of infection and risks being singled out regionally and nationally.

The actions for the coming year to reduce *C. difficile* are listed in the annual plan and some require resourcing. This is particularly difficult given the withdrawal of COVID-19 IPC funding. Additional elements, which were not included in the previous year's plan, include:

- Reduction in the use of cefuroxime, which is a particularly high-risk antibiotic for *C. difficile* that has been used for unexplained sepsis
- Co-production of a business case for Ultraviolet light system (UV-C) to more rapidly decontaminate the environment (turnaround time shorter than "fogging," which has been difficult to deploy during these times of severe operational pressure)
- Active monitoring of deployment of UV-C or "fogging" via a new IT system
- Co-production of a business case for extra domestic resource in order to become compliant with new national cleaning standards
- Production of a case to maintain rapid testing to more efficiently use isolation capacity
- Production of a case to maintain some redi-room isolation capacity when COVID-19 monies are withdrawn, to manage times of high incidence of infectious disease (e.g., influenza season)

There will continue to be a focus on the basics including prompt assessment of patients with diarrhoea, sampling and isolation, as well as hand hygiene, environmental cleanliness and antimicrobial stewardship, as evidenced by audit. Appendix 3 contains an update of the actions agreed following the NHS England review of C.*difficile.* The detail of these actions are overseen by the Infection Prevention and Control committee.

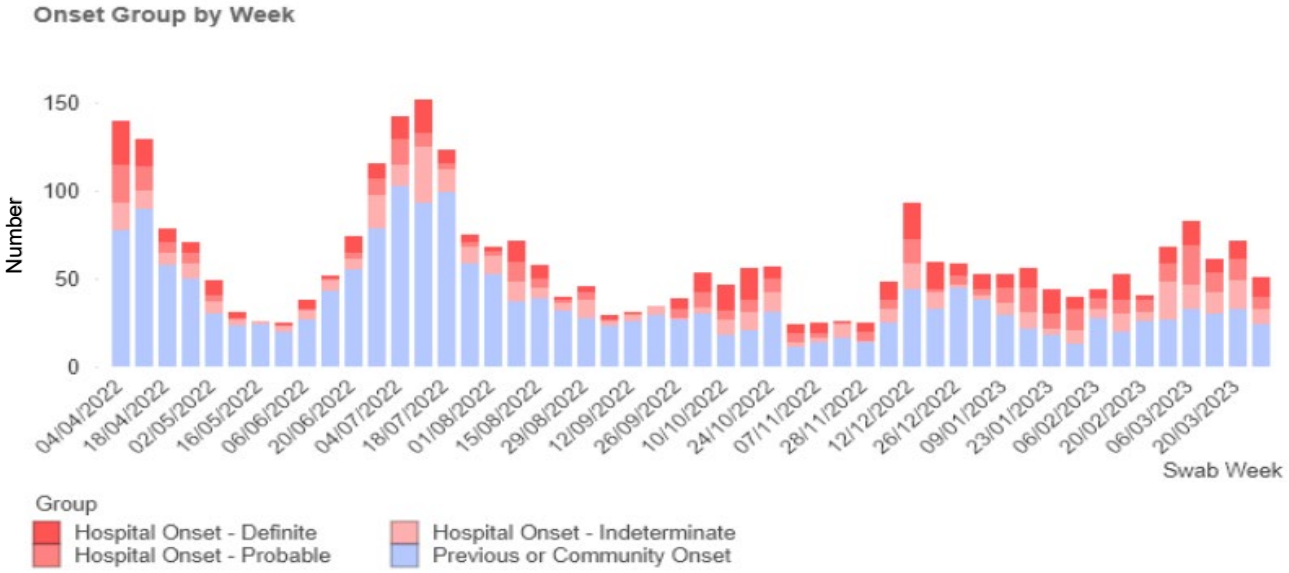
2.3 SARS coronavirus-2 (SARS-CoV-2) - COVID-19

On 31 December 2019, World Health Organisation (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified. The virus is mainly transmitted by respiratory droplets and aerosols, and by direct or indirect contact with infected secretions. Infection control, which, in large part, relies on segregation of infected from non-infected individuals, is incredibly difficult as one third of infected individuals have no symptoms but are still able to transmit the infection to others. We suffered from key

disadvantages as compared to other similar trusts when it comes to preventing nosocomial COVID-19, mainly relating to its estate:

- Only 20% of the beds at LTHTR are in side rooms making it difficult to segregate patients.
- A large number of hospital bays have virtually no ventilation and COVID-19 spreads more readily in poorly ventilated areas.
- A 2-metre separation between bed spaces was not possible in most areas.

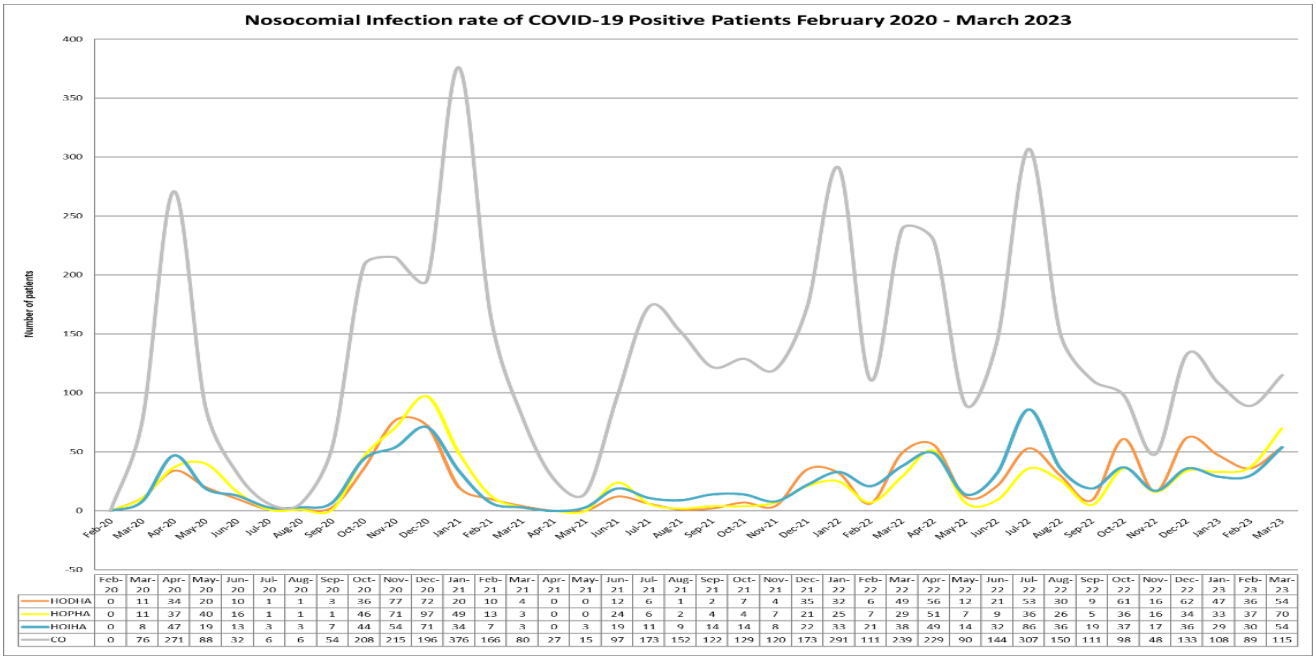
Figure 4 Hospital Onset versus Community Onset COVID-19 infections



Source: LTHTR data

During the year 2022/23 updates in National Guidance for COVID-19 changed regarding testing, isolation and the management of patients and staff members. Changes were implemented in accordance with the National Guidance with the exception of continued universal mask-wearing. The COVID-19 Trust policy was continuously updated in line with the National Guidance. Any changes were discussed prior to being introduced. Figure 5 shows the total numbers of COVID-19 positive inpatients broken down by nosocomial infection from the beginning of the pandemic in March 2020.

Figure 5 Nosocomial Infection rate of COVID-19



	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
HODHA	0	11	34	20	10	1	1	3	36	77	72	20	10	4	0	0	12	6	1	2	7	4	35	32	6	49	56	12	21	53	30	9	61	16	62	47	36	54
HOPHA	0	11	37	40	16	1	1	1	46	71	97	49	13	3	0	0	24	6	2	4	4	7	21	25	7	29	51	7	9	36	26	5	36	16	34	33	37	70
HOHA	0	8	47	19	13	3	3	7	44	54	71	34	7	3	0	3	19	11	9	14	14	8	22	33	21	38	49	14	32	86	36	19	37	17	36	29	30	54
CO	0	76	271	88	32	6	6	54	208	215	196	376	166	80	27	15	97	173	152	122	129	120	173	291	111	239	229	90	144	307	150	111	98	48	133	108	89	115

Source: LTHTR data

Key
HODHA- Hospital Onset Definite Healthcare Associated
HOPHA- Hospital Onset Probable Healthcare Associated
HOHA- Hospital Onset Healthcare Associated
CO – Community Onset

2.4 Gram-negative bacteraemia

NHSE published objectives for Trusts to reduce *Escherichia coli (*E. *coli)*, *Klebsiella species,* and *Pseudomonas aeruginosa* in 2022/23.The 2022/23 objective for E. *coli* bloodstream hospital associated infections was 112. LTHTr ended the year with a total of 108 hospital associated *E. coli* cases which was 4 cases below the objective.

The 2022/23 objective for *Pseudomonas aeruginosa* bacteraemia bloodstream hospital associated infections was 13. LTHTr ended the year with a total of 19 hospital associated *Pseudomonas aeruginosa* bacteraemia bloodstream cases for the year 2022/23, this is 6 cases above the objective of 13.

The 2022/23 objective for *Klebsiella* species bloodstream hospital associated infections was 26. LTHTr ended the year with a total of 23 hospital associated *Klebsiella* species cases for the year 2022/23, which was 3 cases below the objective.

To better understand themes and trends related to gram-negative bacteraemia, the DIPC, Matron, Lead Nurse, and data administrator from IPC, met on a regular basis to review *E. coli* bacteraemia HOHA cases for 8 months in 2022/23. Table 2 outlines the sources that were identified.

Table 2 Sources of *E. coli* bacteraemia HOHA cases

Source of infection	Frequency	Percentage
Urinary tract infection	14	36.8
Gastrointestinal/intraabdominal collection	10	26.3
Hepatobiliary	5	13.2

Catheter associated UTI	2	5.3
PICC infection	2	5.3
CAPD peritonitis	1	2.6
Diabetic ulcer	1	2.6
Prosthetic Hip infection	1	2.6
Skin infection /diabetic foot	1	2.6
Unknown	1	2.6

Patient hydration and urinary catheter care were identified as key interventions to reduce risk and will be the focus of intervention in the coming year.

2.5 OTHER OUTBREAK INVESTIGATIONS IN 2022/23

Norovirus Outbreaks

The year 2022/23 saw 4 Norovirus outbreaks:

Acute Frailty Unit – October 2022

- Number of positive patients – 3
- Number of symptomatic staff members – 1
- Number of bed days lost – 12
- Summary – 2 Bays affected and both bays closed. Staff isolated patients within Redi-rooms which delayed the incubation period prolonging the outbreak time in total.
- Outcome – Education on the use of Redi-rooms and IPC practices

Cardiac Cath Lab with Ward 23 – November 2022

- Number of positive patients – 8
- Number of symptomatic staff members – 1
- Number of bed days lost – 0
- Summary – 2 Bays affected on Cardiac Cath Lab which seeded into Ward 23
- Potential cause of outbreak – shared staff between wards and shared staff break room.
- Outcome – strengthen IPC practices

Fellview – January 2023

- Number of positive patients – 6
- Number of symptomatic staff members – 0
- Number of bed days lost – 0
- Summary – Index case identified as positive in ED by rapid test and transferred to an isolation room on Fellview. 2 Bays affected 5 days later – potential cross infection
- Potential cause of outbreak – Introduction from ED and then spread on the ward from the side-room
- Learning – strengthen IPC practices

SAU – March 2023

- Number of positive patients – 2
- Number of symptomatic staff members – 1
- Summary – Index case admitted with symptoms of Norovirus, admitted to Bay, identified positive on rapid GI and isolated, 1 contact patient in bay tested positive.
- Potential cause of outbreak – community acquired infection admitted to Bay

- Learning – Complete rapid test earlier and completion of SBAR documentation

Historically, Norovirus outbreaks have resulted in closure of entire wards and a large number of trapped beds. In January and February 2019, there was an outbreak of Norovirus in the neurosurgery unit which led to 156 bed days lost.

In the past, Norovirus testing was only performed by the laboratory when specifically requested by the Infection Prevention and Control Team and this generally occurred when a ward outbreak was already established. Emergency Department (ED) staff are now encouraged to isolate and test all patients who present with suspected infectious diarrhoea with the rapid intestinal test. If the patient is negative, the patient does not require isolation. A positive result will ensure that the patients are managed appropriately from an Infection Prevention and Control perspective so that a ward outbreak is prevented. Every case of Norovirus not managed appropriately, because staff are unaware of the diagnosis, has the potential to cause an outbreak.

The introduction of the rapid intestinal screening test trial has been integral in the early identification of patients with Norovirus and the management of these patients. As seen in Table 3, 48 of 105 (45.7%) of rapid tests identifying Norovirus were taken in the emergency departments. By this early identification patients were able to be promptly isolated preventing spread and therefore reducing potential outbreaks across the organisation.

The rapid test has also facilitated the closure of affected bays as opposed to ward closures as Norovirus can be rapidly excluded in patients with diarrhoea in unaffected bays on the ward. Unaffected bays are therefore not inappropriately regarded as part of the outbreak. Due to this, 3 of the 4 reported Norovirus outbreaks reported in 2022/23 resulted in 0 bed days lost with 1 outbreak on the Acute Frailty Unit resulting in 12 bed days lost, of which 1 day was due to maintenance issues in the bay.

Table 3 The number of positive Norovirus patients per location

Row Labels	Emergency Departments	Assessment Units	Inpatient areas
Norovirus GI: POSITIVE	19	1	4
Norovirus GII: POSITIVE	29	11	41
Grand Total	48	12	45

Influenza

Influenza is an acute viral infection of the respiratory tract that spreads easily from person to person. Influenza viruses cause seasonal epidemics in winter in temperate climates, as in UK. There are 2 groups of Influenza virus, Influenza A and Influenza B which cause infection in humans. The epidemiology of Influenza is unpredictable as Influenza viruses continually change and evolve, which is why a new vaccine is developed for each season.

Transmission of Influenza occurs mainly by droplets, which can travel up to 2m through the air and by direct and indirect contact. Aerosol generating procedures such as bronchoscopy and non invasive ventilation can produce small particles which can travel further than droplets and remain in the air for longer. Prevention of influenza is by vaccination and basic hygiene including hand hygiene and cough / sneeze etiquette.

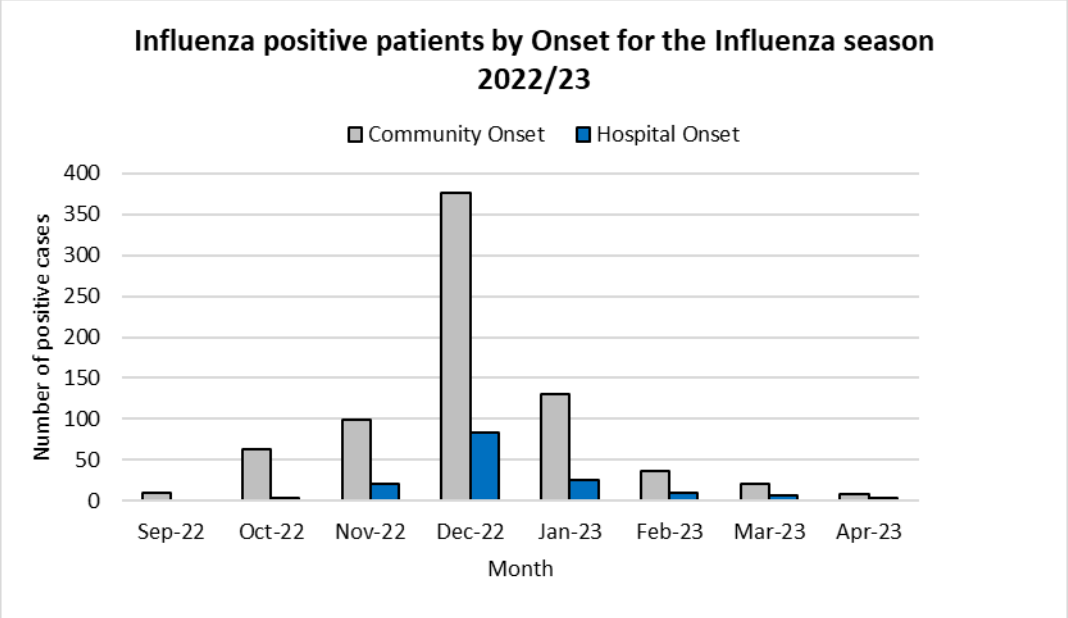
Isolation in single rooms and use of appropriate personal protective equipment (PPE) for suspected and confirmed Influenza cases is also key to preventing Influenza transmission in healthcare. When the number of single rooms exceed the single room capacity, cohorting Influenza cases can be implemented by subtype. In temperate climates, the incidence of influenza is seasonal and peaks in winter usually between January and March.

Influenza season 2022/2023

The year 2022/23 has seen the first Influenza season since before the COVID-19 pandemic began in 2020. The Influenza season in LTHTR for 2022/23 started at the end of October 2022 in line with the national pattern and peaked in December 2022. Influenza A was the most predominant strain with a small number of cases of Influenza B.

Figure 6 shows the total number of Influenza cases diagnosed in the Trust including both patients who were admitted and those who were not admitted broken down into nosocomial onset. The high number of cases in 2022/23 is consistent with national reporting. Point of care testing was continued to differentiate between Influenza and COVID-19 with both having similar symptoms. The rise in Influenza cases along with COVID-19 cases proved difficult in terms of capacity and isolation leading to the cohorting and boarding of patients.

Figure 6 Influenza positive patients by Onset



Source: LTHTR data

Mpox National Outbreak

Mpox is a viral zoonotic disease that until May 2022, was primarily identified in Central and West Africa. There are 2 historical clades of Mpox – a Central African clade with a reported mortality of 10% and a West African clade with a reported mortality of 1% from epidemiological cluster and outbreak reports from Africa. Prior to 2022, it was occasionally identified in other countries related to travel from endemic areas in Central and West Africa.

From 13 May 2022, cases began to be reported in multiple countries that do not have endemic Mpox virus in animal or human populations, including countries in Europe, North America, and Australasia. This represented community transmission (particularly in men who have sex with men) in multiple non-endemic countries.

At the beginning of the epidemic, LTHTr IPC leads met with colleagues in the Integrated Care System (ICS) and led in the development of robust community clinical pathways which avoided the need for patients to come to hospital for investigation. Although an Infection Prevention and Control policy was developed, if this should occur, the Trust never needed to manage an actual case of the infection.

Group A streptococcus / IGAS

Group A streptococcus (GAS), also referred to as Strep A is a common bacterium. Many people carry it in their throats and on their skin and it doesn't always result in illness. However, GAS does cause a number of infections, some mild and some more serious.

Milder infections caused by GAS include scarlet fever, impetigo, cellulitis and pharyngitis. These can be easily treated with antibiotics. The most serious infections linked to GAS come from invasive group A strep, known as iGAS.

These infections are caused by the bacteria getting into parts of the body where it is not normally found, such as the lungs or bloodstream. In rare cases an iGAS infection can be fatal. Whilst iGAS infections are still uncommon, there was a national increase in cases in 2022/23, particularly in children under 10 with a small number of deaths.

We saw an increase in community iGAS cases in LTHTr following the national increase however all patients were managed accordingly and there was no nosocomial spread or outbreaks identified.

2.6 KEY INTERVENTIONS TO PREVENT NOSOCOMIAL INFECTION

Antimicrobial Stewardship

The Trust Antimicrobial Management Group (AMG) meets every two months to review antimicrobial stewardship and includes representation from microbiology, pharmacy in both LTHTR and the Community and the IPCT.

In 2022/2023 the antimicrobial stewardship (AMS) team have continued with a broad range of antimicrobial stewardship activities including guideline updates, antimicrobial ward rounds, audit, and teaching. The AMS team undertakes quarterly antibiotic prescription point prevalence audits to promote good antimicrobial stewardship and safety in the management of antibiotics. The Trust has remained >90% compliant with documented indication on the drug chart, >85% compliant with antimicrobial choice in line with guidelines or recommended by microbiology and >75% compliant with documented review within 72hrs.

There has previously been a lack of compliance with antimicrobial review documented within 72hrs on the prescription chart, however, the improvement work completed at the end of last year, which included embedding antimicrobial reviews within a ward round proforma, has significantly increased compliance and this has been sustained throughout the year. The results in this area of the audit are lower than other areas, as compliance relies on use of the ward round proforma. The AMS Team have provided feedback to specialities that have not demonstrated high compliance and action plans have been completed.

The AMS Team has worked closely with the sepsis team to roll out a key update in sepsis management guidelines in line with new national guidance. Use of the National Early Warning Score has been recommended to help identify patients with suspected sepsis who are critically ill and need treatment quickly as well as the circumstances under which more time can be taken to perform tests to identify source of infection before initiating antibiotic treatment.

During World Antimicrobial Awareness Week (WAAW) 2022 the Microbiology Team held their first trust wide webinar. This covered a range of topics including empiric infection management, C. *difficile* infection, penicillin allergy and sepsis.

The NHS standard contract for 2022-23 required a 4.5% reduction in use of antimicrobials which fall into 'Watch' and 'Reserve' categories (as defined by the World Health Organisation) from 2018 baseline. Performance data reported on *Rx Define* indicates our trust has met this target. For the next financial year, a new target has been set and to reach this a further 10% reduction in use of 'Watch' and 'Reserve' category antibiotics is needed over the next 12 months.

Water Safety

The Trust Water Safety Group (WSG) has continued to meet virtually during and following the COVID-19 pandemic with official reporting to the Trust Health and Safety Governance Committee and information provided to the Infection Prevention and Control Committee in relation to any potential waterborne infection risks. In 2023 The Trust Water Safety Group will be supported with the implementation of an operational Estates Water Safety Meeting which will focus primarily on operational and capital technical issues.

The Trust Water Safety Plan remains in place and capital developments are managed in line with this. Hydrop who provide our Authorising Engineer for Water have updated the Trust Water Safety Plan in line with new/revised guidance however this remains in draft format awaiting a review by all stakeholders. The Authorising Engineer conducted the water safety audit in line with Health Technical Memoranda (HTM) 04 in January 2023. Overall, the audit outcome is positive, and an action plan has been implemented to progress the identified improvement work.

Training for Estates staff has been successful in 2022/2023. Engineering managers have successfully completed the responsible/authoring person course in line with HTM 04. Also, all relevant trade staff have successfully undertaken Competent person training in line with HTM 04.

Water testing for *Pseudomonas aeruginosa* (P. *aeruginosa*) continues in Augmented Care Areas in line with Health technical memoranda (HTM) 04-01 with samples collected every 6 months. If out of range results occur, then these are dealt with in line with the Water Safety Plan and HTM guidance. Additional water samples are taken following remedial works in response to this.

Legionella sampling regimes was revised in 2022 to strengthen compliance with the HTM and advice received from the Authorising Engineer to ensure both local and systemic contamination may be detected in high-risk areas. The areas have been identified in collaboration with Estates, microbiology, and the Authorising Engineer. The testing regime has been largely increased to sample quarterly. If out of range results occur, then these are dealt with in line with the Water Safety Plan and HTM guidance. Additional water samples are taken following remedial works in response to this.

The Hydrotherapy Pool has returned to full capacity following the pandemic. Pool Water Treatment Advisory Group (PWTAG) Technical Notes on management of pools during COVID-19 were adopted and have since stayed in place. The Hydrotherapy Policy was fully reviewed and updated in 2021. Weekly microbiological testing continues in line with this and there have been no significant abnormalities with these results. The Hydrotherapy Review Group continues to meet on a quarterly (minimum) basis and reports to Water Safety Group.

Ventilation

The Estates services department continue to implement the relevant guidance issued during the pandemic to minimise the risk of airborne particulate transmission. Following a change of structure and management, the operational Estates services work closely with the Estates capital team and independent authorising engineers to ensure new mechanical ventilation systems comply with new HTM guidance.

All workplaces need an adequate supply of fresh air. That can be provided either by natural ventilation from doors and windows, or by mechanical ventilation. The recommendations and the health care standards have changed over the time. Therefore, there is a high variety of standards and design specifications regarding mechanical ventilation in use across LTHTR. New HTM guidance is not retrospective to already installed mechanical ventilation systems. A proportion of mechanical ventilation systems throughout LTHTR are in general ageing condition and have reached recommended life cycle. Some of the inpatient areas in Royal Preston Hospital are particularly poorly ventilated in general.

Estates services have engaged a specialist contractor (Medical air Technology) who have carried out all the re-verifications of critical ventilation systems throughout LTHTR in line with Health Technical Memoranda (HTM) guidance. The Estates services have written and implemented a ventilation policy which is now available on the trust heritage portal.

Estates services have implemented a Health Technical Memoranda (HTM) compliant training schedule for all mechanical staff working with the mechanical ventilation systems. Authorised person ventilation training is scheduled for the new engineering managers who have recently joined the trust. Competent person training for all mechanical trade operatives is scheduled within June/July 2023.

As funding and access (to retrospectively upgrade ward ventilation) is constrained there was a need to mitigate the risk of the poor ventilation related to the potential spread of COVID-19 infection. To do this the Trust has procured over 100 mobile air purifier machines. These units are capable removing bacteria and viruses from closed areas. Their capacities are limited and cannot be used everywhere, and it should be noted that they re-circulate air inside as opposed to replacing with fresh air. These air purifiers have been deployed in the most at risk inpatients areas including the non-compliant ward bays and COVID Majors unit in the Emergency Department. Poorly ventilated outpatient clinics undertaking high risk procedures have also been supplied with air purifiers in order to reduce the fallow times in between the patients for aerosol generating procedures. Additional Air purifying systems have been resourced for offices and staff rest rooms to prevent in house spread of COVID-19 infection among staff.

Decontamination

External Audit of Sterile Services as per ISO 13485:2016

The water testing company SGS annual external audit took place January 2023 on Standard ISO 13485: 2016 certificate and audit passed with 100% compliances on standards. No major or minor non-conformance reported.

1. PPE and Infection and prevention control
2. The department has implemented the best practice PPE policy on staff uniforms since February2023. Staff in the washroom wear raspberry scrubs, while staff in the clean room wear blue scrubs, to ensure that there is no cross contamination between the two sides.

Staff training

The department has recently recruited several new staff, leading to the implementation of an online training programme in October 2022 Additionally in April 2023, a manufacturer training session was arranged to familiarise the new staff with the decontamination equipment. The results have been substantial, with the number of Datix reports being reduced and numerous near miss incidents being avoided.

Decontamination Strategic committee Group and appointment of new decontamination lead

The Decontamination Strategic Committee Group was recently formed, chaired by the newly appointed Decontamination Lead, and comprised of members from various areas. The last decontamination committee held on 17th of April 2023 has addressed operational issues and created area reports. The chairperson has submitted these reports to the Health and Safety Governance and Estates and Facilities divisions.

Endoscopy

The new build decontamination unit at Preston endoscopy is now operational with fully compliance with HTM01-06 standards. All theatres and endoscopy units' monthly decontamination audits are up to date. Weekly water samples, weekly tests and equipment validations are all up to date. Finally, plans for new operational meetings for endoscopy decontamination have been discussed with user groups.

Environmental Cleaning /Disinfection and Waste Management

Monitoring Arrangements

Domestic Services monitoring results are reviewed monthly to highlight performance trends and areas which have received two consecutive monitoring scores which are below the required target. This information is collated into a monthly report, submitted to, and presented at each Directorate Infection Prevention Control Committee (IPCC) / Always Safety-First (ASF) monthly meetings and forms part of the Main Infection Control Committee report. In addition to the Monitoring and Quality Assurance audits undertaken by Domestic Services the internal STAR audits and formal and informal complaints and feedback received from service users is reviewed. This information can be utilised to identify and implement specific domestic services changes including amendments to work schedules, changes of practice or service delivery. Any complaints are reviewed by the IPCC/ASF Groups to ensure that any trends are noted and addressed accordingly.

Service review of target scores help contribute to our commitment to raise the performance and standards of domestic service provision across the organisation. A Domestic services style Root Cause Analysis tool is used when an area fails to achieve its required monitoring target for 2 consecutive months. This positive initiative allows full scrutiny of service provision.

To provide Trust assurance that monitoring results are accurate, the Domestic Services team conduct thorough monitoring of cleaning standards. As we move forward, we will align this to the National Standards of Cleaning (NSoC). In addition, the Trust uses the Monitoring Team, to perform formal audits of all areas of the Trust in line with current frequency guidance. Extrapolated from this, monthly reports are shared via the IPCC/ASF meetings and reported to safety and quality committee. .

The Domestic Service team also contribute to the management of water safety and attend the Trusts Water Safety Committee. Domestic services also actively participate in the STAR audit process, working to improve cleanliness across all sites.

Patient Led Assessment of the Care Environment (PLACE)

Patient Environment Action Team (PEAT) was the annual assessment of inpatient healthcare sites in England, for wards with more than 10 beds. A pre cursor to Government led change in 2013 to PLACE (Patient Led assessment of the Care Environment). PLACE continues as a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care. Performance is measured in key areas including:

- Food
- Cleanliness
- Privacy and Dignity
- Patient environment (including bathroom areas, lighting, floors, and patient areas)

PLACE assessments were suspended for the duration of the pandemic. The Monitoring Team and Domestic Services did conduct an internal PLACE – LITE audit in November/December 2022 across both RPH and CDH. The results of this assessment were not shared nationally however they were used within the department to inform our position and to identify any areas of concern.

The Trust will be re-engaging with the full national PLACE programme this year 2023/2024 with exact dates to be confirmed.

Specialised Cleaning Provision

The Domestic Services department has a dedicated Rapid Response Team consisting of 14.6 WTE (approx. 4 staff per shift) providing an infectious discharge cleaning service. The team can be contacted 24 hours per day to support wards with discharge and turn around cleans, to expedite patient flow.

Decontamination is provided via the use of Hydrogen Peroxide Vapour (HPV) commonly referred to as fogging. The Trust currently uses OxyPharm Nocospray in response to C. *difficile*, VRE, CPE infections or outbreaks or as otherwise instructed via IPC. The system is effective, robust, and affordable. However, the system is recognised as time consuming, requiring significant resource to operate and maintain. The system is outdated and has been superseded by other systems and manufacturers. A typical side room with en-suite can take anywhere between 1.5 – 3 hours to complete a cycle and is significantly affected by

atmospheric conditions. (This does not consider the time to perform the manual aspect of the clean). Domestic services have been trialling alternative solutions and have assessed three competitor systems.

TecCARE Control

HPV fogging system – first trialled, however the technology was found to be unreliable and not suited to the fabric of our current estate. The trial delivered minimal time benefit and was difficult to utilise in many areas of the Trust. As a result of some safety issues, the trial was not pursued as a viable option.

Innivos ULTRA -V UV

Ultraviolet light system (UV-C). This trial commenced February 2023 – running until April 2023. The Domestic Services team welcomed UV-C system. Easy to use and simple to set up, once in operation the technology requires one operative. This enables more effective use of Rapid Response resources. Innivos uses monitors, placed around the room to validate the effectiveness of the cycle, and generate a detailed digital report, to be shared with registered stake holders. This provided informed assurance alongside reduced manual administration. A side room with en-suite took as little as 15-20 minutes. (This does not consider the time to perform the manual aspect of the clean). No chemicals are dispersed into the room, further removing the need for Estates assistance to shut down services such as air handling and smoke heads. Amore timely, effective option, with no areas identified that were unsuitable for the system.

Clinell Violet UV.

Training commenced 9 May 2023 in preparation to trial the Violet UV system from Clinell.

Ward of the Week Scheduled Cleans

In conjunction with infection control, this service continues to be provided across the Trust. The initiative includes deep cleaning a ward area, with specialist cleaning of key areas using Hydrogen Peroxide, coupled with a 7-day period when a Chlorine releasing cleaning product is used for cleaning all areas and surfaces. The aim of the programme is to further reduce any environmental contamination with C. *difficile* spores.

National Standards of Cleaning (NSoC) (2021)

To ensure that Lancashire Teaching Hospitals cleaning standards are compliant with National Standards of Cleaning (2021), a medium to longer term, phased approach to implementation will be adopted. As part of this scope, each site will aim to implement National Standards of Cleaning (2021), leading to:

- Safe and effective cleaning, supporting patient care.
- Phased local delivery, to support full implementation overtime.
- Improved service offer, aligned to NSoC functional risks.
- Workforce and service review to deliver the standards.

Recognised constraints and assumptions include:

- Time limits, staff training and funding availability to support full implementation in 2023. Assessment of current standards and practice to dovetail into NSoC.
- Designated Cleaning leads.
- Funding for additional equipment

- Staffing availability for training
- Additional auditing and monitoring activity time.
- Phased roll out to meet critical FR standards, leading to delayed full compliance to the standards.

As part of the Trust service approach, we will:

- Agree an affordable Local Service Delivery Model
- Establish decision making and escalation routes.
- Agree program of delivery
- Agree resource availability/budget.
- Seek approval to proceed.
- Engage with Domestic, Monitoring, and Clinical services.

The 2021 standards reflect modern methods of cleaning, infection prevention and control and other changes. It has been and continues to be vitally important for visibly transparent cleaning services, post pandemic, to assure patients, the public and staff that safe standards of cleanliness are embedded. The intention of Trust in response to this standard will be a key driver in strategic development and future proofing the service, with consideration given to the appropriate response for each site. Compliance will be monitored through ERIC and PAM systems annually from 2023.

The Domestic Service has undertaken a contemporary, representative review of current domestic service across both sites, aligned to NSoC functional risks priority, to determine implementation to meet compliance, ensuring a safe service offer that can be executed and sustained.

Comparative to the NSoC recommendation to implement all six functional risks, the current domestic service model does not align itself to achieving to full compliance in the short term. We operate a Monday – Sunday service, with minimal reduction in service at weekends, resulting from reduced patient contact. There remains a significant gap between our current position and full implementation of the standards. Following consideration, a realignment exercise is needed to meet critical NSoC risks (FR1 and FR2), ensuring, preservation of IPC and patient safety, working within our available resource. This exercise will involve a root and branch assessment of current cleaning regimes, workforce availability, workforce capacity, reasonable adjustments, monitoring and maintenance of ratings.

As part of the NSoC there is shared responsibility for achieving the standards. Facilities, Estates, and Clinical colleagues are critical in delivering and meeting the standards and evidencing achievement. The age profile of both estates (RPH and CDH) is a significant factor and could be prohibitive to short term successful modelling. Capital improvement to wards, theatres etc are large schemes, often lengthy in duration. Throughout any capital building phase, the estate will not support embedded delivery of the full standards. This will affect scoring outcomes and star ratings.

The Trust has a significant journey to undertake to meet the full standards. With careful planning and innovative, new ways of working, compliance may be achieved in the medium and longer term. As part of the local offer, a short-term and medium-term implementation model, embedded within a longer-term business rolling plan will be developed to achieve the standards.

Waste

Waste production is now returning to more normal levels following the pandemic, which is now allowing us to focus more on sustainable waste management systems. Over the next year the Trust will be implementing the colour coding system for clinical waste streams across our various sites. This will ensure that we are not over treating waste, as well as moving to more cost-effective disposal routes.

Our non-clinical waste continues to be recycled or recovered, with zero waste to landfill. We still have separate recycling streams for; cardboard, plastic bottles, wood, metal waste electrical and electronic equipment, batteries, mattresses, fluorescent tubes, confidential paper waste (following shredding), cooking and engine oils. Food waste is recovered via anaerobic digestion and green waste from our grounds, is composted. Our challenge for this next year is to look at how to minimise food waste, to reduce the amount we need to treat.

The Trust re-use portal for furniture and equipment continues to grow in membership and not only saves us money not having to procure new items, but also on disposal costs. In addition, we have a local company providing an upholstery service for various types of furniture, allowing more items to be reused rather than disposed of.

Moving forward we need to put more onus on our suppliers and providers to review their sustainability policies and procedures to benefit the NHS. This must involve less reliance on single use products, in particular plastics. In turn all wards and departments also need to make more informed purchasing decisions to reduce waste completely, or where this is not possible, ensure that waste can be reused, recycled, or recovered more easily.

The Trust now has a Sustainability Group who regularly meet to review our activities, introduce sustainable practices, raise awareness and work towards the implementation of our overall Green Plan.

A key element of making changes to our waste management systems will involve raising awareness and staff training, which will be introduced alongside the colour coding changes. This will hopefully encourage our staff to think differently about waste and prioritise waste minimisation, reuse, recycling and recovery over disposal whilst still ensuring compliance and health and safety.

3. Financial implications

There are a number of schemes identified to reduce C.*difficile* infection rates. The teams are working to rationalise the overall approach to ensure the most cost-effective approach is proposed whilst addressing the increase rates observed. This includes:

- Co-production of a business case for Ultraviolet light system (UV-C) to more rapidly decontaminate the environment (turnaround time shorter than “fogging,” which has been difficult to deploy during these times of severe operational pressure).
- Co-production of a business case for extra domestic resource in order to become compliant with new national cleaning standards
- Production of a case to maintain rapid testing to more efficiently use isolation capacity
- Production of a case to maintain some redi-room isolation capacity when COVID-19 monies are withdrawn, to manage times of high incidence of infectious disease (e.g., influenza season)

These will be managed through the Trusts normal processes and where possible include stopping undertaking one activity in place for a more effective and efficient approach.

4. Legal implications

There are no legal implications within this report.

5. Risks

ID	Title	Current Score
693	Covid 19	9
1157	Increased C. *difficile* Infection	16
1302	Insufficient side rooms to meet Infection prevention & control requirements & demand	12

6. Impact on stakeholders

Infection control plays a critical role in patient safety and experience outcomes. Infection leads to increase in treatments and length of stay and colleague sickness. Therefore, the prevention of infection plays an important role in the available bed and colleague capacity within the services.

7. Recommendations

It is recommended that:

I. The Board of Directors note the contents of the Annual report and confirm that it is assured of progress against the 2022/23 Annual Plan (Appendix 1).
II. Approve the IPC Annual Plan 2023/2024 (Appendix 2).

Appendix 1 – IPC 2022/23 Annual plan
Appendix 2 – IPC 2023/23 Annual plan
Appendix 3 – C. *difficile* improvement plan

Infection Prevention and Control (IPC) Annual Programme 2022/2023

The annual programme for 2022/2023 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2021/2022. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of lessons learned,especially following post infection reviews (PIR), is a key strategy to support the Annual Programme. The PIR process introduced in 2017/2018 continues to be strengthened. This PIR process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) Staffing 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Post infection review 6) Environment 7) Antimicrobials 8) Winter preparedness 9) policies and procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning amnd communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection.These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

		Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N
	1.1.0							
IPC Team	1.1.1	Develop closer working of the IPC Team with the operational site management team to support operational bed management and patient safety	1,2	Deputy Nursing, Midwifery & AHP Director	Restructure the membership of the IPCC and include Trust operational management in the membership	Deputy Nursing, Midwifery & AHP Director	Q1	Y
	1.2.0							
IPC Team	**1.2.0**	Restructure of the IPC Team	4,5,6	Matron IPC / Deputy Nursing, Midwifery & AHP Director	Investigate financial funding for the expansion of the IPC Team	Deputy Nursing, Midwifery & AHP Director	Q2	Y
	1.3.0							
Inter-relations / Wider Community / Strategic working	1.3.1	Standardise working across the ICS	1,2,3,4,5,6,7,8,9	Matron IPC / DIPC	Work collaboratively with the ICS providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q4	Y
	1.3.2	Provide consultancy for external charites to support in IPC practice	1,2,3,4,5,6,7,9	Matron IPC	Liase with Derian House to provide IPC advise, auditing and education	Matron IPC / IPC Team	Q2	Y

					Ongoing Task	Milestone		
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N
	2.1.0							
Education Programme	2.1.1	Ensure that there is a comprehensive education programme that meets the needs of Trust staff	4, 6, 10	Matron IPC	To review and update if necessary, the mandatory infection prevention and control education delivered to clinical and non-clinical staff	IPC Team / Lead nurse / Blended Learning team	Q4	Y
	2.1.2	Expand IPC education to the bed management team to support operational management in the Trust	4, 6, 10	Matron IPC	To develop bespoke learning for the bed management team based on best practice guidelines and real life clinical cases	IPC Team	Q1,2,3,4	Y
	2.1.3	Continue the Infection Prevention and Control link worker programme throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1,2	Lead IPC Nurse	Increase the number of education sessions for IPC link workers and continue to provide a quarterly report on progress of the link worker programme at IPCC	IPC Team	Q1,2,3,4	Y
	2.1.4	Improve knowledge surrounding sampling and isolation for patients with diarrhoea in the Trust	1,2,3,4,5,6,7	Matron IPC	Provide bespoke training focusing on the management of diarrhoea	Lead IPC Nurses / IPC Team	Q2	Y
	2.1.5	Manage isolation rooms accordingly	1,2,6,7,9	Matron IPC	Implement a live system on QuadraMed to identify infectious patients in side rooms to produce reports to support Bed Management in the de-isolation of patients to ensure isolation rooms are utilised effectively.	Bed Management / IPC Team	Q2	Y
	2.1.6	Improve compliance with mandatory IPC / ANTT training with Foundation (Junior) Doctors	1,4,6	Educational Supervisor Lead	Create a mandatory IPC / ANTT training plan for Foundation (Junior) Doctors	Educational Supervisor Lead	Q3	Continued into 2023/24 Annual Plan due to timescale to allow for completion. Discussions were held in IPCC, AMG, and with Health Education England regarding mandatory training. Face-to-face sessions are scheduled for the next intake of Foundation Doctors

		Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N
	3.1.0							
Electronic Communications		Enhance communication, education and awareness of IPC issues in the Trust via social media	4,6	Matron IPC	Use the IPC Team Twitter account to communicate to Trust and local community and Health economy including other local acute Trusts about activities and themed events	IPC Team	Q 1,2,3,4	Y
	3.2.0							
Patient Lived Experience	3.2.1	Sharing learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to provide quartely patient lived experience / story to share learning and good practice or lessons learnt	Divisional Leads	Q 1,2,3,4	Y

		Ongoing Task	Milestone					
Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N
	4.1.0							
Infection Prevention and Control Reports	4.1.1	To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2022/2023	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2022/23	DIPC	Q1	Y
	4.2.0							
Surgical Site Infection	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4	Y
	4.2.2	To improve the auditing process for the surveillance of Surgical Site Infections	1,5,8	Orthopaedic Directorate	BI to standardise IT applications to improve the auditing process	Orthopaedic Directorate / Bi-portal	Q3	Not completed - On relfection this was not required. Business Intelligence unable to progress with this. Surgery will continue using the current systems in place for assurance and will continue to bring bi-annual report to IPCC.
	4.2.3	To reduce vascular device associated bloodstream infections	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4	Y
	4.3.0							
Gram negative bloodstream infection	4.3.1	To reduce Gram-negative bacteraemia cases	1,5,6,8	DIPC / CCG Quality & Performance Specialist / Always Safety First Leads	Task and Finish Group including the CCG as part of the Always Safety First Improvement process to promote education and standardisation of documentation to allow consitant auditing	DIPC / CCG Quality & Performance Specialist / Always Safety First Leads	Q3	Continued into 2023/24 Annual Plan. Timescale not achievable due to volume of work involved. A contenience and bowel care working group has been established reviewing documentation, education, and review of services across the Trust and community.
	4.3.2	Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR as part of the Central Lancashire Health Economy reduction plan for 2022/23	1,5,6,8	DIPC / CCG Quality & Performance Specialist	Work with the CCG on producing High Impact Interventions for the reduction of Gram negative bacteraemia	DIPC / CCG Quality & Performance Specialist	Q 2,4	Continued into 2023/24 Annual Plan. Timescale not achievable due to volume of work involved. A contenience and bowel care working group has been established reviewing documentation, education, and review of services across the Trust and community.
	4.4.0							
Surveillance	4.4.1	Monitor and review Line infections in NICU to improve line management and reduce infection	1,5,6,8	Bi-portal / NICU Consultant	BI-portal team to review and put a system in place to provide line surveillance for NICU patients	Bi-portal / NICU Consultant	Q3	No longer required. NICU developed their own software system.
	4.4.2	Review what we are auditing and the audit process and ensure cycle complete	1,2	DIPC / Matron IPC	IPC Matron and Quality Matron to review and update audits to improve the IPC section of the STAR audit	DIPC / Matron IPC	Q2	Y
	4.4.3	Continue with senior Infection Prevention and Control Environmental checks	1,2	DIPC / Deputy Director of Nursing / IPC Team	Review estate and identifiy any environmental issues	DIPC / Deputy Director of Nursing / IPC Team	Q1,2,3,4	Y
	4.5.0							
Sepsis management improvement	4.5.1	To improve sepsis management iin LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4	Y

			Ongoing Task	Milestone				
Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N
	5.1.0							
Post Infection reviews	5.1.1	To share and embed the learning from Post Infection Reviews (PIRs)	1,4,6	DIPC	Completion of the Action plan from PIRs to be detailed in Divisional IPC reports and presented at Trust IPCC	IPC Team	Q1,2,3,4	Y
	5.1.2	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	Deputy Nursing, Midwifery & AHP Director	Demonstrate an improvement in the frequency of IPC incidents and complaints	IPC Data Admin	Q1,2,3,4	Y
	5.1.3	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4	Y

		Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N
	6.1.0							
Water safety		Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide quarterly reports to IPCC and the Trust Health and Safety Governance Group on water safety management including abnormal results and remedial actions	Water Safety Group	Q1,2,3,4	Y
	6.2.0							
Environmental and Equipment Cleaning and Decontamination	6.2.1	To improve the cleanliness of the environment	2	Matron IPC	Review and define the Trust cleaning standards in compliance with National Cleaning standards for 2022/2023	Associate Director of Facilities	Q2,Q4	Continued into 2023/24 Annual Plan. Escalated to Chief Nursing Officer due to lack of progress. Weekly executive oversight meetings were introduced to review plans to meet the national cleaning standards with the completion of a frequency 1 and 2 starting 2023/24 financial year.
	6.2.2	To improve the cleanliness of environment	2	Associate Director of Facilities	Chairs report Estates and Facilities partnership board	Hotel Services Manager	Q1,2,3,4	Y
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions on a monthly basis.	2	Associate Director of Facilities	Monitor progress and compliance and report monthly to IPCC. IPC Team to support and provide guidance on products.	Hotel Services Manager/IPC Team	Q1,2,3,4	Y
	6.2.4	To ensure all cleaning information is up to date	2	Matron IPC / Associate DIPC	Review and monitor all literature and available information is kept up to date. Review new fogging and decontamination systems to ensure that areas are decontaminated appropriately and efficiently.	Domestic Management / IPC Leads. Associate DIPC	Q3	Continued into 2023/24 Annual Plan. Escalated to Chief Nursing Officer due to delays in progress. Weekly executive oversight meetings were introduced to review plans to meet the national cleaning standards with the completion of a frequency 1 and 2 starting 2023/24 financial year.
	6.2.5	Ensure Matresses are fit for purpose and replenished as required	1,2	Associate Director of Facilities	Complete Annual Mattress audit to discard of any Mattresses that do not meet the Trust's standards	Associate Director of Facilities	Q3	Y
	6.3.0							
Decontamination	6.3.1	To provide assurance to the IPCC in regards to Decontamination management	2	Decontamination Lead	Provide quartely reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4	Y
	6.3.2	Identify and report Decontamination audit gaps in standards through divisional IPC.	2	Decontamination Lead	Provide monthy reports to divisional IPC meetings to strengethen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4	Y
	6.4.0							
Ventilation	6.4.1	Review and implement a strategy on air purification and ventilation	1,2	Estates	Provide a bi-annual report and create a ventilation policy	Associate DIPC / Assistant Director of Estates	Q2, 4	Y
	6.5.0							
Medical Devices	6.5.1	Reduce the number of incidents of dirty equipment going back to medical services.	1,2	Divisional Nursing Directors	Task and Finish group meeting to be held to review a Trust-wide process	Divisional Nursing Directors	Q1	No longer required. Divisions have oversight of incidents which are discussed at the monthly IPC divisional meetings. A SOP for all inpatient areas for patient equipment has been completed.

			Ongoing Task	Milestone				
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N
	7.1.0							
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMR Lead	Quarterly report on point prevalence audits	AMR lead	Q1, Q2,Q3,Q4	Y
	7.1.2	Strengthen knowledge and skills of IPC nursing team around antimicrobial stewardship	3	Deputy Nursing, Midwifery & AHP Director	IPC nursing team member to complete non-medical prescribing course.	Matron IPC & Lead Nurse	Q4	Continued into 2023/24 Annual Plan. Course start date only in October 2023 due to delays with COVID-19. Ward rounds continue with IPC Nurse attendacne at AMG.

8.0 Winter Preparedness & Resilliance

Ongoing Task | Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N
	8.1.0							
Norovirus	8.1.1	Improve Norovirus management and knowledge across the organisation	5, 6	Deputy Nursing, Midwifery & AHP Director	Ensure the Norovirus policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q1	Y
	8.2.0							
Influenza	8.2.1	IPC preparation including POCT for seasonal influenza in place	5, 6	Deputy Nursing, Midwifery & AHP Director	Hold a multidisciplinary meeting led by Operations/Emergency preparedness team and report to IPCC to reinforce management and risk assessment of all patients with suspected influenza	DIPC/Matron IPC	Q2	Continued into 2023/24. Unable to complete in financial year due to COVID-19 and other capacity issues taking prority at the time. Meeting scheduled to review this on an Annual basis
	8.3.0							
Emergency Preparedness	8.3.1	Review the emergency prepardness plan		Head of EPRR and Patient Flow	Review and update the emergency prepardness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Team	Q1	Continued into 2023/24. Unable to complete in financial year due to COVID-19 and other capacity issues taking prority at the time. Meeting scheduled to review this on an annual basis

				Ongoing Task	Milestone			
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N
	9.1.0							
Policy and procedure	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4	Y

Ongoing Task Milestone

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N
	10.1.0							
CDI Reduction Plan	10.1.1	Improve Nursing documentation surrounding diarrhoea	1,4,6	Chief Nursing Information Officer	Include a question around diarrhoea in standardised nursing documentation	DNDs Delegates DIPC IPC Matron	Q1	Y
	10.1.2	Timely management of treatment and isolation of patients	1,2,7	DIPC / IPC Team	Explore Risk assessing all Type 5,6,7 stools as per the Department of Health Guidelines	DIPC / IPC Team	Q1	Y
	10.1.3	Improve estates issues in areas with high C.difficile infection rates	1,2,7	Assistant Director of Estates	Develop an action plan to correct estates issues prioritising areas with high C.difficile infection	Matron IPC	Q3	Continued into 2023/24. IPC team completed review of high risk areas and completed ward rounds to identify estate concerns. IPC Matron meets with the Capital team and E&F monthly to prioritise funding and workstreams within the year. Larger piece of work that will continue for a number of years with disucssion in the E&F partnership board and IPCC. Any immediate concerns are being discussed in the weekly executive meeting.
	10.1.4	Have a collective Trust-wide approach on diarrhoea and isolation compliance	1,2,4,5,7	DIPC / IPC Team	Education on use of whiteboards to review patients with diarrhoea and isolation compliance	DIPC / IPC Team	Q1	Y
	10.1.5	Identify CDI rapidly to aid in the appropriate isolation and management of patients	1,2,4,5,6,7	DIPC / IPC Team	Encourage use of Rapid Intestinal Testing to identify patients with CDI and other infections to utilise isolation facilities and improve patient safety	DIPC / IPC Team	Q1	Y
	10.1.6	Ensure the case for Rapid Intestinal testing is established		DIPC / IPC Team	Perform an evaluation on the efficacy of the Rapid Intestinal Testing	DIPC / IPC Team	Q1	Y
	10.1.7	Timely management of treatment and isolation of patients		IPC Team	Ensure diarrhoea dashboard is reviewed daily and shared with Clinical Leader / Nurse co-ordinator	IPC Team	Q1	Y
	10.1.7	Gain assurance on the completion of fogging following cases of C.difficile	1,2	Director of Facilities	Highlight the hotspot areas of C.difficile in the Trust and develop an action plan regarding fogging and the implementation of planned fogging	Matron IPC	Q2	Continued into 2023/24. IPC team identified hotspot areas in relation to C. difficile infection rates. Three trials were completed for UV decontmaination. This piece of work was extended to 2023/24 due to plans for a system to identify completion and outstanding areas for fogging which will aid in completion.

				Ongoing Task	Milestone					
Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	11.1.0									
Living with COVID 19		Introduce living with COVID-19 Guidance	1, 2, 5, 6	Deputy Nursing, Midwifery & AHP Director	Provide education and updates on recent changes in National Guidance. Update Trust policy in accordance to changes	Deputy Nursing, Midwifery & AHP Director	Q1	Y		Living with COVID-19 26.04.22.pptx

Infection Prevention and Control (IPC) Annual Programme 2023/2024

The annual programme for 2023/2024 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2022/2023. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of lessons learned,especially following post infection reviews (PIR), is a key strategy to support the Annual Programme. The PIR process introduced in 2017/2018 continues to be strengthened. This PIR process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) Staffing 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Post infection review 6) Environment 7) Antimicrobials 8) Winter preparedness 9) policies and procedures

This annual programme details developments and changes to the IPC service, which will be introduced to improve patient safety, reduce healthcare associated infections and strengthen learning amnd communication.

The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection.These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

1.0 IPC Infrastructure

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	1.1.0									
Interrelations / Wider Context / Strategic working	1.1.1	Standardise working across the ICS	1,2,3,4,5,6,7,8,9	Matron IPC / DIPC	Work collaboratively with the ICS providing IPC strategic working, expertise and driving future changes	Matron IPC / DIPC	Q3			
	1.1.2	Provide consultancy for external charities to support in IPC practice	1,2,3,4,5,6,7,9	Matron IPC	Provide Derian House Children's Hospice with IPC support and Annual Audit	Matron IPC / IPC Team	Q2			

2.0 Education and Development

Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	2.1.0									
Education Programme	2.1.1	Ensure that there is a comprehensive education programme that meets the needs of Trust staff	4, 6, 10	Matron IPC	To review and update the mandatory infection prevention and control education delivered to clinical and non-clinical staff	IPC Team / Lead nurse / Blended Learning team	Q3			
	2.1.2	Expand IPC education to the bed management team to support operational management in the Trust	4, 6, 10	Matron IPC	Strengthen learning for the bed management team based on best practice guidelines and real life clinical cases	IPC Team	Q2, Q4			
	2.1.3	Continue the Infection Prevention and Control face-to-face study days throughout the Trust to strengthen IPC communication and cascade IPC training for frontline staff	1,2	Lead IPC Nurse	Increase the number of education sessions for IPC across the Trust	IPC Team	Q1,2,3,4	On track	Q1	
	2.1.4	Reduce reoccurring themes and trends identified in post infection reviews and/or outbreak outcomes	1,2,3,4,5,6,7	Matron IPC	Provide bespoke IPC training for departments following post infection reviews or outbreaks	Lead IPC Nurses / IPC Team	Q1, Q3	On track	Q1	
	2.1.5	Manage isolation rooms accordingly	1,2,6,7,9	Matron IPC	Continue to provide education on the correct use of isolation rooms and audit current usage to support capacity	Bed Management / IPC Team	Q2, Q4			
	2.1.6	Improve compliance with mandatory IPC / ANTT training with Foundation (Junior) Doctors	1,4,6	Educational Supervisor Lead	Create a mandatory IPC / ANTT training plan for Foundation (Junior) Doctors	Educational Supervisor Lead	Q2			

3.0 Communications

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
Electronic Communications	3.1.1	Enhance communication, education and awareness of IPC issues in the Trust via social media	4,6	Matron IPC	Use the IPC Team Twitter account to communicate to Trust and local community and Health economy including other local acute Trusts about activities and themed events	IPC Team	Q 1,2,3,4	On track	Q1	
	3.2.0									
Patient Lived Experience	3.2.1	Sharing learning and examples of good practice around IPC within the Trust.	1, 4, 6	Divisional Leads	Divisional leads to share learning and good practice or lessons learnt from Post Infection Reviews, patient lived experience / story, and outbreaks	Divisional Leads	Q 1,2,3,4	On track	Q1	
	3.3.0									
Glove Awareness	3.3.1	To educate all staff across the Trust on the correct use of Gloves	1,9	Matron IPC	Promote a new campaign for Glove awareness across the Trust	IPC Lead Nurses, IPC Team, Divisional Leads	Q 1,2,3,4	On track	Q1	

4.0 Audit and Surveiliance

Domain	Reference	Aim	Relevant Hygiene Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	4.1.0									
Infection Prevention and Control Reports	4.1.1	To communicate the LTHTR performance against mandatory infection objectives in the IPC Team report and Board papers for 2023/2024	1,4	DIPC	Review IPC Team report to reflect changes in mandatory reporting and the objectives for 2023/24	DIPC	Q1	Y	Q1	
	4.2.0									
Surgical Site Infection	4.2.1	Ensure that LTHTR is compliant with reporting on mandatory surgical site infection surveillance in orthopaedics and completes actions for continuous improvement	1,4	Orthopaedic Directorate	To report collated quarterly data and ongoing actions for improvement to IPCC	Divisional Nursing Director/ Mandatory SSI lead	Q 2,4			
	4.2.2	To reduce vascular device associated bloodstream infections	4,6	Divisions	To report progress biannually to IPCC and quarterly to Divisions	Divisions with support of CVAD team	Q 2,4			
	4.3.0									
Gram negative bloodstream infection	4.3.1	Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Focus on improving practice and education identified by the E. coli deep-dive investigation	DIPC / IPC Matron / Lead IPC Nurses	Q4			
	4.3.2	To reduce Gram-negative bacteraemia cases and improve continence and bowel care services across the ICB	1,5,6,8	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	An collaborative approach to review continence and bowel care across the ICB to improve services	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Q3			
	4.3.3	Improve intelligence about contributory factors for Gram negative bacteraemia in LTHTR	1,5,6,8	DIPC / IPC Matron / Lead IPC Nurses	Focus on improving practice and education identified by the E. coli deep-dive investigation	DIPC / IPC Matron / Lead IPC Nurses	Q 2,4			
	4.3.4	Promote Hydration across the ICB	1,5,6,8	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Develop a trust strategy to ensure that patients receive appropriate hydration via key stakeholders	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Q4			
	4.3.5	Reduce Catheter associated UTIs across the ICB	1,5,6,8	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Develop a trust strategy to ensure that urinary catheters are inserted in the correct patients and managed and removed appropriately	DIPC / ICB Quality & Performance Specialist / Patient Safety Matron / DND's	Q4			
	4.4.0									
Surveillance	4.4.1	Annual review of what we are auditing and the audit process and ensure cycle complete	1,2	DIPC / Matron IPC / Quality Assurance Matron	IPC Matron and Quality Matron to review and update audits to improve the IPC section of the STAR audit	DIPC / Matron IPC / Quality Assurance Matron	Q4			
	4.4.2	Maintain a collective Trust-wide approach on diarrhoea and isolation compliance	1,2,4,5,7	DIPC / Matron IPC / Quality Assurance Matron	Strengthen the STAR report to monitor usage of IT systems	DIPC / Matron IPC / Quality Assurance Matron	Q3			
	4.4.3	DIPC and Matron to continue Infection Prevention and Control Environmental checks	1,2	DIPC / Deputy Director of Nursing / IPC Team	Review estate and identify any environmental issues	DIPC / Deputy Director of Nursing / IPC Team	Q1,2,3,4	On track	Q1	
	4.4.4	Improve CPE surveillance for inpatients in augmented care	1,5,6,7,9	DIPC	Strengthen BI portal by adding CPE inpatient screening data	DIPC / BI team	Q2			
	4.5.0									
Sepsis management improvement	4.5.1	To improve sepsis management in LTHTR	4,6	Divisional Nursing Directors / Matron IPC	To present a report on progress around improving the management of sepsis and monitor the actions set in IPCC	Sepsis Lead	Q1,2,3,4	On track	Q1	

5.0 Review of incidents and Risks

Domain	Reference	Aim	Relevant Hygeine Code Criterion	Lead	Actions	Action By	Completion Due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	5.1.0									
Post Infection reviews	5.1.1	To share and embed the learning from Post Infection Reviews (PIRs)	1,4,6	DIPC	Completion of the Action plan from PIRs to be detailed in Divisional IPC reports and presented at Trust IPCC	IPC Team	Q1,2,3,4	On track	Q1	
	5.1.2	Identify and themes and trends and promote learning following CDI Post Infection Reviews	1,4,6	DIPC	Produce a biannual Lapses in Care report	DIPC	Q2, 4			
	5.1.3	Ensure IPC incidents, complaints, patient feedback and IPC risk register are visible in IPCC	1,4,6	Deputy Nursing, Midwifery & AHP Director	Demonstrate an improvement in the frequency of IPC incidents and complaints	IPC Data Admin	Q1,2,3,4	On track	Q1	
	5.1.4	Share learning from Outbreak management to highlight good practice and areas for learning and improvement	1,4,6	Matron IPC	Include any outbreaks and periods of increased incidents within the IPC Team report	IPC Team	Q1,2,3,4	On track	Q1	

6.0 Environment

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	6.1.0									
Water safety	6.1.1	Provide assurance to IPCC in regards to water safety management	2	Assistant Director of Estates	Provide quarterly reports to IPCC and the Trust Health and Safety Governance Group on water safety management including abnormal results and remedial actions	Water Safety Group / Head of Operational Estates	Q1,2,3,4	Y		The water safety assurance has been reviewed and noted by the health and safety committee in June 2023 and this has now been received by IPC team which will go to IPC Committee in August 2023. The checks for legionella and pseudomonas are up to date and no issues flagged.
	6.2.0									
Environmental and Equipment Cleaning	6.2.1	To improve the cleanliness of the environment	2	Assistant Director of Facilities	Review and define the Trust cleaning standards in compliance with National Cleaning standards for 2023/2024	Head of Facilities	Q1, Q4	Y	Q1	Cleaning standards position assesed by external assesor. Further work required to update on closing the gap between required and established.
	6.2.1.1	To improve the cleanliness of the environment	2	Assistant Director of Facilities	Establish a working group to analyse requirements of closing the gap.	Head of Facilities	Q2			
	6.2.2	To improve the cleanliness of environment	2	Director of Estates & Facilities	Chairs report Estates and Facilities partnership board	IPC Matron	Q1,2,3,4	On track	Q1	
	6.2.3	Provide assurance of the Trust's environmental cleanliness and report the findings to Divisions on a monthly basis.	2	Director of Estates & Facilities	Monitor progress and compliance and report monthly to IPCC. IPC Matron to support and provide guidance on products.	Hotel Services Manager / IPC Matron	Q1,2,3,4	N	Q1	Not completed in quarter 1 as planned. Monthly cleaning data presented through Safety and Quality Dashboard. Escalation of the requirement to strengtheining practice in relation to assurances in this area has occurred through chairs report from IPCC. Executive oversight for single item has commenced in relation to cleaning and C.*difficile*.
	6.2.3.1	Cleaning single item executive oversight group initated to provide increased support and oversight of	2	Chief Nursing Officer	Initiate weekly Executive oversight of C.*difficile* actions and progress	Chief Nursing Officer	5.7.2023	Y		
	6.2.4	To ensure all cleaning information is up to date	2	Matron IPC / Associate DIPC	Monitor IT rapid response to fogging and deep cleaning	Domestic Management / IPC Leads. Associate DIPC	Q1,2,3,4	on track		Work is underway to deliver improved oversight in this area. This will be delivered in Q2,
	6.2.5	Review UV cleaning as an alternative to fogging	2	Assistant Director of Facilities	Provide a report on the findings on the completion of the UV trials	Head of Facilities	Q2			
	6.3.0									
Decontamination	6.3.1	To provide assurance to the IPCC in regards to Decontamination management	2	Decontamination Lead	Provide quarterly reports to IPCC on Decontamination management including track and trace and remedial actions from findings	Decontamination Lead	Q1,2,3,4	On track	Q1	
	6.3.2	Identify and report Decontamination audit gaps in standards through divisional IPC.	2	Decontamination Lead	Provide monthly reports to divisional IPC meetings to strengthen the current audit and for feedback and improvement for assurance of current gaps in audits	Decontamination Lead	Q1,2,3,4	On track	Q1	
	6.4.0									
Ventilation	6.4.1	Review and implement a strategy on air purification and ventilation	1,2	Head of Operational Estates	Maintain assurances for ventilation and update risk register and Trust policy accordingly	Head of Operational Estates	Q2, 4			

7.0 Antimicrobials

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	7.1.0									
Antimicrobial stewardship	7.1.1	Provide assurance of Trust performance against Start Smart and Focus antimicrobial stewardship standards'	3	AMS Lead	Quarterly report on point prevalence audits	AMS Team	Q1, Q2,Q3,Q4	On track	Q1	
	7.1.2	Identify any themes and trends relating to antimicrobial prescribing in CDI cases	3	AMS Lead	Provide a report of antimicrobial use associated with CDI cases	AMS Team	Q2			
	7.1.3	New sepsis strategy to reduce the use of Cefuroxime for "unexplained sepsis"	3	AMS Lead	Review guidelines for the treatment of "unexplained sepsis"	AMS Team, DIPC	Q3 Q1	On track	Q1	Enacted early due to feedback.
	7.1.4	Reduce the use of "watch and reserve" antimicrobials	3	AMS Lead	Monitor Antibiotic usage	AMS Team	Q2			
	7.1.5	Strengthen knowledge and skills of IPC nursing team around antimicrobial stewardship	3	Deputy Nursing, Midwifery & AHP Director	IPC nursing team member to complete non-medical prescribing course.	Matron IPC & Lead Nurse	Q2			

8.0 IPC Preparedness & Resilliance

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
Norovirus	8.1.1	Improve Norovirus management and knowledge across the organisation	5, 6	Deputy Nursing, Midwifery & AHP Director	Ensure the Norovirus policy is shared within the Divisions and educated to Link Nurses and implemented in outbreak management	DIPC/Matron IPC	Q1 **Revised Date Q2**	N		Date amended in response to increased focus required on C.*difficile*.
	8.2.0									
Influenza	8.2.1	IPC preparation including POCT for seasonal influenza in place	5, 6	Deputy Nursing, Midwifery & AHP Director	Hold a multidisciplinary meeting led by Operations/Emergency preparedness team and report to IPCC to reinforce management and risk assessment of all patients with suspected influenza	DIPC/Matron IPC	Q1 **Revised Date Q2**	N		Date amended in response to increased focus required on C.*difficile*.
	8.3.0									
Emergency Preparedness	8.3.1	Review the emergency preparedness plan	1, 2, 5, 6	Head of EPRR and Patient Flow	Review and update the emergency preparedness plan collaboratively	DIPC / Head of EPRR and Patient Flow / IPC Team	Q1 **Revised Date Q2**	N		Date amended in response to increased focus required on C.*difficile*.
	8.3.2	Ensure that we are prepared for any future epidemics and / or pandemics	1, 2, 5, 6	Deputy Nursing, Midwifery & AHP Director	Provide education and updates on recent changes in National Guidance. Update any IPC Trust policies in accordance to changes	Deputy Nursing, Midwifery & AHP Director	Q1,2,3,4	On track	Q1	

9.0 Policies and Procedures

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	9.1.0									
Policy and procedure	9.1.1	Provide assurance policies and procedural documents are in date and complete to enable the prevention of infections and education of staff	1,4,9	IPC Matron / DIPC	Provide assurance through the monthly IPC report of the status of policies owned by IPC and that they are in date and reviewed within the required time	IPC Matron / DIPC / IPC Team	Q1, 2, 3, 4	On track		

10.0 C.*difficile*

The approach to managing C.difficile is evident throughout the IPC annual plan, therefore only actions in addition to those outlined within the annual plan are captured here in relation to C.difficile.

Domain	Reference	Aim	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	10.1.0									
C. difficile	10.1.1	Improve estates issues in areas with high C. difficile infection rates	1,2,7	Deputy Director of Estates & Facilities	Review priorities of Estate improvement / maintenance / Capital across the Trust	Deputy Director of Estates & Facilities / Matron IPC	Q1, Q3	On track		Q1 - MAU CDH - Williams suite upgraded positively impacting the environment where patients are assesed in the Medical Assesment unit at CDH. Q1 - upgrade work commenced on the acute admissions unit. Q1 - confirmation of the successful capital bid to upgrade the Medical and Surgeical Assesment Units at RPH. Work will be completed by July 2024. Q2 - Prepare a capital bid to enable the opportunity to bid for capital funds to improve the ED environment at RPH
	10.1.2	Timely management of treatment and isolation of patients	1,2,7	IPC Team	Ensure diarrhoea dashboard is reviewed daily and shared with Clinical Leader / Nurse co-ordinator	IPC Team	Q1	Y		Dashboard created and used to understand side room occupancy.
	10.1.3	Prevent cross-infection of CDI	1,2,7	DIPC / IPC Team	Monitor CDI cases for any PIIs / outbreaks and provide bespoke training, education and prioritisation of remedial works	DIPC / IPC Team	Q3			
	10.1.4	Review the current mitigations for the reduction of C. difficile	1,2,7	DIPC	Co-produce and submit business cases for redi-rooms and rapid intestinal PCR testing	DIPC / Matron IPC	Q2			
	10.1.5	Review the current mitigations for the reduction of C. difficile	1,2,7	Head of Facilities	Co-produce and submit business case to support U/V decontamination	Head of Facilities / Matron IPC	Q2			

Infection Prevention and Control (IPC) NHSE Response

The annual programme for 2021/2022 will continue to have a strong focus on effective communication, education and learning to provide clean, safe care. It will strengthen and embed actions implemented in 2018/2019. In order to improve patient safety and reduce healthcare associated infections, infection prevention and control must continue to have a high profile as an evidence-based specialty and patient safety issue within the organisation.

Communication of lessons learned,especially following post infection reviews (PIR), is a key strategy to support the Annual Programme. The PIR process introduced in 2017/2018 continues to be strengthened. This PIR process comprises a multidisciplinary team meeting including clinical teams, support services and governance and has been applied to a range of infection prevention and control incidents.

The annual programme is based upon SMART principles and has 9 sections, all of which have the relevant Health & Social Care Act Hygiene Code criteria assigned. The 9 sections are as follows: 1) Staffing 2) Education & Development 3) Information sharing and communication 4) Audit & Surveillance 5) Post infection review 6) Environment 7) Antimicrobials 8) Winter preparedness 9) policies and procedures

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The Divisions and IPC team will be responsible for delivery of this programme and progress will be monitored monthly at the Trust Infection Prevention and Control Committee (IPCC) meetings

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection.These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

			Ongoing Task	Milestone			
Domain	Reference	Recommendation/observation	Lead	Actions	Actioned By	Completion due	Complete Y/N
	1.1.0						
IPCT	1.1.1	To embed infection prevention more firmly within fundamental care it would be useful to fully engage with aligned specialities, for example, tissue viability, the sepsis team and also the urology team and for them to consider joint working and dovetail improvement projects according to issue and related drivers. Together with relevant joint communications going out to staff and patient.	Sarah Marsh	Review attendance at IPCC to include representatives from specified groups with monthly attendance	Sarah Marsh	Dec-22	Y
	1.1.2	To embed infection prevention more firmly within fundamental care it would be useful to fully engage with aligned specialities, for example, tissue viability, the sepsis team and also the urology team and for them to consider joint working and dovetail improvement projects according to issue and related drivers. Together with relevant joint communications going out to staff and patient.	Sarah Marsh	Review IPC agenda so that it is inclusive of the specified groups	Sarah Marsh	Dec-22	Y
	1.1.3	To embed infection prevention more firmly within fundamental care it would be useful to fully engage with aligned specialities, for example, tissue viability, the sepsis team and also the urology team and for them to consider joint working and dovetail improvement projects according to issue and related drivers. Together with relevant joint communications going out to staff and patient.	Sabina Bashir	Ensure that sepsis leads are invited to AMG	Sarah Marsh	Dec-22	Y

			Ongoing Task	Milestone		
Domain	Reference	Recommendation/observation	Lead	Actions	Completion due	Complete Y/N
	2.1.0					
Education Programme	2.1.1	**Education** and training since the start of the pandemic has relied on electronic learning modules for IPC. although there is some ward-based face to face training delivered by an IPC health care assistant (HCA) This could be further enhanced with support from your commercial partners such as GAMA and GOJO whose products you use extensively	Michelle Newby	Contact GAMA and GOJO so that they can provide more education sessions for staff	Dec-22	Y
	2.1.2	In addition, other key training relating to sepsis, urinary catheters, venous access has also been reduced to the bare minimum and in some circumstances remains stopped. This needs to reverse and reimplemented to reduce harm caused by invasive devise management.	Sarah Marsh	Review training of Sepsis, Urinary Catheters and venous access with the training department in light of NHSE findings	Jan-23	Y
	2.1.3	To reinstate invasive device training for both insertion and ongoing management.	Sarah Marsh / Chris Ellis	Factual accuracy check with evidence of training that is happening	Jan-23	Y
	2.2.0					
	2.2.1	It was encouraging to hear that teaching is provided for both F1 and F2 groups for AMR. This could be widened to include all prescribers – NMPs and senior clinicians. Targeting training to the level of staff and using lived examples can have more impact than more generic, didactic approaches.	Catherine Gregory /David Orr	Factual accuracy that we do e-learning for all prescribers	Dec-22	Y
	2.2.2	Review of oral hygiene provision, education and training	Cecilia Jaques	Provide information on the training that is available	Dec-22	Y

Ongoing Task Milestone

Domain	Reference	Recommendation/observation	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	3.1.0									
No recommendations raised										

			Ongoing Task	Milestone		
Domain	**Reference**	**Recommendation/observation**	**Lead**	**Actions**	**Completion Due**	**Complete Y/N**
	4.1.0					
IPC audit	4.1.1	Conversations in relation to audit and peer review identified some good practices but it also highlighted the need to strengthen this process and what to look for throughout the inspection and how to use the information for quality/system improvement as opposed to performance management.	Michelle Newby / Helen Leach	Provide information and training on the key elements and standards that are audited against. The common failing points and what good looks like	Dec-22	Y
	4.1.2	Working with Matrons and ward managers to review and develop the audit process so that it becomes part of the improvement portfolio	Michelle Newby / Helen Leach	Provide information and training on the key elements and standards that are audited against. The common failing points and what good looks like	Feb-23	Y

			Ongoing Task	Milestone		
Domain	Reference	Recommendation/observation	Lead	Actions	Completion Due	Complete Y/N
	5.1.0					
Post infection reviews	5.1.1	More in-depth interrogation, beyond identifying whether there was a 'lapse in care', might identify areas of learning and opportunities for improvement; for example, where antibiotic prescribing has been deemed suitable and in line with guidance, was an actual focus of infection confirmed as opposed to being satisfied with treatment is in response to sepsis of unknown origin.	David Orr / Sabina Bashir / Suganya Reddy	Review the PIR form so that it is refocused on diagnosis of infection (symptoms and signs)	Dec-22	Y
	5.1.2	The new national Patient Safety Incident Response Framework (PSIRF) would be a useful tool to adopt to investigate infection incidents and develop plans from the subsequent learning and the regional team suggest that the IPC team work together with the patient safety team to design this process.	David Orr / Catherine Gregory / Michelle Durkin / Sabina Bashir/ Sarah Marsh	Review the PIR process and ensure that the correct staff are in the room for the correct cases	Dec-22	Y
	5.1.3	It was noted that no analysis is carried out on frequency of individual agents – this can be a useful tool to see patterns in incidence.	Sabina Bashir / Lois	Collate antimicrobials from the PIR forms	Feb-23	Y

			Ongoing Task	Milestone		
Domain	**Reference**	**Recommendation/observation**	**Lead**	**Actions**	**Completion due**	**Complete Y/N**
	6.1.0					
Environmental and Equipment Cleaning and Decontamination	6.1.1	It would be helpful if the IPC team and facilities team meet regularly to discuss prioritisation of work, cleaning and refurbishments	Sarah Marsh	Provide evidence that the meetings are taking place	Dec-22	Y
	6.1.2	It would be helpful if the IPC team and facilities team meet regularly to discuss prioritisation of work, cleaning and refurbishments	Sarah Marsh / Stephen Eccles / Joanne Ashley / Louise Testa	Meeting documentation needs to be more robust and evidence is collated	Dec-22	Y
	6.1.3	At present there is very little potential for career progression within the domestic teams we suggest exploring the provision of higher banding for 'specialist' cleaning/ rapid response staff as this may help both recruitment and retention. Additionally targeting university students for part time work may be of use.	Joanne Ashley	Investigate the feasibility	Mar-23	Y
	6.1.4	Consideration of alternative cleaning methodologies and cleaning strategies would support this. i.e. utilising the faster UVC instead of HPV in certain scenarios.	Sarah Marsh / Stephen Eccles / Joanne Ashley	Factual accuracy - provide evidence that the meetings are taking place	Jan-23	Y
	6.1.5	To ensure that the IPC team and soft facilities are involved early in any planning for future changes of use or alterations.	Sarah Marsh / Cliff Howel / Louise Testa	Factual accuracy - provide evidence that we are involved	Dec-22	Y
	6.1.6	Suggestion of need for decant facility	Faith Button	Explore options to ensure fogging occurs	Jan-23	Y
	6.2.0					
Data	6.2.1	**Data** – it was positive to see that the digital processes are core to understanding around patient care, however one concern was the limited availability of hardware for the staff involved in care and the heavy reliance on a few mobile laptops which could be a barrier to access for health care assistants or nursing staff involved in recording vital signs, fluid balance or stool charts etc. It is possible that this will increase the overall risk from transcription errors or double working.	Janet Young, Mandy Barker	Ensure appropriate hardware available in all areas e.g., MAU	Feb-23	Y
	6.3.0					
Hand Hygiene	6.3.1	Review of hand hygiene availability and signage within corridors and wards departments.	Sarah Marsh	Invite GOJO in to audit the areas and review availabiltiy of HH and signage	Dec-22	Y

			Ongoing Task	Milestone		
Domain	**Reference**	**Recommendation/observation**	**Lead**	**Actions**	**Completion due**	**Complete Y/N**
	7.1.0					
Antimicrobial stewardship	7.1.1	There is evidence of high usage of cefuroxime as first line for treating sepsis of unknown origin and this may be contributing to the high c. difficile numbers and also the increasing E. coli resistance patterns.	Suganya Reddy/ Sabina Bashir	Review antibiotic treatment guidelines for sepsis	Jan-23	Y
	7.1.2	LTH and Greater Preston are higher prescribers than neighbouring trusts. It would be useful to ensure a wider system approach to antimicrobial stewardship, as primary care prescribing may be adding to the c. difficile burden	Suzanne Penrose	Primary care to provide an action plan	Jan-23	Y
	7.1.3	Speaking to the surgical assessment unit (SAU) pharmacist, this has decreased missed doses due to long stays in ED but does mean that the patient may come to the ward having had up to 48 hours of antibiotics without senior review since the post-take ward round. While routine prescription review is not a usual part of an ED or admissions pharmacist role, this may need to be considered in periods of prolonged frontend stays	Sabina Bashir/ED Team	For ED Team to review patient flow	Jan-23	Y
	7.1.4	Point prevalence is not the best way to establish course length compliance as, by its nature, you are assessing patients before the end of their course. Duration is best assessed retrospectively.	Katie Naylor/ Sabina Bashir	Audit antibiotic duration/course length	Jan-23	Y
	7.1.5	'Sepsis of unknown origin' is a much-used term – it would be useful to remove this as a dropdown option to prompt more specific recording of diagnoses. This would still be an option as free type if there was truly no source suspected.	Suganya Reddy/ Sabina Bashir	Risk of prescribers free-typing more, term is needed for small patient group and covered in antibiotic guideline however can work to improve review process	Jan-23	Y
	7.1.6	The mandated documentation of review within the ePMA system is valuable, although I note many are 'Continue' without clarification of reasoning. It would be useful (if the system will allow) to introduce additional details here, e.g. 'continue on IV as NBM'	Sabina Bashir/ Suganya Reddy/ Katie Naylor	Explore system for more robust review/information when 'continue' is selected for antimicrobial review	~~Jan-23~~ Jan-24	Y
	7.1.7	I note also that a prescription with any review is marked as compliant without regard to appropriateness for the patient.	Katie Naylor	Snapshot audit of appropriateness of documented review. (PPA audit is automated due to scale of audit).	~~Jan-23~~ Aug-23	Y
	7.1.8	A good system of ward rounds was reported, being carried out four times a week on medical wards. ITU was separate, with surgery also involved via multidisciplinary team (MDT) only. It may be useful to consider widening the ward round scope, as surgical patients who would not warrant an MDT discussion would not be included in a ward round. The ward rounds may benefit from a more robust system of patient selection, either by targeting infection types, antibiotic groups, course lengths, or referrals.	Rob Shorten/Ashley Horsley/ Sabina Bashir	Review ward round approach to maximise scope.	Jan-23	Y
	7.1.9	There appears to be significant reliance on CRP as a marker of bacterial infection, both to start antibiotics and to de-escalate. It would be useful to clarify guidance around this, as it is not sufficiently sensitive or specific alone to provide guidance and indeed, in such cases as COVID-19, specifically advised against being used as a marker for bacterial infection. If the sepsis team had been available, it would have been useful to explore the process of identifying sepsis, and the senior review within that route – there were points within the deteriorating patient dashboard where it is not clear if patients are having timely, in-person, senior reviews.	Catherine Roberts	NHSE to provide explanation, ?to discuss with sepsis team	Jan-23	Y
	7.1.10	Explore availability of bezlotoximab	Sabina Bashir	Check availabity/ use in other trusts	Jan-23	Y

		Ongoing Task	Milestone							
Domain	Reference	Recommendation/observation	Hygiene Code Criterion	Lead	Actions	Actioned By	Completion due	Complete Y/N	RAG	Embedded Evidence Y/N N/A
	8.1.0									
No recommendations raised										

Ongoing Task | Milestone

Domain	Reference	Recommendation/observation	Lead	Actions	Completion due	Complete Y/N
	9.1.0					
Policy and procedure	9.1.1	Considerations of fans and responsibility for who cleans them was an area for debate therefore cleaning responsibilities should be reviewed and communicated.	Sarah Marsh	Factual accurary check - Fan policy.	Dec-22	Y
	9.1.2	Considerations of fans and responsibility for who cleans them was an area for debate therefore cleaning responsibilities should be reviewed and communicated.	Sarah Marsh	Ensure that the policy is communicated and available on Quicklinks	Dec-22	Y
	9.1.3	We had discussions on the need to consider TWOC services as this may impact on the numbers of CAUTI admitted into the trust especially from care settings and the use catheter passports to improve community pathways.	Louise Gracie	Factual accurary check - we have a TWOC service	~~Feb-23~~ Mar-24	Extended. Timescale not achievable due to volume of work involved. A contenience and bowel care working group has been established reviewing documentation, education, and review of services across the Trust and community.
	9.1.4	We had discussions on the need to consider TWOC services as this may impact on the numbers of CAUTI admitted into the trust especially from care settings and the use catheter passports to improve community pathways.	Louise Gracie	Review documentation around catheters and catheter passports	~~Feb-23~~ Mar-24	Extended. Timescale not achievable due to volume of work involved. A contenience and bowel care working group has been established reviewing documentation, education, and review of services across the Trust and community.
	9.1.5	Considerations of equipment and who cleans them were an area for debate therefore cleaning responsibilities should be reviewed and communicated.	Sarah Marsh	Factual accurary check - there has been work performed to list all items and who is responsible for cleaning them	~~Dec-22~~ Mar-23	Y
	9.1.6	Considerations of equipment and who cleans them were an area for debate therefore cleaning responsibilities should be reviewed and communicated.	Sarah Marsh / Joanne Ashley	When live, implement a strategy to ensure staff are aware of their responibilities	~~Dec-22~~ Mar-23	Y
	9.1.7	Indirectly linked to the IPCT we would recommend a review of local continence services as this may directly link to cases of infection within the ICB.	Louise Gracie	Develop the case for creation of a continence service	~~Feb-23~~ Mar-24	Extended. Timescale not achievable due to volume of work involved. A contenience and bowel care working group has been established reviewing documentation, education, and review of services across the Trust and community.
	9.1.8	Ensure PPI policy is available and implemented with support from pharmacy	Aneisha Wai	Publish policy and develop a strategy for implementation	~~Feb-23~~ Jul-23	Y

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Patient Experience Annual Report 2022/2023			
Report to:	Board of Directors	**Date:**	3rd August 2023
Report of:	Chief Nursing Officer	**Prepared by:**	J Howles, C Gregory
Part I	✓	**Part II**	

Purpose of Report					
For Assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary

The purpose of this report is to provide an update to the Board of Directors with the outcomes associated with the patient experience and involvement strategy 2022 to 2025. The report demonstrates what progress has been achieved over the last 12 months.

A summary of the 2022/23 position is:

I. The new strategy has been launched and every clinical department in the organisation has a patient experience champion, trained and part of a patient experience network.
II. During 2022/23 a total of 2,664 compliments were received.
III. Friends and Family Test response rates have improved compared to 2021/22 with 7075 more valuable pieces of feedback collected in 2022/23.
IV. Friends and Family ratings for adults have remained above 90% recommendation for outpatients and day case. Maternity and Adult/Children inpatients are not yet achieving consistent performance of greater than 90% recommended, although Maternity has achieved a 90% quarter recommendation in one quarter of the year.
V. 3036 patients have had the opportunity to talk about what safety means to them when in hospital, the feedback from those who have not felt safe (8%) has been the need to improve delays and communication.
VI. The number of complaints has reduced by 93 when comparing 2021/22 to 2022/23.
VII. There have been 4 Parliamentary Health Service Ombudsman (PHSO) referrals in the last 12 months, these numbers remain relatively small but represent families and patients who have not been satisfied with the response received.
VIII. National Picker survey results demonstrate upper quartile performance in Cancer and Maternity services, performance in line with median in Emergency Medicine and lower quartile performance in Adult inpatient services.
IX. A number of significant improvements have been noted during 2022/23 in response to patient feedback.

The transformation programme for Urgent and Emergency Care aims to reduce the time patients spend in the Emergency Department (ED) and delayed in hospital and plays a key role in addressing the negative patient experiences described. The outpatient transformation programme aims to create a more efficient experience for

patients and the elective transformation programme aims to reduce the backlog and extended waiting times for patients. In addition to this, the Our Culture counts work, part of the Leadership and organisational development strategy and the Magnet for Europe research study are aimed at creating positive care environments for colleagues and patients and therefore improve the way colleagues feel about their work leading to the provision of higher quality care.

It is recommended that the Board of Directors:

I. Receives the report and discusses the content.
II. Notes the update on year one Patient Experience and Involvement Strategy 2022-2023

Appendix 1 – Patient Experience and Involvement strategy

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☐
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Safety & Quality Committee May 23

1. Introduction

The mission of Lancashire Teaching Hospitals 'Excellent care with compassion'. This Trust published its three-year Patient Experienced Involvement Strategy for 2022 to 2025 in 2022/23. This strategy was developed and co-produced with our patients, families, carers, and staff. This report outlines what has been achieved in the first year of the strategy. As part of this report, it is important to remember that people's lived experience is a powerful tool to improve existing services and meeting their holistic needs. This report will demonstrate how we have used the patient voice to develop pathways and improve experiences within the organisation.

2. Discussion

2.1 Patient Experience and Involvement

The new strategy has set the tone to listen more and act on patient experiences, this means really listening to the experience of patients and families when they do not go well and also when they do go well. We asked patients, relatives, carers, colleagues, governors and patient and partner organisations to contribute to setting the actions in the strategy. We have actively sought the views of patient groups who represent those with protected characteristics and recognise the importance of intersectionality when considering this feedback. The patient experience and involvement strategy has strong links with a number of Trust strategies including the Equality, Diversity and Inclusion, Leadership and Organisational Development - Our people plan, the Mental Health, Dementia and the Always Safety First (ASF) strategy.

The structure is divided into 3 sections:

1. Insight - improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information.
2. Involvement - equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.
3. Improvement - design and support improvement programmes that deliver effective and sustainable change.

2.2 Year 1 strategy review

To support the delivery of the strategy, three key things have occurred which have enabled the strategy to progress and move forward in its first year. Firstly, the appointment of the Associate Director of Quality and Experience is now in place. The official launch of the strategy through a webinar was completed with great success. The recruitment of patient champions across the organisation is now complete.

The achievements of the year are outlined below.

Insight

- Patient experience dashboard has been launched that pull together for each area at a glance friends and family, complaints and compliments to make it easy for leaders to share and talk about experience with their teams.

- Increase in the satisfaction ratings through friends and family feedback from 86% to 87%. The data demonstrates a deteriorated picture in Quarter 1 compared to last year but an improvement in Quarter 2, Quarter 3 and Quarter 4 compared to last year.
- It is now possible to differentiate experience captured through friends and family from patients who present with a mental health diagnosis in the Emergency Department.
- Continued participation in the patient experience research led by Imperial College Healthcare NHS Foundation Trust.
- The Governors are now involved with the STAR accreditation visits and lead the 15 step process.
- Thematic review of patient experience feedback collated through STAR to enable key learning to be shared within the divisions.
- A reduction of 93 complaints when comparing 2021/22 to 2022/23.
- Increase of 7075 more responses in friends and family.

Involvement

- The new 'Patients as Partners' role has been agreed, linked to the Always Safety First strategy. Recruitment expected to be complete by June 2023.
- Patient champions recruited from all clinical and a growing number of administrative parts of the organisation with a champions event held in partnership with advocacy services, patients and colleagues.
- Volunteer recruitment to Patient Advice Liaison Service (PALS) team.
- Continued work with partners Galloway's, Healthwatch and NCompass.
- Forums (Carers, Cancer) have been used to help change policy within the Trust.
- Patients' involvement in recruitment.
- Growth of the use of the Essential Carer role.
- Continued improvement in leaflet standards by increasing the languages available, introduction of QR codes and size of font.

Improvement

- Revised approach to complaint quality sign off introduced.
- Thematic reviews have taken place in Maternity and Children's services leading to a focus on maternity triage, antenatal clinic experiences and the paediatric emergency pathway.
- Agreement of a set of actions that will be undertaken to support multi faith events.
- Patient group review of the Nutrition and Hydration policy using feedback from STAR to shape this.
- Recruitment of a Patient Experience lead for children leading on improving the experience of patients and families with protected characteristics within Children and Young People services.
- The main entrance Gordon Hesling renovation work is completed, creating a welcome desk, volunteer area and a place to rest for visitors.
- The Charters restaurant renovation and the café at Preston (yet to be named) have been renovated to provide increased quality environments.
- Multifaith resources have been created to support the end of life CARING campaign to help make it easy to respond to the spiritual needs of patients at the end of life.
- The renovation of the multifaith area and Muslim prayer room at Preston provides a calm, respectful culturally appropriate area for patients and staff to pray. CDH prayer facilities will be the next focus.
- The remembrance garden has been renovated next to charters with a tree recognising those that have donated organs created as a centre piece, providing a calm outdoor space for patients and colleagues.

- The remembrance garden at Chorley and South Ribble District General Hospital (CDH) opened in 2022 enabling the same quiet, reflective space at the CDH site. The baby remembrance garden will be the next focus.
- Finney House opened as an alternative for patients who do not meet the criteria to reside.
- Property policy reviewed with the intention of reducing the amount of lost property of patients.
- Transformation Programme Boards launched to focus on urgent, elective and outpatient care.
- Cancer forum used to access feedback from patients to help support projects and policies such as Patients Contribution to Case Notes (PCCN).
- Patient Experience lead in place for radiotherapy focusing on improving the experience on attendance to radiotherapy by arranging department visits for future patients.
- Flow Coaching Academy (FCA) big rooms running and routinely use patient stories to open the rooms.
- Neonatal Intensive care have been awarded a green standard award for Family Integrated Care. (Ficare)
- Created in Carers week June 2021, a now well-established Carers forum is in place, run in collaboration with Lancashire Carers Service which continues to support our carers with speakers from the ambulance and fire services.
- Renal service opened a new unit in Blackburn, Burnley and Ulverston improving the experience of our renal dialysis patients.
- Chorley & South Ribble District General Hospital is one of eight surgical hubs to be awarded Getting it Right First Time (GIRFT) accreditation as part of a pilot scheme to ensure the highest standards in clinical and operational practice.

2.3 Always Safety First – what our patients say and feel about safety?

The Always Safety First (ASF) programme of work led to the development of a strategy launched in 2021. As part of this strategy, there was a commitment to involve patients in their care and treatment in relation to safety, to meet the requirements of the National Framework for Involving Patients in Patient Safety.

The Patient Experience and Patient Advice and Liaison Service (PALS) team visited wards across the organisation to visit patients and ask them a series of questions. The pilot was initiated to ascertain what safety means to patients. We asked patients the following questions.

- Have you felt safe and if so, why was that?
- Have you felt unsafe at any time and why was that?
- Overall, what has been positive/negative about your hospital stay?
- Overall, what improvements do you think we could make?

Over the last 12 months, a total number of 3036 surveys were completed across the Chorley and South Ribble District General Hospital and the Royal Preston Hospital sites. Out of the 3036 surveys completed, 250 patients described not feeling safe in our hospitals. Out of the 250, 2 key themes were clearly evident.

1. Waiting for investigations or medications
2. Communication

When patients were asked **'What does safety mean to you? '**

470 people told us it was linked to feeling looked after, spoken to by compassionate people and this made them feel safe. A summary of the words chosen is shown in image one.

Image 1 – Patient Feedback (n3036) on what safety means 1st April 2022 – 31st March 2023

2.4 Patient and Experience and Involvement Group

Throughout the last 12 months the Patient Experience and Involvement Group meets monthly and provides a chairs report to the Trusts Safety and Quality Committee. The group is very diverse and is represented by all divisions, patients, support groups, governors and advocacy groups. The group gains monthly updates from a variety of different services and divisions.

In the last 12 months a review of the terms of reference and cycle of business has been carried out allowing for clarity of expectations.

3. Patient Feedback

3.1 Friends and Family Feedback

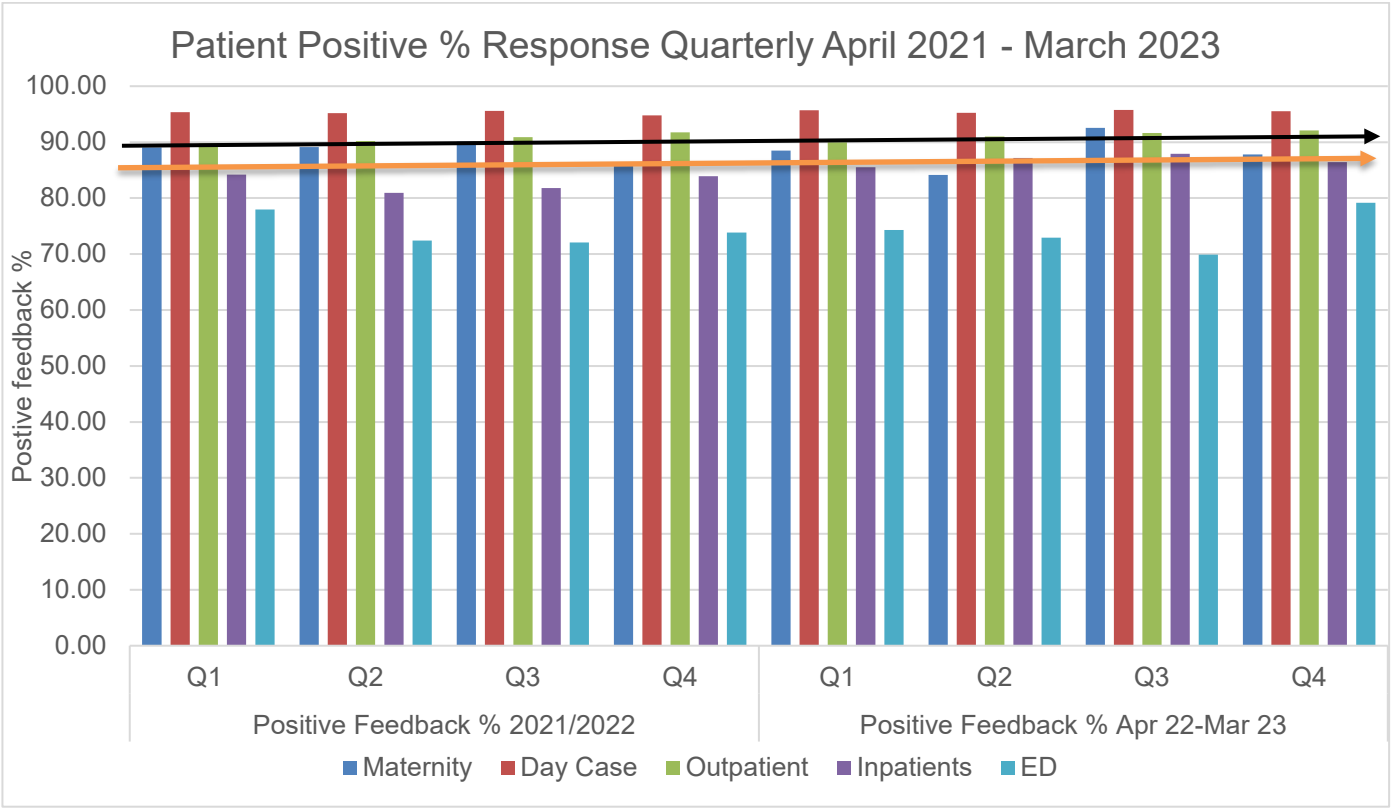
The Friends and Family Test (FFT) is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

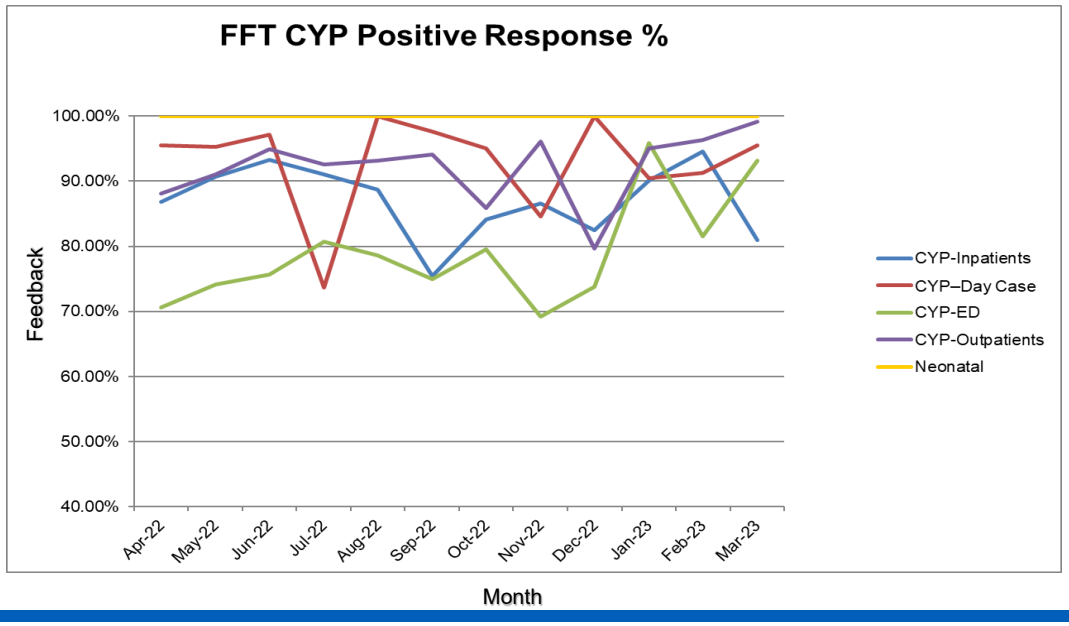
A target of 90% (black line) is set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department (orange line). Image 2 below demonstrates

that Maternity has achieved this in Q3, Day case have consistently achieved in excess of 90% in all four quarters, outpatients have achieved this for the past three quarters with inpatients and the Emergency Department under the target percentage in all four quarters. The data in Graph 1 demonstrates an overall increase in responses and an increase in usage of the various methods of collection.

Graph 1- Positive patients responses through friends and family recommendation question



Graph 2 – Children and young people Friends and Family response



The Trust also undertakes surveys in Children and Young People's services. The neonatal service has maintained a sustained performance of 100% recommended care. Children's ED and inpatients have remained a focus for some time with positive evidence in both the friends and family test and the most recent Picker survey's that experiences are improving. The development of a child specific ED pathway and staffing model alongside focus on the Paediatric assessment pathway is starting to demonstrate positive results.

3.2 Friends and Family response rate

Expanding the methods used to collect feedback is important if we are to understand what matters to patients. The response rate is an area we set out to improve and the data below demonstrates this has been achieved with a total of 7075 more valuable pieces of feedback than what was collected in 2021/22.

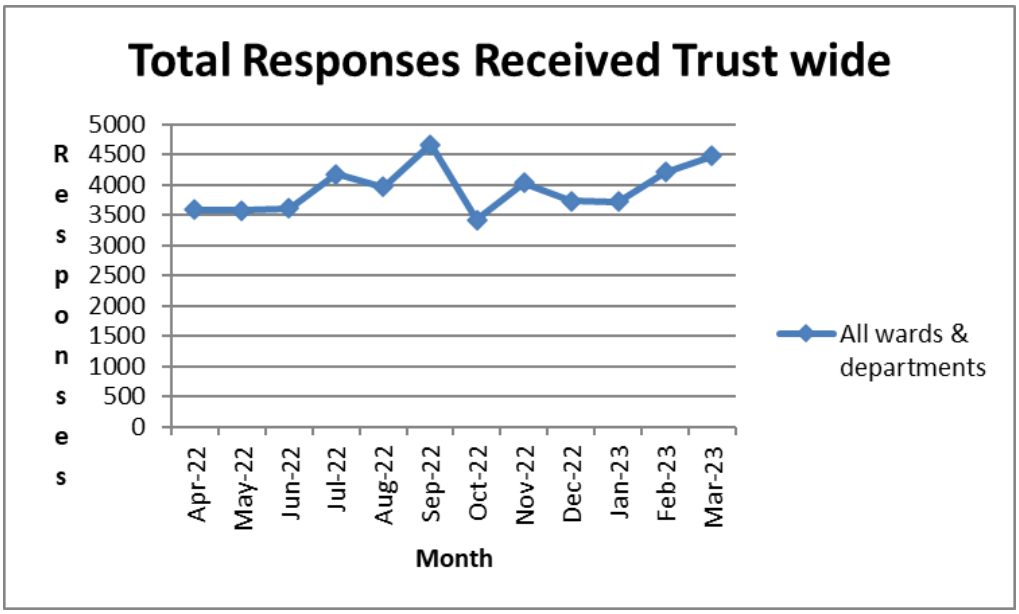
It is not yet possible to view this feedback through the lens of protected characteristics of deprivation. However, this will be part of the plan for the health inequalities work for 2022/23.

When comparing 2021/22 to 2022/23 there has been an increase in the amount of feedback received.

- 1437 more QR code/online link responses totalling 2905 responses for 2022/23.
- 3959 more paper survey responses totalling 6788 responses for 2022/23
- 737 more telephone survey responses totalling 4421 responses for 2022/23
- 942 more text message responses totalling 37,070 responses for 2022/23.

We are actively training staff to use the system and ensure the patient experience boards are kept updated with the "You said, we did" posters and various reports that can be downloaded using CIVICA. Monthly reports are being sent to all governance and divisional leads to ensure the results are being reviewed and shared throughout the Trust.

Graph 3 – friends and family Total responses received 2021/22



3.3 Complaints

During 2022/2023 the Trust received 487 formal complaints, a decrease of 93 (16%) from 2021/2022. It is important to note, in the previous year there was a substantial increase in complaints, following the COVID-19 pandemic. Whilst there has been a reduction in the complaints received into the Organisation, they appear to be more complex than previously.

Table 1 - Comparator data for Complaints 2020 to 2022/23

Year	Complaints received	Increase/reduction
2020-21	361	-96
2021-22	580	+219
2022-23	487	-93

Table 2 - Trend of ratio of complaints per patient contact 2020 to 2022/23

Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints topatient contacts
2020-21	361	717,213	1:1,987
2021-22	580	821,526	1:1,416
2022-23	487	849,328	1:1,744

Source: LTHTR Datix

Table 3 - Number of Complaints by Division – April 2022 to March 2023

Division	Number (%)	Division	Number (%)
Medicine	189 (40%)	Women and Children's Services	80 (16%)
Surgery	172 (35%)	Diagnostics and Clinical Support	31 (6%)
Estates and Facilities	6 (1.2%)	Corporate Services	9 (1.8%)

3.4 Complaint Themes

Whilst there are many more compliments than complaints,complaints are an important source of feedback. There are a number of key complaints themes that run across all divisions. These are communication, consent, confidentiality, clinical assessment and nursing care.

Diagnostic clinical support (DCS)

Within the diagnostic clinical support division, the key theme is communication. A trend from within this, is clearly related to communication in regard to appointments and explanation of procedures and diagnostics. Patients have shared examples of wasted journeys, unanswered questions and communications of ongoing plans.

Action: The outpatient transformation board will oversee a series of actions to create a more efficient outpatient experience for patients.

Action: The division is working on improving the information provided within letters and in the internet site that informs patients.

Medicine

From a medical division perspective, the Emergency Department length of stay and subsequent delays is a key theme. There are several key work streams and continuous improvement projects in progress to

consistently ensure it is acknowledged as a key priority. Whilst these issues are being resolved, action has been taken to continually review the number and skill mix of nurses and doctors within the department alongside improvements in the equipment available to attempt to mitigate extended waits. Patients describe being sat in the waiting room for extended periods of time and delays in treatment and an overall challenging experience in the department.

Action: The Urgent and Emergency care transformation board will drive improvements in the length of time patients wait to be seen and spend in hospital through projects such as ambulance handover, same day emergency care, virtual wards, discharge lounge use.

Action: Finney house opened in November 2022 and has led to a 4% reduction in patients who no longer meet the criteria to reside and a more appropriate rehabilitation environment for patients. The number of complaints in comparison to being in hospital is remarkably lower with one formal complaint received to date in a 6 month period of 64 beds being open.

Action: The clinical environment of the RPH Emergency Department was expanded during covid, leading to more patients spending longer period of time in the ED. Plan to reduce the size again, decreasing occupancy and length of stay in the ED have so far led to 7% fewer patients waiting longer than 12 hours from October 2022 to April 23. A further improvement in the median time to triage of 15 minutes has now consistently being achieved from 16 minutes in July 22 to 10 mins in March 23.

Surgery

The surgical division shows the key themes of consent, confidentiality and communication. A key trend in particular is around communication of plans in relation to care, treatment and discharge. The patients describe missing communication regarding future plans.

Action: The accreditation of the CDH as the elective care hub aims to streamline patients that require elective surgery into an elective hub environment. Evidence nationally suggests hubs are more efficient and effective and patient outcomes are better. It is anticipated this will improve urgent patients experiences by reducing occupancy levels in inpatient wards.

Action: The division is continuing to role out the essential carer role which aims to improve the communication and plans with patients and families.

Womens and children (WACS)

Within the women's and children's division there is a key theme around treatment. Within women services the experience of patients from the emergency department to gynaecological teams requires focus as does the experience of early pregnancy loss. Some of the negative experiences are described as hurtful and have further impacts on patients mental health. Within maternity feedback on antenatal, induction and triage processes features as areas that lead to a loss of confidence. In children the communication of ongoing plans and treatment is a key trend.

Action: A specific improvement project is in place for early pregnancy and the Gynae Assessment Area (GAU). A recognised gap in leadership around GAU and increased activity has been highlighted and is being addressed as part of the safe staffing review 2022/23. The environment requires upgrading and a capital programme is in development to address this.

Action: The appointment of a patient experience lead for the children's team has allowed for improved information and timely feedback thus allowing improvements to be made.

Action: Maternity service have redesigned maternity triage to provide an improved experience and confidentiality. Antenatal clinic has also undergone a significant number of changes in response to the feedback from women regarding long delays. The induction process and communication around this has been strengthened with partner sleep over facilities made available to support women.

3.5 The Parliamentary Health Service Ombudsman (PHSO)

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1st April 2022 to 31st March 2023 there were 4 cases referred to the PHSO; 1 was not upheld and 3 are ongoing. During this period, the PHSO sent final reports for 3 cases which were opened prior to April 2022 and the outcome of these were that 1 was not upheld and 2 were partly upheld. In addition, there was 1 other case opened prior to April 2022 which the PHSO closed as premature (Trust to undertake further local resolution). There are a further 2 cases referred to the PHSO prior to April 2022 which are still under investigation by the PHSO, and a final decision is yet to be reached. Also, during this period a further 2 cases have been referred to the PHSO which are being actioned through the PHSO's local dispute resolution process; 1 has been resolved, 1 is ongoing with a view to a meeting date is to be arranged.

3.6 Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2022/23 a total of 2,664 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. There has been an increase in the number of compliments received this year by 574. Departments are being encouraged to actively log compliments on the Datix system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions.

3.7 Involvement services

Our Patient Experience and Involvement Strategy is centred on engaging with people who use our services by providing opportunities to share their views, identify areas for change and shape our services. Our overall ambition is to deliver excellent care through promoting positive patient experiences, improving outcomes and reducing harm. Involvement has gone from strength to strength over the last year with more collaborative workstreams than ever before.

Patient forums help us to learn and engage with our service users. They give us the opportunity to understand the experience felt by our patients and actively work together to ensure the pathways and services are designed to meet expectations.

Through our patient forums many improvements and developments have been made:

- Ward Activity Boxes
- Policy for Registered Assistance Dogs
- Reasonable Adjustments via the Harris Flex system
- Patient contribution to case notes document (PCCN)
- Multi Faith Boxes on all wards
- Lancashire Eye Centre
- Signage

- Patient Information Leaflets
- The design of the new Renal Centres
- The Hospital Passport
- The Multi-Faith Guidebook

Created in Carers week June 2021, we have a well established Carers forum, which is run in collaboration with the Lancashire Carers Service. The forum is designed for carers who use services throughout Lancashire and South Cumbria. Attendees are also Carers UK, Age Concern, NW Disability Equality, Alzheimer UK and chairs representing the North West Ambulance Service (NWAS), NCompass and the V.I forum. The purpose of the group is to work with Carers, listen to experiences that are gained through using the hospital, the wider NHS and council/community services throughout the region. Since it's beginning the group have redesigned and contributed to services in the following areas:

- The Carers Charter, Carers Lanyard and the Essential Carers Guide.
- Discharge process and inclusion of the Carers Role in all activities.
- Inpatient Physiotherapy processes.

They have also provided feedback and support many projects:

- Talking Table Project
- NWAS transport facilities
- Hospital Passports
- Hospital Mealtimes

4. National Surveys

4.1 Maternity Survey 2022

Lancashire Teaching Hospitals NHS Foundation Trust is ranked 19th out of 65 Trusts in 2022 surveyed by Picker. This is compared to the 2021 survey, where the Trust was ranked 11th out of the 66 Trusts surveyed. The response rate to the Maternity survey of 44% was lower than the national average of 48%.

There were no areas identified where the Trust was significantly worse than the 2021 survey.

There were 2 areas identified where the Trust was significantly better than the 2021 survey:

- Partner/companion involved (during labour and birth) – 95% compared to 86% in the 2021 survey.
- Found partner was able to stay with them as long as they wanted (in hospital after birth) – 94% compared to 36% in 2021.

We were significantly better that the national Picker average on the following five questions:

- Offered a choice of where to have baby – 93% compared to Picker average of 81%.
- Partner/companion involved (during labour and birth) – 95% compared to Picker average of 91%.
- Found partner was able to stay with them as long as they wanted (in hospital after birth) – 94% compared to Picker average of 41%.
- Involved enough in decisions about their care – 96% compared to Picker average of 92%.
- Not left alone when worried (during labour and birth) – 82% compared to Picker average of 73%.

We were significantly worse that the national Picker average on the following two questions:

- Provided with relevant information about feeding their baby – 73% compared to Picker average of 82%.
- Given information/advice on risks of induced labour – 47% compared to Picker average of 64%

Overall, the results for our Trust showed:

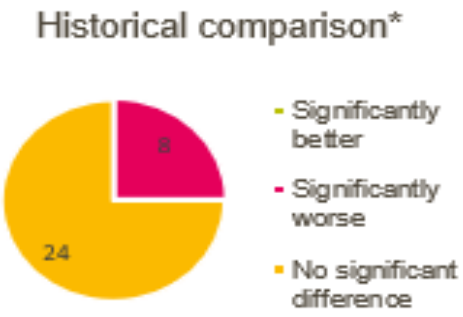
- 97% treated with respect and dignity (during labour and birth)
- 95% had confidence and trust in staff (during labour and birth)
- 95% involved enough in decisions about their care (during labour and birth)

4.2 Emergency and Urgent Care survey 2022 (this remains embargoed)

It is a requirement that CQC Surveys are undertaken in a uniformed way to allow national comparisons. Picker administered 62 UK organizations to undertake the Urgent and Emergency Care Survey 2022. The Type 1 survey is based on a sample of patients who attended the Emergency Department between 7th November 2021 and 10th March 2022 inclusive. A total of 1250 patients from Lancashire Teaching Hospitals were sent a questionnaire. 1207 patients were eligible for the survey, of which 301 returned a completed questionnaire, giving a response rate of 25%, a decrease of 13% from the 2020 survey. The average response rate for the 62 'Picker' Trusts in 2022 was 22%. It should be noted that nationally overall there has been a decrease in response across most organisations surveyed.

Have we improved since the 2020 Type 1 survey?

A total of 59 questions were used in the 2022 Type 1 survey, of these 33 can be compared historically to questions in 2020. Compared to the 2020 survey, Lancashire Teaching Hospitals has achieved a positive score change and is ranked 18th out of the 62 Trusts surveyed, compared to 34th out of the 66 Trusts in 2020.



Significantly better than the last survey

There were no areas identified where the Trust was significantly better for any of the questions than the last survey.

Significantly worse than the last survey on the following 8 questions

1. Waited under four hours in A&E to speak to a doctor/nurse – 91%, compared to 97% in 2020
2. Informed how long would need to wait – 21%, compared to 47% in 2020

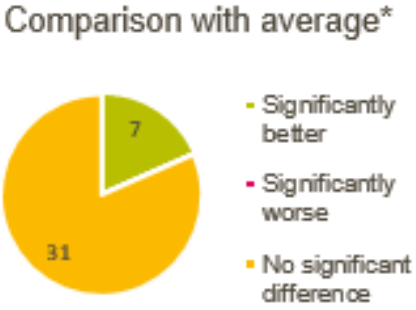
3. Understood results of tests – 83%, compared to 99% in 2020
4. Staff helped control pain – 81%, compared to 90% in 2020
5. A&E department was very or fairly clean – 95%, compared to 98% in 2020
6. Did not feel threatened by other patients or visitors – 91%, compared to 96% in 2020

7. Staff discussed transport arrangements before leaving A&E – 47%, compared to 61% in 2020
8. Rated experience as 7/10 or more – 75%, compared to 88% in 2020

Overall

- 75% rated care as 7/10 or more
- 95% treated with respect and dignity
- 93% doctors and nurses listened to patient

How do we compare to other Trusts?



Significantly better than the Picker average on the following 7 questions

1. Enough privacy when discussing condition - 91%, compared to the average of 87%
2. Waited under an hour in A&E to speak to a doctor/nurse - 86%, compared to the average of 71%
3. Waited under four hours to be examined by a doctor/nurse – 91%, compared to the average of 85%
4. Able to get help whilst waiting – 56%, compared to the average of 46%
5. Able to get suitable food or drink – 73%, compared to the average of 64%
6. Staff discussed the need for further health/social care after leaving A&E – 81%, compared to the average of 70%
7. Expected care and support available after leaving A&E – 78%, compared to the average of 68%

Significantly worse than the Picker average on the following question

There were no areas identified that were significantly worse for any of the questions compared to other Trusts.

Views from survey about the Trust as a whole	2020	2022
Overall: rated experience as 7/10 or more	88%	75%
Overall: treated with respect or dignity	97%	95%
Doctors: had confidence and trust	95%	93%
Trust Top 5 Scores (compared to Picker average)	**Trust**	**Picker Avg**
1. Waited under an hour in A&E to speak to a doctor/nurse	86%	71%

2. Staff discussed need for further health/social care after leaving A&E	81%	70%
3. Expected care and support available after leaving A&E	78%	68%
4. Able to get help whilst waiting	56%	46%
5. Able to get suitable food or drink	73%	64%
Trust Bottom 5 scores (compared to average)	**Trust**	**Picker Avg**
1. Enough information to care for condition at home	77%	80%
2. Informed how long would need to wait	21%	24%
3. Understood explanation of condition and treatment	89%	91%
4. Understood results of tests	83%	86%
5. Family/friend/carer able to talk to health professional	84%	86%
Trust Most improved from 2018 Survey	**2020**	**2022**
1. Staff discussed need for further health/social care after leaving A&E	75%	81%
2. Told side-effects of medications	52%	56%
3. Told about symptoms to look for	72%	74%
4. Able t get suitable food or drink	72%	73%
5. Doctors/nurses didn't talk in front of patients as if they weren't there	84%	85%
Trust Least improved from 2018 survey	**2020**	**2022**
1. Informed how long would need to wait	47%	21%
2. Understood results of tests	99%	83%
3. Staff discussed transport arrangements before leaving A&E	61%	47%
4. Rated experience as 7/10 or more	88%	75%
5. Able to get help whilst waiting	66%	56%

4.3 Cancer Services

The 2021 National Cancer Patient Experience survey (NCPES) involved all adult patients confirmed with a primary diagnosis of cancer who were discharged from an inpatient episode or day case attendance for cancer related treatment during the period of April - June 2021. The fieldwork was undertaken during period of October 2021 - February 2022.

The survey is designed to:

- Monitor national progress on cancer care,
- Provide information to drive local quality improvements,
- Assist providers and to inform the work of the various stakeholders supporting cancer patients,
- Understand what patients think about their cancer care.

The survey reflects the views of 1,233 patients with a response rate of 56%, which is lower than the previous year response of 65% but just above the national rate of 55%. Most of the respondents completed the survey by paper and were white British aged over 55. Only 3% of respondents were from an ethnic minority

background. The distribution between male and females' responses were almost equal and responses from males were more positive overall.

LTH areas of good practice with teams achieving 100% score:

- The patient has a main contact - Upper Gastro-Intestinal (UGI) team.
- The patient found advice from their main contact very helpful - Head & Neck (H&N) and UGI teams.
- Review of care plans with patients - all teams except Gynae team
- The patient received all the information about diagnostic tests - Gynae team.
- Patients receiving easily understandable information - H&N team (all other teams scored well)
- The patient was given information regarding side effects - UGI team.
- Patients were given enough information regarding radiotherapy - H&N and Colorectal teams.
- Information given regarding progress with radiotherapy treatment - Colorectal team.

LTH areas to improve care.

- To improve information regarding referral particularly with the lung and gynae pathways
- Finding out the patient has cancer in lung and gynae pathways.
- Discussing treatment options
- Supporting information for families and loved ones on how to care for patient at home.
- Respect and dignity whilst an inpatient
- UGI and Prostate scores were lower regarding inpatient care.

The positive results of the survey and many positive patient comments regarding the care of cancer patients at Lancashire Teaching Hospitals cancer centre show the dedication and effort of our staff to provide a highly specialised service with patient care at the centre of our work.

4.4 Children's and Young People

There have not been any picker survey results in this reporting period for Children and Young People but is due in June 2023.

5. Financial implications

None.

6. Legal implications

None.

7. Risks

Inpatient experience is the most significant area within the organisation that requires improvement. This is predominantly as a result of flow and communication. Both topics have strategies aimed at resolving the challenges.

8. Closing year 1, moving into year 2

The strategy identifies the actions that will be taken in year 2, however a number of year 1 strategies will be carried over to be delivered also. From the year 1 strategy the delivery of a training package for leaders to understand local resolution, concerns and complaints will be commenced. The revitalisation in regard to PCCN, bedside handovers and CARING will be a key focus of delivery. The continued work and expansion of forums to be used to influence Trust policy, pathways across the organisation with be a key driver in change and delivery.

The impact of the patient safety as partners will be evident as they will sit on a number of meetings and will support in the delivery of the Always Safety first strategy. Alongside this progress with the volunteers and expansion of them in recommended areas or pathways will be progressed.

The continued focus on end of life care delivery and cancer care will be a further developed using the cancer forum as support. A focus on MPACE project alongside McMillan will be delivered.

The continued socialisation of the patient voice through the use of patient case studies in appropriate meetings alongside the recording of patient pod casts so that families stories can be heard, will enable valuable learning.

9. Equality, Diversity, and Inclusion

The Equality, Diversity and Inclusion strategy is the golden thread that runs through the Patient Experience and Involvement Strategy. It is vitally important that as part of this strategy we are always consciously inclusive in everything we do. As part of being wholly inclusive and diverse we need to ensure we gather as much patient voice from those who are hard to reach, so a real focus on those with protected characteristics alongside those in deprivation using the core20plus5 as a guiding strategy.

The requirement to understand experience by protected characteristic and deprivation is not yet available easily and will form a large part of the focus on data for year 2 of the strategy.

10. Conclusion

The continued drive to engage and listen to our patients and work in partnership in regard to their lived experience is clearly evident. There is evidence of increased engagement this year as the organisation recovers from the pandemic. A reduction in complaints, increased friends and family recommendations and increase in improvement work aims to continue to address feedback received from patients and families and in year 2 improvements will be prioritised around the emergency pathways across all specialties.

11. Recommendations

It is recommended the Board of Directors:

i. Receives the report and discusses the content.
ii. Notes the update on year one Patient Experience and Involvement Strategy 2022-2023

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust







Patient Experience and Involvement Strategy
2022–2025

Excellent care with compassion

Always Safety First

@LancsHospitals

Contents

Patient Experience is everybody's business

Foreword

"Patients and their carers are our best witnesses of healthcare. Being centre of the healthcare process, unlike most staff, they observe almost the whole process of care, meaning that they can provide invaluable insights into the quality and delivery of care provision. An evidence-based approach to patient experience can help improve services for both patients, and those delivering services" (Health Foundation 2013).

At Lancashire Teaching Hospitals NHS Foundation Trust, we understand that improving the experience for patients and their carers, our staff and our partners is fundamental to everything that we do. As we launch our second Patient Experience and Involvement strategy, we have reviewed the evidence base for improving patient experience and engaged with our patients, families, carers, colleagues, and governors as our strongest partners to co-produce our vision, strategy and implementation plan to continually improve our patients experience.

In developing this strategy our teams have reviewed the Patient Experience Improvement Framework (NHS England, 2018), an evidence-based organisational development tool that gives Trusts a framework to assess their current approaches to experience of care. This framework uses the areas of leadership, culture, collecting data, triangulating data, learning for improvement and reporting to inform the development of Patient Experience strategies and delivery plans to cover all aspects of experience of care from patients, families and carers as well as staff.

We understand that during the Covid-19 pandemic improving patient experience was difficult for healthcare organisations, especially during times when visitors were not permitted. As we launch this strategy, we commit to maximising improvements in patient experience. By working together, we can build on our compassionate culture, recognising the connectivity between staff and patient experience and nurture the conditions required for continuous improvement in patient experience to flourish.

People's lived experience is a powerful tool to improve existing services and identify new and better ways to meet their needs (King's Fund, 2022). We will listen and learn from the local communities that we serve in a variety of different ways moving forward. Through this strategy we commit to using the insights and intelligence from our extensive sources of data from local Healthwatch teams to large scale national patient surveys, citizen assemblies and service user stories to co-produce our improvements.

We also commit to learning from the best as we further involve our patients and local communities. Co-production is a meeting of minds coming together to find shared solutions. From the launch of this strategy, we will involve people who use our services not only in consultations but through working together from the start to the end of any project that affects them, we will co-produce better solutions and services together. "When co-production works best, people who use services and their carers are valued by organisations as equal partners, can share power and have influence over decisions made" (King's Fund 2022) and this is our commitment to the communities we serve.

Through this strategy and implementation plan we will also embed patient experience into our improvement programmes at every level and will co-produce and deliver an ambitious patient experience improvement programme, aiming to learn from global leaders in this field.

We thank our patients, local communities, staff, partners and governors who have been involved in the development of this strategy and look forward to working with you as equal partners to deliver this strategy.

Sarah Cullen
Nursing, Midwifery & AHP Director

Kevin McGee
Chief Executive

Prof. Paul o'Neill
Acting Chairman

Dr. Gerry Skailes
Medical Director

Strategy overview

Our three year strategy (2022-2025) is designed around our Trust ambition to Consistently Deliver Excellent Care for our patients and describes the Lancashire Teaching Hospitals ambition to deliver a positive patient experience delivered in partnership, whilst improving outcomes and reducing harm, getting it right first time and ensuring a safe, caring environment.

Developing the strategy

Our previous Patient Experience and Involvement Strategy ended in March 2022. Continuing the work, we have focused on listening and learning, whilst setting a vision for our new Patient Experience and Involvement Strategy 2022-2025. We asked patients, relatives, carers, colleagues, governors, and partner organisations to contribute to setting the actions in the strategy. We have actively sought the views from patient groups who represent those with protected characteristics and recognise the importance of intersectionality when considering this feedback. We have also used intelligence and insight from patient feedback, national patient surveys, friends and family tests, complaints, concerns and compliments and Care Quality Commission (CQC) reports to inform our actions. We will continue to work in partnership with these forums to review progress and constantly look for ways to improve and involve patients in any changes we make to our services.

We understand that patient experience has been impacted upon by the COVID-19 pandemic and this has potentially changed what good patient experience feels and looks like whilst also changing some of the processes and ways of working in clinical environments. Whilst challenging, this brings an opportunity to reshape what good looks like in the 'living with Covid-19' world.

We have learned from our feedback that whilst we often get things right for our patients, further improvements are required to ensure consistency across pathways of care and coordinated compassionate care in all of our services.

The Patient Experience and Involvement Strategy is closely linked to a number of our Trust strategies including our Equality, Diversity and Inclusion strategy, our Workforce Strategy, our Mental Health and Dementia Strategy and also our Safety Strategy, Always Safety First. We know that patients and families often identify risks and if listened to, this provides an opportunity to avoid harm in healthcare settings. This is an important part of our strategy and aligns closely to the Always Safety First Strategy.

We also know the environment where care is provided has a significant impact on experience. Lancashire Teaching Hospitals is part of the New Hospitals Programme nationally. This recognises the age of the estate and the limitations this presents in upgrading estate work. However, our patients tell us that cleanliness is one of the most important features and we will strive, particularly where the estate remains challenging to ensure cleanliness is prioritised.

It is important to us that our staff feel proud of the care they deliver and would recommend the organisation as a place to work and a place to receive care. These principles should be seen as golden threads throughout the strategy.

Defining our approach to patient experience

NHS Improvement published a patient experience improvement framework in June 2018 which identified the following consistent themes which have been incorporated into the framework to support self-assessment at an organisational level. The self-assessment will be undertaken in partnership with our patients to provide a baseline measure.

Theme	Key elements that impact on patient experience
Leadership	• Where all the workforce and stakeholders were aware of and worked with an organisation strategy with an explicit patient safety focus, this reflected services that were well designed to meet the needs of patients. • Where staff were proud of the organisation and engagement in quality improvement and the strategy were strong, this was reflected in excellent interactions between staff and patients and between staff themselves. • Visible and accessible leadership sets the tone for the staff. • Where the board heard a patient story at every meeting the executive and non-executive directors appeared to have an understanding of patients' experiences.
Organisational Culture	• An open and transparent organisational culture has a positive impact on staff and patients. • Where there were highly encouraged and evident innovation and quality improvement programmes, there was also a notable improvement in the patient experience. • Where there is a culture of all staff groups showing pride in their work and in being part of the organisation, this seemed to lead to a real commitment to learn from mistakes. • Where staff were proud of their organisation as a place to work and spoke highly of the culture coupled with consistently high levels of constructive engagement, staff at all levels were keen to contribute to service improvement which led to a positive patient experience. • Patients also have a positive experience where there is a culture of safety across an organisation that puts the patient first and gives patient experience the highest priority with the implementation of real-time patient feedback.
Compassionate Care	• Patient experience is positive when staff give care that is compassionate, involves patients in decision-making and provides them with good emotional support. • Patient experience was enhanced when staff ensured there was time for patients to ask questions, when people using the services were treated as individuals and their specific emotional needs considered, including their cultural, emotional and social needs. • Patients and public voice should be heard through a number of sources including the council of governors feeding information into the trust, with clear processes for feedback. • Where staff created a strong, visible, person-centred culture, they were highly motivated and inspired to offer the best possible care to patients. • The appointment of a head of patient experience indicated organisational commitment to this aspect of quality. • Patient experience was positive when patients and their families felt involved and understood what to expect in relation to their care. Patient experience was improved where staff treated patients with dignity and respect at all times.

Safe Staffing Levels	• Nurse staffing levels appear to be a decisive factor in good patient experience. • When escalation processes were well defined and embedded throughout the organisation to ensure safe staffing this appeared to link to a positive patient experience. Staff did not appear to feel the burden of nurse vacancies when staffing levels and skill mix were planned, implemented and reviewed to keep patients safe at all times. • A strong culture of shared ownership for patients, along with effective multidisciplinary working, had a direct impact on patient and staff experience. • Effective multidisciplinary working secured good outcomes and seamless care. Where a multidisciplinary approach was actively encouraged there were examples of co-ordinated care having a positive impact on patient experience. When staff in all disciplines worked well together for the benefit of patients, patient experience was positive, and this correlated with Friends and Family Test and the staff survey
Consistent Incident Reporting and learning lessons	• Where there was a strong 'just'* culture staff felt empowered to report incidents and recognised the importance of reporting them to ensure patient safety. • Patients had a positive experience even when complaining as long as complaints were responded to in a timely and appropriate manner. This usually resulted from in a conversation with the patient and being open about the incident. In these cases the Duty of Candour was followed and trust processes were open and transparent for patients, families and carers. • Where there was a wide range of data to monitor and measure clinical outcome this was related to a positive patient experience, assurance provided at board level and an Outstanding-rated organisation. • Where there was effective governance and assurance the board had clear oversight of the risks affecting the quality, experience, and safety of care for patients.

Source: Adapted from the NHS Improvement Patient Experience Framework
*This has been updated from the self assessment of the framework to reflect the latest work on just culture.

Coproduction - a new way of working (King's Fund 2022)

Coproduction outlines a different way of working in which the relationship between patients and local communities who use our services changes from basic engagement or consultation to a more meaningful form of involvement with a more equitable level of power between partners. Within this strategy we make a commitment to work in partnership with our patients, their carers, staff, governors and wider partners to coproduce the service improvements that will deliver improvements in patient experience on an equal footing. Working together we will design and deliver a comprehensive patient experience programme.

Our patients' experience is also a key component of quality improvement, where patient feedback can identify areas that need improving and how they could be improved. There is a strong link between people having positive experiences of care and other aspects of quality, including clinical effectiveness and patient safety *(Doyle et al 2013)*.

Measuring Impact

The Health Foundation have undertaken an evidence scan focused on measuring patient experience which included a review of 328 empirical studies.

Strategies for measuring patient experience can be viewed along a continuum, from those that collect detailed descriptive feedback to those that collate numerical data. The measurement plan for this strategy will include both quantitative and qualitative data.

The Strategy

The strategy has been divided into three sections:

(i) **Insight**: Improve our understanding of patient experience and involvement by listening and drawing insight from multiple sources of information.

(ii) **Involvement**: Equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.

(iii) **Improvement**: Design and support improvement programmes that deliver effective and sustainable change.

Through this strategy we recognise the opportunity to shape a culture that is more sensitive to listening and acting on feedback that is consciously inclusive, individualised and sensitive to the needs of the patient and family. By doing this we aim to change the way services are delivered to design out the health inequalities in our systems and processes.

Our ambition is to better and consciously meet the needs of people, who due to protected characteristics are more likely to incur negative experiences.

Key enablers and stakeholders are identified within the strategy, specifically creating the infrastructure for improving patient experience. The successful delivery of this strategy is underpinned by culture, leadership, engagement and education programmes of work. These programmes of work will be supported by robust data analysis at patient group level to ensure we are able to listen and act more effectively.

Measurement Strategy

We will have a suite of outcome measures that will enable us to measure success and these are aligned to Our Big Plan. The improvement measures are identified within the insight section of the strategy and include:

- Reduction in complaints
- Improved recommendations via Friends and Family test
- Increased responses to Friends and Family test
- Increased compliments
- Improved outcomes in National patient surveys
- Improved response times to concerns and complaints
- Reduced number of 2nd complaints
- Increased evidence of patient co-production
- Improved training metrics in communication, customer care and early resolution

Our Big Plan strategy

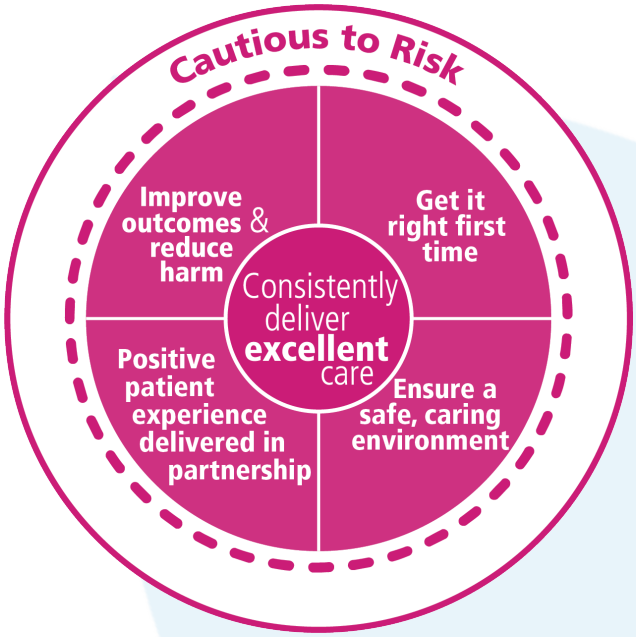
Alignment to Trust objectives

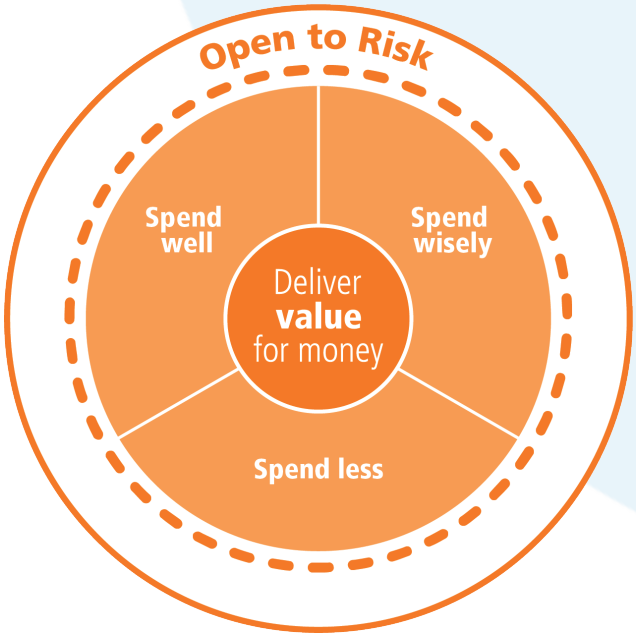
The objectives defined in this plan are framed on the Trust's core objectives which are:

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

These objectives are translated into key deliverables founded on four ambitions:

Our three year strategy (2022-2025) is designed around our Trust ambition to Consistently Deliver Excellent Care for our patients and describes the Lancashire Teaching Hospitals ambition to deliver a positive patient experience delivered in partnership, whilst improving outcomes and reducing harm, getting it right first time and ensuring a safe, caring environment. However, patient experience is reliant on each of the ambitions within our big plan and as such the strategy should be read alongside Our Big plan and supporting strategies.





How our patients will see and feel our values in action

At Lancashire Teaching Hospitals our values set out the behaviours we expect our staff to show to one another when caring for you as one of our patients. Our values are at the very centre of what we all do and define who we are both as individuals and as an organisation.

Our values are more than just words, they are the bedrock of our organisation and should remain constant in every situation. We seek to live by our values so we can create a positive, trusting, supportive atmosphere enabling us to always deliver an exceptional quality of care. We have high standards for our staff, we believe that we should always act with professionalism, integrity, compassion, empathy, understanding, showing dignity and respect to staff, patients and families from all groups or backgrounds.

We hope as a patient or relative you will be able to see us live the values in how we communicate, behave, work and care, we would want them to be apparent in every interaction we have with you.

The five core values we live by are;

Being Caring and Compassionate

To demonstrate we are working in line with this value we will:

- Use every opportunity to show care and compassion
- Have 'I'm here to help' frame of mind
- Try to understand what it is like to be in your shoes
- Be honest
- Give you the time and opportunity to express how you feel
- Take action to help make things better
- Provide you with information as a way of reducing the fear of the unknown
- Provide feedback to explain what has happened if things go wrong
- Be welcoming and friendly at all times

Recognising Individuality

To demonstrate we are working in line with this value we will:

- Listen to you in order to understand your views
- Ask you how you feel about your treatment
- Seek to understand your needs so we can provide you with the most appropriate care or service
- Check that you understand what we have said and provide you with a more simple explanation if need be
- Be self aware, understanding the impact our behaviour has on you and your relatives
- Try to understand your feelings and identify what we can do to assist you
- Give feedback in a sensitive yet constructive manner
- Be respectful of all

Seeking to Involve

To demonstrate we are working in line with this value we will:

- Ask you for your opinion, making you feel equal in any conversation
- Address you and not talk in front of you as though you are not there
- Use a communication style that emphasises listening over lecturing
- Seek to involve other colleagues, in order to provide you with the right level of expertise and determine what approach would be the best for you
- Give thanks and value all contributions regardless of who makes it
- Offer to get involved rather than waiting to be asked
- Explain why, so you can understand the reasons for the decision and what it means for you
- Offer guidance when complex choices have to be made

Building Team Spirit

To demonstrate we are working in line with this value we will:

- Work as one joined up team towards a common goal – providing you with high quality care
- Do what it takes to provide a high quality service by stepping outside of our 'normal' job roles if necessary to smooth out problem areas
- Take a shared approach to your care by effectively communicating across the team, ensuring colleagues have the information they need to understand your situation and to prevent you from having to repeat information
- Make use of each others' strengths, using colleagues' skills and knowledge to provide the best possible service
- All work to the same standards providing a seamless service regardless of the situation, time of day and who is involved
- Be courteous and polite
- Challenge colleagues in an appropriate manner if standards are not being met or values are not being 'lived'
- Use tact and tolerance when dealing with others

Taking Personal Responsibility

To demonstrate we are working in line with this value we will:

- Welcome constructive feedback then take steps to make changes in line with the feedback received
- Reflect on our own behaviour/performance identifying what could be improved
- Take a problem solving approach to challenges, issues or difficulties
- Propose solutions to resolve problems or processes that are not working
- Take issues on as they arise, rather than pretending we haven't noticed them in the hope someone else will sort it out
- Recognise that each of us is responsible for our own deeds, actions and language used
- Apologise for mistakes made and seek to put things right
- Be concerned when things are 'not right'

Delivering the Plan

The Patient Experience and Involvement Group, a sub-committee of the Safety and Quality Committee will oversee the implementation of this strategy, the committee will focus on the three major areas of work: insights, involvement and improvement.

This committee is made up of patients, carers, patient and carer groups, governors and staff colleagues and has a flattened hierarchy of team members to optimise our data and experience driven intelligence to identify the improvement priorities ('insights'),further improving the involvement of our patients, staff and stakeholders in designing the improvements required ('involvement') and overseeing the design, testing, implementation and monitoring of our improvement programmes ('improvement').

The deliverables outlined in this strategy will be delivered through the Patient Experience and Involvement sub-committee and monitored by the Trust Safety and Quality Committee, the committee will use the intelligence created through the subcommittee to inform future priorities of 'Our Big Plan'.

Progress will be monitored through a Patient experience dashboard, which will be developed. Progress will be reported via an annual report to the Safety and Quality Committee.

The Safety Triangulation Accreditation (STAR) Programme will be a key vehicle to test the deliverables of the strategy in action from ward to board and reported to Safety and Quality Committee and Board.

The strategy is applicable to all areas of the organisation including inpatient, outpatient, community and satellite services, adult,children and young people, maternity, intensive care and rehabilitation services.

The action plan will be reviewed quarterly to ensure delivery continues to remain on track and to ensure it continues to fully align with the Trust's Big Plan

The strategy will be considered as a fundamental strategy of the organisation and will evolve each year, considering broader learning elicited through other strategies across the organisation.

Our clinical and corporate teams will work together to implement this strategy. Each team will have a clearly defined role in supporting improvements in patient experience.

The 3 Year Patient Experience and Involvement implementation Plan

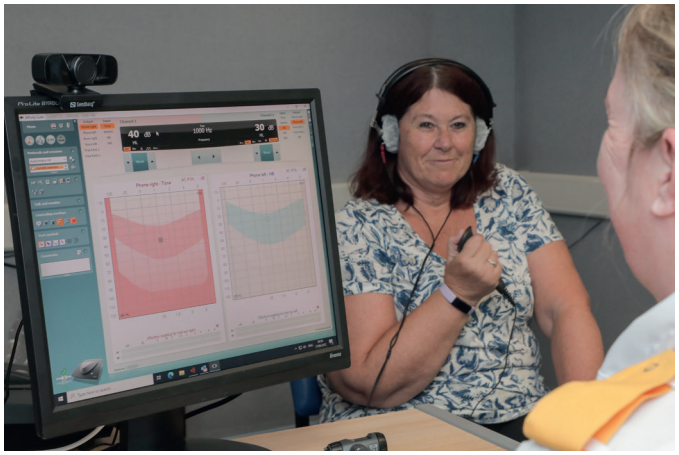
1. INSIGHT	**AIM:** *Improve our understanding of patient experience and involvement by listening and drawing insight from multiple sources of information.*

We will adopt and promote key patient experience measurement principles and use culture metrics to better understand how good patient experience is by:.

- Having an emphasis on continual feedback from patients, families and carers and measurement for improvement.
- Listening to patients
- Identify opportunities for improvement based on real feedback and act on these responsively

Year 1	Year 2	Year 3
Driving improvement We will create a dashboard of patient experience and involvement measures. Initiate key programmes of work and define reporting and monitoring arrangements for programmes of work. The dashboard will triangulate feedback sources e.g., themes from complaints, Friends and Family test, patient surveys to keep focus on our key areas of improvement.	**Driving improvement** We will use intelligence from the patient experience and involvement committee to inform improvement priorities for MCA.	**Driving improvement** We will review and refine the approach. We will deliver the improvement programme identified at the end of year 2.
Defining key programmes of work We will define key improvement (top 5 programmes of work) and initiate Plan-Do-Study-Act (PDSA) cycles on leading patient experience programmes of work.	**Defining key programmes of work** We will evaluate outcome of the PDSA methodology, refine and apply to next set of key programmes of work. We will establish a way to capture live feedback that enables services to be more responsive.	**Defining key programmes of work** We will design an improvement programme focused on leveling up the clinical areas to the level of the best.
Patient experience equality, diversity and inclusion We will mandate collection of each protected characteristic to enable the analysis of inequalities and patient experience processes, functions and outcomes. We will organise reports within the organisation to enable teams to review data through the eyes of people with protected characteristics developing a road map for year 2.	**Patient experience equality, diversity and inclusion** Based on a year 1 of analysis, we will identify key priorities within each area based on protected characteristic data. We will expand the definition of protected characteristics to include Indices of multiple deprivation analysis.	**Patient experience equality, diversity and inclusion** We will demonstrate improvements in identified areas of inequalities based on year 1 and 2 analysis and programmes of work.
Thematic analysis We will carry out a thematic analysis of patient complaints and concerns to be undertaken in each division, using the outcomes to inform areas of focus to improve patient experience. We will use this to understand gap where there may be an under-representation of feedback, and consider opportunities for feedback in the patient's journey (for example mental health).	**Thematic analysis** We will repeat thematic analysis to identify new themes to address, building the findings into the work programme.	**Thematic analysis** We will repeat thematic analysis to identify new themes to address, building the findings into the work programme.

Year 1	Year 2	Year 3
Friends and family feedback We will ensure all departments are actively participating in friends and family. We will increase the number of ways that patient can provide feedback including paper and other languages and acting upon the responses.	**Friends and family feedback** We will increase by 10% the volume of feedback from Friends and family looking at maximising ways to do this and acting upon the responses.	**Friends and family feedback** We will maintain the increase in friends and family feedback acting upon responses.
Patient experience culture We will establish baseline measurement of patient experience culture triangulating information from surveys, and patient feedback (including information communicated through patient forums).	**Patient experience culture** We will agree how to measure culture in relation to patient experience.	**Patient experience culture** We will repeat and embed learning from the feedback.
Research We will participate in The Health Foundation 'Scale, Spread and Embed' research project coordinated by Imperial College Healthcare NHS Foundation Trust. As a Phase 1 site, we will collaborate and test the use of natural language processing of free text specifically on patient experience feedback.	**Research** We will continue to participate in The Health Foundation 'Scale, Spread and Embed' research project coordinated by Imperial College Healthcare NHS Foundation Trust. In collaboration with the Phase 1 and 2 sites, refine and innovate to develop intelligence and insights provided by the digital advances testing the approach through continuous improvement methodology. We will proactively seek to be involved in research relating to patient experience.	**Research** We will internally develop advances made within the research period to refine and embed the digital advances to support Trust improvement initiatives specifically relating to patient feedback.



Year 1	Year 2	Year 3
National patient experience surveys We will ensure that results of each of the national surveys learning to be presented to Patient Experience and Involvement sub-committee and Safety and Learning Group to broaden opportunity to learn and develop action plans in response.	**National patient experience surveys** We will ensure delivery of the actions agreed in response to the National patient experience surveys.	**National patient experience surveys** We will evaluate the success to date and plan and deliver the work programme for year 3.
We will benchmark national survey and Benchmarking Standard responses to peer organisations to learn from what is working well elsewhere and strive to improve the national ranking position.	We will incorporate learning from peer organisations into Trust action plans and aim to improve the national ranking position.	We will evaluate actions to date and aim to improve the national ranking position to the next best quartile.
Improving patient experience communications We will link with the communications team to ensure that key lessons learned from thematic analysis of patient feedback is cascaded across the organisation and externally.	**Improving patient experience communications** We will develop sources of communication to ensure that learning is far reaching and evaluate the approach.	**Improving patient experience communications** We will re-evaluate lessons learned and modes of communication to continue to reiterate key messages.
We will link with the Always Safety First Committee to ensure that key patient experience themes related to safety are incorporated into the Always Safety First Bulletin and be physically displayed throughout key public areas of the organisation demonstrating a transparent approach to learning from safety within the organisation.	We will ensure that learning from Always Safety First will be evident throughout the organisation, with case studies and teams celebrating the successes of the programmes.	Teams will be supported to gain national recognition for their achievements.
We will ensure that colleague and patient experience feedback is displayed in all areas.	We will evaluate the display of patient experience feedback and improve if and where necessary.	We will continually improve the way that patient feedback is displayed and increase learning from other organisations and external partners.
STAR accreditation We will review the patient experience metrics embedded within the STAR process. We will reintroduce Governors to be involved in the STAR accreditation visits to enable real time patient feedback. We will collate themes and trends from patient experience measures to inform opportunities for improvement. Plans will be monitored.	**STAR accreditation** We will evaluate actions and improvements in response to STAR accreditation visits,. re-evaluate questions and actions agreed.	**STAR accreditation** We will continually learn from thematic analysis from STAR accreditation process to inform actions and learning.
Seldom Heard groups We will define those at highest risk and agree the approach to collecting feedback on what matters to the people in these groups. We will seek new ways to collect insights from groups that are less heard.	**Seldom Heard groups** A programme of improvement work will be created for these groups to spread learning across the organisation.	**Seldom Heard groups** We will build on the new insights and agree year 3 actions with the evolving sources of feedback.
Equality Quality Impact Assessment We will review the policy to ensure EQIA are undertaken in partnership with patients and the results are meaningful and apply to all change projects.	**Equality Quality Impact Assessment** We will develop a mechanism for sharing the outputs of EQIA processes to broaden insight in all divisions on patients views and feelings on change proposals.	**Equality Quality Impact Assessment** We will routinely access patient views and have mechanisms in place in all divisions to do so in an inclusive way.

2. INVOLVEMENT	**AIM:** *Equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.*

We will commit to nurture a culture in our organisation where all teams are focused on creating a positive experience for each other and our patients:

- Plan and deliver people's care and treatment with them, including what is important and matters to them.
- Work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.
- Treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
- Listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

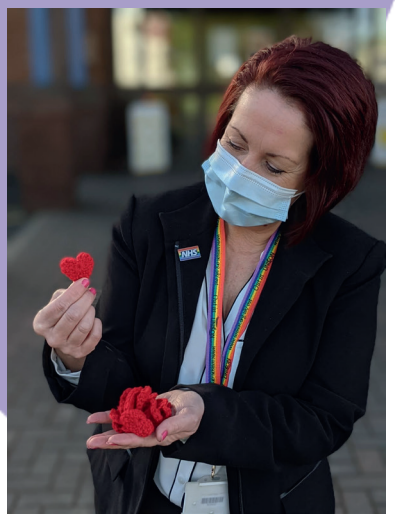
Year 1	Year 2	Year 3
Patients, carers, families and lay people as partners in safety We will align with the Always Safety First strategy and recruit to the role of Patient Safety Partners (PSP) representative of the community we serve. We will ensure that the PSP will reflect the diversity of the community we serve.	**Patients, carers, families and lay people as partners in safety** We will take feedback from the PSP to review the Always Strategy First year 1 and ensure year 2 reflects the areas that are important to them.	**Patients, carers, families and lay people as partners in safety** We will evaluate the PSP role and identify priorities for delivery in year 3.
The PSP will join the Always Safety First subcommittee and participate in the evaluation of evidence and design of solutions focusing on what matters to patients. We will recruit a senior midwifery advocate.	We will create a network of advocates and Patient safety Partners across the organisation to share experiences across specialities.	We will take the learning from year 1 and 2 and agree year 3 with the Patient safety Partners and senior Midwifery advocate.
Leadership We will define the role of leaders within the organisation in relation to patient experience and involvement and working with patients as partners.	**Leadership** We will ensure that Leaders at every level of the organisation will have an objective linked to improving patient experience as part of their annual appraisal.	**Leadership** We will evaluate effectiveness of interventions and activity in year 2 and use to inform year 3 priorities.
We will commit that all clinical areas will identify patient experience and involvement champions. The champions will continue to work with existing mental health , safeguarding and learning disability champions.	Representatives from the champions will be present to share their views at the patient experience and involvement group.	Patient champions will ensure that patient forums are established in their specialties.
We will increase ward leadership in wards greater than 28 beds in recognition of the challenges of managing large clinical areas.	We will commit to evaluating the impact on patient experience and involvement that having 2 leaders on large wards has made.	We will embed the learning from the evaluation once we understand the impact made on experience and involvement having 2 leaders has made.
Patient experience and involvement training We will agree a training programme and hierarchy of training needs.	**Patient experience and involvement training** We will train all clinical and non-clinical department managers as per training requirements.	**Patient experience and involvement training** We will monitor the training plan at departmental level.
We will develop leaders aligned with our Organisational Development programme so that living the values is directly linked to patient experience front and centre in all that we do.	We will showcase leaders who are creating cultures focused on patient experience.	We will continue to showcase leaders who are creating cultures focused on patient experience.

Year 1	Year 2	Year 3
We will develop a training module for leaders to understand the principles of local resolution, concern and complaints and how to respond.	We will achieve training for leaders by 50%. We will ensure this training is implemented and evaluated for effectiveness.	We will further increase training for leaders by 50%. We will continue to embed training and evaluate contribution to improving patient experience during annual appraisal.
Training in co-design will be identified, this will be delivered through FCA and MCA programmes.	All clinical departments will participate in improvement via FCA and MCA and embrace the patient co-design work.	Evaluate the impact of MCA and FCA participation on patient experience.
We will support all staff and students with a booklet about our Involvement services for patients, carers and our community.	We will increase access to this information ensuring colleagues can access the involvement booklet via clinical practitioners, induction, QR codes and our staff intranet.	We will maintain and update the Involvement booklet via our Patient Experience and Involvement team.
We will develop training sessions that have experts by experience co-delivering the training, to ensure learning from the patient, family or carer.	We will continue to develop the training to enhance the skills of our staff to support patients in enhanced levels of care and the use of activity or helpful strategies.	We will provide training in intersectional approach understanding that no one has just one identity and making sure that one identity e.g. a physical disability is not seen as a stand alone issue.
Volunteer involvement We will create a template and single point of contact for volunteers to give feedback on areas that can improve patient experience and involvement.	**Volunteer involvement** We will ensure that this feedback is acted upon and monitored for improvement.	**Volunteer involvement** We will develop the volunteer service via feedback and learning to continue to improve.
We will recruit a core group of volunteers to work with the patient experience team to enhance involvement and promote improvements. We will ensure full representation of the local diverse community to share their views on services and what matters most to them through the Patient Experience Involvement Group and other annual events, such as PRIDE, Windrush etc.	We will enhance volunteer training to enable them to support patient experience projects. We will use the feedback from each event to make a commitment to improve an area based on the feedback received.	We will continue to use feedback from patients/carers to explore and develop projects such as 'Navigation guides' using the volunteer service.
Working in partnership We will refresh the organisations approach to. "Hello my name is". We will ensure that all staff names are visible to patients.	**Working in partnership** We will ensure that "hello my name is" becomes embedded and is assessed via the STAR process.	**Working in partnership** We will continue to promote "Hello my name is". We will continue to assess via STAR process.
We will ask all inpatients what matters to them, and bed boards will be completed holistically and specifically based on the patient's preferences.	We will ensure that this process is embedded using direct feedback and the STAR process.	We will evaluate the use of bedboards.
We will engage with external partners and charities e.g. Galloways, Healthwatch, NCompass and our local Partnership Boards, amongst others via the patient experience and involvement group to be fully inclusive and ensure views and experiences are heard.	We will review membership and continue to check we are fully inclusive and learning.	We will continue to review membership of the involvement group and continue to check we are fully inclusive and learning from lived experiences.

Year 1	Year 2	Year 3
We will agree an approach that engages patients in new developments from their inception. We will continue to promote access to healthcare by events such as 'Our Health Day' for people with a learning disability and / or autism.	We will ensure that patients views are paramount and heard in all change and new developments using a checklist approach.	We will ensure that no new projects can be agreed unless it is evident that patient's views have been sought as part of the scoping work.
We will ensure that holistic assessment of patient's requirements are made and any reasonable adjustment plans are in place where needed.	We will ensure all staff are trained in Reasonable adjustments on internal systems.	We will ensure use of data from reasonable adjustments for clarity on our communities' diverse needs.
We will work in partnership to promote shared decision making between disabled people and health services, utilising the Kings fund publication Partnering for inclusion. https://www.kingsfund.org.uk/sites/default/files/2022-07/Partnering_for_inclusion_easy_read.pdf.	We will ensure all chairs of Trust patient forums report and feed into the Patient Experience and Involvement Group.	We will use new approaches developed through partnering for inclusion to hear more from those less well heard and design improvements fro specific groups.
We will build on current internal patient forums and connect with external partners to make system changes that affect a large number of people most likely to experience inequalities.	We will agree priorities as a system and work with partners across central Lancashire to improve experiences f those most likely to suffer health inequalities.	We will encourage collaboration and promotion of projects beneficial to patients and our communities.
Sharing lived experiences We will use narrative, data and lived experience to frame issues and engage towards a shared purpose with staff, patients and carers to improve learning and effect change in team meetings.	**Sharing lived experiences** We will have evidence examples of learning from sharing lived experiences and provide examples of positive patient experience change as a result.	**Sharing lived experiences** We will share examples of lived experiences as part of learning bulletins and partnership with patients to improve services.
Engaging with faith leaders We will ensure that we listen to what our patients tell us they need in relation to their faith.	**Engaging with faith leaders** We will continue to ensure representation of all faiths and cultures.	**Engaging with faith leaders** We will continue to provide information and education support for all staff in the production of guidebooks around culture and faiths.
We will continue to improve on recognising the needs from patients in all ethnic and religious groups.	We will use STAR to test the availability of faith resources as agreed in our faith forums.	We will continue to research and provide staff with support around any additional religious needs that may be required.
We will ensure that the bereavement boxes are present on every ward and this is tested as part of STAR. We will acknowledge religious events and ensure that these are treated with respect.	We will continue to provide and update the Trust Equality Diversity and Inclusion calendar to share relevant religious dates.	We will enhance our participation in religious events which will be inclusive of more services such as catering and communications.
We will provide the appropriate faith leader (if requested) to work collectively to deliver end-of-life care.	When requested cultures and faiths are respectfully recognised and represented during the patient journey.	Chaplaincy will ensure multi-faith representation is available.

Year 1	Year 2	Year 3
Patient Contribution to Case Notes (PCCN), Forget Me Not, Patient passports We will develop and implement a plan to ensure wards and departments are effectively using tools to enhance patient experience whilst in hospital. We will monitor progress via STAR. We will embed these tools in the role of the clinical area patient experience champions.	**Patient Contribution to Case Notes (PCCN), Forget Me Not, Patient passports** We will evidence increased utilisation of the tools, gathering feedback around their effectiveness.	**Patient Contribution to Case Notes (PCCN), Forget Me Not, Patient passports** We will share examples of the contribution these tools have made to improving patient experience and continue to embed.
Interpreter services We will assess the interpreter services provision for the current service needs to ensure current technology, advice and guidance for staff to access on behalf of patients and their carers.	**Interpreter services** We will evaluate interpreter service provision to ensure it maintains fit for purpose.	**Interpreter services** We will continue to evaluate interpreter service provision. Interpreter services to be commissioned jointly with patients and carers.
We will increase recruitment of volunteers who can use sign language.	We will create a data base for volunteers who can use sign language.	We will continue to recruit volunteers who use British sign language to welcome patients before contracted interpreters are sourced.
We will measure feedback and satisfaction with users of interpreting services.	We will act upon feedback from users of interpreting services.	We will continue to evaluate and act upon feedback as part of quality assurance meetings with providers.
We will carry out thematic review of any incidents/complaints in relation to interpreter services.	We will ensure an action plan is in place to respond to learning from incidents/ complaints regarding interpreter services.	We will ensure actions are embedded in practice and continue to evaluate.
Bedside handovers We will engage with patients to review our process for bedside handovers, updating policy and maintaining confidentiality. We will consider areas that can be used for confidentiality when discussing sensitive matters or when external assessment is being completed (for example mental health).	**Bedside handovers** We will audit the process via STAR.	**Bedside handovers** We will review and re-audit the process.
Transformation programmes We will ensure that patients are involved in co-production of transformation projects ensuring that value-added components of the programmes is intrinsically linked to patients value added.	**Transformation programmes** We will ensure that all transformation programmes have evidence of patient involvement.	**Transformation programmes** We will ensure that all transformation programmes have evidence of patient involvement and co-production.
Making every contact count We will ensure that we take every opportunity to promote healthy lifestyles engaging in opportunities to offer advice and guidance around smoking cessation, reducing alcohol intake and promoting healthy lifestyles.	**Making every contact count** We will capture health promotion information and discussions on Quadramed.	**Making every contact count** We will capture health promotion information and discussions on Quadramed.

Year 1	Year 2	Year 3
Accessible Information Standard We will obtain a baseline of current standards that are met and mitigate any gaps creating an action plan towards making health care information accessible to identify, record, flag, share and meet information and communication support needs of patients, service users, carers and patients with a disability, impairment or sensory loss. https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/	**Accessible Information Standard** We will review annually in order to benchmark current position ensuring actions are being progressed and audit under the responsive Key Line of Enquiry to confirm k compliance with the standard.	**Accessible Information Standard** We will review annually to benchmark current position ensuring actions are being progressed and audit under the responsive Key Line of Enquiry to confirm compliance with the standard.
Patients Key Contacts We will respond to the feedback from patients with chronic or long term conditions who tell us that they value the role of a key worker as a point of contact to help navigate and support decision making. We will review what is working well and set this as our standard and benchmark where there are gaps in this provision.	**Patients Key Contacts** We will ensure that patients who do not have a key worker are informed of who they should contact and work towards improving this provision.	**Patients Key Contacts** We will ensure that patients who do not have a key worker are informed of who they should contact and work towards improving this provision.
Research We will continue to raise the profile of involving patients in research by promoting research studies and explaining why involvement in research is important for overall patient experience.	**Research** We will increase the number of patients involved in research and share stories of what this has meant to them and how this has affected their experience.	**Research** We will promote patient experience at research topics for internal degree and masters research topics and share the outcomes.



3. IMPROVEMENT	**AIM:** *Design and support improvement programmes that deliver effective and sustainable change.*

We will commit to continuously improve the experiences of patients and families in our organisation. We will seek to improve:

- the patient journey from admission, treatment and discharge
- the successful handover of accurate information to reduce duplication and increase confidence in the care patients and families receive.
- waiting and confidential areas for patients and families
- the therapeutic interventions for people in hospital beds

Year 1	Year 2	Year 3
Nutrition and hydration and assistance with meals We will provide food which is inclusive, tailored to patient's needs at the right time, right place and right patient.	**Nutrition and hydration and assistance with meals** We will measure the quality and provision of catering as a thematic review to establish whether actions taken have led to improvements.	**Nutrition and hydration and assistance with meals** We will gather feedback and continue to evaluate the effectiveness of actions taken to improve, identifying and responding to new intelligence.
We will celebrate with inclusive food faith events ensuring this is time sensitive when necessary.	We will improve the rating of food in the national surveys. We will improve the PLACE rating.	We will improve the rating of food in the national surveys. We will improve the PLACE rating.
We will ask you what you want to order and provide you with information so that you can make the right choice for yourself. We will ensure that patients with special requirements have their needs met e.g. such as patients who have Parkinson's and need to eat with medication. This will be tested through STAR. We will ensure all that require support at meal times, receive this and this is tested through STAR.	We will increase the availability of reasonable adjustments to support nutrition and hydration.	We will test the effectiveness of this using experts by experience.
Quality assurance We will agree a process to quality assure the responses to complaints and concerns and implement this process.	**Quality assurance** We will agree a process to quality assure the responses to complaints and concerns and implement this process.	**Quality assurance** We will agree a process to quality assure the responses to complaints and concerns and implement this process.
Maternity & Neonatal Transformation We will ensure that women will not feel alone and will treat them with kindness and respect. This will be measured through the national maternity survey.	**Maternity & Neonatal Transformation** We will utilise national initiatives such as the "15 steps" approach and "Whose Shoes?" to review and improve the care provided and environment it is provided in.	**Maternity & Neonatal Transformation** We will continue to gather feedback and evaluate the effectiveness of actions taken to improve the maternity service.
We will make sure that women have the contact details of their midwife. We will ensure that women are able to make a personalised care and support plan during their pregnancy, for labour and birth and following the birth of their baby.	We will continue to implement new national directives as they emerge and ensure action plans are shared with the Maternity Voices Partnership.	We will continue to implement new national directives as they emerge and ensure action plans are shared with the Maternity Voices Partnership.
We will ensure women can access help and advice and advice about feeding their babies during their care journey.	We will ensure breastfeeding areas will be improved across the organisation and in line with the baby friendly initiative.	We will increase the number of breastfeeding areas will increase. We will increase compliance with baby friendly Initiative (BFI) accreditation.

Year 1	Year 2	Year 3
We will seek to receive feedback in addition to Friends and Family and complaints to understand ways in which our services can improve experience for parents.	We will continue to co-design service improvements. We will upgrade the provision of birthing pools to ensure water births are accessible for all who choose this as a birthing option.	We will continue to co-design service improvements.
We will involve parents in the co-production of neonatal services utilising the "neomates" group to facilitate this.	We will become a neonatal network accredited Family Integrated Care Unit (FiCare).	We will respond to family feedback and focus on improvement in response to their experience
We will ensure partners can stay and support women during antenatal periods on the ward.	We will provide an outdoor space for women in labour that is conducive to the birth process.	We will identify the next area to improve with our Maternity Voices Partnership.
We will improve the facilities and experience for women who experience miscarriage. We will participate and achieve accreditation in standards set to support women who have had a miscarriage.	We will provide an improved baby memorial area. We will provide 7-day bereavement support services.	We will improve the facilities further for women who experience miscarriage.
Children and Young People We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas.	**Children and Young People** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas and monitor.	**Children and Young People** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas and monitor.
We will improve overnight facilities to optimise young people and children's outcomes.	We will improve review feedback on overnight facilities to optimise young people and children's outcomes.	We will review feedback on overnight facilities to optimise young people and children's outcomes.
We will ensure that age-appropriate activities are provided for 16 and 17 year olds being cared for on adult wards.	We will ensure that age-appropriate activities are provided for 16 and 17 year olds being cared for on adult wards.	We will ensure that age-appropriate activities are provided for 16 and 17 year olds being cared for on adult wards.
We will introduce a parent group to gain feedback and promote co-production in service change.	We will agree parent priorities to improve and co design these.	We will continue to work in partnership exploring the needs of looked after children using social care advocates
We will provide a multi-sensory space for children with disabilities at the Broadoaks site.	We will explore the provision of outdoor play for children on each of our sites.	We will implement increases in outdoor play provision.
We will introduce the role of patient experience lead for children to provide additional support across all areas.	We will learn from this and adopt the learning to clinical areas where children are seen in across the organisation.	We will continue to share the learning from the patient experience lead.
We will ensure that children and young people have an appropriate process to raise concerns or make a complaint and we will ensure feedback from the Emotional Health Family and Friends Test is collated and reviewed for learning. We will identify a training plan in relation to play for children's ward and ED.	We will enact the plan and train 50% of the staff in formal play training. We will roll out the process for children to raise a concern to all clinical areas they are seen in the organisation.	We will monitor the impact of the improvements through the national patient and parent surveys.

Year 1	Year 2	Year 3
Estate In recognition of the impact that our estate makes on patient experience we commit to a refurbishment plan for three clinical areas each year. Year 1 . • Gordon Hesling Building entrance – introduction of volunteer support space • Mental health facilities in ED for Children and adults • Create an alternative to hospitals for patients who do not meet the criteria to reside.	**Estate** We will commit to a refurbishment plan for three further clinical areas each year.	**Estate** We will commit to a refurbishment plan for three further clinical areas each year.
Pain management We will focus on improving pain management and test the effectiveness of this through STAR.	**Pain management** We will share learning from areas that manage pain more effectively.	**Pain management** We will see improvements in national audits relating to pain management.
End of life care We will continue to use the end of life Big Room to deliver integrated, collaborative palliative and end of life care and improve patient and carer experience and service outcomes based on principles of respect, dignity and compassion.	**End of life care** We will explore areas to be used for end of life quiet rooms for families.	**End of life care** Provide quiet areas for families of patients at end of life and for bereaved families.
We will define an increased target audience for advanced communication skills training.	We will achieve the target set once the audience is reviewed.	We will extend the number of people training in advanced communication skills.
We will embed the CARING model as our pledge to patients in last days of life and their loved ones.	We will monitor and evaluate CARING through the STAR audit.	We will continue to evaluate the impact of the CARING approach.
We will recruit families who have had experiences of bereavement to work in partnership to improve services.	We will use the national NACEL audit to drive the areas we focus on improving.	We will review and set an improvement goal for each of these in year 3.
We will deliver in partnership a Hospice at Home service to increase the number of patients who are able to die in their preferred place of care.	We will create the case to formally commission hospice at home pending outcome measures supporting hypothesised benefits.	We will deliver in partnership a hospice at home service that meets the need of the local population.
We will ensure bereavement services are available to all who experience loss 7 days per week.	We will ensure bereavement services are available to all who experience loss 7 days per week.	We will ensure bereavement services are available to all who experience loss 7 days per week.
Lost property We will ensure our processes around patient valuables is robust using patient experiences to build on the procedures we have in place.	**Lost property** We will ensure our process is established within all areas and test this using STAR. We will investigate when items are lost and share lessons learned to reduce the occurrence of this.	**Lost property** We will monitor this service regularly and listen to feedback in order to instil confidence from our patients and visitors to the Trust.

Year 1	Year 2	Year 3
Improve facilities for people while they wait We will ensure patients know timescales of any delays in clinical areas.	**Improve facilities for people while they wait** We will ensure details are provided of expected wait times and regularly update this information.	**Improve facilities for people while they wait** We will monitor wait times in clinical areas and adapt time slots if data shows continual trends of long waits.
We will provide comfortable and appropriate seating, that meets the needs of those using it in line with reasonable adjustments. This will be tested through STAR.	We will ensure that areas that experience long waits such as ED will have access to comfortable environments.	We will continue to listen to feedback from our patients and develop services.
Improving patient flow We will engage in improvement programmes via the Urgent and Emergency care transformation board to improve our patient flow throughout the hospital. This will reduce time patients spend in the emergency department and assessment units and ensure that patients time in hospital is value added and reduce waiting for services that will progress the pathway of care. We will ensure that discharge is well coordinated and occurs early in the day.	**Improving patient flow** We will continue to monitor our performance and seek out opportunities to continually improve patient flow, asking patients what matters to them.	**Improving patient flow** We will monitor our outcome measures and seek new ways to maintain progress.
Improve patient experience for those living with dementia We will promote understanding of our dementia community.	**Improve patient experience for those living with dementia** We will ensure all staff complete Dementia training.	**Improve patient experience for those living with dementia** We will continue to educate staff through e-learning packages.
We will ensure purple activity boxes are available to all patients and tested through STAR.	We will ensure purple activity boxes are available to all patients and updated following patient feedback over the year.	We will introduce innovative approaches to managing the experience of patients with dementia.
We will ensure promotion of Dementia champions in all clinical areas. We will ensure this Patient Experience Strategy is in line with the Dementia Strategy and progress monitored in relation to pathways, the Dementia Experience and Empowerment project (DEEP) and co-production with patients living with a dementia and their families and carers.	We will continue to promote the use of Forget Me Not passports. We will report progress on the Mental health and dementia strategy to the safeguarding Board and patient experience group.	We will report progress on the Mental health and dementia strategy to the safeguarding Board and patient experience group.

Year 1	Year 2	Year 3
Improve facilities for patients with a physical disability, autism, learning disability, mental health condition We will continue to promote the use of the Hospital Passport.	**Improve facilities for patients with a physical disability, learning disability, mental health condition** We will ensure a copy of the passport is taken so we can provide specific individualised care.	**Improve facilities for patients with a physical disability, learning disability, mental health condition** We will provide staff with information and updates on sources available through our Patient experience and Involvement team.
We will ensure all reasonable adjustments are recorded on our systems and test the use of this through STAR.	We will collate data so future appointments can be adapted to the requirements of the patient.	We will evidence increased use of reasonable adjustment tab on Quadramed.
We will ensure staff liaise with the Learning Disabilities team for specialist advise.	We will review progress with our partners to agree the next set of actions for blind, visually impaired	We will evidence an increased number of MDT care planning forums take place leading to improved person centred care.
We will continue to provide ward activity boxes for partially sighted or blind communities and test this through STAR.	We will review progress with our partners to agree the next set of actions for blind, visually impaired.	We will review progress with our partners to agree the next set of actions for blind, visually impaired.
We will continue to upgrade estate with hearing adjuncts in line with best practice and ensure we work with local groups to test the impact of our focus on hard of hearing and deaf communities.	We will review progress with our partners to agree the next set of actions for deaf and hard of hearing	We will review progress with our partners to agree the next set of actions for deaf and hard of hearing.
We will engage in the Learning Disability partnership Board and Autism Partnership Board working alongside experts by experience and our multi-agency partners to re-establish a Health sub group.	We will implement the national learning disability and autism strategy.	We will implement the national learning disability and autism strategy.
We will ensure promotion of the Learning Disability Champions and Mental health Champions. We will ensure this Patient Experience Strategy is in line with the Mental Health Strategy, the Learning Disability Plan and Autism Strategy.	We will monitor this through the safeguarding and patient experience and improvement group.	We will monitor this through the safeguarding and patient experience and improvement group.
Cancer care We will introduce a patient experience lead in Radiotherapy with a focus on improving the experience for patients attending for radiotherapy and establish a service user group.	**Cancer care** We will evaluate the impact that the patient experience lead in Radiotherapy with a focus on improving the experience for patients attending for radiotherapy and establish a service user group.	**Cancer care** We will ensure the patient experience lead is embedded in practice.
We will establish a cancer patient listening service to gain live feedback from cancer patients and address issues at the time if possible.	We will explore involvement in addressing the needs and support of service users receiving services from different clinical teams e.g. Buddying in different services and co-facilitating training with Macmillan Engagement Facilitator to build confidence, skills and knowledge.	We will involve patients and volunteers to work alongside the Macmillan assistant manager to work with patients in the community and provide care closer to home.
We will develop a cancer and end of life service user recruitment strategy.	We will continue Service users to be involved with the MPACE project and close working with key Macmillan figures.	We will explore a partnership approach with the third sector to share volunteer opportunities and collaborative working.
We will provide the Hope course using service users to facilitate the course in partnership with third sector partners..	We will continue to implement Service user involvement in all cancer interviews. We will continue to deliver and promote the HOPE courses for patients with cancer.	We will ensure Cancer patient and carers forum increases in membership.

Year 1	Year 2	Year 3
We will develop a work programme for the promotion of service user opportunities.	We will increase the diversity of patients and partners.	We will develop a process for patients as partners to present to the Board of Directors the progress made in this area.
We will develop a virtual forum for patients and carers to link in when they want and to choose which opportunities, they wish to be involved in.	We will continue to recruit service users for the forum and widen recruitment to the forum for diverse range of services users and carers to include BME, LGBTQ, over 75s, working age, disabilities, from all economic backgrounds etc.	We will deliver on the areas determined as priority areas for each protected characteristic group.
We will develop an standard operating procedure. to involve service users in all interviews for cancer staff. We will develop a training package guide for service users to assist in opportunities they can be involved in.	We will evaluate the effectiveness of this approach in partnership with patients.	We will focus on specialities that evaluate less effectively in the national cancer survey.
We will continue Service user involvement with the MPACE project and close working with key Macmillan figures.	We will test the cancer website against the exemplar and agree the next year improvements.	We will celebrate achievements and share the positive areas of practice.
We will continue to work with patients in develop the cancer website.	We will focus on specialities that evaluate less effectively in the national cancer survey	We will continue to focus on specialities that evaluate less effectively in the national cancer survey.
Patient involvement in safe discharge We will commence discharge planning from the time patients are admitted to the hospital	**Patient involvement in safe discharge** We will use discharge improvement work to ensure discharge occurs earlier in the day for patients and families.	**Patient involvement in safe discharge** We will continue to evidence improvement in this area.
We will ensure that discharge needs are clearly documented and shared with partner organisations where consent is given, this will reduce the need for patients and carers to repeat needs and wishes to achieve safe discharge.	We will commit that learning from discharge incidents will be shared and actions agreed.	We will learn from discharge incidents wand this will be shared and actions agreed.
We will review our patient information leaflet and relaunch this so it is shared with all patients to ensure a safe discharge.	We will ensure that the use of the patient information leaflet is tested through STAR.	We will ensure that use of the patient information leaflet will continue to be monitored.
We will introduce live feedback on the discharge process, this will be used to drive improvement in this area. Wards will be tested on this through STAR.	We will use feedback to change process or information shared.	We will build a reporting dashboard that tracks and time stamps discharge process.
We will continue to plan ahead for discharges and ensure where possible discharge letter and take-home medication is on the ward with the patient the day before their planned discharge.	We will work closely with carers service to better identify informal carers when planning patient discharges and offer onward referral for carers support and assessment. We will fully embed the "nothing said about me without me" principle for all discharge planning discussions.	We will evaluate the effectiveness of these interventions through the national patient survey.
We will implement post discharge follow up calls to a minimum of 50 patients per week (within 48hrs of discharge) who have has an inpatient stay, this will support ensuring they are safe, identify if any unmet needs were missed prior to discharge and ensure signposted or referred for relevant support. We will also gather feedback around their discharge and what could be improved.	We will include patient representatives on future improvement workstreams internally and across partner organisation improvement work. We will implement using patient feedback, changes and improvements to the process, this will be tested through the national patient survey.	We will implement using patient feedback, changes and improvements to the process, this will be tested through the national patient survey.

Year 1	Year 2	Year 3
We will have consistent representation at the care home collaborative to understand discharge impact on care and nursing homes with the aim to improve relationships and trust between organisations building further on the trusted assessor model.	We will demonstrate a year on year increase in the number of trusted assessments between the regulated care sector. We will evaluate progress on improving discharges with regulated care settings and agree priorities.	We will evaluate progress on improving discharges with regulated care settings and agree priorities.
Essential carer role We will introduce the essential carer role into a small number of adult inpatient test sites and evaluate the effectiveness using Plan, Do, Study, Act (PDSA) cycles.	**Essential carer role** Following evaluation of the test sites we will role this out to all wards in order to meet patient's needs.	**Essential carer role** We will embed the principles of the essential carer role as standard practice.
We will develop an Essential carer role standard operating procedure and an information leaflet to support implementation.	Based on the feedback and learning we will adapt the essential carer role so we achieve the best patient and essential carer experience.	We will embed changes using feedback to promote better Carer experience.
We will continue to support our Carers via our Carers Forum.	We will share learning from carers forums and use to influence improvement.	We will set year 3 priorities based on listening to carers.
We will consistently ensure we use Carers Lanyard.	We will use Carers stories and experiences to develop and improve services.	We will monitor and record Carer feedback, involvement and inclusion in all areas of patient care.
We will promote services available to Carers such as Z beds. We will continue to promote our Carers Charter and test this in practice using STAR.	We will use our Involvement services to educate staff around services available for our Carers.	We will improve facilities for carers to take a break form caring when in the organisation.
We will ensure Carers involvement in all clinical assessments and test this through STAR. We will incorporate Johns Campaign into our way of doing things.	We will ensure all clinical services recognise carer involvement.	We will include carer involvement in the newly designed electronic patient record and test this through STAR.
Promote get up get dressed keep moving We will encourage patients to get up, get dressed and keep moving wherever possible to prevent deconditioning and maximise rehabilitation and experience. We will embed this in practice in 3 wards across the organisation.	**Promote get up get dressed keep moving** We will share the learning from the pilot sites to role out across all inpatient wards.	**Promote get up get dressed keep moving** We will embed these principles as our standard.
Promote occupational and purposeful activities for our inpatients We will encourage our inpatients to engage in occupational and purposeful activities and when indicated provide suitable resources. e.g. activity packs with items such as colouring, paint sets, knitting, cross stitch, cross words, puzzles, poetry, creative writing etc. We will ensure the Intranet has accessible resources for staff to download for our patients. We will roll out the newly developed Reminiscence Boxes for use with our patients living with dementia.	**Promote occupational and purposeful activities for our inpatients** We will review resources and gather feedback from patients and staff.	**Promote occupational and purposeful activities for our inpatients** We will review resources and gather feedback from patients and staff.

Reference List

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The Heath Foundation (2013)Measuring patient experience https://bit.ly/3SmPuBV

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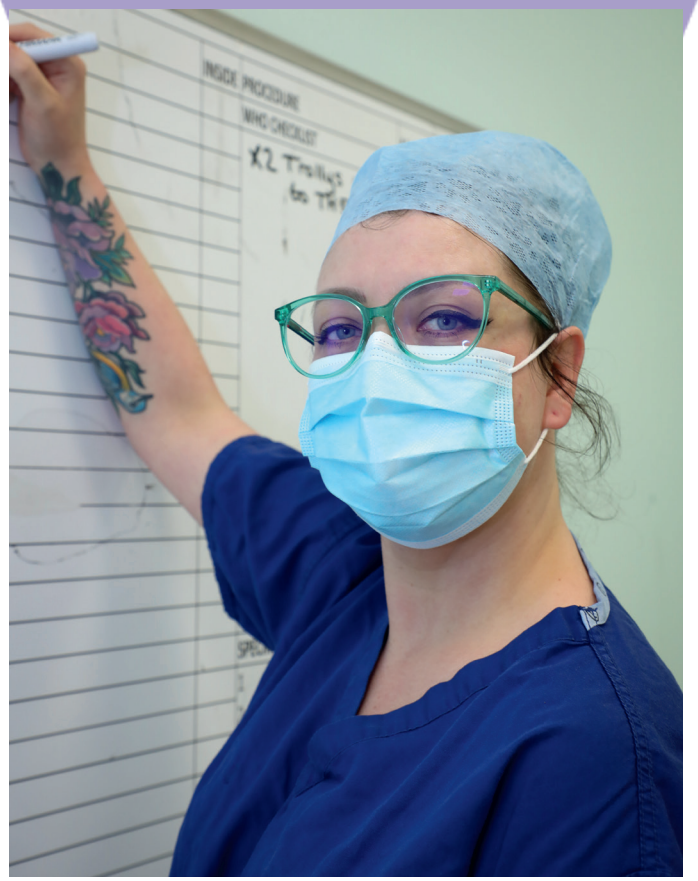


Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity and Neonatal Services Update					
Report to:	Board of Directors	**Date:**	3 August 2023		
Report of:	Chief Nursing Officer Divisional Midwifery and Nursing Director	**Prepared by:**	J Lambert		
Purpose of Report					
For Decision	☒	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Trust Board with an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report details progress against work streams relating to the ten Clinical Negligence Scheme for Trusts (CNST). NHS Resolution is operating in year 5 of the maternity incentive scheme and this report also includes summary of the new requirements published in May 2023.

The service has remained on track with all the requirements set out in year 4 incentive scheme following the Trust Board submission of the declaration of compliance to NHS Resolution on the 2nd February 2023 and is now working towards the additional actions required to ensure that the service is able to declare compliance with year 5 safety standards. The service is currently 40% (4/10) compliance with CNST actions, this is as expected as the new year commences.

To demonstrate that there are robust processes and safe staffing in place and provide assurance to the Trust Board on maternity and neonatal safety and quality outcomes, the perinatal quality surveillance dashboard includes nationally mandated specified minimum data set requirements and additional local level indicators. The dashboard triangulates workforce information with safety, patient experience and clinical effectiveness indicators to provide assurance of a safe service.

The Three-Year Delivery Plan for Maternity and Neonatal Services published in March 2023, sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families utilising 4 high level themes:

1. Listening to women and families with compassion
2. Supporting our workforce
3. Developing and sustaining a culture of safety
4. Meeting and improving standards and structures.

This plan sets out provider, commissioning and national level responsibilities to ensure delivery of high-quality care and what measures will determine success, these are provided within the report. The response to this plan is in development and will be presented to Board in October 2023.

The Board is recommended to:

i. Approve the CNST update report and recommendations.
ii. Note the expectations of the Three-Year Delivery Plan and associated safety bundles.
iii. Receives the associated action plans for assurance.

Appendix
PMRT cases

1.a PMRT ongoing actions StEIS 2022 5184
1.b PMRT ongoing actions StEIS 2022 6919
1.c PMRT ongoing actions HSIB MI-011710
1.d PMRT ongoing actions HSIB MI-14079

1. Avoiding term admissions into neonatal units and neonatal transitional care action plan outstanding actions from overarching plan.
2. MNVP provisional workplan
3. Workforce action plan
4. Saving babies lives dashboard.
5. Maternity red flag data.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place to Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For the Future	☒

Previous consideration

None

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services specifically relating to the ten CNST maternity safety actions included in year five of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. The Report also triangulates workforce information with safety, patient experience and clinical effectiveness indicators to provide assurance to the Board of a safe maternity service.

2. MATERNITY INCENTIVE SCHEME

A summary of progress to date regarding the attainment of all ten safety actions is detailed in the progress tracker below. (Table 1)

To date, all ten of the safety actions are being benchmarked against and have work ongoing. Further information is awaited from the national team regarding safety action 6 and recruitment is ongoing for the MVP chair for safety action 7. Monthly updates will be provided to the committee using this tracker.

Table 1 Progress Tracker

Safety Action	Progress Update	RAG Rating	Areas of concern/Update
Safety Action 1 - PMRT	On track		Compliant with requirements. Expected to deliver.
Safety Action 2 - MSDS	On track		New function within the Maternity dashboard to input provisional data and the service is commencing the implementation of this in preparation for the July data required for this submission. Expected to deliver.
Safety Action 3 - ATAIN	On track		Compliant with requirements. Expected to deliver.
Safety Action 4 – Clinical Workforce planning	At risk		Medical workforce review is being prepared and will be completed by 31.8.23. Risk to delivery – financial implications.
Safety Action 5 – Midwifery workforce staffing	At risk		BirthRate Plus staffing requirements within the bi-annual safe staffing report have been endorsed by Safety and Quality Committee and will be discussed at Board in August 2023. Risk to delivery financial implications.
Safety Action 6 – SBLV2	At Risk		New requirements. Awaiting confirmation from the national team
Safety Action 7 – Maternity Neonatal Voices Partnership (MNVP)	At Risk		New Requirements Healthwatch leading the appointment of a new MNVP lead. Expected to deliver.
Safety Action 8 - Training	On track		Updating Maternity Training Needs Analysis to meet Core competency Framework V2 Expected to deliver
Safety Action 9 – Board Assurance	On track		Compliant with requirements. Expected to deliver
Safety Action 10 – NHS Resolution	On track		Compliant with requirements. Expected to deliver

3. SAFETY ACTIONS UPDATE

A progress update is provided within this report on the key areas of focus within each safety action.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard? (• All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth).

To meet the requirements of standard 1, Trust Executive Boards must receive a report each quarter from 30 May 2023 that includes details of all deaths reviewed. Any themes identified and the consequent action plans should be included for oversight. The report should also evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) (table 1) have been met.

As of the 16th of July 2023, there were three eligible cases (Appendix1). All cases were notified to MBRRACE-UK within seven working days and surveillance completed within one calendar month of the death. The service is on track to met the defined thresholds for multi-disciplinary reviews using the PMRT, where 95% are started within two months of the death, and a minimum of 60% of multi-disciplinary reviews are completed to the draft report stage within four months of the death and published within six months. Table 2 details the current position for all perinatal mortality reviews.

Table 2: Perinatal Mortality Tool progress tracker

Safety Action 1 (Standard A) *	**Compliance score**		**RAG**
i. All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	**Notification**	**3/3**	
	Surveillance	**3/3**	
Safety Action 1 (Standard B) *			
i. For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	**On track**		
Safety Action 1 (Standard C) *			
i. For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months	**On track**		
Safety Action 1 (Standard D) *			
i. Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023 onwards that include details of all deaths reviewed, thematic learning and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**April 2023**		
	July 2023		
Neonatal Deaths			
I. The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death	**2/2 on track**		
II. Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information.	**3/3 on track**		

***Exclusions:** If the surveillance form needs to the assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts,

should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.

Appendix 1 details the progress against each review and the outstanding action plans are included for oversight. A single notification portal (SNP) is planned by NHS England in 2024. Once this is released notifications of deaths including neonatal deaths notified to Child Death Overview Panels (CDOPs) must be made through the SNP and this information will be passed to MBRRACE-UK.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

This standard relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans for improvements. Specifically, Trust Boards are advised to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. (Published in October 2023). The service utilises the NHS England Data Quality Submission Summary Tool to demonstrate ongoing tracking and monitoring of data quality monthly. These reports will be shared with the Trust Board for assurance.

The service confirms that it continues to be on track with 11 out of 11 CQIMS. The National Maternity Dashboard is now able to publish provisional data part way through the two-month data submission window. The service is moving towards utilising this function and will commence submitting provisional data from this month. The service is due to report an MSDS submission for July 2023 data by the end of August 2023. This will, alongside the Data Quality Submission Summary Tool, provide assurance that standard 2 is achieved.

In additional to the defined data quality CQIM metrics, Trusts must have at least two people registered to submit MSDS data to SDCS Cloud working in the service. The digital lead midwife and the information technology midwife are responsible for submission and are registered to the SDCS cloud.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal (ATAIN) units Programme?

Pathways of care into transitional care and ATAIN continue to be prioritised, jointly agreed, and monitored by the maternity and neonatal teams. The Working Better Together Group convenes on a fortnightly basis to undertake multi-professional audit of all admission to the neonatal unit from 37 week+0-days gestation.

The service confirms that the current provision for keeping mothers and babies together is modelled on the principles of the family integrated care (FiCare) and the neonatal unit received accreditation in December 2022.

The ATAIN and transitional care dashboards continue to be in progress and the division of Women's and Children's continues to track performance and monitor outcomes for babies requiring neonatal admission or transitional care. In addition, high level review of the primary reason for admission is included in the ATAIN quarterly performance report. Respiratory distress syndrome (RDS) remains the highest indicator for term admissions accounting for 65%. A deep dive review is underway, the reported numbers mirror the national picture for term admission to NICU.

The joint transitional care and ATAIN quarter 4 report, dashboard and joint action plan has been shared with Maternity Champions in June 2023 and with the LMNS and ICB Quality Assurance Panel in July 23. Progress against the outstanding actions is detailed in Appendix 2 for oversight by the Trust Board.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a) Obstetric medical workforce

In order to demonstrate that safe processes are in place for obstetric locum employment, the service is required to confirm that short term locum doctors either currently work in their tier 2 or 3 rota, have worked in their unit in the last 5 years as a post graduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

In addition, Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings and implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.

Finally, the service is required to demonstrate engagement with the Royal College of Obstetricians and Gynaecologists (RCOG) 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' document and action plans to review any non-attendance to the clinical situations listed in the document are detailed in the monthly audits. In June 100% compliance was achieved.

To provide additional assurance and oversight, the acute obstetric unit medical staffing and consultant availability (daytime labour ward cover and out of hours/on call) is monitored monthly and reported on the Perinatal Surveillance dashboard. The data reflects the actual medical staffing compliance for the acute obstetric service, in relation to the planned staffing levels. In June 2023 100% of the rota was covered.

Trusts/organisations should use the monitoring/effectiveness tool contained within the 'RCOG guidance on the engagement of long-term locums in maternity' to audit their compliance with the recommendations for locum doctors and have a plan to address any shortfalls in compliance. The service plans to use this tool to monitor compliance and will audit against this to provide the relevant assurance. A SOP will also be developed to provide assurance that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. A paper was shared with the Divisional Board demonstrating compliance with this recommendation from January to December 2022. This will be reviewed on a quarterly basis and compliance confirmed. A copy of the rota will be used as evidence of compliance and must be received before the 7th December 2023.

c) Neonatal medical workforce

Within the CNST reporting period a review of the neonatal medical workforce should be undertaken of any 6-month period between 30 May 2023 – 7 December 2023. In addition, and following this review, the Trust is required to formally record in Trust Board minutes whether it meets the relevant British Association of Perinatal Medicine (BAPM) recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A review will be undertaken within this time frame and presented to the Trust Board. In addition to this BAPM medical and nurse staffing outcome data will be included in the perinatal quality surveillance dashboard.

d) Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. The service is seeking clarification regarding the workforce planning toolkit from the national team and once this has been received a review will be conducted before 7th December 2023.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Birth Rate Plus® is a recognised endorsed tool (NICE 2015) used to review midwifery staffing establishments. The tool uses case mix data and activity levels to determine the safe clinical midwifery establishment required for the service. The calculation used to determine safe staffing levels is based upon traditional models of care and includes the Trusts 23% uplift for annual, sickness and study leave, and 15% community travel uplift but does not include modifications for the implementation of continuity models of care. The uplift requirements following the most recent Birth Rate Plus assessment for both midwifery and support staff has been included as part of the biannual safe staffing review and shared with this committee. The paper is scheduled for approval at Board in August 2023. Given the financial controls in place. This will require further consideration by the ICB. An uplift of Maternity Support Workers for Maternity Triage has already been agreed and is out to advert utilising existing vacancies budget.

Recruitment of 16.0 WTE international midwives in the next 12 months is underway. Currently there are 4 WTE international midwives working in the service in a supernumerary capacity. This approach demonstrates the continued strategic approach to future workforce planning.

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

The Saving Babies' Lives Care Bundle' (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. Updated guidance was produced on the 1st June 2023 to include an additional element related to the management of pre-existing diabetes in pregnancy for women with Type 1 or Type 2 diabetes, as the most significant modifiable risk factor for poor pregnancy outcomes.

As part of the three-year delivery plan for maternity NHS trusts are responsible for implementing SBLCBv3 by March 2024 and Integrated Care Boards (ICBs) are responsible for agreeing a local improvement trajectory with providers, along with overseeing, supporting, and challenging local delivery. A new implementation tool is being made available to support maternity services to track and evidence improvement and compliance with the requirements set out in Version 3.

To evidence adequate progress against this deliverable by the submission deadline in February 2024, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages will be calculated within the national implementation tool once this becomes available.

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity and Neonatal Voices Partnership (MNVP) to coproduce local maternity services. Specifically, that the service listens to women, parents and families using maternity and neonatal services and co-produce services with users

In line with the single delivery plan and MNVP guidance the service must ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place**.** The MNVP lead and maternity service should also develop an action plan based on the CQC maternity survey, service user feedback and national

agenda. Actions agreed should include response to feedback received in the free text of the survey report, prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation. Progress should be monitored regularly by safety champions and LMNS Board.

Written confirmation is required from the service user chair that they and other service user members of the MVP committee can claim out of pocket expenses, including travel, parking, and childcare costs in a timely way. Support is being provided by LMNS following the establishment of the Integrated Care Board (ICB) to confirm the ongoing funding arrangements.

The service confirms that the process to appoint a new MNVP lead is in progress and that the MNVP lead, will be supported by the LMNS to be employed or remunerated and receive appropriate training, administrative and IT support. A plan to update the work plan is in place once the new lead is in post. Appendix 3 details the provisional MNVP work plan for 2023.

Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In collaboration with the national maternity and neonatal partner organisations, the Maternity Transformation Programme published an updated Core Competency Framework (CCFv2) in June 2023 This publication replaces the first version and sets clear expectations for both the minimum standard and the stretch target for excellence.

The CCFv2 requirements Training Needs Analysis (TNA) now includes 6 modular elements instead of 5 in the CCFv1 and the service is in the process of benchmarking and updating the training plan to include the new requirements. The Trust Board will receive an update within the next report to Board to confirm that the TNA standards have been aligned with version 2 of the CCF and that the service remains fully compliant.

Overall compliance with fetal monitoring training and Practical Obstetric Multi-Professional Training (PROMPT) emergency skills is 96% and 94% respectively in July 2023. However, each eligible staff group is required to meet the 90% speciality threshold and lower than target compliance is noted within the specialties of obstetrics and anaesthetic staffing. Actions for improvement are ongoing with training dates booked to ensure compliance across all eligible staff groups is maintained.

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

The expectation from the service and Board is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly.

The Perinatal Quality Surveillance dashboard (Table 4) provides performance data in relation to key indicators of safety and quality to ensure that clinical quality is reviewed regularly and that the board-level perinatal safety champion and wider Board retains oversight of perinatal safety.

In June 2023 a new Non-Executive Director (NED) Victoria Crorken was appointed to the Board Safety Champion role alongside Sarah Cullen, Chief Nursing Officer. The service continues to work with the Board Safety Champions to provide assurance relating to safety data and service intelligence and feedback.

The Trust's claims score card continues to be reviewed quarterly alongside incident, complaint and patient experience data and a divisional report has outlined the detailed findings and targeted intervention for improvement. Analysis of the Q4 2023 report demonstrates that the themes identified within both the new referrals to NHS resolution, new claims, the claims score card, concluded StEIS investigations and the

complaints within this quarter triangulate. The most common theme identified related to delays or failures in the initiation of treatment.

Reviewing trends and themes from complaints and claims provides the maternity service with the opportunity to learn and improve care and systems. Assurance is provided that actions have already been implemented by the maternity service to learn from the triangulated themes/trends identified within the new referrals to NHS resolution, the new letters of claim/ claims being considered, the claim score card, patient complaints and the concluded StEIS investigation reports. All StEIS investigations (including HSIB investigated incidents) are subject to detailed actions plans and compliance with associated actions monitored through the maternity Safety and Quality committee.

Trust level safety intelligence, learning from excellence and incidents is shared via the Lancashire & South Cumbria Local Maternity and Neonatal System Serious Incident Review group. The Serious Incident (SI) meetings provide a system level approach to sharing high level themes, learning from incidents, and provide a forum for peer and system support and review.

The Maternity and Neonatal Board Safety Champions (BSC) continue to support the perinatal quadrumvirate in their work focusing on positive cultures within the services. The divisional people plan is being updated following the publication of the staff survey results to drive forward improvements in divisional culture. A focus to engage, retain, reward, and recognise team members is underway and a workforce plan detailing specific actions is included in Appendix 4. Further updates on progress will be shared with the Board in due course.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?

An audit of compliance to confirm that 100% of qualifying cases to HSIB and to NHS Resolution's Early Notification Scheme (EN) is completed on a quarterly basis. The Q4 report 2023 has been published and confirms continued compliance of 100% providing assurance that this standard continues to be met.

4. HEALTH SAFETY INVESTIGATION BRANCH (HSIB) REFERRALS AND SERIOUS INCIDENTS

In line with national reporting recommendations, details of all HSIB referrals are included in this report to enable the committee to triangulate incidents with safety outcome data.

- No HSIB case were reported in June 2023 or July 2023.
- One HSIB case has been concluded in July 2023. This was a case of neonatal death. The baby was born at a Birth Centre at term in an unexpected poor condition. The baby was resuscitated and transferred to NICU where therapeutic cooling treatment was commenced. The post cooling Magnetic resonance imaging (MRI) scan showed severe hypoxic ischemic encephalopathy (HIE) and a decision was made for a compassionate reorientation of care.

Table 3 details the HSIB ongoing investigations.

Table 3 details the HSIB investigations that remain ongoing:

MI number	Case Summary	Early Notification applicable	Early notification completed
021966	Severe shoulder dystocia (22 minutes) following instrumental birth. Therapeutic cooling treatment initiated. Post cooling MRI showed moderate HIE.	Yes	Yes
022696	Induction of labour. Fetal bradycardia on the antenatal ward. Category one caesarean section. Therapeutic cooling treatment initiated. Post cooling MRI showed severe HIE.	Yes	Yes
024639	Induction of labour. , Abnormal fetal heart rate auscultated, Therapeutic cooling treatment initiated. Post cooling MRI showed mild HIE.	Yes	Yes

5. THREE YEAR DELIVERY PLAN MATERNITY AND NEONATAL SERVICES

NHS England has launched a three-year delivery plan for maternity and neonatal services, which aims to respond to concerns raised by several independent reviews and by users of these services. This plan aims to deliver change rather than set out new policy. It seeks to help each part of the NHS to plan and prioritise their actions by bringing together learning and action from a range of national reports and plans into one overarching document.

Utilising 4 high level themes: listening to women and families with compassion, supporting our workforce, developing and sustaining a culture of safety and meeting and improving standards and structures, the plan also sets out provider, commissioning and national level responsibilities to deliver safer maternity care.

The maternity services team are working with the ICB to develop the plan to respond to this document and will present this to Board in October 2023.

1. LISTENING TO, AND WORKING WITH, WOMEN AND FAMILIES WITH COMPASSION.

Care should be personalised, and service users have an informed choice. Voices of all women including those from diverse backgrounds must be heard, and services should work closely with all service users to collaboratively plan, design, and improve care. All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed, and by 2025, improved neonatal cot capacity.

Success will be determined through the CQC maternity survey, the presence of perinatal pelvic health and perinatal mental health services and UNICEF Baby Friendly Initiative (BFI) accreditation.

2. GROWING, RETAINING, AND SUPPORTING OUR WORKFORCE WITH THE RESOURCES AND TEAMS THEY NEED TO EXCEL.

There must be sufficient highly skilled staff across the whole maternity and neonatal team whilst combatting workforce inequalities. Staff should feel valued, with plentiful opportunity for skills and career development to facilitate a lifelong career in the NHS. Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.

During 2023/24, Trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention. From 2023, NHS England, ICBs, and Trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Success will be determined through the staff survey, national education and training survey and the GMC training survey. Progress measures will include the number of staff in post against required establishment, sickness and turnover rates.

3. **DEVELOPING AND SUSTAINING A CULTURE OF SAFETY, LEARNING, AND SUPPORT.**

There should be a positive safety culture in every maternity and neonatal service, where everyone takes responsibility for safer care and learning, and leaders understand, and act based on how it feels for their teams to work at their organisation. Throughout 2023, all Trusts must effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents. NHS England, ICBs, and Trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Success will be determined by listening to people working and using the services through patient, staff and training surveys. Trust Boards will be asked to use an appreciative enquiry approach and focus on how staff report the organisation share and act on learning from incidents and learning more generally.

4. **STANDARDS AND STRUCTURES THAT UNDERPIN SAFER, MORE PERSONALISED, AND MORE EQUITABLE CARE**.

Best practice should be consistently implemented across the country, with timely, accurate data available to support learning and early identification of emerging safety issues. Women can access their records and interact with their plans and information to support informed decision-making. Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.By 2024, services will progress work to enable women to access their records and interact with their digital plans.

Success will be determined by

- **Focusing on existing clinical outcomes including maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. Local implementation of version 3 of the Saving Babies' Lives Care Bundle.**
- **For women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care.**
- **The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.**
- **In addition, a periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.**

5. THE PERINATAL QUALITY SURVIELLENCE DASHBOARD

To meet the requirements of the perinatal quality surveillance model, the service must inform the Board regarding safety intelligence, including the number of incidents reported as serious harm, themes identified serious issues, complaints and proactively gather ongoing learning and insight, to inform improvements in the delivery of perinatal services. Table 4 details the performance over time from July 2022- June 2023.

Table 4 Perinatal Quality Surveillance Dashboard

(Formally maternity specific safety and quality matrix)

Metric	Red flag		Green flag		July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23	April 23	May 23	Jun 23
CNST 10 Key safety actions (Year 5 scheme updated in 31st May 2023)					**80%**	**80%**	**80%**	**80%**	**80%**	**80%**	**100%**	**100%**	**100%**	**100%**	**100%**	**40%**
Births					373	348	362	354	354	318	350	304	376	298	339	371
Total stillbirth rate (per 1,000 births)	>	4.9	≤	4.9	8.0	11.5	2.8	8.5	2.9	6.3	5.7	0.0	5.3	3.4	2.9	0.0
Stillbirth rate excluding termination for fetal abnormality										3.1	2.9	0.0	5.3	3.4	2.9	0.0
Examination of the newborn completed within 72 hours	<	95 %	≥	95 %	95%	98%	95.9%	97.7%	95.9%	96.5%	95.1%	95.7%	94.7%	95.6%	96.2%	95.7%
Breastfeeding initiation	<	70 %	≥	70 %	78%	77%	76.0%	60.1%	76.0%	75.9%	73.9%	76.3%	82.9%	79.8%	76.3%	77.6%
Booked by 9+6	<	50 %	≥	50 %	32%	38%	39.3%	49.4%	51.0%	45.8%	32.6%	38.7%	47.3%	42.2%	51.5%	44.9%
Booked by 12+6	<	90 %	≥	90 %	85%	86%	87.1%	90.1%	93.1%	90.7%	88.0%	90.8%	88.9%	83.3%	92.7%	86.8%
Women giving birth in a midwife-led setting	<	25 %	≥	30 %	21%	21%	18.1%	19.2%	20.0%	18.0%	17.5%	16.6%	15.1%	16.6%	14.2%	15.8%
Continuity of carer					28%	32%	28%	28%	28%	28%	26%	30%	32%	31%	TBC	28%
Home birth	<	1.7 %	≥	2.0 %	4.1%	3.5%	2.2%	3.7%	2.0%	1.9%	2.3%	3.3%	2.1%	3.7%	3.2%	2.4%
Incidence of severe tears grade 3 and above	≥	2.4 %	<	2.4 %	3.0%	2.6%	2.7%	4.5%	1.6%	4.2%	2.4%	2.1%	2.8%	2.3%	1.5%	3.1%
One-to-one care in labour in Delivery Suite	<	95 %	=	100%	97%	97%	95.2%	98.2%	98.9%	97.7%	99.6%	98.4%	99.7%$	99.2%	97.6%	100%
One-to-one care in labour in Preston Birth Centre	<	95 %	=	100%	100%	100%	97.2%	100%	100%	100%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Chorley Birth Centre	<	95 %	=	100%	97%	100%	100%	100%	100%	92.9%	100%	100%	100%	100%	100%	100%
One-to-one care in labour overall	<	95 %	=	100%	100%	97.6%	95.9%	98.5%	99.1%	97.7%	99.7%	98.6%	99.7%$	99.4%	97.9%	100%
HDU trained midwife per shift															99.57%	99.57%
Supernumerary status of DS coordinator	<	95 %	=	100%	100%	100%	100%*	100%*	100%	100%	100%	100%**	100%	100%	100%	100%
CTG update training	<	90 %	≥	90 %	92%	92%	95%	97%	95%	94%	92%	93%	94%	96%	99%	98%
Annual competency (K2 Training Package)	<	90 %	≥	90 %	92%	91%	97%	98%	99%	98%	99%	99%	99%	97%	97%	96%
Antenatal CTG	<	90 %	≥	90 %	94%	94%	98%	***	***	***	***	***	***	***	***	***
Intrapartum CTG	<	90 %	≥	90 %	93%	92%	97%	***	***	***	***	***	***	***	***	***
Intrapartum IA	<	90 %	≥	90 %	95%	94%	97%	***	***	***	***	***	***	***	***	***
GAP/GROW (Growth Assessment Protocol Training)	<	90 %	≥	90 %	83%	81%	84%	82%	87%	87%	82%	82%	87%	83%	80%	82%
Emergency skills Training (PROMPT – Practical Obstetric Multi-Professional Training)	<	90 %	≥	90 %	89%	89%	90%	97%	97%	98%	93%	93%	94%	93%	96%	94%
Incidents of moderate harm and above					1	0	2	0	4	3	1	2	2	0	0	3
HSIB referrals opened.					1	0	2	0	0	2	0	2	1	0	0	0
Complaints					1	2	2	2	1	2	2	3	2	2	2	2
Prevention of future deaths regulation 28					0	0	0	0	0	0	0	0	0	0	0	0
Maternal Death	> 1		<1		0	0	0	1	0	0	0	0	0	0	2 *	0

Number of Consultant hours on obstetric unit	<70 hrs	=/> 96.5hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5% hrs	76.6% hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs
RCOG obstetric benchmarking compliance			94%	100%	100%	100%	100%	100%	93%	95%	94%	100%	100%	100%
24-hour Acute obstetric medical staffing fill rate		100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Births per Funded Clinical Midwife WTE	>28	≤26	25	23	25	24	24	21	23	22	25	21	23	21
Staff sickness rate	4%	4%	9.8%	10.7%	7.43%	7.2%	7.6%	11.5%	8.7%	8.6%	8.6%	7.9%	8.47%	8.6%
Fill rate RM Day	<85%	>85%	71%	71%	81%	82%	78%	73%	82%	81%	81%	82%	NA	93%
Fill rate MSW Day	<85%	>85%	68%	68%	67%	70%	77%	67%	77%	72%	71%	73%	NA	93%
Fill rate RM Night	<85%	>85%	81%	87%	82%	90%	88%	89%	95%	94%	90%	97%	92%	90%
Fill rate MSW Night	<85%	>85%	108%	100%	97%	98%	95%	89%	95%	94%	95%	100%	94%	89%
Registered Midwife shifts sent to agency per month. (New Jan 23)									122	143	152	107	110	110
Registered Midwife Agency shifts filled. (New Jan 23)									71	73	77	51	51	61
Registered Midwife Agency hour fill rate percentage. New Jan 23.									58%	51%	51%	51%	46%	45%
Maternity Diverts	> 1	<1	1	0	0	1	0	0	0	0	0	0	0	0
Red flags			7	6	38	78	12	2	5	12	126	44	71	218
In- utero transfers declined to accept from other units (maternity)			4	10	2^	2	0	4	1	2^	2	0	2	5
In- utero transfers declined to accept from other units (NICU)			0	0	2	0	0	0	0	4	0	2	1	1
In- utero transfers from LTHTR to another Trust (Antenatal)			0	0	2	0	0	0	0	0	0	0	10	0
NICU Closure			0	0	2	0	0	0	0	3	2	5	13	1
Percentage of women seen by a midwife within 15 minutes of attendance in Maternity Triage									90%	89%	86%	94%	90%	91%

*Unrealted to maternity

** Data amended following publication of new guidance

*** Recording methodology changed and now reported as overall compliance following roll out of full day training.

^ Rates adjusted in months where previously both maternity and neonatal declined IUT were recorded cumulatively

8.0 STILLBIRTH RATES

The stillbirth rate continues to be monitored monthly by maternity Safety and Quality Committee. In June 2023, the stillbirth rate was 0 which is below the national average of 4.9 per 1000 births. The Statistical Process Control (SPC) analysis shows variation of the stillbirth rate that is within the expected range with no cause for concern identified. The maternity service continues to closely monitor the incidence of stillbirth and the MBRRACE real time monitoring tool is utilised to track cases.

8.2 BOOKING BY 9+6

Key performance related to booking by 9+6- and 12+6-weeks' gestation has been below the expected target range since October 2021. An improving position was demonstrated in May 2023 for antenatal referral and booking completed by 9+6- and 12+6-weeks' gestation which reflects the positive impact of the ongoing weekly monitoring and oversight by the Division. However, performance related to timely booking by a midwife in June 2023 was below target range once again. It is anticipated that this trend will continue throughout July, August and September 2023 as a result of increasing midwifery vacancies, long term sickness absence (4.8 WTE) and maternity leave. Improvements are anticipated once 18 WTE newly

qualified midwives join the service in October 2023 and intermediate actions to mitigate the risk and rationalise the service are being considered.

8.3 CONTINUITY OF CARER (MCOC)

The Trust is required to confirm that Board level discussions related to the ability of the maternity workforce to maintain current and future rollout of MCoC have taken place. The service confirms that the current level of MCoC (28%) can continue to be delivered safely without impacting on the safety of the service. However, until staffing has stabilised, there will be no further expansion of MCoC.

Although there are no plans to expand the MCoC at the current time, work to consider the geographical population demographic within Preston and South Ribble has been undertaken so that priority can be given to those most likely to experience poorer outcomes first, including women from Black, Asian and mixed ethnicity backgrounds and those living in the lowest decile of deprivation.

8.4 SAFE STAFFING

The service currently has 10 vacancies and 20WTE on maternity leave. This is leading to higher use of bank and agency within the service. The fill rate is between 89% and 93% however, it should be noted a number of mitigating staffing measures have been taken to deploy clinicians from a variety of settings to mitigate the current staffing shortfall. This is maintaining safety within the service. Midwifery red flags highlight potential areas of staffing concern within the service and are highly valuable intelligence for service leaders. There was an increase in red flag reporting in June 2023 with the highest reporting area being midwifery led services. A theme this month has been the requirement to rearrange community visits in response to staffing. In all instances where a community home visit had to be deferred, a risk assessment and telephone consultation was performed by the midwife in accordance with the standard operating procedure for deferring or cancelling community home visits. There have been no adverse outcomes reported for mother's or baby's that had a community home visit deferred or rearranged, however, the negative impact on patient experience is recognised by the service and is captured as a risk on the risk register.

09. CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The reports confirms progress against the ten new workstreams set out by the Clinical Negligence Scheme for Trusts (CNST) NHS Resolution for year 5 of the maternity incentive scheme and provides a 40% achievement of CNST to date.

The three year maternity and neonatal transformation plan outlines the requirements of the ICB and providers and the maternity service is working in partnership with the ICB to develop the plan. The perinatal quality surveillance dashboard is indicating a stable service despite midwifery staffing challenges at this time.

10. Recommendations

The Board is recommended to:

i. Approve the CNST update report and recommendations.
ii. Note the expectations of the Three-Year Delivery Plan and associated safety bundles.
iii. Receives the associated action plans for assurance.

Appendix 1 – PMRT cases

ID (Datix/ PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report complete within 4 months	Actions ongoing
85064	33+0	Stillbirth	Essential hypertension in pregnancy on Labetalol and Nifedipine	Yes 06.06.22	81875	Yes		Rapid Incident review (RIR) held no immediate care concerns
85187	25+2	Stillbirth	Known fetal abnormality declined TOP	Yes 06.06.22	81871	Yes		RIR held no immediate care concerns
85442	31+4	Stillbirth	Booked on MSP fundal height no measured at 28/40 baby on 2nd centile at birth	Yes 06.06.22	81875	Yes		RIR held Duty of candour (DOC)Level 2 investigation
86077	27	Neonatal death	Known fetal abnormality declined TOP IUT from external provider	Yes 13.6.22	82008	Yes		RIR held no immediate care concerns
82096 PMRT		Neonatal death	Live birth following termination of pregnancy for fetal anomaly	Yes 20.06.22	82096	NA	N/A for reporting purposes only	For reporting purposes only – PMRT criteria not met
82467 PMRT		Neonatal death	Live birth following termination of pregnancy for fetal anomaly	Yes 12.07.22	82467	NA	N/A for reporting purposes only	For reporting purposes only – PMRT criteria not met
82517 PMRT	Approx 22 weeks	Still birth Estimated at 22 weeks gestation	Un-booked. Presented to Emergency Department	Yes 14.07.22	82517	Mother declined	Mother declined	For reporting and surveillance purposes only – PMRT investigation not supported as mother un-booked
89525	Term+10	Intrapartum Stillbirth	Referred and accepted for investigation by HSIB	Yes 15.07.22	82570	Yes		RIR StEIS reported HSIB investigation ongoing
89530	26+3	Antepartum stillbirth	In utero transfer from external provider. Multiple pregnancy IUD of twin 1, twin 2 live born & admitted to NICU	Yes 18.07.22	82580	Yes		Shared PMRT with external lead provider
94193	29+6	Termination of pregnancy	IUT from external provider –fetal anomaly. Decision for Termination of Pregnancy (TOP)	Yes 28.07.22	82732	N/A	N/A for reporting purposes only	For reporting and surveillance purposes only – PMRT criteria not met
91074	37+0	Antepartum stillbirth	Antenatally diagnosed fetal anomaly	Yes 02.08.22	82812	Yes		N/A
93007	29+3	Antepartum stillbirth	Recently arrived in the UK – not booked when presented	Yes 23.08.22	83167	Yes		DOC letter
93596	39+0	Antepartum stillbirth	RIR – no care concerns identified	Yes 30.08.22	83272	Yes		DOC letter
94118	26+5	Neonatal death	Postnatal transfer from external provider	Yes 31.08.22	83324	Yes		PMRT held jointly with external provider
94418	38+1	Intrapartum stillbirth	Referred and accepted for investigation by HSIB	Yes 01.09.22	83343	Yes		RIR StEIS reported HSIB investigation ongoing
95934	29+6	Neonatal death	Antenatally diagnosed fetal anomaly	Yes 20.09.22	83587	Yes		N/A
83944 PMRT	25+5	Antepartum stillbirth	Multiple pregnancy – FDIU of baby diagnosed 20.07.22. Pregnancy continued for 2nd twin, twins delivered 05.10.22	Yes 10.10.22	83944	N/A	N/A for reporting purposes only	For reporting and surveillance purposes only – PMRT criteria not met due to the circumstances of the case.
98479	25+5	Neonatal death	Postnatal transfer from external provide	Yes 10.10.22	83929	Yes		N/A
98775	34+2	Antepartum stillbirth	Low PAPP-A, external review of antenatal ultrasound scans awaited	Yes 17.10.22	98775	Yes		N/A
100221	27+5	Antepartum stillbirth	Antenatally diagnosed fetal anomaly	Yes 31.10.22	84055	Yes		N/A
101722	27+1	Antepartum stillbirth	Eclamptic seizure DOC and StEIS reported.	Yes 12.11.22	84476	Yes		DOC letter StEIS level 3 investigation.
100955	38	Neonatal death	Collapsed at 4 hours postnatal. Stabilised and transferred to tertiary centre . Baby sadly died.	NA as died at Alder Hey	84996	Yes		DOC letter StEIS level 3 investigation.

84965 PMRT	32+2	Termination of pregnancy	Fetocide TOP for fetal anomalies	10.12.22	84965	N/A	N/A for reporting purposes only	For reporting and purposes only – PMRT criteria not met as termination of pregnancy.
105125	39+4	Neonatal death	Born in poor condition and transferred from CBC to NICU for cooling. Post cooling MRI showed severe HIE. Compassionate reorientation of care.	22.12.22	85135	Yes	HSIB Investigation. In draft by deadline	DOC letter StEIS HSIB investigation.
106111	27+1	Intrapartum stillbirth	Breech birth on route to the hospital. Prolonged head entrapment. Delivered outside of hospital. Resuscitation unsuccessful.	22.12.22	85133	Yes		DOC letter StEIS level 3 investigation.
107529	24+4	Neonatal death	Ex-utero transfer from external region. Multiple pregnancy.	10.01.23	85419	Yes		Review completed jointly with external provider.
85530 PMRT	27+4	Termination of pregnancy	Fetocide TOP for fetal anomalies	12.01.23	85530	N/A	N/A for reporting purposes only	For reporting and purposes only – PMRT criteria not met as termination of pregnancy.
85696	24+1	Antepartum stillbirth	Multiple pregnancy – FDIU of one twin diagnosed at 24+1. Pregnancy continued until 37/40 for surviving twin. PMRT rapid review – no care concerns identified.	02.02.23	85696	Yes	In draft within deadline.	
110873	41+1	Neonatal death	Ex-utero transfer from external provider for therapeutic cooling. Reorientation of care. Referred to HSIB	10.02.23	85998	Yes	Awaiting external provider – in draft within deadline.	Joint review shared with external provider. HSIB investigation ongoing – referred by external provider. Awaiting HSIB final report.
112806	24+2	Neonatal death	In-utero transfer from external provider with early onset severe growth restriction.	28.02.23	86270	Yes	Awaiting external provider - in draft within deadline.	
113887	34+4	Antepartum stillbirth	Presented with reduced fetal movements. Rapid incident review completed; no care concerns identified.	07.03.23	86386	Yes	In draft within deadline.	
115981	38+5	Antepartum stillbirth	Rapid incident review completed, and no care concerns identified. Birth weight on 10th customised growth centile.	04.04.23	86692	Yes	27.07.23	
117009	26+5	Antepartum stillbirth	Transfer booking from external provider . Birth weight on 0th customised growth centile.	05.04.23	86858	Yes	04.08.23	Joint review with external provider .
119880	01.05.2023 24+4	Antepartum stillbirth	Rapid incident review completed, and no care concerns identified.	02.05.23	87271	Yes	01.09.23	
125023	08.06.2023 33+1	Neonatal death	In-utero transfer from external provider with fetal hydrops.	20.06.23	88023	Yes	08.10.23	Joint review with external provider
125969	18.06.2023 24+5	Neonatal death	Multiple pregnancy. Admission with severe antepartum haemorrhage. Emergency caesarean section following stabilisation. Total blood loss 7.5L.	27.06.23	88146	Yes	18.10.23	
88277 PMRT	05.07.2023 33+1	Antepartum stillbirth	Multiple pregnancy. FH slowed and stopped during ultrasound scan, transferred for category 1 caesarean section but resuscitation unsuccessful.	07.07.23	88277	Yes PMRT card	05.11.23	

Appendix 1a - PMRT Ongoing actions – StEIS 2022 5184

RAG	Key
Action outstanding	
Action on track but not yet delivered	
Action delivered	
Action delivered and assurance evidence collated	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	To share the report with mother	To invite the family for a face-to-face meeting to feedback the findings of the level 3 investigation and the PMRT review.	Consultant obstetric lead for clinical governance	31/08/2022	29.07.22 – PMRT meeting organised. 06.10.22 EG – the PMRT review has been completed and a family meeting has been facilitated to feedback both the PMRT and the investigation findings	
2	To disseminate the learning	CTG to be shared with the fetal monitoring lead midwife, for use in future staff training.	Fetal monitoring lead midwife	30/09/2022	29.07.22 – CTG and case history has been anonymised and is being used in a human factors teaching session delivered by EG on the fetal monitoring study day	
		Case presentation at doctors teaching	Consultant obstetric lead for clinical governance	31/08/2022	29.07.22 EG – CL to deliver teaching session to obstetric team 06.10.22 EG – CL delivered the case presentation at new doctors induction in August 2022	
		Case presentation at midwifery study days	Divisional midwifery clinical governance and risk manager	30/09/2022	29.07.22 – CTG and case history has been anonymised and is being used in a human factors teaching session delivered by EG on the fetal monitoring study day	
3	The practice of the consultant obstetric bleep being carried by the second middle grade doctor should cease with immediate effect.	A second middle grade bleep should be procured	Clinical director for obstetrics	31/05/2022	Completed and bleep procured	
		When on call, the consultant on call should be visible on the delivery suite.	Clinical director for obstetrics	31/07/2022	29.07.22 – the “role of the consultant obstetrician on call” guideline has been updated and reflects this recommendation	
4	Abnormal CTG’s should be reviewed at the mother’s bedside and not remotely	Learning template to be generated regarding the management of abnormal antenatal CTG’s.	Divisional midwifery clinical governance and risk manager	31/07/2022	29.07.22 - Learning template produced and shared	
5	Implementation of a formal escalation process	Guideline written regarding the formal process for clinical escalation	Matron for specialist midwifery services	31/10/2022	29.07.22 – development is ongoing. 6.10.22 Draft Appendix to be discussed and added to Northwest Escalation Policy as local adaptation. 30.03.23 ACTION COMPLETED. Guideline has been published on heritage.	
		Ward manager to attend the morning handover so that there is helicopter	Matron for complex midwifery care	31/05/2022	29.07.22 EG – email confirmation received from LC that this action has been completed	

		oversight of the activity on maternity ward A				
6	Implementation of the RCOG (2022) escalation toolkit	Implementation of the AID communication strategy (RCOG 2022)	Fetal monitoring lead midwife	31/10/2023	29.07.22 EG – implementation has begun – strategy has been included in the human factor's presentation on the fetal monitoring study day	
		Implementation of the teach or treat communication strategy (RCOG 2022)	Fetal monitoring lead midwife	31/10/2023	29.07.22 EG – implementation has begun – strategy has been included in the human factor's presentation on the fetal monitoring study day	
7	Implementation of the RCOG (2022) Team of the shift in all intrapartum areas and maternity ward A.	RCOG (2022) toolkit Implementation recommendations actioned within the service.	Clinical director for obstetrics	31/10/2023	29.07.22 EG – implementation has begun – strategy has been included in the human factor's presentation on the fetal monitoring study day	
		Team of the shift" boards should be introduced in the intrapartum areas and the antenatal ward.	Ward managers	31/10/2023	29.07.22 EG – implementation has begun – strategy has been included in the human factor's presentation on the fetal monitoring study day	
8	Where the CTG is suggestive of hypoxia in a preterm infant and urgent delivery of the baby is indicated, the decision to deliver should not be delayed optimising with magnesium sulphate	The clinical guideline for fetal neuroprotection should be updated accordingly	Divisional midwifery clinical governance and risk manager	31/08/2022	29.07.22 EG – email to guideline lead to request addition to the current clinical guideline 30.03.2023 EH – ACTION COMPLETED. Updated guideline published on Heritage.	
9	CTG audit to assess compliance with current antenatal CTG guideline	Audit completed and presented at divisional audit meeting	Fetal monitoring lead midwife	31/07/2022	29.07.22 EG – audit has been completed by LM and presented at audit.	
10	Undertake a review of current fetal monitoring teaching materials to provide assurance that they are fit for	Update teaching materials	Fetal monitoring lead midwife	31/07/2022	29.07.22 EG – confirmation from LM that teaching materials have bene reviewed and updated. Furthermore, CTG and case history has been anonymised and is being used in a human factors teaching session delivered by EG on the fetal monitoring study day	

	purpose and include management of antenatal CTG's.					

Appendix 1b - PMRT Ongoing actions – StEIS 2022 6919

RAG	Key
Action outstanding	
Action on track but not yet delivered	
Action delivered	
Action delivered and assurance evidence collated	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	To share the report with the patient / family / advocate	To write to the patient / family / advocate and offer a copy of the final report	Clinical governance consultant obstetrician	31/08/2022	21.7.22 EG Family meeting to be organised by CB to feedback the investigation report and the PMRT report 06.10.22 CL and CB have met with the family. Both the PMRT review and the level 3 investigation report have been fed back to the family. CL has sent a summary letter to the family.	
2	Neonatal stethoscopes to be available on all Tom Thumbs and Panda resuscitaires	Purchase additional neonatal stethoscopes	Delivery suite lead	30/04/2022	21.7.22 EG Equipment procured and now in place	
3	Umbilical vein catheter (UVC) should be available on the neonatal emergency trolley	Confirmation that UVC tray is a check listed item on the neonatal emergency trolley	Neonatal unit manager	30/04/2022	21.7.22 EG Confirmed by NICU - equipment is included on the checklists and is in place	
4	Feedback of the investigation to the ST2 doctor	Feedback meeting	Educational supervisor	31/08/2022	21.7.22 EG - CL/ KR to feedback to the trainee. 06.10.22 EG – reflective piece received from the trainee and the incident has been discussed with the doctor by the college tutor.	
5	ST2 doctor to reflect on incident	Reflective discussion with education supervisor	Educational supervisor	31/05/2022	21.7.22 EG Completed and written evidence provided	
6	Feedback of the investigation to the ST6 doctor	Feedback meeting	Educational supervisor	31/08/2022	21.7.22 EG - CL to feedback to the ST6 doctor 06.10.22 EG – confirmation from CL that this action has been completed	
7	Sharing the learning from the incident	Sepsis learning template to be shared with the midwifery and	Clinical governance and risk management midwife	30/04/2022	21.7.22 EG Cervical cerclage learning template written and shared with staff	

		obstetric teams regarding cervical cerclage				
8	A formal process should be implemented for the management of specimen results within the maternity service. This should include the management of results in both an outpatient and inpatient setting.	SOP developed and implemented	Matron for specialist midwifery services	~~31/10/2022~~ 30.09.2023	21.7.22 EG Development of the SOP is in advanced development stages and awaiting launch date. 6.10.22 Testing phase ongoing in ANC. Issues related to the work list on Badgernet escalated to Clever Med. Action reclassified as high priority. 17.07.23 EH – SOP has been implemented following testing. Audit of effectiveness required before action can be closed therefore deadline extended.	
9	Recognition of best practice feedback to the neonatal team	Email to the Neonatal team	Clinical governance and risk management midwife	31/03/2022	21.7.22 EG completed	
10	Recognition of good practice feedback to delivery suite midwife	Email to the delivery suite midwife	Clinical governance and risk management midwife	31/03/2022	21.7.22 EG completed	
11	Implement an education strategy to raise awareness of the severity of sepsis and the importance of timely and efficient sepsis management across the maternity service and involving the multidisciplinary team.	Overarching sepsis action plan to be developed and implementation of action plan supported by the development of a multi-disciplinary sepsis working party.	Matron for specialist midwifery services	30/09/2022	21.07.22 EG A sepsis working party has been established and an extensive overarching sepsis action plan has been developed which is being monitored through maternity safety and quality committee. 6/10/22 Actions ongoing to be tracked through the Sepsis working party for assurance. Action closed	
12	Targeted training should be undertaken with the maternity assessment suite (MAS) team regarding the identification of sepsis risk factors and the management of sepsis in accordance with the sepsis 6 care bundle.	Targeted training undertaken	Practice educator	30/09/2022	21.07.22 EG Teaching materials have been written and agreed. Launch of the training package is delayed due to recent national changes to sepsis guidelines – awaiting a divisional decision regarding any changes to obstetric sepsis guidelines. 6.10.22 Plan to implement teaching in MAS agreed. 31.01.23 EG – targeted training delivered and registers saved in T-drive as evidence of action being completed.	
13	Future doctors' induction programmes should include protected time to complete human factors e-learning	Doctors' induction programme updated accordingly	College tutor	31/08/2022	21.7.22 EG action to implemented by college tutor and rota master	

	training and annual obstetric emergency skills drills update training				06.10.22 EG – all aspects have been included in the August 2022 new doctors induction programme	
14	"Team of the shift" (RCOG 2022) should be introduced in all intrapartum areas across the service (prior to clinical handover) and in addition, should also introduced on maternity ward A and the maternity assessment suite.	"Team of the Shift" implemented as advocated by the RCOG (2022) in the escalation toolkit	Matron for specialist midwifery services	30/09/2022	21.07.22 EG Team of the shift implementation teaching has become – being shared at the CTG study day 6.10.22 Team of the shift introduced week commencing 3/10/22. Actions for implementation agreed at Delivery Suite Coordinator meeting. Action closed	
15	The investigation recommends that a formal process for escalation is implemented as a priority.	Implementation of the teach or treat communication strategy as advocated by the RCOG (2022) in the escalation toolkit. Furthermore a formal process for clinical escalation should be developed and implemented	Service Development Midwife	30/10/2023	21.07.22 EG – RCOG escalation tool kit is in the process of being implemented. 6.10.22 Early QI project work being undertaken by service development Midwife. Action lead changed to reflect this. 05.12.2022 Socialisation of the escalation toolkit on fetal monitoring study day ongoing. Wider full implementation of the MatNeo SIP programme in progress in line with national work stream. Draft Guideline currently being reviewed.	
16	A second middle grade bleep should be procured, and the practice of the ST2 doctor carrying the registrar bleep should stop with immediate effect.	Second middle grade bleep should be procured	Clinical director for obstetrics	31/05/2022	21.07.22 EG second bleep procured and implemented	
17	Review of the cervical cerclage guidelines against the recently published RCOG Green Top guideline.	Review and update guideline as necessary	Clinical governance consultant obstetrician	31/05/2022	21.07.22 EG guideline has been reviewed and updated.	
18	Review the suitability of the maternity assessment suite (MAS) operating from the maternity ward at night.	Review of MAS standard operating procedure	Matron for complex midwifery care	31/08/2022	21.07.22 EG minor improvement works request has been requested. 18.11.22 LC Minor improvement request still awaiting action – f/up by area lead. I.T. Midwife sourcing necessary digital equipment.	

					30.03.23 ACTION COMPLETED. Minor improvement works have been action on the maternity ward and the maternity A hub room has been implemented.	
19	ST2 doctor to complete all outstanding mandatory update training	ST2 doctor completes all outstanding mandatory update training	ST2 doctor	31/08/2022	21.07.22 EG college tutor to monitor progress 30.05.2023 EH – ACTION COMPLTED	
20	The maternity service should attend and contribute to the Trust deteriorating patient and sepsis big room forums.	Maternity services representation at the deteriorating patient and sepsis big room forums	Safety and quality audit midwife	31/08/2022	21.07.22 EG quality and safety audit midwife is attending Trust sepsis big room and is reporting to maternity sepsis working party	

Appendix 1c - PMRT Ongoing actions – HSIB MI-011710

RAG	Key
Action outstanding	
Action on track but not yet delivered	
Action delivered	
Action delivered and	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner.	Refer to HSIB	Clinical governance and risk management midwife	30.07.2022	HSIB investigation completed, and final report received	
		StEIS report	Clinical governance and risk management midwife	30.07.2022	StEIS number obtained when 72-hour report submitted	
		Formal duty of candour	Clinical governance and risk management midwife	18.07.2022	Verbal and formal DOC provided to the parents prior to discharge from hospital	
		Perinatal Mortality Review Tool (PMRT) review	Clinical governance and risk management midwife	28.02.2023	PMRT review completed on 31.01.23 graded as D and B. HSIB involved in the PMRT review and agree with the grading.	
2	**HSIB safety recommendation:** The Trust is to ensure that staff are supported to undertake a robust risk assessment including review of existing and emerging risk factors	Review the auto-population of management plans within the Badgernet digital maternity record	Deputy divisional nursing and midwifery director	30.08.23	Deadline extended as requires involvement of Clevermed	
3	**Ockenden safety action –** All Trusts must maintain a clear escalation and mitigation policy where maternity staffing levels	Link incident to risk 1033 – obstetric staffing risk	Clinical governance and risk management midwife	31.08.22	Action completed	

	fall below the minimum staffing levels.	Link incident to risk register – digital outcoming of appointments/ DNA que	Clinical governance and risk management midwife	31.08.22	Action completed	
		Review the process for the booking of follow up appointments in the antenatal clinic.	Antenatal clinic manager	~~31.03.23~~ 30.10.23	Awaiting action update from action lead 26.06.23 – Deadline extended as work is ongoing with the robotics team to review and improve the appointment booking system in the antenatal clinic. This is a large piece of ongoing work which will requires full system review.	
		Escalation of case to Divisional Medical Director and Clinical Director) due to identification of obstetric staffing concerns within review findings	Divisional Midwifery and Nursing Director	22.07.22	Action completed	
4	**HSIB safety recommendation:** The Trust is to ensure that staff are supported to follow local guidance when slow or static growth is identified	Flow and capacity coordinator to be recruited who will have the responsibility for elective caesarean section and induction of labour booking and management.	Divisional nursing and midwifery director	30.05.2023	Deadline extended. Flow co-ordinator position currently being advertised. Risk regarding IOL being added to the risk register. Clinical guideline for IOL currently under review. 30.05.23 Flow and capacity co-ordinator now in post.	
		Review the process for women declining induction of labour. Update the current clinical guideline to offer advice on continuing fetal surveillance when induction of labour is declined.	Clinical governance and risk management midwife	~~28.02.2023~~ 30.03.2023	30.03.23 IOL guideline has been updated and published on heritage	
5	**Ockenden safety action –** staff must be able to escalate concerns if necessary.	Implement the RCOG teach or treat communication strategy – for use when questioning/ challenging decision making	Deputy divisional nursing and midwifery director	~~30.05.2023~~ 30.08.2023	Deadline extended; implementation work currently ongoing as part of the mat neo safety improvement work.	
		Implement the RCOG AID communication strategy – for use when escalating care/ concerns	Deputy divisional nursing and midwifery director	~~30.05.2023~~ 30.08.2023	Deadline extended; implementation work currently ongoing as part of the mat neo safety improvement work	

		Support for the staff involved in the incident	Clinical director for obstetrics	31.08.2022	Confirmation received from matron of staff support.	

Appendix 1d - PMRT Ongoing actions – HSIB MI-14079

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner.	Refer to HSIB	Clinical governance and risk management midwife	12.09.2022	MI number obtained	
		StEIS report	Clinical governance and risk management midwife	10.09.2022	StEIS number obtained	
		Formal duty of candour	Clinical governance and risk management midwife	02.09.2022	DOC letter	
		Perinatal Mortality Review Tool (PMRT) review	Clinical governance and risk management midwife	28.02.2023	PMRT review completed 28.02.2023	
2	Support for the staff involved in the incident	Staff to be sent PETALS support information	Matron for complex midwifery care	30.09.2022	Email of confirmation	
3	Ongoing support should be provided to the family	Bereavement support for the family	Specialist midwife for bereavement	30.09.2022	Email of confirmation	
4	**HSIB safety recommendation:** The Trust to ensure that staff are supported to consider the full clinical picture when providing telephone triage advice and ensure that the triage assessment guidance is embedded into practice.	Review of BSOTS and the maternity assessment suite service to be undertaken by the nursing and midwifery director given the current midwifery and obstetric staffing deficit.	Acting nursing and midwifery director	~~31.10.2022~~ 30.05.2023	01.03.2023 external review to be undertaken in mid-March, deadline extended. 30.04.2023 External review completed by the BSOTS Birmingham team. Formal report with recommendations received and divisional position paper written in response to the findings with action plan for achievement of full implementation.	

		Lead midwife for the maternity assessment suite (MAS) to discuss the incident with the MAS team – "back to basics" initiative	Lead midwife for the maternity assessment suite	31.10.2022	Email of confirmation	
5	**HSIB safety recommendation:** The Trust to ensure the triage risk assessment tools support an individualised holistic review recognising developing risk factors, prompting early escalation and care planning.	Implementation of BSOTS	Lead midwife for the maternity assessment suite	~~30.04.2023~~ 31.12.2023	30.04.2023 External review completed by the BSOTS Birmingham team. Confirms that implementation of BSOTS is partial at present. Formal report from the external received with recommendations. A divisional position paper has been written in response to the findings with action plan for achievement of full implementation. Deadline extended to allow for the necessary work to be completed.	
6	**HSIB safety recommendation:** The Trust to ensure that a fetal heart rate is confirmed with a handheld Doppler or Pinard stethoscope before a CTG is started and the mother's heart rate is documented on the CTG	Learning template to be generated from the incident.	Clinical governance and risk management midwife	31.10.2022	Learning template generated and shared which included the recommendations regarding auscultation of the fetal heart rate with a sonic aid or Pinard when commencing a CTG.	
		Additional fetal Doppler equipment to be purchased for the maternity assessment suite	Lead midwife for maternity assessment suite	31.03.2023	30.06.2023 Additional equipment has been purchased and a fetal monitoring equipment committee has been established led by the fetal monitoring specialist midwife. A monthly audit has been developed by the specialist midwife and is recorded on AMAT.	
		Maternity digital team to spend a day in MAS and investigate CTG connectivity issues in real time. Urgent escalation of any identified	Digital lead midwife	31.03.2023	30.06.2023 Following review the CTG'S have been wall mounted at each bed space in MAS and this appears to	

		issues is required to address the connectivity issues.			have reduced connectivity issues.	
		Audit to be undertaken regarding the documentation of the maternal pulse at the start of the CTG and use of a Pinard/ sonic aid to confirm the fetal heart at the commencement of the CTG.	Lead midwife for fetal monitoring	~~30.04.2023~~ 30.06.2023	30.06.2023 the fetal monitoring specialist midwife has added this measure to the audit. The audit reports are available on AMAT.	
7	**HSIB safety recommendation:** The Trust to ensure that staff understand the function of the alarms on the CTG and are supported to recognise why they are activated and respond as required to ensure that the fetal heart at is being monitored and not the maternal pulse.	NICE baseline assessment tool to be completed following publication of the newly revised fetal monitoring guidelines.	Lead midwife for fetal monitoring	31.01.2023	NICE baseline assessment tool has been completed.	
		Fetal monitoring guidelines to be updated and reflected the actions to be taken when a coincidence alarm sounds.	Lead midwife for fetal monitoring	~~31.05.2023~~ 03.07.2023	Guideline is currently under review following publication of the revised NICE guidelines 03.07.2023 updated fetal monitoring guideline published on heritage 03.07.2023 and badger updated to reflect the updated criteria.	
		Learning from incident to be included on the fetal monitoring study day	Lead midwife for fetal monitoring	~~31.03.2023~~ 03.07.2023	03.07.2023 has been included in teaching to raise awareness of the incident and monitoring of maternal pulse.	
		Medical device training for CTG machines to include the actions to take when a coincident alarm sounds.	Lead midwife for fetal monitoring	~~31.03.2023~~ 03.07.2023	03.07.2023 medical device training for CTG machines is included in fetal monitoring training. The medical device training includes coincidence alarms.	
8	**HSIB safety recommendation:** The Trust to support staff to ensure that obstetric review encompasses the mother's whole clinical picture. This	Clinical director for obstetrics/ consultant obstetric lead for clinical governance to meet with the obstetricians involved in the incident and feedback the investigation findings	Clinical director for obstetrics/ consultant obstetric lead for clinical governance	31.10.2022	Email of confirmation received	

	should include her risk factors, physical assessment, and review of the CTG to ensure safe care is provided in the right environment					
9	Review of the appointment process in the antenatal clinic	Review the process for the booking of follow up appointments in the antenatal clinic.	ANC lead midwife	~~31.03.2023~~ 30.10.2023	26.06.23 – Deadline extended as work is ongoing with the robotics team to review and improve the appointment booking system in the antenatal clinic. This is a large piece of ongoing work which will requires full system review.	
10	Review of the large for gestational age to be undertaken and amended as appropriate	Large for gestational age guideline to be updated with a “management of expediential growth” section	Guideline lead	~~30.04.2023~~ 30.08.2023	26.06.2023 Deadline extended additional information regarding the incident requested by the consultant lead to inform the revision of the guideline.	

Appendix 2 – Avoiding term admissions into neonatal units and Neonatal Transitional Care Action Plan Outstanding actions from overarching plan.

Organisation:	Lancashire Teaching Hospitals Womens and Children's Division
Lead Officer:	Maria Esslinger-Raven/Neonatal Outreach Manager
Position:	Safety & Quality Audit Midwife/Neonatal Outreach Manager

Status Key	
1	**Action outstanding**
2	**Action on track but not yet delivered**
3	**Action delivered**
4	**Action delivered and assurance evidence collated**

Ref	Standard	Actions	Lead Officer	Deadline for action	Progress Update	Current Status 1 2 3 4
1	ATAIN Collect data for future reporting to meet requirements of CNST 4 safety action 3(e)	1.1 Revise current ATAIN spreadsheet	Continuous Improvement Midwife	31.09.2021	30.09.21 New data requirements added to current ATAIN spreadsheet (located on t drive-Womens Health RPH-ATAIN)	
		1.2 Work with data analyst to create graphs to display data for future quarterly reports	Continuous Improvement Midwife	30.11. 2021	09.05.22 Q4 ATAIN report produced incorporating data display charts and all subsequent reports will include these data display charts.	
2	ATAIN	2.0 Develop ATAIN Dashboard to demonstrate performance and actions to be undertaken	Continuous Improvement Midwife Business Intelligence Analyst	31.03.2021	11.01.2 Q4 dashboard complete	
		2.1 Set up new data collection process to enable capture and validation of future data	Continuous Improvement Midwife	31.03.2022	01.10.21 ongoing weekly meetings commenced with transitional care lead and safety and quality midwife to support the required manual data collection	
3	ATAIN Quarterly review of the reasons for full term	3.0 Complete a high-level review of the primary reasons for all admissions to neonatal unit should be completed	Safety and Quality Audit Midwife	31.01.2022	11.01.23 Q4 report complete	

	babies being admitted to neonatal unit	3.1 Focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed.	Safety and Quality Audit Midwife	31.01.2022	11.01.23 Included in Q4 report	
4	ATAIN Quarterly review of the reasons for full term babies being admitted to neonatal unit	4.0 Twice Monthly ATAIN reviews ongoing with actions and lessons learnt.	Continuous Improvement Midwife Safety and Quality Audit Midwife	31.03.2022 Ongoing	11.01.23 WBTG continue to meet every 2 weeks.	
5	TC Ensure relevant staff aware of: Importance of keeping mother and baby together both by avoiding admission to NNU and by stepping baby down as soon as possible Criteria for admission to TC particularly that term babies can meet criteria for TC and that babies do not necessarily need admission to NNU for NGT feeing alone	5.0 Review and update the Transitional care guideline to ensure that it is benchmarked against and details operating processes for admission and timely stepdown from NNU care.	Neonatal unit Matron Neonatal Outreach Manager	~~28.02.2022~~ 31.07.2023	22.4.22 amendments to appendix for TC guideline being undertaken following actions from operational group. Awaiting update on heritage. 20.6.23 - original action complete however BAPM released a new framework for late preterm babies in January 2023 so this has been incorporated into the TC guideline. This has been reviewed by NICU senior team and is due to be reviewed by maternity guideline group by end of June 2023 and can then be ratified in July 2023.	
		5.1 Add information to Transitional Care newsletter and circulate to relevant staff	Neonatal Outreach Manager	31.12.2021	16.12.2021 Newsletter circulated and updated regularly as required to all specialities.	
		5.2 Share information at neonatal ops meeting system wide	Neonatal Outreach Mananger Postnatal ward manager	30.11.2021	01.04.22 TC Divisional Board report produced and shared at S&Q.	
		5.3 Share information at neonatal band 7 coordinators meeting	Neonatal Outreach Mananger	30.11.2021	01.04.22 TC divisional board report produced and shared with band 7 co-ordinators.	
		5.4 Share information at neonatal consultants meeting	Neonatal Outreach Mananger	30.11.2021	01.04.22 TC divisional board report produced and shared with consultants at grand ward round.	

6	TC Ensure babies step down from NNU as soon as criteria for TC are met	6.0 Implement process to include discussion on each neonatal ward round whether baby now meets criteria for stepping down to TC	Neonatal consultant	31.1.2021	14.10.2021 Discussion now included in each ward round and process discussed at team meetings.	
7	TC Ensure full and transparent understanding of TC staffing	7.0 Ensure staff aware to accurately and consistently complete neonatal bed state to reflect the appropriate work load detailing when the coordinator is unable to provide TC.	Neonatal unit Matron	30.11.2021	12.11.2021 Information shared at Friday communications meeting Evidence meeting minutes.	
		7.1 Staff to complete Datix if TC nurse not available	Neonatal Outreach Manager	30.11.2021	12.11.2021 Information shared at Friday communications meeting. 8.2.22 Datix that are linked to staffing TC will be reviewed at the weekly governance meeting.	
8	TC Ensure clarity regarding role of the TC nurse	8.0 Remit of the transitional care roles and responsibilities agreed by Matron and service leads	Neonatal unit Matron	31.12.2021	Dec 2021 Meeting held with JS/JC/HA/PD , agreement made to revise the role of the TC (TC nurse to take over care of babies on the septic pathway as well as preterm). 8.2.22 Day in the life of the TC nurse Circulated.	
9	TC Maintain oversight of operations of TC service	9.0 Reinstate the TC Operational Group Meetings	Deputy Divisional Nursing & Midwifery Director	31.01.2022	11.01.2022 TC Operational group meetings recommenced and scheduled for next 12 months	
10	TC Ensure TC nurses receive training on Maternity Badgernet system	10.0 Digital Midwife to deliver training to TC nurses	Neonatal Outreach Manager	31.01.2022	22.4.22 documentation review ongoing to confirm process is embedded. 5/7/22 All NTC documentation now on BN	

11	TC Review of the Transitional care booklet to ensure that this can be translated into the electronic record	11.0 Digital Midwife to discuss requirements at clever med IT change board and confirm that changes can be made to an electronic form	Neonatal Outreach Manager	28 02.2022	January 2022 Transitional care booklet shared with digital team for discussion and transfer to electronic maternity record. 15/3/2022- All staff trained. Pathway testing ongoing with EA Consultant midwife and JS/KN	
12	TC Quarterly review of the findings from the transitional care data collection and audit of the pathway	12.0 Review of the transitional care dashboard and pathway of care findings to inform the transitional care action plan	Neonatal Outreach Manager		09.05.22 Q4 ATAIN report incorporating joint ATAIN/TC action plan produced. Monthly review of the progress actions to be undertaken for assurance.	
13	TC Obtain data to establish if administration of antenatal corticosteroids is a viable project.	13.0 Audit Midwife to obtain data for percentage of **all** CS births with an admission to NNU for RDS and the percentage of **all** inductions of labour which have an admission to NNU for RDS	Safety and Quality Audit Midwife	30.4.2022	11.5.2022 Data collection completed and presented to the WBTG.	
	Respiratory Distress Syndrome (RDS) identified as most frequent reason for admission	13.1 Deep dive review of data relating to RDS ongoing	Safety and Quality Audit Midwife Cathy Langley	31.03.2024	5.7.22 Improving outcomes for high-risk baby's special interest group commenced to optimise theatre as a birth environment. Running alongside the MatNeoSIP optimisation. 05.10.22 3rd Improving outcomes for high-risk babies meeting to take place in October 2022. 11.01.23 Improving Outcomes sub-group unable to meet in Q4 due to clinical pressure but workstreams identified in previous groups continue to be implemented into practice. 20.06.2023 Improving Outcomes sub-group unable to meet but Working Better Together meetings undertaken regularly, and outcomes reviewed here. CNST TC reviews continue to be utilised to review care.	
14	Procure Digital EPR for TC to align end to end	14.0 Neonatal Team to work with Trust IT team to consider use of	Neonatal unit Matron	31.03.2024	22.4.22 Awaiting outcome from IT.	

	maternity and neonatal systems	end-to-end BadgerNet system pan specialty			21.4.22 IT scoping undertaken, and funding confirmed by Deputy CIO. Awaiting allocation of project lead. 20.6.23 - funding for a 12-month secondment or fixed term neonatal digital nurse post agreed. Interviewing on 27th June 2023. Implementation of neonatal BadgerNet EPR system project can begin once digital nurse in post (CleverMed requirement).	
15	A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded.	15.0 Ability to undertake analysis and review of NTC activity	Neonatal unit Matron	Ongoing	5.7.22 Escalated to DMND and DND lack of capacity to complete deep dive review. 20.6.23 - TC Lead Nurse has been extracting data from maternity and neonatal BadgerNet to capture TC data for the dashboard and quarterly reports. Anticipated long term absence for TC Lead Nurse so neonatal team are in the process of identify an alternative person for reviewing and analysing the TC data.	
16	Sub-Group 'Improving Outcomes for High Risk Babies' to identify workstreams required aiming to reduce the numbers of Term Admissions for RDS.	16.0 Improving Outcomes for High-Risk Babies group to continue to meet and progress actions identified.	Safety and Quality Audit Midwife	~~11.01.23~~ 31.03.2023	8.6.22 Improving Outcomes for High-Risk Babies meetings commenced and workstreams/actions identified. October 2022. 11.01.23 Improving Outcomes sub-group unable to meet in Q4 due to clinical pressure but workstreams identified in previous groups continue to be implemented into practice. 20.06.2023 Improving Outcomes sub-group unable to meet due to clinical pressures but Working Better Together meetings undertaken regularly and CNST TC reviews continue to be utilised to review care in this forum.	
17	Deeper level review of babies admitted for hypoglycaemia to mothers with diabetes.	17.0 Via continuous collection of data for term admissions for hypoglycaemia, obtain further detail of maternal blood sugars during labour.	Safety and Quality Audit Midwife	Completed	05.10.22 Reviews of mothers with diabetes now routinely include detail of maternal blood sugars during intrapartum care.	

18	ATAIN: Avoiding separation by treating NAS babies requiring oramorph on the postnatal ward with mother.	18.0 New guideline/policy for babies receiving oramorph for NAS treatment to remain on TC with mother to avoid separation, exemptions allowed i.e., social issues.	Neonatal consultant	Completed	31/05/2023 Policy and guideline introduced and utilised by maternity and neonatal team.	
19	NTC: Undertake and complete the benchmarking exercise for the NEW BAPM compliance	19.0 Multi- profession MDT review and benchmarking exercise to be undertaken to provide assurance of compliance	Maternity and Neonatal Team	1.08.2023	1.07.2023 Benchmarking exercise planned.	

Appendix 3 – MNVP provisional work plan

MNVP/LTHTR Co-production action plan – 2023

Organisation:	Maternity Voices Partnership
Lead Officer:	Jo Lambert
Position:	Deputy Divisional Midwifery and Nursing Director
Tel:	01772 528327
Email:	Joanne.lambert@lthr.nhs.uk

Version	Date
1.0	1.5.2023
2.0	20.6.2023
3.0	1.7.2023

Status Key	
1	Not complete
2	Actions partly achieved or on track to meet delivery timescale.
3	All actions complete , evidence outstanding
4	All actions completed and supporting evidence provided

The Lancashire Teaching Hospitals Maternity and Neonatal Voice Partnership (MNVP) work plan is based on the principles included in the 3-year single delivery plan, the Ockenden, Kirkup reports and Clinical Negligence Scheme for Trust. Its aim is the co-produce and design a safer caring and personalised maternity service that is equitable to service users, modern and personal to women and families. The actions included in the plan are written in response to national external recommendations, complaints, and patient experience feedback. It is expected that once the new MNVP lead is appointed that actions will be adjusted to ensure that the plan is co-produced and meaningful to the local population of Preston and South Ribble for both maternity and neonatal services.

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Listening to women and families with compassion which promotes safer care**	Engaging with local communities to seek feedback and to hear the voice of families using maternity services.	MNVP Lead	1.9.2023	1.5.2023 Arrange quarterly engagement events chaired by the MNVP lead which are both virtual and in community locations. Whilst MVP chair is absent, alternative engagement events will be used to collect feedback.	
					January 2023 Final Latent labour Infographic co-produced with service users and distributed via BadgerNet.	
					6/7.01.2023 January 2023 Partial MVP 15 steps undertaken.	
					April 2023- Leaflet for balloon induction shared with service user and awaiting feedback	
					June 2023 – Leyland Fair – completed.	

					March to June 2023 Gynaecology Improvement plan service user individual meetings held to seek views of women using the early pregnancy service.	
		15 Steps Assessment	Matron for midwifery Led Care	1.02.2023	06/07.01.2023 January 2023 Partial MVP 15 steps undertaken. Did not fulfil the criteria for quoracy of representation but walk round undertaken and actions agreed.	
		15 steps action plan	Matron for Safety and Quality	1.8.2023	1.03.2023 Develop a system level action plan for co-design and improvement.	
		Collate a 15 Steps Response paper	Matron for Safety and Quality	1.08.2023	30.06.2023 Response paper and associated action plan written.	
		Undertake a repeat baseline 15 steps walk round when new MNVP chair appointed	MNVP Lead/ Matron for Midwifery Led Care.	1.9.2023	1.5.2023. Arrange a co-produced 15 steps to seek views of local service users so that service can be co-designed.	
2	**Ensuring pregnant women and new mothers have access to pelvic health services.**	Develop accessible pelvic health services.	Divisional Director of Midwifery and Nursing	1.9.2023	1.5.2023 Employ a specialist lead midwife for pelvic health. Funding approved	
					20.06.2023 Recruit to band 7 Pelvic Health Midwife. 23.6.2023 Post awaiting approval at Vacancy Control Panel.	
3	**Rolling out perinatal mental health services**	Ensure that women have equitable access to mental health services during the perinatal period	Divisional Director of Midwifery and Nursing	1.9.2023	01.05 2023 Review current service offer with new MNVP Lead	
					01.05.2023 Specialist lead midwife and ANC in place.	
					23/06/2023 Liaise with the reproductive trauma service quarterly to seek anonymised thematic feedback. Meet date to be confirmed.	
4	**Choice and personalisation** Enhance the antenatal experiences and choices of	To make care safer, more personalised, and more equitable.	Deputy Divisional Midwifery Director/ MNVP Lead	1.9.2023	1.5.2023 Personalised care plans are utilised for all women and birthing people so that they can make informed decisions about where to have their baby. Need to collate evidence via BadgerNet.	

	mothers and their families					
					1.5.2023 Choice and personalisation conversations with a midwife at 34 weeks supports birth choices.	
					A birth options clinic is available for women who need additional information to support them with informed choice.	
5	**Bereavement Services**	Improve availability of bereavement services across 7 days a week by the end of 2023/24.	Divisional Director of Midwifery and Nursing	30.06.2023	20.6.23 Completed the LMNS funding work plan detailing work plan for additional bereavement funding.	
					1.7.2023 Funding agreed. Bid to be approved at ICB Quality Assurance Panel 7.7.23.(Not yet received outcome)	
6	**Rainbow Service antenatal education and peer support**	Review current provision for specialised antenatal education and peer support offer for families experiencing a rainbow pregnancy	Lead Midwife for Bereavement and service user.	1.09.2023	30.6.2023 Lead midwife for bereavement working with service users to develop an antenatal and peer support offer for rainbow families.	
7	**Bereavement Services Review bereavement service offer (including miscarriage and stillbirth**	Plan services that are responsive to 31 August 20 provided by service users.	Director of Patient experience/ Matron for Safety and Quality.	1.09.2023	1.5.2023 Learn from concerns and complaints and review complaints quarterly to ensure that thematic concerns are identified and used to co-design services. Themes reviewed and used to inform gynaecology experience improvement plan 2023/24 and maternity experience improvement plan 2023/24.	
		Gynaecology experience Improvement Plan	Deputy Divisional Midwifery Director/ MNVP Lead Matron for Gynaecology	1.12.2023	1.5.2023 Agree key priorities for early pregnancy service based on experience data, service user feedback, concerns, and complaints. Action completed	

					20.6.23 Improvement actions confirmed, and journey posters developed.	
					01.05.2023 Charitable bid submitted for lead nurse for bereavement for early pregnancy (2 year)	
					01.06.2023 Awaiting final costing agreement for environmental improvement to waiting areas, ambulatory care and the scan room in GAU. To co-produce environment once build completed.	
		Undertake National Bereavement Pathway external review	National Bereavement Pathway	30.06.2023	1.5.23 External review of maternity, neonatal and gynaecology by National Bereavement team commissioned to benchmark service against standards. (13th 14th July 2023)	
		National Bereavement Pathway to seek Feedback from service users who have experienced pregnancy loss, termination of pregnancy	National Bereavement Pathway	15.07.2023	1.06.2023 National Bereavement review to include meetings with service users who have experienced pregnancy loss, termination and stillbirth	
8	**Integrated care systems (ICSs) will publish equity and equality plan and take action to reduce inequalities in experience and outcomes.**	Promote cultural diversity and ethnicity engagement in maternity care.	Deputy Divisional Midwifery Director/ MNVP Lead	1.09.2023	1.06.2023 Co-produce and implement local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality based on LMNS equity plan. Require MNVP chair to complete this. Healthwatch due to recruit during July 23.	

9	**Improve Health inequalities**	Services listen to and work with women from all backgrounds to reduce inequality and improve access, plan, and deliver personalised care.	Divisional Midwifery and Nursing Director NMVP Lead	1.09.2023	1.5.2023 Seek opportunity through MNVP and other public sector. organisations and such as community leaders, schools to hear the local population voices.	
		Deputy Divisional Midwifery Director/ MNVP Lead	Chief Nursing Officer	1.8.2023	1.7.2023 Chief Nursing Officer to link with local Muslim girls' school to arrange a visit to seek views of young women who are future service users.	
10	**Update Web pages** Refresh Trust internet page using feedback provided in MVP LTHTR gap analysis	Refresh and review in collaboration with MNVP to reflect changes required to improve accessibility	MVP Chair Deputy Divisional Midwifery and Nursing Director	31/09/23	1.5.2023 Review gap analysis document and update website with new MNVP Lead. Action carried over from 2022. .	
8	**Strategic Engagement and collaboration**	In collaboration with the service ensure that any joint communication is agreed by all stakeholders. Attend any local, regional, or national events.	MNVP Lead	28.04.2023	28.04.2023 Insight visit undertaken by MVP Chair (Pennine LSC). Feedback received for action. *Co-production- acknowledge the MVP Chair vacant but as a Trust you are clearly committed and have continued to undertake various pieces of work with services users.*	
				31.03.2024	1.5.2023 Ongoing action as required.	
9	**Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.**	As per updated October 2022 standards the MNVP should: - Evidence that the MVP Chair is invited to attend maternity governance meetings. - Create Maternity experience improvement plan.	MNVP Lead Lead midwife for Governance	31/03/2023	01.07.2023 Invite East Lancs MNVP to Maternity Safety and Quality in the absence of MNVP Lead. Awaiting appointment. Email sent.	
			MNVP chair and Divisional Midwifery and Nursing Director	30.8.23	23.06.23 Improvement plan/roadmap created following thematic review of experience feedback.	
			MNVP chair and Divisional	01.09.23	23.06.2023 Maternity experience roadmap to be reviewed with new MNVP chair. Action ongoing	

			Midwifery and Nursing Director			
11	**Forward planning for 2023**	The MNVP and Service to following appointment to confirm and updated work plan to include maternity and neonatal services workplan for 2023/24	MNVP Divisional Midwifery and Nursing Director/Neonates CYP	5/2/23	28/11/22 Meeting to be arranged in January 2023 to schedule co-production work plan for 2023 and sign off plan with LMNS. 1.7.2023 Awaiting appointment of new MNVP lead to confirm requirements of local work plan.	
		The new MNVP chair will review the co-production plan and confirm this is appropriate for 202324.	MNVP chair and Divisional Midwifery and neonatal Director	31.8.23	Meeting to be scheduled once appointed.	

Appendix 4 Workforce action plan

RAG	Key
Action outstanding	
Action on track but not yet delivered	
Action delivered	
Action delivered and assurance evidence collated	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Review temporary staffing solutions.**	Introduce Thursday 11am weekly operational planning meeting between the ward managers and matrons. Sickness absence should also be discussed during the meetings.	Matrons	~~01.05.2023~~ ~~01.06.2023~~ 01.08.2023	24.04.2023 To commence week beginning 15.05.2023. 15.05.2023 First meeting planned. 03.07.2023 First meeting held. Template to be revised and the regular meetings to be set up.	
		Develop a midwifery staffing team's channel.	Matron for complex midwifery care	01.05.2023	24.04.2023 JG to provide MR with a list of people to be added to the team's channel. 15.05.23 List collated and teams' channel open.	
		Develop a weekly staffing meeting template to record meetings and actions.	Matron for complex midwifery care	~~01.05.2023~~ ~~07.07.23~~ 01.08.2023	24.04.2023 Draft template to be updated by MR 03.07.2023 Template trialled and to be revised.	
		Consideration of an on-call system for the unit.	Matrons	~~30.06.2023~~ 01.09.2023	24.04.2023 Offer on-call shifts as a volunteer temporary arrangement to staff. Draft an expression of interest for staff. Considered and excluded	
		Consult summer leavers to understand if they will consider deferring end date.	Matron for midwifery led services	30.06.2023	24.04.2023 Staff have been consulted and majority are going to new positions. Action closed.	
		Request 10WTE agency midwives block booking for 6-month period.	Chief Nursing Officer	06.07.23	03.07.23 - Request made through temporary staffing and agency recruitment for block booking ongoing based on unfilled shifts through top October 2023.	

		Explore use of registered Nurses from critical care within maternity services.	Chief Nursing Officer	31.07.23	03.07.23 -Request made of critical care team for nursing staff to support when appropriate and in line with "Safe practice principles for adult nurses working as part of multidisciplinary teams (MDT) in Maternity Services" published by NHS England on 25th May 2023. Options for other nurse roles within maternity services to be explored.	
		Publicise bank shifts within and external to the unit	Recruitment team	06.07.23	03.07.23 -Request made of recruitment	
		Additional shifts created for band 2 and 3 shifts to provide support on reduced fill rate shifts.	Deputy Midwifery and Nursing Director	ongoing	03.07.23 - In place	
		Bank midwifery advert agreed with Chief Nursing Officer	Chief Nursing Officer	ongoing	3.07.2023 Advert for bank midwives published.	
2	**Utilisation next 3 months**	Review Newly Qualified Midwife (NQM) preceptorship clinical rotation plan to identify any possible rotations which could be better utilised within the service.	Team leaders	~~30.04.2023~~ 31.05.2023	24.04.2023 Shifts have potentially been identified in ANC – assessment to be completed to identify prioritisation of the clinical areas to receive the additional staffing. 15.05.2023 Scoping of hours undertaken. Unable to progress at this time as movement of NQM from ANC will potentially impact on essential planned work re-organisation. Action closed.	
		Review of the birth centre staffing models because of the current birth rates within midwifery led services.	Matron for midwifery led services	30.06.2023	24.04.2023 review is ongoing. Potential for the third person to be a "floating midwife". 15.05.2023- Matron for MLS reviewed percentage of births in co-located birth centre. Plan to reduce staffing to 2 per shift from 3 per shift from the 10th of June 2023. Action closed.	

		Identify and consider potential withdrawal of non-essential services.	Divisional midwifery and nursing director.	30.05.2023	24.04.2023 identify the non-essential services. 15.05.2023 Unable to identify any non-essential services at present. Non-viable option. Action closed.	
		Identify areas of the service that could be distributed to other staff groups.	Public Health Midwife	~~30.06.2023~~ 31.07.23	15.05.2023 To explore vaccination services. Potential for a nurse to administer vaccines. Public health midwife liaising with LMNS to consider wider system options.	
		Telephone consultation/ virtual services for differed visits.	Matron for midwifery led services	30.05.2023	24.04.2023 Scoped whether there is appetite for a leaver to stay and complete hybrid virtual working. Non-viable option. Action closed.	
		Determine which specialist midwives can be utilised to work clinical shifts during anticipated summer pressures.	Senior management team	~~30.04.2023~~ 30.05.2023	24.04.2023 Specialist midwives identified: screening midwives, midwifery practice educator, preceptorship and retention lead, public health midwife, infant feeding and potentially service development midwife. 15.05.2023 8 specialists will contribute 1 day a week to ANC, Maternity A, B and DS from the 10.06.2023 Action Closed.	
		Consult specialist midwives regarding the preferrable pattern of clinical working (i.e.) 2 days per week or one block week.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting 25.04.2023. 15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		All managers to have time to lead reduced to days per week during anticipated summer pressures.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting. 15.05.2023. All managers and team leaders to increase clinical shifts from 1 day per week to 2 days per week from 10.06.2023.	
		Consult team leaders and ward managers regarding the preferrable pattern of clinical working.	Matrons	30.06.2023	15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	

		Consider rationalisation of meeting schedule.	Deputy DMND	~~30.06.2023~~ 01.08.2023	15.05.2023 Review speciality meetings to consider rationalisation and defined attendance over months of June, July, August and September 23.	
3	**Birth rate plus data utilisation**	Review the latest birth rate plus data and complete a paper for board.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 Paper to be shared with chief nurse and then presented to board for review. 15.05.2023 Paper to be presented as part of bi-annual staffing review in May 2023 26.05.23 Biannual staffing report presented to S&Q. Action closed	
		Complete the training for the ward acuity tool.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.23	24.04.2023 date agreed for training with the external providers. Staff to attend currently being agreed. 15.05.2023 Ward managers assigned to attend, and additional staff released if possible. Session will be recorded for use later. App not working at this time action paused	
		Launch the acuity tool across the ward areas.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.2023	24.04.2023 to be launched in June 2023 following completion of training. Action paused as above.	
4	**Roster management**	Meet with the health roster term to specify supernumerary tiles which will not be included in the unfilled rate.	Matron for complex midwifery care	30.06.2023	24.04.2023 MR has met with health roster team. Health roster team to review request and feedback. 15.05.2023 Email request for speciality meeting. 30.06.2023 Supernumerary tiles now in place. Action closed	
		Matron review of roster templates to ensure that templates reflect the establishment for each area.	Matrons	01.07.2023	15.05.23 Meeting to be arranged with e-roster team to confirm templates reflect staffing requirements. Awaiting update that all areas reviewed.	
		Meet with team leaders/ ward managers regarding summer annual leave planning.	Matron for complex midwifery care	30.04.2023	24.04.2023 MR has pulled the roster reports and confirmed that the annual leave is booked and does not exceed	

		Reiteration that maximum allowance is 17%.			the maximum requirement. Action closed	
		Creating a new cost centre for preceptees or team midwives	Finance BP	31.07.23	15.05.2023 Finance BP to create new cost centre. Update awaited.	
		Unused roster hours to be reviewed by the matrons at sign off.	Matrons	30.04.2023	24.04.2023 Healthroster to be reviewed as part of monthly sign off with each area to utilise un-filled shifts. Action closed	
		Maternity ward B roster to be reviewed for balance. Review MSW staffing ratios across day and night.	Matron for complex midwifery care	30.05.2023	24.04.2023 MR to discuss with HA. 15.05.2023 Staffing gaps have been reviewed to reflect the service requirement. Action closed	
		Consider options for assessing and balancing staff numbers across whole service and develop plan for June-October 2023.	Matrons	30.05.2023	15.05.2023 Matrons to meet to review establishments and confirm plan for distribution of staff across the areas with highest establishment gaps. 03.07.23 – This is now done on a weekly basis. Action closed	
5	**Recruitment**	Continuation of the preceptorship lead midwife post for further 11 months.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 awaiting confirmation from finance. JG has completed the workforce form for the extension. Action closed	
		Recruit up to 16 international recruits.	Preceptorship and retention leader midwife	~~30.07.2023~~ 31.12.2023	24.04.2023 – 3 currently in post, 2 coming to the testing centre in May 2023. Awaiting further information. Recruitment ongoing. 15.05.2023 Deadline date extended to reflect ongoing recruitment plan. 01.07.23 – 4 RM in post. Action ongoing.	
		Vacancy and maternity leave tracker to be overseen workforce committee.	Matrons	~~30.05.2023~~ 30.06.23	24.04.2023 – two external recruits successfully made week commencing 17.04.2023. 15.05.2023 Deadline date extended to reflect ongoing and continuous monitoring of vacancies.	

					30.06.2023 Item to be added to workforce committee in July 2023.	
		Recruitment to delivery suite core team.	Matron for complex midwifery care	30.05.2023	24.04.2023 – shortlisting has been completed awaiting date for interview. 15.05.2023 Core team recruited. Action closed	
		Recruitment to the birth centre core team.	Matron for midwifery led services.	30.05.2023	24.04.2023 – successfully completed	
		Recruitment to the Mat A/B ward core team.	Matron for midwifery led services.	31.08.23	01.07.23 - Advert out currently	
		Recruitment to the caesarean section team as core (1.6 WTE).	Matron for complex midwifery care	~~30.05.2023~~ 30.06.2023	24.04.2023 – advert for the team has been completed and approved by EA. Advert to go to vacancy control this week. 15.05.2023 Shortlisting outcome awaited. Deadline extended. 01.7.23 – recruited to successfully.	
		Associate leader positions to be considered.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – stand down as non-viable at present time.	
		Band 5 advertisement to be released.	Matron for midwifery led services	~~30.04.2023~~ ~~30.06.2023~~ 01.09.2023	24.04.2023 – advert has been approved by EA and RC. Currently with vacancy control anticipated release 28.04.2023. 15.05.2023 Shortlisting in progress. Deadline extended. 01.07.23 – continuous adverts out.	
		Recruitment open day for band 5 midwives.	Matrons	~~30.05.2023~~ 31.07.2023	24.04.2023 – to be organised once the vacancy is released. 15.05.2023 Consider whether open day or engagement of new starters required. 01.07.23 – ongoing next recruitment event to be confirmed.	

		Consider recruitment to the band 4 practice development post once the funding becomes available.	Divisional midwifery and nursing director	~~30.05.2023~~ 01.09.2023	24.04.2023 – awaiting outcome of funding. 15.05.2023 Update awaited. 01.07.23 – paper to LMNS submitted and awaiting final approval to recruit.	
		Band 3 allocation to be reviewed across the service.	Divisional midwifery and nursing director	~~30.05.2023~~ 01.09.2023	24.04.2023 – needs finance review. Long term funding of the roles needs to be reviewed. 01.07.23 – Birth rate plus report taken to Board May 2023.	
		Increase consultant obstetricians by 3 WTE to support demand and capacity and increase in complexity	Divisional Director and Deputy Medical Director	01.01.2024	03.07.23 Demand and capacity assessment has taken place and business case has been created to discuss with finance. Business case will support 98 hours obstetric cover, antenatal clinics, caesarean section list, induction of labour and maternity triage	
6	**Retention** **Flexible working**	Line manager to have conversations with all staff about flexible working opportunities. Flexible Working Toolkit available	All Managers	1.11.2023	30.06.2023 Flexible working conversations to be included in appraisals and as part of team meetings.	
7	**Retention Seeking Feedback**	To seek feedback from staff via TED surveys, listening events, team meetings	All Managers	31.09.2023	30.06.2023 All areas to undertake a TED survey and develop local ways to seek feedback from teams.	
8	**Retention Retain, Reward and Recognise – Staff Satisfaction**	Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.03.2023	30.06.2023 Monthly thank you awards nominated by the band 5 team for a team member who offering supportive mentorship and professional support.	
		Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.10.2023	17.04.2023 Shining Star award. A monthly award for outstanding kindness and team work continues	
		Engage in Microsystems Coaching Programme via CI team.	Divisional midwifery and nursing director	31.10.2023	17.04.2023 Divisional Engagement with flow and micro coaching programmes	
		Opportunities for development and career progression	Divisional midwifery and nursing director	31.10.2023	30.03.2023 CPD requests submitted. HDU courses, NIPE, PMA, Fetal	

		available via CPD funding work streams			monitoring speciality training, maternal medicine. ANNB ARC.	
9	**Retention Engagement**	Alternate month mobile coffee catch up with leadership team visiting clinical areas scheduled for 12 months.	Leadership Team	31.03.2024	30.06.2023 Mobile coffee catch up sessions ongoing.	
8	**Retention of Students**	Link with the LMNS 2-day course to be facilitated by university to link with colleges for perspective midwives.	Divisional midwifery and nursing director	~~30.06.2023~~ 01.01.2024	24.04.2023 – awaiting further information. 15.05.2023 Action ongoing.	
		Explore continuation of funding for midwifery clinical placement facilitator.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – awaiting further information to meet. 15.05.2023 Meeting arranged for 19.05.23 to discuss PEF funding. 03.07.23 – Meeting held and funding continued for PEF with other funding streams being explored therefore action closed	
9	**Retention Health and wellbeing**	Maternity conference to be organised for 15/06/2023 for current midwives and maternity support workers.	Matron for midwifery led care	30.06.2023	24.04.2023 – progressing well. Agenda in development. 15.05.2023 Planning on track 15.06.2023 – Maternity conference delivered as planned	
		Establish and agree the PMA offer.	Divisional midwifery and nursing director	~~30.05.2023~~ 01.09.2023	24.04.2023 – date to meet with PMA's to be arranged. 15.05.2023- Meeting with DMND to be confirmed. 01.07.23 – Trust structure agreed for PNA/PMAs. 5 PMA trained. Staffing limiting activity. To remain on workplan and meeting to be arranged with PMAs to agree development of this service.	
		International day of the midwife – cups and biscuits for the clinical areas/ teams.	Deputy divisional nursing and midwifery director.	30.05.2023	24.04.2023 – Cup designs have been developed and order placed.	

					15.05.2023 Mugs and biscuits distributed to all areas. Celebrated IDM 2023. Action closed	
		Expansion of the unit coordinator role to include ward and area managers.	Matrons	~~30.05.2023~~ 30.06.2023	24.04.2023 – to discuss with ward managers. Action deadline extended. No further progress. Action stood down	
		Introduce de-brief tool to support hot de-briefing.	S&Q matron	~~30.05.2023~~ 31.08.2023	24.04.2023 – EH to explore hot debrief tool and feedback at the next meeting. 15.05.2023- Options for debrief ongoing. Deadline extended.	
		OD department to develop division wide action plan with ideas for action which are specific to each area	OD leads	01.09.2023	03.07.23 – Meeting held with OD lead for division and area action plans to be developed.	
10	**Correlation between staffing and safety intelligence**	Monitor safety data daily, including red flags, BR plus acuity, coordinator feedback at safety huddles, PALS, service user feedback, governance systems.	Divisional midwifery and nursing director	Ongoing	Systems in place. Daily monitoring	
		Monthly oversight of safety and quality metrics through the maternity safety dashboard to safety and Quality group in division and Board.	Divisional midwifery and nursing director	Ongoing	Systems in place	
11	**Well Led**	Trust development programme based on ward manager and matron handbook to develop leadership capability and capacity.	Chief Nursing Officer	30.09.23	Chief Nurse leading	
		To undertake a training needs analysis of the leaders and managers within the Division, understanding who has completed which development programme, where additional tailored support can be provided and who may need performance management intervention.	OD and Divisional Board to commit & enable attendance	1.11.2023	30.06.2023 Scoping work to understanding of level of capability and confidence in department. What development support is needed, how expectations are communicated and reinforced to improve management effectiveness across the Division.	

		To set up a Band 7 Action Learning set where leaders come together monthly to have the headspace, facilitated support, consultancy support to identify how to make improvements in team engagement and staff satisfaction, enabling them to develop actions plans which improve colleague experience	OD and Divisional Board to commit & enable attendance	31.10.2023	30.06.2023 Action Learning groups to be set up from October 2023 after new recruits in post.	
		Based on the findings of the training needs analysis consider the delivery of a series of bespoke leadership 'away days.	OD and Divisional Board to commit & enable attendance	30.09.2023	30.06.2023 Agree bespoke series of meetings following review of leadership TNA and from listening to feedback from the team.	
		To improve the quality of appraisal conversations/paperwork, objective and development planning in appraisal. This will be achieved by all appraisers attending the Appraisal Masterclass.	OD and Divisional Board to commit & enable attendance	31.03.2024	30.06.2023 Improved appraisal quality audit rating. Increased use of 360 feedback in appraisal. Increased number of appraisals with objectives and personal development plan completed. Increased scores benchmarked against the 2022 National Staff Survey for questions relating to having a quality appraisal.	
		Increased capacity within senior midwifery team through creation of: - Deputy Divisional midwifery and Nursing Director - Creation of Safety and Quality matrons - Creation of the Specialist Midwife for maternal medicine - Creation of the Planned work,	Chief Nursing Officer	~~31.04.23~~ 01.09.23	03.07.23 – All posts recruited.	

		capacity, and flow co-ordinator - Enhanced antenatal and newborn screening leadership capacity				

Appendix 5 – New Saving Babies Lives Dashboard (national toolkit awaited)

Process description	Frequency	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Target
Percentage of women where CO measurement at booking is recorded. (From April 2021 Data from BadgerNet SBL unit report)	Monthly	92.1%	86.6%	88.1%	87.9%	91.6%	90%	80%
Percentage of women where CO measurement at 36 weeks is recorded *(From April 2021 Data from BadgerNet SBL unit report)*	Monthly	83.2%	78.1%	79.0%	86.7%	86.8%	82.3%	80%
Percentage of women with a CO measurement ≥4ppm at booking *(From April 2021 Data from BadgerNet SBL unit report)*	Monthly	8.2%	8.5%	6.6%	9.1%	9.5%	8.90%	No target
Percentage of women with a CO measurement ≥4ppm at 36 weeks. *(From April 2021 Data from BadgerNet SBL unit report)*	Monthly	10.1%	6.5%	7.5%	5.6%	9.6%	5.90%	No target
Percentage of women who have a CO level ≥4ppm at booking and <4ppm at the 36-week appointment. *(From April 2021 Data from BadgerNet SBL unit report)*	Monthly	26.1%	36.7%	36.0%	21.1%	26.8%	36%	No target
Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date **(New metric)**	?Monthly							
Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks **(New metric)**	?Monthly							
Percentage of pregnancies where a risk status for FGR is identified and recorded using a risk assessment pathway at booking and at the 20 week scan.	Quarterly unless special cause is identified.	96.4%	92.5%	85%	90%	100%	100%	80%
Percentage of pregnancies where an SGA/FGR fetus is antenatally detected and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital **(New metric)**	Quarterly	52.0%			80%		60%	
CNST 4 action 1) Specifically confirm women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards **(Metric may no longer be required)**	Bi-annually unless special cause is identified		100%					No target
CNST 4 action 2) Specifically confirm that in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation **(Metric may no longer be required)**	Quarterly	95.0%	95.0%	88.2%	98.0%	98%	100%	80%
CNST 4 action 3) Specifically confirm there is a quarterly audit of percentage of babies born <3rd centile >37+6 weeks' gestation **(Metric may no longer be required)**	Quarterly unless special cause is identified.							No target

CNST 4 action 3) quarterly review of babies born <3rd Centile >37+6 weeks **(Metric may no longer be required)**	Quarterly unless special cause is identified.							No target
Percentage of babies born <3rd centile >37+6 weeks gestation	Monthly	17.4%	54.0%	44%	47%	67%	69%	No target
Percentage babies born <10th centile >39+6 weeks gestation **(Metric may no longer be required)**	Monthly	15.8%	36.0%	21%	28%	20%	23%	No target
Percentage of babies (live births & still births) >3rd birthweight centile born <39+0 weeks gestation. **(New metric)**								
Overall Percentage of staff who have completed GAP/GROW competency. **(Metric may no longer be required)**	Monthly	82%	82.0%	87%	83%	83%	82%	90.0%
Percentage of Midwives who have completed GAP/GROW competency. **(Metric may no longer be required)**	Monthly	87%	84%	89%	88%	87%	86%	90.0%
Percentage of consultants who have completed GAP/GROW competency. **(Metric may no longer be required)**	Monthly	73%	80%	89%	63%	73%	67%	90.0%
Percentage of all other obstetric doctors who have completed GAP/GROW competency. **(Metric may no longer be required)**	Monthly	52%	61%	65%	54%	52%	58%	90.0%
Percentage of women booked for antenatal care who had received paper leaflet/information by 28+0 weeks of pregnancy. **(Metric may no longer be required)**								All women as Badger notes online.
Percentage of women booked for antenatal care who have received digital RFM leaflet by 28 weeks of pregnancy. **(Metric may no longer be required)**	Quarterly unless special cause is identified.	100%		100%	100%	100%	100%	No target
Percentage of women with RFM discussed at each antenatal check. **(Metric may no longer be required)**	Quarterly unless special cause is identified.	100%		100%	100%	100%	100%	100.0%
Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short-term variation)	Monthly	98.2%	96.4%	95.1%	95.9%	94.7%	95.90%	80%
Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation) - adjusted figure following manual audit of cases reported as non-compliant.	Monthly	100%	100%	99%	100%	99%	99%	80%

Proportion of women who attend with recurrent RFM* who had an ultrasound scan to assess fetal growth. **(New metric)**								
Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation	Quarterly	0%	0%	0%	0%	0%	0.60%	No target
Percentage of staff who have attended local CTG update teaching sessions in addition to mandatory training. **(Metric may no longer be required)**	Monthly	92%	93%	94%	96%	93%	94%	90.0%
Percentage of staff who have successfully completed mandatory annual competency assessment. **(New metric)**							96%	
Breakdown; Percentage of Midwives who have attended local CTG update teaching sessions in addition to mandatory training.	Monthly	91%	93%	94%	97%	91%	97%	90.0%
Breakdown; Percentage of Obstetric Consultants who have attended local CTG update teaching sessions in addition to mandatory training.	Monthly	100%	90%	100%	88%	100%	78%	90.0%
Breakdown; Percentage of Other Obstetric Doctors who have attended local CTG update teaching sessions in addition to mandatory training.	Monthly	100%	96.0%	100%	96%	100%	92%	90.0%
90% of eligible staff have attended local multi-professional fetal monitoring training annually	Monthly	93%	93%	93%	93%	97%	94%	90%
Overall Percentage of staff who have received training on CTG interpretation and auscultation, human factors and situational awareness	Monthly	99%	93%	93%	93%	94%	99%	90.0%
Breakdown : Percentage of Midwives who have received training on CTG interpretation and auscultation, human factors and situational awareness	Monthly	91%	93%	94%	95%	91%	99%	90.0%
Breakdown: Percentage of Obstetric Consultants who have received training on CTG interpretation and auscultation, human factors and situational awareness	Monthly	90%	90%	100%	75%	100%	96%	90.0%
Breakdown: Percentage of Other Obstetric Doctors who have received training on CTG interpretation and auscultation, human factors and situational awareness	Monthly	96%	96.0%	100%	96%	100%	96%	90.0%
Overall Percentage of staff who have successfully completed mandatory annual competency assessment	Monthly	99%	99%	99%	97%	97%	96%	90.0%
Breakdown: Percentage of Midwives who have successfully completed mandatory annual competency assessment	Monthly	99%	98%	98%	98%	98%	97%	90.0%

Breakdown: Percentage of Obstetric Consultants who have successfully completed mandatory annual competency assessment	Monthly	90%	100%	100%	100%	100%	78%	90.0%
Breakdown: Percentage of Other Obstetric Doctors who have successfully completed mandatory annual competency assessment	Monthly	91%	96%	100%	88%	81%	92%	90.0%
Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). **(New metric)**		100.0%	100.0%	100.0%	100.0%	100%	100%	80%
Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth (from BadgerNet monthly report with manual audit of records where BadgerNet data not complete)	Monthly	90.1%	100%	85.7%	66.7%	33.3%	54%	80%
Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids (from BadgerNet monthly report with manual audit of records where BadgerNet data not complete) **(Metric may no longer be required)**	Monthly	0%	0%	0%	0%	33.3%	0%	No target
Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth	Monthly	60%	100%	50%	100%	33.3%	100%	80%
Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).	Monthly	100%	100%	100%	100%	100%	100%	80%
Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. **(New metric)**							100%	
Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. **(New metric)**							77%	
Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. **(New metric)**							62%	
Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. **(New metric)**							38%	
Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (1 to 7 above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation) **(New metric)**							23%	

Mortality to discharge in very preterm babies (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner) **(New metric)**						Q4 report and mortality report for 2022		
Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: Germinal matrix/ intraventricular haemorrhage. Post haemorrhagic ventricular dilatation. Cystic periventricular leukomalacia **(New metric)**								
Percentage of perinatal mortality cases annually (using PMRT for analysis) where the prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue. **(New metric)**								
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: In the late second trimester (from 16+0 to 23+6 weeks) **(New metric)**	Monthly	0.6%	1.0%	0.6%	1.0%	1.2%	1.0%	No Target
The incidence of women with a singleton pregnancy giving birth (liveborn and stillborn) as a % of all singleton births: Preterm (from 24+0 to 36+6 weeks) **(New metric)**	Monthly	10.5%	6.4%	10.5%	6.0%	5.9%	6.7%	No Target
Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant. **(New metric)**								
Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes. **(New metric)**								LTHTR is a tertiary unit for maternity care which cares for women with type 1 and 2, and gestational diabetes. There is a continuity team in place which provides antenatal, intrapartum and postnatal care to women and families.
Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. **(New metric)**								LTHTR is a tertiary unit for maternity care which cares for

								women with type 1 and 2, and gestational diabetes. There is a continuity team in place which provides antenatal, intrapartum and postnatal care to women and families.
Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. **(New metric)**				100.0%				As per maternal care for type 1 and 2 diabetes and gestational diabetes care, blood glucose monitoring is now completed either by a continuous monitor or uploaded onto the GDM app
Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities and availability of expertise. **(New metric)**								Manual quarterly audit collected from lead of diabetic/tulip team
The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashBoard (aiming for >95% of women). **(New metric)**				100.0%				
The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the 49 start of the third trimester (aiming for >95% of women) **(New metric)**				50.0%				Manual quarterly audit collected from lead of diabetic/tulip team
Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant. **(New metric)**								Manual quarterly audit collected from lead of diabetic/tulip team

CNST 4 Standard 1) Percentage of perinatal mortality cases annually where the screening and management of FGR was a relevant issue using the PMRT.	Monthly	0%	0%	0%	0%	0%	0%	No Target
CNST 4 Standard 1) Percentage of stillbirths which had issues associated with RFM management identified using PMRT.	Monthly	0%	0%	0%	0%	0%	0%	No Target
CNST 4 Standard 1) Percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor using the PMRT.	Monthly	0%	0%	0%	0%	0%	0%	No Target

Appendix 6 – Maternity red flag data

Maternity Red Flag Data: 2022 - 2023															
Red flag Reporting Metrics	**Apr -22**	**May -22**	**Jun -22**	**Jul -22**	**Aug -22**	**Sept -22**	**Oct -22**	**Nov -22**	**Dec -22**	**Jan -23**	**Feb -23**	**Mar -23**	**Apr-23**	**May 23**	**Jun 23**
Delay in time critical activity	0	0	1	1	25	11	16	2	1	2	13	54	22	17	17
Missed or delayed care> 60 mins in washing or suturing	0	0	0	0	1	0	2	0	0	0	0	1	0	0	1
Failure for women to receive the medication required	2	0	0	1	6	2	3	2	0	0	0	1	0	0	0
>30-minute wait for pain relief.	0	0	1	0	0	2	1	0	0	0	0	1	0	0	0
Lack of full examination when woman presents in labour.	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0
>2-hour delay in induction?	12	2	3	2	27	15	19	3	1	1	0	10	1	6	4
Delay in recognition of and action of abnormal signs.	2	2	0	0	0	1	1	0	0	0	0	2	2	0	0
Inability to provide one to one care in labour?	0	0	1	2	5	4	5	0	0	0	0	2	0	0	0
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS	0	0	0	0	0	1									
>30-minute wait for triage.	0	0	0	1	2	2	1	1	0	1	1	40	15	15	15
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)							1	0	0	0	0	0	0	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)							13	3	0	1	0	7	3	5	3
Was there a delay in transfer once labour was established? (New parameter Oct 22)							3	0	0	0	0	1	0	0	1
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)							1	0	0	0	0	0	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)							1	1	0	0	0	0	0	1	0

Has there been a deferred date of planned induction of labour? (New parameter Oct 22)							9	0	0	0	0	2	0	1	0
Has there been any cancelled or delayed community work? (New parameter Oct 22)							1	0	0	0	1	4	1	27	177
Total numbers of red flags	**16**	**4**	**5**	**7**	**66**	**38**	**78**	**12**	**2**	**5**	**15**	**126**	**44**	**72**	**218**

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

LTH Health Inequalities Delivery Plan			
Report to:	Board of Directors	**Date:**	3 August 2023
Report of:	Chief Nursing Officer	**Prepared by:**	K Marshall

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this paper is to outline the early work of the LTH Health inequalities delivery plan. The Chief Nursing Officer is the executive lead for this programme of work, supported by a team consisting of clinical, operational and business intelligence colleagues.

The NHSE Core20PLUS5 framework is a national approach to inform action to reduce healthcare inequalities at both national and system level which is based on the theory of social determinants of health. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

The delivery plan is structured around the ICB health inequalities programme and will evolve to link closely with the Preston and Chorley health and well being partnership Boards, of which LTH is a member. There are a number of projects underway to target specific groups of the population to reduce health inequalities. A health inequalities group has been established and it is suggested this will report into the transformation boards and safety and quality committee.

There are both strategic and operational actions required to integrate this agenda fully into the organisation. These will take time and require resource. Neighbouring organisations have selected to employ a Consultant in public health and this is something that is being explored. The team are exploring opportunities to bid for money to support this work.

There are a number of related strategies that will support the delivery of this plan. These include; Always Safety First, Patient Experience and Involvement, Mental Health, Learning Disability, Autism, Green Plan and the social value strategy that speaks to the ongoing work fulfilling our role as an anchor institution.

The internal projects are focused on;

- Institute for Health Improvement (IHI) Accelerator Collaborative (NHS England) early cancer diagnosis
- Outpatient Did Not Attend (DNA)/Was Not Brought (WNB) Children and Young People
- Muslim Girls School Health awareness and education programme.
- Long wait harm review – Severe mental Illness and learning disability
- Peer Support workers in the Emergency Department
- Continuity of Carer – maternity services
- CURE smoking and alcohol screening and brief interventions
- Special care dentistry- Learning Disability and autism
- Audiology- Learning Disability and autism
- Annual Our Health Day – Learning Disability and autism

- Childrens mental health
- Prisoner access to healthcare services

The team involved in this work are working in partnership with the ICB team to agree plans that are aligned across Lancashire and South Cumbria for 2024/25 and building their knowledge to create the leadership capability required to deliver this agenda. This plan will continue to evolve as the year progresses and it is proposed will be reported annually to the Safety and Quality committee.

The Safety and Quality committee has approved the delivery plan for health inequalities noting its early stages, the requirement to develop a deeper internal knowledge of current practice that contributes toward CORE20PLUS5 delivery and the developing links with the new PLACE and ICB health inequalities teams. It has also requested monthly chairs reports from the health inequalities group and a 6 month update position to ensure the work is progressing in line with the plan.

Recommendation
The Board is asked to confirm it is assured of the delivery plan and actions underway.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☒	Deliver Value for Money	☐
		Fit For The Future	☒

Previous consideration

1. Context

The NHSE 2023 planning guidance re-iterates the role of the NHS in improving Population Health and tackling Health Inequalities through an Executive led programme. The Chief Nursing Officer is the executive lead for this programme of work, supported by a team consisting of clinical, operational and business intelligence colleagues.

As a secondary care provider the Trust will focus on:

1. Providing equity of access,
2. Providing equity of experience,
3. Providing equity of outcomes.

The LTH Health Inequality delivery plan is in early stages and evolving in line with the Place based partnership approach and Lancashire & South Cumbria Integrated Care Board (ICB). The ICB have developed a provider level action plan to tackle health inequalities which include a series of strategic, operational and clinical actions from short term to long term changes.

The development of a Trust delivery plan will follow the framework set out in NHS Standard Contract 2022/23, schedule N, which determines 4 key workstreams for health inequality work to ensure consistency and quality across programmes of work based on:

1. Better data and intelligent use of data
2. Community engagement
3. Access to and provision of the Services
4. Implementation, monitoring and evaluation

There are a number of related strategies that will support the delivery of this plan. These include; Always Safety First, Patient Experience and Involvement, Mental Health, Learning Disability, Autism, Green Plan and the social value strategy that speaks to the ongoing work fulfilling our role as an anchor institution.

A health inequalities group has been established and it is suggested this will report into the transformation boards and safety and quality committee.

2. Discussion

2.1 Determinants of Health

Social, or sometimes referred to wider, determinants of health are the social, environmental and economic circumstances that influence the health of people throughout their lives. Living in poverty is associated with adverse outcomes for patients, on account of:

- Employment opportunities and income
- Access to services, including healthcare, welfare and community, network and spaces
- Poor diet, smoking, obesity, multimorbidity
- Air pollution
- Education
- Housing

Some patients may experience financial hardship, which may affect their ability to access treatment. Dahlgren and Whitehead's wheel shows factors that contribute to ill-health, image 1 below. [1]

[1] Dahlgren G, Whitehead M. Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies, 1991.

Image 1: Dahlgreen and Whiteheads wheel

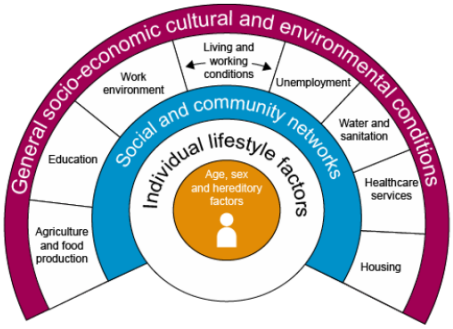
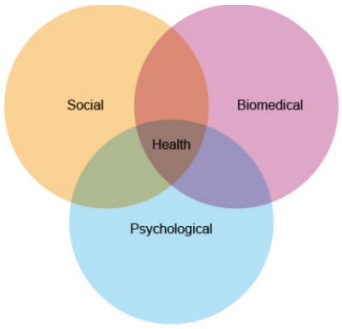


Image 2. Engel biopsychosocial model



The biopsychosocial model was first conceptualised by George Engel in 1977, suggesting that to understand a person's medical condition, it is not simply the biological factors to consider, but also the psychological and social factors.[2]

2.2 NHSE Core20PLUS5 Framework

The NHSE Core20PLUS5 framework is a national approach to inform action to reduce healthcare inequalities at both national and system level which is based on the theory of social determinants of health. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement, shown in image 3 and 4 below.

The 'Core20'

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

The 'PLUS'

PLUS population groups should be identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups such as coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

The '5'

There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

The Trust will use the NHSE Core20PLUS5 framework for adults, and children and young people as the scope and direction of work to focus on tackling health inequalities.

[2] Engel GL. The need for a new medical model: a challenge for biomedicine. Science 1977;196(4286):129-136.

Image 3. Core20PLUS5 Framework for Adults

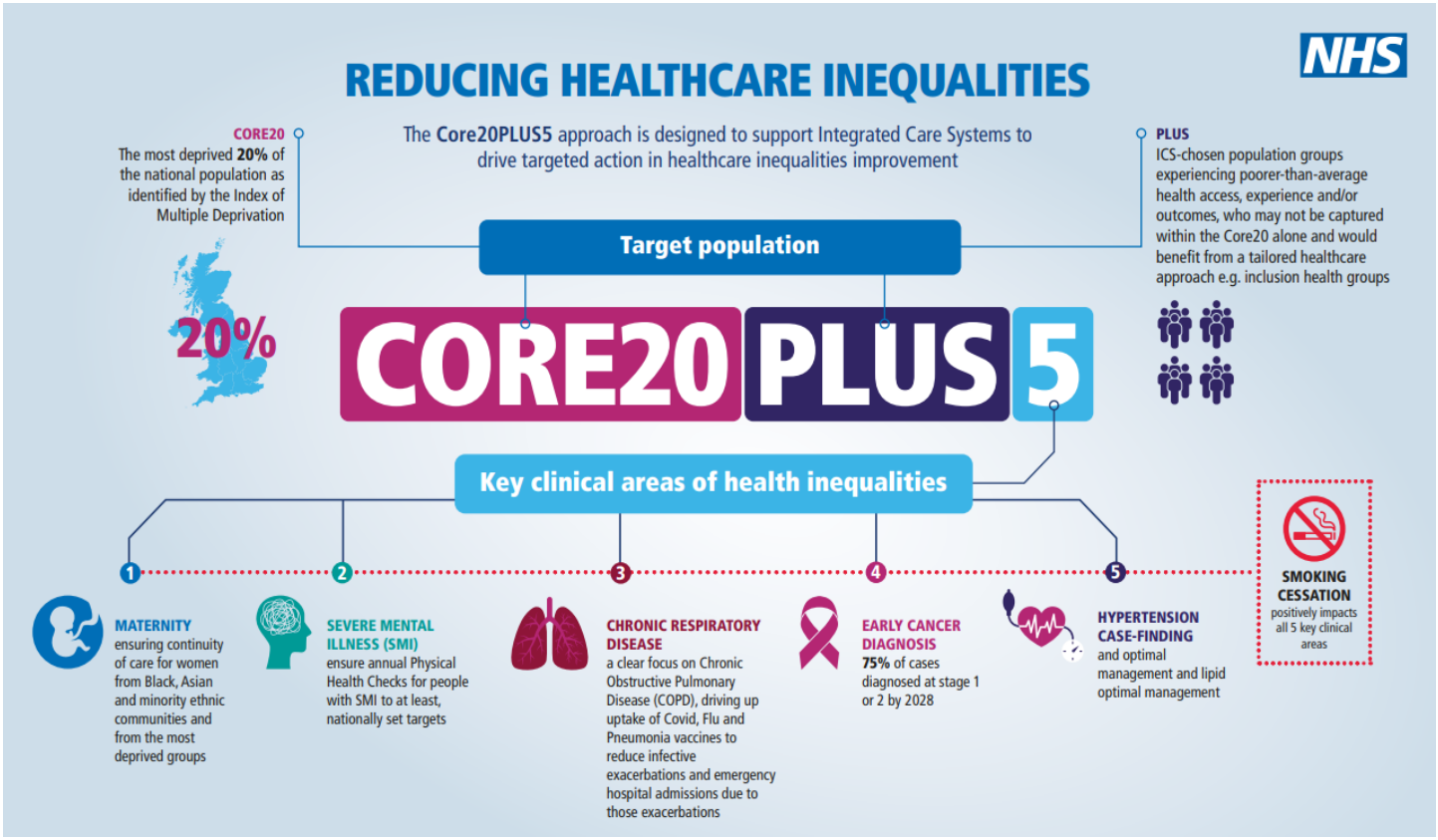
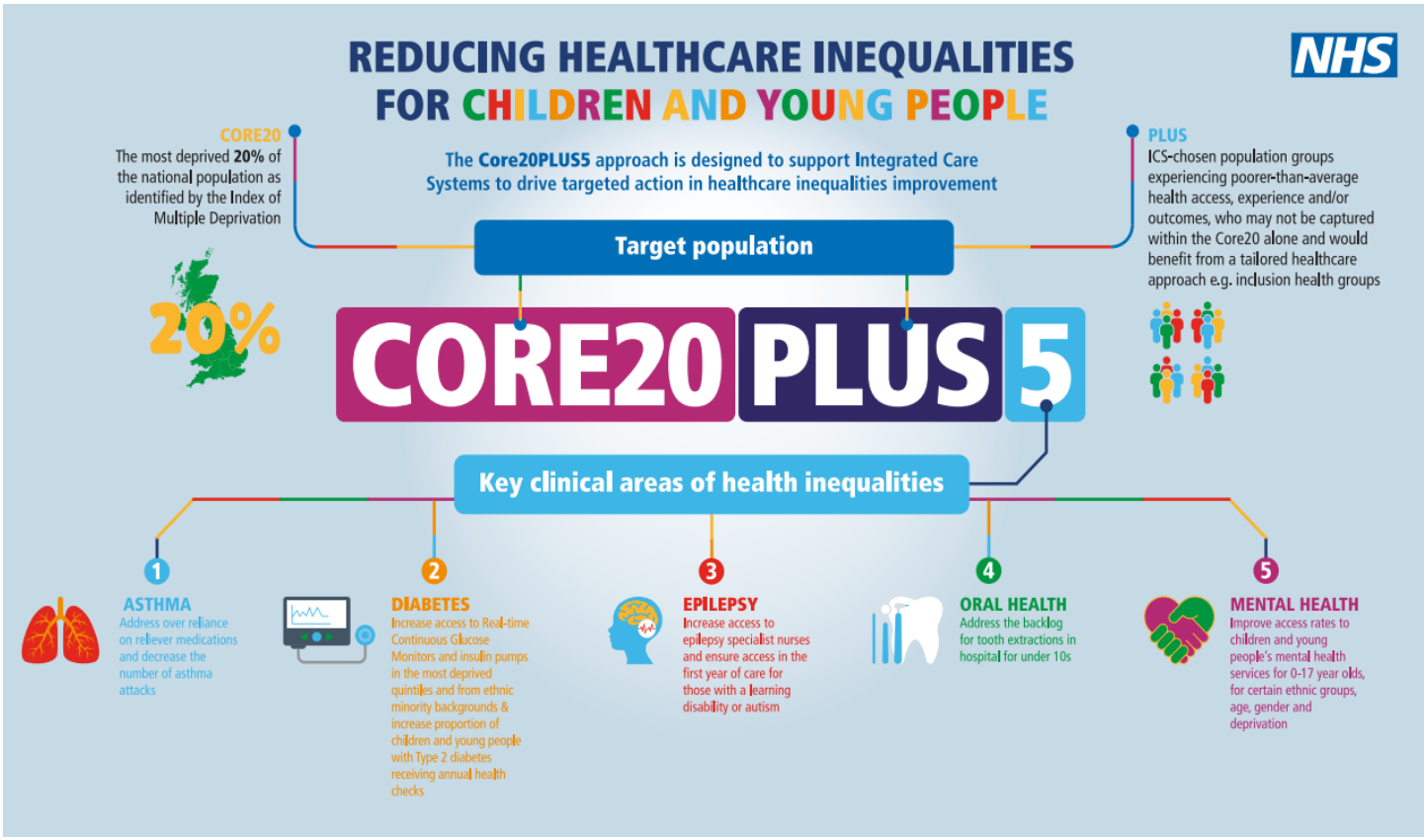


Image 4. Core20PLUS5 Framework for Children & Young People



2.3 Core20PLUS5 in Lancashire and South Cumbria

The Lancashire and South Cumbria ICS has a population of 1.8m people, as the specialist provider it is important we think about inequalities across the whole of Lancashire and south Cumbria as well as the local Central Lancashire footprint. Lancashire and South Cumbria 5 key factors affecting health outcomes.

1. **Aging population** - over 75s will double by 2035
2. **Diverse** – 10% of the population are BAME, within Lancashire Pendle and Preston 20% of people are BAME, the highest BAME population of 31% is in Blackburn with Darwen, (3 times higher than the national average), 28,000 BAME people live in Preston, with 18,000 in in Pendle, 10,000 in Burnley.
3. **Deprivation** - 20% of population are in 10% of the most deprived nationally, children living in poverty ranges from 12% to 38% against a national average of 30%. 20% of over 65s living in poverty
4. **Long Term Conditions** - High levels of mental health incl. depression, cardiovascular disease, heart failure, hypertension, asthma, dementia. The variation in healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of 68 years for children born today. In some neighbourhoods, healthy life expectancy is 46.5 years.
5. **High rates** of alcohol and respiratory related admissions, and late cancer diagnosis, 18.5% of adults smoke in Lancashire and South Cumbria, the national average for England is 17.2%. Approximately 40% of ill-health in Lancashire and South Cumbria is due to smoking, physical inactivity, obesity and substance misuse.

2.4 How does the population of Lancashire and South Cumbria compare nationally ?

Population over 65

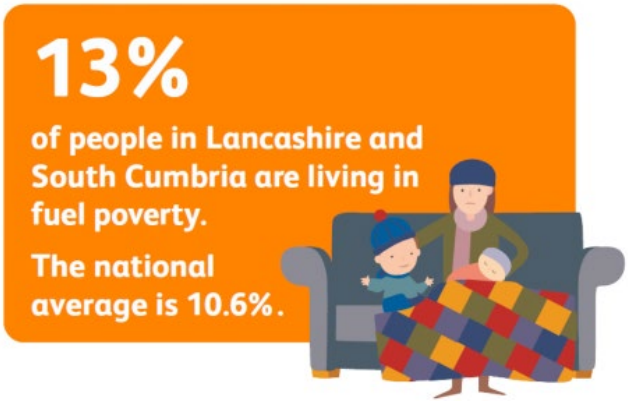
- In Lancashire and South Cumbria it is 19.9%
- The national average for England is 18.2%

One person households with people aged 65 or over

- In Lancashire and South Cumbria it is 14%
- The national average for England is 12.4%

Population in rural communities

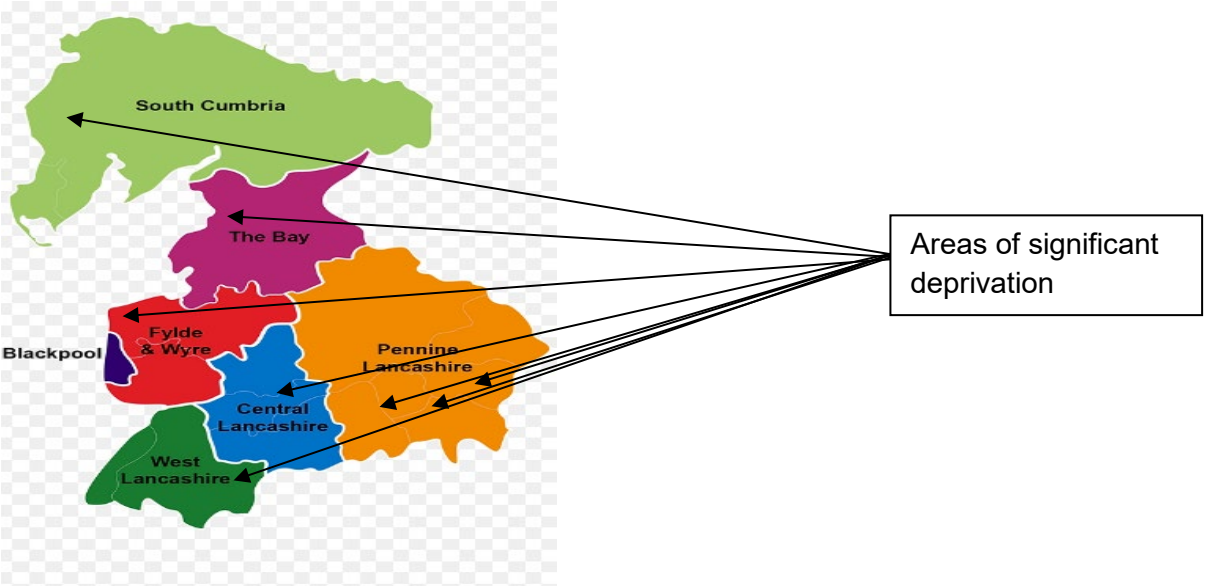
- In Lancashire and South Cumbria it is 20.4%
- The national average for England is 17%



The ‘Core20’

Core20 accounts for 31% of our population in Lancashire and South Cumbria, however in some of our places it is a much higher proportion, in Blackpool 70% are within the 20% most deprived areas.

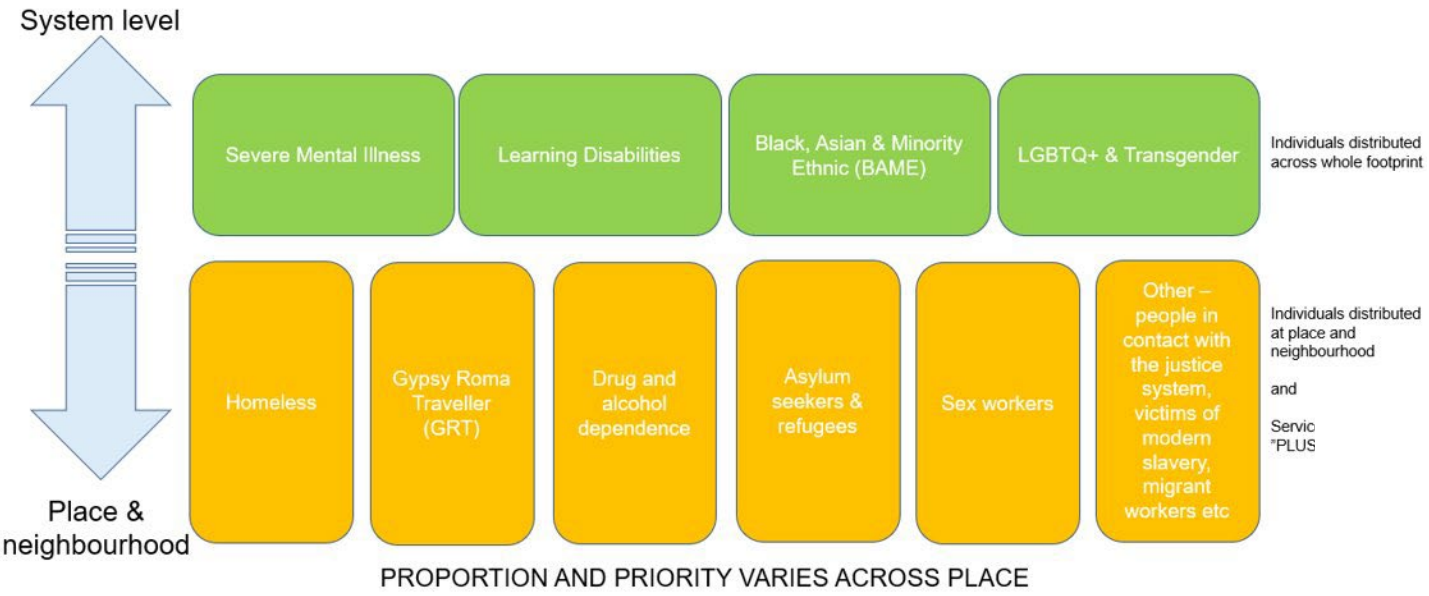
Image 5. Map of most deprived areas in L&SC



The ‘PLUS’

Our locally determined population groups with poorer than average experience of health services include individuals distributed at place and neighbourhood level, as well as Service-defined ‘PLUS’ groups. There are also individuals within populations distributed across the whole footprint, as shown in image 6 below.

Image 6. PLUS population for L&SC



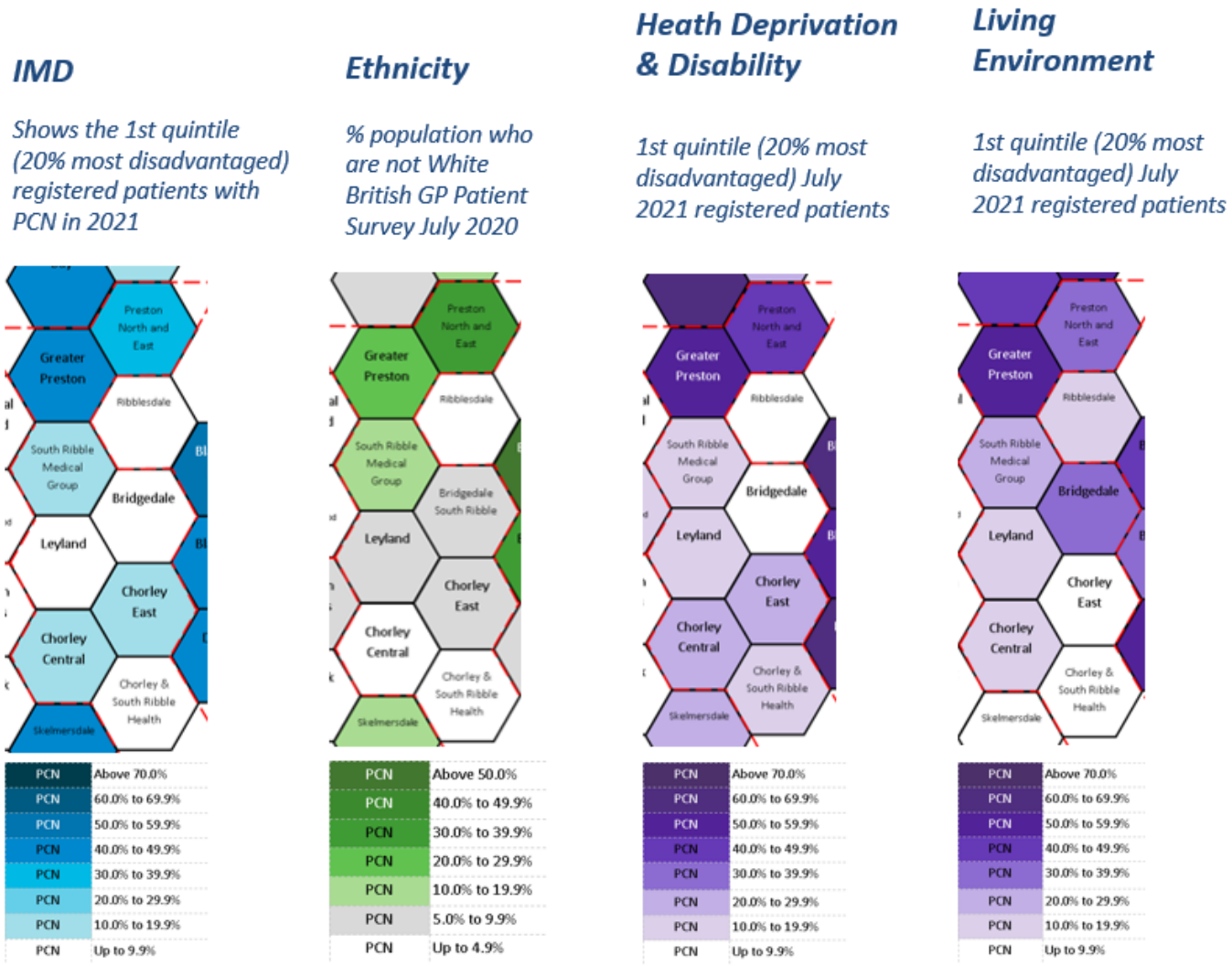
The ‘5’

Within the L&SC region out of the 5 target clinical areas some conditions are more prevalent across L&SC. Including high levels of severe mental health, cardiovascular disease, heart failure, hypertension, asthma and dementia. Alongside high rates of alcohol and respiratory related admissions, and late cancer diagnosis

2.4 Central Lancashire Locality

Using data split by Primary Care Network (PCN) enables a view of patients in Central Lancashire shown through the lens of social determinants of health. This gives specific areas and lead to target populations to focus improvements and changes to improve health outcomes. Central Lancashire PCN networks include: Preston and North East, Greater Preston, South Ribble Medical Group, Leyland, Bridgedale, Chorley Central, Chorley East, Chorley & South Ribble.

Image 7: Infographics for Central Lancashire PCNs



2.5 Partnership working

Successfully tackling health inequalities will require working in partnership with stakeholders in and outside of health. Across these partner organisations there is a synergy in the ambition but also where each organisation can help to connect either data, intelligence or programmes of work that have the same aims.

The Place based Health Inequalities strategy is being developed in partnership between the Lancashire & South Cumbria ICB and Lancashire County Council. The aim is to join up services to enable residents of Lancashire and South Cumbria to live better lives.

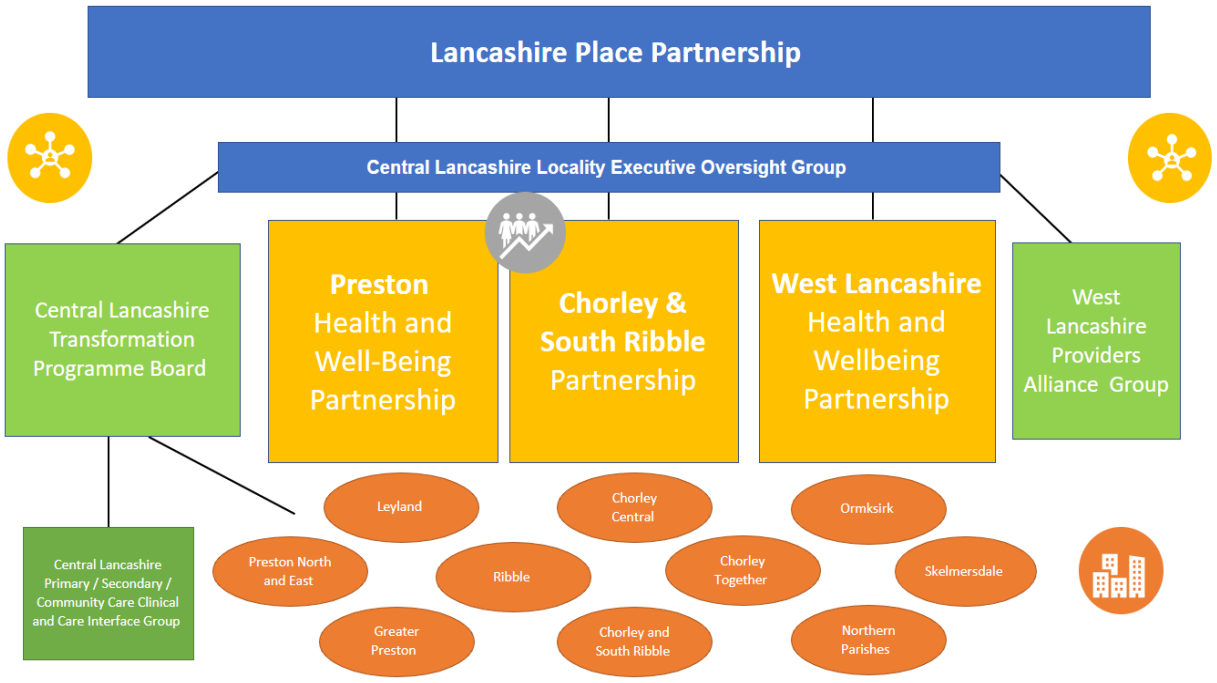
This will be delivered through the governance structure as shown in image 8 below. The two main forums for Preston and Chorley are:

1. Preston Health & Wellbeing Partnership (to be established) which has priority areas;
    - Oversight for Integrated Neighbourhood Teams
    - Development of integrated support for our homelessness population
    - Deep dive into priority wards which will result in ward level action plans

2. Chorley and South Ribble Partnership (to be expanded), which has priority areas:
    - Oversight for the Integrated Neighbourhood Teams,
    - An initial area of focus has been identified to investigate and develop action around early years and family, in particular school readiness, which will impact on a wide number of strategic themes that include employability, mental wellbeing and households in poverty

Lancashire Teaching Hospitals Programme Director for Primary and Community Integration has been invited to participate in each of these forums and will provide a key link to ensuring the work aligns across PLACE.

Image 8.Lancashire Place Partnership governance.



The ICB has developed a model to deliver the ICB statutory duties, shown below image 9:

1. Keeping our population well by reducing preventable ill-health
2. Reducing avoidable health inequalities in access, experience and outcomes

Image 9. ICB Population Health Model

LTH role in reducing health inequalities

During 2023/24 LTH will work with the ICB Population Health team to deliver the projects identified within LTH for 2023/24 and create a delivery plan for 2024//25. Together we will focus on:

- What good looks like for 2024/25 in terms of "what we do" (together and separately) and “how we do this" (how our teams work in a more aligned way) .
- The actions required to deliver this and associated timescales.
- What conditions or cultural changes might be needed to move towards greater alignment.
- How we will work in partnership with our workforce to understand their experienced health inequalities.
- We will continue to recognise our role as an anchor institution to the local community and build on the work already underway in this area.
- We will work in partnership at all levels of the system recognising our role in contributing to this agenda.
- We will start to understand our performance, incident and feedback data through the lens of protected characteristics and take action to reduce systemic inequalities.
- We will identify the leadership structure and team required to deliver this work.
- We will create the skill and knowledge base within the organisation to know how to make a difference in this area.

2.6 ICB Provider Action Plan

Specific provider level actions have already been detailed by the ICB based on the Core20PLUS framework. These detail a series of strategic, operational and clinical actions. The ICB has requested that LTH submits a quarterly stocktake of the action plan, first submission was completed May-23.

The action plan is based on the key elements as described in this paper from Core20PLUS5 framework, the NHS contractual duties and the Trust as an Anchor organisation.

Table 1. ICB Health Inequality Action Plan Headlines

Action detail	Status	Target date
To be addressing the actions set out in the 5 priority actions for addressing health inequalities:	Open	
a. To have an Executive lead for health inequalities	Complete	March 2023
b. To have waiting lists disaggregated and analysis undertaken of ethnicity and deprivation	In Progress	October 2023
c. For the Board to have performance packs reported and published that include waiting lists broken down by ethnicity and IMD quintile focused on unwarranted variation	In Progress	December 2023
d. To have developed and published Equality and Health Inequality Impact Assessments for elective recovery plans	In Progress	TBC
e. To complete the annual NHS Equality Delivery System return as part of the NHS Contract	Complete (ongoing)	TBC
f. To have plans in place to improve data collection on ethnicity	In Progress	TBC
g. To be demonstrating how local population data is used to identify the needs of communities experiencing inequalities in access, experience and outcomes	In Progress	December 2023
h. To be accelerating preventative workstreams, including for example:		
i. Delivering the Tobacco Prevention Programme	In Progress	Ongoing
ii. Increasing screening and vaccinations, particularly in those populations with lowest uptake	In Progress	TBC
To have an action plan covering the Trust's plans to address health inequalities (ref.2022/23 NHS Standard Contract, Schedule N	In Progress	
1. Better data and intelligent use of data	In Progress	Ongoing
2. Community engagement	In Progress	Ongoing
3. Access to and provision of the Services	In Progress	Ongoing
4. Implementation, monitoring and evaluation	In Progress	Ongoing
To be playing a part in delivery of CORE20PLUS5 as the NHS's approach to address health inequalities: Trusts have a key role to play in improving how we meet the needs of those in our Core20PLUS population in the 5 clinical domains		
i. CVD – Hypertension case finding and optimal management; Lipid optimal management;	In Progress	Ongoing
ii. Chronic Respiratory Disease – through increasing uptake of the Covid, Flu & Pneumonia vaccines;	In Progress	Ongoing
iii. Delivering earlier cancer diagnosis;	In Progress	Ongoing
iv. Improving the uptake of annual physical health check for people with SMI	In Progress	TBC
v. Providing continuity of carer in maternity with a focus on ethnic minorities and deprived communities	In Progress	March 2024
vi. Plus the cross cutting ambition of reducing smoking	In Progress	Ongoing
In addition, Trusts have an important role in reducing health inequalities in children and young people through the Core20PLUS5 approach for children:		
i. Asthma: Addressing over reliance on reliever medications and decreasing the number of asthma attacks.	In Progress	TBC

ii. Diabetes: Increasing access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds and increasing the proportion of those with Type 2 diabetes receiving recommended NICE care processes	In Progress	TBC
iii. Epilepsy: Increasing access to epilepsy specialist nurses and ensuring access in the first year of care for those with a learning disability or autism.	In Progress	TBC
iv. Oral health: Reducing tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.	In Progress	TBC
v. Mental health: Improving access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation.	In Progress	TBC
Trusts as anchor organisations	**In Progress**	
a. Trusts have significant opportunities to contribute towards the efforts to address the wider determinants that impact on the health of our populations through becoming anchor organisations and working with partners in our communities. Trust specific actions		
Stakeholder engagement	In Progress	ongoing
Current and future state mapping	In Progress	December 2023
Workforce support	In Progress	ongoing
Patient and carer support	In Progress	ongoing

2.7 Health Inequality Projects

There are several workstreams already underway with a specific focus on tackling health inequalities including, but not limited to:

- **Institute for Health Improvement (IHI) Accelerator Collaborative (NHS England)** – Focus on early cancer diagnosis for one population in Preston. 'Inch wide, mile deep' methodology to deep dive root cause for one small population, focussed engage with patients and co create interventions around access and awareness.

- **Outpatient Did Not Attend (DNA)/Was Not Brought (WNB)** Review (NHS England) - review of DNAs through health inequality lens. Targeted review of patients from high areas of deprivation and in the top 5 clinical domains to find root cause of DNA and ways the Trust can support patients to attend their appointments. Initial focus on paediatrics.

- **Muslim Girls School Health awareness and education programme** – Utilising existing and developing relationships with Imams and Alimas to create awareness of cervical cancer, HPV vaccine, breast health and maternal health.

- **Long wait harm review-** Utilising waiting list data focused on Severe Mental Illness (SMI) and Learning Disability (LD), a harm review process has been designed to enable specialties to understand which patients on the waiting list have a SMI or LD leading to a proactive review of these patients. The progress with this is measured through the elective care Board and will be monitored through the governance dashboards.

- **Peer Support in Emergency Department –** Recognising the adverse experiences that may occur when a patient who uses drug and alcohol regularly, the ED team are working with Red Rose recovery to pilot a peer support worker in the ED that will specifically focus on providing peer support, establishing when health checks were last undertaken and signposting to health and social care services.

- **Continuity of Carer –** The Continuity of Care teams currently provide care to all women who have diabetes, mental health, learning disability, declared domestic abuse, dug and alcohol and teenage pregnancy. The next stage of this work will be to expand this to focus on Black Asian and Minority Ethnic groups.

- **CURE smoking and alcohol screening and brief interventions –** As part of the big plan, smoking and alcohol screening and interventions are monitored, ensuring teachable moments are acted upon during a hospital inpatient episode.

- **Special care dentistry** – the service has developed generic resources (films and easy read information) and bespoke welcome meetings with patients who have a learning disability or autism to improve access to services. These continue to be well received by patients and families and lead to successful dental extractions alleviating patients of the pain they experience.

- **Audiology –** the audiology team have developed easy read and access pathways for patients with learning disabilities to reduce the fear and anxiety associated with using the audiology services. The pre-appointment calls enable the service to understand if longer appointment times and adjustments are required to ensure patients are able to access the services.

- **Annual Our health Day** – held in June 2023 – this year's day focused on emergency, elective and outpatient pathways with the learning disability and autism community to reduce fear and anxiety in accessing healthcare.

- **Prisoner access to healthcare services –** The Chief Operating Officer has commenced work with the prison service to understand how health inequalities relating to prisoner access can be reduced.

There is an acknowledgement that are multiple projects/programmes of work underway in the Trust to reduce health inequalities at a departmental level that are not visible enough, therefore there is a missed opportunity to share this good practice that can be built into everyday interventions at speciality level. As a part of wider engagement and bringing focus to these areas the proposal is to hold an in-person show case event for each specialty team to be invited to showcase their work, their success and challenges in this area to share learning and develop our joint thinking in this field and a local project tracker.

2 Financial implications

There is no current funding specifically allocated for health inequalities work within LTH. As a part of the development of the health inequality plan, there will be a resource requirement to lead and operationalise this work. The Trust will work with the ICB on an approach that is consistent across the ICS footprint. Funding routes outside of the organisation are currently being explored.

3 Legal implications

Non specific to this work at this time.

4 Risks

A key part of tackling health inequalities is cultural changes in our understanding of care delivery as an acute provider. The work being done now will create generational changes, this is not short term, quick win work and will require executive and board level support for the approach. This means it is likely that tracking benefits will be over a much more protracted timeframe than being providing direct in year benefits. This

risks the ability to provide assurance on outcomes and evidence of impact on delivery. This requires a long term commitment to this way of thinking and risks disengagement and lack of resources being allocated to the work due to lack in tangible and quantifiable benefits. This will need to be managed as part of the programme of work.

5 Impact on stakeholders

The anticipated impact of this work on stakeholders specific to CORE20PLUS5 adults are:

- Continuity of career for women in BAME communities and the most deprived groups leading to a reduction in adverse outcomes.
- Physical health checks and signposting for people with severe mental illness to improve management of long term conditions, reduce ill health and early death in these groups
- Promotion of health vaccines uptake, specifically for patients with COPD, disease management guidance provided for patients in these groups leading to fewer hospital admissions and improved quality of life
- Increase in cases of cancer diagnosed at stage 1 and 2, improving outcomes for people diagnosed with cancer
- Increase number of patients admitted to hospital with hypertension signposted to GP for hypertension management to reduce the number of cardiovascular events
- Increase smoking and alcohol brief interventions within the hospital setting to improve outcomes associated with smoking and alcohol.

The anticipated impact of this work on stakeholders specific to CORE20PLUS5 children and young people are:

- Promotion of asthma treatment regimes that reduce reliance on reliever medications leading to fewer asthma attacks and child deaths from asthma.
- Promote options relating to the use of real time glucose monitoring and insulin pumps in BAME and the most deprived populations to reduce the long term effects of poor diabetes management.
- Increase access to specialist epilepsy nurses in the first year for people with a learning disability or autism to reduce the number of seizures experienced and admissions to hospital.
- Improve the number of children under 10 waiting for tooth extractions to reduce likelihood of long term poor dental health.
- Improve mental health offer in hospital aiming for equity in mental and physical health to reduce long term burden of mental health and reduced life expectancy.

The aims of the LTH projects are detailed in section 2.7.

6. Conclusion

The Safety and Quality committee has approved the delivery plan for health inequalities noting its early stages, the requirement to develop a deeper internal knowledge of current practice that contributes toward CORE20PLUS5 delivery and the developing links with the new PLACE and ICB health inequalities teams. It has also requested monthly chairs reports from the health inequalities group and a 6 month update position to ensure the work is progressing in line with the plan.

7. Recommendation

The Board is asked to confirm it is assured of the delivery plan and actions underway.

Chair's Report

Committee:	Education, Training and Research Committee
Chairperson and role:	Professor Paul O'Neill, Non-Executive Director
Date(s) of Committee meeting(s):	13 June 2023
Purpose of report:	To update the Board on the business discussed by the Education, Training and Research Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and for escalation to the Board

Committee Chair's narrative

The Committee conducted a comprehensive review of the scheduled items on the agenda, approved the minutes of the April meeting and noted the status of the action log.

The Committee scrutinised the core skills training report, which provided a summary of compliance status at Trust and Divisional level. The Trust now met or exceeded compliance in 21 out of 26 subjects presented in the report. There had also been significant increases in compliance and work was being undertaken with clinical teams for improvement of trajectories. The Committee also acknowledged the need for replacement of defibrillators across both sites.

The Committee received the Quality Assurance report (GMC survey update), which gave an update on progress made against actions from the April 2023 meeting.

The Committee was presented with the Education Annual Report Strategy update (full report), which provided reviewed strategy objectives and an overview of achievements in education and training aligned to information in the Trust annual report.

The Committee received an update on research and innovation and noted the positive achievements up to year end.

The Committee was provided with an update on Edovation from the past 6 months, considered risks around termination of projects and future ways of working.

The Committee noted and accepted the Terms of Reference and Cycle of Business.

The Committee considered and agreed the strategic risk rating should remain at 20 but careful consideration would be given at the next meeting whether some of the discussion today had mitigated the risk for it to be reduced.

The Committee noted positive and negative escalations from the ETR feeder groups - Training Compliance and Assurance Committee, Education Delivery and Student Support Committee, Finance Sub-Committee, and Research and Innovation Committee.
Items for the Board's attention
Positive escalation
None.
Negative escalation
None.
Committee to Committee escalation
None.
Items recommended to the Board for approval
None.
Committee Chairs reports received
a) Training Compliance and Assurance Sub-committee b) Education Quality and Performance Sub-committee c) Finance Sub-Committee d) Research and Innovation Sub-committee
Items where assurance was provided and/or for information
a) Core skills training report b) Quality Assurance report (GMC survey update) c) Research & Innovation update d) Edovation update
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 8 August 2023 using Microsoft Teams.

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Education, Training and Research Committee agenda (13 June 2023)

Education, Training and Research Committee

13 June 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	1.00pm	Verbal	Information	P O'Neill
2.	Apologies for absence	1.01pm	Verbal	Information	P O'Neill
3.	Declaration of interests	1.02pm	Verbal	Information	P O'Neill
4.	Minutes of the previous meeting held on 11 April 2023	1.03pm	✓	Decision	P O'Neill
5.	Matters arising and action log	1.05pm	✓	Decision	P O'Neill
6	Strategic risk register review	1.10pm	Verbal	Assurance	P O'Neill
7.	PERFORMANCE				
7.1	Core skills training report	1.15pm	✓	Assurance	L O'Brien
7.2	Quality Assurance report (GMC survey update)	1.30pm	✓	Assurance	A Sykes
8.	STRATEGY & PLANNING				
8.1	Education Annual Report Strategy update (full report)	1.45pm	✓	Decision	L O'Brien
8.2	Research & Innovation update	2.00pm	✓	Information	P Brown
8.3	Edovation update	2.10pm	✓	Information	P Brown
9.	GOVERNANCE & COMPLIANCE				
9.1	Cycle of Business & Terms of Reference	2.20pm	✓	Information	J Foote
9.2	Strategic risk review and update	2.30pm	✓	Assurance / Decision	P O'Neill
10.	ITEMS FOR INFORMATION				
10.1	Feeder group Chair's reports negative/positive escalations: a) Training Compliance and Assurance Sub-committee b) Education Quality and Performance Sub-committee	2.40pm	✓	Information	L O'Brien / P Brown

№	Item	Time	Encl.	Purpose	Presenter
	c) Finance Sub-Committee d) Research and Innovation Sub-committee				
10.2	Items for referral to the board or items to/from other committees	2.45pm	Verbal	Information	P O'Neill
10.3	Reflections on the meeting and adherence to the Board Construct	2.55pm	✓	Assurance	P O'Neill
10.4	Date, time, and venue of next meeting: 8 August 2023, 1pm via MS Teams	3.00pm	Verbal	Information	P O'Neill

Chair's Report

Committee:	Workforce Committee
Chairperson and role:	Jim Whitaker, Non-Executive Director
Date(s) of Committee meeting(s):	11 July 2023
Purpose of report:	To update the Board on the business discussed by the Workforce Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the scheduled items on the agenda and approved the minutes of the meeting on 9 May 2023 and noted the status of the action log.

The Committee scrutinised the Workforce and Organisational Development integrated performance report review, noted the key metrics, improvements made and continued areas of challenge.

The Committee received the annual workforce advice update report, which provided an update around progress in reduction of the number of formalised disciplinary investigations and showed an increase in the number of suspensions.

The Committee was presented with the equality impact of key workforce policies between 1 April 2022 and 31 March 2023.

The Committee reviewed the annual health and wellbeing strategy report, which provided an annual summary of progress against the strategic health and wellbeing priorities, along with an assessment of impact and an update on the Lancashire and South Cumbria collaboration around Occupational Health and wellbeing. Some of the key achievements within the report were highlighted.

The Committee received the 'just culture' strategic aim update report, which provided details of the findings from the annual 'Our Culture Counts' cultural assessment, a summary of achievements during the last 12 months against the strategic aim 'To Create a Positive Organisational Culture' to support cultural transformation and the proposed actions for the next 12 months.

The Committee was presented with the Workforce Disability Equality Standard (WDES) Return) and the Workforce Racial Equality Standard (WRES) Return, which included priority areas for action, based on analysis of the results which included workforce data and findings from the latest staff survey.

The Committee reviewed the Guardian of Safe Working quarterly report for the period December 2022 to March 2023, and the annual report for the period 1 January 2022 to 31 December 2022. The reports

provided assurance that the issues identified were being addressed by the relevant specialities/departments, through escalation of the concerns to the appropriate teams by the work of the Guardian. The Committee reviewed the strategic risk register and agreed the risk rating should remain at 16.
Items for the Board's attention
Positive escalation
Annual health and wellbeing strategy report.
Negative escalation
None.
Committee to Committee escalation
None.
Items recommended to the Board for approval
WRES (Workforce Racial Equality Standard) Return. WDES (Workforce Disability Equality Standard) Return.
Committee Chairs reports received
Temporary staffing group.
Items where assurance was provided and/or for information
Exception report from the DIFs Terms of Reference and Cycle of Business Guardian of Safe Working reports
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 12 September 2023 using Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Workforce Committee agenda (11 July 2023)

Workforce Committee

11 July 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	J Whitaker
2.	Apologies for absence	1.01pm	Verbal	Information	J Whitaker
3.	Declaration of interests	1.02pm	Verbal	Information	J Whitaker
4.	Minutes of the previous meeting held on 9 May 2023	1.03pm	✓	Decision	J Whitaker
5.	Matters arising and action log	1.05pm	✓	Assurance	J Whitaker
6.	Strategic risk register review	1.10pm	Verbal	Assurance	J Whitaker
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	1.15pm	✓	Information	K Downey
7.2	Exception report from the DIFs	1.20pm	✓	Assurance	S Cullen
8. TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE					
8.1	Annual workforce advice update report	1.25pm	✓	Assurance	R O'Brien
8.2	Equality impact assessment of policies	1.35pm	✓	Assurance	R O'Brien
9. TO BE INCLUSIVE AND SUPPORTIVE					
9.1	Annual health and wellbeing strategy report	1.45pm	✓	Assurance	R O'Brien
10. TO CREATE A POSITIVE ORGANISATIONAL CULTURE					
10.1	Just culture strategic aim update report	1.55pm	✓	Assurance	L Graham
11. GOVERNANCE AND COMPLIANCE					
11.1	Workforce Disability Equality Standard (WDES) Return	2.05pm	✓	Decision	L Graham
11.2	Workforce Racial Equality Standard (WRES) Return	2.20pm	✓	Decision	L Graham

№	Item	Time	Encl.	Purpose	Presenter
11.3	Terms of Reference and Cycle of Business	2.35pm	✓	Information	J Foote
11.4	Guardian of Safe Working reports	2.40pm	✓	Assurance	D Kendall
11.5	Strategic risk register review	2.45pm	✓	Decision	J Whitaker
11.6	Reflections on the meeting and adherence to the Board construct	2.47pm	✓	Information	J Whitaker
11.7	Items for escalation to the Board or items to/from other committees	2.48pm	Verbal	Information	J Whitaker
12. ITEMS FOR INFORMATION					
12.1	Feeder group Chair's report: Temporary staffing group	2.49pm	✓	Information	K Downey
12.2	Date, time, and venue of next meeting: *12 September 2023, 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	J Whitaker

PLEASE NOTE FOLLOWING THIS MEETING A RESTRICTED ITEM WILL BE DISCUSSED (SEPARATE AGENDA HAS BEEN ISSUED)

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Workforce Disability Equality Standard (WDES) Submission 2023							
Report to:	Board of Directors			**Date:**	3 August 2023		
Report of:	Interim Chief People Officer			**Prepared by:**	L Graham		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☒		**For information**		☐

Executive Summary:

The purpose of this report is to share the data which will form the submission and subsequent publication of the 2023 Workforce Disability Equality Standard (WDES) for our Trust. It sets out priority areas for action based on analysis of the results which include workforce data and findings from the latest staff survey. The Board is asked to review and approve the contents of the report for publication and to consider the areas for action and associated next steps which are to consult with the Disability Inclusion Forum with regards to the results, understand their lived experience, the actions which will make the greatest impact and to seek feedback on the draft action plan, making changes where necessary.

The priority areas recommended for action are those which are indicating disabled colleagues are being adversely impacted or disadvantaged according to the four-fifths rule:

Metric 3 – Likelihood of colleagues with a disability entering the formal capability process.
Metric 4a – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public.
Metric 4b – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from managers.
Metric 4c - Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from colleagues.
Metric 6 – Percentage of colleagues who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7 - Percentage of colleagues saying that they are satisfied with the extent to which their organisation values their work.

It is recommended that the Board, receive the report, note the content, approve the priority areas for action and approve external publication of our results.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☐	Consistently Deliver Excellent Care	☐
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☐
To drive innovation through world-class education,	☐	Deliver Value for Money	☐

teaching and research		Fit For The Future	☐

Previous consideration

Workforce Committee (11 July 2023)

INTRODUCTION

The Workforce Disability Equality Standard (WDES) is a mandated requirement through the NHS standard contract which was launched in April 2019, making this the fifth WDES report. Organisations are instructed to report and publish their WDES data on an annual basis, illustrating organisational progress against ten indicators relating to workforce disability equality.

RESULTS

For each of the indicators the data is compared for Disabled colleagues and non-disabled colleagues. National staff survey averages and organisational results for the last 4 years have been included for comparative purposes where applicable to the metric being reviewed.

The approach used by the national WDES team with regards to the ongoing Disability Disparity Audit work is to utilise the four-fifths ("4/5ths" or "80 percent") rule to highlight whether practices have an adverse impact on an identified group, e.g. a sub-group of ethnicity or disability. For example, if the relative likelihood of an outcome for one sub-group compared to another is less than 0.8 or higher than 1.2, then the process would be identified as having an adverse impact.

Summary Data

Improvements have been seen for Disabled colleagues across the following indicators;

- **Metric 1 – Representation**, we have seen some increases in the percentage of disabled colleagues across our workforce as a whole, furthermore it is positive to note increase in representation in bands 8a, 8c, as well as in Very Senior Manager roles. Whilst there is much more work to do to increase disclosure of disability and supporting disabled colleagues to progress we are making small steps forward.
- **Metric 2 – likelihood of appointing disabled candidates from shortlisting.** This has improved in year and is now within the expected disparity ratio range of 0.8-1.20.
- **Metric 3 – Likelihood of entering formal capability process.** This metric has improved in the last 12 months compared to last years return, however disparity ratio is at 1.90 above the recommended range indicating an adverse impact for disabled colleagues. However the numbers of disabled colleagues entering a formal capability process remains low, in addition to this we are aware that not all colleagues with a disability/long term condition have declared this, therefore care must be taken when drawing conclusions.
- **Metric 4a – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public.** The disparity ratio indicates a negative impact on disabled colleagues, however it has improved since last year.
- **Metric 4b – Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from managers.** The disparity ratio indicates a negative impact on disabled colleagues, however it has improved since last year.
- **Metric 4c - Percentage of colleagues experiencing harassment, bullying or abuse in the last 12 months from colleagues.** The disparity ratio indicates a negative impact on disabled colleagues, however it has improved since last year.
- **Metric 4d - Percentage of colleagues saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.** This score has both improved since last year and is within the race disparity ratio boundaries to indicate no adverse impact for disabled colleagues.

- **Metric 8 - Percentage of disabled staff saying their employer has made adequate adjustments to enable them to carry out their work.** This score has improved this year and is above the national average.
- **Metric 10 – Board Representation.** 10.5% of voting Board members identify as having a disability, this has increased since last year and above the NHS national average.

The following indicator shows a **deterioration** in the experience of our Disabled colleagues;

- **Metric 5 - Percentage believing the trust provides equal opportunities for career progression or promotion.** This score has deteriorated since last year, however it remains within the disability disparity ratio boundaries to indicate no adverse impact for disabled colleagues.
- **Metric 6 – Percentage of colleagues who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.** This score has deteriorated since last year, it still falls above the disparity ratio boundary indicating that there is an adverse impact for colleagues who are disabled.
- **Metric 7 - Percentage of colleagues saying that they are satisfied with the extent to which their organisation values their work.** This score has deteriorated since last year and is above the disability disparity ratio boundaries to indicate there is an adverse impact for disabled colleagues.

Metric 9 – Staff Engagement. The disparity ratio has remained stable this year, is in line with the national average, and shows no adverse impact for disabled colleagues

METRIC 1 – REPRESENTATION

This section details the percentage of colleagues in each of the AFC bands 1-9 and VSM for both clinical and non-clinical colleagues who are disabled and non-disabled compared with colleagues in the overall workforce.

Currently we know that 481 of our colleagues have recorded they have a long-term condition or disability which equates to 4.8% of our workforce. We understand from the most National Staff Survey completions however that 29.3% of those colleagues who took part in the staff survey indicated they have a long-term condition/disability (at least 986 colleagues – as only 47% of total workforce participate in staff survey, so this figure is likely to be more). If these colleagues updated ESR to reflect their long-term condition/disability, this would help to support greater accurate data for this metric, metric as well as metric 2, 3 and 9.

As displayed in the table below, disabled colleagues have stronger representation in non-clinical roles which are at band 3, 7, 8a, 8b and VSM. For a number of bands we have seen an increase in the percentage of disabled colleagues, of note is the band 8a, band 8b and VSM increase.

For clinical roles, there has been an increase in disabled colleague representation in band 2, band 4, Band 5, band 6, band 8a, and band 8c in comparison to 2022 data. For both clinical and non-clinical roles we need to take action to improve the percentage of disabled colleagues in more senior level roles, from band 8a and above.

Agenda for Change Workforce

Non-Clinical	% Disabled 2022	% Disabled 2023	Clinical	% Disabled 2022	% Disabled 2023
Under Band 1	12.5	14.3	**Under Band 1**	50.0	-
Band 1	-	-	**Band 1**	-	-
Band 2	4.2	4.8	**Band 2**	5.5	6.3
Band 3	6.6	6.4	**Band 3**	4.4	4.9
Band 4	4.5	5.0	**Band 4**	6.0	7.3
Band 5	3.0	5.2	**Band 5**	4.6	4.7
Band 6	2.5	2.3	**Band 6**	3.7	5.6
Band 7	6.9	6.3	**Band 7**	3.1	3.6
Band 8a	6.8	7.5	**Band 8a**	5.4	5.3
Band 8b	-	7.4	**Band 8b**	2.5	2.1
Band 8c	3.8	4.2	**Band 8c**	13.3	4.5
Band 8d	-	-	**Band 8d**	-	-
Band 9	-	-	**Band 9**	-	-
VSM	-	10.0	**VSM**	-	50.0
Total	4.0	4.7	**Total**	4.2	4.8

With regards to the Medical and Dental Workforce, there is limited levels of self-declaration of long-term condition, illness of disability, as illustrated in the table overleaf. Work needs to be undertaken with this workforce group to encourage self-reporting, changing perceptions around disclosing a disability and creating feelings of psychological safety in sharing this information with us as an employer.

Medical and Dental Workforce

Role	% Disabled Background 2022	% Disabled Background 2023
Consultants	0.9	0.9
Non-consultant career grade	1.3	2.3
Trainee grades*	1.1	2.3

*Excludes Lead Employer Medical and Dental Trainees

METRIC 2– LIKELIHOOD OF APPOINTMENT FROM SHORTLISING

The table below, indicates the likelihood of disabled candidates being appointed from shortlisting. The disparity ratio for this indicator has improved since last year, moving from 1.21 in 2022 to 1.13 in 2023; this now falls within the disparity ratio boundary of 0.80-1.20.

	2021 - 2022		2022 - 2023	
	Disabled (n=)	Non-Disabled (n=)	Disabled (n=)	Non-Disabled (n=)
Number of shortlisted applicants	717	9385	842	9255
Number appointed from shortlisting	247	3915	225	2800
% appointed from shortlisting	34.45%	41.72%	26.72%	41.7%
Disparity ratio	**1.21**		**1.13**	

METRIC 3 – LIKELIHOOD OF ENTERING FORMAL CAPABILITY PROCESSES

Metric 3 indicates disabled colleagues are 1.90 times more likely to enter the formal capability process, this is substantial improvement from last years results. Whilst an improvement it is still an area for action as it falls above the disparity ratio. Upon reviewing the supporting data, the average cases are very low, therefore care must be taken before drawing a conclusion, across 2022 - 2023 there was an average of 13.5 formal capability cases per year involving disabled staff and an average of 108 for non-disabled colleagues.

	2021- 2022		2022 - 2023	
	Disabled (%)	Non-Disabled (%)	Disabled (%)	Non-Disabled (%)
% of colleagues entering the formal capability process	0.89%	0.27%	0.52%	0.27%
Disparity ratio	**3.28**		**1.90**	

METRIC 4 – BULLYING, HARRASSMENT OR ABUSE

METRIC 4A – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM PATIENTS, SERVICE USERS OR THE PUBLIC IN THE LAST 12 MONTHS

The data displayed overleaf highlights an improvement from last year's WDES reporting position for the extent to which colleagues with a disability, LTC or illness experience bullying, harassment or abuse from patients, service users or the public. With a disparity ratio of 1.46, this is it considered to have an adverse impact for colleagues with a disability, LTC or illness compared with colleagues without a disability, LTC or illness as it falls

below the range of 0.8 – 1.2. Our disparity ratio is more favourable for disabled colleagues than the national benchmark.

Organisation Data for 2022 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	27.0%	18.5%	1.46	Improvement
National Benchmark	33.0%	26.2%	1.26	Improvement

Performance for this indicator as indicated in the table indicates that the disparity ratio continues to be an area for improvement.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2021	27.7%	18.7%	1.48	Deterioration
2020	27.1%	20.8%	1.30	Deterioration
2019	30.6%	23.6%	1.29	Improvement
2018	34.5%	24.0%	1.44	-

METRIC 4B – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM MANAGERS IN THE LAST 12 MONTHS

The data displayed below focuses on colleagues who have a disability, LTC or illness who have experienced harassment, bullying or abuse from managers. The disparity ratio is concerning and show a greater adverse impact for disabled colleagues, the disparity ratio indicates there continues to be a need for further immediate action.

Organisation Data for 2022 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	13.2%	6.9%	1.91	Improvement
National Benchmark	17.1%	9.9%	1.73	Improvement

Performance for this indicator over time as displayed below has been mixed, with the 2021 data showing the worst position since WDES reporting was initiated.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2021	14.7%	7.4%	1.98	Deterioration
2020	16.5%	9.8%	1.68	Improvement
2019	19.2%	11.3%	1.70	Deterioration
2018	20.4%	12.5%	1.63	-

METRIC 4C – PERCENTAGE OF STAFF EXPERIENCING HARASSMENT, BULLYING OR ABUSE FROM COLLEAGUES IN THE LAST 12 MONTHS

The data displayed below focuses on colleagues who have a disability who have experienced harassment, bullying or abuse from colleagues. Again, the disparity ratio is concerning and shows a greater adverse impact

for disabled colleagues, it is also slightly higher than the national benchmark, indicating a need for further immediate action.

Organisation Data for 2022 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	25.4%	16.2%	1.57	Improvement
National Benchmark	26.9%	17.7%	1.52	Improvement

Performance for this indicator over time as displayed below has been mixed, with this years results indicating we may be starting to see an improvement.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2021	24.2%	14.0%	1.72	Deterioration
2020	26.7%	17.3%	1.54	Deterioration
2019	27.5%	18.5%	1.49	Improvement
2018	29.0%	18.1%	1.60	-

METRIC 4D – PERCENTAGE OF STAFF SAYING THAT THE LAST TIME THEY EXPERIENCED HARASSMENT, BULLYING OR ABUSE AT WORK, THEY OR A COLLEAGUE REPORTED IT

The data found that 53.2% of colleagues with a disability, LTC or illness and 51.7% of colleagues without a LTC or illness reported if they experienced harassment, bullying or abuse. The disparity ratio falls between 0.8 – 1.2 indicating, for this metric, there is no adverse impact for colleagues with a disability, LTC or illness. The organisations score is similar to the national benchmark.

Organisation Data for 2022 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	53.2%	51.7%	0.97	Improvement
National Benchmark	48.4%	47.3%	0.98	Improvement

Performance for this indicator over time as displayed below is fairly static, however we have now seen improvements for the last 2 consecutive years.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2021	46.6%	46.1%	0.99	Improvement
2020	49.4%	46.1%	0.93	Deterioration
2019	48.3%	47.2%	0.98	Deterioration
2018	46.5%	46.2%	0.99	No comparator

METRIC 5 – CAREER PROGRESSION AND PROMOTION

The data found that 52.4% of colleagues with a disability and 61.4% of colleagues without a disability believed that our organisation provides equal opportunity for career progression or promotion. The disparity ratio falls just between 0.8 – 1.2 indicting for this metric there is no adverse impact for colleagues with a LTC or illness. The organisations score is similar to the national benchmark.

Organisation Data for 2022 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	52.4%	61.4%	1.17	Deterioration
National Benchmark	51.4%	57.3%	1.11	Same

Performance for this indicator over time as displayed below remains fairly constant, without much movement in disparity ratio.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2021	52.8%	60.0%	1.14	Deterioration
2020	55.4%	61.6%	1.11	Improvement
2019	53.8%	61.8%	1.15	Deterioration
2018	51.8%	58.1%	1.12	-

METRIC 6 – PRESSURE TO COME TO WORK WHEN NOT FEELING WELL ENOUGH

The data found that 26.1% of colleagues with a disability and 18.4% of colleagues without a disability, LTC or illness felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. The disparity ratio falls outside of the 0.80 – 1.20 range at 1.42 indicting for this metric there is an adverse impact for colleagues with a disability, LTC or illness. The organisations score is very slightly better than the national benchmark.

Organisation Data for 2022 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	26.1%	18.4%	1.42	Deterioration
National Benchmark	30.0%	20.8%	1.44	Deterioration

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2021	27.9%	21.7%	1.29	Improvement
2020	29.9%	21.9%	1.37	Deterioration
2019	29.4%	21.6%	1.36	Deterioration
2018	32.1%	24.0%	1.34	-

METRIC 7 – FEELING VALUED

The data found that 33.0% of colleagues with a disability and 48.4% of colleagues without a disability felt satisfied with the extent to which the organisation values their work. The disparity ratio falls outside of the 0.80 – 1.20 range at 1.47 indicating for this metric there is an adverse impact for colleagues with a LTC or illness. The organisations score is worse than the national benchmark. This disparity ratio has significantly worsened year on year for this indicator, which is mirrored in the national benchmark figures too.

Organisation Data for 2022 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	33.0%	48.4%	1.47	Deterioration
National Benchmark	32.5%	43.6%	1.34	Deterioration

Performance for this indicator over time as displayed below shows that the disparity ratios have steadily declined since 2018.

Organisation Data Over Time

	Colleagues with a LTC or illness	Staff without a LTC or illness	Disparity Ratio	Change From Previous Year
2021	35.8%	47.0%	1.31	Deterioration
2020	41.0%	51.4%	1.25	Deterioration
2019	39.5%	48.4%	1.23	Deterioration
2018	39.1%	47.0%	1.20	No comparator

METRIC 8 – ADEQUATE ADJUSTMENTS

This metric is concerned with the percentage of staff with a disability, LTC or illness who say the organisation has made adequate adjustments to enable them to carry out their work, 75.1% of colleagues with a disability, LTC or illness believed this has been their experience. We are unable to apply the disparity ratio to this metric as we do not have comparison data for colleagues who do not have a LTC or illness, as they are not invited to give feedback to this item in the National Staff Survey if they do not self-disclose to fall into having this protected characteristic. The organisations score is better than the national benchmark.

Organisation Data for 2022 and National Benchmark Comparator

	Colleagues with a disability, long term condition or illness	Change From 2021
Lancashire Teaching Hospitals	75.1%	Improvement
National Benchmark	71.8%	Improvement

Performance for this indicator over time has been mixed, typically with around 70-80% of colleagues with an LTC or illness feeling adequate adjustments have been made to support them to carry out their work across this period.

Organisation Data Over Time

	Colleagues with a disability, long term condition or illness	Change From Previous Year
2021	72.6%	Deterioration
2020	80.8%	Improvement
2019	74.7%	Improvement
2018	73.3%	-

METRIC 9 – ENGAGEMENT AND HAVING A VOICE

METRIC 9A – STAFF ENGAGEMENT SCORE

Colleagues with a disability had an engagement score of 6.4, those colleagues without a disability, LTC illness level of engagement was 7.0. This indicates that disabled staff continue to feel less engaged than non-disabled staff. The disparity ratio falls within the 0.8 – 1.2 range at 0.92 indicating for this metric there is no adverse impact for colleagues with a LTC or illness. The organisations score is the same as the national benchmark.

Organisation Data for 2021 and National Benchmark Comparator

	Disabled	Non-Disabled	Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	6.4	7.0	0.92	Same
National Benchmark	6.4	6.9	0.92	Same

Performance for this indicator has remained stable over time.

Organisation Data Over Time

	Disabled	Non-Disabled	Disparity Ratio	Change
2021	6.4	7.0	0.92	Improvement
2020	6.7	7.1	0.94	Same
2019	6.6	7.0	0.94	Deterioration
2018	6.6	7.0	0.95	-

METRIC 9B – FACILTIATING THE VOICES OF DISABLED STAFF TO BE HEARD

Whilst this is not measured as part of the National Staff Survey therefore it is not possible to share performance in the last 12 months or the disparity ratio for this metric. There is a Living with Disability Ambassador Forum set up within the Trust, along with a Neurodiversity Group offering support and a forum to discuss lived experiences. We are fortunate to have Kate Smyth as Non-Executive Director to be a Board level champion and national lead for disabled colleagues to ensure we continue to strive to improve the experiences of colleagues with a disability, LTC or illness and ensure their voices are heard with responsive actions taken.

METRIC 10 – BOARD MEMBERSHIP

10.5% of the Board's voting membership identify as having a disability, this is greater than the NHS average of 3.7% and increase from our position of 7.14% reported last year. Further actions are required to understand if there are a proportion of Board members who have not disclosed their disability or long-term illness/condition, as well as taking supportive actions which continue to increase the diversity of Board membership.

WDES ACTION PLAN

Nationally, NHS England have set six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.
The improvement plan aims to improve the outcomes, experience and culture for those with protected characteristics under the Equality Act 2010 (although it is not limited to these groups) and links to the NHS People Plan. The six actions are as follows, all of which have been built into our strategic EDI action plan:

1) Chief Executives, Chairs and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2) Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3) Develop and implement an improvement plan to eliminate pay gaps.
4) Develop and implement an improvement plan to address health inequalities within the workforce.
5) Implement a comprehensive induction, onboarding and development programme for internationally-recruited colleagues.
6) Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Organisations are mandated to produce a detailed WDES action plan, elaborating on the priority areas identified in this report and setting out the next steps with milestones for expected progress against the WDES metrics. The actions to supporting improvements against WDES are incorporated within the Workforce and Organisational Development strategic action plan for equality, diversity and inclusion. A copy of the strategic action plan is provided in Appendix 1. The strategic action plan, alongside this WDES report will be discussed with colleagues who participate in the organisations Living with Disability Inclusion Forum.

The strategic action plan will address the priority areas for improvement as found through the analysis of our data against the 10 WDES indicators alongside the views, ideas and actions valued by colleagues in the Disability Inclusion Forum. For clarity the strategic action plan for the next 12 months to support WDES improvements are:

- Increase the declaration rates of disabilities and long-term conditions by colleagues
- Reduce the % of ‘not known’ against the disability field in our electronic staff record
- Reduce the likelihood of disabled colleagues entering the formal capability procedure
- Improve the experience of disabled colleagues in respect of experiencing harassment, bullying or abuse from patients, relatives or other members of the public; managers and other colleagues
- Increase the percentage of disabled staff saying they are satisfied with the extent to which the organisation values their work.
- Increase the percentage of disabled colleagues who feel they have equal opportunity to access career development and promotion opportunities.
- Increase the percentage of colleagues who say the organisation has made adequate adjustments to enable them to carry out their work

A Zero Tolerance toolkit is due to be launched this month as part of a Trust wide campaign to encourage colleagues who are bystanders to challenge inappropriate behaviour whilst promoting an environment of safety, mutual care, respect and understanding, aiming to support a reduction in discrimination, violence, aggression, bullying and abuse.

A significant piece of work has commenced in respect of Reasonable/Adequate Adjustments; training around Reasonable/Adequate Adjustments has been provided to our recruitment team and a Managers Update session is also scheduled for line managers across the organisation. Further work includes developing an online training package for colleagues and line managers, review of the processes and touchpoints which can encourage colleagues to disclose a disability and/or report a recently acquired disability/long term condition, information sent out at interview stage to candidates (which encourages disclosure and to request adequate adjustments if needed) as well as guidance to Recruiting Managers. Consideration will also be given to centralising requests for adequate adjustments to enable monitoring and reporting in addition to ensuring the provision of a consistently positive experience for colleagues.

An action scheduled for progression over the next 6 months is to overhaul our recruitment processes and embed a talent management strategy that targets under-representation and lack of diversity and specifically addresses the issues around attracting and retaining younger talent, as well as equity of career progression opportunities for staff of all protected characteristics and particularly for internationally recruited staff.

Agreed actions will form part of the wider action plan for the Equality, Diversity and Inclusion agenda under the Equality Strategy and the Our People Plan.

Next steps:

- To share this report with the Living with Disability Inclusion Forum to seek their views and lived experience in relation to these findings as well as to understand the actions they believe will help to reduce inequality and increase inclusion.
- To share the draft Workforce and Organisational Development strategic action plan for equality, diversity and inclusion and seek their views on the content, understand what else forum members would want to see and make further amendments based on feedback.
- Submit results and action plan to the WDES team.
- Communicate results and action plan to our workforce through
    - Sharing results and actions with the Equality, Diversity and Inclusions Steering Group, for consideration as to how themes from the WDES report can support both corporate and divisional levels actions.
    - Sharing through Divisional Workforce Committee meetings.
    - Sharing further updates with the Disability Inclusion forum.
    - Managers Update Sessions.
    - Specific organisation wide communications in conjunction with the Communications team.
- Publish our results and action plan externally on the Trust website
- The strategic action plan will be implemented, with progress measured through the Equality Strategy Group and outcomes will be reviewed utilising the 2023 Staff Survey in conjunction with 2023 workforce data results.

FINANCIAL IMPLICATIONS

Research evidence indicates that, when organisations are more diverse and have a greater focus on inclusion colleagues report greater engagement, there is a correlation with safer care for patients, reduced turnover, less sickness absence and improved financial performance.

LEGAL IMPLICATIONS

Unsatisfactory progress may leave the Trust open to legal challenges. We are required to demonstrate all staff have access to provision of services and are not discriminated against because of a protected characteristic.

RISKS

Unsatisfactory progress would be a risk to our reputation; both as a provider of Excellent Care with Compassion but also as an employer of choice.

IMPACT ON STAKEHOLDERS

Research evidence within the NHS tells us that the experiences of our colleagues acts as a good barometer for the experience of our patients; the more positive the experience of our colleagues, the more positive the experience of our patients.

RECOMMENDATIONS

It is recommended that the Board:

- Receive the report and note the content.
- Approve the priority areas for action.
- Approve publication of our results externally.

The Workforce Disability Equality Standard 2023

Together

NHS Lancashire Teaching Hospitals NHS Foundation Trust

The Workforce Disability Equality Standard (WDES) is a set of ten specific metrics which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The infographic below (for 2023) highlights the differences between the experience and treatment of Disabled colleagues and Non-Disabled colleagues, as an organisation we are committed to closing those gaps through the development and implementation of actions to bring about continuous improvement over time.

OUR DATA AND KEY FINDINGS

REPRESENTATION

4.8% of colleagues have declared they have a disability or long-term health condition.

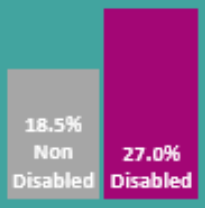
SHORTLISTING

Non-disabled colleagues are **1.13** times more likely to be appointed from shortlisting.

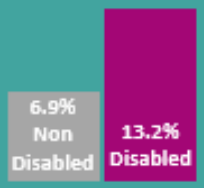
CAPABILITY PROCESS

Disabled colleagues are **1.9** times more likely to enter the formal capability process.

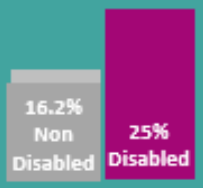
BULLYING, HARRASSMENT AND ABUSE



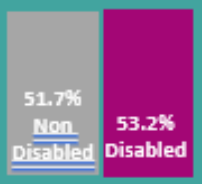
Colleagues experiencing harassment, bullying or abuse from patients, relatives or public



Colleagues experiencing harassment, bullying or abuse from managers



Colleagues experiencing harassment, bullying or abuse from colleagues



Colleagues reporting harassment, bullying or abuse

CAREER PROGRESSION

52.4%

of Disabled colleagues believe that the Trust provides equal opportunities for career progression or promotion, compared with 60.0% of Non-Disabled colleagues.

PRESSURE TO WORK

26.1%

of disabled colleagues have felt pressure from their manager to come to work, despite not feeling well enough to perform duties., compared with 21.7% of Non-Disabled colleagues.

FEELING VALUED

33%

of Disabled colleagues are satisfied with the extent to which their organisation values their work, compared with 47.0% Non-Disabled Colleagues.

REASONABLE ADJUSTMENTS

75.1%

Of Disabled colleagues saying their employer has made adequate adjustments to enable them to carry out their work.

STAFF ENGAGEMENT SCORE

Disabled colleagues feel less engaged at work

6.4/10 Disabled

7/10 Non-disabled

BOARD MEMBERSHIP

2 Board Members identify with having a disability or long-term health condition out of a total of 19 Board Members

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Workforce Race Equality Standard (WRES) Submission 2023							
Report to:	Board of Directors			**Date:**	3 August 2023		
Report of:	Interim Chief People Officer			**Prepared by:**	L Graham		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☒	**For information**	☐		

Executive Summary:

The purpose of this report is to share the data which will form the submission and subsequent publication of the 2023 Workforce Race Equality Standard (WRES) for our Trust. It sets out priority areas for action based on analysis of the results which include workforce data and findings from the latest staff survey. The Board is asked to review and approve the contents of the report for publication and to consider the areas for action and associated next steps which are to consult with the Ethnicity Inclusion Forum with regards to the results, understand their lived experience, the actions which will make the greatest impact and to seek feedback on the draft action plan, making changes where necessary. The Trust is part of the Lancashire and South Cumbria Integrated Care Board (ICB) Belonging Delivery Group and are working collaboratively to identify some key objectives with the aim to improve the WRES data.

The priority areas recommended for action are those which are indicating ethnic minority colleagues are being adversely impacted or disadvantaged according to the four-fifths rule:

Indicator 2 – Relative likelihood of staff being appointed from short listing across all posts.

Indicator 7 – Percentage of staff believing that trust provides equal opportunities for career progression or promotion.

Indicator 8 – In the last 12 months, have you personally experienced discrimination at work from your manager or colleagues.

Indicator 1 and 9 – Increased representation of ethnic minority colleagues in senior, VSM or voting Board member roles.

It is recommended that the Board receive the report, note the content, approve the priority areas for action and approve external publication of our results.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☐	Consistently Deliver Excellent Care	☐
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒

To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐

Previous consideration

Equality, Diversity and Inclusion Steering Group
Workforce Committee (11 July 2023)

INTRODUCTION

The Workforce Race Equality Standard (WRES) is a mandated requirement through the NHS standard contract and is the eighth report since it was established in 2016. Organisations are mandated to report and publish their WRES data on an annual basis, illustrating organisational progress against nine indicators relating to workforce race equality. This report allows us as an organisation to understand where the data indicates the areas of greatest challenge and where we are performing well. It also enables us to benchmark our position as a Trust against nationally available findings for each of the 9 WRES Indicators.

RESULTS

For each of the indicators the data is compared for White and Black, Minority Ethnic colleagues. National staff survey averages have been included for comparative purposes. National staff survey averages and organisational results for the last 3 years have been included for comparative purposes where applicable to the metric being reviewed.

Summary Data

Improvements have been seen for Ethnic Minority colleagues across the following WRES indicators;

- **Indicator 3 – Likelihood of entering a formal disciplinary process.**
  This score has remained static since last year and indicates no adverse impact for ethnic minority colleagues.
- **Indicator 4 – Access to non-mandatory training and continuous professional development.** This metric has improved since last year. The race disparity ratio is 1.02 and indicates there is no adverse impact on ethnic minority groups.

The following indicator shows a **deterioration** in the experience of our Ethnic Minority colleagues;

- **Indicator 1 – Representation.** Action is needed to increase the representation of ethnic minority colleagues in more senior roles.
- **Indicator 2 – Relative likelihood of appointment from shortlisting.** The metric score has worsened from last year illustrating white colleagues are 1.34 times more likely to be appointed from shortlisting.
- **Indicator 5 – Percentage of colleagues experiencing bullying, harassment or abuse from the public.** This score has worsened since last year from 16.2% to 17.2%. However the race disparity ratio is 0.8 indicating there is no adverse impact on ethnic minority groups.
- **Indicator 6 – Percentage of colleagues experiencing bullying, harassment or abuse from colleagues.** This score has worsened since last year from 18.2% to 22.7%. However the race disparity ratio is 1.09 indicating there is no adverse impact on ethnic minority groups.
- **Indicator 7 - Percentage believing the Trust provides equal opportunities for career progression or promotion.** The percentage of ethnic minority colleagues reporting they believe there are equal opportunities for career development or promotion has improved since last year from 45.5% to 48.5% yet the race disparity ratio has deteriorated and indicate an adverse impact for ethnic minority colleagues.
- **Indicator 8 – Percentage of colleagues experiencing discrimination from managers or colleagues.** The percentage of colleagues reporting they've experienced discrimination from managers or colleagues has worsened sightly since last year from 12.5% to 12.9%.. The race disparity ratio is 1.98 and an indication that ethnic minority colleagues are twice as likely to report experiencing discrimination from managers or colleagues than white colleagues.
- **Indicator 9 –** Ethnic diversity of Voting Board Members. At present there is no ethnic minorities represented on the Trust Board. Action needs to be taken to further enhance the diversity of our board so it is proportionately representative of the ethnic makeup of our wider workforce and community.

The approach used by both the national WRES team and the Race Disparity Unit, with regard to the ongoing Race Disparity Audit work, is to utilise what is referred to as the four-fifths (or "80 percent") rule to

highlight whether practices have an adverse impact on an identified group e.g., a sub-group of ethnicity. If the relative likelihood of an outcome for one sub-group compared to another is **less than 0.8 or higher than 1.2**, then the process would be identified as having an adverse impact on one of those sub-groups.

INDICATOR 1 – REPRESENTATION

This section details the percentage of colleagues in each of the AFC bands 1-9 and VSM for both clinical and non-clinical colleagues who are white and belonging to an ethnic minority background compared with colleagues in the overall workforce.

As of 31 March 2023, the Trust Headcount was 9,989. White 7238 (72.5%), ethnic minority 2620 (26.2%), unknown 131 (1.3%).

As detailed below the greatest representation of ethnic minority colleagues in non-clinical roles are in bands 2 and below (below band 1 tend to be apprentices). Across all bands with the exception of apprentices, bands 1 and 2, ethnic minority colleagues are underrepresented when compared against the Trust wide ethnic minority workforce.

From a clinical workforce perspective the highest percentage of ethnic minority colleagues can be found in band 5 roles. With the exception of band 5 clinical roles, ethnic minority colleagues are underrepresented in all other bands when compared against the Trust wider ethnic minority workforce.

It is positive to note that across the majority of the agenda for change bands we have seen an increase in the percentage of ethnic minority colleagues within our workforce in the last 12 months. Areas for improvement are to increase the percentage of ethnic minority colleagues in more senior roles 8a and above, specifically in band 9 and VSM roles.

Agenda for Change Workforce

Non-Clinical	% Ethnic Minority Background 2022	% Ethnic Minority Background 2023	Clinical	% Ethnic Minority Background 2022	% Ethnic Minority Background 2023
Under Band 1	25.0	71.4	**Under Band 1**	-	100
Band 1	22.2	40.0	**Band 1**	-	N/A
Band 2	24.8	25.8	**Band 2**	17.4	21.0
Band 3	10.1	14.0	**Band 3**	19.0	23.9
Band 4	7.4	9.1	**Band 4**	12.6	13.1
Band 5	10.7	11.4	**Band 5**	35.0	44.6
Band 6	11.5	13.8	**Band 6**	14.7	17.1
Band 7	10.9	14.3	**Band 7**	9.1	9.6
Band 8a	8.2	7.5	**Band 8a**	9.4	10.6
Band 8b	26.3	7.4	**Band 8b**	7.5	6.4
Band 8c	7.7	16.7	**Band 8c**	6.7	4.5

Band 8d	-	-	**Band 8d**	10.0	9.1
Band 9	-	10.0	**Band 9**	-	-
VSM	-	-	**VSM**	-	-
Total	**16.3**	**17.8**	**Total**	**25.1**	**29.5**

We have seen further increases in clinical band 5 roles and this large increase may be attributed to the successful recruitment of nurses from overseas.

The medical and dental workforce has a higher proportion of ethnic minority colleagues in all roles than white colleagues.

Medical and Dental Workforce

Role	% Ethnic Minority Background 2022	% Ethnic Minority Background 2023
Consultants	53.1	52.6
Of which Senior Medical Manager	53.3	37.7
Non-consultant career grade	68.4	69.3
Trainee grades*	66.4	71.4

*Excludes Lead Employer Medical and Dental Trainees

Towards the end of 2019 the WRES team issued "A Model Employer" document which set out the challenge of ensuring Black, Asian and Minority Ethnic representation at all levels of the workforce by 2028, particularly across senior management bands (8a and above). If we review the trajectory as shown below we can see that as a Trust we have made strong progress in achieving and for some bands exceeding the expected trajectory for 2023 for bands 8a – 8d, however as mentioned earlier in the narrative for this indictor with further work needed to support the progression or recruitment of colleagues from an ethnic minority background into band 9 and VSM roles.

Model Employer Proposed Trajectory for bands 8a and above

	2020		2021		2022		2023	
	Ambition	**Actual**	Ambition	**Actual**	Ambition	**Actual**	Ambition	**Actual**
Band 8a	17	**16 (-1)**	19	**21 (+2)**	20	**27 (+7)**	22	**32 (+10)**
Band 8b	5	**6 (+1)**	5	**8 (+3)**	6	**8 (+2)**	6	**5 (-1)**
Band 8c	1	**1**	2	**1 (-1)**	2	**3 (+1)**	3	**5 (+2)**
Band 8d	0	**0**	0	**1 (+1)**	1	**1 (-)**	1	**1 =**
Band 9	0	**0**	0	**0**	1	**0 (-1)**	1	**1 =**
VSM	0	**0**	0	**0**	1	**0 (-1)**	1	**0 (-1)**

INDICATOR 2 – LIKELIHOOD OF APPOINTMENT FROM SHORTLISING

The table below, indicates the likelihood of white and ethnic minority candidates being appointed from shortlisting. The race disparity ratio for this indicator has deteriorated since last year, moving to 1.34 (from 1.28). This means that white candidates are 1.34 times more likely to be appointed from shortlisting than candidates from and ethnic minority. The disparity ratio is slightly above the range of 0.8 – 1.2, therefore further action needs to be taken.

	2022		2023	
	White (n=)	**Ethnic Minority Background (n=)**	**White (n=)**	**Ethnic Minority Background (n=)**

Number of shortlisted applicants	7316	2861	6376	3793
Number appointed from shortlisting	3201	981	2108	934
Relative likelihood of appointment	43.75%	34.29%	33.06%	24.62 %
Race disparity ratio	**1.28**		**1.34**	

INDICATOR 3 – LIKELIHOOD OF ENTERING FORMAL DISCIPLINARY PROCESSES

The data displayed in the table below shows that for this reporting year 2022 – 2023 we have seen the race disparity ratio remain static and below the race disparity ratio, meaning this is not a priority area for action in this reporting year.

	2021 - 2022		**2022 - 2023**	
	White (n=)	**Ethnic Minority Background (n=)**	**White (n=)**	**Ethnic Minority Background (n=)**
Average Number of colleagues entering the disciplinary process *(over 2yr rolling period)*	42.5	9.5	47.5	13.0
Race disparity ratio	**0.76**		**0.76**	

INDICATOR 4 – ACCESS TO NON-MANDATORY TRAINING AND CONTINUOUS PROFESSIONAL DEVELOPMENT

This indicator has improved significantly in the last 12 months, with the race disparity ratio of 1.02 indicating that colleagues from ethnic minority groups are almost equal in being able to access non mandatory and continuous professional development than their white counterparts. This information is displayed in the table overleaf. Whilst ability for all colleagues both from white and ethnic minority backgrounds to access training and professional development has improved it is important to ensure we make further progress over the next 12 months.

The race disparity ratio for this indicator is at its lowest in the past 6 years.

	2022		**2023**	
	White (%)	**Ethnic Minority Background (%)**	**White (%)**	**Ethnic Minority Background (%)**
Percentage of colleagues accessing non-mandatory training and CPD	17.65%	11.90%	18.01%	17.7%
Race disparity ratio	**1.48**		**1.02**	

INDICATOR 5 – BULLYING AND HARRASSMENT FROM THE PUBLIC

As displayed in the Organisation Data (taken from the National Staff Survey 2022 Results) for this indicator found that 17.2% of ethnic minority staff and 21.2% of white colleagues have experienced bullying, harassment or abuse from patients, relatives or other members the public in the last 12 months. The race disparity ratio of 0.81 indicates there is no adverse impact for ethnic minority colleagues for this indicator, this is an deterioration from our last years WRES submission for indicator 5. Our race disparity ratio is more favourable for ethnic minority colleagues than the national benchmark.

Organisation Data for 2022 and National Benchmark Comparator

	White	Ethnic Minority Background	Race Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	21.2%	17.2%	0.81	Deterioration
National Benchmark	26.9%	30.8%	1.14	Deterioration

Performance for this indicator as indicated in the table below over the last 4 years has indicated a mixed picture, with 2020 and 2022 seeing a deterioration after a year of improvement.

Organisation Data Over Time

	White	Ethnic Minority Background	Race Disparity Ratio	Change From Previous Year
2022	21.2%	17.2%	0.81	Deterioration
2021	21.6%	16.2%	0.75	Improvement
2020	22.5%	19.5%	0.87	Deterioration
2019	25.6%	19.5%	0.76	Improvement

Ethnic Group National Staff Survey Data

From reviewing National Staff Survey Data for this item for this WRES indicator by ethnic minority group it was found that 18.6% of Black/African/Caribbean/Black British colleagues experienced at least one incidence of bullying, harassment or abuse from patients, relatives or other members of the public over the previous 12 months, with, 17.5% of Asian/Asian British colleagues also experiencing bullying, harassment and abuse from patients or other members of the public.

	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups	

Comparator (Organisation Overall)	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Mixed/ Multiple ethnic groups	Other ethnic groups	White
n = 4440	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
20.4%	17.5%	18.6%	15.8%	13.3%	21.2%

INDICATOR 6 – BULLYING AND HARRASSMENT FROM COLLEAGUES

The data displayed below for indicator 6, highlights a deterioration from last year's WRES reporting position with a race disparity ratio of 1.08 for colleagues experiencing harassment, bullying or abuse from colleagues in the last 12 months. As the 1.08 ratio falls between 0.8 and 1.2 is it considered that there are no adverse impacts for ethnic minority colleagues. Our race disparity ratio is more favourable for ethnic minority colleagues than the national benchmark.

Organisation Data for 2022 and National Benchmark Comparator

	White	Ethnic Minority Background	Race Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	20.9%	22.7%	1.08	Deterioration
National Benchmark	23.3%	28.8%	1.24	Deterioration

Performance for this indicator, as shown in the table below, over the last 3 years has indicated again a further mixed picture and inconsistent patterns or trends, with 2019 and 2021 seeing a small improvement, with other years seeing a deterioration in the race disparity ratio.

Organisation Data Over Time

	White	Ethnic Minority Background	Race Disparity Ratio	Change From Previous Year
2022	20.9%	22.7%	1.08	Deterioration
2021	20.3%	18.2%	0.90	Improvement
2020	23.6%	26.2%	1.11	Deterioration
2019	25.9%	24.0%	0.93	Improvement

Ethnic Group National Staff Survey Data

From reviewing National Staff Survey Data for this item for this WRES indicator, it was found that colleagues who identified as being from Other Mixed Ethnic Background reported the greatest incidence of bullying, harassment and abuse from colleagues with 25.8% reporting one or more incident.

	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
n = 4440	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
21.3%	22.3%	23.2%	23.4%	25.8%	20.8%

INDICATOR 7 – CAREER PROGRESSION AND PROMOTION

As displayed in the Organisation Data for this indicator for 2022, 48.5% of ethnic minority colleagues and 62% of white colleagues believes our organisation provided equal opportunities for career progression and promotion. The race disparity ratio of 1.28 indicates there is an adverse impact for colleagues from an ethnic minority background. Our race disparity ratio is slightly more favourable for ethnic minority colleagues than the national benchmark.

Organisation Data for 2022 and National Benchmark Comparator

	White	Ethnic Minority Background	Race Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	62.0%	48.5%	1.28	Deterioration
National Benchmark	58.6%	47.0%	1.25	Improvement

Performance for this indicator as indicated in the table below has remained fairly static over the last 4 years with a dip in 2021.

Organisation Data Over Time

	White	Ethnic Minority Background	Race Disparity Ratio	Change From Previous Year
2022	62.0%	48.5%	1.28	Improvement
2021	60.7%	45.5%	1.33	Deterioration
2020	62.4%	49.5%	1.26	Same
2019	62.4%	49.7%	1.26	Improvement

Ethnic Group National Staff Survey Data

The National Staff Survey data when broken down by ethnic minority group found that colleagues from Mixed/Multiple Ethnic Groups were most likely to state they did not believe there was equal opportunities for career progression or promotion For comparison 62.0% of white colleagues believe the Trust provide equal opportunities for career progression and promotion. The race disparity ratio in addition to colleagues experience as measured through the staff survey indicates we need to take further action.

	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**

n = 4440	n = 657	n = 97	n = 77	n = 31	n = 3538
59.2%	49.6%	44.8%	42.1%	45.2%	62.0%

INDICATOR 8 – EXPERIENCE OF DISCRIMINATION FROM MANAGER OR COLLEAGUES

The table below displaying the Organisation Data for indicator 8, shows that 12.9% of ethnic minority colleagues and 6.5% of white colleagues have experienced discrimination at work from a manager, team leader or other colleagues. This leads to a race disparity ratio of 1.98. This shows there is a negative impact for colleagues with ethic minority backgrounds for this indicator, furthermore this race disparity ratio is the worst out of all of the WRES indicators measured. Whilst the organisation's race disparity ratio is more favourable than the national benchmark, improvement work needs to take place to reduce discrimination against colleagues from ethnic minority backgrounds.

Organisation Data for 2022 and National Benchmark Comparator

	White	Ethnic Minority Background	Race Disparity Ratio	Change From 2021
Lancashire Teaching Hospitals	6.5%	12.9%	1.98	Deterioration
National Benchmark	6.5%	17.3%	2.66	Deterioration

This year we have seen a deterioration in the race disparity ratio. The results across the last four years have remained fairly static aside from an increase in ethnic minority colleagues reporting discrimination in 2020.

Organisation Data Over Time

	White	Ethnic Minority Background	Race Disparity Ratio	Change From Previous Year
2022	6.5%	12.9%	1.98	Deterioration
2021	6.9%	12.5%	1.81	Improvement
2020	6.0%	17.6%	2.94	Deterioration
2019	5.8%	12.9%	2.22	Deterioration

Ethnic Group National Staff Survey Data

To look more closely of the experience of different ethnic minority groups the National Staff Survey data for this item was reviewed, it was found that colleagues who are from a Black / African / Caribbean ethnic group report experiencing the most discrimination with 15.6% stating they have personally experienced discrimination from their manager or colleagues, this was followed by Asian / Asian British colleagues at 13.4% . The organisational average for this question was 7.9% colleagues reporting to have experienced discrimination from colleagues or their manager.

	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic groups				
Comparator (Organisation Overall)	**Asian/ Asian British**	**Black/ African/ Caribbean/ Black British**	**Mixed/ Multiple ethnic groups**	**Other ethnic groups**	**White**
n = 4440	**n = 657**	**n = 97**	**n = 77**	**n = 31**	**n = 3538**
7.9%	13.4%	15.6%	10.4%	10.0%	6.5%

INDICATOR 9 – BOARD MEMBERSHIP

At present 0% of the Board's voting membership has an ethnic minority background, compared with an overall workforce representation of 26.2%. As there are no ethnic minority board members this is 26.2% lower than our workforce, therefore is not proportionately representative.

MEDICAL WRES (MWRES) & BANK WRES

For the first time this year, the national WRES team have asked organisations to provide additional workforce data to further explore and quantify race disparities experienced in both the medical workforce and the bank workforce.

Medical WRES

It has been recognised that the medical workforce has several challenges which sets it apart from the rest of the healthcare profession, and so a bespoke set of indicators, the MWRES, were developed in 2020. The publication of the very first national MWRES report in 2021 identified racial disparity experienced by minority ethnic doctors in terms of recruitment, promotion, pay, experience of bullying and harassment, and representation in senior positions. This was especially evident for international medical graduates and specialty and associate specialist (SAS) doctors.

There are eleven MWRES indicators overall and some of the indicators have subsections. The indicators present data on Workforce ethnicity composition, Career Progression, Rewards and Staff feedback. Four of the indicators focus on workforce data, six are based on data from the national NHS Staff Survey questions, one indicator focuses upon minority ethnic representation on boards in Royal and Other Medical Colleges and one indicator focuses on minority ethnic representation as Deans of Medical Schools.

MWRES indicators

Indicator	Indicator Description	2023 Data Source
1a	Number of staff in each medical and dental sub group, disaggregated by ethnicity	Trust Data
1b	Number of staff eligible for, who applied for, and who were awarded a Clinical Excellence Award, disaggregated by ethnicity and origin of primary medical qualification	Trust Data
1c	Number of clinical academics disaggregated by ethnicity	Medical Schools Council
2	Consultant recruitment following completion of postgraduate training, disaggregated by ethnicity	Trust Data via TRAC/NHS jobs
3a	Complaints, referrals to the GMC, and GMC Investigations, disaggregated by ethnicity and origin of primary medical qualification	Trust Data & GMC Data
3b	Deferral of revalidation, disaggregated by ethnicity and origin of primary medical qualification	Trust Data & GMC Data
4a	Admissions into medical schools disaggregated by ethnicity	UCAS
4b	Differential pass rates in Royal College postgraduate examinations	All Medical Colleges (AoMRC)
4c	Annual review of competence progression (ARCP) - unsatisfactory outcomes by PMQ - core medical training	GMC Data
5-10	NHS Staff Survey	NHS Staff Survey Data
11a	Number of doctors on college boards (royal colleges and other medical colleges), disaggregated by ethnicity, type of board membership, and voting rights	All Medical Colleges (AoMRC)
11b	Number of senior staff in medical schools, disaggregated by ethnicity	Individual Medical Schools

Just like the WRES, the MWRES aims to highlight any differences between the experience and treatment of white medical colleagues and ethnic minority medical colleagues in the NHS, with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

This year organisations have only been asked to provide data to the national teams in respect of three metrics;

Metric 1a – The composition of the Medical & Dental Workforce
Metric 1b – Clinical Excellence Awards
Metric 2 – Consultant Recruitment

Metric 1a – Composition of Medical & Dental Workforce*

The number of staff in each medical and dental contract group as at the last calendar day of the stated financial year.

	2022-2023					
Role	**White**	**Black**	**Asian**	**Other**	**Not Known**	**Total**
Medical Director	1	-	-	-	-	1
Clinical Director **	-	-	-	-	-	
Consultant	211	17	173	51	7	459
SAS	25	6	39	14	3	87
Locally Employed Doctor	36	20	50	46	1	153
Doctor in Postgraduate Training	36	11	40	21	3	111
All other medical and dental staff	-	-	-	-	-	-
Total	309 *38.1%*	54 *6.7%*	302 *37.2%*	132 *16.3%*	14 *1.7%*	811

** Excludes Lead Employer Doctors-in-Training*
*** Definition of Clinical Director "… usually works for a Primary Care Network (PCN), supporting a group of practices in partnership with community services, social care, mental health and other healthcare providers. Clinical Directors are accountable leaders, responsible for delivery and key to leading improvement and challenging poor outcomes across the PCN"*

Due to the national definition of Clinical Director, our Clinical Directors have been incorporated into the 'Consultant' category which hampers our ability to review representation across senior level medical positions. White and Asian colleagues make up the largest section of the medical and dental workforce at 38.1% and 37.2% respectively.

Metric 1b – Clinical Excellence Awards
The number of staff eligible for, and who were awarded a Clinical Excellence Award within the stated financial year.

	2022-2023				
	White	**Black**	**Asian**	**Other**	**Not Known**
No. eligible to apply	132	12	130	30	6
No. applied	132	12	130	30	6
No. awarded	132	12	130	30	6

Since COVID, all eligible to apply for a Clinical Excellence Award have received one so there has been no disparity between those who applied and those who were awarded. Consideration will need to be given to the application and decision-making process to ensure the process is fair and equitable when it reverts back.

Metric 2 – Consultant Recruitment *
Consultant Recruitment within the stated financial year.

	2022-2023				
	White	**Black**	**Asian**	**Other**	**Not Known**
No. of applicants	30	4	116	40	6
No. shortlisted	17	3	45	19	5
No. appointed	11	2	22	9	4
% appointed from shortlisting	*64.7%*	*66.7%*	*48.9%*	*47.4%*	*80%*

** Figures do not represent a full 12 months as TRAC deletes historical data after 12 months. Data was extracted on 29th June 2023 and so covers 29th June 2022-31st March 2023.*

Bank WRES
In addition, this year the national team are expanding the scope of WRES to cover bank-only workers for the first time too. To support NHS England's strategic aims of improving the quality of bank provision as a flexible option for staff, a set of indicators has been developed for NHS bank only workers aligned to the People Promise and People Plan. The Bank WRES will focus on colleagues who choose to work in the NHS on a casual contract and who have no other NHS employment contract in place; the aim is to understand how ethnicity and gender (along with contract type) intersects with experience for this part of the NHS workforce.

Metric 1:	Percentage of ***active workers by ethnic group and gender** across key grades and staff groups.
Metric 2:	Relative likelihood of bank workers **entering a formal disciplinary process** by ethnic group in the last 12 months.
Metric 3:	Relative **likelihood of bank workers being formally dismissed** by ethnic group, in the last 12 months (for conduct and capability).
Metric 4a:	Percentage of bank workers **experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in last 12 months**.
Metric 4b:	Percentage of bank workers **experiencing harassment, bullying or abuse from: other colleagues in the last 12 months**
Metric 4c:	Percentage of bank workers **experiencing harassment, bullying or abuse from: Managers in the last 12 months.**
Metric 4d:	Percentage of bank workers **who experienced harassment, bullying or abuse at work who then proceeded to report it?**
Metric 5a:	Percentage of bank workers that have **personally experienced physical violence from patients/service users, their relatives, or other members of the public in the last 12**

	months.
Metric 5b:	Percentage of workers who **experienced physical violence at work who then proceeded to report it**?
Metric 6a:	Percentage workers who would, **in the next 12 months consider moving to work in a form of permanent employment in the NHS.**
Metric 6b:	Percentage of bank workers that **feel there are opportunities to develop their career** in the organisation.
Metric 6c:	Percentage of workers whose **main paid source of work is on the bank**.
Metric 6d:	How long have bank only workers solely worked on the bank.
Metric 7a:	Percentage of bank workers that have **in the last 12 months personally experienced discrimination at work from managers/ team leaders or colleagues**.
Metric 7b:	Percentage of bank workers that have **in the last 12 months personally experienced discrimination at work from: patients, relatives, or members of the public**.
Metric 8a:	Percentage of bank workers **who feel that the organisation values their work contribution**.
Metric 8b:	Percentage of bank workers **that feel safe to speak up about anything that concerns them in their organisation.**
Metric 8c:	Percentage of bank workers that **think the organisation respects individual differences** (e.g. cultures, working styles, backgrounds, ideas, etc.)
Metric 8d:	Percentage of bank workers that **feel they receive the respect they deserve from colleagues** at work.
Metric 9:	Percentage of bank workers wh**o were originally recruited to the NHS from outside of the UK and now work in a bank only position**.

This year, organisations have been asked to provide data to the national teams in respect of three metrics only;

Metric 1: Percentage of *active workers by ethnic group and gender across key grades and staff groups.
Metric 2: Relative likelihood of bank workers entering a formal disciplinary process by ethnic group in the last 12 months
This indicator (2) is also applicable to externally provided bank workers used in NHS organisations.
Metric 3: Relative likelihood of bank workers being formally dismissed by ethnic group, in the last 12 months (for conduct and capability).

Metric 1: Percentage of *active workers by ethnic group and gender across key grades and staff groups.

Clinical

	Clinical																	
	Female									Male								
	Non-AfC	Under band 1	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7+	Non-AfC	Under band 1	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7+
White: British	-	-	-	169	311	16	54	39	12	-	-	-	30	50	-	5	1	2
White: Irish	-	-	-	1	8	-	-	1	-	1	-	-	-	5	-	-	-	-
White: Any other White background	-	-	-	5	15	-	-	-	-	-	-	-	-	6	-	-	-	-
BME - Mixed: White and Black Caribbean	-	-	-	5	2	-	2	1	-	-	-	-	1	2	-	-	-	-
BME - Mixed: White and Black African	-	-	-	1	3	-	-	-	-	-	-	-	1	1	-	-	-	-
BME - Mixed: White and Asian	-	-	-	2	1	-	-	-	-	-	-	-	1	1	-	-	-	-
BME - Mixed: Any other mixed background	-	-	-	-	3	-	-	-	-	-	-	-	-	2	-	-	-	-
BME - Asian or Asian British: Indian	-	-	-	27	33	-	5	1	-	-	-	-	11	14	-	-	-	-
BME - Asian or Asian British: Pakistani	-	-	-	16	13	1	1	-	-	-	-	-	4	3	-	1	-	-
BME - Asian or Asian British: Bangladeshi	-	-	-	2	4	-	-	-	-	-	-	-	-	1	-	-	-	-
BME - Asian or Asian British: Any other Asian backgroun	-	-	-	-	4	-	1	-	-	-	-	-	-	5	-	-	-	-
BME - Black or Black British: Caribbean	-	-	-	3	5	-	-	-	-	-	-	-	-	-	-	-	-	-
BME - Black or Black British: African	-	-	-	19	58	-	4	-	-	-	-	-	4	11	-	1	-	-
BME - Black or Black British: Any other Black backgroun	-	-	-	-	3	-	1	-	-	-	-	-	-	-	-	-	-	-
BME - Other Ethnic Groups: Chinese	-	-	-	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-
BME - Other Ethnic Groups: Any other ethnic group	-	-	-	3	3	-	-	-	-	-	-	-	-	5	-	-	-	-
Not stated	1	-	-	-	4	-	-	1	-	-	-	-	-	2	-	-	-	-

There are significantly more female clinical bank workers than males. Across both male and female groups, the majority of bank colleagues sit at band 3. The majority of bank workers are White: British with Chinese being the least represented.

Non-clinical

	Non-Clinical																	
	Female									Male								
	Non-AfC	Under band 1	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7+	Non-AfC	Under band 1	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7+
White: British	-	-	-	69	10	-	-	1	1	-	-	-	60	1	4	-	-	2
White: Irish	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
White: Any other White background	-	-	-	5	-	-	-	-	-	-	-	-	-	-	-	-	-	-
BME - Mixed: White and Black Caribbean	-	-	-	1	-	-	-	-	-	-	-	-	1	1	-	-	-	-
BME - Mixed: White and Black African	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-
BME - Mixed: White and Asian	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
BME - Mixed: Any other mixed background	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-
BME - Asian or Asian British: Indian	-	-	-	14	1	-	-	-	-	-	-	-	25	1	-	-	-	-
BME - Asian or Asian British: Pakistani	-	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	-	-
BME - Asian or Asian British: Bangladeshi	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
BME - Asian or Asian British: Any other Asian backgroun	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
BME - Black or Black British: Caribbean	-	-	-	1	-	-	-	-	-	-	-	-	1	-	-	-	-	-
BME - Black or Black British: African	-	-	-	2	-	-	-	-	-	-	-	-	1	-	-	-	-	-
BME - Black or Black British: Any other Black backgroun	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
BME - Other Ethnic Groups: Chinese	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
BME - Other Ethnic Groups: Any other ethnic group	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
Not stated	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-

There are similar numbers of female and male clinical bank workers. Across both male and female groups, the majority of bank colleagues sit at band 2. The majority of bank workers are White: British.

Medical & Dental

	Medical & Dental	
	Female	Male
	NULL	NULL
White: British	14	24
White: Irish	-	-
White: Any other White background	2	2
BME - Mixed: White and Black Caribbean	-	-
BME - Mixed: White and Black African	-	-
BME - Mixed: White and Asian	1	2
BME - Mixed: Any other mixed background	-	2
BME - Asian or Asian British: Indian	7	5
BME - Asian or Asian British: Pakistani	9	24
BME - Asian or Asian British: Bangladeshi	2	1
BME - Asian or Asian British: Any other Asian backgroun	2	2
BME - Black or Black British: Caribbean	-	1
BME - Black or Black British: African	3	4
BME - Black or Black British: Any other Black backgroun	1	-
BME - Other Ethnic Groups: Chinese	1	4
BME - Other Ethnic Groups: Any other ethnic group	1	5
Not stated	1	2

There are significantly more male medical and dental bank workers than female. The majority of bank workers are White: British with Asian or Asian British, Pakistani a close second.

Metric 2: Relative likelihood of bank workers entering a formal disciplinary process by ethnic group in the last 12 months

	White: British	White: Any other white background	BME: Mixed, White & Black Caribbean	BME: Black or Black British, Caribbean	BME: Black or Black British, African
Number of colleagues entering the disciplinary process	2	1	1	1	1

Metric 3: Relative likelihood of bank workers being formally dismissed by ethnic group, in the last 12 months (for conduct and capability)

	White: British	White: Any other white background	BME: Mixed, White & Black Caribbean	BME: Black or Black British, Caribbean	BME: Black or Black British, African
Number of colleagues being formally dismissed	1	1	1	-	1

At present, in isolation, it is not possible to draw any conclusions from our data as a Trust however we will review the national MWRES and Bank WRES reports once they are published, discuss the themes with our Ethnicity Ambassador forum and determine any additional actions we can take as a result. It is anticipated that the MWRES will be published in March 2024.

WRES ACTION PLAN

Nationally, NHS England have set six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

The improvement plan aims to improve the outcomes, experience and culture for those with protected characteristics under the Equality Act 2010 (although it is not limited to these groups) and links to the NHS People Plan. The six actions are as follows, all of which have been built into our strategic EDI action plan:

1) Chief Executives, Chairs and Board Members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2) Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3) Develop and implement an improvement plan to eliminate pay gaps.
4) Develop and implement an improvement plan to address health inequalities within the workforce.
5) Implement a comprehensive induction, onboarding and development programme for internationally-recruited colleagues.
6) Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Organisations are mandated to produce a detailed WRES action plan, elaborating on the priority areas identified in this report and setting out the next steps with milestones for expected progress against the WRES indicators. The actions to supporting improvements against WRES are incorporated within both the Equality, Diversity and Inclusion Strategic Action Plan and the dedicated workforce focused actions as outlined in Our People Plan which is the Workforce and Organisational Development Strategy for the strategic aim To Be Supportive and Inclusive. A copy of the strategic action plan for equality, diversity and inclusion is provided in Appendix 1, this brings together the actions under the EDI Strategy and People Plan into one document. The draft strategic action plan, alongside this WRES report will be discussed with colleagues who participate in the organisation's Ethnicity Ambassador Forum.

In addition to the Trust wide EDI Strategy and People Plan, we are working collaboratively with the Lancashire and South Cumbria Integrated Care Board (ICB) Belonging Delivery Group. There is a ICB Belonging Group focus on improving the following key WRES metrics that are again in alignment with the Trust's EDI action plan:

- Increase diverse recruitment from shortlisting
- Targeted talent management and career development opportunities
- Reduction in bullying and harassment from the public and patients
- Equal board representation

The strategic action plan addresses the priority areas for improvement as found through the analysis of our data against the 9 WRES indicators alongside the views, ideas and actions valued by colleagues in the Ethnic Minority Inclusion Forum. For clarity the strategic action plan for the next 12 months to support WRES improvements are:

- Increasing the likelihood of candidates from an ethnic minority background being appointed from short listing across all posts/bands.
- Increase the percentage of colleagues from an ethnic minority background occupying more senior roles (specifically Band 9, VSM and voting Board member roles).
- Reducing the percentage of colleagues from an ethnic minority background experiencing discrimination at work from their manager, team leader or other colleagues

Work has already commenced to support the career progression of ethnic minority colleagues with the launch of the Inclusive Leadership in Lancs programme in 2021. The programme was co-designed with colleagues, specifically to support our talented ethnic minority aspiring leaders of the future who currently occupy band 5-8a posts. The first cohort has completed all learning elements and will be evaluated over the next few months culminating in a celebratory graduation event. Part of the evaluation will seek to understand how the programme has benefitted the development of colleagues in addition to what other support would be beneficial in supporting their ongoing career progression.

We have also taken positive action to ring fence a proportionally representative percentage of accredited (e.g. Institute of Leadership and Management Level 2, Consultant Leadership Development etc.) and non-accredited (e.g. Continuous Improvement Programmes, Core People Management Skills, Senior Leadership Development etc.) taught programmes for colleagues with protected characteristics.

A Zero Tolerance toolkit has recently launched as part of a Trust wide campaign to encourage colleagues who are bystanders to challenge inappropriate behaviour whilst promoting an environment of safety, mutual care, respect and understanding, aiming to support a reduction in discrimination, violence, aggression, bullying and abuse.

An action scheduled for progression over the next 6 months is to overhaul our recruitment processes and embed a talent management strategy that targets under-representation and lack of diversity and specifically addresses the issues around attracting and retaining younger talent, as well as equity of career progression opportunities for staff of all protected characteristics and particularly for internationally recruited staff.

Next steps:

- To share this report with the Ethnic Minority Inclusion Forum to seek their views and lived experience in relation to these findings as well as to understand additional actions they believe will help to reduce inequality and increase inclusion.
- To consult and co-produce with the Ethnic Minority Inclusion Forum on the strategic action plan for

equality, diversity and inclusion and seek their views on the content, understand what else forum members would want to see and make further amendments based on feedback.

- Communicate results and action plan to our workforce through
    - Sharing results and actions with the Equality, Diversity and Inclusions Steering Group, for consideration as to how themes from the WRES report can support both corporate and divisional levels actions.
    - Sharing through Divisional Workforce Committee meetings.
    - Sharing further updates with the Ethnic Minority Inclusion forum.
    - Managers Update Sessions.
    - Specific organisation wide communications in conjunction with the Communications team.
- Publish our results and action plan externally on the Trust website
- The strategic action plan will be implemented, with progress measured through the Equality Strategy Group and outcomes will be reviewed utilising the Staff Survey in conjunction with workforce data results.

FINANCIAL IMPLICATIONS

Research evidence indicates that, when ethnic minority colleagues report greater engagement, there is a correlation with safer care for patients, reduced turnover, less sickness absence and improved financial performance.

LEGAL IMPLICATIONS

Unsatisfactory progress may leave the Trust open to legal challenges. We are required to demonstrate all staff have access to provision of services and are not discriminated against because of a protected characteristic.

RISKS

Unsatisfactory progress would be a risk to our reputation; both as a provider of Excellent Care with Compassion but also as an employer of choice.

IMPACT ON STAKEHOLDERS

There is a wide body of research evidence within the NHS which tells us that the experiences of our ethnic minority colleagues acts as a good barometer for the experience of our patients; the more positive the experience of our ethnic minority colleagues, the more positive the experience of our patients.

RECOMMENDATIONS

It is recommended that the Board:

- Receive the report and note the content.
- Approve the priority areas for action.
- Approve publication of our results externally.

THE WORKFORCE RACE EQUALITY STANDARD 2023

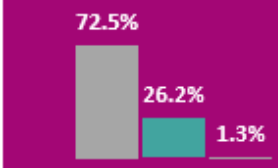
Together

NHS Lancashire Teaching Hospitals NHS Foundation Trust

The NHS Workforce Race Equality Standard (WRES) was devised to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. There are nine WRES indicators. The infographic (for 2023) below highlights any differences between the experience and treatment of White colleagues and ethnic minority colleagues, as an organisation we are committed closing those gaps through the development and implementation of actions to bring about continuous improvement over time.

OUR DATA AND KEY FINDINGS

REPRESENTATION



APPOINTMENTS

White candidates are **1.34** times more likely than **ethnic minority** candidates to be appointed from shortlisting

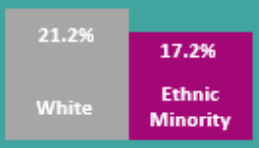
DISCIPLINARY PROCESS

Ethnic minority colleagues are **0.76** times less likely to enter a formal disciplinary process than **white** colleagues

TRAINING AND DEVELOPMENT

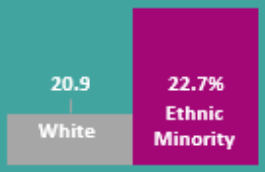
White colleagues are **1.02** times more likely to access non-mandatory training and CPD compared to ethnic minority colleagues

BULLYING AND HARRASSMENT FROM PAITENTS AND THE PUBLIC



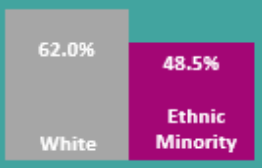
17.2% of Ethnic Minority colleagues experienced harassment, bullying or abuse from patients, relatives or public in the last 12 months

BULLYING AND HARRASSMENT FROM COLLEAGUES



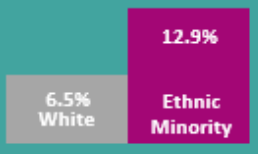
22.7% of **Ethnic Minority** colleagues experienced harassment, bullying or abuse from other colleagues in the last 12 months

CAREER PROGRESSION



48.5% of **Ethnic Minority** colleagues believe that the Trust provides equal opportunities for career progression or promotion

DISCRIMINATION



12.9% of **Ethnic Minority** colleagues reported experiencing discrimination from their manager / team leader / colleagues within last 12 months

BOARD MEMBERSHIP

0 Board Members identify as belonging to an ethnic minority group, out of a total of 15 Board Members

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

GUARDIAN OF SAFEWORKING ANNUAL REPORT 2022							
Report to:	Board of Directors			**Date:**	3 August 2023		
Report of:	Interim Chief People Officer			**Prepared by:**	D Kendall and Lisa Eccles		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☒	**For decision**	☐		**For information**		☐

Executive Summary:

In this annual report I have looked back over the exception reporting data, vacancies data, the Guardian of Safe working (GOSW) quarterly reports and junior doctor forum minutes from January 1st 2022 to December 31st 2022 to provide a summary for the year.

- NHS employers states the purpose of the GOSW annual report is to provide assurance (or otherwise) to the board with regards to safe staffing levels for the doctors in training across the trust, particularly in reference to vacancy rates and subsequent rota gaps.
- From August 2021 a new mirrored 2016 T&Cs were introduced for all trust doctors (junior and senior clinical fellows) and as such they are entitled to exception report as well and any exception reports raised are included within this report.
- There has been a significant increase in exception reporting in 2022 to 607 reports (compared to 387 in 2021) and there were 16 immediate safety concerns (ISCs) (compared to 10 ISCs in 2021). Likely reasons are for this increased trend are due to the exceptionally busy winter surge, gaps in rotas and staff sickness. Increased exceptions were particularly seen in Chorley Medicine (115), Renal Medicine at RPH (118) and the Surgical Specialties at RPH (165). Most exceptions are submitted by FY1 doctors, particularly in the first 3-4 months after they start in August. The main reasons for the Exceptions were extra hours worked and lack of senior support. The trend may also be reflective of a supportive approach to exception reporting in the Trust and is to be expected during particularly busy times, when all staff are highly likely to be working extra hours.
- There are issues across the trust with high vacancies in non-training middle grade staff that impacts upon trainee rotas, affects the supervision of junior grades and increases the workload for the doctors who are left to fill the gaps. The actions taken to address these vacancies and rota gaps are detailed in this report.
- There were 3 junior doctor forums held during 2022 and the problem with lack of out of hours catering was consistently raised.

It is recommended that the Board note areas of risk identified, particularly with reference to lack of out of hours catering and staffing/support levels in Chorley Medicine and RPH Surgical Specialties leading to high numbers of exception reports and ISCs.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐
Previous consideration			
Workforce Committee (11 July 2023)			

1. **Introduction**

The purpose of this report is to provide assurance (or otherwise) to the Board of Directors that there are safe staffing levels at the trust, that junior doctors are safely rostered within the trust and are working hours that are safe and in line with the new safe working rules as set out within the 2016 Junior Doctors' contract.

The report outlines the following:

- Number of exception reports submitted in the year with reasons and discussion
- Summary of areas of concern and actions undertaken by GOSW in response to exception reports
- Trust Vacancy position and discussion
- Summary of Junior Doctor Forum meetings
- Key issues arising, and actions taken

2. Discussion

2.1 Numbers of Doctors covered by this report

Table 1: Number of doctors in (Dec 22) who are covered by this report:

	No Dr's in post
Doctors in Training*	364
Locally Employed Doctors **	103

** All trainees now employed on the 2016 JDC*

*** Since August 2021 Junior and Senior Clinical Fellows have been employed on a new LED trust Dr T&Cs (mirroring the 2016 JDC). Implemented Aug 2021 – this table shows doctors engaged on this contract*

2.2 Exception Reporting Summary

Table 2: Exception reports submitted in 2022

Exception Reports (01/01/2021 – 31/12/2021)	
Total number of exception reports received	607
Number relating to immediate patient safety issues	16
Number relating to hours of working	501
Number relating to pattern of work	1

Number relating to educational opportunities	87
Number relating to service support available to the doctor	17
Number relating to missed breaks	1

Table 2 shows an overall summary of the 607 exception reports submitted in 2022.

The number of exception reports submitted has increased year on year since 2020 as shown in the table below:

Table 3: Number of exception reports submitted each year:

Year	Number of Exceptions
2020	233
2021	387
2022	607

This shows that there has been a significant increase in 2022. Throughout the whole year the acute services have been very busy and the winter surge led to doctors working longer hours. The trend may also be reflective of a supportive approach to exception reporting in the Trust and is to be expected during particularly busy times, when all staff are highly likely to be working extra hours. Exception reporting is the mechanism by which the doctors are given time back in lieu or payment for any extra hours worked.

Table 4: The following table shows exceptions by grade (2022)

Grade	Number of Exceptions
FY1	408
FY2	76
ST1-2	48
ST3+	75
Grand Total	607

The highest number of exception reports is from FY1 doctors with 408 (67%) exception reports and it is pleasing to see we continue to have more senior grades of doctors submitting more exceptions than previous years. The number of exception reports increases significantly in August-December (after the new FY1 doctors start) and trends down over the course of the year as the doctors become more experienced and confident.

Table 5: below shows the breakdown of exceptions by specialty, grade and type of exception (as per rota)

Row Labels	Educational	Hours	Pattern	Rest	Service Support	Grand Total
Emergency Medicine (FY1)	1	3				4
Emergency Medicine (FY2) | Rota A		4				4
Emergency Medicine (FY2) | Rota B		2				2
Emergency Medicine (Medical Intern Year 1)		5				5
Emergency Medicine (Medical Intern Year 2)		1				1
Emergency Medicine (ST1-2)		6				6
A&E (LTFT)	1	2				3
GP (FY2) | Library House Surgery	1					1
GP (FY2) | St Fillans Medical Centre		1				1
Intensive Care (FY2)		1				1
MAU (FY2)	1	5				6
MAU (ST1 - ST2)					1	1
MAU CDH (FY2)	1	1				2
MAU CDH (SCF)						
Medicine CDH (FY1)	19	81			8	108
Medicine CDH (FY2)		1				1
Medicine CDH (ST1 - ST2)		5				5
Medicine CDH (LTFT)		1				1
Medicine RPH (FY1)	1	21			1	23
Medicine RPH (FY2) | Rota A	4	11			2	17
Medicine RPH (FY2) | Rota B	1	4				5
Medicine RPH (Medical Intern Year 1)		3				3
Medicine RPH (ST1 - ST2) | Rota A		3				3
Medicine RPH (LTFT)		3				3
Neonates (FY2)	1					1
Obs & Gynae (FY1)		10				10
Obs & Gynae (FY2)	2					2
Oncology (FY1)	1	29				30
Oncology (JCF) | Non On-Call		2				2
Paediatrics (FY1)		1				1
Paediatrics (LTFT) | Dr Linzi Knowles		1				1
Paediatrics (ST1 - ST2)		8				8
Renal (FY1)		43				43
Renal (ST3 - ST5)	2	40				42
Renal (ST4 - ST5)		8				8
Renal (ST6 - ST8)		25				25
Surgical Specialties (FY1)	35	113			4	152
Surgical Specialties (FY2)	4	8				12
Surgical Specialties (Med. Intern)		1				1
Trauma & Orthopaedics (FY1)	4	29				33
Trauma & Orthopaedics (FY2)	4					4
Trauma & Orthopaedics (ST1 - ST2)		4		1	1	6

Trauma & Orthopaedics (LTFT)		1				1
Urology (JCF)		4				4
Vascular Surgery (JCF)	4	9	1			14
Grand Total	**87**	**501**	**1**	**1**	**17**	**607**

The highest number of exceptions relate to extra hours worked with (83%) in this category.

Typically this is between half an hour to 2 hours extra work and is usually related to work left over from the day that needs completing or patients becoming ill towards the end of the shift and needing attention before the doctor can finish the shift.

The exceptions relating to missed educational opportunities are dealt with by the postgraduate department of education and are not covered in this report. Those reported above mainly cover missed teaching and missed SDT time.

2.3 Immediate Safety Concerns

There were 16 exceptions that were submitted as immediate safety concerns over the course of the year, compared to 10 in 2021. The specific details of the reports are included in the GOSW quarterly reports. The 2 main themes identified included lack of senior support and low medical staffing levels, leading to concerns about patient safety. We encourage doctors to submit Datix for all the ISCs so that any specific patient safety concerns can be investigated through the appropriate governance routes.

Table 6 shows the Immediate Safety Concerns by Specialty

Specialty	Number of ISC
CDH Medicine	8
RPH Surgical Specialties	3
RPH Medicine	3
CDH MAU	1
CDH Surgery	1

2.4 Areas of Concern and Actions Taken (work schedule reviews):

Chorley Medicine

Issues at Chorley continued from 2021 in the Department of Medicine with increased exception reports (115, 19%), 8 ISCs and concerns expressed in various forums (JDF and Foundation Forum) by FY1s, regarding lack of senior supervision, low staffing levels (particularly overnight and weekends) and long hours of work. These issues are persistent and have been raised consistently over the past 3 years. Even when rotas are full, the concerns remain, indicating that the establishment numbers may be too low for the current service. If senior members of a particular team are on leave or off after nights or weekends, this leaves the more junior team members without that senior support. Many of the ISCs have arisen in Chorley due to both the consultant and registrar being off at the same time, sometimes leaving the FY1 alone. There is very little flexibility for senior cover when Consultant and/or middle grades are off at short notice and it is very difficult to recruit suitable candidates.

There were several meetings in 2022 with regards to Chorley Medicine including the GOSW, the management team, rota co-ordinator, CD, DMD and Education. It has been identified that there are comparatively less middle grade doctors at Chorley compared to Preston and less trainee doctors. The teams are also smaller than the RPH teams and so cross-cover between teams is far more difficult. Furthermore there are general team support, cultural and inter-team dynamic issues that have become evident from some of the exception

reports. On-going work to improve the medical staffing levels continues by the CDH management and the rota co-ordinator team. The concerns outlined in the GOSW quarterly reports (particularly the ISCs) were further triangulated with the help of the Foundation team and were escalated, by the DME, to the Medical Director. Actions taken included the implementation of additional SHO grade doctors at CDH over the weekends, so that FY1s were not left covering the wards alone anymore. Further work is also being led by the DMD with the assistance of the OD team to address the cultural issues identified.

Surgical Specialties RPH

The largest category of exceptions at RPH is in the surgical specialties FY1 and FY2 (165 exceptions, 27%) and this trend was particularly evident in the later part of 2021 (Nov,Dec) and has continued into 2022. There were also 3 ISCs. The trend has been raised with the surgical business unit management team including the DMD. The main themes from the exceptions included staffing issues with last minute sickness and failure to employ locums, high patient numbers, increased patient acuity, extremely busy nights and generally increased workload.

The increased exception reports in the surgical specialities were raised with the surgery management team and the feedback was that the exception reports appeared to correlate with short staffing on those days. The staffing levels within General Surgery and Urology tend to be very good and they rarely have gaps, however they went through a period of high COVID absence in early 2022.

The SOTW was a particular theme and reduced cover on Mondays and particularly Fridays seemed, perhaps unsurprisingly, to be particularly busy days leading to proportionally higher numbers of exception reports. Additional staff have now been added on these days.

Renal Medicine RPH

There were 118 (19%) exception submitted in Renal Medicine, including a significant number from more senior doctors at the start of the year. This follows the pattern seen in 2021 and has reduced over the course of 2022 following a work schedule review. The exceptions are predominantly for overtime and refer to busy wards, dealing with sick patients, performing more procedures and low registrar staffing. There is clearly a high workload in renal medicine and there is also a very supportive approach to the submission of exception reports. A work schedule review was undertaken by the Renal CD towards the end of 2021 and details were included in the 2021 GOSW report.

2.5 Vacancies within the Trust

Vacancies vary month on month across the trust and particularly following each rotation. Vacant posts on rotas are also confounded by trainees who are off sick/on-long term sick and on maternity leave. COVID isolation has also affected numbers working on rotas.

Junior rotas are often made up of both Trainees and local employed doctors, for completeness their vacancies have been included in the report below.

Table 6: below shows vacancies by grade across the 2022

	Doctors in Training				Locally Employed doctors		
Quarter	FY1	FY2	ST1-2	ST3+	Junior Clinical Fellow	Senior Clinical Fellow	SAS
Jan 2022	0	0	11	10	30	32	9
Jun 2022	0	0	9	19	20	27	21

Dec 2022	1	1	8	17	27	39	20

**Please note these figures are manually generated from a spreadsheet held within medical workforce – these figures do not include any doctors who are maternity leave or long term sick leave or those who work less than full time in a full time slot. From 2023 we will be generating vacancy reports from the trust ledger.*

In the training grades the highest number of vacancies is in the ST3+ category. The number of vacancies at this more senior level does give cause for concern with more senior specialist posts more challenging to fill/retain.

The raw vacancy data across all specialties is shown in Appendix 1 for Dec 22 and this highlights that there are particular concerns with gaps (non-consultant) in some specialties including Middle grade vacancies in A&E, ICU and some medicine specialties such as respiratory and Gastro and elderly.

Strategies to support recruitment to medical posts include:-

- Monthly reports by HRBP to the Divisional Workforce Committees include the detailed status of each vacant post; divisional teams use this information to identify posts which require advertising.
- Reviewing job descriptions and creation of promotional activity, aligning job descriptions to the new employment brand and elements to make posts more attractive for example rotations and dedicated time for audit, research and teaching. We have re-written and developed job plans in a number of specialties including some surgical specialties, emergency medicine and acute.
- Continuing to promote vacancies through social media, relevant journals and websites such as the BMJ.
- Sourcing hard to fill posts though linked in and developing contacts with medics who are searching for a job.
- Continuing to source doctors where required through international placement agencies.
- Continuing to source doctors through the Medical Training Initiative in liaison with the Royal Colleges and recruitment into CESR posts with ongoing work to develop and ICS model for CESR.
- Work by Associate Medical director to develop and improve induction and embed the NHS international induction framework to all new international doctors.
- Placement of FY3 doctors into vacant posts from August 2022 – expression of interest gathered and all posts matched where possible reducing the need to advertise vacant posts and offered continually of employment to doctors who may not be accessing ST training. This will continue in August 2023.
- Continuation of the medical intern program in partnership with the University of Manchester and the University of Mansoura in Egypt. This 2 year appointment where doctors rotate every 6 months to gain relevant skills and experience whilst undertaking a post graduate diploma. To date we have had 19 interns working in the trust, with a further 10 starting in August 2023. Out of those ending their posts in 2022 we had a number join national training and 3 remain in posts within the trust. These posts continue to fill vacant junior clinical fellow gaps and where required vacant FY2/ST1 posts.
- Initiation of ORDER project, as part of this program we have become a GMC sponsor and we are looking to recruit international fellows onto a program offering support and development and a post graduate program. We have identified approx. 12 posts for this program and posts are due to be advertised w/c 5th June 2023. This post is being used to target the middle grade gaps highlighted above.
- Continue to utilise doctors who are sourced through the Wigan McH program to fill vacant middle grade posts.
- Continue to utilise our medical and dental in-house banks to reduce reliance on agency workers and reduce cost. This has enabled us to utilise our own doctors to work additional hours and therefore improves quality of care because doctors are familiar with patients and the hospital. There are

currently approximately 120 medical bank workers working regular shifts. We adhere to an ICS agreed medical bank rate from 1 April 2022.

- Training for Clinical Directors development program focusing one session on recruitment, at which we covered topics such as effective recruitment strategies including development of job descriptions and management of candidates through to starting.

2.6 Trainees outside the Trust overseen by the LTHTR guardian

There are a number of FY2 doctors who undertake placements in either GP practice or Psychiatry and these doctors are encouraged to exception report the same as all doctors working within the trust. There were just 2 exceptions submitted in 2022 (one for missed education and one for extra hours worked).

2.7 Junior Doctor Forum (JDF)

There were three junior doctor forums in 2022 on 9th March, 7th September and 6th December. Attendance was good and at each meeting, the exception reports were discussed and opportunity given for feedback on any issues.

A forum was held on 9th March 2022 via Microsoft teams. An issue was raised that some trainees had been discouraged from exception reporting in their local inductions. The new exception reporting policy was launched with all the consultants and clinical supervisors/educational supervisors setting out the clear responsibilities and contractual requirements around exception reporting. The GOSW presented the policy to the CRG and highlighted the importance of supporting the submission of exception reports. The trust is committed to supporting a positive exception reporting culture.

A further JDF in May was cancelled due to lack of doctors in attendance and we have held a few online drop-in sessions where juniors could drop in to discuss any concerns as they arise.

A forum was held on 7th September 2022 via Microsoft teams. Several operational and education issues were raised, particularly around patients waiting long periods in A&E and some difficulties in completing e-portfolios. The lack of catering at night was raised and some issues with adequate time to complete induction, particularly prescribing. These issues have been escalated to the relevant teams.

A F2F forum was held on 6th December and the interface between ED and MAU was brought up regarding patients with long stays on ED waiting for beds on the wards, safety issues for these patients not having senior review within 14 hours and lack of training opportunities on post-take rounds. The issues are well known and are being addressed at departmental level. There are steps being taken to achieve a timely and educational post-take ward round. Lack of catering at night was raised as an issue again.

A persistent theme raised at all the junior doctor forums across the year was the level of medical staffing at Chorley hospital in Acute Medicine, with particular concerns regarding supervision for FY1s, long hours of work and poor staffing in the out of hours period.

A new exception reporting policy was launched in 2022 to strengthen procedures relating to exception reporting and there is now a link on the intranet for the GOSW contact details and the policy.

Policy: http://lthtr-documents/current/P2169.pdf.

GOSW page with links to relevant information:
https://intranet.lthtr.nhs.uk/extranet/circle/39551df6775f6d17edbaede723960525?page=42e7aaa88b48137a16a1acd04ed91125

3 Financial implications Unknown at this stage

4 Legal implications None

5 Risks

- Lack of catering in the out of hours period – risk of tired and hungry staff with low moral.
- Increased exception reports and ISCs suggesting that medical staffing levels in CDH Acute Medicine and RPH surgery can be a problem, particularly in the out of hours periods – risk to staff welfare, moral and patient safety

6 Impact on stakeholders

Lack of adequate provision of hot food at night is a risk for all staff in the hospital. This undoubtedly lowers moral and may led to tired and hungry staff under-performing.

Exception reports and ISCs have increased significantly in 2022 and are likely to continue to increase through 2023. It is evident that doctors are working long hours and this can affect moral and impact staff welfare; and increase patient safety risks.

We are pleased that the extra hours that are exception reported, are mostly taken as time back in lieu. Payment can also be arranged if the time back cannot be allocated.

7. Recommendations

It is recommended that the Board note areas of risk identified, particularly with reference to lack of out of hours catering and staffing levels in Chorley Acute Medicine and RPH surgery leading to high numbers of exception reports and ISCs.

Board of Directors Report

Appendix 1: Vacancies Breakdown (Dec 2022)

Grade	Specialty	Vacant	Filled	Grand Total	Vacancy Rate
FY1	Medicine - Diabetes CDH	1	2	3	33.33 %
FY2	Emergency Medicine	1	6	7	14.29 %
ST1	ENT	1	1	2	50.00 %
	Intensive Care	1	6	7	14.29 %
	Medicine - Diabetes RPH	1	2	3	33.33 %
	Medicine - Elderly CDH	1	2	3	33.33 %
	Neonatal	2	3	5	40.00 %
	Orthopaedics	1	2	3	33.33 %
	Surgery	1	4	5	20.00 %
ST3+	Anaesthetics	3	16	19	15.79 %
	Histopathology	1	2	3	33.33 %
	Microbiology	1		1	100.00 %
	Neonatal	1	2	3	33.33 %
	Neurosurgery	1	5	6	16.67 %
	Oncology	2	8	10	20.00 %
	Orthopaedics	2	6	8	25.00 %
	Paediatrics Hospital	1	6	7	14.29 %
	Plastics	1	5	6	16.67 %
	Radiology	1	8	9	11.11 %
	Renal	1	6	7	14.29 %
	Vascular	2	1	3	66.67 %
Junior Clinical Fellow	Emergency Medicine	7	12	19	36.84 %
	ENT	1	2	3	33.33 %
	Medicine - Diabetes CDH	1	1	2	50.00 %
	Medicine - Diabetes RPH	1		1	100.00 %
	Medicine - Elderly RPH	4	3	7	57.14 %
	Medicine - MAU CDH	5	6	11	45.45 %
	Medicine - MAU RPH	4	5	9	44.44 %
	Neurosurgery	2	3	5	40.00 %
	Plastics	1	2	3	33.33 %
	Urology	1	1	2	50.00 %
SAS	Anaesthetics	1	16	17	5.88 %
	Dermatology	1	2	3	33.33 %
	Emergency Medicine	4	5	9	44.44 %

	Intensive Care	3	5	8	37.50 %
	Medicine - Cardiology RPH	2		2	100.00 %
	Medicine - Diabetes RPH	1		1	100.00 %
	Medicine - Respiratory CDH	1		1	100.00 %
	Neurology	2		2	100.00 %
	Palliative Care	2	1	3	66.67 %
	Radiology	2	1	3	66.67 %
	Restorative Dentistry	1	1	2	50.00 %
SCF	Anaesthetics	1	5	6	16.67 %
	Emergency Medicine	4	7	11	36.36 %
	Intensive Care	2	10	12	16.67 %
	Medicine - Elderly CDH	1		1	100.00 %
	Medicine - Elderly RPH	2	1	3	66.67 %
	Medicine - Gastroenterology CDH	1		1	100.00 %
	Medicine - Gastroenterology RPH	2	3	5	40.00 %
	Medicine - MAU RPH	2	3	5	40.00 %
	Medicine - Respiratory RPH	5	3	8	62.50 %
	Medicine - Stroke RPH	1	3	4	25.00 %
	Microbiology	1	1	2	50.00 %
	Neurosurgery	1	9	10	10.00 %
	Obs & Gynae	4	1	5	80.00 %
	Oncology	1		1	100.00 %
	Ophthalmology	1	1	2	50.00 %
	Paediatrics Hospital	1	5	6	16.67 %
	Plastics	3	6	9	33.33 %
	Renal	1	2	3	33.33 %
	Surgery	4	2	6	66.67 %
	Vascular	1	1	2	50.00 %

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Guardian of Safe Working Quarterly Report			
Report to:	Board of Directors	**Date:**	3 August 2023
Report of:	Interim Chief People Officer	**Prepared by:**	D Kendall and L Eccles
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide assurance to the Board of Directors that junior doctors are safely rostered within the trust and are working hours that are safe and in line with the new safe working rules as set out within 2016 contract.

This is a report for the period from 1 December 2022 to 31 Mar 2023 (4 months) and outlines the following:

- Number of exception reports submitted with reasons – there were 131 exception reports raised in the time period above (NB over 4 months) and this is slightly higher than the previous quarter (3 months-120).
- There were 3 immediate safety concerns (ISCs): 2 from doctors (FY1 and FY2) in CDH Medicine and one from FY1 RPH General Surgery.
- Assurance is provided in relation to the actions undertaken by the Guardian of Safe Working (GOSW) in response to these exception reports and ISCs,
- No guardian fines were applied during the reporting period,
- The vacancy position is highlighted and shows a reduction in vacancies across the trust for most grades, apart from JCF where we have seen an increase.
- Bank and agency usage is detailed,
- A junior doctor forum was held with the new doctors in early December 2022 and the lack of hot food catering at night was highlighted as an issue.

It is recommended that the Board:

- Note the contents of the report
- Confirm they are assured that the issues identified are being addressed by the relevant specialities/departments, through escalation of the concerns to the appropriate teams by the work of the Guardian

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☐	Consistently Deliver Excellent Care	☒

To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☐
Previous consideration			
Workforce Committee (11 July 2023)			

1.0 INTRODUCTION

The purpose of this report is to provide assurance to the Board of Directors that junior doctors are safely rostered within the trust and are working hours that are safe and in line with the new safe working rules as set out within 2016 contract.

This report covers a 4 month period and covers 1st December 2022 – 31st March 2023 and outlines the following:

- Number of exception reports submitted in the quarter with reasons,
- Actions undertaken by the Guardian of Safe Working (GOSW) in response to exception reports and ISCs (work schedule reviews instigated),
- Fines applied,
- Trust vacancy position,
- Bank and Agency Usage.

2.0 EXCEPTION REPORTS

Exception reporting is the mechanism used by doctors engaged through the 2016 contract to report variances from their agreed work schedule. Reasons for exception reporting include variance to hours/rest, difference in pattern of hour's worked, educational opportunities and support provided. From Feb 2020 all doctors who are engaged on a national training program are employed through the new 2016 junior doctor contract.

From August 2021 a new mirrored 2016 T&Cs were introduced for all trust doctors (junior and senior clinical fellows) and as such they are entitled to exception report as well and any exception reports raised are included within this report

There were 131 exception reports raised in the time period above (NB 4 months) and this is higher than the previous quarter (120, NB 3 months).

Most of the exceptions are for extra hours worked across a number of specialties, although there have been a number of missed teaching and service support issues raised.

The largest proportion of exception reports were submitted by doctors working in Medicine at CDH (55) and surgical specialties rotas (36).

The number of exceptions in renal medicine has decreased from 18 to 4 in this quarter.

All exception reports are sent to both the clinical and educational supervisor and a resolution is sought where possible within 7 working days. However we are continue to experience difficulties gaining responses within this timeframe due to leave etc. In response to additional hours worked, the trust offers time off in lieu or payment: if the trainee is unable to take this TOIL by 3 months or the end of the rotation (whichever is first) then payment is made.

A new exception reporting policy has been developed and this has now been circulated to relevant parties and published on the trust intranet http://lthtr-documents/current/P2169.pdf.

Table 1: Exception reports between 1 Dec 2022 to 31 Mar 2023

Rota/Grade	Missed Teaching	Natural Breaks	Overtime	Service Support	Grand Total
Acute Medicine CDH (SCF)			1		1
Anaesthetics Non On-Call (ST1 - ST2)	3				3
Emergency Medicine (FY1)	1				1
GP (FY2) | Library House Surgery	1				1
Intensive Care (ST1 - ST2)	4				4
MAU CDH (FY2)	1				1
Medical Education Academic (FY2)	1				1
Medicine CDH (FY1)	5	2	28	2	37
Medicine CDH (FY2)	2		7		9
Medicine CDH (ST1 - ST2)		1	6	1	8
Medicine CDH (ST3 - ST5)			1		1
Medicine RPH (FY2) | Rota B	1		4		5
Obs & Gynae (FY1)			1		1
Obs & Gynae (FY2)	1				1
Oncology (FY1)	1		10	1	12
Ophthalmology (ST1 - ST2)			1		1
Paediatrics (LTFT)			1		1
Paediatrics (ST1 - ST2)			1		1
Renal (FY1)		1	3		4
Surgical Specialties (FY1)	13		4	1	18
Surgical Specialties (FY2)	7			11	18
Trauma & Orthopaedics (FY1)	1				1
Trauma & Orthopaedics (FY2)	1				1
Grand Total	**43**	**4**	**68**	**16**	**131**

2.1 Immediate Safety Concerns

There were 3 exception reports which stated immediate safety concerns (ISC) in this period and all were related to service support: 2 from FY1 and FY2 doctors in CDH Medicine and one from FY1 RPH General Surgery.

1. Chorley Medicine

The 2 ISCs were submitted for the same incident (lack of service support) on 9th Feb, by an FY1 and an FY2, when a consultant failed to attend for a ward round and the doctors believed that there was no registrar cover as they were in clinic. The doctors were not informed that the consultant would not be there in the morning for the ward round.

The situation was escalated to the Chorley Medicine Rota Co-ordinator, the performance manager and the GOSW raised the issue with the ADMD.

On further investigation this related to a week when the Consultant who was covering the ward, does not ever work on Thursday mornings and the juniors were unaware. The doctors had not been informed what to do in this situation and were unsure how to proceed or who to contact for advice about sick patients. A Senior Doctor was in clinic and was available for any immediate patient concerns, but the juniors were not aware of this.

The feedback from the management was that they would plan to arrange senior ward cover on subsequent Thursdays, to prevent this happening again. The doctors were also informed what to do if a similar circumstance happened again.

No further similar exceptions have been submitted since.

2. RPH Surgical Specialties

An ISC was submitted by an FY 1 who was working nights in March 2023.

The concerns raised covered all his night shifts that week and included:

1. High levels of stress were reported as the FY2s take all the acute referrals, often for the first time in their careers. The stress of taking referrals and covering the wards are compounded by lack of food and of rest.
2. Unsustainable workload - covering all surgical wards, as well as taking referrals for urology & general surgery, attending major trauma calls, and often having to help clerk vascular surgery patients as well. While the bleep may be going off repeatedly, there are all the prescribing requirements for the surgical ward patients, as well as those who must be reviewed because they start scoring on their NEWS.
3. Urology clerking - Between 12-8am there is only the SHO who can clerk urology. Urology patients may be at risk of harm when the SHO is tied up on wards, has to go theatre or has to go to a major trauma call.
4. On a positive note, the surgical registrar was very supportive and the H@N team were helpful too – but this did not really alleviate the workload

The trainees submitted the concerns on datix and to the Foundation Board. Support was provided for the trainee.

The GOSW has raised the concerns with the SBM and surgical management team for a work schedule review. An update on staffing levels is still awaited.

2.2 Work Schedule Reviews

Exception reporting, feedback from the junior doctor forum and queries/concerns raised by doctors directly to the Guardian of Safe working may result in a work schedule review. A work schedule review is to ensure rotas remain compliant to safe working rules and are fit for purpose and trainees are paid correctly for the work they do.

RPH Surgical Specialties.

The number of exception reports in surgery and the ISC have been escalated to the surgical management team and a response has been requested (remains outstanding). The rotas are to be reviewed and options for extra cover will be considered. Although the number of exceptions has reduced in this quarter, concerns are still being raised with regards to high workload, particularly at night.

2.3 Guardian Fines

There have been no guardian fines imposed in the period of time this paper.

3.0 VACANCIES

Vacancy rates are monitored monthly and each division is provided with a monthly report showing % vacancy rate and an update on on-going recruitment.

Table 3 - Vacancy rates at the end of quarter reported:

Grade	May-22			Aug-22			Nov-22			Mar-23		
	% Vac.	Total Posts	Vacant	% Vac.	Total Posts	Vacant	% Vac.	Total Posts	Vacant	% Vac.	Total Posts	Vacant
FY1	0.0%	55	0	180.0%	56	1	3.5%	56	2	1.8%	57	1
FY2	0.0%	58	0	0.0%	55	0	1.9%	54	1	3.6%	56	2
ST1-2	8.7%	115	10	6.8%	119	8	6.0%	109	6	2.6%	116	3
ST3+	10.4%	154	16	8.7%	161	14	11.8%	143	16	7.2%	155	11
JCF	21.2%	85	18	36.0%	86	31	27.4%	61	23	29.5%	85	25
SCF	23.9%	113	27	28.0%	118	33	30.1%	86	37	26.5%	125	33
SAS	17.0%	94	16	22.6%	93	20	19.4%	75	18	16.4%	98	16

We have had a reduction in vacancies across the trust for most grades apart from JCF where we have seen an increase during the quarter reported.

A number of these vacancies are in MAU, we have been working closely with the department to develop their job descriptions and advertising and as a result of this work have managed to offer a number of posts.

We have undertaken a campaign for A&E in Dec 2022 and have made 4 offers to SCF posts, these doctors are due to start shortly.

We have launched the new middle grade program the ORDER program which aims to sponsor international doctors to undertake a 2-year post, during which they undertake a post graduate qualification through UCLAN. The aim of this program is to fill vacancy middle grade posts and reduce our vacancies long term through development of these doctors, some of which may wish to undertake CESR programs in the future..

We have identified 15 posts across various specialties which have not been filled through traditional recruitment and we are currently working on advertising all of these with an aim these doctors will start by the 1st October.

We have also recruited a further 10 medical interns from Egypt who will start in late July, these doctors complete a 2-year rotational post whilst undertaking a post graduate qualification with the University of Manchester.

4.0 BANK AND AGENCY USAGE

The trust has an established medical and dental staff bank, all doctors employed by the trust or on placement can register to cover shifts through the bank. We are currently finalising a campaign to recruit bank doctors.

The medical bank rates are determined through the temporary staffing policy and no escalation of rates can happen without Executive approval. The bank rates increased from 1 April 2022 in line with an ICS wide agreement to standardise rates across our region.

The hours worked through the bank are recorded and monitored and the following table shows hours worked

Table 4 – Hours worked per grade through the medical and dental bank.

Medical and Dental Staff Bank Hours worked	FY1	FY2	ST1	ST2	ST3	Specialty Doctor
2022 – Apr	292	3,671	211	125	1,344	1,319
2022 - May	285	4,780	113	35	1,387	1,613
2022 – Jun	344	4291	37	7	1709	1,708
2022 – Jul	370	4,372	150	27	1,694	1,509
2022 - Aug	256	5,816	113	69	2,201	2,757
2022 – Sep	124	4,135	504	840	2852	1,623
2022 – Oct	219	5,203	1,434	983	1,313	2,075
2022 – Nov	236	3,600	273	865	2761	1,793
2022 – Dec	259	4,575	384	17	2,089	2,226
2023 – Jan	499	6097	439	106	2,484	2,483
2023 – Feb	241	4,788	331	270	1,775	2,148
2023 - Mar	248	4,398	323	237	2,016	2,219

NB – All booking are placed according to grades defined in the table above but these are not just filled by trainees working bank but trust doctors and those doctors who are registered as pure bank.

4.1 Medical and Dental Agency Usage (including staff bank +)

In addition to the medical and dental bank – shifts that cannot be filled using bank are filled through agency. In the hours filled though agency can be found below.

Table 5 – Hours worked through agency

Staff Bank plus and Agency	FY2	ST1	ST2	ST3
2022 – Apr	20	0	1,100	2,407
2022 - May	12	0	1,133	2,324
2022 – Jun	0	0	844	822

2022 – Jul	0	0	975	1,233
2022 - Aug	0	0	541	1,545
2022 – Sep	247	0	493	1,436
2022 – Oct	590	0	1,301	2064
2022 - Nov	114	0	1,383	1,841
2022 – Dec	163	49	2,102	3,178
2023 – Jan	220	0	2,789	3,827
2023 – Feb	45	0	2,363	3,658
2023 - Mar	113	0	2,895	3,172

NB – Please note that this table shows hours invoiced in a month so may not be representative of what has been worked in that month.

5.0 JUNIOR DOCTOR FORUM

A forum was held on 6th December 2022 (minutes attached) F2F in the doctor's mess at RPH. The lack of catering at night was raised again.

7.0 LEGAL IMPLICATIONS

None

8.0 RISKS

The main risk identified in this report is the on-going concern with regards to lack of service support in Chorley Medicine, and the ISC regarding workload at night and number of exception reports in RPH FY1 surgical specialties.

9.0 IMPACT ON STAKEHOLDERS

Not applicable

10.0 RECOMMENDATIONS

It is recommended that the Board:

- Note the contents of the report,
- Confirm they are assured that the issues identified are being addressed through escalation of the concerns to the appropriate management teams by the work of the Guardian,
- Escalate discussions regarding the report to the Board of Directors as appropriate.

11.0 APPENDICES

1. Minutes of JDF December 2022

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Junior Doctor Forum

Agenda
Tuesday, 6th December 2022
1pm – 2pm
Junior Doctors' Mess, Royal Preston Hospital

	Item	Time	Format	Purpose	Owner
1	Introductions and Apologies	1pm	Verbal	Noted	DK
	Attendees Dr Kendall Dr Kidner Dr Philips Dr Paes Dr Al-Hakim Dr Jackson				
2	Exception reporting summary	1.15pm	Verbal	Discuss	DK
	There were 169 exception reports raised in previous quarter (June-August 2022) and this is slightly higher than the previous quarter (154) with increased numbers from FY1 CDH Medicine and FY1 RPH surgical specialties. There were 2 immediate safety concerns (ISCs) in CDH Medicine and RPH Surgery. No fines have been issued since the last forum meeting but there has been a bank usage increase. CDH medical cover has improved and the FY1 at CDH is no longer doing ward rounds alone at weekends and additional senior support has been added. One of the issues at CDH is that the medical teams are smaller than at RPH and so there is less opportunity for cross cover when doctors are on leave, sick or education/study days.				
3	Feedback from trainees regarding current work schedules, any issues etc	1.25pm	Verbal	Discuss	all
	The interface between ED and MAU was brought up regarding patients with long stays on Ed waiting for beds, safety issues for these patients not having senior review within 14 hours and lack of training opportunities on post-take rounds.				

	The issues are well known and are being addressed at departmental level. There are steps being taken to achieve a timely and educational post-take ward round.				
4	Feedback from trainees for any training and teaching issues	1.35pm	Verbal	Discuss	all
	None raised				
5	Exception reporting policy update and SOP for rota design	1.55pm	Verbal	Discuss	DK
	SOP for rota design – work in progress but there is more involvement from trainees in rota design				
6	Any other business	2pm	Verbal	Discuss	DK
	There is a business case with execs currently for 24 hour catering The new exception reporting policy has been developed and this has now been circulated to relevant parties and published on the trust intranet http://lthtr-documents/current/P2169.pdf. There is also a GOSW page with links to relevant information: https://intranet.lthtr.nhs.uk/extranet/circle/39551df6775f6d17edbaede723960525?page=42e7aaa88b48137a16a1acd04ed91125				
7	Date and Time of Next Meeting	1pm			
	Wednesday 29th March via teams				

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside - Non-Executive Director
Date(s) of Committee meeting(s):	23 May 2023
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 23 May 2023. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 25 April 2023, and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

- Financial performance
- Cost Improvement targets and plans
- Operational performance
- Planning framework update covering programmes identified as being of Board level significance

In addition, the Committee received reports for consideration/discussion for:

The month 1 finance report provided an update on the Trust's financial performance up to the end of April 2023. The Committee noted that the month one results were not untypical compared to other organisations but it was clear the year would be challenging.

An update on cyber security including the controls, recent improvements, and challenges faced by the Trust. The Committee endorsed the eradication of the generic accounts, the associated risks, and the unsupported systems be managed and where possible, eradicated from the Trust's network. It was noted that the broader report would be discussed at the Audit Committee. There would need to be consideration given to the risk score of 15, as the Committee noted that seemed quite high considering the strength of cyber security controls that were in place. It was noted that the Audit Committee would then make a referral back to Finance and Performance Committee.

The Committee received the Green Plan update with an explanation that the NHS became the world's first health service to commit to reaching carbon net zero in October 2020 ahead of COP26 in response to the increased threat posed by climate change. The Trust Board approved its 3-year Green Plan in support of the NHS commitment in February 2022. Good progress had been made, 33% of the actions within the plan rated as green and 54% as amber, with the remaining not yet started.

The Estates Maintenance Backlog Update was presented to the Committee and provided a summary of the survey undertaken by an external firm of property surveyors. The survey was used to establish the extent of current and impending backlog maintenance within Trust-owned premises. Assurance was

provided to advise that the estates team focused on the statutory compliance as a priority, external inspections were undertaken and work was prioritised to ensure full compliance was achieved.

Items for the Board's attention

Positive escalation

- The Committee endorsed the risk appetite and risk tolerance for the Trust's ambition to 'Deliver Value for Money' as open and welcomed the planned update on the new strategic decision making tool to be presented for approval at a future Board meeting.
- The continued progress on reducing waiting lists, especially for those patients urgently referred by their GP and those awaiting treatments for Cancer.
- The progress that had been made in establishing the transformation programme (focused on Urgent and Emergency Care; Elective Recovery; and Outpatients with a new project incepted for unwarranted variation) under new Governance arrangements, whilst also acknowledging the scale of the challenge and tremendous amount of work still to be undertaken.
- The finance team were recognised for their work undertaken to produce the year end results and month one reports in parallel to each other.

Negative escalation

- The Committee noted the adverse month one financial position regarding the deficit and plan. Further assurances were requested around the recovery of the month one position and the benefit trajectories from the significant transformation programmes, across the residual of the year.
- The impact of the constrained capital investment for estate maintenance given the demands for equipment repair/replacements. The Committee noted the difficult decisions taken to prioritise equipment operability over estate maintenance and received assurance that this was understood. The increased risk was referred to the Safety and Quality Committee to provide assurance of the mitigations in place and further assurance with regards to the impact to business continuity risks.

Committee to Committee Referral

Safety and Quality Committee: To provide assurance of the mitigations in place for the risk to health and safety in relation to the difficult decisions to prioritise essential equipment maintenance over maintenance of the estate due to the financial constraints.

Items recommended to the Board for approval

None.

Committee Chair's/Update reports received

- Capital Planning Forum
- New Hospitals Programme Flash Report
- ICS, ICP, PCB system update

Items where assurance was provided and/or for information

The Exception report from Divisional Improvement Forums.

Progress against the Committee's cycle of business

The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 27 June 2023, via Microsoft Teams

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Finance and Performance Committee agenda (23 May 2023)

Finance and Performance Committee

23 May 2023 | 2.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	2.00pm	Verbal	Noting	T Whiteside
2.	Apologies for absence	2.01pm	Verbal	Noting	T Whiteside
3.	Declaration of interests	2.02pm	Verbal	Noting	T Whiteside
4.	Minutes of the previous meeting held on 25 April 2023	2.03pm	✓	Decision	T Whiteside
5.	Matters arising and action log (a) Annual Report	2.04pm	✓	Discussion	T Whiteside
6.	Strategic Risk Review	2.10pm	✓	Discussion	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M1 Finance report	2.20pm	✓	Discussion	A Mulholland-Wells
8.	OPERATIONAL PERFORMANCE				
8.1	Performance assurance progress report (inc Speciality Based Recovery Plans)	2.35pm	✓	Discussion	E Ince
8.2	Contract Performance	2.45pm	✓	Noting	A Mulholland-Wells
9.	STRATEGY AND PLANNING				
9.1	Continuous Improvement and Transformation Update	3.00pm	✓	Noting	A Brotherton
9.2	Financial Improvement Plan	3.15pm	✓	Noting	A Mulholland-Wells
9.3	Estates Maintenance Backlog Update	3.30pm	✓	Discussion	D Hounslea
9.4	Green Plan	3.45pm	✓	Discussion	G Doherty
9.5	Planning Framework Update	4.00pm	✓	Discussion	G Doherty

№	Item	Time	Encl.	Purpose	Presenter
10.	GOVERNANCE AND COMPLIANCE				
10.1	Cyber Security Update	4.15pm	✓	Noting	S Dobson
10.2	Items for referral to the Board or to/from other Committees.	4.30pm	Verbal	Noting	T Whiteside
10.3	Reflections on the meeting and adherence to the Board compact	4.40pm	✓	Discussion	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Exception report from Divisional Improvement Forums		✓		
11.2	**Chairs' reports**: (a) Capital Planning Forum (b) New Hospitals Programme Flash Report (c) ICS, ICP, PCB system update		✓		
11.3	Date, time, and venue of next meeting: 27 June 2023, 2.00pm, Microsoft Teams	4.50pm	Verbal	Noting	T Whiteside

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Integrated Performance Report			
Report to:	Board of Directors	**Date:**	3rd August 2023
Report of:	Executive Team	**Prepared by:**	Executive Directors
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Board with an update on the Trust's performance as at the end of June 2023, unless otherwise stated.

- **The report reflects the revised 2023/24 Big Plan measures agreed by each sub-committee.**

Consistently Deliver Excellent Care

Operational Performance

Emergency care performance headlines:

- In June, 173 patients waited between 30-60 minutes: a decrease of 108 from last month. 22 patients waited over 60 minutes to be handed over from NWAS to the Trust in June, a decrease of 85 from last month, reflecting a significant improvement. Ambulance handover delays remain a high priority and a local improvement collaborative is in place.

- 4 Hour ED performance is showing a slight decrease to 73.9% compared to 74.7% in May, just above the national average position of 73.3% and 7th out of the acute trusts in the North West. This will be a focus, to achieve the 76% target for March 24.

- Performance relating to the number of patients waiting over 12 hours (admitted and non-admitted) in ED for June has seen a continual improving trend to 7.5% from 10.1% in October 2022 of which a small number are mental health patients and the Trust continues to work with LSCFT on joint management of these whilst in the ED and a longer term plan for best clinical locations.

- The occupancy metric has been updated to reflect the new requirement to: *reduce adult general and acute (G&A) bed occupancy to 92% or below*, with Trust occupancy for June at 97%. The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) has decreased slightly this month, with 68 patients (on 19th July). There has been good utilisation of available capacity in the Home First service, and the Community Healthcare Hub at Finney House.

Unfunded capacity and operational changes:

There have been a number of changes to processes and services, including Finney House, Virtual Ward, reprofiling of space in the Emergency Department to create an Acute Assessment Unit and an update to the organisational response to demand related escalation. This has enabled the following changes to be put in place:

Ward/Area	Impact	Delivery Date	Status
Closure of Avondale	Reduction of 28 G&A beds	Mar-23	Completed
Closure of Cath Lab & RAU	Reduction of 14 G&A beds	May-23	Budget change transacted and From June these areas require Exec approval to escalate into
Closure of acute ward	Reduction of 17 G&A beds	Jul-23	On track
Establishment of Acute Assessment Unit	Reduced ED footprint, reducing long waits in ED	Apr-23	Completed
No overnight escalation into Same Day Emergency Care	Reduced need for additional staffing, protects SDEC function	May-23	Completed
No ED escalation into CT wait area in hours	Reduced need for additional staffing, protects CT function	Jun-23	Completed
Co-location of Mental Health Urgent Access Centre (MHUAC)	Reduced cubicle space in ED, improved environment for patients awaiting MH assessment/treatment	Nov-23	Capital bid not sucured – alternatives being explored
MAU/SAU Development	Right-sizing MAU and SAU to improve UEC pathways and increase direct access	2024/25	Capital bid successful – planning underway

The Trust continues to work with health and social care organisations across the Central Lancashire system to support improvement and in addition to system plans, the Trust has its own internal programme of improvement being delivered through the Urgent Care Transformation Board.

Elective performance headlines:

- Patients continue to wait for a significant amount of time to receive non-urgent surgery. Progress against the plan to reduce all waits to no longer than 65 weeks by March is reviewed weekly and is ahead of target. A small number of 78 week waits remain in the system, reflecting the impact of the industrial action, a plan is in place to treat these patients alongside the continued reduction in the number of patients waiting 65 weeks.

- Diagnostics performance beyond 6 weeks was 37.72% for June. Urgent and cancer patients are seen within 2 weeks.

  - Endoscopy remains pressured, Changeology continue their work with the Trust, to review waiting lists and booking processes and increased productivity can be evidenced in Qtr 1 activity this year

- From a cancer perspective, the 2-week performance in June improved to 87.3% compared to 84.5% in May.

- 62-day performance - the number of patients over 62 days increased in June to 257 from a May position of 225 but this natural variation with operational impacts of strikes , however this has reduced back down in July and is now on track to achieve July month end target. The Trust has tumour site specific actions plans that are monitored weekly, with additional support from the National Cancer Transformation Director supporting faster recovery.

Elective and outpatient activity has been significantly affected by periods of industrial action. The recent Junior Doctors action from the 14th to the 16th of June resulted in the cancellation of 115 elective inpatient and day case (IP/DC) and 808 outpatient/diagnostic (OP/D) appointments.

Cancer recovery:

The table below shows how the Trust compares with England averages by tumour group for 62 day performance at week ending 2nd July: This is significant progress from over 6 months ago when 22% of the waiting list was over 62 days.

Suspected Tumour Type	Total waiting list	Number past day 62	Number past day 62 - DTT	% of waiting list past day 62	Change in number past day 62 (4 weeks)	Change in number past day 62 (12 weeks)	England % of waiting list past day 62	Distance from England average (>62 days)
Urological	233	61	15	26.2%	-19	-7	17.9%	19
Gynaecological	194	26	7	13.4%	-1	-1	8.1%	10
Head & Neck	162	22	8	13.6%	6	5	7.4%	10
Haematological	9	9	0	100.0%	3	6	14.6%	8
Upper Gastrointestinal	136	17	2	12.5%	7	11	8.0%	6
Skin	763	31	24	4.1%	11	6	3.6%	4
Sarcoma	33	7	0	21.2%	1	4	12.3%	3
Breast	131	5	2	3.8%	-3	0	2.6%	2
Children's	7	0	0	0.0%	0	0	4.6%	0
Other	13	0	0	0.0%	0	0	3.8%	0
Lung	51	6	2	11.8%	3	-2	14.4%	-1
Brain/Central Nervous System	71	0	0	0.0%	0	-3	2.6%	-2
Lower Gastrointestinal	567	55	10	9.7%	8	14	10.1%	-2
All Suspected Cancers	2,370	239	70	10.1%	16	33	8.0%	57

NHS England requirements:

The NHS England letter of 25 October 2022 to NHS Trust and Foundation Trust chief executives and chairs set out the following expectation for those Trusts in a Tier 1 regime for cancer:

Expectation	Current Status	Update
Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance.	Completed	The Trust access policy follows best practice and performance is overseen at weekly external Tier 1 meetings.
All patients past 62 days for cancer and 78 weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.	On track – not yet delivered	The Trust is implementing a 0 Zero Day PTL approach with a focus on ensuring patients that do not have cancer are advised as soon as possible. Colorectal complete, Urology underway and Gynae planned. This approach is being extended across certain specialties for 78 week waits.
Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.	Completed	The review has been completed and part of the task includes a data quality and reporting element - this is a new measure across several clinical systems.
Ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single Patient Tracking List (PTLs) across the system.	ICS rather than Trust action	The Trust is influencing this work at ICS and national level, key stakeholders in the meeting structures.
Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity.	ICS rather than Trust action	The Trust is influencing this work at ICS and national level, key stakeholders in the meeting structures.

Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.	Completed	This is in place within 6-4-2 meetings and management of capacity.
Cancer pathway re-design for Lower GI, Skin and Prostate There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally.	On track – not yet delivered	Further detailed narrative on progress included in the report.
Lower GI: Full Implementation of FIT in the 2ww pathway	Completed	This is in place.
Full implementation of Teledermatology in the suspected skin cancer pathway	On track – not yet delivered.	First phase in place. Further detailed narrative on progress included in the report. Full implementation will be at ICS level and Cancer Alliance led.
Full implementation of the Best Practice Timed Pathway for prostate cancer. All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy.	On track – not yet delivered	Further detailed narrative on progress included in the report.
Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.	On track – not yet delivered	Plans in place, working with clinical leads on opportunities and GIRFT best practice.
Surgical and theatre productivity It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter.	Completed	Elective activity protected, including over winter; theatre efficiency programme in place.

2023/24 Cancer targets:

Performance against the tumour group specific trajectories for the Cancer 62 day recovery plan, to March 24 is below:

Speciality		Recovery period	Apr 23	May 23	Jun 23	Position at 10 July 2023	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	Brain	Trajectory	2	2	2	2	2	2	2	2	2	2	2	1
		Actual	8	0	0	0								
	Breast	Trajectory	8	7	7	7	7	6	6	6	6	6	6	6
		Actual	4	6	2	6								
	Colorectal	Trajectory	53	52	50	48	46	44	42	41	42	44	40	38
		Actual	42	39	51	39								
	Gynaecology	Trajectory	28	27	26	25	24	24	23	22	22	24	21	20
		Actual	34	27	29	30								
	Haematology	Trajectory	10	9	9	9	9	8	8	8	8	8	8	7
		Actual	4	7	7	4								
	Head & Neck	Trajectory	25	24	23	22	21	21	20	19	20	21	19	18
		Actual	13	15	22	20								
	Lung	Trajectory	13	13	12	12	12	11	11	10	11	11	10	10
		Actual	12	10	6	10								
	Sarcoma	Trajectory	4	4	4	4	4	4	4	3	4	4	3	3
		Actual	3	9	8	6								
	Skin	Trajectory	25	24	23	22	21	20	20	19	20	20	19	18
		Actual	22	23	37	34								
	Upper GI	Trajectory	8	8	7	7	7	7	6	6	6	7	6	6
		Actual	8	12	19	16								
	Urology	Trajectory	74	72	71	68	65	63	60	58	59	63	56	53
		Actual	71	87	76	64								
	Total	Trajectory	250	242	234	226	218	210	202	194	200	210	190	180
		Actual	221	235	257	227								

The trajectory is to month end and shows an actual position on 10th July. The target for 2023/24 is 180 and is therefore achievable over the next year with support from the Cancer Alliance, against agreed tumour group specific trajectories for FDS and 62 day are detailed in the report.

Cancer FDS actual position against trajectory to June 23:

	Apr-23			May-23			Jun-23		
Tumour Group	**Trajectory**	**Actual**	**Var**	**Trajectory**	**Actual**	**Var**	**Trajectory**	**Actual**	**Var**
Brain	40.8%	41.5%	0.7%	46.3%	64.1%	17.8%	52.6%	50.8%	-1.9%
Breast	93.0%	98.2%	5.2%	93.0%	96.6%	3.6%	93.0%	96.0%	3.0%
Breast Symptomatic	94.3%	94.4%	0.1%	94.3%	96.6%	2.3%	94.3%	98.9%	4.6%
Colorectal	50.0%	50.2%	0.2%	55.6%	44.1%	-11.4%	61.1%	58.8%	-2.3%
Gynaecology	49.5%	45.8%	-3.7%	52.2%	57.6%	5.4%	54.9%	78.0%	23.0%
Haematology	0.0%	20.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Head and Neck	70.9%	77.2%	6.3%	71.8%	73.9%	2.0%	72.7%	86.8%	14.0%
Lung	65.2%	66.7%	1.5%	68.1%	80.0%	11.9%	71.0%	72.4%	1.4%
NSS	75.0%	80.0%	5.0%	75.0%	75.0%	0.0%	75.0%	100.0%	25.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Paediatric	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%
Sarcoma	59.5%	65.0%	5.5%	61.9%	50.0%	-11.9%	64.3%	61.5%	-2.7%
Skin	90.0%	93.7%	3.7%	90.0%	96.1%	6.1%	90.0%	95.3%	5.3%
Upper GI	75.4%	70.2%	-5.2%	75.4%	71.6%	-3.8%	75.4%	67.0%	-8.4%
Urology	45.8%	43.3%	-2.5%	51.9%	36.8%	-15.1%	55.7%	46.9%	-8.8%
Grand Total	**70.1%**	**72.6%**	2.5%	**72.4%**	**73.4%**	1.0%	**74.4%**	**79.2%**	4.8%

A Cancer Transformation Plan is in place to support delivery in 2023/24.

Cancer pathway re-design for Lower GI, Skin and Prostate:

In relation to the specific asks of Tier 1 Trusts for Lower GI, Skin and Urology pathways*:*

- **Lower GI: Full Implementation of FIT in the 2ww pathway**

  This is in place at the Trust with clinical review of all existing patients awaiting OPD for double fit negative results / no other red flags and removal from 62-day PTL.
  Performance detailed below against indicators relating to the proportion of double negative FIT Test colorectal cancer referrals that underwent a Colonoscopy:

  1) All Patients referred on a Colorectal Cancer Pathway with Double Negative FIT Test, of these the number that underwent a Colonoscopy:

Referral Month	Double Negative	Colonoscopy	% Colonoscopy
01/04/2022	58	39	67.24%
01/05/2022	70	46	65.71%
01/06/2022	71	55	77.46%
01/07/2022	77	43	55.84%
01/08/2022	83	42	50.60%
01/09/2022	87	23	26.44%
01/10/2022	70	25	35.71%
01/11/2022	79	28	35.44%
01/12/2022	58	10	17.24%
01/01/2023	63	10	15.87%
01/02/2023	70	21	30.00%
01/03/2023	91	33	36.26%
01/04/2023	69	23	33.33%
01/05/2023	79	42	53.16%
01/06/2023	107	42	39.25%
Grand Total	**1132**	**482**	**42.58%**

- **Skin: Full implementation of Teledermatology in the suspected skin cancer pathway**

  Implementation is co-ordinated across the ICS and Teledermatology started on 7th November, undertaken in the main by medical illustration departments in secondary care.

Performance detailed below against an indicator relating to the proportion of 2-Week Rule Dermatology Attendances undertaken in the Teledermatology Clinic, this has been maintained at a high level with June performance at 74% compared to 88% in May 23.

	Jun-23
Total 2WR Attendances (incl Tele-Derm)	623
Attendances at Tele-Derm Clinic	464
Proportion attending Tele-Derm Clinic	74%

- **Full implementation of the Best Practice Timed Pathway for prostate cancer**

  The BPT pathway has been agreed and was due to be fully implemented in 22/23, this has been impacted by capacity issues and full implementation will be completed by the end of Q3 - consumable supplies for biopsies (now resolved) and capacity for multiparametric MRI (MpMRI) slots.

The Performance Recovery Group continues to monitor performance and work through solutions with actions reviewed to ensure focus on key areas.

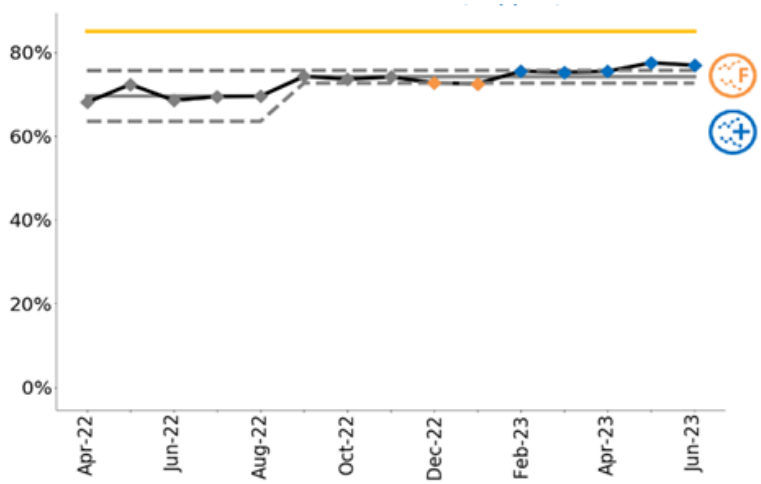
Elective restoration 78 and 65 weeks:

Clearing the 78 and 65-week waits is a priority for the divisional teams with performance under constant review. Additional capacity continues to be required either in-house or through utilisation of Independent Sector and mutual aid capacity, to clear the backlog of long waits.

A small residual number of 78 week waits remained in June due to the impact of the ongoing industrial action. The activity lost during the industrial action, as agreed with NHSE, will be worked through in Qtr 2.

The 65-week trajectories factor in the impact of improved theatre productivity, utilisation of the independent sector and waiting list initiatives. A Theatre Efficiency Programme reports progress through the Elective Care Transformation Board.

The current capped theatre utilisation rates are shown below indicating an improving capped performance over the last 8 months:



The current 65-week specialty cohort month end trajectories to March 2024 are detailed below with actual 10th July position:

		Baseline	30/04/2023			31/05/2023			30/06/2023			31/07/2023			August	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March
Division	Specialty	01/04/2023	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var								
DCS	C. Immunology	921	846	787	-59	762	718	-44	670	628	-42	582	604	22	490	402	310	218	138	46	0	0
DCS	Pain	834	766	664	-102	690	576	-114	606	473	-133	526	449	-77	442	362	278	194	122	38	0	0
Medicine	Cardiology	1290	1185	1036	-149	1068	820	-248	938	612	-326	815	580	-235	685	562	432	302	190	60	0	0
Medicine	Diabetes	81	74	59	-15	67	51	-16	59	39	-20	51	35	-16	43	35	27	19	12	4	0	0
Medicine	Elderly Care	52	48	37	-11	43	23	-20	38	12	-26	33	11	-22	28	23	18	13	9	4	0	0
Medicine	Endocrinology	640	588	572	-16	530	485	-45	466	371	-95	405	349	-56	341	280	216	152	97	33	0	0
Medicine	Gastroenterology	1153	1059	964	-95	954	791	-163	839	590	-249	729	556	-173	614	504	389	274	174	59	0	0
Medicine	General Medical	1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	1	1	1	1	1	0	0
Medicine	General Medicine	1947	1787	1752	-35	1610	1556	-54	1415	1338	-77	1229	1295	66	1034	848	653	459	291	97	0	0
Medicine	Neurology	5327	4891	4613	-278	4407	3762	-645	3874	3086	-788	3365	2946	-419	2832	2323	1790	1257	797	264	0	0
Medicine	Rehabilitation	26	24	17	-7	22	10	-12	19	6	-13	17	5	-12	14	12	9	6	4	1	0	0
Medicine	Renal	232	213	113	-100	192	76	-116	169	55	-114	147	49	-98	124	102	79	56	36	13	0	0
Surgery	Clinical Oncology	224	206	189	-17	186	164	-22	164	134	-30	143	133	-10	121	100	78	56	37	15	0	0
Surgery	Colorectal Surgery	1699	1560	1455	-105	1406	1220	-186	1236	991	-245	1074	954	-120	904	742	572	402	256	86	0	0
Surgery	Dermatology	534	490	426	-64	442	359	-83	389	189	-200	338	137	-201	285	234	181	128	82	29	0	0
Surgery	ENT	1345	1235	1064	-171	1113	850	-263	978	583	-395	850	550	-300	715	587	452	317	201	66	0	0
Surgery	General Surgery	1007	924	795	-129	833	701	-132	732	554	-178	636	519	-117	535	439	338	237	150	49	0	0
Surgery	Maxillo-Facial	464	426	411	-15	384	316	-68	338	264	-74	293	229	-64	247	202	156	110	70	24	0	0
Surgery	Medical Oncology	38	35	25	-10	32	25	-7	28	20	-8	24	19	-5	20	16	12	8	5	1	0	0
Surgery	Neurosurgery	3095	2842	2637	-205	2561	2163	-398	2252	1724	-528	1956	1615	-341	1647	1351	1042	733	465	156	0	0
Surgery	Ophthalmology	2113	1940	1780	-160	1748	1442	-306	1536	1090	-446	1334	1038	-296	1122	920	708	496	313	101	0	0
Surgery	Oral Surgery	372	341	295	-46	307	216	-91	270	175	-95	234	159	-75	197	161	124	87	55	18	0	0
Surgery	Orthodontics	263	241	250	9	217	240	23	191	234	43	166	232	66	140	115	89	63	40	14	0	0
Surgery	Orthopaedics	1560	1432	1277	-155	1290	1015	-275	1134	811	-323	985	777	-208	829	680	524	368	233	77	0	0
Surgery	Plastic Surgery	1722	1581	1492	-89	1424	1241	-183	1252	1069	-183	1087	1031	-56	915	750	578	406	258	86	0	0
Surgery	Surgical Dentistry	1612	1481	1445	-36	1334	1253	-81	1173	1137	-36	1019	1111	92	858	704	543	382	242	81	0	0
Surgery	UGI	515	473	457	-16	426	379	-47	374	313	-61	325	305	-20	273	224	172	120	75	23	0	0
Surgery	Urology	1960	1799	1734	-65	1621	1460	-161	1425	1227	-198	1237	1186	-51	1041	853	657	461	292	96	0	0
Surgery	Vascular Surgery	1826	1677	1640	-37	1511	1404	-107	1329	1133	-196	1155	1057	-98	973	799	617	435	277	95	0	0
WCS	Breast Surgery	62	57	56	-1	51	53	2	45	45	0	39	43	4	33	27	21	15	9	3	0	0
WCS	Gynaecology	674	619	550	-69	558	451	-107	490	363	-127	426	346	-80	358	294	226	158	99	31	0	0
WCS	Neonatology	1	1	1	0	1	0	-1	1	0	-1	1	0	-1	1	1	1	1	1	1	0	0
WCS	Paed. Cardiology	78	72	59	-13	65	40	-25	57	18	-39	50	14	-36	42	35	27	19	12	4	0	0
WCS	Paediatrics	877	805	737	-68	725	591	-134	637	411	-226	553	373	-180	465	381	293	205	129	41	0	0
Total	**Total**	**34545**	**31719**	**29389**	**-2330**	**28581**	**24451**	**-4130**	**25125**	**19695**	**-5430**	**21825**	**18707**	**-3118**	**18369**	**15069**	**11613**	**8158**	**5172**	**1717**	**0**	**0**
	Monthly reduction		-2826			-3138			-3456			-3300			-3456	-3300	-3456	-3455	-2986	-3455	-1717	0

Those specialties at small numbers now are expected to achieve and maintain 65 weeks in the next few months.

- The 65-week snapshot position on 10th July was 1382, with a cohort (end March 2024) position of 18,707 – 4857 admitted and 13,850 non-admitted cases a reduction of over 16,000 in this cohort patients since April. This remains a key focus operationally.

There are a number of risks to delivery of the required reduction in the number of patients waiting in excess of 65 weeks, these include:

- Further industrial action including the July industrial action and the associated impact on activity, with an announcement of further Consultant action in August.
- Workforce - sickness and vacancies
- Anaesthetist capacity
- Urgent care pressures – COVID, Flu, NMC2R and poor patient flow
- Number of complex cases and particular pressures in Urology and Gynaecology.

Pressure Ulcers
Pressure ulcer incidence is within common cause variation but remains an area of risk within the Trust due to the increase in harm associated with these incidents. Pressure ulcer reduction and improvement has been included in the Always Safety First Improvement Programme that was launched 10th May and will be tracked through the Always Safety First Committee reporting into Safety and Quality Committee. The Always Safety First divisional groups are refreshing and refocusing their approach to this improvement work with the assistance of the Continuous Improvement team.

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Falls
Falls improvement work continues through the Always Safety First programme of work. The improvement target for the big plan is now identified within the SPC chart. There have now been three positive consecutive months of special cause variation.

HSMR
Mortality metrics remain stable and within expected parameters.

STAR
STAR Quality assurance accreditation awards of silver and above is consistently higher than we would expect within normal variation.

INFECTION PREVENTION AND CONTROL

Clostridium *difficile*
The data is demonstrating continued variation and. Actions to isolate patients earlier in the pathway continue. Whilst deep cleaning is taking place routinely, occupancy levels are hindering routine fogging of clinical areas. There is an increased focus on antimicrobial stewardship. C.*difficile* actions and improvements are tracked through the Infection, Prevention and Control Committee and oversight is provided to the Safety and Quality committee. A programme of work has commenced to focus on bowl and bladder continence with a focus on catheter care, insertion, and removal.

Registered Nurse and Midwifery Fill Rates
There have been two consecutive months with over 95% fill rate. This is an average of all areas, and the safety and Quality committee is presented with detailed information that is triangulated with patient outcomes. The improved fill rate is positive and correlates with significant reduction in vacancies across the organisation following a positive and ongoing international recruitment programme.

Always Safety First
The annual target for basic and intermediate safety training was met in 2022/23. The new target audience for intermediate safety training has not yet been set and therefore compliance with this metric is not a true reflection and will be updated in next month's Board. .

A Great Place to Work

The overall sickness absence rate increased marginally during June, and this was attributable to an increase in short-term absence. Encouragingly, the long-term absence rate reduced slightly after an increase in May. We will closely monitor the overall absence trend, as we had previously observed a downwards pattern since January. Our priority focus continues to be reducing the average duration of psychological and musculoskeletal absence episodes, as these are our two top reasons for full time equivalent days lost. We exceeded our target around this for musculoskeletal absence during May and June, and psychological absence duration was only slightly above target. Since we implemented outreach calling to colleagues off sick for psychological health reasons in August 2022, we have met the average duration target in 4 out of the 10 months and been slightly above target in a further two months. This is positive early evaluation data. In May, we also implemented our rapid access, remote physiotherapy service, for colleagues at risk of sickness absence due to a musculoskeletal condition or injury. We will evaluate the impact of this over the next few months.

We continue to experience high levels of violence and aggression incidents, although it reduced during May. We are taking a continuous improvement approach to implementing our violence prevention and reduction strategy, and we are specifically focusing on the experience of colleagues in areas with high incidents, encouraging them to share their stories to help us identify the support they need and opportunities for learning.

At an overall Trust position, we are now at a 0% vacancy rate for registered ward-based nursing. We continue to have some areas of over and under establishment, whilst our international nurses become fully competent. Work has started to redeploy international nurses across over/under established areas once they achieve full competence to further mitigate on going premium spend in these areas.

Our medical premium spend is under review and our Workforce Business Partners will be presenting resourcing papers to Divisional DIF/Financial Recovery meetings with options. These include review of resourcing strategy, campaign review and job plan/skill mix reviews and related risk to activity delivery. We have had some success in Neurosurgery and Plastics in filling posts that have been impacting on activity delivery, with numerous offers in place and applicants due to start August/September 2023.

We implemented the new ICS nursing agency rate card, which saw a 50p reduction from May 23 and de-escalated our ED agency rate. We are also seeing a reduction in spend as our international nurses achieve competence and review of agency escalations. A positive savings trajectory continues to be realised through the nursing rate card reduction schedule.

Delivering Value for Money

Income and Expenditure

The Trust reports a YTD Month 3 deficit position for 2023/24 of £18.4m against a £15.1m deficit plan, this gives a YTD Variance on Plan of £3.3m. This can be explained mainly by the £1.1m under-delivery of CIP, £1.6m of double running nursing costs, £0.6m for the cost of strikes, £0.8m activity impact of strikes £0.2m for £6m 22/23 Accrual Gap and £0.3m of Net Restoration underspends offset by £2.5m of operation underspends.

Capital Position

Capital expenditure in the year to date was ahead of plan. This has been a conscious decision to bring forward work on backlog maintenance to free up staff capacity to manage some of the larger projects later in the year. No issues are anticipated with achieving the plan for the year.

Cash Position

The Trust drew down cash support amounting to £5.2m in April and has submitted an application for further support in July and September which will fully exhaust the cash available as deficit support. The requirement for cash support in excess of the deficit support materialises in September.

Cost Improvement Programme

The 2023/24 core Financial Improvement Plan (FIP) target is £48.5m or 6.2% of total OPEX, of which £5.9m is carry forward of undelivered recurrent FIP from 2022/23. The Trust was requested to separate out the value of the unfunded beds classified as FIP (£11.4m) and deliver a minimum of 5.5% FIP. In addition, the value of the system gap is £18.5m. The combined FIP target and system gap comes to £67m. As of June 2023, month 3, £5.3m has been delivered against a YTD plan of £6.4m, an adverse variance of £1.1m.

Use of Resources

The Trust is in Segment 3.

Segment 3 is where there are significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence.

Segment 3 means the Trust will receive mandated support that is led and co-ordinated by NHS England and NHS Improvement regional teams with input from the national intensive support team where requested.

The Agency spend in 2023/24 in YTD Month 3 was £6.6m against an Agency Ceiling of £4.5m. This is an overspend of £2.1m mainly due to a slower than expected benefits from international recruitment the Trust, cost of strikes in Month 1 and significant costs of agency spend associated with some service developments such as CDCs, Finney House as well as some legacy issues.

Fit for the Future

These qualitative indicators will be reported separately to board within the normal cycle of board business.

It is recommended that:
I. The Board note the contents of the report and the action being taken to improve performance.

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching, and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Finance and Performance Committee, Workforce Committee, Safety and Quality Committee

Excellent care with compassion

Always Safety First

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors

Performance to June 2023

INTRODUCTION

Performance to 30th June 2023

Mission

To provide excellent care with compassion

Strategic Aim

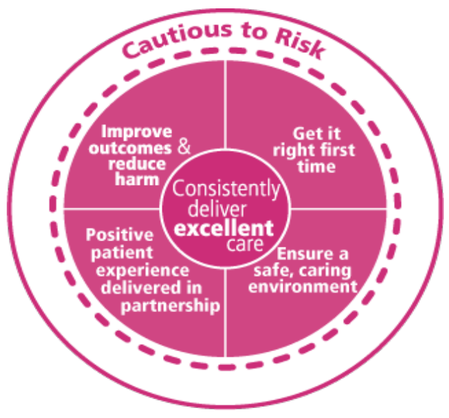
To provide excellent healthcare to our local communities

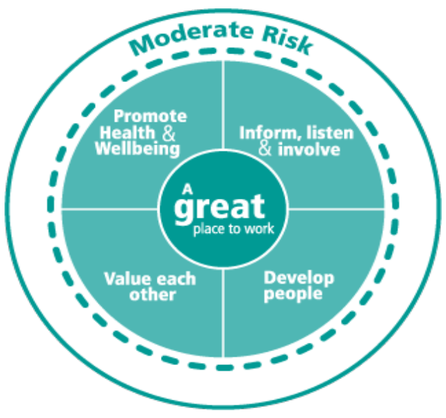
Strategic Aim

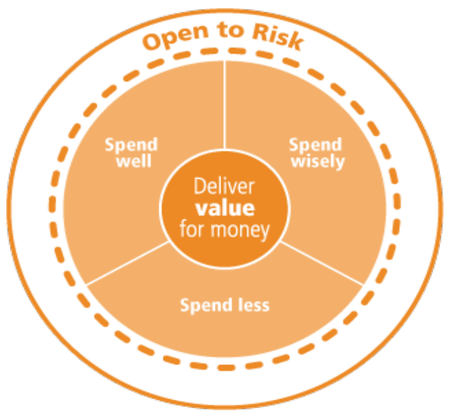
To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

Strategic Aim

To drive innovation through world class education, training and research*







In order to ensure that the we are continually monitoring delivering against our Big Plan, the metrics within the Integrated performance report for the Board of Directors are aligned to the Big Plan 2021/24 outcomes and provide details of performance against the agreed KPIs. Each of the ambitions upon which our Big Plan is founded is aligned to a board sub committee which will undertake more detailed scrutiny of progress in achieving the identified outcome, understand risk and seek assurance against delivery.

Kevin McGee
Chief Executive

Continuously deliver excellent care

Together

Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One – Improve outcomes and prevent harm										
CQC	Big Plan	To achieve a rating of good with one outstanding service	M | T-D-S | TB-SQ | ALL	Yes	Progress towards CQC rating of good is ongoing					
	Sub Metric	Percentage of Must and Should do's completed			-	-	-	100%	95%	-
Pressure Ulcers	**Key Metric**	**Reduce the number of people developing pressure ulcers by 5% Includes device related pressure ulcers (Rate per 1000 beddays)**	M | T-D-S | TB-SQ | SC	No				1.68	2.91	3.69
	Big Plan	Reduce the number of device related pressure ulcers by 5% (Rate per 1000 beddays)		No				0.21	0.82	0.75
Maternity safety	Big Plan	Maintain compliance with the 10 safety actions for maternity services		No	-	-	-	100.0%	100.0%	-
	Big Plan	Deliver year 1 of the national maternity & neonatal improvement plan		UNDER DEVELOPMENT						
Children and Young People safety	Big Plan	Develop 10 safety actions for children and young people and achieve compliance		10 safety actions created for children and Young people, reported through the Divisional Improvement Forum						
Contribute to PLACE Adult and Children CORE20 PLUS 5 strategy	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – Adults and maternity. Deliver year 1 actions		Delivery Plan in place						
	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – CYP. Deliver year 1 actions		Delivery Plan in place						
Segment Two – Get it right first time										
Mortality	**Key Metric**	**Continue to achieve a mortality HSMR figure of <100 (Hospital Standardised Mortality Ratio (56 Basket – Adult)**	M | T-D-S | SQ | GS	No	Lower Than Expected				75.3	-
Access Standards	**Key Metric**	**Achieve the Emergency Department within 4 hours target**	M | T-D | FPC | FB	No				76%	73.9%	74.2%
	Key Metric	**Reduction in patients waiting +12 hours in Emergency Department**	M | T-D | FPC | FB	No				2%	7.5%	9.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 15 minutes**	M | T-D | FPC | FB	No				65%	57.0%	38.8%
	Key Metric	**Reduction in ambulance turnaround times - seen within 30 minutes**	M | T-D | FPC | FB	No				95%	91.8%	74.2%
	Key Metric	**Reduction in ambulance turnaround times - 60 minutes**	M | T-D | FPC | FB	No				98%	99.1%	89.4%
	Key Metric	**Achieve agreed trajectory for reducing 52 week waiters**	M | T-D-S | FPC | FB	No				5185	4208	7434
	Key Metric	**Eliminate waits over 65 weeks for elective care by March 2024**	M | T-D-S | FPC | FB	No				1168	1255	1355
	Key Metric	**Eliminate waits over 78 week waiters**	M | T-D-S | FPC | FB	No				0	126	697
	Key Metric	**Achieve Cancer - 28 day FDS**	M | T-D-S | FPC | FB					74%	79%	53%
	Key Metric	**Number of patients waiting over 62 days**	M | T-D-S | FPC | FB	No				234	249	239
	Key Metric	**Moving or discharging 5% of outpatient attendances to a PIFU pathway**	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
	Key Metric	**Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels**	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
	Key Metric	**Reduce adult general and acute (G&A) bed occupancy to 92% or below**	M | T-D-S | FPC | FB	No				92%	97%	96%
	Key Metric	**Achieve 5% of patients in hospital who no longer meet the criteria to reside**	M | T-D-S | FPC | FB-SC	No				87	82	
	Key Metric	**Reduce length of stay to next best quartile**	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
SDEC	Big Plan	Divert 10 ambulances a day from ED (to SDEC or the appropriate service; SAU, MAU AAU, 2hr UEC response) (Target of 1924 ambulance arrivals per month based on a reduction of 10 amulance arrivals per day on 2022/23 actuals)	M | T-D-S | FPC | FB	No				1924	2378	2228
Pre-procedure elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to planned surgery	M | T-D-S | FPC | FB	No				0.15	0.26	0.33
Pre-procedure non-elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to unplanned surgery	M | T-D-S | FPC | FB	No				0.50	0.26	0.57
Elective Inpatient Average length of stay (Spell)	Big Plan	To reduce the average length of stay for patients undergoing planned surgery	M | T-D-S | FPC | FB	No				3.30	2.77	3.06
Cancer	Big Plan	Implement pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result)	M | T-D-S | FPC | FB	No				80%	31.58%	28.61%
	Big Plan	Full implementation of Teledermatology in the suspected skin cancer pathway	M | T-D-S | FPC | FB	No				80%	74.00%	47.25%
	Big Plan	Full implementation of the Best Practice Timed Pathway for prostate cancer	M | T-D-S | FPC | FB	No	No Patients Currently on this Pathway					

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
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Variation Icon \ Assurance Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
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Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Continuously deliver excellent care

Together

Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment Three – Ensure a safe, caring environment										
Falls	Big Plan	Reduce the number of falls by a further 5% - per 1000 bed days	M | T-D-S | SQ | SC	No	F			3.72	4.56	5.84
Infection	**Key Metric**	**Achieve less than the annual tolerance for C.difficile**	M | T-D-S | SQ | SC-GS	Yes	F			10	14	16
	Big Plan	Achieve zero MRSA bacteraemia	M | T-D-S | SQ | SC-GS	No	-	-	-	0	0	-
Safety	Big Plan	Maintain 90% staff trained in basic safety training	M | T-D-S | ETR | NL	No	P		-	90%	96.2%	94.7%
	Big Plan	Achieve 90% staff trained in intermediate safety training	M | T-D-S | ETR | NL	No			-	90%	93.2%	90.4%
Segment Four – Work in partnership to deliver a positive patient experience										
Complaints	Big Plan	Reduce the number of complaints relating to communication.	M | T-D-S | SQ | SC	No			-	22	14	13
Patient involvement	**Key Metric**	**Achieve a minimum of 90% of patients reporting their experience of good or very good (including neither good/bad)**	B | T-D-S | SQ | SC	No			-	90%	91%	89%
Candour	Big Plan	Maintain >90% compliance with duty of candour for all moderate and above harm incidents.	M | T-D-S | SQ | SC-GS	No			-	90%	98%	96%
Safe Staffing	Big Plan	Maintain Registered Nurse and Midwife fill rates of > 90%	M | T-D-S | SQ | SC-GS	No	F		-	95%	96%	89%

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
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Variation Icon \ Assurance Icon	*Will consistently fail target within expected variation*	*Could both pass or fail target within expected variation*	*Will consistently pass target within expected variation*
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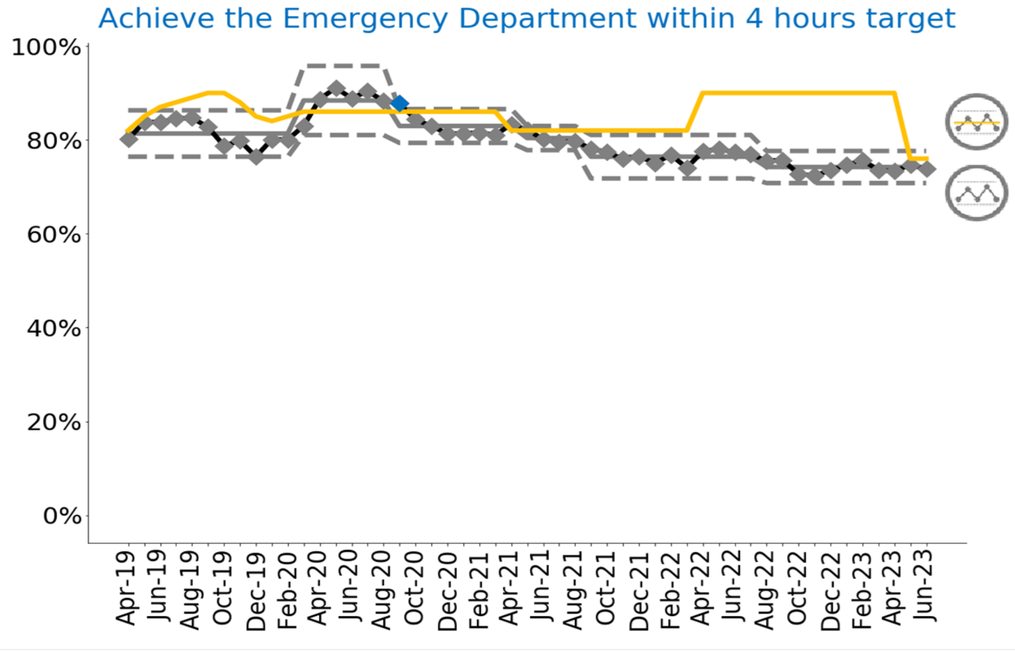
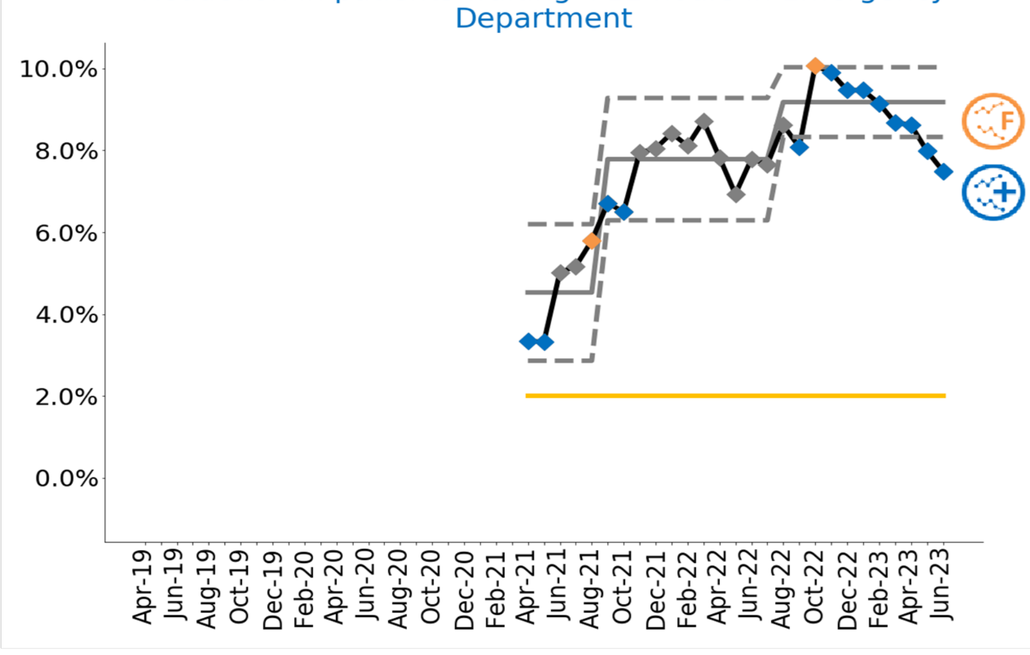
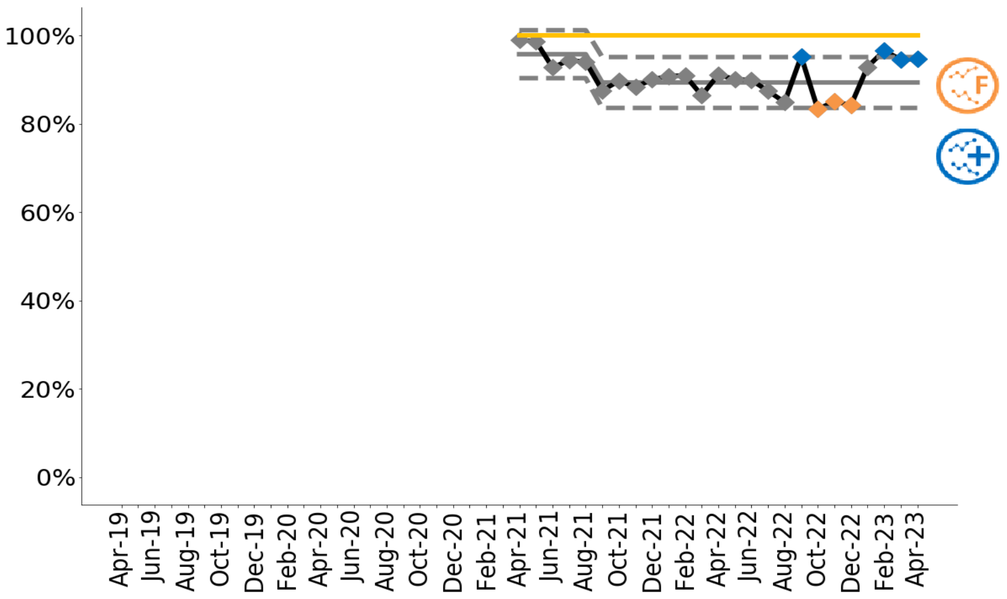
Achieve the Emergency Department within 4 hours target



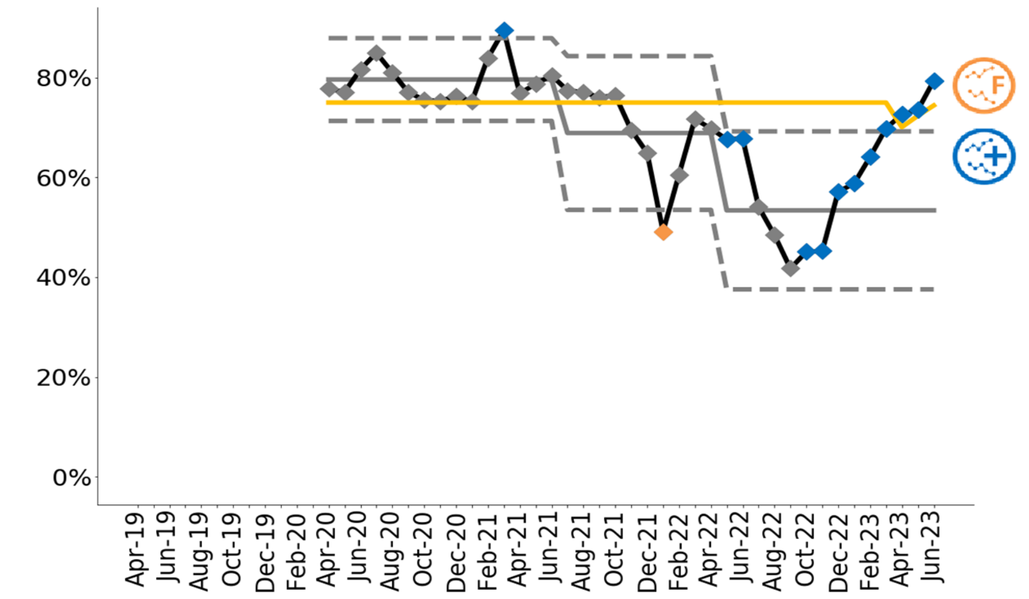
Reduction in patients waiting +12 hours in Emergency Department



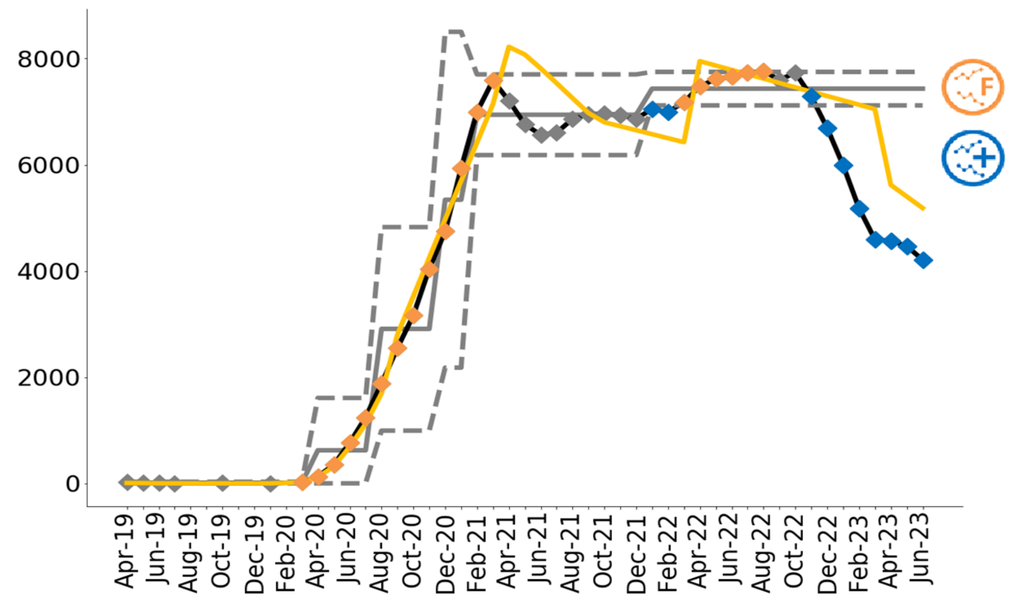
Reduction in ambulance turnaround times - 60 minutes



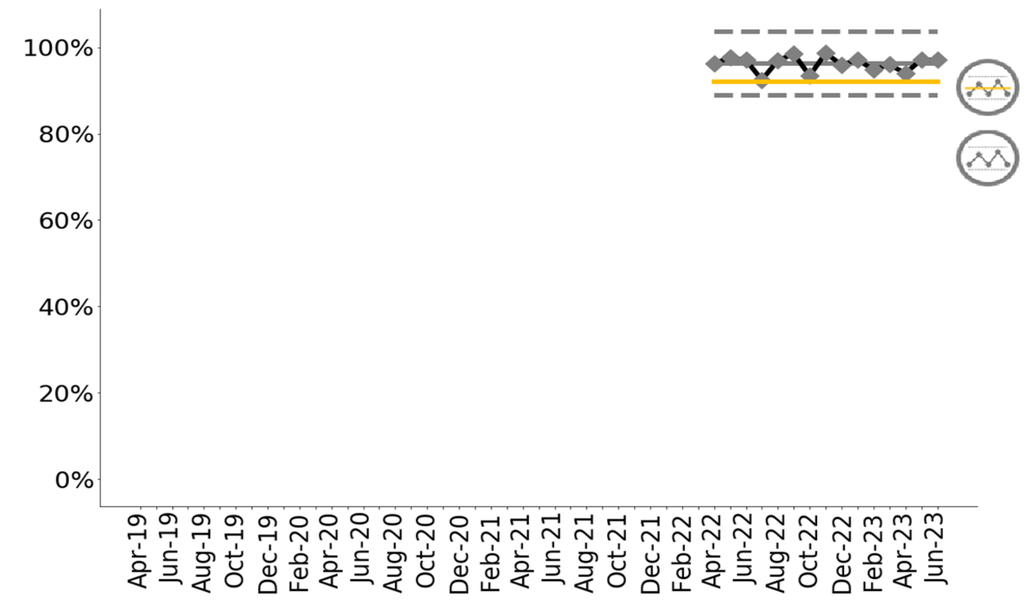
Achieve Cancer - 28 day FDS



Achieve agreed trajectory for reducing 52 week waiters



Reduce adult general and acute (G&A) bed occupancy to 92% or below



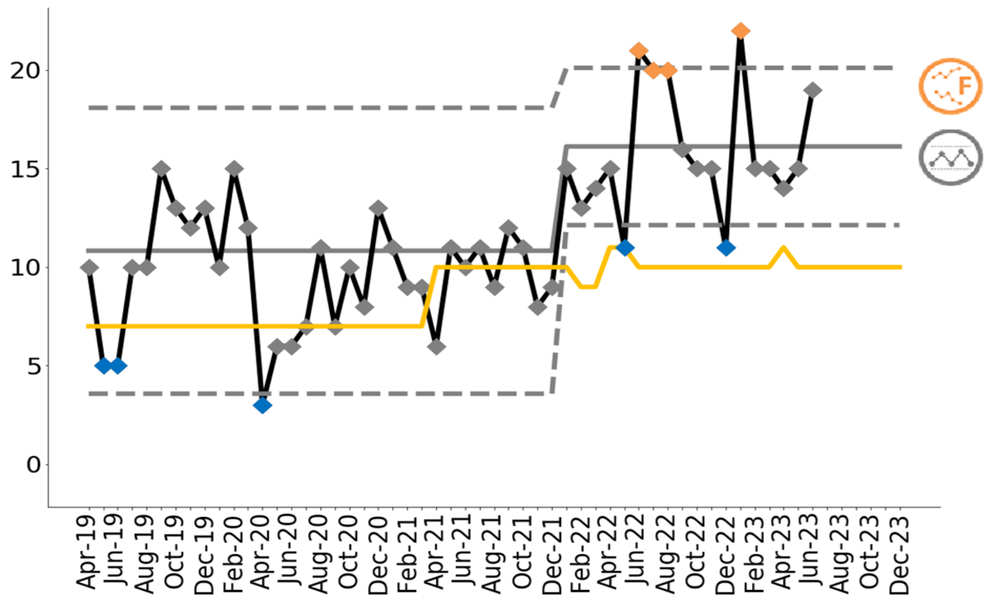
Assurance Icons – How likely are we to hit the set target in future?

It's possible the target could be either passed or failed within the expected month to month variation of the measure	*The target will be consistently failed within expected variation unless the process is changed*	*The target will be consistently passed within expected variation unless the process is changed*

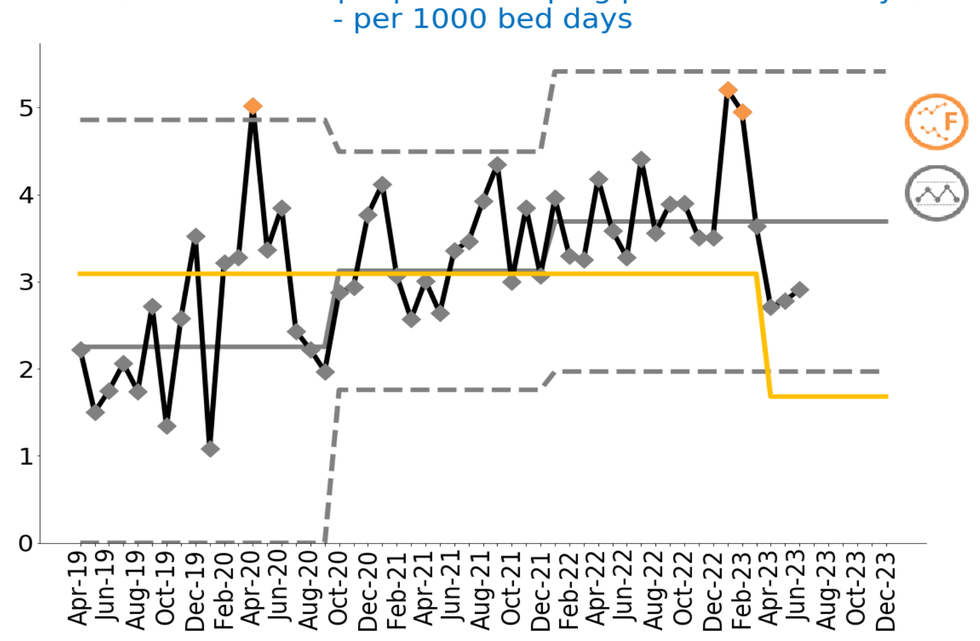
Variation Icons – Is the measure showing signs of change over time?

No signs of change over time evident in recent data	*An example of concerning change is evident in the recent data*	*An example of positive change is evident in the recent data*

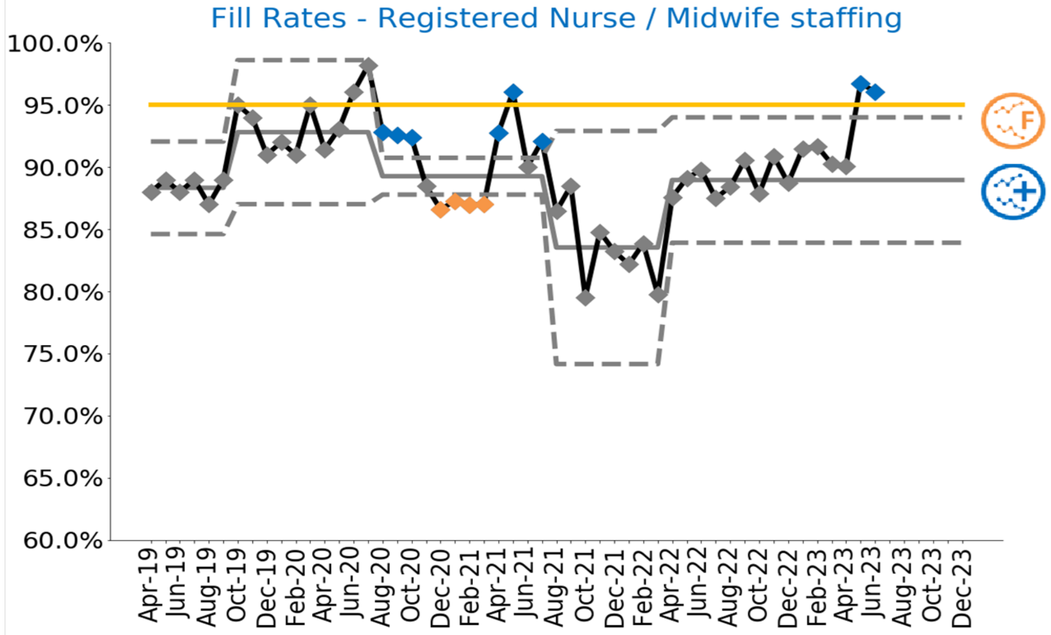
Achieve less than the annual tolerance for C.difficile



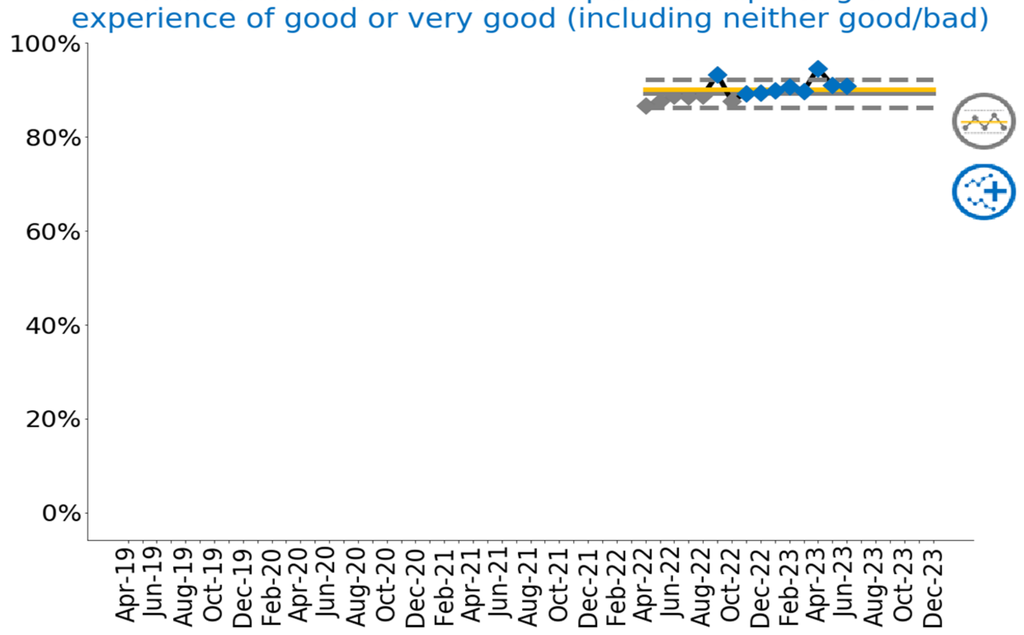
Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days



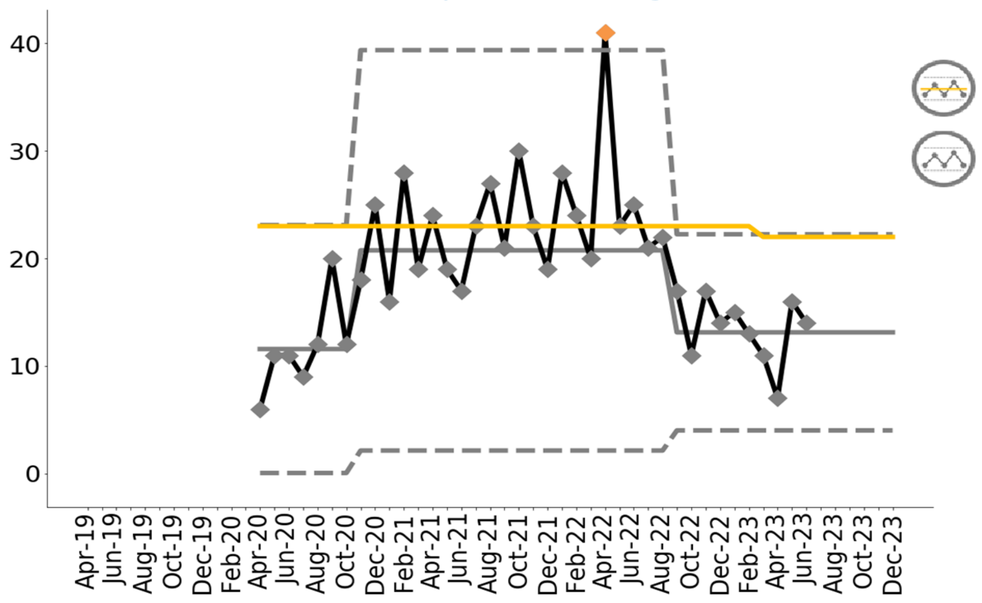
Fill Rates - Registered Nurse / Midwife staffing



Achieve a minimum of 90% of patients reporting their experience of good or very good (including neither good/bad)



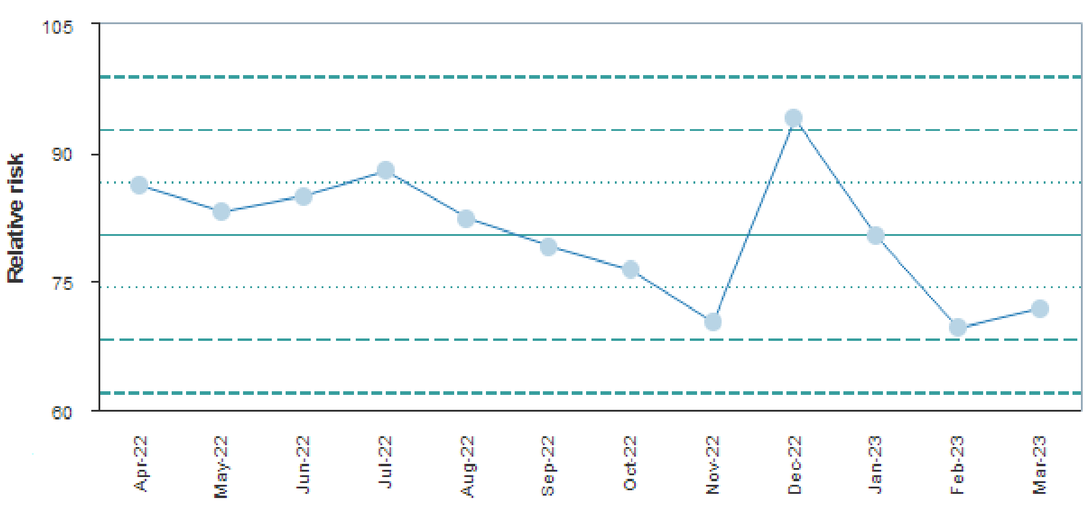
Reduce the number of complaints relating to communication



Diagnoses - HSMR | Mortality (in-hospital) | Apr 2022 - Mar 2023 | Trend (month)

Age (adult/child): Adult

Period: **Month** *Measure*: **Relative risk** *Additional measure*: **No additional measure**



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A GREAT PLACE TO WORK
Reviewed monthly / quarterly

Together

	Metric Description	Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Sickness Absence	Reduce overall sickness absence to 5.00% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 5%	5.59 %	6.14 %
	Reduce short-term sickness absence to 1.75% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 1.75%	1.94 %	1.99 %
	Reduce long-term sickness absence to 3.25% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 3.25%	3.65 %	4.16 %
Health & Wellbeing	Reduce average duration of psychological health related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 33.11	36.30	37.07
	Reduce average duration of MSK-related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 20.11	13.74	22.54
	Drive forward zero tolerance of violence and aggression toward staff by reducing the number of incidents by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 73	80	59.00
Develop People									
Turnover	Maintain annual staff turnover between 8% and 11% FTE (annual assessment; ESR in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 0.83%	0.62 %	0.76 %
Vacancies	Reduce the number of vacancies by a further 5% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 6%	5.70 %	9.05 %
Appraisals	Maintain 90% HC compliance rate for appraisals	M | T-D-S-C | W | KS	-				≥ 90%	88.85 %	
Mandatory Training	Maintain 90% HC compliance against all core skills training requirements (module compliance reported)	M | T-D-S-C | ETR | KS	-				≥ 90%	95.02 %	
Medical Devices	Achieve 90% HC compliance with medical device training	M | T-D-S-C | ETR | KS	-				≥ 90%	84.44 %	
Inform, Listen and Involve									
Staff Engagement & TED	Increase the number of teams that have undertaken TED by 15% (annual assessment; in-month reported)	M | T-D | W | KS	-			-	≥ 17	17	7.92
	Ensure 60% of our staff would recommend us as a place to work	Q | T-D | W | KS	-			-	≥ 60%	52.45 %	61.79 %

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Reporting Requirements Key

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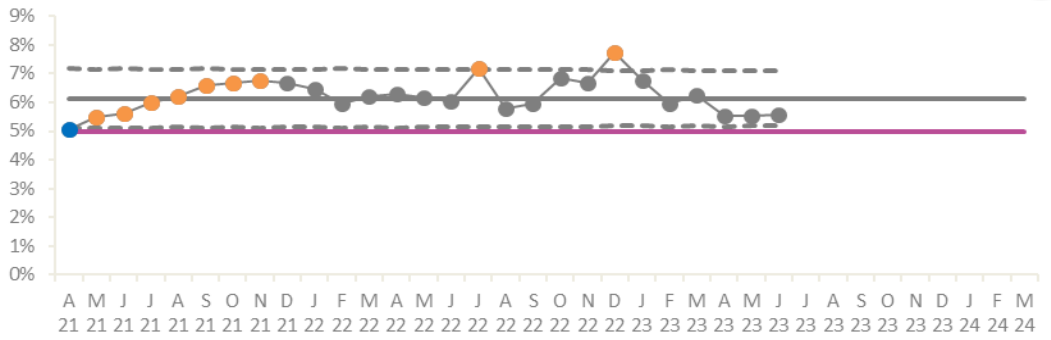
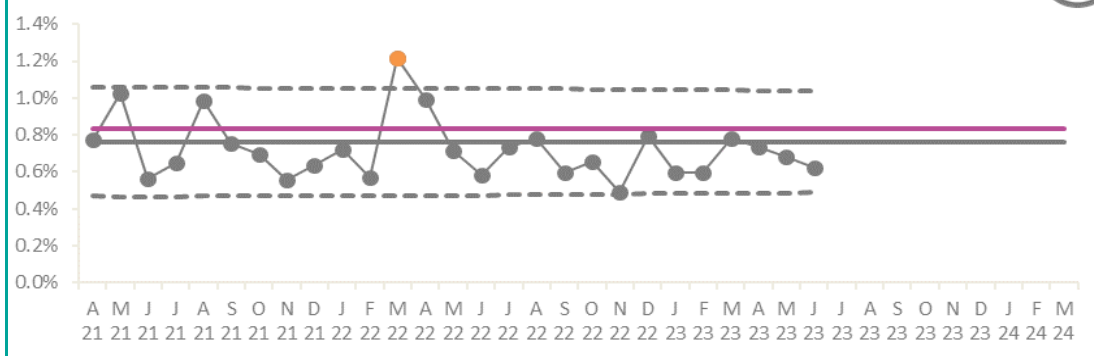
Metric Description		Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Enivronment	Upgrade a further five local staff rest areas	B | T | W | JW							
	Create five agile activity based workspaces	B | T | W | JW							
	Create outdoor recreational space on both the Chorley and Preston sites	B | T | W | JW							
Health & Wellbeing	Increase staff perception that the organisation takes positive action on health and wellbeing to 40%	A | T-D-S-C | W | KS							
	Support staff to stay well by ensuring adequate rest and recuperation in line with working time regulations	B | T-D-S-C | W | KS							
Develop People									
Appraisals	Improve staff perception of the quality of appraisals by 5%	A | T-D | W | KS							
Inform, Listen and Involve									
Just Culture	Reduce further the number of grievances that are managed through formal processes to monitor the move to a just culture	B | T | W | All							
	Reduce the gap between the scores achieved in the annual culture survey between staff perception of the current and desired culture	A | T-D-S | W | All							
Freedom to Speak Up	Ensure all staff accessing the Freedom to Speak Up team are satisfied with how their concerns were managed	A | T | W | KS							
Staff Engagement & TED	Increase the staff engagement score, as measured by the annual staff survey, to 7 out of 10	A | T-D | W | KS							
	Ensure 50% of our staff complete the annual staff survey	A | T-D | W | KS							
Value Each Other									
Race Equality	Reduce the number of staff from BAME backgrounds that have personally experienced discrimination at work to be in line with that of their white colleagues	A | T | W | All							
	Increase the number of colleagues from a BAME background in senior roles (AfC Band 8a and above)	A | T | W | All							
Disability Equality	Reduce the number of disabled staff that experience harassment, bullying and abuse from managers to be in line with the experience of non-disabled colleagues	A | T | W | All							
Corporate Social Responsibility	Engage with our local communities through a range of workforce and education programmes	A | T | W | KS							

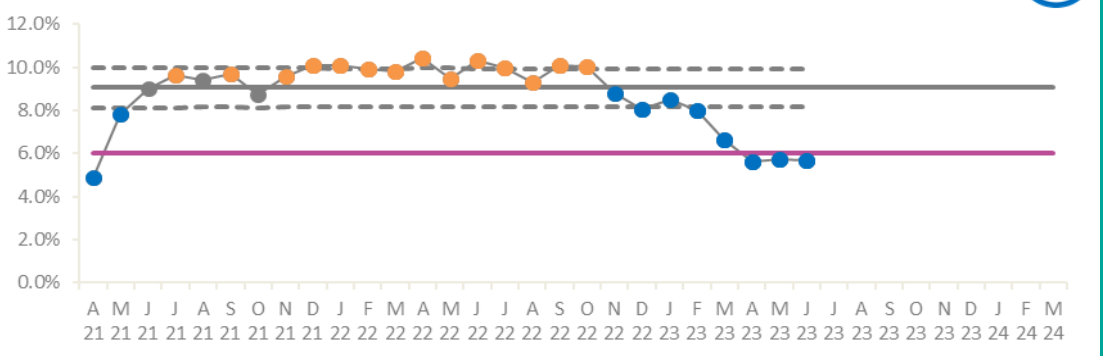
Overall Sickness (% FTE)



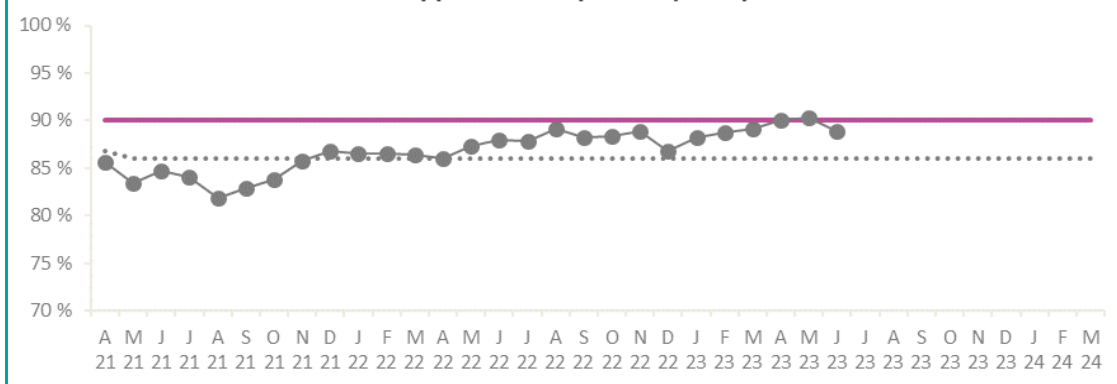
ESR Turnover (% FTE)



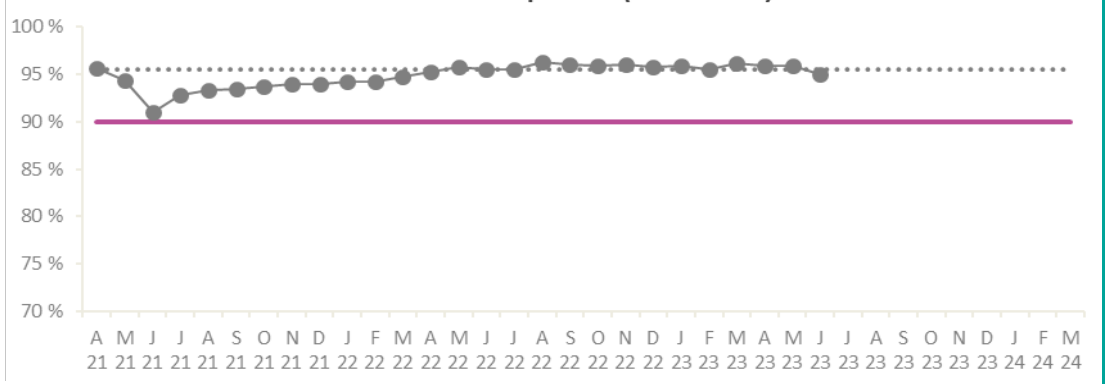
GL Vacancy Rate (% FTE)



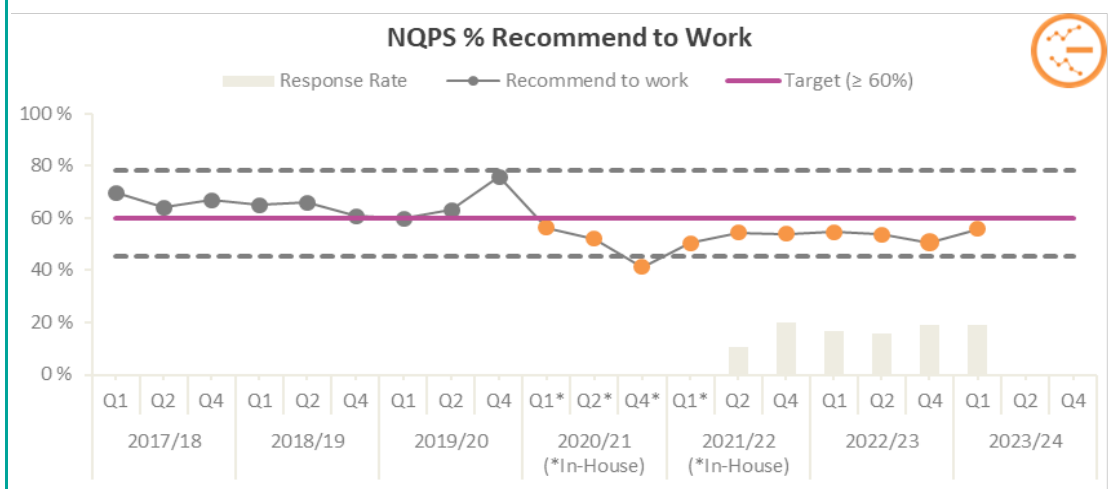
Appraisal Compliance (% HC)



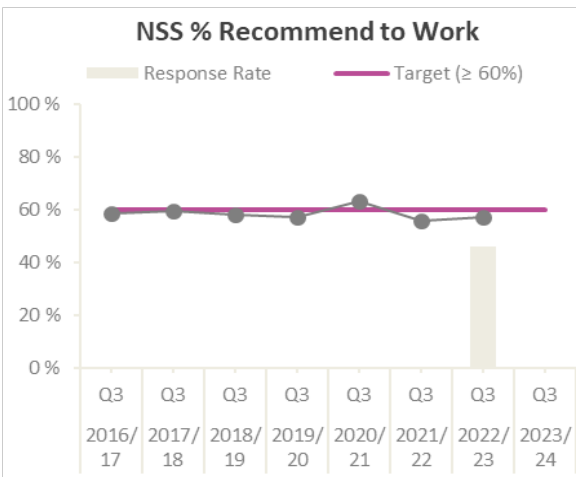
CSTF Compliance (% modules)



NQPS % Recommend to Work



NSS % Recommend to Work



Deliver Value for Money

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One - Spend Less (Economy)												
Agree revenue and capital financial plan with ICB	**Key Metric**		Deliver 100% of the agreed targeted reduction in our underlying financial deficit	A | T | TB - FPC | JW	This indicator is reported separately agreed at Trust level at budget setting							
Deliver agreed cost improvement delivery target	**Key Metric**		To deliver 100% of agreed cost improvement target	M | T-D-S | FPC | JW	No	-	-	-	2328	2556	-
Segment Two - Spend Well (Efficiency)												
Bed Occupancy Rate (Including Escalations)	Big Plan		Achieve a bed occupancy rate of no higher than 90%	M | T-D-S | FPC | FB	No	F			90%	94.9%	94.3%
Theatre Efficiency	Big Plan		RPH - Theatre capped utilisation rates are no lower than 80%	M | T-D-S | FPC | FB	No	-	-	-	80%	78.6%	-
	Big Plan		CDH - Theatre capped utilisation rates are no lower than 85%	M | T-D-S | FPC | FB	No	-	-	-	85%	78.9%	-
GIRFT (Model Hospital)	Big Plan		Achieve 85% day case basket using GIRFT	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
OP Follow Ups	Big Plan		Reduce OP follow ups by 25%	M | T-D-S | FPC | FB	UNDER DEVELOPMENT						
Supplier payments (BPPC)	Big Plan		To ensure all suppliers are paid in line with national guidance	M | T | FPC | JW	No			-	95%	96.3%	-
Segment Three - Spend wisely (Effectiveness)												
Agency costs	Big Plan		Reduce agency costs to 3.7% of the total pay bill	M | T-D-S | W | SC-GS	No	-	-		3.7%	5.06%	-
Delivery of Activity and Revenue Plan	**Key Metric**		To ensure 100% delivery of the Trust's activity and revenue programme	M | T | FPC | JW	No	-	-	-	-15125	-18386	-
Capital	**Key Metric**		To ensure 100% delivery of the Trust's Capital programme	M | T | FPC | JW	No	-	-	-	4430	4586	-

Reporting Requirements Key

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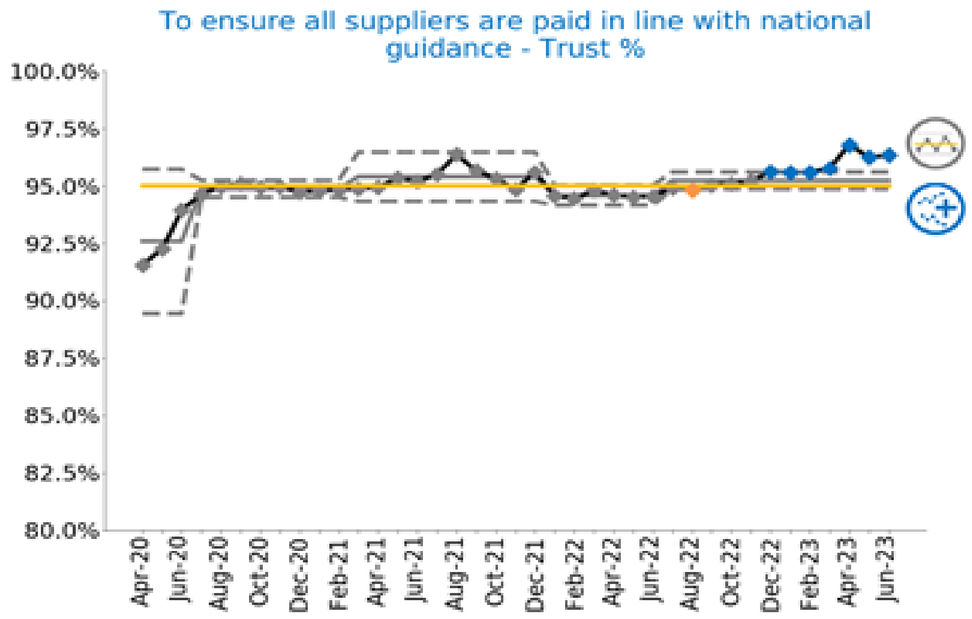

Assurance Icons – How likely are we to hit the set target in future?

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Variation Icons – Is the measure showing signs of change over time?

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Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Segment One – Strategy and Transformation												
Clinical Services Strategy	Big Plan	FFTF-1	To deliver the 23/24 actions in the LTH clinical services strategy, including addressing the challenges and opportunities of multi-site working:	B | T-D | TB | GS		▬	▬				
			To provide outstanding, sustainable healthcare to our local communities and in our tertiary services			▬	▬				
			To drive health innovation through world class education, teaching and research			▬	▬				
			System working in a new NHS landscape			▬	▬				
Outpatients Transformation	**Key Metric**	**FFTF-2**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:**	M | T | FPC | GS		▬	▬				
			Deliver Personalised Outpatient Care (Patient Initiated Follow up & Patient Stratified Follow Up)			▬	▬				
			Referral optimisation and demand management			▬	▬				
			Deliver our follow up reduction target to drive the outpatient element of our Financial Improvement Plan			▬	▬				
Elective Care Transformation	**Key Metric**	**FFTF-3**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan**	M | T | FPC | FB		▬	▬				
			Deliver agreed national waiting list improvement targets and productivity benchmarks			▬	▬				
			Develop our elective strategy to include repatriation of activity from the independent sector and other regions, and the maximisation of our surgical hub capacity			▬	▬				
			Deliver our planned care financial targets in support of the Financial Improvement Plan			▬	▬				
Urgent and Emergency Care Transformation	**Key Metric**	**FFTF-4**	**Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:**	M | T | FPC | AB		▬	▬				
			Focus on pre hospital pathway/front door to include integrated mental/physical health services and a 40% reduction in ambulance conveyances			▬	▬				
			Reduce Lengths of stay by 10% reduction in LoS on 10 pilot wards and reduce Not Meeting Criteria to Reside reduced to 5% (system aim)			▬	▬				
			Deliver agreed financial benefits to support Financial Improvement Plan			▬	▬				
Unwarranted Variation	Big Plan	FFTF-5	Deliver the 23/24 actions and outcomes from the agreed Transformation Plan including:	M | T | FPC | GD		▬	▬				
			Fully establish and embed the programme governance			▲	▲				
			Undertake deep dive reviews into the 9 identified priority specialities, agreeing and deliver the consequent improvement plans			▲	▲				
			Deliver agreed financial benefits to support Financial Improvement Plan			▬	▬				

Financial Improvement Plan	Big Plan	FFTF-6	Deliver the 23/24 actions and outcomes from the agreed Improvement Plan:	M | T | FPC | JW							
			Fully embed FIP governance & reporting								
			Fully embed FIP delivery framework								
			Develop and agree 3 year FIP								
Segment Two – Place Based Partnership											
Collaboration and Integration at Place	**Key Metric**	**FFTF-7**	**Fully establish the required governance structure and processes for Place based working, agree and deliver the 23/24 agreed Place strategies, actions and outcomes**	Q | T | TB | GD							
			Agree a comprehensive set of priorities & programmes								
			Deliver the Core20PLUS5 action plan and outcomes								
			Deliver the Frailty improvement action Plan & Outcomes								
Social Value	Big Plan	FFTF-8	Building on our Social Value Framework, work with partners to develop a Social Value Strategy driving a place based focus on equality, wider determinants of health, poverty and social capital:	B | T | TB | GD							
			Review and refresh Green Plan and deliver agreed actions/metrics								
			Prepare for Level 2 Social Value Quality Mark accreditation application in 2024/25								
			Deliver the Core20PLUS5 action plan and outcomes								
Segment Three – System Working											
ICB Joint Forward Plan	**Key Metric**	**FFTF-9**	**Deliver the 23/24 actions and outcomes from the agreed JFP. Work with ICB to:**	Q | T | TB | GD							
			Finalise the JFP								
			Align strategies and plans with the JFP priorities								
			Develop detailed delivery plans								
Clinical Collaboration	Big Plan	FFTF-10	Deliver the 23/24 actions and outcomes from the agreed Clinical Collaboration work plan including:	M | T | FPC | GS							
			Develop & deliver implementation plans for new models of care in Vascular, Head & Neck, Urology, Stroke and Elective Hubs								
			Agree next set of specialties for the implementation of new models of care and develop implementation plans								
			Undertake challenged services review of fragile and financially challenged services, and deliver agreed action plans								
Central Services Collaboration	Big Plan	FFTF-11	Deliver the 23/24 actions and outcomes from the agreed Central Services Collaboration work plan including:	M | T | FPC | JW							
			Target Operating model agreed and mobilised								
			Phase 1 transactional services (Payroll and General Ledger provision) underway								
			Bank and Agency Collaborative proposal sign off/implementation								
			Deliver the 23/24 actions and outcomes from the agreed Digital/EPR work plan								

Digital Northern Star / EPR Convergence	Big Plan	FFTF-12	EPR tenders evaluated, and preferred supplier awarded	M | T | FPC | SD-GD		▲	▲				Scripts and videos scored, awaiting final moderation and on track for a preferred supplier status in quarter 2. OBC progressing.
			Digital Convergence programme governance reviewed and revised			▲	▲				Governance in place.
			Implement Secure data Environment			▬	▬				14M allocated through treasury. FBC progressing through North West Approval process.
Elective Recovery	Big Plan	FFTF-13	Deliver the 23/24 actions and outcomes from the agreed ECRG work plan – maximise system working to deliver:	M | T | FPC | GD		▬	▬				
			National waiting times targets			▬	▬				
			National productivity targets			▬	▬				
			Surgical Hub Strategy			▲	▲				
New Hospitals Programme	Big Plan	FFTF-14	Milestones and metrics to be finalised following further discussions with national teams	M | T | FPC | JW							

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	K JW = Jonathan Wood	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	J\ FB = Faith Button	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	FI SC = Sarah Cullen	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee		

Green Delivering actions and outcomes

Amber On track to recover actions & outcomes

Red Significantly off track with actions & outcomes

Chair's Report

Committee:	Audit Committee
Chairperson and role:	Tim Watkinson, Non-Executive Director
Date(s) of Committee meeting(s):	23 June 2023
Purpose of report:	To update the Board on the business discussed by the Audit Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the Annual Report and Financial Accounts for 2022/23. As mentioned at the June Board meeting, Committee members had taken the opportunity to review the financial accounts in detail with the finance team prior to final audit.

As part of the process, the Committee received reports from its internal and external auditors. It was pleasing to note that for the third year the Head of Internal Audit Opinion provided Substantial Assurance which had been reached based on the design of the board assurance framework; the outcomes of risk-based reviews and core work; and responses by the Trust to audit recommendations during the year. It was also pleasing to receive an unqualified opinion from the external auditors on the Trust's financial statements. The annual report, annual governance statement and Audit Committee annual report were considered and it was noted that the report covered all statutory requirements as prescribed by the Annual Reporting Manual issued by the Department of Health and Social Care.

The Committee recommended to the Board of Directors approval of the 2022/23 Annual Report and Financial Accounts for laying before Parliament in line with the timescales for the first cohort and e-laying processes. The report was laid before Parliament on 4 July 2023 and was subsequently published on the Trust website. A copy of the report would also be published in the papers for the August Board meeting for information.

On behalf of the Committee, the Chair thanked all those involved in producing the document.

The Committee received a report on compliance with the NHS Foundation Trust Code of Governance which required a permanent Chair to be in place before the Board could be assured of full compliance with the Code.

The Committee undertook its annual effectiveness review the outcome of which would feed into an overarching Board development plan for the year.

Items for the Board's attention

Positive escalation

(a) Substantial assurance from MIAA in their Head of Audit Opinion for the third year.
(b) Unqualified opinion provided by KPMG on the Trust's financial statements.
(c) Recommendation to the Board of the 2022/23 Annual Report and Financial Accounts without issue.

Negative escalation
The only aspect of negative escalation related to the external auditors featuring financial sustainability in their risk assessment which was in line with the Board's view. However, the auditors concluded that there was no significant weakness in the Trust's arrangements in this regard.
Committee to Committee escalation
Final audit reports providing limited assurance would be referred to the appropriate Committees of the Board for assurance.
Items recommended to the Board for approval
The Annual Report and Financial Accounts for 2022/23 were recommended to and approved by the Board of Directors at a meeting on 27 June 2023.
Committee Chairs reports received
There were no feeder groups reporting to the Audit Committee.
Items where assurance was provided and/or for information
(a) Strategic Risk Register (b) Internal Audit annual plan for 2023/24 following some minor scheduling changes (c) MIAA final audit reports relating to: - WHO Checklist - Theatre List Management
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 21 September 2023.

Recommendation:

- The Board is asked to receive the report and note the contents.

Appendix 1 – Audit Committee agenda (23 June 2023)

Audit Committee

23 June 2023 | 1.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.30pm	Verbal	Information	T Watkinson
2.	Apologies for absence	1.31pm	Verbal	Information	T Watkinson
3.	Declaration of interests	1.32pm	Verbal	Information	T Watkinson
4.	Minutes of the previous meeting held on 20 April 2023	1.33pm	✓	Decision	T Watkinson
5.	Matters arising and action log	1.34pm	✓	Decision	T Watkinson
6.	Internal audit progress report	1.35pm	✓	Assurance	MIAA
7. ANNUAL REPORT AND ACCOUNTS 2022-23					
7.1	Head of Internal Audit Opinion 2022-23	1.45pm	✓	Assurance	MIAA
7.2	(a) Draft ISA 2607.3a - (b) External audit annual report 2022-23 (c) External Audit Opinion	1.55pm	✓	Assurance	KPMG
7.3	(a) Draft financial accounts 2022-23 (b) List of movements from circulated accounts	2.15pm	✓	Assurance	B Patel
7.4	Management representation letter: financial accounts 2022-23	2.35pm	✓	Decision	KPMG
7.5	Draft annual report 2022-23	2.40pm	✓	Assurance	J Foote
7.6	Review of draft Annual Governance Statement *(included in the annual report pages **92** to **109**)*	2.50pm	----	Assurance	J Foote
7.7	Audit Committee annual report 2022-23 *(included in the annual report pages **117** to **121**)*	3.00pm	----	Assurance	T Watkinson
7.8	Recommendation of 2022-23 Annual Report and Accounts to Board of Directors	3.17pm	----	Decision	T Watkinson
8. OTHER COMMITTEE BUSINESS AND ITEMS FOR INFORMATION					
8.1	NHS FT Code of Governance compliance	3.20pm	✓	Decision	J Foote
8.2	Committee Effectiveness Review	3.40pm	✓	Information	T Watkinson

№	Item	Time	Encl.	Purpose	Presenter
8.3	Items for escalation to the Board or referral to/from other Committees	3.57pm	Verbal	Information	T Watkinson
8.4	Reflections on the meeting and adherence to the Board Compact	3.58pm	✓	Information	T Watkinson
9. ITEMS FOR INFORMATION					
9.1	Strategic Risk Report		✓		
9.2	Internal audit plan 2023-24 (final)		✓		
9.3	**MIAA final audit reports**: (a) WHO Checklist (b) Theatre List Management		✓		
9.4	Date, time and venue of next meeting: *21 September 2023, 10.30am, Microsoft Teams*	4.00pm	Verbal	Information	T Watkinson

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Review of Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD)

Report to:	Board of Directors	**Date:**	3 August 2023
Report of:	Company Secretary	**Prepared by:**	J Foote
Part I	✓	**Part II**	

Purpose of Report

For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

The Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SORD) set out the authority and accountability for dealing with financial matters in the Trust. The documents sit alongside the Standing Orders of the Board beneath the Constitution.

There has been a significant period of time since the documents were last reviewed, but the current set are now fit for purpose and recognise the requirement for the Trusts to work within the ICS and allow for the recognition of current constraints in place as directed by NHSE.

Both the SFIs and SORD are presented in full for review and adoption.

The Board is also requested to approve the inclusion of reference to the powers delegated to the PCB by the Board in the Board Standing Orders.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Not applicable

1. Background

The Trust is required to have in place both an approved set of SFIs and a SORD. They serve to advise the Board on the management and implementation of its decision-making responsibilities and should be read in conjunction with the Standing Orders of the Board.

2. Current Revision

The current version of both documents has been in place without review for a significant period of time. The opportunity has been taken to align both documents to reflect clear and unambiguous guidelines on the financial accountability and decision-making process of the Trust. The duplication present in previous versions has been limited to the minimum needed to ensure a consistency of guidance.

The SFIs and SORD now reflect the position of the Trust within the ICS and take account of mechanisms to reflect in year direction from NHSE on financial management. In addition, as agreed by resolution of the Board earlier this year, the new delegation of powers out of the Trust to the PCB has been articulated (with the expectation that the Standing Orders approved by the Board in February can also now be updated to reflect the same delegated authority).

The SFIs are set out at Appendix 1, and the SORD is set out at Appendix 2.

3. Financial implications

No additional costs involved in the review.

4. Legal implications

The Trust is required to adopt both a set of SFIs and a SORD.

5. Risks

It is important to ensure that future reviews are planned into the cycle of business to ensure that the documents remain fit for purpose.

6. Impact on stakeholders

Clarity of purpose and guidance supports positive financial stakeholder relations.

7. Recommendations

Having reviewed the documents, the Board of Directors is asked to:

i. Adopt the revised SFIs and SORD as set out in the appendices to the report; and

ii. The following wording be added as a Standing Order:
The Board may delegate such powers and responsibilities for its functions not otherwise reserved to the joint committee known as the Provider Collaborative Board. These delegated functions shall be as set out in the PCB Terms of Reference and may be amended or rescinded by the Board at its discretion.

STANDING FINANCIAL INSTRUCTIONS

Lancashire Teaching Hospitals
NHS Foundation Trust

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CONTENTS

1. INTRODUCTION

General

1.1 These standing financial instructions (SFIs) shall have effect as if incorporated in the Trust's standing orders (SOs).

1.2 These standing financial instructions detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and the requirements of NHSE in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the reservations of powers to the Board and delegation of powers adopted by the Trust.

1.3 These standing financial instructions identify the financial responsibilities that apply to everyone working for the Trust and its constituent organisations, including trading units. They do not provide detailed procedural advice. These statements should, therefore, be read in conjunction with the detailed departmental and financial procedure notes. The Chief Finance Officer must approve all departmental financial procedures.

1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Chief Finance Officer or Director of Operational Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs, incorporating the scheme of delegation.

1.5 All staff of the Trust must comply with the Trust's standing financial Instructions at all times, failure to do so may result in disciplinary action which could result in dismissal.

Terminology

1.6 Any expression to which a meaning is given in health service acts, or in the financial directions made under the acts, shall have the same meaning in these instructions; and

"Act"	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)
"Board of Directors" and (unless the context otherwise requires) "Board"	means the Executive and Non-Executive Directors of the Trust, including the Chair, collectively as a body
"Budget"	means a plan, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust
"Budget holder"	means the director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation
"Charitable Fund"	means funds held on trust with the Trust as corporate trustee
"Chair"	means the Chair of the foundation Trust, appointed under the constitution

“Chief Executive”	means the Chief Executive Officer of the Trust
“Commissioning”	means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources
“Committee”	means a committee of the Board of Directors
“Commissioner requested services (CRS)”	means those services described at condition G9(2) and G9(3) of the provider licence, and which have not ceased to be such a service in accordance with condition G9(9) of the Provider Licence.
“Company Secretary”	means the Company Secretary of the Trust appointed under the constitution
“Council of Governors”	means the Council of Governors of the Trust as defined in the constitution
“Constitution”	means the current version of the constitution of Lancashire Teaching Hospitals NHS FT, approved in accordance with s.37(1) of the 2006 Act
“Integrated Care Board” (ICB)	Means the Integrated Care Board as established for oversight of the Lancashire and South Cumbria Integrated Care System under the Health & Social Care Act 2022
"Trust"	means Lancashire Teaching Hospitals NHS Foundation Trust, which is a public benefit corporation
“Executive Director”	means a member of the Board of Directors who holds an executive office of the Trust
"Chief Finance Officer"	means the chief financial officer of the Trust
“Funds held on trust”	means those funds which the Trust holds at its date of incorporation or chooses subsequently to accept. Also referred to as charitable funds
“Lancashire Procurement Cluster (LPC)	The Lancashire Procurement Cluster (LPC) is a shared collaborative procurement and supply chain service for Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust and Lancashire Teaching Hospitals NHS Foundation Trust.
“Member of the Board”	means an Executive or Non-Executive Director. (Member of the Board in relation to the Board of Directors includes its Chair)
“NHSE”	means the body corporate known as NHS England within the meaning of the Health & Care Act 2022
“Nominated officer”	means an officer charged with the responsibility for discharging specific tasks within standing orders and standing financial instructions

"Non-Executive Director"	means a member of the Board of Directors who does not hold an executive office of the Trust
"Officer"	means an officer of the Trust or any other person holding a paid appointment or office with the Trust
"Provider Collaborative Board" (PCB)	Means joint committee established by the five Trusts in Lancashire and South Cumbria to discharge collective oversights and decisions on behalf of the member trusts.
"Provider licence"	means the licence described at s.81 of the 2012 Act, issued by NHSE in accordance with ss.87 or 88 of the 2012 Act
"SFIs"	means the Standing Financial Instructions of the Trust
"SOs"	means the Standing Orders of the Trust (of the Board of Directors)
"SORD"	means the Scheme of Reservation of Powers to the Board and delegation of powers

1.7 Wherever the title Chief Executive, Chief Finance Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised in writing to represent them.

1.8 Wherever the term "employee" or "staff" is used, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

2. RESPONSIBILITIES AND DELEGATION

Board of Directors and Chief Executive

2.1 Certain powers and decisions may only be exercised by the Board as set out in the "Reservation of Powers to the Board" document.

2.2 The Board will delegate responsibility for the performance of its functions in accordance with the scheme of delegation, the SORD, the Standing Orders and Standing Financial Instructions adopted by the Trust. The Board should keep the extent of delegation under review.

2.3 The Board may delegate such powers and responsibilities for its functions not otherwise reserved to the joint committee known as the Provider Collaborative Board. These delegated functions shall be as set out in the PCB Terms of Reference and may be amended or rescinded by the Board at its discretion.

2.3 The Board exercises financial supervision and control by:

(a) Ensuring the financial strategy is consistent with, and an integral part of the business plan;

(b) Requiring the submission and approval of expenditure budgets within overall forecast income;

(c) Independent monitoring of the financial viability of the Trust;

(d) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation and the SORD.

2.4 The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

2.5 The Chief Executive and Chief Finance Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.6 It is a duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within these instructions.

2.7 All directors and officers, severally and collectively, are responsible for:

(a) The security of the property of the Trust;

(b) Avoiding loss;

(c) Exercising economy and efficiency in the use of resources; and

(d) Conforming to the requirements of standing orders, standing financial instructions, financial procedures and the scheme of delegation.

2.8 Any contractor or officer of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2.9 For any and all directors and officers who carry out a financial function, the form in which financial records are kept and the manner in which directors and officers discharge their duties must be to the satisfaction of the Chief Finance Officer.

Chief Finance Officer

2.10 The Chief Finance Officer may delegate the operational responsibility for the following but will retain accountability under these SFIs for:

(a) Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) Ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these Instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and, without prejudice to any other functions of directors and employees to the Trust, the duties of the Chief Finance Officer include:

(i) The provision of financial advice to the Trust and its directors and employees;

(ii) The design, implementation and supervision of systems of financial control;

(iii) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for carrying out its statutory duties; and

(d) Regardless of the arrangements for providing financial services, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of income and payment to appropriate bodies.

3. AUDIT

3.1 The Trust shall comply with the directions of NHSE under paragraph 24(5) of Schedule 7 to the Act with respect to the standards, procedures and techniques to be adopted.

Audit Committee

3.2 In accordance with Standing Orders (and as set out in the Audit Code for NHS Trusts, issued by NHSE), the Board of Directors shall establish a committee of Non-Executive Directors as an Audit Committee with formal terms of reference to perform such independent regulating, reviewing and other functions as are appropriate to provide an independent and objective view of internal control. This shall be achieved by monitoring the degree to which organisational risk management, control and governance processes support the achievement of the Trust's agreed objectives.

3.3 The Audit Committee shall operate within its Terms of Reference as approved by the Board.

Internal Audit Service

3.4 The NHS foundation trust accounting officer memorandum requires the foundation trust to have an internal audit function.

3.5 The internal audit service will provide:

(a) an independent and objective opinion to the accountable officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives.

(b) an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

3.6 Internal Audit will act in accordance with regulatory and recognised professional best practice, review, appraise and report upon:

a) The extent to which the achievement of the Trust's objectives are monitored,

b) The extent of compliance with, and the financial effect of, or risk associated with relevant established policies, plans and procedures;

c) The adequacy, efficiency and application of financial and other related management controls;

d) The suitability and effective usage of financial and other related management information and data; and

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences,

(ii) waste, extravagance, inefficient administration,

(iii) poor value for money or other causes.

3.7 The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the public sector internal audit standards. The reporting system shall be reviewed at least every 3 years.

3.8 The Head of Internal Audit will produce an annual audit opinion on the effectiveness of the system of internal control.

3.9 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer and local counter fraud officer must be notified immediately. (See also SFI 16 – disposals and condemnations, losses and special payments).

3.10 The Chief Internal Auditor and / or the Audit Manager will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

3.11 The Head of Internal Audit shall report direct to the Chief Finance Officer and shall refer audit reports to the appropriate officers designated by the Chief Executive. Failure to take the necessary remedial action within a reasonable period shall be reported to the Chief Finance Officer. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chief Executive, Chair or any Non-Executive Director of the Trust.

3.12 The Chief Internal Auditor shall co-ordinate internal audit plans and activities with line managers, external audit and other review agencies to ensure the most effective audit coverage is achieved and duplication of effort is minimised.

3.13 A final report will be issued to the appropriate manager(s) and directors and to the Chief Finance Officer. All final reports will be available to the Chief Executive and the Audit Committee members. The Audit Committee will also receive a report from the Chief Internal Auditor at each of its meetings, summarising the final reports issued and the adequacy of the management response.

3.14 The Trust will provide the Chief Internal Auditor with every facility and all information which he or she may reasonably require for the purposes of his or her functions under the Terms of Reference.

3.15 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided.

3.16 In doing so the Chief Finance Officer is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) Ensuring that the purpose, authority and responsibility of internal audit is formally defined by the Trust in terms of reference with regard to professional best practice;

(c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities.

(d) Ensuring that an annual internal audit report is provided for the consideration of the audit committee. The report must cover:

(i) A clear statement on the effectiveness of internal financial control, risk management and organisational controls, including:

(ii) Progress against plan over the previous year,

(iii) Major internal financial control weaknesses discovered,

(iv) Progress on the implementation of internal audit recommendations,

(v) Strategic audit plan covering the coming three years,

(vi) A detailed plan for the coming year.

(vii) An annual audit opinion on the effectiveness of the system of internal control.

3.17 The Chief Finance Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) Access at all reasonable times to any land, premises or employee of the Trust;

(c) The production of any cash, stores or other property of the Trust under an employee's control; and

(d) Explanations concerning any matter under investigation.

External Audit

3.18 It is for the Council of Governors to appoint or remove the external auditors at a general meeting of the Council of Governors.

3.19 The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by NHSE within the audit code for NHS Foundation Trusts, at the date of appointment and on an on-going basis throughout the term of their appointment.

3.20 External audit responsibilities (in compliance with the requirements of NHSE) are:

(a) To be satisfied that the accounts comply with the directions provided, i.e. that the accounts comply with the DHSC group accounting manual for NHS Foundation Trusts;

(b) To be satisfied that the accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment this is applicable to the accounts;

(c) To be satisfied that proper practices have been observed in compiling the accounts;

(d) To be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources;

(i) to comply with any directions given by NHSE as to the standards, procedures and techniques to be adopted, i.e. to comply with the Audit Code for NHS Foundation Trusts;

(ii) To consider the issue of a public interest report;

(iii) To certify the completion of the audit;

(e) To express an opinion on the accounts; and

(f) To refer the matter to NHSE if the Trust, or an officer or director of the Trust, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

3.25 External auditors will ensure that there is a minimum of duplication of effort between themselves and Internal auditors. The auditors will discharge this responsibility by:

(a) Reviewing the statement made by the Chief Executive as part of the Annual Governance Statement and making a negative statement within the audit opinion if the Annual Governance Statement is not consistent with their knowledge of the Trust;

(b) Reviewing the results of the work of relevant assurers, for example the Care Quality Commission, to determine if the results of the work have an impact on their responsibilities;

(c) Undertaking any other work that they feel necessary to discharge their responsibilities.

3.26 The Trust will provide the external auditor with every facility and all information which he may reasonably require for the purposes of his functions under Schedule 10 of the Act.

3.27 The Trust shall forward a report to NHSE within 30 days (or such shorter period as NHSE may specify) of the external auditor issuing a public interest report in terms of schedule 5 paragraph 3 of the Act. The report shall include details of the Trust's response to the issues raised within the public interest report.

4. FRAUD, BRIBERY AND CORRUPTION

General

4.1 The Chief Executive and Chief Finance Officer shall ensure compliance with good practice to counter fraud and corruption.

4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.

4.3 The Local Counter Fraud Specialist will report to the Trust's Chief Finance Officer.

Procedures

4.4 The Chief Finance Officer is responsible for providing detailed procedures to enable the Trust to minimise and where possible to eliminate fraud, bribery and corruption. These procedures set out action to be taken by persons detecting a suspected fraud and persons responsible for investigating it.

4.5 The measures that are put in place shall be sufficient to satisfy all external bodies to whom the Trust is accountable to, through;

(a) Encouraging prevention;

(b) Promoting detection; and

(c) Ensuring investigation and remedial actions are undertaken promptly, thoroughly and effectively.

4.6 Proven instances of fraud, bribery and corruption should be considered as gross misconduct.

4.7 It is expected that all officers shall act with the utmost integrity, ensuring adherence to all relevant regulations and procedures. It is the responsibility of the Chief Finance Officer to produce and issue these to the appropriate directors and managers who should ensure that all staff have access to these.

Prevention

4.8 The Chief Executive shall ensure that an appropriate officer at a senior level is responsible for ensuring that steps are taken at recruitment stage to establish as far as possible the previous record of potential officers in terms of their propriety and integrity, in line with the NHS Employers Employment Check Standards.

4.9 Staff are expected to act in accordance with the trust's standing orders, code of business conduct for directors and employees, following the guidance on the receipt of gifts and hospitality.

4.10 Non-Executive Directors and Governors are subject to the same high standards of accountability and are required to declare and register any interests which might potentially conflict with those of the Trust.

4.11 The Local Counter Fraud Specialist shall be informed of all suspected or detected fraud so that they can consider the adequacy of the relevant controls and evaluate the implication of fraud for their opinion on the system of risk management, control, and governance.

Detection and resulting action

4.12 Staff are encouraged to raise any concerns they may have regarding suspected fraud and / or corruption. They can do this through:

(a) Their line manager,

(b) Internal audit,

(c) The Chief Finance Officer,

(d) The Company Secretary

(e) The Trust's local counter fraud specialist

(f) The NHS national fraud hotline, or

(g) The Freedom to Speak Guardian.

4.13 The Chief Finance Officer is responsible for ensuring that action is taken to investigate any allegations of fraud or corruption through the Local Counter Fraud specialist. The steps to be taken are incorporated in the Trust's Anti-fraud, Bribery and Corruption Policy.

4.14 Senior managers are expected to deal firmly and promptly and in accordance with the Trust's disciplinary procedure with anyone who attempts to defraud the Trust or who acts in a corrupt manner.

4.15 Any abuse of the procedures, such as unfounded or malicious allegations, is itself subject to full investigation and appropriate disciplinary action.

5. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND INDEPENDENT REGULATION

Preparation and approval of the Trust annual business plan and budgets

Trust Business Plan

5.1 The Chief Executive shall delegate the preparation of the Trust's statement of strategic direction to be produced every three years, for approval by the Board of Directors.

5.2 The Chief Executive (or a director designated by the Chief Executive for this purpose) shall compile and submit to the Board of Directors an annual business plan in accordance with the requirements of NHSE.

5.3 The Trust business plan will take into account financial targets and forecast limits of available resources. The Trust Business Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of workload, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHSE.

5.4 The Trust will provide information as to its forward planning in respect of each financial year to the independent regulator, NHSE in accordance with NHSE requirements.

5.5 This information will be prepared by the Directors, who must have regard to the views of the Council of Governors.

Business cases

5.5 Planned 'in year' businesses cases will be identified as much as is reasonably possible via the Annual Business Plan process. Only approved business cases will be included in the Annual Business Plan

and budget setting. An adjustment to plans will be made in year for those that are subsequently approved.

5.6 Whereas ordinarily business cases below £1m annual revenue implication are to be approved by Chief Executive and those in excess of £1m require Board of Director approval, for the duration of the implementation of the double and triple lock (as directed by NHSE):

i. investments above £50,000 require the approval of both the Board of directors and ICB (the double lock)

ii. investments above £100,000 require the approval of the Board of Directors, ICB and NHSE Region (the triple lock).

iii. At such time as the above additional approvals are removed or suspended, the limits as set out for the ordinary consideration of business cases will revert.

5.6 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an ongoing basis to budget holders and other relevant officers to help them produce and implement in year business cases.

Trust Budget

5.7 The Chief Finance Officer will, on behalf of the Chief Executive, prepare and submit income and expenditure budgets and reports thereon in a timely fashion, for approval by the Board. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the annual business plan;

(b) Accord with demand and workforce plans;

(c) Be produced following discussion with appropriate budget holders;

(e) Identify potential risks.

5.8 The Chief Finance Officer shall report financial performance against financial targets. The Chief Operating Officer will report activity and other performance targets. Performance reports shall be presented by the relevant directors not less frequently than quarterly.

5.9 Employees / officers shall provide the relevant directors with all financial, statistical and other relevant information as necessary, for the compilation of such budgets, plans, estimates and forecasts.

5.10 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an ongoing basis to budget holders to help them manage within allocated budgets successfully.

5.11 The Chief Finance Officer will keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards, inflation and other events and trends affecting the financial position of the Trust.

Budgetary delegation

5.12 The Chief Executive and all delegated budget holders must not exceed the budgetary totals set by the Board of Directors in the annual revenue plan.

5.13 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;

(b) The purpose(s) of each budget heading;

(c) Individual and group responsibilities;

(d) Authority to exercise virement (in accordance with the Trust Virement Policy);

(e) Achievement of planned levels of service; and

(f) The provision of regular reports.

5.14 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.15 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

Budgetary control and reporting

5.16 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to the Board of Directors in a form approved by the Board containing:

(i) Financial performance against delegated budgets;

(ii) Financial performance against contracts by exception

(iii) Summary cash flow

(iv) Summary balance sheet;

(v) Capital project spend and projected outturn against plan;

(vi) Explanations of any material variances that explain any movement from the planned retained surplus/deficit at the end of the current month position;

(vii) Details of any corrective action where necessary and the Chief Executive's and/or Chief Finance Officer's view of whether such actions are sufficient to correct the situation;

(viii) Key performance indicators;

(ix) Financial risk and mitigating actions.

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) Investigation and reporting of variances from financial and staffing budgets;

(d) Monitoring of management action to correct variances; and

(e) Arrangements for the authorisation of budget virements.

5.17 Each budget holder is responsible for signing off their budget in advance of the commencement of the financial year and ensuring that:

(a) Any likely overspending or reduction of income which cannot be met by virement (subject to controls in accordance with the Trust Virement Policy) is not incurred without the prior consent of the Chief Finance Officer;

(b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) No permanent employees/officers are appointed above the funded establishment unless approved by the Chief Executive;

(d) The systems of budgetary control established by the Chief Finance Officer are complied with fully.

Capital expenditure

5.18 The general rules applying to delegation and reporting shall also apply to capital expenditure.

5.19 The Board shall approve the capital programme for the Trust, consistent with the approved annual financial plan.

5.20 The Chief Executive shall ensure that regular reports to the Board are prepared, containing:

(a) Progress reports on the programme

(b) Explanations of any changes to the programme

Financial performance Monitoring

5.21 The Chief Executive is responsible for ensuring that:

(a) Financial performance measures have been defined and are monitored;

(b) Reasonable targets have been identified for these measures;

(c) A robust system is in place for managing performance against the targets;

(d) Reporting lines are in place to ensure overall performance is managed;

(e) Arrangements are in place to manage/respond to adverse performance.

Significant transactions

5.22 The Trust may enter into a significant transaction in accordance with the relevant provisions in the Trust constitution.

5.23 ‘Significant transaction’ is, as defined in the constitution.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Chief Finance Officer, on behalf of the Trust, will:

(a) Keep accounts, and in respect of each financial year must prepare annual accounts, in such form as NHSE, with the approval of the Secretary of State, may direct.

(b) Ensure that, in preparing annual accounts, the Trust complies with any directions given by NHSE with the approval of the Treasury as to:

(i) The methods and principles according to which the accounts are to be prepared; and

(ii) The information to be given in the accounts.

(c) Ensure that a copy of the annual accounts and any report of the external auditor on them, are laid before Parliament and that copies of these documents are sent to NHSE, within the prescribed timetable.

6.2 The Trust will prepare annual reports as required by paragraph 26 of Schedule 7 of the Act. These will be presented to the Board of Directors for approval and will be received by the Council of Governors at a public meeting. A copy will be forwarded to NHSE.

7. BANK ACCOUNTS

General

7.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

7.2 The Board shall approve the banking arrangements.

Bank accounts

7.3 Whereas the function may be delegated, the Chief Finance Officer is responsible for:

(a) Bank accounts;

(b) Establishing separate charitable bank accounts for the Trust's charitable funds;

(c) Reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn;

(d) Ensuring that no employee / officer other than the Chief Finance Officer, or in his/her absence his/her authorised deputy, shall open a bank account in the name of the Trust.

(e) Ensuring that all funds are held in accounts in the name of the Trust.

Banking procedures

7.4 The Chief Finance Officer will prepare detailed instructions on the operation of bank accounts which must include:

(a) The conditions under which each bank account is to be operated;

(b) The limit to be applied to any overdraft; and

(c) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

7.5 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

Tendering and review

7.6 The Chief Finance Officer will review the banking arrangements of the Trust at regular intervals not exceeding five years, to ensure they reflect guidance, best practice and represent best value for money. Following such reviews, the Chief Finance Officer shall determine whether or not to seek competitive tenders for the Trust's banking business.

7.7 The results of such reviews will be reported to the Audit Committee.

8. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

Income procedures

8.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with procedures for the proper recording, invoicing, collection and coding of all income due.

8.2 The Chief Finance Officer is also responsible for arranging the facilities to effect prompt banking of all monies received.

8.3 The Chief Finance Officer will ensure that any restrictions on income imposed by NHSE will be complied with.

8.4 The Trust shall ensure that the proportion of total income of the Trust in any financial year derived from private charges and other sources shall not be greater than that received from providing goods and services for the NHS. Any increase from non NHS sources that is greater than 5%, will be notified to the Council of Governors and appropriate authorisation sought.

Fees and charges

8.5 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges. Independent professional advice on matters of valuation shall be taken as necessary.

8.6 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate / deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

8.7 Employees must obtain the approval to income generation schemes prior to implementation in line with the Scheme of Delegation (section 7 and 8)

Debt recovery

8.8 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

8.9 Income not received should be dealt with in accordance with losses procedures (see SFI 16 – disposals and condemnations, losses and special payments).

8.10 Overpayments should be detected (or preferably prevented) and recovery initiated.

Security of cash, cheques and other negotiable instruments

8.11 Whereas the function may be delegated, the Chief Finance Officer is responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) The provision of adequate facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(c) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust; and

(d) Ordering and securely controlling any of the stationery referred to in paragraph 8.11(a) above.

8.12 Official money shall not under any circumstances be used for the encashment of private cheques.

8.13 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received except under arrangements approved in writing by the Chief Finance Officer.

8.14 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.15 Where cash collection is undertaken by an external organisation, this shall be subject to such security and other conditions as required by the Chief Finance Officer.

8.16 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned shall be reported immediately in accordance with the agreed procedure for reporting losses (see also SFI 16 – disposals and condemnations, losses and special payments). Any loss or surplus of cash should be immediately reported to the Chief Finance Officer.

8.17 All payments made on behalf of the Trust to third parties should normally be made using the bankers automated clearing system (BACS), or by crossed cheque and drawn in accordance with these instructions, except with the agreement of the Chief Finance Officer, as appropriate, who shall be satisfied about security arrangements. Uncrossed cheques shall be regarded as cash.

9. TENDERING AND CONTRACTING PROCEDURE

Duty to comply with Standing Orders and Standing Financial Instructions

9.1. The procedures to be followed by the Trust in relation to all contract opportunities with the Trust and for awarding all contracts with the Trust shall comply with these SFIs and the Trust's SOs (except where the Standing Order relating to the suspension of SOs is applied)

Legislation Governing Public Procurement.

19.2.1 When procuring goods, services and works, the Trust will ensure compliance with World Trade Organisation's (WTO) Government Procurement Agreement (GPA).

The WTO's GPA is a voluntary trade agreement that governs public procurement. Procurement in the UK post-Brexit followed rules set by OJEU; these rules will now shift to be in line with the GPA. The GPA includes both EU member states and non-EU states. It also outlines procurement principles, thresholds and rules that all those in agreement must adhere to. This agreement will allow the UK to have access to international public procurement. procurement law and the UK's implementing regulations to the extent that these are applicable to the goods, services or works being procured. In particular, it will ensure compliance with the requirements of:

- The Public Contracts Regulations (PCR) 2015 (as amended):and
- The Treaty Principles;
- Procurement and Competition regulations (no 2) 2013
- Relevant UK procurement case law

9.2.2 Together the WTO GPA Procurement Rules include any updated European and/or UK Legislation and case law which updates, amends or replaces them.

9.2.3 Any UK government-issued procurement policy notes (PN) which provide guidance on best practice will also be taken into account by the Trust.

9.2.4 The Procurement Legislation as from time to time amended shall have effect as if incorporated into these SFIs.

9.2.5 The Trust shall consider the application of any applicable duty to consult or engage the public or any relevant overview and scrutiny Committee of a local authority prior to commencing any procurement process for a contract opportunity.

9.2.6 When procuring goods and services, the Trust will have regard to the requirements of the Public Services (Social Value) Act 2012. Trust and Procurement policy concerning this Act will inform the application of recommendations in the act with regard to the weight given to this criteria when evaluating Tenders.

Guidance on Procurement and Commissioning

9.3.1 The Trust will have regard to all relevant guidance issued in relation to the conduct of procurement practice, including but not limited to:

i. NHSE Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts

ii. Under regulations 106, 108, 110 and 112 of the Public Contracts Regulations 2015 (PCRs 2015). Contracting authorities must ensure that any procurement opportunities and contract awards above certain low thresholds are published on Contracts Finder as per any current guidance.

iii. In the case of non-clinical consultancy contracts any current guidance or direction on limits and approvals as set by NHSE from time to time.

Decision to Tender and Exceptions to Requirement to Tender

Formal Competitive Tendering

General Applicability

9.4.1. The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);

(c) for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals compliant with the requirements of Contracts Finder.

Exceptions and instances where formal tendering need not be applied

9.5.1 Where a contract opportunity is required to be tendered under SFI, tendering procedures need not be applied where:

(a) the estimated expenditure or income does not, or is not reasonably expected to exceed the levels set out in the Reservation of Powers and Scheme of Delegation;

(b) any disposal falling within SFI 9.35

(c) the requirement can be met by an existing contract without infringing Procurement Legislation where the Trust requirement to demonstrate Value for Money can be evidenced by the requestor and verified by LPC.

(d) the Trust is entitled to call off from a Framework Agreement and the requirements of SFI (use of Framework Agreements) have been followed; and the commissioning department can demonstrate value for money has been delivered and this is verified by LPC.

(e) a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the Trust; or

(f) The National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health and Social Care.

(g) The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (e.g. change of scope, or increase in value of 10% or more), or result in a shift in the economic balance of the contract in favour of the contractor;

(h) A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed;

Inter-provider NHS Contracts Exceptions

9.6.1 In addition the established overarching Inter-provider Service Level Agreements with acute ICS (Integrated Care Services) partners is considered a special category that does not require a waiver.

9.6.2 Any NHS to NHS contracts need not be tendered (commonly known as SLAs). This does not preclude the requirement to have a valid contract to legitimise the relationship.

Formal tendering below WTO GPA threshold

9.7.1 Procedures may be waived in the following circumstances:

(a) in exceptional circumstances where the appropriate authorised Trust officers in line with the Reservation of Powers and Scheme of Delegation decides that formal tendering procedures would not be practicable or the estimated expenditure would not warrant formal tendering procedures, and the circumstances are formally detailed and maintained in an appropriate Trust waiver document;

(b) where the timescale genuinely precludes competitive tendering for reasons of extreme urgency brought about by events unforeseeable by the Trust and not attributable to the Trust. Failure to plan work properly is not a justification for waiving the requirement to tender;

(c) where the works, services or supply required are available from only one source for technical or artistic reasons or for reasons connected with the protection of exclusive rights;

9.7.2 When the goods required by the Trust are a partial replacement for, or in addition to, existing goods and to obtain the goods from a supplier other than the supplier who supplied the existing goods would oblige the Trust to acquire goods with different technical characteristics and this would result in

(a) incompatibility with the existing goods;

(b) disproportionate technical difficulty in the operation and maintenance of the existing goods; but no such contract may be entered in for duration of more than three years.

(c) disproportionate cost

9.7.3 When works or services required by the Trust are additional to works or services already contracted for but for unforeseen circumstances such additional works or services have become necessary and that such additional works or services:

(a) cannot for technical or economic reasons be carried out separately from the works or services under the original contract without major inconvenience to the Trust; or

(b) can be carried out or provided separately from the works or services under the original contract but are strictly necessary to the latest stages of performance of the original contract, provided that the value of such additional works or services is below both of the following values:

(i) the relevant threshold governing the application of the Regulations; and

(ii) 10% of the initial contract value for service and supply contracts or 15% of that value for works contracts, provided that the modification does not alter the overall nature of the relevant agreement.

Monitoring and Audit of Decision to Tender

9.8.1 The waiving of competitive tendering and quotation procedures should not be used with the object of avoiding competition or solely for administrative convenience.

9.8.2 The LPC will consider all requests to waive tendering and quotation requirements as set out in these Standing Financial Instructions based upon both the information presented and appropriate research.

9.8.3 Approval will be granted or declined in the first instance by the LPC detailing the rational for the decision and the form will then be submitted to the Chief Finance Officer and if required by the Scheme of Delegation to the Board.

9.8.4 If either party declines the waiver request the LPC will brief and advise the commissioning officer of the reason.

9.8.5 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

9.8.6 In addition to procurement regulations competitive tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concorde) without Departmental of Health and Social Care approval.

Contracts which subsequently breach thresholds after original approval not to tender

9.9.1 Contract opportunities estimated to be below the financial limits as set out in this SFI or below the threshold for the application of the requirement to tender under the Regulations, for which formal tendering procedures are not used, but which subsequently prove to have a value above such limits shall be formally reported to the appropriate authorised Trust officers in line with the Reservation of Powers and Scheme of Delegation and be recorded in and

9.9.2 be subject to the tender waiver process should the Trust decide not to Tender the requirement according to the Trust tender thresholds.

Use of Framework Agreements

9.10.1 The Trust may utilise any available and compliant framework agreement to satisfy its requirements for works, services or goods but only if it complies with the requirements of Procurement Legislation in doing so, which include (but are not limited to) ensuring that:

(a) the framework agreement was procured on its behalf. The Trust should satisfy itself that the original procurement process included the Trust within its scope;

(b) the framework agreement includes the Trust's requirement within its scope. The Trust should satisfy itself that this is the case;

(c) where the framework agreement is a multi-operator framework agreement, the process for the selection of providers to be awarded call-off contracts under the framework agreement is followed; and

(d) the call-off contract entered into with the provider contains the contractual terms set out by the framework agreement.

(e) any and all framework activity is authorised and conducted in accordance with the Trust Scheme of Delegation including but not limited to submitting waiver requests for non-competed direct awards on framework

In-House Services: Decision to Tender Services

9.11.1 The appropriate authorised Trust officers in line with the Reservation of Powers and Scheme of Delegation shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by benchmarking services or competitive tendering.

Tendering Procedure / Equality of Treatment

9.12.1 The Trust shall ensure that no sector of any market (public, private, third sector / social enterprise) is given an unfair advantage in the design or conduct of any tender process.

Non-Discrimination

9.13.1 The subject matter and the scope of the contract opportunity should be described in a non-discriminatory manner. The Trust should utilise generic and/or descriptive terms, rather than the trade names of particular products or processes or their manufacturers or their suppliers.

9.13.2 All participants in a tender process should be treated equally and all rules governing a tender process must apply equally to all participants.

Advertisement of Contract Opportunities

9.14.1 Where advertisement of a contract opportunity is required under the Trust's Scheme of Delegation and applicable public contracts regulations.

(a) and where a contract opportunity falls within the applicable public contracts regulations and a process compliant with these regulations is required, a Find a Tender Notice (or general public sector regulation notice) should be utilised; or

(b) where a contract opportunity does not fall within the applicable public contracts regulations the Trust shall utilise a form of advertising for such contract opportunity that is sufficient to enable potential providers (including providers in states other than the UK) to access appropriate information about the contract opportunity so as to be in a position to express an interest; or

(c) where neither the circumstances described above apply the Trust shall advertise utilising an online procurement portal.

Choice of Procedure

9.15.1 Where a contract opportunity falls within the applicable public contracts' regulations and a process compliant with the Regulations is required then the Trust shall utilise an available tender procedure under the Regulations, with mandated prior consultation with Procurement.

9.15.2 In all other cases the Trust shall utilise a tender procedure proportionate to the value, complexity and risk of the contract opportunity and shall ensure that invitations to tender are sent to a sufficient number of providers to provide fair and adequate competition.

Invitation to Tender

9.16.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

9.16.2 Every invitation to tender must require each bidder to give a written undertaking, not to engage in collusive tendering or other restrictive practice and not to engage in canvassing the Trust, its employees or officers concerning the contract opportunity tendered.

9.16.3 It must be made clear that the Trust takes a zero tolerance approach to fraud, bribery and corruption of any form.

Opening Formal Tenders and Register of Tenders

9.17 As soon as practicable after the date and time stated as being the latest time for the receipt of formal tenders, tenders issued electronically via the TM System should be submitted and opened The Tenders will remain within the TM System under a password controlled and time locked secure electronic environment.

Admissibility of Tenders

9.18.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

9.18.2 Where only one tender is sought and/or received, the Chief Executive and Deputy Chief Executive/Director of Finance or their designated officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and shall ensure value for money for the Trust.

Late Tenders

9.19.1 Tenders received after the due time and date, but prior to the opening or accessing of the other tenders, may be considered only if the Chief Executive, or his/her nominated officers, decides in consultation with procurement that there are exceptional circumstances i.e. Upload attempted in good time but delayed through no fault of the tenderer.

9.19.2 Only in the most exceptional circumstances shall a tender be considered which is received after the accessing of the other tenders and only then if the tenders that have been duly accessed have not left the electronic Trust tender management system, which shall record all formal tender activity in an auditable way.

9.19.3 The TM System will require the Trust's authorised officers to approve the opening of tenders received past the tender return date – until this is agreed they will be stored securely online

9.19.4 Accepted late tenders shall be reported to the Board.

Quotations: Competitive and Non-Competitive / Requirement to Obtain Competitive Quotations

9.20.1 Subject to exceptions as set out in these SFI, competitive quotations are required for all contract opportunities where formal tendering procedures are not adopted and where the intended expenditure or income exceeds the level set out in the Reservation of Powers and Scheme of Delegation but does not exceed the relevant financial threshold.

9.20.3 The requirement for competitive quotations may be waived in exceptional circumstances where the appropriate authorised Trust officers in line with the Trust Reservation of Powers and Scheme of Delegation decides that seeking competitive quotations would not be practicable for that estimated expenditure would not warrant seeking competitive quotations, and the circumstances are formally detailed and maintained in an appropriate Trust waiver document and where required reported to the Audit Committee at each meeting.

9.20.5 Nothing in this SFI shall prevent the Trust seeking competitive quotations should it wish to do so, notwithstanding any minimum threshold requirements

Competitive Quotations

9.21. Where competitive quotations are required:

(a) digitally evidenced quotations should be obtained in line with the Reservation of Powers and Scheme of Delegation;

(b) all tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000, be treated as confidential and are to be retained (for inspection) and ultimately disposed of as set out in paragraph 9.27.6 of this document; and

(c) the appropriate authorised Trust officers in line with the Reservation of Powers and Scheme of Delegation should evaluate each quotation received by applying evaluation criteria in accordance with SFI and select the quote which gives the best value for money. If this is not the lowest, then this fact and the reasons why the lowest quotation was not chosen should be set out in an appropriate Trust record.

Instances where formal competitive tendering or competitive quotation is not required

9.22.1 Subject to any exemptions as explicitly articulated in these SFI, non-competed written quotations must be obtained for any contract opportunity where formal tendering procedures are not adopted and where competitive quotations are not required. These written quotations to be retained digitally/electronically for a minimum of 6 years or the length of the contract whichever is greater:

9.22.2 The Trust shall use the NHS Supply Chain for procurement of all goods and services where appropriate as defined by the Trust clinical and financial imperatives.

9.22.3 If the Trust does not use NHS Supply Chain - where tenders or quotations are not required, because expenditure is below the Trust required financial limit as specified in the Scheme of Delegation, the Trust shall procure goods and services in accordance with procurement procedures and scheme of delegation approved by the Director of Finance and record this accordingly.

Quotations to be within Financial Limits

9.23. No quotation shall be accepted by the Trust which shall commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with SFIs except with the authorisation

of either the Chief Executive or the Chief Finance Officer or appropriate authorised Trust officers in line with the Reservation of Powers and Scheme of Delegation and in consultation with the LPC.

Evaluation of Tenders and Quotations / Overriding duty to achieve best value

9.24.1 The Trust shall ensure that it seeks to obtain best value for each contract opportunity.

9.24.2 The standard cost/non-cost ratio for the criteria of weighted evaluation scores must reflect the Trust's non-pay spend policy, endorsed by the Chief Executive and reflected in the Procurement strategy.

9.24.3 Deviations from this recommended balance must be endorsed by the relevant budget owner according to the Trust's Scheme of Delegation and approved by the LPC.

9.24.4 These ratios will include a recommended weighting for Social Value and Environmental considerations according to Trust strategy and where appropriate to the category of spend.

Choice of Evaluation Methodology

9.25.1 The Trust must for each contract opportunity which is subject to a tender or a competitive quotation choose to adopt evaluation criteria based on either:

(a) the lowest price; or

(b) the most economically advantageous tender, based on criteria linked to the subject matter of the contract opportunity including but not limited to some or all of:

- cost / whole life costing–
- quality –
- specification
- function
- technical support
- quality management
- social value, including environmental impact and modern slavery act considerations
- implementation / project management
- patient confidentiality, data protection compliance.
- sustainability
- continuous improvement

9.25.2. Each invitation to tender or invitation to supply a competitive quotation, must state the evaluation criteria to be used to evaluate the tender or quotation and the relative weightings of each such criterion.

Pass/Fail Criteria

9.26 Will be established according to the Trust's relevant policy – including but not limited to:

- the Trust's commitments on slavery and human trafficking pursuant to section 54(1) of the Modern Slavery Act 2015
- the Trust's commitments to Social Value pursuant to the Social Value Act 2012 and the relevant economic, social and environmental well-being policies of the Trust.

Award of Contracts / Acceptance of formal tenders

9.27.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his/her tender before the award of a contract shall not disqualify the tender.

9.27.2 Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative after the due time for receipt) should be dealt with in the same way as late tenders.

9.27.3 Where examination of tenders reveals errors which would affect the tender figure, the tenderer may be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

9.27.4 No tender shall be accepted by the Trust which shall commit expenditure in excess of that which has been allocated by the Trust except with the authorisation of the appropriate authorised Trust officers in line with the Reservation of Powers and Scheme of Delegation.

9.27.5 No tender shall be accepted by the Trust which is obtained contrary to these SFIs except with the authorisation of the appropriate authorised Trust officers in line with the Reservation of Powers and Scheme of Delegation.

9.27.6 All tenders should, subject to compliance with the provisions of the Freedom of Information Act 2000, be kept confidential and should be retained as follows:

(a) Unsuccessful tenders: 3 years from the date set for the receipt of tenders for inspection.

(b) Successful tenders: tender period plus 6 year limitation period (subject to the execution format, for example, a Deed will require a 12 year limitation period).

Authorisation of Tenders and Competitive Quotations

9.28.1 Providing all the requirements set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided in accordance with the approved delegated financial limits set out in the Reservation of Powers and Scheme of Delegation**.**

9.28.2 Formal authorisation must be put in writing. In the case of authorisation by the Board this shall be recorded in its minutes.

9.28.3 These levels of authorisation may be varied or changed by the Trust**.**

Tender Reports to the Board

9.29. Reports to the Board shall be made on an exceptional-circumstances basis only and in accordance with the Trust's scheme of delegation. The Audit Committee at each meeting shall receive a report summarising tenders received and awarded.

Form of Contract

9.30.1 The Trust shall consider – with prior consultation with LPC - the most applicable form of contract for each contract opportunity with preference for NHS Standard. Upon advice from the LPC, the Trust should consider obtaining support from a suitably qualified professional advisor (including where appropriate) legal advisors.

9.30.2 No officer shall enter into any form of contract on behalf of the Trust unless they have specific authority to do so, in line with the Scheme of Delegation and relevant Trust policies and procedures. This applies even if the contract has no obvious financial value attached to it.

9.30.3 No officer should enter into any form of contract on behalf of the Trust which commits the Trust to operating according to the Supplier's terms and conditions without prior consultation and agreement with the LPC.

Capital Investment including Contracts for Building or Engineering Works

9.31.1 The Chief Financial Officer is responsible for:

a) Ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
b) Ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost; and
c) Ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences.
d) Where the value of the capital investment exceeds delegated limits as set out by NHSE and/or the ICB, ensuring that capital investment is not authorised without evidence of NHSE and/or ICB approval.

9.31.2 For every capital expenditure proposal the Chief Financial Officer is responsible for ensuring there are processes in place to ensure that a business case is produced setting out:

a) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
b) Confirmation that a designated officer has examined and confirmed the appropriateness of the costs and revenue consequences detailed in the business case.
c) The involvement of appropriate NHS England personnel and external agencies;
d) Appropriate project management and control arrangements.

9.31.3 For a capital investment where the contract stipulates stage payments, the Chief Financial Officer is responsible for ensuring there are processes in place to issue procedures for their management.

9.31.4 The Chief Financial Officer is responsible for ensuring there are processes in place for the issue of procedures for the regular reporting of expenditure and commitment against authorised expenditure.

9.31.5 The approval of a capital programme does not constitute approval for expenditure on any scheme included within that programme.

9.31.6 The Chief Financial Officer is responsible for ensuring there are processes in place to issue to the Officer responsible for any scheme has:

a) Specific authority to commit expenditure;
b) Authority to proceed to tender; and,
c) Approval to accept a successful tender.

9.31.7 The Chief Financial Officer is responsible for ensuring there are processes in place to issue procedures governing the financial management, including variations to contract, of capital investment projects

and valuation for accounting purposes. These procedures should fully take into account the delegated limits for capital schemes issued by the Department of Health and Social Care.

9.31.8 The Chief Financial Officer is responsible for ensuring there are processes in place to ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within "Concode" and the prevailing Procurement regulations and routes relating to WTO GPA procurement regulations, Private Finance Initiative (PFI), Private Finance 2 (PF2), Procure 22 (P22), Public Private Partnerships (PPP), Local Improvement Finance Trust (LIFT).

Formal Waiver Process

9.32.1. Where any officer or employee of the Trust wishes to adopt a process that requires a waiver under, then such waiver must be authorised prior to any such process being implemented, by an appropriate authorised Trust officer in line with the Reservation of Powers and Scheme of Delegation who shall (where he agrees to such a process being adopted) authorise such process by completing and issuing Formal Waiver documents.

9.32.2 Each officer authorising any waiver shall seek the approval of the Trust's Procurement department prior to issuing any such waiver and shall take the advice of the Trust Procurement department into account in reaching his/her decision.

9.32,3 All Trust Formal Waiver documents must be maintained by the appropriate authorised Trust officers or their nominated representatives in line with the Reservation of Powers and Scheme of Delegation.

Employment, agency and consultants' contracts

9.33 The Chief Executive shall nominate officers with delegated authority to enter into permanent and temporary contracts of employment and other contracts for agency staff or persons engaged on a consultancy basis.

Compliance requirements for all contracts

9.34. The Trust may only enter into contracts within the statutory powers delegated to it by the Secretary of State or otherwise derived from statute and each such contract shall:

(a) comply with the Constitution of the Trust;

(b) comply with the Trust's Standing Financial Instruments (SFIs);

(c) comply with all other statutory provisions;

(d) comply with any relevant guidance including that issued by NHSE ;

(e) embody substantially the same terms and conditions of contract as were the basis on which tenders or quotations were invited;

(f) be entered into and managed to obtain best value;

(g) have an officer nominated by the Chief Executive to oversee and manage each contract on behalf of the Trust.

SPECIFIC REQUIREMENTS

Disposals

9.35.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/ her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with Trust policy;

(c) items to be disposed of with an estimated sale value as detailed in the Scheme of Delegation;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract; and/or

(e) land or buildings concerning which guidance has been issued by Monitor but subject to compliance with such guidance.

9.35.2 Disposals are subject to the restrictions on disposal of protected property as set out in the Trust's Licence and other relevant guidance.

Private finance for capital procurement

9.36. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

(b) The Trust must seek all applicable approvals and comply with the requirements of all relevant guidance published by NHSE;

(c) The proposal must be specifically agreed by the Board; and;

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations compliant with the duties set out in these SFI.

Accountability where in-house bid

9.37.1 In all cases where the Board of Directors determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) specification group, comprising the Chief Executive or nominated officers and specialist officers whose function shall be to draw up the specification of the service to be tendered;

(b) in-house tender group, comprising a nominee of the Chief Executive and technical support to draw up and submit the in-house tender submission; and

(c) evaluation group, comprising normally a specialist officer, procurement or commissioning officer and an Executive Deputy, Chief Executive / Director of Finance representative whose function is to shortlist expressions of interest received and evaluate tenders received. For services having a likely annual expenditure exceeding £250,000 a Non-Executive Director should be a member of the evaluation team.

9.37.2 No officer or employee of the Trust directly engaged or responsible for the provision of the in-house service subject to competitive tendering may be a member of any of the specification or evaluation group but the specification group may consult with and take into account information received from such officers or employees in drawing up the Trust's specification subject at all times to observing the duty of non-discrimination. No Member of the in-house tender group may participate in the evaluation of tenders.

9.37.2 The evaluation group shall make recommendations to the appropriate authorised Trust officers in line with the Reservation of Powers and Scheme of Delegation.

Cancellation of contracts

9.38. Except where specific provision is already made in any applicable mandatory NHS standard contract conditions to be utilised by the Trust, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if;

(a) the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to have done any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or forbearing to show favour or disfavour to any person in relation to the contract or any other contract with the Trust, or

(b) if the like acts shall have been done by any person employed by him/her or acting on his/ her behalf (whether with or without the knowledge of the contractor), or

(c) if in relation to any contract with the Trust the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Bribery Act 2010 and other appropriate legislation.

Determination of contracts for failure to deliver goods or material

9.39.1 There shall be inserted into every written contract for the supply of goods, materials or services a clause to secure that, should the contractor fail to deliver the goods, materials or services or any portion thereof within the time or times specified in the contract, the Trust may, without prejudice, determine the contract either wholly or to the extent of such default and purchase other goods, materials or services of similar description to make good:

(a) such default, or

(b) in the event of the contract being wholly determined the goods, materials or services remaining to be delivered.

9.39.2 The clause shall further secure that the amount by which the cost of so purchasing other goods, materials or services exceeds the amount which would have been payable to the contractor in respect of the goods, materials or services shall be recoverable from the contractor.

Contracts Involving funds held on trust

9.40 Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

10. CONTRACTS WITH COMMISSIONERS

10.1 The Chief Executive is responsible for negotiating contracts with commissioners for the provision of services to patients.

10.2 Contracts with commissioners are legally binding and shall comply with best costing practice and shall be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income.

10.3 In carrying out these functions, the Chief Executive should take into account the advice of directors regarding:

(a) Costing and pricing of services;

(b) Payment terms and conditions;

(c) Billing systems and cash flow management;

(d) The contract negotiating process and timetable;

(e) The provision of contract data;

(f) The national tariff ;

(g) Contract monitoring arrangements;

(h) Amendments to contracts; and

(i) Any other matters relating to contracts of a legal or non-financial nature.

10.4 The Chief Operating Officer and the Chief Finance Officer shall produce regular reports detailing actual and forecast service activity income with a detailed assessment of the impact of the variable elements of income.

11. TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYEES

Remuneration and terms of service

11.1 The Board should agree the terms of reference of the Appointments, Remuneration and Terms of Employment Committee ("the Committee"), specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

11.2 The remit of the Committee will be as set out in its Terms of Reference.

11.3 The Committee has full powers of decision over those matters within its remit.

11.4 The Trust will remunerate the Chair and Non-Executive Directors as determined by the Council of Governors.

Funded establishment

11.5 The workforce plans incorporated within the annual budget will form the funded establishment.

11.6 The funded establishment of any department may only be varied with the approval of the Chief Executive or other officers authorised by him / her to do so.

Staff appointments

11.7 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) Unless authorised to do so by the Chief Executive or other officers authorised by him / her to do so; and

(b) Unless within the limit of the approved pay budget and funded establishment; and

(c) Unless in accordance with human resources advice and compliance with employment legislation.

Processing of payroll

11.8 The Chief Executive shall delegate to an executive director the responsibility for the processing of payroll, including:

(a) Specifying timetables for submission of properly authorised time records and other notifications;

(b) The final calculation of pay;

(c) Making payment on agreed dates; and

(d) Agreeing method of payment.

(a) Verification and documentation of data;

(b) The timetable for receipt and preparation of payroll data and the payment of employees;

(c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) Security and confidentiality of payroll information;

(e) Checks to be applied to completed payroll before and after payment;

(f) Authority to release payroll data under the provisions of relevant statutory acts;

(g) Methods of payment available to various categories of employee;

(h) Procedures for payment by cheque, bank credit or cash to employees;

(i) Procedures for the recall of cheques and bank credits;

(j) Pay advances and their recovery;

(k) Maintenance of regular and independent reconciliation of pay control accounts;

(l) Separation of duties of preparing records and handling cash; and

(m) A system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

11.9 Appropriately nominated managers shall have delegated responsibility for:

(a) Completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;

(b) Submitting time records, and other notifications in accordance with agreed timetables;

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

11.10 Regardless of the arrangements for providing the payroll service, the Chief Executive or their nominated Director shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.11 The above paragraphs relate to the payment of staff employed within the Trust. In the event of the Trust providing a salaries and wages service to any other organisation it will be necessary for the Chief Finance Officer to have prepared a contract to cover the operation of the service provided.

Contract of employment

11.12 It is the responsibility of the Chief Executive or their nominated director to ensure that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and executes variations to, or termination of, contracts of employment.

12. NON-PAY EXPENDITURE

Delegation of authority

12.1 The Board of Directors will approve the level on non-pay expenditure as part of the annual budget and the Chief Executive will determine the level of delegation to appropriate managers prior to the start of the financial year to which the budget relates.

12.2 The Chief Executive will set out in the SORD:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) The maximum level of each requisition and the system for authorisation above that level.

12.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

Choice, requisitioning, ordering, receipt and payment for goods and services

12.4 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. To that end the procurement department must be engaged at the outset of the decision to procure goods/services (irrespective of WTO GPA thresholds). This will allow the procurement department sufficient time to establish routes to market and timetable any resultant procurement project.

12.5 The Trust's Chief Executive shall be responsible for ensuring that the Trust complies with all applicable laws in relation to choice, requisitioning, ordering and receipt for goods and services. The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

12.6 In relation to supplies to, and disposals by, the Trust, the Chief Executive will;

(a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. When applied to leases or recurring service contracts the thresholds will be applied to the total costs over the term of the lease or contract. (and, once approved, the thresholds should be incorporated in the scheme of delegation and regularly reviewed);

(b) Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of directors/officers (including specimens of their signatures (or an appropriate electronic equivalent signature) authorised to certify invoices.

(ii) Certification that:

(a) Goods have been duly received, examined and are in accordance with specification and the prices are correct;

(b) Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

(c) In the case of contracts based on the measurement of time, or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

(d) Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained

(e) The account is arithmetically correct;

(f) The account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance department.

(e) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as 11.7 below).

(f) Be responsible for ensuring that value added tax (VAT) is correctly accounted for.

12.7 Prepayments are only permitted with the approval of the Chief Finance Officer or his/her authorised deputy and where exceptional circumstances apply.

12.7 Official orders must:

(a) Be numbered

(b) Be in a form approved by the Chief Finance Officer;

(c) State the Trust's terms and conditions of trade; and

(d) Only be issued to, and used by, those duly authorised by the Chief Executive.

12.9 All staff must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

(a) All contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

(b) Contracts above specified thresholds are advertised and awarded in accordance with current national and European legislation.

(c) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars, the value not to exceed the sums detailed in the Scheme of Delegation;

(ii) Conventional hospitality, such as lunches in the course of working visits, as detailed in the scheme of delegation;

(d) No requisition / order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Chief Executive;

(e) Excepting where the Chief Finance Officer has sanctioned approval not to do so, all goods, services, or works are ordered on an official order. Specifically excluded are purchases from petty cash and purchases using a purchasing card;

(f) Verbal orders must only be issued very exceptionally - via the supplies department and only in cases of emergency or urgent necessity. These must be confirmed by an official order within two working days and clearly marked "confirmation order";

(g) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(i) Changes to the list of directors/officers authorised to certify invoices are notified to the Chief Finance Officer;

(j) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued from time to time by the Chief Finance Officer; and

(k) Petty cash records are maintained in a form as determined by the Chief Finance Officer.

12.10 The technical audit of building and engineering contracts shall be the responsibility of the relevant director.

12.11 The Chief Finance Officer will ensure capital charges are paid in accordance with department of health requirements.

12.12 The Chief Finance Officer shall ensure that systems and processes are in place to identify and discharge all relevant tax liabilities.

13. EXTERNAL BORROWING AND INVESTMENTS

13.1 The Chief Finance Officer will be responsible for the management of the Trust's cash flow.

External borrowing

13.2 The Chief Finance Officer is responsible for securing Board approval for all loans or working capital facilities. The Chief Executive, the Chief Finance Officer and the Operations Director of Finance shall be the designated signatories to all external loans, working capital facilities and overdrafts (including utilisation requests) entered into by the Trust, with the signature of any two required in any one instance. All major finance leases must be approved by the Board of Directors, in line with the scheme of delegation.

13.3 The Board of Directors will monitor the Trust's financing arrangements.

13.4 The Chief Finance Officer will secure the most preferential interest rates for borrowing within the freedom available to the Trust.

13.5 The Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing.

13.6 Any application for new borrowing will only be made by the Chief Finance Officer or by an employee so delegated by him / her.

13.7 The Chief Finance Officer must prepare detailed procedural instructions concerning applications for new borrowing which comply with instructions issued by NHSE.

13.8 Assets used to provide commissioner requested services (CRS) under the Trust's provider licence shall not be used as collateral for borrowing from commercial organisations. Assets not used to provide CRS services will be eligible as security for a loan with the agreement of the Board of Directors.

13.9 The Chief Finance Officer is responsible for reporting periodically to the Board concerning the originating debt and all loans, overdrafts and associated interest.

Investments

13.10 The Board shall approve the Treasury Management Strategy within the guidance issued by NHSE.

13.11 The Chief Finance Officer will, when required, prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13.12 The Chief Finance Officer must ensure that all covenants attached to borrowings by the lender are adhered to.

Capital investment including contracts for building or engineering works

13.13 The Chief Finance Officer is responsible for:

- Ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- Ensuring that there are processes in place for the management of all stages of capital schemes, that will ensure that schemes are delivered on time and to cost; and
- Ensuring that capital investment is not authorised without evidence of availability of resources to finance all revenue consequences.

13.14 For every capital expenditure proposal the Chief Finance Officer is responsible for ensuring there are processes in place to ensure that a business case is produced setting out:

- An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
- Confirmation that a designated Officer has examined and confirmed the appropriateness of the costs and revenue consequences detailed in the business case.
- The involvement of appropriate NHS England personnel and external agencies;
- Appropriate project management and control arrangements.

13.15 For a capital investment where the contract stipulates stage payments, the Chief Finance Officer is responsible for ensuring there are processes in place to issue procedures for their management.

13.16 The Chief Finance Officer is responsible for ensuring there are processes in place for the issue of procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.17 The approval of a capital programme does not constitute approval for expenditure on any scheme included within that programme.

13.18 The Chief Finance Officer is responsible for ensuring there are processes in place to issue to the Officer responsible for any scheme has:

- Specific authority to commit expenditure;
- Authority to proceed to tender; and,
- Approval to accept a successful tender.

13.19 The Chief Finance Officer is responsible for ensuring there are processes in place to issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures should fully take into account the delegated limits for capital schemes issued by the Department of Health and Social Care.

13.20 The Chief Finance Officer is responsible for ensuring there are processes in place to ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within “Concode” and the prevailing Procurement regulations and routes relating to WTO GPA procurement regulations, Private Finance Initiative (PFI), Private Finance 2 (PF2), Procure 22 (P22), Public Private Partnerships (PPP), Local Improvement Finance Trust (LIFT).

Asset registers

13.21 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted.

13.22 The Chief Executive is responsible for the maintenance of a publicly available property register recording assets used in commissioner requested services (CRS), in accordance with the guidance issued by NHSE.

13.23 The Chief Finance Officer shall approve procedures for reconciling balances on accounts recording CRS assets in ledgers against balances on CRS asset registers.

13.24 The Trust will value its assets in accordance with guidance from NHSE.

13.25 Unless NHSE otherwise directs only non-protected assets may be used as collateral to raise funds.

14. SECURITY OF ASSETS

Security of assets

14.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Finance Officer for the accounting aspects and the Director of Estates and Facilities for the physical management and control.

14.2 Asset control procedures (including protected property, non–protected assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Finance Officer and the Director of Estates and Facilities. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset;

(b) Identification of additions and disposals;

(c) Identification of all repairs and maintenance expenses;

(d) Physical security of assets;

(e) Identification and reporting of all costs associated with the retention of an asset;

(f) The asset replacement policy; and

(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments;

14.3 All discrepancies revealed by verification of physical assets to the fixed asset register must be notified to the Chief Finance Officer.

14.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

14.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses. (See SFI 16 – disposals and condemnations, losses and special payments).

14.6 Where practical, assets should be marked as Trust property.

INVENTORY AND RECEIPT OF GOODS

Inventory Stores and Inventory

15.1. Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net realisable value. Inventory shall be controlled on a First In first Out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

15.2 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of pharmaceutical stocks shall be the responsibility of the Deputy Chief Pharmacist; and the control of fuel oil the Director of Estates and Facilities.

15.3 The responsibility for security arrangements and the custody of keys for all inventory stores and locations shall be clearly defined in writing by the Head of Supply Chain wherever practicable, stocks should be marked as Health Service property.

15.4 The Chief Finance Officer, in conjunction with the Director of Procurement and Supply Chain, shall set out procedures and systems to regulate the inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification;

(a) delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt: a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

(b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

15.5 Stocktaking arrangements shall be agreed with the Chief Finance Officer and shall specify:

(a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

(b) That there shall be a physical check covering all items in store at least once a year;

(c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

(d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

(e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the Chief Finance Officer.

15.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

15.7 The Director of Procurement shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the Chief Finance Officer. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods.

15.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the Chief Finance Officer and recorded.

15.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Chief Executive shall identify those authorised to requisition and accept goods from the store.

15.11 It is the duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

Disposals and condemnations

16.1 The Chief Finance Officer, in conjunction with the Director of Estates and Facilities, must prepare detailed procedures for the disposal of assets including condemnations, scrap materials and items surplus to requirements and ensure that these are notified to managers.

16.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will approach the LPC to determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

16.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and

b) Recorded by the condemning officer in a form, approved by the Chief Finance Officer, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

16.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

16.5 The Trust may not dispose of any property used for the provision of commissioner requested services. Permission for disposal must be approved by the Board of Directors and NHSE in line with the guidance issued by NHSE. Disposals must comply with any conditions on the restriction on the disposal of assets as set out in the Trust's provider licence.

Losses and special payments

16.6 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.

16.7 An employee discovering or suspecting a loss of any kind must immediately inform their Head of Department, the Head of Internal Audit, the local Counter Fraud Specialist or, if no other route is appropriate, the Chief Executive. The Head of Department or the Head of Internal Audit must immediately inform the Chief Finance Officer. If theft or arson is involved, the Head of Department must inform the police immediately. In cases where the speed of response from the police is of the essence, such as a crime in progress, employees may contact the police directly, but must inform, immediately thereafter, their head of department, who must then inform the Chief Finance Officer promptly. Out of office hours, if the Head of Department is not on duty, the most senior manager on site should be contacted.

16.8 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if judged trivial by the Chief Finance Officer, the Chief Finance Officer must immediately notify:

(a) The Chief Executive, and

(b) The Local Counter Fraud Specialist

16.9 Within limits established by the Trust, the Board of Directors may consider and if thought fit, shall approve the writing-off of losses (as per the Scheme of Delegation). The Audit Committee shall review the schedule of losses and special payments and make recommendations to the Board.

16.10 The Chief Executive should consult the treasury of any losses or special payments, irrespective of any delegated authorities passed to the Trust or the amount of money concerned if they:

(a) Involve important questions of principle;

(b) Raise doubts about the effectiveness of existing systems;

(c) Contain lessons which might be of wider interest;

(d) Are novel or contentious;

(e) Might create a precedent for other departments in similar circumstances; and

(f) Arise because of obscure or ambiguous instructions issued centrally in line guidance in respect of HM Treasury manual managing public money.

16.11 The Chief Finance Officer shall take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.12 For any loss, the Chief Finance Officer, as appropriate, should consider whether any insurance claim can be made against insurers.

16.13 The Chief Finance Officer shall maintain a schedule of losses and special payments in which write-off action is recorded.

17. INFORMATION TECHNOLOGY

17.1 The Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programmes and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act.

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

17.2 The Chief Finance Officer and Chief Information Officer shall satisfy themselves that new financial systems and amendments to current financial systems (including those obtained by external agency arrangements) are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

17.3 In the case of financial computer systems which are proposed general applications (i.e. normally those applications which other health organisations in the region wish to sponsor jointly) all responsible directors and employees will send to the Chief Information Officer:

(a) Details of the outline design of the system;

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

17.4 The Chief Information Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

17.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Information Officer shall periodically seek assurances that adequate controls are in operation.

17.6 Where computer systems have an impact on corporate financial systems the Chief Information Officer in conjunction with the relevant director shall satisfy themselves that:

(a) Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Finance staff have access to such data; and

(d) Such computer audit reviews as are considered necessary are being carried out.

18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.2 The Chief Executive may delegate responsibility for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

(a) Notices and information booklets,

(b) Hospital admission documentation and property records,

(c) The oral advice of administrative and nursing staff responsible for admissions, that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is greater than £500 but less than £5,000, forms of indemnity shall be obtained.

18.5 Staff must be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19. CHARITABLE FUNDS (FUNDS HELD ON TRUST)

Introduction

19.1 The discharge of the charitable fund corporate trustee responsibilities are distinct from the Trust's responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding principles of financial regularity, prudence and propriety. The Chief Finance Officer will ensure that each fund is managed appropriately with regard to its purpose and to its requirements. The Company Secretary will monitor compliance with legislation and charity commission requirements.

19.2 This section of the Standing Financial Instructions shall be interpreted and applied in conjunction with the rest of these Instructions, subject to modifications contained in this chapter.

19.3 The Board has nominated the Chief Finance Officer and the Charitable Funds Committee to have primary responsibility to the Board for ensuring that these standing financial instructions are applied.

Existing trusts

19.4 The Chief Finance Officer will arrange for the administration of all existing trusts, will ensure that a governing instrument exists for every trust and will produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of directors and employees. Such guidelines shall identify the restricted nature of certain funds including capital assets held as permanent endowments.

19.5 The Chief Finance Officer will periodically review the funds in existence and will make recommendations to the Board's Charitable Funds Committee regarding the potential for rationalisation of such funds within the statutory guidelines, in consultation with the Head of Charities.

19.6 The Chief Finance Officer may recommend an increase in the number of designated funds where this is consistent with the charitable fund's policy for ensuring the safe and appropriate management of restricted funds, e.g. designation for specific wards and departments.

New Trusts

19.7 The Charitable Funds Committee has the authority to approve the creation of a new trust where funds and / or other assets, received in accordance with the charitable fund policies, cannot adequately be managed as part of an existing trust.

19.8 Charitable trust deeds following the standard format prescribed by the Charities Commission shall be prepared for all new trusts and be executed under seal in accordance with the Standing Orders of the Trust.

Sources of new funds

19.9 In respect of donations, the Chief Finance Officer will;

(a) Provide guidelines to officers of the Trust as to how to proceed when offered funds. These to include:

(i) The identification of the donor's intentions;

(ii) Where possible, the avoidance of new trusts;

(iii) The avoidance of impossible, undesirable or administratively difficult objects;

(iv) Sources of immediate further advice; and

(v) Treatment of offers for personal gifts;

(b) Provide secure and appropriate receipting arrangements that will indicate that funds have been accepted directly in the charitable funds and that the donor's intentions have been noted and accepted.

19.10 In respect of legacies and bequests, the Chief Finance Officer will;

(a) Provide guidelines to directors and employees of the Trust covering any approach regarding;

(i) The wording of wills,

(ii) The receipt of funds/other assets from executors;

(b) Where necessary, obtain grant of probate or make application for grant of letters of administration, where the Charitable Fund is the beneficiary;

(c) Be empowered, on behalf of the Charitable Fund to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty,

(d) Be directly responsible for the appropriate treatment of all legacies and bequests.

19.11 In respect of fund raising, the Chief Finance Officer will;

(a) Deal with all arrangements for fund raising by and / or on behalf of the charitable fund and ensure compliance with all statutes and regulations;

(b) Be empowered to liaise with other organisations / persons raising funds for the charitable fund and provide them with an assurance that the funds will be managed, invested and spent appropriately;

(c) Be responsible for alerting the Board Charitable Funds Committee to any irregularities regarding the use of the charitable fund names or their registration numbers; and

(d) Be responsible for the appropriate treatment of all funds received from this source.

19.12 In respect of trading income, the Chief Finance Officer will;

(a) Be primarily responsible, along with the Company Secretary and other designated officers, for any trading undertaken by the Trust as corporate trustee; and

(b) Be primarily responsible for the appropriate treatment of all funds received from this source.

19.13 In respect of investment income, the Chief Finance Officer will be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

Investment management

19.14 The Charitable Funds Committee will be responsible for all aspects of the management of the investment of charitable funds. The issues on which it will be required to provide advice to the Board will include;

(a) The formulation of investment policy within the powers of the Charitable Fund under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

(b) The appointment of advisers, brokers and, where appropriate, fund managers and;

(i) The Charitable Funds Committee will agree the terms of such appointments, and for which

(ii) Written agreements shall be signed by the Chief Executive.

(c) Pooling of investment resources and the preparation of a submission to the charity commission for them to make a scheme;

(d) The participation by the charitable fund in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) That the use of charitable fund assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) The review of the performance of brokers and fund managers;

(g) The reporting of investment performance;

Disposition management

19.15 The exercise of discretion for the utilisation of charitable funds rests solely with the Charitable Funds Committee on the advice of the Chief Finance Officer. In so doing the Committee will be aware of the following;

(a) The objects of various funds and the designated objectives;

(b) The availability of liquid funds within each trust;

(c) The powers of delegation available to commit resources;

(d) The avoidance of the use of Trust funds to discharge charity fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Trust will be discharged by charity funds at the earliest possible time;

(e) That the funds are spent rather than preserved, subject to the wishes of the donor and the needs of the charitable fund;

(f) The definitions of “charitable purposes” as agreed with the charity commission; and

(g) The legal obligations of the Trustees, in particular the duty to spend income funds within a reasonable time of receipt, unless retention can be justified within the reserves policy.

Banking services

19.16 The Chief Finance Officer will advise the Board and, with its approval, ensure that appropriate banking services are available to the Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the charity commission.

Asset management

19.17 Assets in the ownership of, or used by, the Trust as corporate trustee will be maintained along with the general estate and inventory of assets of the Trust. The Chief Finance Officer will ensure;

(a) That appropriate records of all assets owned by the Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought into account

(b) That appropriate measures are taken to protect and / or replace assets, these to include decisions regarding insurance, inventory control and the reporting of losses;

(c) That donated assets received on trust shall be accounted for appropriately;

(d) That all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for and that all other assets so acquired are brought to account.

Reporting

19.18 The Chief Finance Officer will ensure that regular reports are made to the Board , via the Charitable Funds Committee, with regard to, inter alia, the receipt of funds, investments and the disposition of resources.

19.19 The Chief Finance Officer will prepare annual accounts in the required manner. He / she will submit the accounts within agreed timescales.

19.20 The Chief Finance Officer will prepare annual trustee's report and the required returns to the charity commission for adoption by the Board.

Accounting and audit

19.21 The Chief Finance Officer will maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

19.22 The Chief Finance Officer will ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He / she will liaise with external audit and provide them with all necessary information.

19.23 The Chief Finance Officer will advise the Board on the outcome of the annual audit.

Administration costs

19.24 The Chief Finance Officer will identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, will charge such costs to the appropriate trust accounts.

Taxation and excise duty

19.25 The Chief Finance Officer will ensure that the charitable fund's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

20. RETENTION OF DOCUMENTS

20.1 The Chief Executive will be responsible for defining retention periods and maintaining archives, in accordance with best practice and extant guidance, for all documents required to be retained.

20.2 The documents held in archives must be capable of retrieval by authorised persons.

20.3 Documents so held shall only be destroyed at the express instigation of the Chief Executive; records will be maintained of documents so destroyed.

20.4 The above applies to documents held in all formats, including documents held electronically.

21. RISK MANAGEMENT AND INSURANCE

21.1 The Chief Executive will ensure that the Trust has a risk management strategy that will be approved and monitored by the Board.

21.2 The risk management strategy will include;

(a) A process of identifying and quantifying risks and potential liabilities;

(b) Engendering among all levels of staff a positive attitude towards the control of risk;

(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk;

(d) Contingency plans to offset the impact of adverse events;

(e) Audit arrangements including internal audit, clinical audit, health and safety reviews;

(f) Arrangements to review the risk management strategy; and

(g) Decision on which risks shall be insured through arrangements with either the NHS Resolution Authorities Pooling Schemes or commercial insurers.

21.3 The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control within the annual report and accounts.

21.4 The Chief Executive in consultation with his designated officer(s) shall be responsible for ensuring adequate insurance cover is effected in accordance with risk management policy approved by the Board of Directors.

21.5 Each officer shall promptly notify the designated officer of all new risks or property under his control, which require to be insured, and of any alterations affecting existing risks or insurances.

21.6 The designated officer shall ascertain the amount of cover required and shall affect such insurances as are necessary to protect the interests of the Trust.

21.7 The Chief Executive or his designated officer shall make all claims arising out of policies of insurance and each officer shall furnish the Chief Finance Officer immediately with full particulars of any occurrence involving actual or potential loss to the Trust and shall furnish an estimate of the probable cost involved.

21.8 The Director of Estates and Facilities shall ensure that all engineering plant under his control is inspected by the relevant insurance companies within the periods prescribed by legislation.

21.9 The value of all assets and risks insured shall be reviewed or index-linked on an annual basis by the designated officer.

21.10 The relevant directors shall decide if the Trust will insure through the risk pooling schemes administered by NHS Resolution or enter into arrangements with commercial insurers.

21.11 Where the risk pooling schemes are used the relevant directors shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The relevant directors shall ensure that documented procedures cover these arrangements.

21.12 The risk pooling scheme for Trusts requires members to contribute to the settlement of claims (the 'deductible'). The relevant directors shall ensure documented procedures also cover the management of claims and payments below the deductible in each case.

21.13 The relevant directors shall ensure documented procedures cover the management of claims and payments in respect of the arrangements with commercial insurers.

22. GIFTS, HOSPITALITY, DONATIONS AND COMMERCIAL SPONSORSHIP

Acceptance of gifts and hospitality

22.1 The acceptance, of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Bribery Act 2010. The Trust's code of conduct for directors, governors and employees must be followed.

22.2 The Trust operates a zero tolerance approach to any form of bribery, fraud or corruption. Any such concerns in these areas should be reported to the Chief Finance Officer or the Trust's local counter fraud specialist in the first instance.

22.3 Where offers of goods and services do not involve inducement or reward officers should not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If such gifts arrive unsolicited, the advice of the Company Secretary should be sought.

Private transactions

22.4 Officers having official dealings with contractors or other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

Donations

22.5 The NHS has benefited substantially from donations and the Trust would not wish to discourage donations that improve the service that it provides to its patients. The Trust's code of business conduct for directors, governors and employees must be followed.

Commercial sponsorship

22.6 The Trust would not wish to decline appropriate offers of commercial sponsorship and the Trust's code of business conduct for directors, governors and employees must be followed.

23. SECURITY MANAGEMENT

23.1 In line with their responsibilities, the Chief Executive will NHSE and ensure compliance with directions issued by the Secretary of State for Health on NHS security management.

23.2 The Trust shall nominate a suitable person to carry out the duties of the local security management specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management. The Trust shall nominate a non-executive director to oversee NHS protect service who will report to the Board.

23.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the security management director (SMD) and the appointed local security management specialist.

CONTENTS

RESERVATION OF POWERS - TRUST BOARD

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

1. INTRODUCTION

1.1 The Standing Orders for the Board of Directors sets out the arrangements for the Board of Directors' exercise of functions by delegation.

1.2 The purpose of this document is to clarify the powers reserved to the Board – generally matters for which it is held accountable to NHS England. The Board remains accountable for all its functions, even those delegated to individual Executive Directors and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

Role of the Chief Executive

1.3 The Chief Executive shall exercise all powers of the Trust, which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee, on behalf of the Board. The Chief Executive may delegate these powers to other Executive Directors to facilitate the exigencies of the service unless they are specifically reserved by the Board for the CEO alone.

1.4 All powers delegated by the Chief Executive may be re-assumed by them should the need arise.

Caution over the use of delegated powers

1.5 Powers are delegated to Executive Directors on the understanding that they will not exercise delegated powers in a matter that in their judgment is likely to be a cause for public concern.

Executive Directors' ability to delegate their own delegated powers

1.6 The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

Absence of Executive Directors to whom powers have been delegated

1.7 In the absence of an Executive Director to whom powers have been delegated, those powers shall be exercised by that director's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to them may be exercised by the Deputy Chief Executive or an Executive Director in the role of acting Chief Executive after taking appropriate advice from the Chair.

Role of the Council of Governors

1.8 The role of the Council of Governors is set out in statute and articulated in the Trust Constitution. The Council of Governors has no authority to delegate any of its powers.

2. RESERVATION OF POWERS TO THE BOARD

Accountability

2.1 The code of conduct and accountability which has been adopted by the Foundation Trust requires the Board of Directors to determine those matters on which decisions are reserved unto itself. Board members share corporate responsibility for all decisions of the Board. These reserved matters are set out in paragraph 2.4 below.

Duties

2.2 It is the Board's duty to:

2.2.1 act within statutory fina**n**cial and other constraints;

2.2.2 be clear what decisions and information are appropriate to the Board of Directors and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these;

2.2.3 ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account;

2.2.4 establish performance and quality measures that maintain the effective use of resources and provide value for money;

2.2.5 specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities;

2.2.6 establish Audit and Remuneration (ARTE) Committees on the basis of formally agreed terms of reference that set out the membership of each committee, the limit to their powers, and the arrangements for reporting back to the Board.

General enabling provision

2.3 The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

2.4 The following matters have been reserved to the Board:

Regulation and control

2.4.1 To ensure that the Trust works within the terms of its licence, its Constitution, mandatory guidance issued by NHS England, relevant statutory requirements and contractual obligations.

2.4.2 To approve the Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

2.4.3 To approve the Terms of Reference of Committees of the Board, such terms to include as appropriate, the delegation of powers from the Board to committees.

2.4.4 To approve arrangements for dealing with complaints.

2.4.5 To adopt the senior management structure to facilitate the discharge of business by the Trust and to agree modifications thereto.

2.4.6 To receive reports from committees including those which the Trust is required by NHSE or other regulation to establish and to take appropriate action thereon.

2.4.7 To confirm the recommendations of the Trust's committees where the committees do not have executive powers.

2.4.8 To ratify any urgent decisions taken on behalf of the Board by the Chair and the Chief Executive in accordance with Standing Orders.

2.4.9 To approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust within current legislation and the regulatory framework of the Charities Commission.

2.4.10 To approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2.4.13 To approve the Annual Governance Statement.

2.4.14 To approve the division of responsibilities between the Chair and Chief Executive.

2.4.15 To suspend Standing Orders.

2.4.16 To vary or amend the Standing Orders.

Appointments and dismissals

2.4.17 The Board shall appoint a Non-Executive Director to act as Vice Chair

2.4.18 The Non-Executive Directors of the Board shall appoint the Chief Executive Officer

2.4.19 The Non-Executive Directors of the Board and the CEO shall appoint Executive Directors

2.4.20 The Board shall appoint the Company Secretary.

Policy determination

2.4.21 To approve and review periodically, policies which have wide ranging strategic and/or financial and/or probity implications for the Trust and are fundamental to the Trust's business including:

2.4.22 To ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of code of conduct, and other ethical concerns.

Strategy, business plans and budgets

2.4.23 To approve budgets.

2.4.24 To approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature in accordance with the limits set within the Scheme of Delegation or within any limits or lock mechanisms as may be imposed by NHSE from time to time.

2.4.25 To define the strategic aims and objectives of the Trust.

2.4.26 To approve the Trust's annual business plan and 3 year strategic business plan.

2.4.27 To approve and monitor the Trust's structure and arrangements for the management of risk, including statutory compliance.

2.4.28 To approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by NHSE or other regulatory body.

2.4.29 To approve investments in other organisations including acquisitions and mergers.

2.4.30 To approve any proposal to materially alter the specification or means of provision of any commissioner requested service (subject to compliance with the Trust's licence).

2.4.31 To approve the Trust's capital programme and subsequent amendments in line with the Scheme of Delegation.

2.4.32 To approve private finance initiative (PFI) proposals.

2.4.33 To approve business cases for the introduction or discontinuance of any significant activity or operation (with gross annual income or expenditure at the level set out in the Scheme of Delegation).

2.4.34 Any matter listed above considered to be a significant transaction will also require the approval of the Council of Governors

Financial and performance reporting arrangements

2.4.35 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees, associate directors and officers of the trust as set out in management policy statements. All monitoring returns required by the Integrated Care Board, NHS England and the Charity Commission shall be reported, at least in summary, to the Board.

2.4.36 To approve banking arrangements.

Audit arrangements

2.4.37 The appointment (and where necessary dismissal) of the internal auditors. Responsibility for the appointment or removal of the external auditors is held by the Council of Governors.

2.4.38 To receive the annual management letter received from the external auditor and agree the proposed action, taking account of the advice, where appropriate of the Audit Committee.

2.4.39 To approve the appointment (and where necessary dismissal) of external auditors for the separate audit of funds held on trust (charitable funds).

2.4.40 To receive an annual report from the internal auditor and agree action on recommendations where appropriate of the Audit Committee.

Direct operational decisions

2.4.41 To approve proposals for the disposal of, or relinquishing of control over, any relevant asset (subject to compliance with the Trust's licence).

2.4.42 To approve proposals for the acquisition, disposal or change of use of land and/or buildings:

i. in line with guidance issued by NHS England; and

ii. where the disposal involves disposal of a relevant asset, subject to compliance with the Trust's licence.

2.4.43 To approve losses and compensations at the levels set out in the Scheme of Delegation.

2.4.44 To approve severance payments in line with relevant HM Treasury guidance and at the limits set out in the Scheme of Delegation.

2.4.45 The discharge of functions as trustees with regard to the charitable funds held by the Trust, in accordance with the requirements of the Charity Commission.

2.4.46 To approve all loans including the working capital facility, and major finance leases at the limits set out in the Scheme of Delegation.

2.4.47 To approve the use of assets that are not "relevant assets" as security for a loan.

2.4.48 To approve income and expenditure in excess of the financial limits set out in the Scheme of Delegation.

Annual report and accounts

2.4.49 To receive and approve the Foundation Trust's annual report and annual accounts prior to being laid before Parliament.

2.4.50 To receive and approve the annual report and accounts for funds held on trust (charitable funds).

3. DELEGATION OF POWERS

Delegation to committees

3.1 The Board of Directors may determine that certain of its powers shall be exercised by standing committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors, in accordance with Standing Orders

Delegation to the Provider Collaborative Board (as a Joint Committee)

3.2 The Board of Directors may determine that certain of its powers shall be exercised by the Provider Collaborative Board (PCB) as a Joint Committee. Such powers shall be articulated in the Terms of Reference of the PCB and may be rescinded by the Board on its sole determination at any time.

Accounting Officer

3.3 The Accounting Officer of the Trust is the Chief Executive.

3.4 The following responsibilities are defined through the Foundation Trust Accounting Officer memorandum.

3.5 The Accounting Officer has responsibility for the overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

3.5.1 There is a high standard of financial management in the Foundation Trust as a whole;

3.5.2 Financial systems and procedures promote efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Foundation Trust; and

3.5.3 Financial considerations are fully taken into account in decisions on Foundation Trust policy proposals.

3.6 The specific personal responsibilities of a Foundation Trust Accounting Officer are:

3.6.1 The propriety and regularity of the public finances for which they are answerable;

3.6.2 The keeping of proper accounts;

3.6.3 Prudent and economical administration;

3.6.4 The avoidance of waste and extravagance; and

3.6.5 The efficient and effective use of all the resources in their charge.

3.7 The Accounting Officer must:

3.7.1 Personally sign the accounts and, in doing so accept personal responsibility for ensuring their proper form and content as prescribed by NHSE in accordance with the act.

3.7.2 Comply with the financial requirements of the Trust's licence.

3.7.3 Ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form

prescribed for published accounts (so that they disclose with reasonable accuracy, at any time, the financial position of the NHS FT).

3.7.4 Ensure that the resources for which they are responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official.

3.7.5 Ensure that assets for which they are responsible such as land, buildings and other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate.

3.7.6 Ensure that any relevant asset (or interest in) is not disposed of without the consent in writing of NHS Improvement.

3.7.7 Ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, Council of Governors or in the actions or advice of the Foundation Trust staff, including themselves.

3.7.8 Ensure that, in the consideration of policy proposals relating to the expenditure for which they are responsible as Accounting Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the Board of Directors.

3.8 The Accounting Officer should ensure that effective management systems appropriate for the achievement of the Foundation Trust's objectives, including financial monitoring and control systems have been established. The Accounting Officer should ensure that managers at all levels:

3.8.1 Have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives.

3.8.2 Are assigned well defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS FT), including a critical scrutiny of output and value for money.

3.8.3 Have the information (particularly about cost), training and access to the expert advice which they need to exercise their responsibilities effectively.

3.9 Accounting Officers must make sure that they have arrangements for delegation, promotion of good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the g*overnment internal audit standards* document.

Executive Management Team

3.10 The Accounting Officer (CEO) may delegate to the Executive Management Team the authority to vary or suspend any financial control mechanism in response to budgetary constraints, financial management requirements or direction for the ICB/NHSE. Such changes or variations shall be recorded, including the duration of the variation.

SCHEME OF DELEGATION

SCHEME OF DELEGATION
DELEGATION OF POWERS AND DELEGATED LIMITS

All powers delegated by the Chief Executive within this scheme can be re-assumed by them at any time, at their discretion, should the need arise. As Accountable Officer, the Chief Executive is accountable to NHS England for the funds entrusted to Trust.

This document specifies the lowest level to which responsibility can be delegated.

Powers may be delegated to individual post holders on the understanding that they would not exercise delegated powers in a matter that in their judgement was likely to be a cause for public concern.

In the absence or unavailability of the post-holder, the Chief Officer, in conjunction with the Chief Executive, must nominate an officer as acting post-holder. The Chief Officer must inform the Chief Finance Officer and the Lancashire Procurement Cluster (LPC) Head of Procurement in writing. This can be a standing arrangement if required, provided the written notification clearly states this to be the case.

In the absence of the Chief Officer and the nominated acting post holder, an individual must refer any matters to the line manager of the Chief Officer or the Chief Executive as appropriate.

In the absence of the Chief Executive and the Deputy Chief Executive and Chief Finance Officer, the Chair will designate an Executive Director as Acting Chief Executive who will undertake the full range of responsibilities of the post as set out in this Scheme of Delegation.

Further delegation of more limited amounts cannot be made without an approved change to the Scheme of Delegation. Such requests must be made to the Chief Finance Officer.

All staff of the Trust must comply with Standing Orders and Standing Financial Instructions at all times.

All amounts quoted include VAT where appropriate and refer to the whole life cost of the transaction in question.

Staff must not act in a manner devised to avoid financial limits specified in this document.

Definitions

“Chief Officer”	means the person appointed by the Chief Executive to manage the income and expenditure for the totality of services within the area of their responsibility. The Chief Executive must inform the LPC Head of Procurement and the Chief Finance Officer of the services to be managed, the name of the Chief Officer and confirm a sample of the Chief Officer’s signature or a suitable alternative unique identifier for the purposes of authorisation through an electronic financial system This will include Corporate Directors, Clinical Directors, Divisional Directors, and General Managers, unless they are specifically identified for the purposes of financial limits
“Budget Supervisor”	means the manager appointed by the Chief Officer to supervise a number of budgets within the totality of their services. The Chief Officer must notify the Head of Procurement and the Chief Finance Officer the names of each budget supervised by the Budget Supervisor, the name of the Budget Supervisor and confirm a sample of the Budget Supervisor’s signature. or a suitable alternative unique identifier for the purposes of authorisation through an electronic financial system

"Budget Holder"	means the manager appointed by the Chief Officer to manage a budget within the Chief Officer's total budgetary responsibility. The Chief Officer must notify the LPC Head of Procurement and the Operations Director of Finance of the name of each budget, the name of the Budget Holder, and confirm a sample of the Budget Holder's signature. or a suitable alternative unique identifier for the purposes of authorisation through an electronic financial system
"Fund Advisor"	means the person appointed by the Chief Officer to manage expenditure from specified Charitable funds. The Chief Officer must notify the LPC Head of Procurement and the Chief Finance Officer of the name of the fund, the name of the Fund Advisor and confirm a sample of the Fund Advisor's signature or a suitable alternative unique identifier for the purposes of authorisation through an electronic financial system.

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
1. MANAGEMENT OF BUDGETS **1.1 Keep income and expenditure within budget**						
1.1.1 At individual budget level						✓
1.1.2 For the totality of budgets supervised by a budget supervisor					✓	
1.1.3 For the totality of services managed by a chief officer				Chief officer		
1.1.4 For the totality of the Trust's services		✓				
1.2 Transfer income and expenditure from one budget to another Provided that: i. The proposed use of income and expenditure accords with the Trust's and directorates' business plans, ii. The directorate will be able to keep its revenue expenditure within budget, iii. The use of any savings which have occurred as a result of plans not being implemented have the approval of the Chief Executive, and :						
1.2.1 Within the budget holder's responsibility						✓+ Chief Executive for 3.2 (iii)
1.2.2 Between budget holders within the Budget Supervisor's responsibility					✓+ Chief Executive for 3.2 (iii)	
1.2.3 Between budget holders within the Directorate				Chief Officer + Chief Executive for 3.2 (iii)		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
1.2.4 Between Directorates				Chief Officer + Chief Operating Officer + Chief Executive for 3.2 (iii)		
1.3 Adjust income and expenditure budgets in respect of income generation schemes funded from non-NHS sources for:						
1.3.1 Net income up to and including £10,000 in any one year				Chief Officer		
1.3.2 Net income over £10,000 in any one year.			✓+ Chief Officer	Chief Officer + Finance Director		
1.3.3 Gross income over £50,000 in any one year			✓+ Chief Officer	Chief Officer + Finance Director		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
2. REQUISITIONING, ORDERING AND PAYMENT OF GOODS AND SERVICES FOR ALL REQUISITIONS, ORDERS AND PAYMENTS (all limits include all taxes) Provided that: i. funds are available, ii. the purchase is appropriate to the budget, iii. the purchase is in accordance with the business plan and contracts, iv. the order does not exceed a period of one year, v. if the requisition relates to leases or tenancy agreements, the Finance Director has been notified before making any commitment, vi. if the expenditure is capital, and is included within the approved capital programme, the approval of the appropriate delegated officer must be obtained, vii. if the expenditure is capital and is not included within the approved capital programme, the written approval of the Chief Executive to commit expenditure and, if appropriate, to proceed to tender has been obtained, viii. the necessary quotations or tenders and approval to the acceptance of the selected supplier have been obtained, and ix. the supplier has not offered any gifts, rewards or other benefits						
2.1 Authorise goods and services excluding capital and drugs	For finance leases					
2.1.1 Financial limits (all limits relate to the total costs over the term of the contract) and are subject to any overrides or additional locks as directed by NHSE	>£1,000,000*	Up to £1,000,000	Up to £500,000	Corporate and divisional directors including Operations Director of Finance up to £200,000 All other Chief Officers (including Clinical Directors, Senior Assistant Finance Director and General Managers) <£150,000 (CBM)	Budget supervisors (including Assistant Finance Directors) <£25,000 (SBM)	Budget holders <£10,000

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
2.2 Authorise drug expenditure		>£1,000,000	<£1,000,000	<£150,000 Chief Pharmacist	<£50,000 Senior Pharmacist	
2.3 Commit non-pay expenditure where there is no budget (subject to the provisos in section 2)		✓				
2.4 Accept goods on trial or loan (limits are based on cost to purchase and as defined in s.2.1) Provided that: i. the Trust is not committed to purchase the goods ii. all other requirements, such as health and safety and insurance have been satisfied iii. the Trust's procedures have been followed iv. the Finance Director has been informed v. if of a capital nature, the Director of Estates and Facilities has been informed (unless IT, when the Finance Director should be informed)		✓	✓	✓ Chief officer and finance director + Director of Estates and Facilities for 2.4(v)	✓ + Finance director + Director of Estates and Facilities for 2.4(v)	✓ Or operational managers up to specified limit + Finance Director + IT technical support manager for IT + Director of Estates and Facilities for 2.4(v)
2.5 Deal with bankruptcies and company liquidations			✓			
2.6 Purchase from petty cash				£50	£50	£50
2.7 Authorise contracts for expenditure and subsequent variations to contracts						
Financial limits as defined in section 2.1		✓	✓	✓ Chief Officer + Finance Director for Information Technology	✓ + IT technical support manager for Information Technology	✓ + IT technical support for Information Technology

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
Provided that: i. contacts over £5,000 are in writing, ii. contracts over £500,000 and in respect of building and engineering work are executed under the common seal, and contract has been approved by the Head of Procurement (except where exemption has been granted by the Head of Procurement e.g. works)				+ Finance Director for 2.0(v) + Delegated Officer for 2.0(vi) + Chief Executive for 2.0(vii) + approval of quotes and tenders via the procurement department and approval of contracts by the Head of Procurement	+ Finance Director for 2.0(v) + Delegated Officer for 2.0(vi) + Chief Executive for 2.0(vii) + approval of quotes and tenders via the procurement department and approval of contracts by the Head of Procurement	+ Finance Director for 2.0(v) + Delegated Officer for 2.0(vi) + Chief Executive for 2.0(vii) + approval of quotes and tenders via the procurement department and approval of contracts by the Head of Procurement
3. QUOTATION, TENDERING AND CONTRACT PROCEDURES (all limits include taxes)						

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
The following requirements for the purchase or sale of goods and/or services must be fulfilled unless the Trust, their purchasing agent or the Department of Health has arranged a contract: i. make the purchase or sale via the Trust's Procurement Manager, ii. obtain appropriate purchasing and service/product specification advice from the Head of Procurement at the outset of the decision to procure goods/services which will allow sufficient time for procurement to invite competitive quotes/tenders. The approval of the Chief Executive must be obtained if this advice is to be disregarded and iii. follow Public Procurement Regulations via the Procurement Department						
3.1.1 Request that the Procurement Department obtain at least 3 written quotes	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1
3.1.2 Request that the Procurement Department obtain at least 3 written competitive tenders	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
3.1.3 Comply with Public Procurement Regulations via the Procurement Department	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1
3.2 Open tenders in accordance with Trust Policy and Procedures All relevant officers who may be involved in the potential purchase of specific goods or services through a tendering process must sign a pre-tender declaration at the earliest opportunity and before the tender specification is drafted. *E-tendering route* For electronic tendering via the Procurement Department, tender documents returned are locked by the external e-tendering provider until the closing date and time. Nominated Trust Procurement Officer(s) have the authority to open submissions therefore making them visible for evaluation and scoring. The exception to this is where the estimated aggregate contract value exceeds £500,000, where the Nominated Trust Procurement Officer shall be required to seek approval from two Board Directors to proceed with: (a) the opening of submissions, and (b) the evaluation of the tender	>£500,000 Two Board Directors			<£500,000 Procurement Officer		
3.2.1 Capital expenditure through non e-tendering (based on pre tender estimate) * independent senior manager must not be from the originating department	>£500,000 Two Board Directors			<£500,000 Director of Estates and Facilities + Independent Senior Manager *		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
3.2.2 Revenue Income or Expenditure through non E Tendering route (based on pre tender estimate) * independent senior manager must not be from the originating department	>£500,000 Two Board Directors			<£500,000 Procurement Manager + Independent Senior Manager*		
3.3 Accept lowest tender or quotation for capital expenditure from the approved capital programme Provided that any excess is reported to the Board of Directors	Board of Directors: >£2,000,000 and > 25% in excess of the approved sum	<£2,000,000 and < 25% in excess of the approved sum	<£500,000 and <10% in excess of the approved sum + Director of Estates and Facilities			
3.4 Accept the lowest tender or quotation for revenue expenditure or the highest for revenue income (Financial Limits as defined in section 2.1)		✓	✓	✓ Chief Officer	✓	✓
3.5 Accept other than the lowest tender or quotation for revenue expenditure or the highest for revenue income Provided that there are good and sufficient reasons that are set out in a permanent record, copied to the Procurement Department and available to the auditor at any time.		>£100,000	<£100,000 + Chief Officer	<£10,000 Chief Officer		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
3.6 Accept other than the lowest tender or quotation for capital expenditure from the approved capital programme Provided that any excess is reported to the Board of Directors and there are good and sufficient reasons that are set out in a permanent record, copied to the Procurement Department and available to the auditor at any time.	Board of Directors: >£2,000,000 and >25% in excess of sum approved	<£2,000,000 and <25% in excess of sum approved	<£500,000 and <10% in excess of sum approved in capital programme + Director of Estates and Facilities			
3.7 Waive quotations and/or tenders Provided that the price paid or received is fair and reasonable as far as practicable, and i. The procurement manager is consulted ii. competition for building and engineering or construction and maintenance is not waived (other than in accordance with ESTATECODE) iii. There must be good and sufficient reasons that are set out in a permanent record, copied to the Procurement Department and available to the auditor at any time.		>£100,000 + advice from Procurement Manager	<£100,000 + advice from Procurement Manager	<£10,000 Chief Officer + advice from Procurement Manager		
3.8 Agree prepayments falling outside the approved financial procedures			✓			
3.9 Receive, endorse and ensure the safe custody of tenders				Relevant director		
3.10 Decision to re-tender if number of tenders returned were lower than those required by 5.1				Relevant director		
3.11 Decide the admissibility of tenders e.g. if late		✓				
3.12 Decide to accept a lower number of quotations and/or tenders than those detailed in 5.1		✓				

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
4 ENGAGEMENT OF NON-NHS AND BANK STAFF (All limits include all taxes) **4.1 Engage non-medical consultancy staff** Financial Limits as defined in section 2.1. Provided that: i. the guidance from the Audit Commission is followed ii. the requirements for non-pay expenditure are fulfilled (section 2.0) iii. those engaged are not classified as self-employed unless they meet the criteria (by asking the Finance Director) and have signed a contract		✓	✓	✓ Chief Officer + Chief Finance Officer where necessary as per 4.1 (iii)	✓ + CFOr where necessary as per 4.1 (iii)	✓ + CFO where necessary as per 4.1 (iii)
4.2 Engage the Trust's solicitors Provided that the requirements for non-pay expenditure have been fulfilled (see section 2.0)				Chief People Officer, Company Secretary and Director of Estates and Facilities		
4.3 Book bank and agency staff Financial Limits as defined in section 4.1 Provided that the requirements for expenditure have been fulfilled (see Section 2.0)		✓	✓	✓ Chief Officer	✓	✓
5. AUTHORISATION OF DRUGS NOT LISTED ON FORMULARY **5.1 Prescribe drugs not listed on the Trust's formulary**				✓ Chief Pharmacist		
5.2 Add drugs to the Trust's formulary Provided that funds are available	Drugs and Therapeutics Committee					
5.3 Add drugs to the Trust's formulary where funds are not currently available		✓				

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
6. INCOME: SETTING FEES AND CHARGES **6.1 Set charges for patient services contracts**			✓ + Chief Officer			
6.2 Set all other prices Provided the Finance Director is consulted				Chief Officer + Finance Director		
7. INCOME: CONTRACTS, AGREEMENTS AND LICENCES **7.1 Prepare all tenancy agreements and licences for all staff**, subject to Trust policy on accommodation for staff				Director of Estates and Facilities		
7.2 Authorise contracts for income and subsequent variations for patient services			✓			
7.3 Authorise contracts for income and subsequent variations for all other contracts Financial Limits as defined in section 4.1 Provided that the contracts are in writing, and contracts over £500,000 in respect of building and engineering work are executed under the common seal		✓	✓	✓ Chief officer	✓	✓
7.4 Sign tenancy agreements and extend leases in respect of accommodation for staff: 7.4.1 for not more than one year and within the agreed policies, procedures and prices 7.4.2 over £1,000 per month or for more than 1 year, provided that leases over 3 years are executed under common seal			Chief Finance Officer & Company Secretary	Director of Estates and Facilities		
7.5 Let premises to outside organisations for no more than one year, provided that the price has been agreed with the Chief Finance Officer				Director of Estates and Facilities		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
7.6 Let premises to outside organisations for more than one year Provided that: i. the price has been agreed with the CFO ii. any change in use of the premises has been approved by the Board of Directors iii. for finance leases, the premises are not protected under the provider licence with NHS Improvement iv. leases over three years are executed under common seal	Board of Directors for 7.6(ii)	✓ + CFO	✓ + Chief Executive and Board of Directors for 7.6(ii)			
7.7 Set rent levels Provided that the Operations Director of Finance has been consulted				Director of Estates and Facilities		
8. CONDEMNING AND DISPOSING OF ASSETS All limits include all taxes and are based on replacement value **8.1 Condemn obsolete, redundant or irreparable assets or assets which cannot be repaired cost effectively** Provided that: i. a written request from the Chief Officer has been received ii. appropriate technical advice has been received iii. a record, in a form approved by the Operations Director of Finance, is held iv. the Operations Director of Finance has been notified in accordance with the capital assets procedure and the losses, write-offs and special payments procedure where appropriate.		>£100,000	<£100,000 and For 8.1(iii) and (iv)	>£30,000 Director of Estates and Facilities + CFO for (iii) <£30,000 + CFO for (iii)		<£5,000 + Assistant Director of Financial Services +CFOfor (iv)
8.2 Condemn obsolete, redundant or out of date drugs Provided that: i. the appropriate records are held ii. the requirements of EL(97)22 for controlled drugs are followed iii. where appropriate, the procedure for losses, write-offs and special payments is followed		>£150,000		<£150,000 Chief Pharmacist		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
9. LOSSES, WRITE-OFFS AND SPECIAL PAYMENTS Provided that relevant SFI has been considered **10.1 Novel, contentious and repercussive payments** The Chief Executive should consult the Treasury of any losses or special payments, irrespective of any delegated authorities passed to the Trust or the amount of money concerned if they: i. involve important questions of principle ii. raise doubts about the effectiveness of existing systems iii. contain lessons which might be of wider interest iv. are novel or contentious v. might create a precedent for other departments in similar circumstances vi. arise because of obscure or ambiguous instructions issued centrally	To be approved by the Board and HM Treasury		Ensure losses and special payments are reported to the Audit Committee			
10.1 Special Payments	To be approved by the Board. HM Treasury approval required for >£95k			Chief People Officer to seek approval from Board and HMT as necessary		
10.2 Special severance payments NHS bodies must obtain HM Treasury's explicit permission before making any staff severance payments that exceed legal or contractual obligations. There is no delegated authority to make any such payments, whatever the value.	To be approved by the Board and HM Treasury					
10.3 Gifts Transactions economically equivalent to free and unremunerated transfers of assets, including the loan of assets, sale of assets at below market value, and donations, other than gift limits covered under the Code of Business Conduct	>£250,000	< £250,000				

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
10.4 All other losses and special payments		>£100,000	> £10,000 < £100,000	< £10,000		
11. CAPITAL SCHEMES All limits include all taxes **11.1 Select architects, quantity surveyors, consultant engineers or other professional advisers within EU regulations**				Director of Estates and Facilities or Chief Information Officer		
11.2 Monitor and report financial progress on all capital schemes			✓ + Director of Estates and Facilities (Estates and medical equipment schemes) or Chief Information Officer (I.T. schemes)			
11.3 Approve the introduction of new schemes to, or the deletion of existing schemes from, the capital programme Provided that the cost can be contained within the approved capital programme and the changes are reported to the Board on a quarterly basis		>£1,000,000	<£1,000,000			
12. CHARITABLE AND ENDOWMENT FUNDS All limits include all taxes **12.1 Approve expenditure**	>£50,000 (NB designation of fund advisors required by Charitable Funds Committee)		<£50,000			<£5,000 Fund advisors
12.2 Negotiate arrangements regarding the administration of a will with executors and discharge them from their duty			>£150,000	Head of Charities up to £150,000		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
13. RESEARCH PROJECTS AND CLINICAL TRIALS **13.1 Authorisation of research projects or clinical trials involving patients**	Ethics Committee					
13.2 Notify the research directorate of all research projects and clinical trials being undertaken for inclusion in the central register				Chief Officer		
14. VARIOUS FINANCIAL MATTERS **14.1 Open and close bank accounts**			✓			
14.2 Maintain and update the Trust's financial procedures			✓			
14.3 Approve the Trust's investment policy (if extant)	Board of Directors					
14.4 Invest funds, including charitable funds, within the Trust's investment policy			✓			
14.5 Apply for temporary overdraft within the terms agreed with NHS England			✓			
14.6 Take out insurance policies			✓ + relevant director			
14.7 Approve business cases (based on gross annual income or gross annual expenditure) NB may be subject to additional lock procedures as imposed by NHSE	>£1,000,000 Board of Directors	<£1,000,000				
14.8 Engagement of Consultants (excluding capital projects)	<£50,000 Submit application for approval to NHS England		>£50,000			

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Board Effectiveness Review 2023							
Report to:	Board of Directors			**Date:**	3 August 2023		
Report of:	Company Secretary			**Prepared by:**	J Foote		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☒	**For information**	☐		

Executive Summary:

The purpose of the report is to provide an overview of the outputs from the Board and Committee effectiveness reviews for 2022/23, including areas of good practice and areas for future focus and improvement. An action plan is outlined in the main body of the report on focused areas of improvement during 2023/24.

The Board is asked to note for the record that it has discharged its responsibilities soundly and competently during 2022/23 and adopt the action plan to address areas identified for improvement.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☒	Deliver Value for Money	☒
		Fit For The Future	☒

Previous consideration

Contributions from the Board and Committees of the Board

1. Reflection on Board Effectiveness Discussion 3 July 2023

Following discussions on the collective effectiveness of the Board during the year 2022/23 and following scrutiny of the outcome of committee effectiveness during the year, the Board is content that it has discharged its responsibilities soundly and competently.

The following were highlighted as good practice during the year:

- Good team dynamic with a culture of open exchange between execs and non-execs
- Escalation and referral system allows for the timely dissemination of issues, concerns and good news
- There is an appropriate level of challenge and debate
- Board visibility programme re-introduced allowing for further engagement with staff outside formal meeting environment
- Hybrid meetings maximises engagement

Areas for future focus and improvement:

- Reports could be formatted better to allow for information to be presented succinctly. Reports need to contain required information only (and this could be managed better within the report format). Often there is a disconnect between the report cover sheet and the body of the report. *Also highlighted as part of the GGI review*.
- The regulatory requirements for presentation of certain reports often 'crowds out' the agenda, leaving little time for strategic discussion
- Reports should only be designated as part II for a valid reason (based on the exemptions in either data protection law or the Freedom of Information Act). More time could be spent within the Part I agenda for forward looking items
- How can the Board show that it is aware of governor concerns and issues

2. Action Plan

	Area of Focus	Action	Owner	By when
1a	Board and committee papers need to contain the level of operational detail which is appropriate for this audience *(GGI report)*.	Review of report structure and format to ensure the balance between assurance and information included. (*GGI)*	Board (CoSec)	January 24
1b	Appendices and additional information needs efficient management.	Explore an appropriate approach to managing the volume of information required to provide assurance supporting the paper presentation. *(GGI)*		
1c	Disconnect between cover report and body of reports.	Cover report sheet to be reviewed and redrafted template established		
2	The regulatory requirements for presentation of certain reports often 'crowds out' the agenda, leaving little time for strategic discussion	Review cycle of business to ensure time is allowed at each meeting for strategic focus	Chair & CoSec	March 24

3a	Reports should only be designated as part II for a valid reason (based on the exemptions in either data protection law or the Freedom of Information Act).	Draft a protocol for the designation of items as PII	CoSec	October 23
3b	More time could be spent within the Part I agenda for forward looking items	Review cycle of business to ensure that this is allowed where possible. Protocol at 3a to ensure that PI discussion is as standard.		
4	How can the Board show that it is aware of governor concerns and issues	As part of the planned CoG review consider how information can flow between CoG and Board. Recognising that this may be through routes other than discussion at Board meetings	Chair	January 24

3. Financial implications

None

4. Legal implications

None

5. Risks

The annual review of effectiveness mitigates against stagnation in corporate governance and focus on the culture of continuous improvement.

6. Impact on stakeholders

Positive impact through improved effectiveness.

7. Recommendations

The Board is asked to note for the record that it has discharged its responsibilities soundly and competently during 2022/23 and adopt the action plan to address areas identified for improvement.