Board of Directors

1 February 2024 | 1.00pm | Lecture Room 3, Education Centre 1, Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, Lancashire, PR2 9HT

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	P White
2.	Apologies for absence	1.01pm	Verbal	Information	P White
3.	Declaration of interests	1.02pm	Verbal	Information	P White
4.	Minutes of the previous meeting held on 7 December 2023	1.03pm	✓	Decision	P White
5.	Matters arising and action log update	1.04pm	✓	Decision	P White
6.	Chair's opening remarks and report	1.05pm (5mins: Pres)	✓	Information	P White
7.	Chief Executive's report	1.10pm (15mins: Q&A)	✓	Information	S Nicholls
8.	Staff Story: Clinical Health Psychology Service	1.25pm (10mins: Pres) (10mins: Q&A)	Pres	Assurance	Dr C Jefferson
9.	Board Assurance Framework	1.45pm (10mins: Disc)	✓	Decision	S Regan
10.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
10.1	Safety and Quality Committee Chair's Report	1.55pm (10mins: Q&A)	✓	Information	K Smyth
10.2	**Report recommended for assurance**: (a) Health and Safety Annual Report	2.05pm (10mins: Q&A)	✓	Assurance	S Cullen
10.3	Maternity and Neonatal Services report	2.15pm (10mins: Q&A)	✓	Assurance	J Lambert
11.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
11.1	Education, Training and Research Committee Chair's Report	2.25pm (10mins: Q&A)	✓	Information	P O'Neill
11.2	Workforce Committee Chair's Report	2.35pm (10mins: Q&A)	✓	Information	J Whitaker
11.3	**Report recommended for approval**: (a) Gender Pay Report	2.45pm (10mins: Q&A)	✓	Decision	N Pease
	Report recommended for assurance: (b) Equality, Diversity and Inclusion Annual Report 2022-23	2.55pm (5mins: Q&A)	✓	Decision	N Pease
12.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
12.1	Charitable Funds Committee Chair's Report	3.00pm (10mins: Q&A)	✓	Information	K Smyth
12.2	Finance and Performance Committee Chair's Report	3.10pm (10mins: Q&A)	✓	Information	T Whiteside

№	Item	Time	Encl.	Purpose	Presenter
12.3	Integrated Performance Report as at 31 December 2023 including Finance update *(considered by appropriate Committees of the Board)*	3.20pm (5mins: Pres) (10mins Q&A)	✓	Assurance	I Devji
13.	**GOVERNANCE AND COMPLIANCE**				
13.1	New Hospitals Programme – Governance and Assurance	3.35pm (5mins: Pres)	✓	Decision	J Foote
14.	**ITEMS FOR INFORMATION**				
14.1	Risk Management Strategy		✓		
14.2	New Hospitals Programme Q3 Report		✓		
14.3	Register of Interests		✓		
14.4	Date, time and venue of next meeting: *4 April 2024, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital*	3.40pm	Verbal	Information	P White

Board of Directors

7 December 2023 | 1.00pm

Lecture Room 1, Education Centre 1, Royal Preston Hospital

Part I

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

Mr U Patel				P	P	
Mr M Wearden	A	A	P	P	P	
Mr P Wilson	A	P	A	A	A	

P – present | **A** – apologies | **D** – deputy | **V** – virtual | ** 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)*

- *Professor P O'Neill was Interim Chair up to and including 31 July 2023 and chaired the August meeting*
- *Mr P White appointed permanent Chair with effect from 1 August 2023*

Governors in attendance: S Brennan, S Heywood, J Miller, and P Spadlo

Observers in attendance: J Lambert, Deputy Divisional Director of Nursing and Midwifery

IN ATTENDANCE TO PRESENT THE PATIENT STORY (Minute ref 209/23)	
Andrea Hardyman	Mental Health Safeguarding Practitioner
John Howles	Associate Director of Patient Experience and Engagement
Maulbrey Mugani	Head of Safeguarding

IN ATTENDANCE TO PRESENT THE BOARD ASSURANCE FRAMEWORK (Minute ref 210/23)	
Simon Regan	Associate Director of Risk and Assurance

IN ATTENDANCE TO PRESENT THE MATERNITY AND NEONATAL SERVICES REPORT (Minute ref 215/23)	
Emma Ashton	Divisional Director of Midwifery and Neonatal Nursing

202/23 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.

203/23 Apologies for absence

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

204/23 Declaration of interests

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

The Chair made a general declaration in respect of his role as Chair of the North West Ambulance Service.

205/23 Minutes of the previous meeting

The minutes of the meeting held on 5 October 2023 were approved as a true and accurate record.

206/23 Matters arising and action log

There were no matters arising and the updated action log was noted.

207/23 Chair's opening remarks and report

The report provided a summary of work and activities undertaken during October and November by the Trust Chair including a resume of the items discussed in the part II Board meeting on 5 October and the two special part II Board meetings in November.

Reference was made to Disability History Month which was taking place from 16 November to 16 December 2023 and, in recognition and support of the UN International Day of Persons with Disabilities held annually on 3 December, Board members either wore something purple or displayed a purple lapel badge. Board members acknowledged the work of Non-Executive Director K Smyth in this arena.

The Chair also paid tribute to Faith Button as this would be her final meeting as Interim Chief Executive prior to Silas Nicholls taking up the substantive role in the new year and Board members acknowledged Faith's contribution during the last three months.

In response to a question regarding the Trust's structured plan for artificial intelligence, the Chief Information Officer described the projects being undertaken in relation to robotic process automation.

208/23 Chief Executive's report

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

Board members recognised the exceptionally difficult environment in which colleagues were working and passed thanks to all colleagues for their dedication and support to patients. At this point, the Interim Chief Operating Officer provided an overview of the up-to-date performance position including progress with virtual wards.

209/23 Patient Story: LeDeR and the Learning Disability Strategy

The patient story related to a patient with learning disabilities and the care they received at Royal Preston Hospital including feedback shared through LeDeR (Learning Disability Mortality Review).

The Mental Health Safeguarding Practitioner read 'Brenda's Story' which focused on the support provided to the patient who needed urgent dental care although was terrified of being in an unfamiliar environment and of receiving any kind of dental treatment. Over the course of many visits to Royal Preston Hospital, the Special Care Dentistry team built trust and confidence, ensuring Brenda was familiar with the department and its staff and clear on the care she would receive. This gentle, measured approach meant that Brenda was able to receive good oral care which in turn contributed to her overall wellbeing and comfort. Although Brenda passed away due to other health issues, the compassionate care she received made a huge difference to both her experience and that of her family.

The team also took the opportunity to share the wider Learning Disability Plan 2023-26 and the good progress that had been made particularly around transition services. The Interim Chief Operating Officer offered to link with the Safeguarding team outside the meeting to discuss broader issues for learning disability patients in areas such as the emergency department and the experiences from a patient perspective.

Discussion was held regarding whether the Trust's preference was to have patients present at the hospital in consideration that it could be more comfortable for patients in their own home or local environment. It was recognised that patients were offered choice and colleagues considered all options and had, on occasion, visited patients in their own home.

The Board thanked members of the Safeguarding team and asked that their gratitude be extended to the Special Care Dentistry team for their care and compassion in treating Brenda which family members had been keen to recognise.

210/23 Board Assurance Framework

The report provided details of risks that might compromise the achievement of the Trust's high level strategic objectives. It was noted that the risks were scrutinised by Committees of the Board and the strategic risks detailed in appendix 2 were those that had been presented to Committees or had been reviewed in preparation for the next Committee meeting at the time the Board report was produced. It was confirmed that there had been no changes to the risk scores since the October Board meeting save for the decrease in score for the strategic aim to Drive Innovation through World Class Education, Training and Research which had reduced from 20 to 16 following review by the Education, Training and Research Committee. Three operational risks remained escalated to the Board relating to exit block (risk ID 23); elective restoration (risk ID 1125); and ongoing strike action (risk ID 1182). A copy of the national IPC BAF had been appended to the report at appendix 3 for information.

Discussion was held regarding the risk profile and whether there was balance in terms of where the Trust was redeploying its resources. It was noted that discussions were held between Executive Directors regarding how priorities were set and consideration of moving resources across the organisation to mitigate risk when the need arose. However, a wider Board discussion on the risk profile may be required at a future date.

The Board RESOLVED that the updates to the Board Assurance Framework be approved.

211/23 Annual Plan 2023-24

The report provided assurance on the Trust's progress against the 31 national NHS ambitions outlined in the 2023-24 priorities and operational guidance published on 23 December 2022. The final plan was adopted by the Board at the June 2023 meeting where a request was made for a progress update at the December Board meeting. It was noted the Board and Committees of the Board received regular updates with regards to performance against national targets and ambitions with the report presented bringing those updates together in a brief summary to provide assurance around compliance and achievement against both the current position and forecast achievement for the year against the metrics. An overview of the Trust's compliance or achievement of the national ambitions by area was presented.

Discussion was held regarding whether there was confidence that the plan would be achieved given the ongoing pressures. Consideration could be given to providing more details on outcomes to assist Board members in understanding whether progress was being made with the plan which would in turn provide confidence on delivery.

The Board confirmed its assurance regarding the delivery of the 2023-24 Annual Plan.

212/23 Clinical Services Strategy

The report presented the refreshed Clinical Services Strategy and sought approval to bring forward the work to early 2024 to develop a new Strategy owing to the material changes in a range of key areas such as the impact of Covid, the financial context, and the level of collaborative and system working.

Clarification was requested on whether a point would be reached where the Clinical Services Strategy was at ICS rather than Trust-level. It was explained that as an organisation there would always be a need for a strategy to be developed at local level although there was ambition to develop a joint approach and the ICB and Place strategy was currently being worked on.

The Board RESOLVED that the decision to bring forward the development the new Clinical Services Strategy to early 2024 be approved.

213/23 Social Value Strategy

The report provided an update on the Trust's Social Value Strategy, summarising progress to date with the social value accreditation quality mark and laying out the intended future actions as part of the Trust's aim and commitment towards anchor institution status as outlined within the Trust's overarching strategy, Our Big Plan. An outline of the contents was provided as detailed in the executive summary.

Board members recognised the positive links between social value and anchor institution status to help with improving population health and health inequalities.

214/23 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee meetings on 29 September and 27 October 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:

- An update on the implementation of the Patient Safety Incident Response Framework (PSIRF) which was a key component of the new National Patient Safety Strategy to replace the NHS Serious Incident Framework. The Committee was assured of the actions taken to commence the transition to PSIRF with effect from 6 November 2023 and would monitor implementation through regular update reports.
- The national Picker Adult and Urgent and Emergency Care Survey 2022 including comparisons between the data submitted for the last surveys undertaken in 2020.
- The findings of the Trust's bi-annual maternity staffing review triangulating workforce information with safety, patient experience, and clinical effectiveness indicators to provide assurance of safe staffing levels.
- The bi-annual update on progress against the Always Safety-First Strategy (2021-24) as at the end of year 2.

Clarification was requested on the process for PSIRF in terms of engagement and involvement of patients and families and how the outcome of a review was

communicated back to patients or family members. It was explained that PSIRF had launched on 6 November 2024 and the initial round of reviews had commenced. By the next quarter the Board should see a different reporting structure which would clearly evidence how incidents were managed.

Discussion was held regarding the current arrangements for boarding patients and any risks that were considered. The Chief Nursing Officer explained that the arrangements had been introduced taking into account occupancy levels in the emergency department. There was a robust standard operating procedure in place and daily checks were undertaken to ensure patient safety. There were other risks in relation to boarding patients, such as infection prevention and control. It was recognised that the position was not ideal but that occupancy levels were driving the need to board patients.

215/23 Maternity and Neonatal Services Report

The report provided an update in relation to the safety and quality programmes of work within the maternity and neonatal services up to and including 15 November 2023. The report detailed progress against work streams relating to the ten Clinical Negligence Scheme for Trusts (CNST). The Divisional Nursing and Midwifery Director jointed the meeting and provided an overview of the contents including other high level service updates.

The Board noted the service was compliant with nine out of ten of the year 5 CNST safety actions with standard 6 (Saving Babies Lives Care Bundle version 3) at risk as a decision was awaited on the funding request for essential equipment. An overview was provided on the Maternity Incentive Schemes Collaborative Advisory Group meeting and discussions on the pressures being experienced from ongoing industrial action, the associate impact on the Trust's ability to meet safety action 8, and application of the rebased target to 80% compliance from December 2022 to December 2023. Training performance for PROMPT continued to be negatively impacted by industrial action however overall training performance had recovered with additional training and teaching sessions and as a result all staff groups had achieved at least 90%, with Gap and Grow being the only training parameter below 90% (actual 85%). The current staffing pressures and gaps within both midwifery and neonatal services were outlined along with the impact on antenatal booking performance, continuing inability to accept all intrauterine transfers, and high levels of red flag reporting. The Chief Finance Officer was progressing discussions with the ICB to attempt to secure funding to resolve the staffing challenges. Since September 2023 five incidents within maternity services had been referred to the Maternity and Newborn Safety Investigation Programme (formerly HSIB) for consideration of external investigation in accordance with the referral criteria and a decision had been taken to undertake a thematic review supported by an external consultant obstetric professional. A range of action plans were appended to the report for information, oversight and assurance. In particular, the Maternity and Neonatal Voices Partnership workplan had been jointly approved and was attached as appendix 6 for approval prior to being shared with the ICB.

Discussion was held regarding the gaps in the workforce including whether it would be possible for nurses to re-train as midwives. It was explained that it was not possible for nurses to undergo conversion and they would need to be on the appropriate area of their professional register. It was recognised that midwifery was a shortage specialty and the service was constantly out to recruit through a number of different routes in order to attract people into the profession. Discussion was also held regarding whether

the Trust offered bursaries and it was confirmed that such grants were open to individuals in the Trust although there had been minimal interest to date. It was also noted that international recruitment had paused and whilst that would assist the financial risk the pause would create other risks in terms of staffing levels.

Reference was made to the five incidents referred to the Maternity and Newborn Safety Investigation (MNSI formally HSIB) programme since September 2023 and clarification was requested on how the position compared to previous years. It was explained that this appeared to be a unique cluster of incidents and a local review had been undertaken. A decision had also been taken to commission an external review which would be undertaken by a Consultant Obstetric Nurse and an update would be provided to the Safety and Quality Committee once the external review had been completed.

The Board RESOLVED that the following be approved:

1. **the CNST update report, with the risks to delivery of all ten CNST safety actions acknowledged.**
2. **the associated action plans provided assurance.**
3. **the Maternity and Neonatal Voices Partnership workplan.**

216/23 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee meeting on 8 November 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:

- Scrutiny of the core skills training report which showed compliance rates for appraisal and medical device compliance as 88.6% and 86.19% respectively against a trajectory of 90%. Overall, six mandatory training metrics were currently below compliance and one new training module had been added to the mandatory group in September 2023.
- The education quality surveillance report provided an update on the NHSE (NW) quality intervention visit on 5 and 7 July 2024 along with an update on progress made against the 2023 General Medical Council national training survey. It was noted that the survey had identified several specialties with poor results in the GMC survey.
- Endorsement of the Health Education England (HEE) annual self-assessment report for placement providers which was submitted on 31 October 2023.
- The Research and Innovation Strategy 2022-25 interim review report updating on progress within research and innovation which highlighted the direction of the department whilst managing financial turnaround and identified some of the departmental, Trust and system-wide barriers, University interactions, and limitations on the innovation agenda.
- The annual Education Showcase focusing on some of the key successes, achievements and challenges during 2022-23. Upcoming developments were also presented alongside the intended full refresh of the Education and Training Strategy.
- Scrutiny and endorsement in principle of the PACCAR draft business case relating to the proposed Technology Enhanced Learning Centre development in Education Centre 3, Chorley and South Ribble Hospital.
- Review of the education and training annual income and expenditure accounts as at the year-to-date and the full year forecast for 2023-24.
- Review of the strategic risk score and recommendation to reduce from 20 to 16.

217/23 Workforce Committee Chair's report

The Chair's report from the Workforce Committee meeting on 14 November 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 the absence of the Committee Chair, Non-Executive Director V Crorken provided an overview of the report and key highlights included:

- Scrutiny of the workforce and organisational development integrated performance report including key metrics and improvements, and continued areas of challenge.
- The increasing number of cases of violence and aggression although the positive work on the Big Room initiative was acknowledged.
- An update on the Trust's rostering strategy with particular focus on nursing and medical rostering, and grip and control.
- An overview of workforce transformation and cost efficiency including an overview of current multiple assessments and audits undertaken, and cost improvement programme checklists that had been completed.
- A review of the progress made to deliver the AHP Strategy during the past year.
- An update on the Corporate Services Collaborative programme.
- An overview of the annual medical employee relation cases during the period October and November 2023 for senior medical and dental employees.
- Scrutiny of the Leadership and Management Development Strategy report and progress to date against the Our People Plan strategic aim to be well led including the associated impact measures.
- An update on the engagement and recognition strategic aim with acknowledgement of the progress made during the year.
- Review of the Guardian of Safe Working report providing assurance that junior doctors had been safely rostered within the Trust and were working hours that were safe and in line with the new safe working rules as set out within the 2016 contract.
- Review of the strategic risk and agreement that the risk score should remain at 16.

Attention was drawn to the Corporate Collaboration Programme (One LSC) and discussion was held regarding whether there was assurance of equity across the programme and for posts being advertised. In terms of the Executive level posts for One LSC, the Managing Director had been advertised to date and other senior roles would be advertised in due course with a full information pack to ensure open and competitive recruitment was followed.

Discussion was held regarding violence and aggression incidences within the Trust and it was noted the zero-tolerance policy was held within security rather than within the People Directorate. The Chief People Officer confirmed that the policy was currently being reviewed and further information would be presented to the Workforce Committee when available.

218/23 AHP Workforce Strategy

The report provided information on progress made against the 10 themes within the Trust's Allied Health Professional (AHP) Workforce Strategy 2022-25. The Board noted that of the 24 objectives expected to be achieved during year 1, 18 had been achieved in full and the remaining six had been partially achieved and continued to be actively worked upon.

Board was reminded that in June 2024, NHSE launched the 'NHS Long Term Workforce Plan' containing similar aims to those outlined in the Trust's AHP Workforce Strategy with a focus on sustainable workforce supply to improve patient care, retention, and recruitment. There was also specific focus on AHP apprentices in the national strategy which complemented local ambitions. An outline was provided of the highlights from the first year. The Board was advised that the overarching aim of the strategy was to influence supply/retention and in turn reduce vacancies and an outline of the vacancy position was provided by professional group from April 2021 to September 2023. Areas of concern related to occupational therapy and dietetics and would remain areas of focus for the next 12 months.

A question was raised regarding how the Trust was working with the ICB and ICS on the AHP strategy. It was explained that there were some highly specialist roles, such as orthotics, neonatal psychology and speech and language therapy, and work was being undertaken within the network to look at hub and spoke models. Discussion was also held regarding whether potential opportunities were looked at for people with specific skills when recruiting, for example drivers with the skills to drive an ambulance. The Chief People Officer advised that the Workforce and OD teams had started to discuss the graduate entry programme and career opportunities and the ideas discussed today would be taken into those discussions with a report presented to the Workforce Committee in due course.

The Board RESOLVED that:

1. **progress during year 1 of the AHP Workforce Strategy be acknowledged.**
2. **an update on the strategy be presented in 12 months' time.**

219/23 Guardian of Safe Working Report

The report was presented to provide assurance that junior doctors were safely rostered within the Trust and working hours that were safe and in line with the new safe working rules as set out in the 2016 contract. The report covered the period 1 July to 30 September 2023 and an overview of the contents was provided by the Chief Medical Officer.

Attention was drawn to section 2.3 relating to guardian fines to potentially be applied to the exceptions in plastic surgery due to breaches in 48 hours and 5 hours continuous rest overnight although such fines had yet to be confirmed. The Chief Medical Officer advised that the application of fines had not happened in the past and this was being investigated with the outcome reported back to the Workforce Committee. The Board would receive an update on the outcome through the Committee Chair's report.

The Board confirmed its assurance that the issued identified within the report were being addressed by the relevant specialties/departments, through escalation of the concerns to the appropriate teams by the work of the Guardian of Safe Working.

220/23 Finance and Performance Committee Chair's report

The Chair's reports from the Finance and Performance Committee meetings on 25 September and 23 October 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.

The Board noted there was good assurance around process and a good understanding on what actions were required to bring the Trust into financial balance although there was a need to determine how that plan would be delivered. It would be critical for a forward-looking plan to be produced including a longer-term view to ensure financial sustainability in future years.

221/23 Integrated Performance Report as of 31 October 2023

The integrated performance report as of 31 October 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 were highlighted from each of the key ambitions in addition to those already reported by respective Committee Chairs.

Reference was made to the junior doctors strikes recently announced and clarification was requested on the Trust's plans. The Chief Medical Officer confirmed that detailed planning would be undertaken over the coming weeks. It was confirmed that there would be a negative effect on clinical activity during the periods of industrial action.

Discussion was held regarding whether anything additional could be escalated with GP colleagues as part of the Engineering Better Care programme and the work being undertaken as part of Place-based forums was described. The Trust was also working with the ICB on the front door model and urgent care services.

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

222/23 CQC 2023 Inspection Report

The report provided a summary of findings from the Care Quality Commission's (CQC) Inspection undertaken during the period May to July 2023. The CQC published their findings on 24 November 2023 and a copy of the report was attached as appendix 1 with a letter summarising next steps. An overview was provided of the areas inspected; findings and ratings; the rationale for ratings' information on a letter of concern and letter of intent issued during the inspection of urgent and emergency care; an overview of outstanding and good practice; and recommendations and next steps.

The Board expressed its disappointment with the outcome of the 2023 CQC Inspection particularly the downgrading of the Chorley and South Ribble Hospital to Requires Improvement. However, it was important that the Trust moved forward and adopted the recommendations and delivery plan at pace. A question was raised regarding how the issues for improvement would be targeted, i.e. by area or by recommendation. The Board was advised that there were some transactional must and should do recommendations although there were also some long-standing issues that must be addressed, such as compliance with mandatory training targets. There were also some must/should do recommendations where improvement would not be feasible, such as those relating to the Trust's estate, and those would need to be carried as a risk. It was intended to work through the recommendations on a targeted basis.

It was suggested that it would be helpful to have visibility of the overarching improvement plans and the Chief Nursing Officer confirmed that the Trust's response to

the CQC Inspection report, including the action plan, would be circulated to Board members by the end of the week. The action plan would include identified leads for each recommendation and progress on the action plan would be monitored through the Safety and Quality Committee. The Board was also informed that internal and external communications had been developed and an invitation had been extended to stakeholders to discuss the inspection findings: to date, two local MPs had taken up the offer of feedback.

Discussion was held regarding staff morale and how the outcome of the inspection had been received. It was noted that for Chorley, the aggregated scoring showed two ratings to be poorer leading to the downgrading and staff had communicated their disappointment. For Preston, there were some positives regarding the feedback although recognition that improvements needed to be delivered. Overall, whilst there was disappointment in the outcome, staff felt the inspection report was a fair reflection.

The Chair noted that the caring domain had not changed since the last inspection which was positive. In terms of the safety domain and the downgrading in some areas, the Board would want to see the improvement actions as soon as possible including timescales for delivery: the Chief Nursing Officer confirmed this would be included in the document to be circulated this week.

The Chair reiterated the commitment to address all the actions that needed to be undertaken as outlined in the report. Board members also noted the many areas of outstanding and good practices which were highlighted in the report and supported the view that the organisation must not lose sight of that when focusing on addressing the areas where improvements were needed.

223/23 Items for information

The Board received the Q2 report on the New Hospitals Programme for information.

224/23 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 1 February 2024 at 1.00pm, onsite venue to be confirmed.

Signed: _____
Chair

Date: _____

Action log: Board of Directors (part I) – 7 December 2023

There are no outstanding actions from previous meetings.

COMPLETED ACTIONS ***(for information)***

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	211/23	5 Oct 2023	*Risk Management Strategy (2023-26)* – strategy to be updated to provide greater clarity on the control framework (as agreed at the Audit Committee meeting on 21 September) and be included on the Board agenda in February.	Associate Director of Risk and Assurance	1 Feb 2024	**Completed** **Update for 1 February 2024** – Risk Management Strategy included on the agenda for information.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chair's Report			
Report to:	Board of Directors	**Date:**	1 February 2024
Report of:	Chair of the Trust	**Prepared by:**	Peter White/Rebecca Black
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 December and January by the Trust 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

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken during December and January.

Chief Executive
Silas Nicholls joined the Trust on the 8th January 2024 and will continue to meet colleagues and visiting departments over the coming weeks as a priority. I look forward to working with him and am sure that his knowledge and previous experience will be an asset to the Trust as we continue to improve the care we give to patients and their families.

Non-Executive Director – Term of Office
I am pleased to confirm that Tim Watkinson has been appointed by Council for his final year in office (subject to a satisfactory appraisal).

Governor – Term of Office
At the last Council of Governors meeting held on Tuesday 23rd January I thanked Lynne Lynch on behalf of the Board, for her commitment to the Trust during her 9 years tenure of service as a governor.

University of Bolton
Following a recommendation from the University Professorial Readership Committee at the University of Bolton, Silas has been awarded the title of Professor of Leadership and Healthcare Management to the Institute of Medicine within the University.

Provider Collaborative
As the Provider collaborative has developed, it now moves into greater collaborative system transformation, so we are now going to review governance, engagement and communication processes.

Council of Governor Elections
Council of Governors elections are underway with the outcome expected at the end of March.

Chair Tenure
Colleagues will recall that on my appointment in August 2023 I agreed with Council that this would be subject to a six month review. I can confirm that this has now been undertaken by the Nominations Committee and Council has therefore ratified its original decision from August for a term of office for three years.

Part II Board of Directors' meetings – 7 December 2023

The items discussed at the December part II Board meeting are outlined below along with a brief resume of the discussions.

1. **Joint Committee Provider Collaborative Board (JCPCB) Terms of Reference** – the Board received and approved the updated JCPCB Terms of Reference.
2. **New Hospitals Programme** – the Board received an outline of key points and the approach to be taken to the draft business case along with an update on next steps.
3. **Contract Award** – the Board approved the award of a contract to support the SNSDE Programme.
4. **Financial Recovery and Transformation Programme** – the Board received an update on the Trust's Financial Recovery Plan and risk adjusted financial forecast for the year as at month 7 (October 2023), which was a follow-on discussion from the Special Board meeting on 22 November..
5. **Finance Deficit Protocol** – the Board received and approved the formal change to the forecast for 2023-24 for submission to NHS England.
6. **Emergency Preparedness Resilience and Response (EPRR) Assurance 2023**-24 **–** following the new check and challenge process adopted by NHS England Northwest for the EPRR core standards annual assurance review, the Board approved the Trust's submission.
7. **Lancashire Hospitals Services (LHS) Ltd** – the Board approved the appointment of the substantive Chief People Officer as a Director of the LHS subsidiary.
8. **Maternity Serious Untoward Incidents** – the Board received the report in line with Ockenden recommendations.
9. **Minutes of meetings** – the Board received copies of relevant approved minutes from meetings of Committees of the Board.

2. Chair's attendance at meetings

a. Details below are the meetings attended and activities undertaken during October and November 2023.

Date	Activity
December 2023	
30th November	Provider Chairs
30th November	Patient Safety Training for the Board
30th November	NED Briefing
30th November	1:1 – Chair, UHMB
30th November	1:1 – Lead Governor
1st December	1:1 – Non-Executive Director

4th December	Race Equity in Health Conference
5th December	Corporate Governance Working Group
5th December	1:1 – Chief People Officer
5th December	1:1 – Interim Chief Executive
5th December	Board Pre-Meeting
7th December	1:1 Chief Executive, Wrightington, Wigan & Leigh
7th December	Non-Executive Director/Company Secretary Meeting
7th December	Board of Directors
8th December	1:1 Company Secretary
8th December	1:1 Cllr A Bradley
8th December	Provider Collaborative Live Communications Briefing
8th December	NHP Meeting
11th December	Election Filming
12th December	1:1 System Collaborative Business Manager
12th December	NW System Leaders Call
12th December	Provider Chairs Meeting
19th December	1:1 Integrated Place Leader – Central Lancashire)
19th December	1:1 Chair, UHMB
19th December	Provider Chairs Meeting
19th December	System Recovery and Transformation Board
20th December	Chairs, Deputy Chairs and Lead Governor Meeting
20th December	Board Agenda Setting
20th December	NHS Strategic Oversight Group
20th December	Visit to Children's Ward
20th December	1:1 Company Secretary
20th December	1:1 Chief Executive
January 2024	

9th January	Provider Chairs Meeting
16th January	Nominations Committee
16th January	ARTE Committee
18th January	Provider Collaborative Board Meeting
22nd January	1:1 Chief Executive
22nd January	Governor Election Workshop
22nd January	1:1 Company Secretary
23rd January	Council of Governors
23rd January	1:1 Non-Executive Director
23rd January	1:1 Chair, UHMB
25th January	1:1 Non-Executive Director
25th January	Provider Collaborative System Meeting
25th January	1:1 System Collaborative Business Manager
25th January	Governor Election Workshop

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

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

6. Impact on stakeholders

c) 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

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	1 February 2024
Report of:	Chief Executive	**Prepared by:**	Naomi Duggan, Director of Communications and Engagement
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to update the Trust Board on matters of interest since the previous meeting.

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 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

Not applicable

CHIEF EXECUTIVE'S REPORT

This is my first Board meeting since joining the Trust as Chief Executive Officer on 8 January 2024, and I would like to thank colleagues for the warm welcome I have received since taking up my new role. In particular, I would like to thank Faith Button, who stepped up from her substantive role as Chief Operating Officer (COO) to become Interim CEO following the departure of former CEO Kevin McGee in September 2023 during what was an exceptionally busy period, and who has supported me over the last few weeks. I must also congratulate Faith on her appointment to an exciting new role as Chief Delivery Officer within the Birmingham and Solihull Integrated Care Board (ICB) which she is due to take up shortly. I know that colleagues throughout the Trust will join me in thanking Faith for her service and in wishing her well for the future.

My thanks also to Imran Devji who continues with us in his role as Interim Chief Operating Officer. The recruitment process for the substantive COO post has been agreed at our Appointment, Remuneration and Terms of Employment (ARTE) Committee and will commence shortly.

In common with partners across Lancashire and South Cumbria, the Trust's financial and operational position remains an exceptionally challenging one and we continue to strive to improve this for our colleagues, patients and the wider communities we serve.

Since the last Board meeting there have been two further periods of junior doctor industrial action between 20 - 23 December 2023 and 3 – 9 January 2024. These were particularly challenging coming either side of the busy Christmas period which always sees high demand for NHS services. The contingency plans that had been put in place helped to mitigate the impact of the strikes in relation to patient care, however inevitably there was some disruption to the elective recovery programme and patient waiting times and experience, although the Trust has remained amongst the top performers in the region for ambulance turnaround times. I would like to thank all our colleagues for their hard work during this period, and our communities for bearing with us as we understand how distressing and frustrating delays to treatment can be. We do of course support the right of colleagues to take industrial action but sincerely hope that a mutually agreeable solution can be found in the very near future.

January has also seen periods of very cold weather and at the time of writing we are experiencing severe storms and amber weather warnings which may be contributing to the current exceptionally high demand for our services. This situation is replicated across the health and social care system in Lancashire and South Cumbria and NHS communication teams across LSC have been working together to deliver a winter communications and engagement plan to provide consistency, reduce duplication in planning and preparation, prepare content and amplify messages to help keep our communities informed about the best ways to access services and keep well during winter.

In addition, work continues to reduce our lengths of stay, to ensure that we get our patients back home or to their most appropriate place of care as quickly as possible. There are lots of reasons why patients experience delays, and in order to address this, we need to be able to identify the largest bottlenecks, and focus on improving them. The Trust is currently testing a digital patient flow system in ten wards which aims to provide data to identify our biggest constraints and better synchronise care for patients. We are already seeing positive results in this pilot and will be assessing the benefits of scaling up this approach across the whole trust.

In respect of our finances, the Trust is now focusing on meeting its agreed year end deficit of £51.5million, as well as planning ahead for the new financial year. A three year financial plan and single Improvement Plan are also under development. Whilst this is a particularly challenging time for our finance community, we are clear that this is a whole Trust responsibility. Colleagues need to ensure that they are following the appropriate processes to reduce spending whilst ensuring that our services remain safe, we deliver value for money and of as a high a quality as possible. We have a robust Equality and Quality Impact Assessment (EQIA) process to ensure that we fully review and understand any impacts of decisions we make to minimise the impact on patient outcome and experience. Given our staff are the experts in what they do, we have recently adapted a system wide campaign called "It All Adds up" and launched this across the Trust to encourage people to share their ideas about how we can reduce waste and improve our services across our hospitals.

In preparation for new hospital builds in our area under the New Hospitals programme a number of colleagues joined system wide partners on a two-day Great Ormond Street Hospital Building Blocks for Clinicians course at Lancaster University's Health Innovation Campus and the new Royal Liverpool University Hospital, giving valuable insight colleagues on the importance of clinicians being involved in redevelopment and enabling us to learn from the experiences of another recent rebuild which will inform our own thinking.

Despite the challenges described there has been much to celebrate within our hospitals over the last two months. In the run up to Christmas we were delighted to receive the support of Preston North End footballers who visited our Children's Ward and Super League Champions Wigan Warriors who visited Ribblesdale ward, both at Royal Preston Hospitals and both armed with gifts and other goodies for our patients who were delighted to meet them. We celebrated the Royal College of Nursing's Support Workers Day for the first time which recognised the fantastic work done to support excellent care within the Trust, during which managers nominated healthcare assistance and support workers who had gone above and beyond in their roles. We also held the Undergraduate Medical Teaching Awards 2022/23 at the Lecture Theatre in Preston, which was a special ceremony to acknowledge the work that takes place in medical education, recognising outstanding contributions from both teachers and students.

In terms of patient safety, it was great to see that both Royal Preston Hospital and Chorley and South Ribble Hospital received an award for their commitment to this from the National Joint Registry which monitors the performance of joint replacement procedures to improve clinical outcomes for the benefit of patients. The 'NJR Quality Data Provider' certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety and to reward those who have met registry targets. In addition, our Sterile Services department passed a recent ISO external audit with flying colours. This is a very specialist service – their decontamination department manages all risks associated with health care acquired infections (HCAI) in the reprocessing of reusable medical devices. Staff working in sterile services are responsible for ensuring that reusable medical devices, such as instruments and equipment are cleaned, sterilised, and repackaged to high standards, ready for reusing in operating theatres and other areas of health care.

I have been impressed to see the Trust's commitment towards developing a continuous improvement culture, particularly through our The Flow Coaching Academy Big Rooms which have recently been highlighted in a case study published by Sheffield Teaching Hospitals NHS Foundation Trust. Shaping our services around those who use them is key to delivering improvement, so we invite patients and partners from the third sector, primary and community care, the Police and mental health into our Big Rooms to ensure that we fully understand the patient journey and the change that is needed to transform our end-to-end pathways. Co-designing the improvements together in this way ensures that we prioritise our efforts on the things that matter the most to our patients which in turn transforms their experience and outcomes.

Over the last two months, we have continued to see further developments across our sites. On the 23 January we opened our newly refurbished Gynaecology and Early Pregnancy Assessment Unit at Royal Preston Hospital, a £90,000 scheme which redesigned the unit and received significant support from the Lancashire Teaching Hospital Charity. This is part of the broader women's health improvement programme to enhance the care for women and families experiencing early pregnancy or acute gynaecological complications including miscarriage and baby loss. I was delighted to welcome the NHS Elect team on site recently as we have been successful in securing a place in the national Thrombolysis in Acute Stroke collaborative, building on the excellent improvement work our stroke team has undertaken through the Stroke Big Room to improve care for stroke patients and our SSNAP ratings. As part of our drive towards greater efficiency a replacement robotic system is being installed in the Pharmacy departments at both our hospitals to help speed up prescription processing to get medication to patients, faster. The robot at Chorley will hold 12,000 packs of medicines, and 30,000 at Preston, and can supply the same number of packs in an hour that can be manually picked in a day. Other benefits include accuracy and improved stock management services. The project is due to be completed before the end of March 2024.

Finally, I would like to reflect on some of the Trust's other awards and achievements, both by individuals and teams. Congratulations to our Organ Donation team who were 'Highly Commended Runner-Up' in the Rosie

Neath Award for Outstanding Achievement in Organ Donation at the North West Organ Donation Collaborative in Manchester, after being recognised for their 'Race for Recipients' initiative, which raises awareness of organ donation. I was delighted to learn that Shondipon Laha, who works as a Consultant Intensivist and Anaesthetist at the Trust, was officially appointed as President-elect of the Intensive Care Society, whose role is to ensure delivery of the highest quality of critical care to patients across the UK. Shond is the first colleague from Preston to take on the role, as well as one of the first Presidents from Asian background. Anu Thomas, one of our Consultant Nurses at the Trust, was recognised for her work in growing the British Indian Nurses Association (BINA) at the recent Royal College of Nursing (RCN) awards, helping to provide pastoral support for international nurses. At the award ceremony in Liverpool Cathedral, Anu represented BINA, who were finalists in the Team of the Year category. Last but by no means least, Professor Alex Woywodt, a Renal Consultant at Lancashire Teaching Hospitals, has recently been recognised for his written work on the impact art can have on the renal community. The article, titled "Beautiful and effective: what art can do for nephrologists and for our patients", was published in the journal for Nephrology, Dialysis and Transplantation, and details how artwork can be a useful communication tool with patients. The article appears here and you can read more on the Trust website.

1. Recommendations

i. It is recommended that the Board receive the report and note its contents for information.

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:**	1st February 2024		
Report of:	Associate Director of Risk & 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:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.
- Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service – remains 8.

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

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:

- Risk to delivery of the Trust's Strategic Ambition of Delivering Value for Money – remains 20.
- Risk to delivery of the Trust's Strategic Ambition to Consistently Deliver Excellent Care – remains 20.
- Risk to delivery of the Trust's Strategic Aim to be a Great Place to Work – remains 16.
- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – remains 16.
- Risk to delivery of the Trust's Strategic Ambition of Fit for the Future – remains 15.
- Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service – remains 8.

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 three operational high risks that continue to 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 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

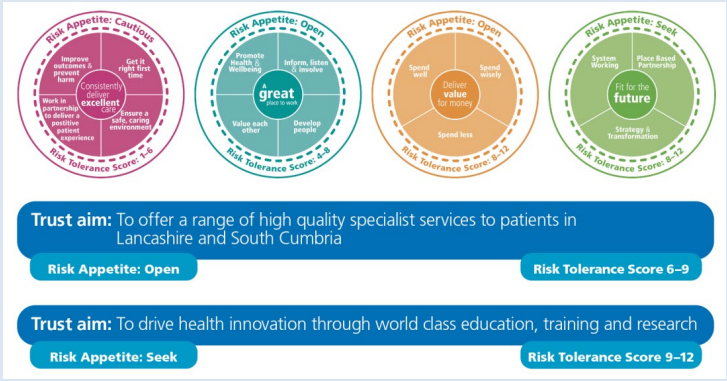
7.1 **It is recommended that Board of Directors:**

i. Note and approve the updates to the BAF.

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

Lancashire Teaching Hospitals NHS Foundation Trust

Trust Aims and Ambitions



Current principal risks on the Strategic Risk Register – February 2024

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	Dec 2022 Score	Feb 2023 Score	Apr 2023 Score	June 2023 Score	Aug 2023 Score	Oct 2023 Score	Dec 2023 Score	Feb 2024 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	12	20	20	20	20	20	16	16	→
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	16	16	16	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

Key Operational Risk Summary for Escalation to the Boards

NHS Lancashire Teaching Hospitals NHS Foundation Trust

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 Chorley District Hospital (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 – in place.
  - 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. Step up pathway in development with Therapy admission avoidance Team and Virtual Ward supporting.
  - Virtual Wards in place to reduce length of stay and avoid admission - open to step down and step up referrals, with an action plan to increase utilisation and increase capacity to 80. Engagement work with primary care ongoing to increase referrals from community and avoid admission where appropriate to utilise virtual ward pathway.
  - Strengthened site management arrangements with 8a Tactical Operational Officers now in place 7.30am – 10.00pm 7 days a week. Plan in place to test extending to 24/7 cover.
  - Working with Lancashire and South Cumbria NHS Foundation Trust (LSCFT) to improve the mental health emergency care pathways. Options appraisal in development.
  - Urgent and Emergency Care Transformation Board established with Executive level leadership will focusing on delivering:
    - Newly developed Urgent Emergency Care strategy
    - Therapy admission avoidance 7/7 team ED and Medical Assessment Unit (MAU) / Surgical Assessment Unit (SAU) - commenced 5/7 from January and will move to 7/7 from February 2024. Initial impact of this initiative is positive with evidence of admissions avoided as a result.
    - 40% reduction in ambulance conveyances to the ED and implementation of a community based single point of access, to include admission avoidance. Single point of access in place and initial impact is positive with increased referrals into community services as a result.
    - 10% reduction in length of stay for inpatients through implementation of Pride and Joy
    - 5% reduction in the patients not meeting the criteria to reside in hospital.
  - New inflow and flow programmes of work established with teams across the organisation working together to improve processes and streamline business as usual activity. An Urgent and Emergency Care (UEC) Performance Recovery Group has also been established, mirroring arrangements for Elective and Cancer.

  The programme of work continues to be delivered, and unfunded G&A escalation beds are reducing as planned. ED continues to remain under pressure and therefore this risk remains escalated to the 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 78 week waits by March 2023 was not achieved due to the displacement of activity during industrial action, however the Trust is now working towards elimination of 78 week waits (with the exception of: orthodontics, which is being managed across Lancashire & South Cumbria due to capacity issues and patients who are choosing to wait longer for treatment) by the end of March 2024 (extended from July 2023, November 2023 and January 2024 due to industrial action) and is continuing to reduce the number of patients waiting over 78 weeks. 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 is focusing on delivering:
  - Repatriation of services
  - Diagnostic efficiency
  - Sustainable workforce models
  - Theatre productivity
  - Streamlining elective pathways

Continued on next page

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

Continued

- **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 and junior doctors. 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) continues to ballot and schedule strike action for junior doctors and consultants. 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 which is having an impact on the hospital's activity, and planned Consultant strikes. Further strike action by junior doctors, consultants and radiographers took place during August – October 2023 and by junior doctors for 3 days from 20th December 2023 and for 6 days from 3rd January 2024, which saw a significant impact on service provision across the NHS. The risk is further compounded by the future inability to use agency staff during strike action. Monitoring of future strike announcements continues.

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: 2nd January 2024

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

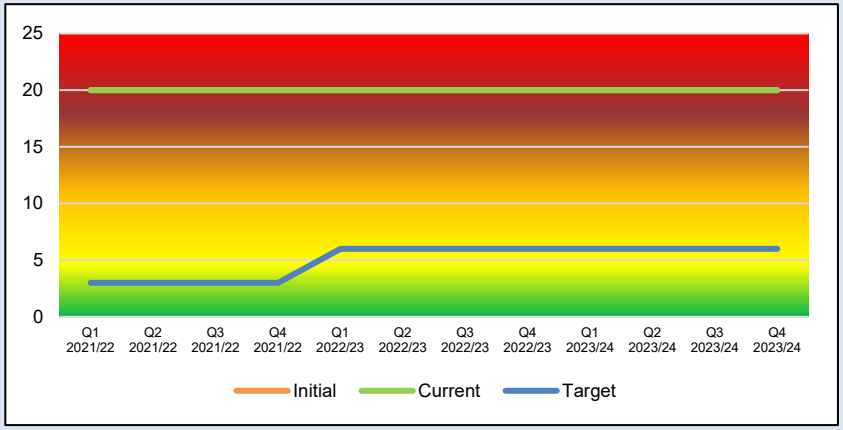
1-6

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.
- Occupancy levels are in excess of 95% leading to extended length if stay in the ED and additional patients on some wards.
- 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.
- 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)
- Recognised health inequalities in the communities we serve.
- The annual safe staffing recommendations are delayed in implementation due to financial constraints.
- The CQC rating for the organisation has remained at 'Requires Improvement'.

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.
- Risk of further financial constraints presenting increased risk to delivery of safe and effective care.

Future Opportunities

- ICS networks and collaboration leading to reconfiguration of vulnerable services.
- New Hospital Programme delivery.
- Reduction in agency use, 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	Gaps in Control	Assurances	Gaps in Assurances

• Workstream related strategies and plans in place
  ○ Always Safety First
  ○ Clinical Strategy
  ○ 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
• 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.
• Health Inequalities delivery plan - Core20PLUS5 adults and children.
• Medical device and replacement programme and process in place with increased oversight through Finance & Performance Committee
	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.
	• 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 current environment within the ED requires upgrading to reduce the risk of environmental decontamination. ***(Ref CDEC 012 and CDEC 019)***
	• The current environment within medical and surgical assessment units does not meet demand. ***(CDEC 014)***
	• The implementation of the national cleaning standards is not yet complete. ***(CDEC 018)***
	• The capital required to address backlog maintenance is not sufficient. ***(CDEC 019)***
		<u>Internal</u>
		• STAR Assurance Framework
		• Always Safety First Group
		• Safety and Learning Group
		• 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
		• Nurse, Midwifery and AHP safe staffing review annual review and recommendations
		• 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
		• Strengthened IPC BAF
		
		<u>External</u>
		• 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
			• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints. ***(CDEC 016 and CDEC 017)***
			• Enhanced approach to risk-based decision making (***DVFM 031***)

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	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	11 August 2023	Completed	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	New Hospital Programme assessment of capital requirements until the New Hospital is built.	Divisional Director of Estates	31 December 2023	31 October 2023	Completed	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	30 September 2023	Completed	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.
CDEC 015	The Board should extend its knowledge in relation to addressing health inequalities through specific Board development activity in this area.	Chief Nursing Officer	5 September 2023	5 September 2023	Completed	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.
CDEC 016	Determine mechanism to fund safe staffing recommendations for 2023 Birthrate plus assessment.	Chief Financial Officer	31 March 2024		Ongoing	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.

CDEC 017	Determine mechanism to fund safe staffing recommendations for 2023 Adult safe staffing assessment.	Chief Financial Officer	31 March 2024		Ongoing	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 018	The national cleaning standards implementation requires delivery – Priority 1.	Chief Financial Officer	1 March 2024		Ongoing	Control	• The implementation of the national cleaning standards is not yet complete.
CDEC 019	The capital planning group will continue to assess the risks relating to backlog maintenance and determine the priorities from within the capital funding envelope provided.	Chief Financial Officer	ongoing		Ongoing	Control	• The capital required to address backlog maintenance is not sufficient.
DVFM 031	Refine approach to making risk-based strategic decisions	Chief Nursing Officer	30.04.24		Ongoing	Assurance	• Enhanced approach to risk-based decision making

Summary of review – December 2023 and January 2024

- Rationale for current score updated and the point regarding the Trust being in Tier 1 for elective care and the point regarding health inequalities have been removed from the narrative. Additional narrative regarding patients routinely waiting longer than some national standards for treatments and in the Emergency Department and recent CQC outcome of "Requires Improvement" noted.
- Narrative in Future Opportunities updated to include reduction in agency use.
- Additional gap in assurance identified and action to address this recorded. This action was initially included in the Strategic Risk to Deliver Value for Money and will be mirrored across all strategic risks to ensure visibility at each committee.

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

Risk ID: 857
Risk owner: Chief Finance Officer
Date last reviewed: 4th January 2024

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

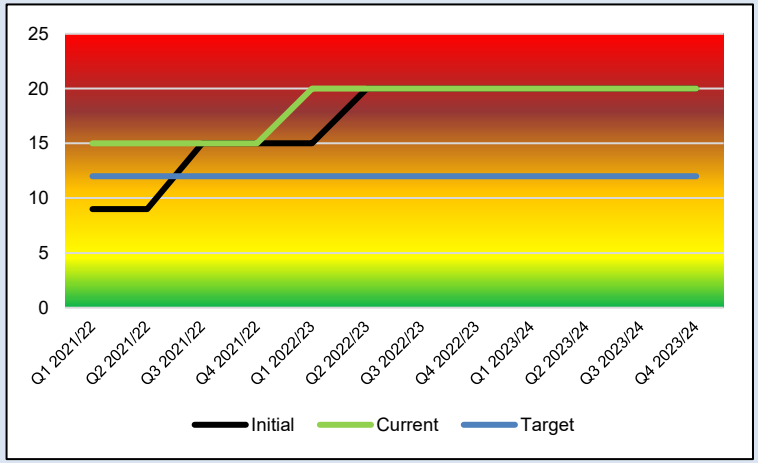
8-12

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.
- **Productivity** – Trust productivity when compared to 2019-20 has decreased. Input costs have essentially risen faster than the measured outputs. This has directly impacted upon 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. • **Planned care -** The failure to reorganise planned care across the system will result in waste and unwarranted variation, resulting in impact on overall value for money. • **Cost control –** There is a risk that input costs rise faster than activity output further eroding VFM. • **Commissioning decisions –** In light of the wider system financial challenges it is likely that the ICB will need to disinvest in services which are likely to exacerbate the financial and operational challenges if unmitigated.	**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. • To meet increasing demand and complexity the ICB will need to determine what commissioned services will be afforded for its population and whether some services will need wider reconfiguration to support sustainability. • Better understand why relative productivity has decreased and seek to mitigate where possible.

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	• 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	• 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.	• 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)*** • To support the drive for improved delivery the governance arrangements require some amendment. ***(DVFM 019 and DVFM 020)*** • 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)*** • Whilst temporary workforce controls have been reviewed by internal audit and has gained a substantial assurance, consideration now need to be given to the adequacy of those controls, particularly with regard to budgetary control. These will be reviewed and reported back to FPC in quarter three 23/24. ***(DVFM 023)***

• 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. • 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. • A system wide vacancy and control panel introduced providing additional oversight of the roles that are being recruited to across the system, particularly but not exclusively in non-clinical areas, consultancy, leases and contracts. • A system wide non pay control group has been established with the aim of prohibiting discretionary spend and improving value for money.	and deployment of system and PLACE Urgent and Emergency Care Strategy) • The financial run rate may improve at a slower rate than that which is required. Recovery plans need to ensure that there is sufficient pace or alternative mitigation to drive change quickly and de-risk the financial position appropriately, whilst maintaining a focus on safety. ***(DVFM 010)***	• 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. • Action plans relating to overspending costs centres are overseen through DIF processes and are reported to FPC. • A monthly update is provided on transformation programmes and the progress on the Financial Improvement Programme • Quarterly monitoring and action plans associated with Use of Resources. Routine reporting have been reintroduced. **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.	• In relation to its transformation programmes, the Trust needs to improve its identification and release of benefits ***(DVFM 026)*** • To supplement its existing transformation programmes two further programmes with be added to the assurance framework: Workforce and Digital ***(DVFM 027)*** • There is a need to update the work on the drivers of financial and operational performance ***(DVFM 029)*** • Improve oversight of the reporting of actions relating to the Improvement and Assurance Group with the Integrated Care Board (DVFM 030) • Enhanced approach to risk-based decision making (DVFM 031)

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	~~18.12.23~~ 31.01.24		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.
						Control	The financial run rate may improve at a slower rate than that which is required. Recovery plans need to ensure that there is sufficient pace or alternative mitigation to drive change quickly and de-risk the financial position appropriately, whilst maintaining a focus on safety.
DVFM 014	Clinical strategy (urgent care)	Director of Transformation & Chief Nursing Officer	30.11.23	30.11.23	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)	Director of Strategy and Planning	06.12.23	06.12.23	Complete	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	06.12.23	06.12.23	Complete	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	30.11.23	30.11.23	Complete	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	30.11.23	30.11.23	Complete	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	Director of Strategy and Planning	30.09.23	30.09.23	Complete	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	Complete	Assurance	The trust has an opportunity to improve the rigour and robustness of its decision-making processes
DVFM 023	Review of effectiveness of internal controls (e.g. budget constraint) relating to temporary workforce	Chief People Officer	~~31.12.23~~ 31.01.24		Ongoing	Assurance	Whilst temporary workforce controls have been reviewed by internal audit and has gained a substantial assurance, consideration now need to be given to the adequacy of those controls, particularly with regard to budgetary control. These will be reviewed and reported back to FPC in quarter three 23/24.
DVFM 024	New workforce and non pay controls Assurance	Chief Finance Officer	31.10.23	31.10.23	Complete	Assurance	Whilst the Trust and ICB have introduced workforce and non pay controls, these need to be shared with the Committee for assurance. These will be reported for information to FPC from October 2023.
DVFM 025	Use of Resources report to be presented to F&P Committee	Director of Strategy and Planning	31.10.23	30.09.23	Complete	Assurance	The Trust stopped the routine monitoring and action plans associated with Use of Resources. Routine reporting needs to be reintroduced in quarter three

DVFM 026	Refine approach to benefits realisation and embedding in arrangements for programme assurance	Director of Improvement and Transformation	31.01.24		Ongoing	Assurance	In relation to its transformation programmes, the Trust needs to improve its identification and release of benefits
DVFM 027	Increase the scope of the Transformation Programmes to include workforce and digital	Director of Improvement and Transformation	30.03.24		Ongoing	Assurance	To supplement its existing transformation programmes two further programmes with be added to the assurance framework: Workforce and Digital
DVFM 028	Reintroduction of Programme Management Office (PMO)	Chief Operating Officer	30.11.23	30.11.23	Complete	Assurance	No dedicated PMO function to oversee programmes/improve pace and delivery
DVFM 029	Update drivers of financial and operational performance	Chief Finance Officer	31.01.24		Ongoing	Assurance	Gaps are mitigated adequately within the Financial Recovery Programme
DVFM 030	Share minutes and actions if IAG meeting with FPC	Secretariate	31.04.24		Ongoing	Assurance	Oversight of agreed actions between ICB and LTH
DVFM 031	Refine approach to making risk-based strategic decisions	Chief Nursing Officer	30.04.24		Ongoing	Assurance	Enhanced approach to risk-based decision making

Summary of updates to risk – December 2023 and January 2024

- Actions DVFM 014, DVFM 015, DVFM 016, DVFM 017, DVFM 018 marked as completed leading to the removal of a gap in assurance that "the Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better."
- Action DVFM 022 updated to be assigned to ICS reporting arrangements for Recovery and Transformation Board and not a Trust-owned action.
- Action DVFM 028 marked as completed, leading to the removal of gap in assurance "No dedicated PMO function to oversee programmes/improve pace and delivery".
- Updated narrative in future and escalating risks regarding Commissioning Decisions.
- Three new gaps in assurance identified related to drivers of financial and operational performance, and oversight of the reporting of actions relating to the Improvement and Assurance Group with the Integrated Care Board, and risk-based decision making, which has led to three new actions being identified in the action plan – DVFM 029 and DVFM 030, and DVFM 031.
- Due dates from Actions DVFM 010 and DVFM 023 extended to the end of January 2024.

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: 22nd December 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

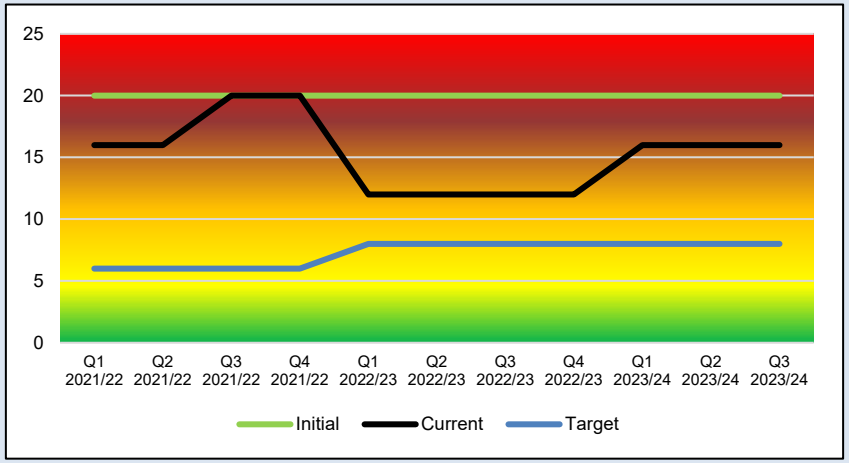
4-8

Rationale for Current Score

- Workforce shortages in some specialities and high sickness levels in some key professional groups, creates pressure on existing staff and increases the need for temporary staffing spend.
- 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.
- Gap between the desired and the current culture indicates improvements are needed.
- Impact of cost-of-living pressures on colleagues.
- 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 pause for all non-clinical roles along with a competitive recruitment market will mean vacant posts will be unable to be filled, creating pressure within the existing workforce.
- 3% reduction in establishment is likely to create additional pressures on existing staff impacting on sickness, wellbeing and morale.
- Local onboarding processes within some teams/departments 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.

Risk Rating Tracker (Likelihood x Consequence)

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



	• 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 some Consultant groups, this takes sensitive navigation and also a requirement that adequate governance is 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 • Central services collaboration may de-stabilise some of the Trust's processes.	**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. • Central services collaboration may provide efficiencies and resilience to some services once in place and embedded.

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 healthcare support workers)
  ○ Workforce policies with EIA embedded
  ○ Health and Wellbeing strategy
  ○ Just culture
	• 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. ***(GPTW001/DVFM002)***
	• Identification and Development of transformation schemes to support long term sustainability and workforce re-
		Internal
		• Divisional Governance Structure and Arrangements
		• Divisional Improvement Forums (including Part II process to address cultural concerns)
		• Raising Concerns Group
		• Workforce Committee
		• Education Training and Research Committee
		• Safety and Quality Committee
			[None]

○ 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 • 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 • Chief People Officer and Deputy/Associate Directors are present at all People and Transformation Meetings at the Provider Collaborative Board	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	• 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	

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 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 – December 2023

- Narrative regarding rationale for current score updated and streamlined to reflect changing priorities in the organisation.

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

Risk ID: 859

Risk owner: Chief Medical Officer

Date last reviewed: 24th January 2024

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.

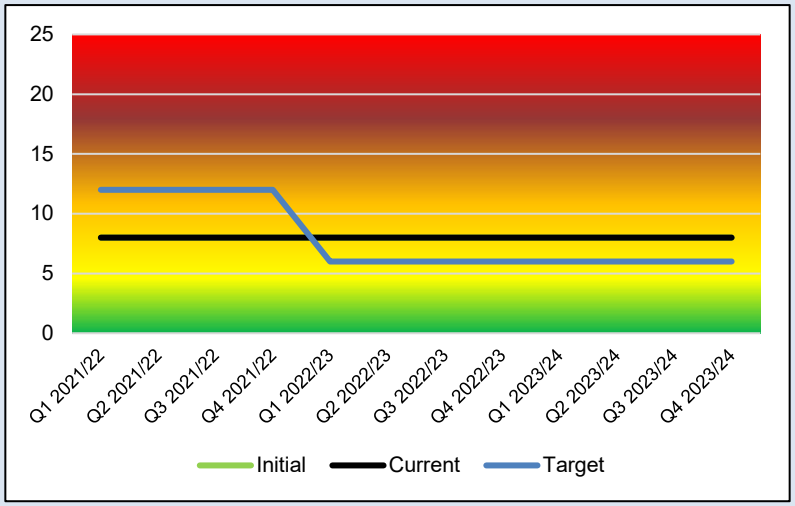
Risk Tolerance 6-9

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 deliver the services our patients and 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 approved.
- 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. The Trust will need to monitor funding allocations and patient access as the changes begin to take shape. Any changes in the commissioning arrangements may cause challenges in developing a future state operating model.

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. • Potential risks associated with changes in specialised commissioning arrangements.	**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 - PCB 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 Consistently Deliver Excellent Care. • ICS Speciality Boards in place for a number of specialist services • Statutory development of the ICS. • Capital Planning Group arrangements in place to provide structure and organised approach to capital investment. • Specialist services included within the planning framework. • PCB/ICB Clinical Strategy Configuration Events held in August and November 2023 with further work planned in 2024	• Services being compliant with the service specification ***(SPEC 002)***	**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	25th September 2023	Complete	Control	• Integration of services and pathway and effective Place and system-based working • PCB clinical strategy still in development
SPEC 002	Agree interim and longer term plan for reconfiguration of specialised services across Lancashire and South Cumbria, aligned to the New Hospitals Programme.	Chief Medical Officer	31st March 2024		Ongoing	Control	• Services being compliant with the service specification

Updates to risk – January 2024

- Risk reviewed by the Chief Medical Officer and no updates required during the review in January 2024.

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 (updated by Deputy Director of Education and Deputy Director of Research & Innovation)
Date last reviewed: 4th December 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

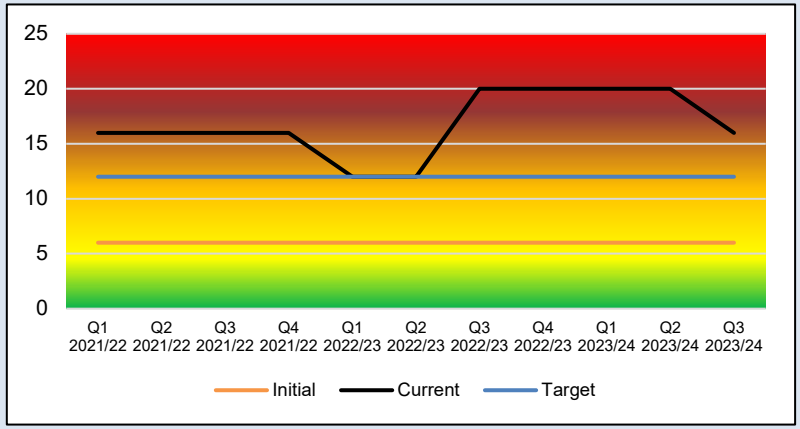
9-12

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 of roles previously funded through education income.
- Ongoing capacity challenges to support education and R&I activity.
- Workforce shortages impacting on capacity and educational quality.
- 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/aseptic backlogs on commercial research income.
- Not meeting compliance in all training subjects and medical device competencies.
- NIHR guidance changes re commercial work and R&I running at reducing loss, year on year, is assisted by the O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist ongoing mitigation. This will assist reductio of system blockages running too many studies post-pandemic.
- There are opportunities to lead on education, innovation and research programmes in NHP and ICB programmes of work.
- 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: 4x4 = 16 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.
- 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

Future Opportunities

- Continued participation and development of funded, commercial and 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.
- 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
- O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist commercial and financial growth

Controls	Gaps in Control	Assurances	Gaps in Assurances

• Workstream related strategies in place:
  ○ Education & Training 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
• International education programmes to be incorporated into 2024-27 strategy.
	• Lack of research leads embedded in divisions ***(ETR 007)***	**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
		• Paper to include R&I involvement at DIFs and Divisional Boards has been drafted for approval by the CMO
		• Monthly finance reviews with corporate finance team and quarterly with R&I budget holders
		• 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	04.12.23	Complete	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~~ 31.03.24		Ongoing	Control	• Lack of research leads embedded in divisions.

Summary of Updates – December 2023

- During ETR in October 2023 it was agreed to reduce the risk score from 20 t 16 based on the recent NHSE visit feedback, as well as financial assurance provided regarding the deferred income. The Education Department now working to utilise funding in year. Also, the new Chief People Officer has been appointed and commences in post December 2023.
- Updates to narrative for Rationale for Current Score, Future Opportunities and Assurances.
- Action ETR 004 has been completed and is recognised in the update of a new control measure – "International education programmes to be incorporated into 2024-27 strategy."

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: 1st February 2024

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.

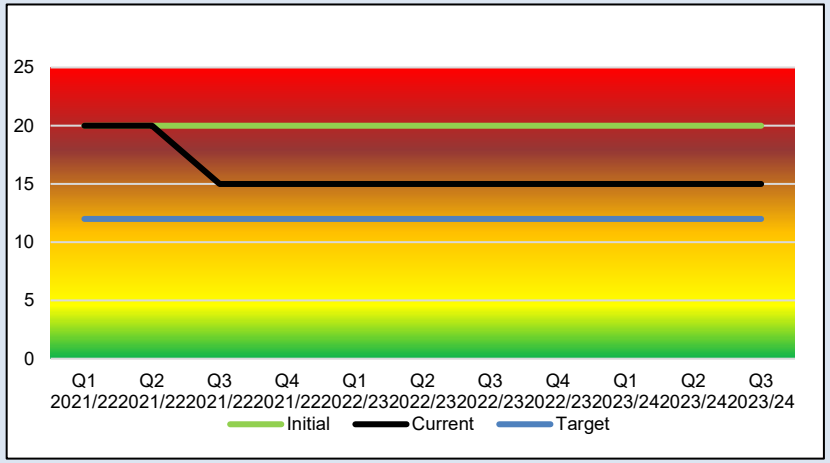
Risk Appetite: Seek – Eager to be innovative and to choose options offering higher rewards, despite inherent business risk.

Risk Tolerance
8-12

Rationale for Current Score

- System working continues to develop but is not yet at the required level of maturity.
- Place based working continues to develop, with discussions underway regarding the approach to place transformation in 2024/25.
- Digital transformation is not progressing at the rate planned.
- 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 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

- LTH establishing a Single Improvement Plan approach, taking best practice from other Trusts/systems drive transformation at pace.
- Workstream related strategies in place
  - Clinical Strategy

Gaps in Control

- Integration of services and pathways. ***(FFTF 001, FFTF 003, FFTF 004, FFTF 005, FFTF 006, FFTF 008)***

Assurances

Internal

- Executive Transformation Group
- Planning Framework updates to Finance and Performance Committee.

Gaps in Assurances

- Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim ***(FFTF 001, FFTF 003, FFTF 004, FFTF 008)***

○ 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. A Central Lancashire Executive Oversight Group has been set up and discussions are underway regarding the options for the Lancashire Place Partnership. The ICB have established a new Recovery Board, with a focus on system wide recovery and transformation • 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 • 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.	• Effective Place and system based working. ***(FFTF 001, FFTF 005, FFTF 007, FFTF 008)*** • Single Improvement Plan approach still under development. (***FFTF 008)*** • Fragile Services programme currently focussed on a "deficit model" and needs to rapidly develop a robust expected benefits plan ***(FFTF 001)***	• 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	

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.

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.
FFTF 004	Develop and deliver Digital Northern Star strategy	Chief Information Officer	31st March 2024		Ongoing	Control	• Integration of services and pathways
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 the 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.

Updates – February 2024

- No change to risk score
- Updates to: Rationale for current score; Controls; Gaps in controls
- A Fit for the Future Deep Dive took place at the Audit Committee on January 18th 2024. A number of suggested areas for improvement/revision were made. An action plan is being developed to progress all the agreed recommendations.
- Action plan updates:

FFTF 001 - link LTHTR strategies with Place, Provider Collaborative and ICS Strategies – following the meeting of senior leaders for the PCB and the ICB in November it was agreed there was a need for a three to six month process to articulate a joint L&SC vision and roadmap for clinical configuration and estates utilisation strategy. The delivery plan to take forward this critical piece of work is currently being finalised, which will include the engagement of external support to support/take forward the process. This will substantially mitigate our risk. The ICB has established a structured review of system programme support to prioritise the available resources to best deliver rapid impact across the quadruple aim, particularly in relation to our system financial position. Work is underway within LTH to review our links into/governance in relation to system working both at the level of individual programmes and at a macro level.

FFTF004 - Develop and deliver Digital Northern Star strategy: a lead has been appointed for the IG target operating model (TOM) and is progressing the workstream. A TOM for the ICS wide technical infrastructure group is under review to align with national standards and to ensure best value from ICB wide alignment of diagnostic programmes such as Digital Pathology, Cardiology, Radiology, Pathology together with Datacentres, Network and identity. As part of the secure data environment programme, data pipelines have been built mapping LTH EPR, cancer and pathology data into the open standard Observational Medical Outcomes Partnership common data model. This will form the core of the ICS data and knowledge architecture supporting secondary uses and research.

FFTF 005 – The Trust Communications team has been involved in several press and media opportunities over the last two months, facilitating three visits for BBC North West Tonight, Sky News and ITN in January focusing on Junior Doctor strikes and winter pressures. We also featured in radio and print articles. Extensive filming has taken place within our chemotherapy and radiotherapy departments with ITV Granada. The coverage has gained national media attention, and Suzy Orr will ring the bell at the end of January, signalling the end of her treatment. Alongside our usual internal communications, the team have also recently produced an 8-page special Trust Matters for the Council of Governor Elections. Recent PCB/collaborative work includes offering communications support for Pathology Services. Internal virtual engagement sessions continue to be well received with the monthly Executive Q&A sessions and weekly Strategic Operation Group updates accessible to staff from across the Trust. Our online presence has continued to increase over the last two months, with 81,000 new users to the Trust website since the start of December 2023. Of our visitors over this two-month period, 90% are new users, with 10% returning - demonstrating a continuing upwards trend of engaging with more of our local population. Our social media channels are also continuing to improve with 82.8k page reaches on Facebook. The intranet is also approaching 18 months since its refresh, achieving over 2.2 million pageviews to date with more colleagues transferring their content onto the platform.

FFTF 008 - strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change - a plan has been developed to establish a PMO (within existing resources) to track the current programmes of work. Details of the plan have been presented at the January Finance & Performance Committee, however, finalising the plan will be taken forward as part of the work to establish our Single Improvement Plan, taking account of best practice from other Trusts.

Chair's Report

Committee:	Safety and Quality Committee
Chairperson and role:	Kate Smyth, Non-Executive Director
Date(s) of Committee meeting(s):	24 November 2023 and 5 January 2024
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

24 November 2023

Following the meeting held on the 24 November 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 maternity; and neonatal and children and young people services.
- Emergency Department Dashboard.
- CQC 2023 Inspection Report Debrief.
- Perinatal Mortality Data Report.
- Sub-contract Monitoring Assurance Report.
- Quarterly Serious Case Thematic Review and Learning Report.
- Clinical Audit and Outcome Report.

5 January 2024

Following the meeting held on the 5 January 2024, 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 and Neonatal Services CNST Validation Report.
- Bi-annual Mortality Update including LEDER.
- Bi-annual Medicines Governance Report.

Items for the Board's attention

The Committee received a detailed Emergency Department report that provided assurance of the outcome measures and actions taken to manage the risk associated with overcrowding in the Emergency Department. The report triangulated the outcome data from the Emergency Department dashboard, incident reporting and patient and colleague feedback. The Perinatal Mortality Data Report provided detail of the processes involved in submission of perinatal mortality data and assurance to the Committee of the accuracy of stillbirth data included in the Commissioning Data Sets submissions. This concluded the deep dive undertaken into the Trust's mortality data reporting, which was an exercise to provide additional assurance. The report included the work undertaken to strengthen processes within the Trust. The Quarterly Serious Case Thematic Review and Learning Report provided a high-level overview of Level 3/Strategic Executive Information System (StEIS) serious incident investigations reported, any emerging concerns in relation to ongoing cases, and the actions and learning from completed cases. It was confirmed that a meeting had taken place with the coroner and key stakeholders in the Trust to review the new process of PSIRF and the approach taken for patients. The coroner was assured of the strong process within the organisation in the way it conducted investigations.	The Maternity and Neonatal Services CNST Validation Report provided the details of the final position relating to the ten Clinical Negligence Scheme for Trusts year five maternity incentive scheme, prior to submission and declaration of compliance to NHS Resolution (NHSR) by the Trust Chief Executive Officer and Integrated Care Board Accountable Officer by the 1 February 2023. As of the 7 December 2023, the service reported that it was on track to deliver 10 out of 10 CNST standards. Quarterly validation and assurance visits had been undertaken throughout the year 5 MIS reporting period with the Local Maternity and Neonatal System on behalf of the Integrated Care Board. The Bi-annual Medicines Management Assurance Report provided a summary of key performance metrics and improvement actions related to medicines management undertaken by pharmacy working with the multidisciplinary team, and assurance this had facilitated safe, effective and responsive person-centred care. The report had been restructured to align key medicines metrics to the Care Quality Commission (CQC) Key Lines of Enquiry (KLOE) for medicines. The paper also contained details of the CQC visit to the Trust in the Summer 2023, the improvement actions identified, and the actions being taken in response and learning and next steps as a result of national incidents relating to medication management.
Positive escalation	
24 November 2023	**5 January 2024**
- The assurance received in relation to perinatal mortality data quality. - The PSIRF implementation was progressing in line with the organisational plan.	- As of the 7 December 2023, the maternity service reported that it was on track to deliver 10 out of 10 Clinical Negligence Scheme for Trusts standards. - Complaints Response Rate Compliance – the backlog had been resolved and complaints were now being managed in line with the Trust policy. - There had been improvement to the patient safety repositioning documentation that had previously been negatively escalated and improvement work continued on the pressure ulcer reduction plan. - There was sustained improvement to the fluid balance and vital signs compliance.

Negative escalation	
24 November 2023	**5 January 2024**
- The Clostridium Difficile Infection rates continued to exceed the trajectory. There was weekly-fortnightly Executive oversight of the action plans, sharing best practice learning from peers and working collaboratively with the multidisciplinary team. - The month of October continued to see a significant increase in occupancy across the inpatient areas relating to boarded patients. Strengthened data was requested by the Committee to fully understand the metrics around the length of stay and care provision for boarded patients. - Lack of compliance with the national cleaning standards was noted with 10 wards now fully implemented. A plan to reach full compliance is formulated however requires funding and therefore discussed as part of the 2024 planning round and highlighted to board via the IPC BAF and as a gap in assurance on the strategic risk for Consistently Deliver Excellent Care. - The committee requested and received a detailed review of the experience of patients in the emergency department, the report demonstrated significant ongoing challenges and requested a review by Finance and Performance committee to ensure the impact of performance is understood.	- The Clostridium Difficile Infection rates continued to exceed the trajectory. There was weekly-fortnightly Executive oversight of the action plans, sharing best practice learning from peers and working collaboratively with the multidisciplinary team. Strengthened evidence of the process measures being enacted to reduce the risks associated with board, the environment and cleaning standards are improving. - The Birthrate Plus maternity staffing requirement remains outstanding due to the financial position, noting the ability to recruit the required number of registered midwives is limited at this time, the required support services could provide some additional benefit to the service. This will be discussed in the 2024 planning round. - The Emergency Department continued to see an increase in children attending with the seasonal illness leading to extended lengths of stay in the ED and children's ward however triage times remained compliant and the service was showing signs of recovering from the surge period. - Both hospitals at Chorley and Preston had experienced an increase in attendance in the Emergency Department. The ambulance handover collaborative improvement group had continued to focus on improving handover delays by implementing additional escalation actions when there were delays for patients. This had a positive impact on reducing delays of over 1 hour from 265 in October to 89 in November.
Committee to Committee referral	
24 November 2023	**5 January 2024**
The Safety and Quality Committee referred concerns to the Finance and Performance Committee around the significant pressure in the Emergency Department to ensure triangulation is taking place with the improvement and transformation work to reduce the impact on patients.	No referrals.
Items recommended to the Board for approval	
24 November 2023	**5 January 2024**

None	None
Committee Chairs reports received	
24 November 2023	**5 January 2024**
(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Medicines Governance Committee (d) Safety and Learning Group (e) Patient Experience and Involvement	(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Safety and Learning Group (d) Medicines Governance Committee (e) Patient Experience and Involvement (f) Mortality and End of Life (g) Health inequalities group
Items where assurance was provided and/or for information	
24 November 2023	**5 January 2024**
The Committee was provided with an update on the risks aligned to the Committee following the development and refinement of the strategic risk register that informed the Board Assurance Framework. There remained three escalated risks to Board, these were the impact of exit block on patient safety, elective restoration and probability of ongoing strike action. The Committee was assured of the mitigating actions that were in place. The Committee received the Safety and Quality dashboard and was assured of the actions being taken to address areas for improvement. The Maternity and Neonatal report provided assurance on the safety and quality programmes of work within the maternity and neonatal services up until and including the 15 November 2023. NHS Resolution was operating in year 5 of the Maternity Incentive Scheme (MIS) and the report detailed progress against work relating to the ten safety actions of the Clinical Negligence Scheme for Trusts (CNST) and other high level service updates. Assurance was provided around the ongoing contract management of the Trust's outsourced material subcontracts for clinical healthcare. The Committee confirmed its assurance in respect of the progress that had been undertaken in contract monitoring and resolved to receive a further update in May 2024.	The Bi-annual Mortality Report provided an update and assurance to the Committee that the Trust had robust governance arrangements in place to review, report and learn from patient deaths including LEDER deaths. The Committee confirmed its assurance in respect of the arrangements in place relating to the management of patient deaths. The Neonatal and Children and Young People report provided a monthly overview of the services staffing and assurance that safe staffing was being deployed. Assurance was provided that risks were being appropriately mitigated. The Safety and Quality Dashboard summarised the highlights and exceptions for November 2023 with further detail on the actions being taken. The report provided assurance of the safe staffing planned and deployed across adult inpatient areas. It also contained the safety and quality metrics for Finney House for both residential and Community Healthcare Hub and the Emergency Department dashboard.
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 26 January 2024 using Microsoft Teams.

Recommendation:

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

Appendix 1 – Safety and Quality Committee agenda (24 November 2023)

Appendix 2 – Safety and Quality Committee agenda (5 January 2024)

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Health and Safety Annual Update			
Report to:	Board of Directors	**Date:**	1st February 2024
Report of:	Chief Nursing Officer	**Prepared by:**	H. Ugradar, M.Cowburn, C.Morris

Purpose of Report					
Part I	✓	**Part II**			
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this paper is to provide Board of Directors with an overview of the management of Health and Safety at Lancashire Teaching Hospitals during 2022/2023 in line with legislative requirements as overseen by the Health and Safety Governance Group.

The paper also summarises the prevailing legislative framework within which Health and Safety concerns are managed and addressed and outlines the local governance arrangements that underpin Health and Safety management within the Trust.

The paper confirms that in order to meet the requirements of the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work 1999 the Trust has a number of processes in place including:

- An up to date Health and Safety Policy.
- Competent persons for Health and Safety.
- An established Health and Safety Governance Group that considers all aspects of Health and Safety with information related to activities overseen by its subgroups.
- Risk assessment and risk register process established.
- Health and Safety Training.

A review of incidents, risks and audit intelligence identifies learning across a number of Health and Safety themes e.g. increasing workplace stress/demands, ageing estate challenges, violence and aggression, sharps disposal, waste management, decontamination of equipment, ventilation, moving and handling, equipment management, safe storage of equipment, food storage and fire safety.

Whilst a number of assurances can be provided both internally and externally, challenges in delivering the Health and Safety agenda under the backdrop of an ageing estate, alongside workplace stress/demands, ageing equipment and financial constraints is evident.

To address these challenges, the Health and Safety teams both corporately and within Estates and Facilities are working collaboratively to revisit the Health and Safety governance arrangements across the organisation.

This will inform the forward management plan for Health and Safety for the Trust to ensure ongoing compliance with all relevant legislation within the current financial envelope.

It is recommended that the Board of Directors:

i. Receive the contents of the report and confirm they are assured of the actions being taken to reduce the risks associated with Health and Safety despite a number of challenges.
ii. Note the Safety and Quality Committee will receive a further update in 6 months' time providing assurance on the areas that require further improvement.

Appendix 1 – Tables and Figures

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 Jan 24

1. Background

1.1 The purpose of this paper is to provide the Board of Directors with an overview of the management of Health and Safety at Lancashire Teaching Hospitals during 2022/2023 in line with legislative requirements as overseen by the Health and Safety Governance Group. Since this annual report is out with the usual schedule of business for Safety and Quality Committee, recent data where relevant has also been provided.

1.2 The paper also summarises the prevailing legislative framework within which Health and Safety concerns are managed and addressed and outlines the local governance arrangements that underpin Health and Safety management within the Trust. The paper also includes information relating to activities undertaken by the Health and Safety Governance Group and its sub-groups with respect to:-

- Asbestos
- Confined spaces
- Fire safety
- Health and safety training provision
- Manual handling and back care
- *Medical gas safety
- Occupational Health and Wellbeing
- Radiation safety
- Operational health and safety management for Estates, including capital projects.
- Risk management
- Security safety
- Waste safety
- Water safety
- Working at height

**Managed through Medical Gases Committee which would refer to Health and Safety Governance group any specific Health and Safety requirements for example staff exposure to Entonox.*

1.3 The Health and Safety at Work Act 1974 provides a legislative framework to promote, stimulate and encourage excellent Health and Safety at work standards. Delegated responsibility through the Chief Executive Officer is with the Chief Nursing Officer to oversee systems that ensure all staff and ancillary contractors, patients and visitors, work in a safe and compliant manner to protect both themselves and other service users from significant or avoidable harm.

1.4 In order to meet the requirements of the Act, the employer must demonstrate that there are safe operations and systems of work, safe access and egress, safe use, handling and storage of dangerous and hazardous chemicals and substances, adequate and appropriate health and safety training and adequate and appropriate welfare provisions.

1.5 In addition, the Management of Health and Safety at Work Regulations 1999 requires employers to make 'assessments of risks' and to ensure that there is effective planning, control, monitoring and review of the subsequent preventive and protective measures. The management of Health and Safety is identified in Health and Safety Executive (HSE) guidance HSG 65 which provides a framework for managing health and safety.

2. Discussion

2.1 Health and Safety Governance Group and Management Structure

2.1.1 The Trust has a Health and Safety Governance Group to plan, manage and monitor organisational compliance with statutory Health and Safety requirements and specific NHS duties. In this way, compliance with external organisational requirements such as the HSE, NHS Resolution (formerly the NHSLA), Department of Health, Care Quality Commission (CQC) etc. are managed.

2.1.2 The Health and Safety Governance Group is co-chaired by the Associate Director of Safety and Learning and the Director of Estates and Facilities on behalf of the Chief Nursing Officer and meets six times a year. The Group reports into the Trust Safety and Quality Committee which in turn reports to the Trust Board.

2.1.3 The Trust has an appointed Health and Safety Manager who is the designated Trust competent person with the necessary qualifications as defined in the requirements of the "Management of Health and Safety at Work Regulations". The Health and Safety Manager is supported by a number of subject matter experts within the Trust.

2.1.4 The Health and Safety Governance Group is tasked with monitoring the development, implementation, audit and delivery of Health and Safety organisational management throughout all working aspects of the Trust's diverse activities.

2.1.5 Table 1 in Appendix 1 gives an overview of the groups that report into the Health and Safety Governance Group**.** Each group oversees ratification of associated policies with chair's reports from each meeting submitted to the Health and Safety Governance Group for review.

2.1.6 The main areas of concern from the Health and Safety Governance Group are related to sharps, waste management and medical device decontamination. Actions are in place to address the issues identified.

2.2 Compliance with legislation

2.2.1 The Health and Safety at Work Act 1974 imposes duties on employers to protect the 'health, safety and welfare' of all their employees, as well as others on their premises, including contractors, visitors, and the general public. The requirements of this Act are covered by The Management of Health and Safety at Work Regulations 1999 that state an employer must identify the risks that employees, contractors, and members of the public may face and take steps to control or mitigate those risks through a formal risk assessment process.

2.2.2 The Trusts Estates and Facilities Department are also governed by Health Technical Memoranda (HTMs) which give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

2.2.3 To ensure the trust complies with its statutory duties under The Health and Safety at Work Act 1974 the trusts Health and Safety Governance Group is tasked with monitoring and managing compliance. The Trusts Health and Safety Governance Team and the Estates and Facilities Department have systems and processes in place to fulfil this function.

2.2.4 Table 2 in Appendix 1 gives an overview of compliance with key Health and Safety legislation.

2.3 Risk Management and Risk Reporting

2.3.1 The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999.

2.3.2 To support the management of risks, the Trust has a Risk Management Strategy and a Risk Management Policy in place. This is supported by a general risk assessment template for reportable hazards and associated risks in line with HSE guidance and is mainly used for the management of local hazards e.g. hazards associated with moving and handling and violence and aggression risks, staff exposure to

radiation or radioactive materials under Ionising Radiation Regulations IRR17, exposure to asbestos, exposure to dangerous chemicals or toxic substances or diseases (e.g. Covid-19 or Tuberculosis).

2.3.3 These risk assessments are overseen and managed at local level by divisions and directorates managers and are reviewed in accordance with their risk rating with advice and guidance from the Health and Safety Manager as required. All risks deemed appropriate by departmental, speciality and divisional leads are fed into the Trust's main risk register to enable corporate planning, the setting of objectives and the establishment of business plans. At the end of December 2023, there were 490 active risks on the Trusts risk register from both clinical and non-clinical identified hazards. See Section 6 for a summary of themes of risks identified on the Risk Register related to Health and Safety.

2.3.4 Alongside locally managed risk assessments, specialist estates staff and contractors complete required risk assessments for the maintenance and operation of the estate such as asbestos, lifts, waste, ventilation, central medical gases provision and water. With this, the Director of Estates and Facilities recommends the appointment of authorising engineers (AEs) and appointed persons (APs) who provide independent expert assurance to the Trust through advice, direction, specialist training, risk assessment and audit, submitting corrective action plans to the estates departments subgroups and capital projects programme. They provide an annual audit of the delivery of the estates and facilities works in relation to the area of appointment. These audits are submitted to the Director of Estates and Facilities and onwards to relevant sub-groups, such as the water safety group, the decontamination committee, and medical gases safety group.

2.3.5 Additionally, these specialists, independently witness and test the installation and operation of systems such as fire alarms, electrical substations providing assurance on the compliance of contractors' work to NHS and Trust specific requirements. By working in this way, side by side with the Trust appointed persons, who are key members of the estates team that have attended specialist training programmes, the Trust is able to ensure that legal requirements are met, and that best practice is followed.

2.4 Policy, Standards and Documentation

2.4.1 The Trust remains aligned to the HSE Managing for Health and Safety (HSG65) 2013 and all policies relating to health and safety are reviewed in line with this standard. The Clinical Governance Team monitors policies and procedures on behalf of the organisation to ensure they are reviewed every three years as a minimum or as defined within individual documents.

2.4.2 The Trust uses a document management system, Heritage, which is available and accessible to all Trust employees. The system is held on the Trust Intranet and is maintained by Clinical Governance Team and Library Services.

2.5 Health and Safety Incident Analysis

2.5.1 Incident reporting is fundamental to the Trust being able to identify, analyse and address its risk areas.

2.5.2 Table 3 in Appendix 1 details Health and Safety incident reporting profiles between two comparative 12 month periods for 2022 and 2023. It should be noted however that the analysis of Health and Safety incident data within this paper excludes incidents affecting patients, as these would be considered clinical incidents managed from a patient safety perspective. It also excludes incidents regarding infection prevention and control, as this is considered within the clinical safety portfolio.

2.5.3 Overall, Table 3 shows that there is a 1.1% increase in the reporting of Health and Safety incidents (5111 incidents in 2022 to 5170 incidents in 2023), with the majority of incidents in the two comparable years resulting in No Harm or Low Harm (97.9% in 2022 and 98% in 2023). There were no Health and Safety incidents reported across the two years with a harm level of Death, however there were 2 incidents of Severe harm reported each year. In 2022, there was 1 Severe harm incident related to Manual Handling of equipment or machinery and 1 Severe harm incident related to physical assault by a visitor. In 2023, there was 1 Severe harm incident related to Manual Handling of equipment or machinery and 1 Severe harm incident related to Slip, Trip or Fall on the same level.

2.5.4 In both years, the highest reporting incident type is "Insufficient staff or workplace stress/demand", although from 2022 to 2023 there is a reduction in the number of incidents reported in this category suggesting improvements to staffing levels (41.3% of incidents reported in 2022 and 38.5% reported in 2023). For workplace stress/demand incidents, the reporting process continues to be mis-interpreted as often staff either report the incident that has caused the stress and not the outcome or report insufficient staff as a workplace stress/demand instead of insufficient staffing. A better indicator of workplace stress/demand is often staff survey data, sickness data and the number of referrals into Occupational Health or Psychological Wellbeing in conjunction with incident data. The Divisional Governance and Risk Team, Health and Safety Manager, Associate Director of Workforce and Divisional Governance professionals are actively reviewing the way this type of incident is being reported so that the Trust is provided with a more precise representation of the problem, and it can be addressed through various services provided by Occupational Health. In the meantime, the Health and Safety Governance Group continue to receive information on Occupational Health and Psychological Wellbeing services to triangulate any themes.

2.5.5 The second highest reported incident type in both years is "Violence and aggression from patient or visitor" with a 23% increase in the number of incidents reported in this category from 2022 to 2023 suggesting that violence and aggression towards staff by patients or visitors is a growing concern (19.2% in 2022 and 23.4% in 2023). A number of papers have been presented to Workforce Committee in 2022 and 2023 which provide an update on a range of workstreams with key areas of progress including listening to colleagues in areas most affected, adopting a continuous improvement approach through the initiation of a Violence and Aggression Big Room, implementation of a Zero Tolerance Toolkit and establishment of a Sexual Safety Working Group. Progress with this work continues to be monitored by the Workforce Committee with a 3 year Violence Prevention and Reduction Strategy also in place.

2.5.6 Other incident types seeing a noticeable increasing trend in reporting are "Lack of Ventilation" (125% increase), "Staff smoking on hospital grounds" (100% increase), "Exposure to extreme temperature" (57% increase), "Contact with sharps" (45% increase) and "Injured during Manual Handling" (31% increase).

- To support the maintenance and routine testing of ventilation systems the Trust has appointed an authorising engineer. There is also a local inspection and service contract, controlled by the mains laboratories for all local exhaust ventilation systems that are used in clinical areas. This covers all fume cabinets and air handling systems and ensures that they are checked annually.
- In response to the increase in staff smoking incidents, discussions are ongoing with Health and Safety representatives in various forums with new protocols in place to support management of incidents related to staff smoking on hospital grounds.
- Challenges remain with extreme temperatures due to the Trust's aging estate until the New Hospital build is in place. Whilst these are mitigated through various methods, the residual cause will not be addressed fully until the new Hospital is built.
- The main reason for sharps related incidents is due to incorrect disposal of sharps including sharps containers in the wrong waste stream and loose sharps and needles being found in domestic

waste. The Safer Sharps Group continues to meet bi-monthly to review incidents with the Health and Safety Manager, Waste Minimisation Officer and Portering Manager actively working with wards and departments in an attempt to reduce these incidents.

- Medical device decontamination continues to be an area of focus with a number of different approaches being worked on to raise the profile of the reasons of why this is important and how to prevent this from occurring including production of a SOP and training.
- Mandatory moving and handling training continues to be provided as an e-learning package. Since August 2022, and the lifting of Covid-19 restrictions, face to face has started to be reintroduced for all new starters, bank staff and clinical established staff. It is expected that the availability of face to face manual handling training will start to demonstrate a notable impact in reducing manual handling incidents.

2.5.7 Incident types seeing a noticeable decreasing trend in reporting are “Pest Infestation” (50% decrease), “Actual exposure to/contact with body fluids/bloods” (47.5% decrease) and “Incorrectly disposed waste” (29% decrease).

2.6 Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reporting analysis

2.6.1 RIDDOR requires the Trust to report work-related incidents to the HSE in certain circumstances. Incidents are only reportable if they arise ‘out of or in connection with’ work but that can include incidents involving visitors, patients, and contractors in our workplaces. Depending on the severity and nature of the injury, and indeed the party affected, the Trust has a legal duty to report this data to the HSE.

2.6.2 This reporting process is undertaken by the Health and Safety Manager with reportable staff incidents divided into five categories:

- The death of any member of staff whilst at work
- A specified injury to a member of staff due to a work activity.
- A dangerous occurrence
- Staff contracting an occupational disease.
- An incident relating to flammable gases or gas fittings.

2.6.3 Table 4 in Appendix 1 details the number and type of incidents reported under RIDDOR in 2022 and 2023.

2.6.4 There is an 18% reduction in the number of incidents reported to RIDDOR between the two comparable years. The highest RIDDOR reported incident type for both years is “slip, stumble or fall”, however there is a 50% decrease in the number of incidents reported between the years.

2.6.5 Full investigations are completed in all cases and the learning is built back into the relevant processes and procedures. To date, for 2023 there has been no requests for further action to be taken from the HSE.

2.7 Health and Safety Training

2.7.1 As part of core skills, there are a number of elements of training relevant in relation to Health and Safety for all staff to complete. Compliance with these is monitored at individual ward/departmental level, divisional level and at Workforce Committee.

2.7.2 Elements of core skills related to Health and Safety are listed below, with a summary of organisational wide compliance at the end of December 2023.

- Health, Safety and Welfare 96.6%

- Fire Safety 96.5%
- Infection Prevention and Control 95%
- Manual Handling (non-clinical) 87.6%
- Manual Handling (clinical) 81.2% - Compliance with this has been affected by challenges in delivering face-to-face training. To improve compliance, the Trust has increased the number of key movers that can provide local training with steady improvements in compliance being seen.
- Conflict resolution training 98.7%

2.7.3 The Trust also has a Leadership Responsibilities in Health and Safety module available. The target audiences for this require review with the education team developing plans to build compliance into regular monthly reporting.

2.7.4 Other training related to Health and Safety is available but is role-specific e.g. security training. In addition, managers and nominated individuals who attend the Health and Safety Governance Group are encouraged to undertake an accredited Institute of Health and Safety Awareness training with 15 members of staff having completed this training in August 2022 and 15 in February 2023. There are also 3 members of staff currently undertaking the National Examination Board in Occupational Safety and Health (NEBOSH) course enhancing their Health and Safety knowledge and understanding.

2.8 Audit and Monitoring

2.8.1 The Health and Safety Department undertake a number of proactive and reactive inspections and audits throughout the year to manage and reduce risk. These include:

- Environmental safety inspections – The Health and Safety support staff undertake inspections and any identified issues would be escalated accordingly. Minor issues are rectified at the time of the inspection.
- Monthly external and internal site inspections – Management of roads, footpaths and internal public areas continues, and is reported to the Senior Estates Manager. Regular proactive safety reports of the grounds and internal areas have highlighted a number of potentially hazardous situations receive appropriate attention through expenditure of capital funds as appropriate.
- Monthly environmental/building inspections - These are carried out in clinical areas by the Health and Safety Team, the results of these are reported internally via Estates and Facilities key staff.

2.8.2 A number of elements of Health and Safety are tested as part of the Safety Triangulation Accreditation Review (STAR).

2.8.2.1 A summary of key learning has been identified and relates to the following:

- Equipment is fit for purpose with testing stickers and serviced – Latest compliance is 84.8%. Whilst support is available from medical engineering, some challenges faced by staff are due to the number of different pieces of equipment, challenges in processing these and awareness of different contractors, accessibility.
- Fire exits are clear of obstruction – Latest compliance is 90.9%. Fire exits are occasionally blocked by linen cages for soiled linen bags due to issues with the linen chutes in the tower block. Although the linen chute is now repaired challenges remain with screens, trollies and other equipment blocking fire exits.
- Oxygen and suction is available and is in working order with kit ready for use – Latest compliance is 87.9%. Where repairs may be required, these can take time and may include waits in receiving parts.
- Sharps waste is appropriate and less than ¾ full with no evidence of gloves or dressings. There are no protruding sharps, and the temporary closure mechanism is in place when not in use. The bin is not stored at floor level - Latest compliance is 87.9%. Overfull sharps bins on occasion or more than ¾ full which increases the risk of sharps injuries.

- Food in both patient and staff fridges are labelled appropriately - Latest compliance is 91.2% - Staff food not always labelled, missing checks and some out of date items on occasions.
- The nurse call systems are within the patient's reach and nurses respond to the call bells in a timely way - Latest compliance is 93%. Occasional issues with call bell supply and awaiting call bell replacements with a number of related risks on the risk register.

2.8.2.2 Areas of good practice include:

- Availability of chlorine based cleaning products for enhanced cleaning, and these being stored correctly in COSHH cupboards – Latest compliance is 96.9%. Historically, these were often not locked with chlorine products left outside. However, with reinforcement through STAR, significant improvements seen. Some wards and departments have also changed locks from keys to having combination locks which helps them remain locked.

2.8.2.3 Overall, the STAR audits have identified some Health and Safety risks and challenges in relation to the general environment. Due to the ageing estate, there is poor flooring and evidence of the environment in poor state of repair. This may lead to an increasing risk of falls and/or infection. Despite this, there is a good reporting culture from staff who generally report any repairs and any equipment out of service dates with the aim of getting these rectified. Though, there are some areas, such as Emergency Department, Critical Care and Theatres where it can be challenging to report and keep track of issues and equipment reported due to their footprints and the number of equipment required in these areas.

2.8.2.4 Learning from STAR is included within the STAR report which is shared with Estates and facilities Partnership Board with Quality Assurance Team support for any escalation as required. Further work is ongoing to further strengthen the learning and communication of Health and Safety themes identified through learning from incidents and audits across the wider organisation.

2.9 Notable external visits

2.9.1 Table 5 in Appendix 1 gives a summary of notable visits that relate to Health and Safety in the last 12 months.

3. Summary and Next Steps

3.1 The paper provides a summary of Health and Safety activity including that of the Health and Safety Governance Group which continues to be strengthened and reinforced through wide engagement with staff, patients and departments operating throughout the Trust to stakeholders from external regulators and organisations and trade union representative.

3.2 Nonetheless, due to the ongoing Health and Safety challenges facing the organisation secondary to the ageing physical estate and ongoing workplace stress/demands, the Health and Safety teams both corporately and within Estates and Facilities are working collaboratively to revisit the Health and Safety governance arrangements across the organisation. This will inform the forward management plan for Health and Safety for the Trust to ensure ongoing compliance with all relevant legislation within the current financial envelope.

4. Financial implications

4.1 Under the Health and Safety and Nuclear Fees Regulation 2022, the HSE will recover costs for the work undertaken when managing certain contraventions of Health and Safety Law. These contraventions are known as “material breaches”. The cost recovery is known as “Fee for Intervention (FFI)”

4.2 There may be some financial implications in mitigating a number of Health and Safety related risks, particularly whilst waiting for the development of the New Hospital.

5. Legal implications

5.1 As outlined in Section 2.2, the Health and Safety at Work Act 1974 imposes duties on employers to protect the 'Health, Safety and Welfare' of all their employees, as well as others on their premises, including contractors, visitors and the general public. Section 2.2 provides further information on compliance with relevant Health and Safety legislation.

6. Risks

6.1 There are a number of risks related to Health and Safety on the Trust's Risk Register which may lead to non-compliance with legislation and risk to Health, Safety and Welfare of employees, as well as others on the Trust's premises. These risks relate to a variety of reasons including food contamination, ventilation issues, fire alarms not working, extreme temperatures, poor lighting, water safety issues, degradation of windows including restrictors, decontamination, electrical issues, road surface issues, risk of exposure to ionising radiation, ligature risks, violence and aggression, moving and handling issues, physical environment challenges e.g. leaks and ageing environment and equipment.

6.2 All risks are managed in accordance with the trusts Risk Management Policy RMS-01 and reported and managed through divisional and corporate meetings. However, due to the ageing estate and ongoing financial challenges, it is difficult to eliminate all Health and Safety risks in their totality.

6.3 Further information on risk management and reporting can be found in Section 2.3.

7. Impact on stakeholders

7.1 The Health and Safety at Work Act 1974 legislation was introduced to apply broad duties and best practice in regard to the Health and Safety of organisations workforce. This includes a duty of care for employees, casual workers, self-employed workers, clients, visitors, and the general public. Robust Health and Safety governance and Physical health and Safety governance will ensure the trust delivers its regulatory duties in line with The Health and Safety at Work Act 1974.

8. Recommendations

8.1 It is recommended that the Safety and Quality Committee:

i. Receive the contents of the report and confirm they are assured of the actions being taken to reduce the risks associated with Health and Safety despite a number of challenges.
ii. Note the Safety and Quality Committee will receive a further update in 6 months' time providing assurance on the areas that require further improvement.

Appendix 1 – Tables and Figures

Table 1 gives an overview of the groups that report into the Health and Safety Governance Group

Group	Description	Chair	Frequency of meeting
Asbestos	Management and monitoring of safe work and overseeing the implementation of the Asbestos Management Plan	Senior Buildings Manager RPH	Bi-monthly
Water safety	Management and monitoring the effective implementation and management of the Trust's Water Safety Plan and water services are managed according to the National Guidance on Legionella.	Senior Engineering Manager	Bi-monthly
Medical devices	Management and monitoring all medical devices ensuring safe procurement, usage, maintenance user training.	Medical Engineering Manager	Bi-monthly
Decontamination	Provide assurance at the operational level of the decontamination environment and that the processes within it are safe and effective.	Decontamination Manger	Bi-monthly
Integrated Partnership	To develop strategies that supports the maintenance and continual improvement of the patient environment.	Matron Infection Prevention Control	Monthly
Radiation Protection and Medical Exposures Committee	Monitor and manage all aspect of radiation protection in line with Ionising Radiations Regulations 999 (IR1999)	Head of Radiotherapy Physics – Consultant Clinical Scientist Trust Radiation Protection Lead	Bi-Monthly
Safer Sharps Group	Monitor and effect solutions to sharps related issues arising.	Health and Safety Manager	Bi-monthly
Waste Management Group	Provides a forum for the discussion of strategic waste related issues, and implementation of relevant legislation and good practice and procedures.	Senior Buildings Manager	Monthly
Joint Consultative Committee	To comply with the requirement to consult staff side representatives.	Strategy Workforce & Education Director	Bi-monthly

Table 2 gives an overview of compliance with key Health and Safety legislation

Governance Health and Safety Compliance	
Legislation	**Actions in place to support compliance with legislation**
Management of Health and Safety at Work 1999	• Health and Safety Policy in place and up to date. • Competent persons in place for Health and Safety. • Health and Safety Governance Group established to consider all aspects of health and safety. This also helps to generate targeted audits for aspects of health and safety. • Sub-groups provide chairs reports to this meeting. • Risk assessment and risk register process established. • Senior management training in health and safety for all band 6's and above. • General Health and Safety training via E-learning.
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)	• Reporting system established. • Investigation process in place for all reportable incidents. • Bi-monthly report to Health and Safety Governance group. • Close links with the legal team
Display Screen Equipment Regulations (DSE)1992 amended 2002)	• To ensure staff have display screen equipment assessment an E-learning package for safe use of display screen equipment has been developed • Work is underway to ensure all relevant staff complete the E-learning package. • Work is also underway to ensure sufficient trained DSE assessors in place if additional support needs are identified for staff,
Control of Substances Hazardous to Health (COSHH)	• Sypol COSHH data bases established and available to all relevant staff. • Authorised chemical disposal route established working closely with waste minimisation. • Annual chemical audit in place. • Personal protective audits carried out in accordance with the COSHH regulations. • Dangerous Goods Safety audit undertaken by specialist contractor. • At the beginning of 2023, in an attempt to be proactive, health and safety have been working with the Occupational Health doctors to introduce an annual health surveillance form that can be completed locally. A trial of the form was completed with all staff working in the labs at Royal Preston Hospital with positive outcomes. The plan is to roll this form out to all areas in 2024.
Ionising Radiations Regulations (IRR) 2017	• Radiation Protection and Medical Exposure Group in place • Personal dosimetry monitoring and annual medical surveillance for staff working with ionising radiations. The Trust is responsible for supplying personal dosimeters to all of LTHTR staff that work with radiation as appropriate. Christies Medical Physics and Engineering (CMPE) provide advice on the level of dosimetry required and the dosimeters are checked locally by the radiation protection Supervisors for any discrepancies. The dosimeters are also audited independently by UKHSA who maintain a data base of the results. This is a legal requirement. And doses throughout 2023 were within acceptable levels without significant variations for previous years. • Currently the Trust has two members of staff that have been classified under the Ionising Radiation Regulations (IRR17(21). This means that they have received an effective (whole body dose) in excess of 6mSV/y of radiation or more than three tenths of the dose limited to the extremities (150mSV/y of radiation). Designation is bases on external exposure, internal exposure or both depending on the nature of the ionising radiation. Both staff have been informed by letter and arrangements have been made to allow for appropriate health surveillance to be carried out on annual basis. CMPE review the dosimetry at the beginning of each year to determine whether the classification will remain. • Arrangements in place for the recording of the secure and safe transportation of stored radioactive materials and radioactive waste • CMPE have been appointed as radiation protection advisors to the Trust, providing expert advice on new imaging designs and existing facilities. • Each modality has its own radiation protection supervisor. • CMPE have devised a programme of regulatory audits in the various departments to check compliance. They provide reports for discussion at the Radiation Protection and Equipment Liaison Group meeting that meet monthly and the Radiation Protection and Medical Exposure

	Committee which meets quarterly. The chairs reports from both report into the Health and Safety Governance Group meeting.
Part II of UK Medical Devices Regulations 2002 (as amended) on medical devices	• Policy for the Management of Medical Devices in place. • Medical Devices Management Group in place with reports to Health and Safety Governance Group. • Medical Engineering Operations Manager. • Also see table 5 for external assurances.
HTM 05-01 **Managing Healthcare Fire Safety**	• Fire Safety Policy in place. • There is a Fire Safety Management System in place. • There is a Fire Safety Manager appointed. • Fire Safety Training in place for all staff. • Fire Safety Reports to the Health and Safety Governance Group. • Fire Risk assessments in place for all areas. • Fire Drills in place. • Currently a focus on role specific training in Fire Safety through Health and Safety Governance Group.

Physical Risk Health and Safety compliance

**The Estates and Facilities Department have a statutory compliance tracker spreadsheet for all relevant legislation and another for all HTM's. The table below references Key Performance Indicators (KPI's) for each element of the legislation or HTM and these are reviewed and scored . There is an associated risk assessment and where compliance is not being delivered an action plan with associated timescales is formulated. Any red KPI's trigger an estates and facilities risk to be entered onto the trusts risk register and managed in accordance with the Trust Risk Management Policy. The Trusts Health and Safety Governance Team monitor, audit and review the effectiveness of organisational Health and Safety management arrangements.

Legislation	Supporting Evidence	KPIs**	Further actions being taken
Lifting Operations and Lifting Equipment Regulations **Heath Technical Memorandums** • **HTM 00** • **HTM 08-02** **Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) L113** **British Standards 7255:2012** • **BS 8210:2012** • **BS 9999:2017** • **BS 5655-10.1.1:1995**	• System of checks for all lifting equipment established with Arjo and Alliance, the Trusts authorising engineers	KPIs** • Compliant 66.67% • Progressing 19.05% • Outstanding 14.29%	Authorising Engineer to undertake audit and results to be taken through the Health and Safety Governance Group
Control of Asbestos Regulations 2012	• Annual Management asbestos survey completed. • Funding allocated for any actions generated.	KPIs** • Compliant 94.44% • Progressing 5.56%	Remedial works actioned and completed. Quotes received for remedial work to plant rooms, identified in the asbestos surveys and periodic

	• Refurbishment and Demolition surveys carried out for major projects as required. • Active Asbestos Management Plan established. • Operational Asbestos Group established. • Reports into the Health and Safety Governance Group Meeting.		inspections awaiting approval for funding.
Electricity at Work Regulations 1989 **BS7671** **HTM 06**	• Authorising Engineers (AE) trained and available to completed general checks.	<u>% KPI Scores Low Voltage**</u> • Compliant – 78.38% • Progressing 21.62% <u>% KPI Scores High Voltage**</u> • Compliant 85.71% • Progressing 14.29%	Recommendations/actions identified in the AE audit to be addressed.
HTM 02-01 **Medical Gas Pipeline Systems (MGPS)**	• MGPS operational policy in place. • Authorising Engineers (AE) trained and available to completed general checks.	KPIs** • Compliant 88.24% • Progressing 11.76%	Recommendations/actions identified in the AE audit to be addressed.
Management Regulations and Confined Spaces Regulations 1997	• Areas within the Trust are assessed to identify if they present confined spaces hazards. • There are procedures for risk assessments to be carried out prior to entry.	KPIs** • Compliant 44.44% • Progressing 11.11% • Outstanding 44.44%	To ensure that suitable and sufficient emergency rescue arrangements are in place for confined space work. Individuals who work in confined spaces to have specific training.
Work at Heights Regulations 2005	• Work at Heights and Ladder Safety policy includes pre use and annual checks including the use of Ladder Safety Checklists and the need to carry out site specific risk assessments for higher risks including developing emergency plans.	Awaiting detail of KPI position. Unavailable at time of report formulation	To be determined and followed up at the next Health and Safety Governance Group.
Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises Part B, Operational management and performance verification	• Ventilation Policy in place. • There is an appointed Authorising Engineer and they suitably trained. • Up-to-date drawings for ventilation systems available. • Permit-to-work system in place.	KPIs** • Compliant 54.55% • Progressing 45.45%	Logbooks to be available on all ventilation plants. Focus on ventilation inspection frequency of checks.

Safe Water in Healthcare Premises **HTM 04-01**	• Water Hygiene Policy in place. • Water Safety Plan in place. • Authorising Engineer for Water Safety. • Trust Water Safety Group (WSG).	KPIs** • Compliant 84.85% • Progressing 15.15%	Risk Assessments reviewed to ensure actions progress and are completed. Development of a training matrix to monitor personal who participate in the water monitoring regime are suitably trained.

Table 3 details Health and Safety incident reporting profiles between two comparative 12 month periods for 2022 and 2023*

Incident Type		2022	2023	Grand Total
Accidents	Burn or Scald	18	24	42
	Collision with an object (e.g. equipment, furniture and/or fittings)	46	44	90
	Contact with Electricity	3	1	4
	Contact with Sharps	160	233	393
	Slips, Trips, Falls	162	164	326
	Hit by a moving vehicle/moving or falling object	38	28	66
	Injured during Manual Handling (equipment, machinery or patient)	71	93	164
	Unexplained injury	36	22	58
Staff Behaviour	Staff smoking on hospital grounds	14	28	42
Violence & Aggression	Violence & Aggression by patient or visitor	984	1211	2195
	Violence & Aggression by staff	185	149	334
Fire Incidents	Fire Incidents (including actual, false alarm and fire hazards)	354	326	680
Environment	Actual exposure to chemical/biological agent (e.g. asbestos)	22	22	44
	Actual exposure to/contact with body fluids/bloods	187	98	285
	Exposure to excessive noise/light	6	10	16
	Exposure to extreme temperature (hot or cold)	137	215	352
	Exposure to smoke	12	14	26
	Exposure to unhygienic environment	113	94	207
	Exposure to unsafe buildings/infrastructure	60	70	130
	Exposure to unsafe equipment/machinery	55	47	102
	Exposure to water/damp	32	30	62
	Flood	4	6	10
	Gas Leak	0	1	1
	Incorrectly disposed sharp	47	30	77
	Incorrectly disposed waste	51	36	87
	Lack of ventilation	4	9	13
	Legionella	2	2	4
	Pest Infestation	28	14	42
	Potential Exposure to chemical/biological agent (e.g. asbestos)	12	12	24
	Pseudomonas	0	1	1
	Unplanned Disruption to Infrastructure (Electricity, Gas, Telephone and Water)	11	16	27
Staffing	Insufficient staff or Workplace Stress/Demand	2112	1992	4104
Security	Security incidents (breaking and entering, public order, vandalism, unsecure estate)	111	96	207
	Restraint incident	34	32	66
Grand Total		5111	5170	10281

** It should be noted however that the analysis of Health and Safety incident data within this report excludes incidents affecting patients, as these would be considered clinical incidents managed from a patient safety perspective. It also excludes incidents regarding infection prevention and control, as this is considered within the clinical safety portfolio.*

Table 4 Details the number and type of incidents reported under RIDDOR in 2022 and 2023

RIDDOR incidents reported by type	2022	2023	Grand Total
Slip, stumble or fall	16	8	24
Other - cause not listed	12	7	19
Pushing or pulling	4	3	7
Lifting, carrying, standing up	1	5	6
Twisting or turning		2	2
Shock, fright, violence, aggression		1	1
Overflow, leak, vaporisation or emission of liquid, solid or gaseous product		1	1
Grand Total	33	27	60

Table 5 gives a summary of notable visits that relate to Health and Safety in the last 12 months

CQC Inspection 2023	During the 2023 CQC inspection, CQC identified fire extinguishers beyond their service date. These checks are carried out by an external contractor and overdue checks monitored by the fire safety officer for the trust. The issue was rectified within the week. The Fire Safety Officer can also evidence the trust also having a current certificate of inspection of fire extinguishers. This inspection is annual, and the trust fire safety manager will liaise with FTS Fire and Security Limited to ensure any changes in estate purpose or building works indicate the need for an inspection ahead of any changes.
HSE Inspection 2023	In February 2023, the HSE made a planned visit to the Trust's main laboratories reviewing both the containment level 3 (CL3) facility and the decontamination service to assess and verify the adequacy of the facilities, management arrangements and procedures in continuing to meet the legal requirements of working with hazardous biological agents. There were a total of 5 recommendations made by the inspectors including further training for laboratory staff in the management and operation of microbiological containment laboratories and improvements made to the existing CL3 lab, including improving ventilation and fumigation processes. Funding has been made available and the capital team are currently in the design stage of the process. During the visit HSE recommended that laboratory should have autoclave test results available for review. The tests are completed on a quarterly and annually basis and are carried out independently of Trust staff (Belimed Ltd). Weekly testing is carried out, in-house by the Trusts authorising engineer. All test results are stored on a central data base within estates engineering. Since the visit the lab staff now have been given access to the relevant information and it is made available via the labs Q-pulse data base, for all relevant staff to review as required.
MIAA Review Estates Statutory Compliance Review 2022/2023	In April 2023, MIAA issued their findings from a review of the systems and processes in place to record compliance against statutory requirements for those services typically covered within the Estates function. Healthcare-specific technical engineering guidance is a vital tool in the safe and efficient operation of healthcare facilities. HTM guidance is the main source of specific healthcare-related guidance for estates and facilities professionals. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 requires that Premises are maintained in accordance with statutory requirements and as such form part of Care Quality Commission (CQC) inspection regime. The overall objective of the audit was to confirm whether the Trust can demonstrate that it has systems in place to ensure that services typically owned by Estates are provided in accordance with the Department of Health HTM requirements and CQC inspection requirements for building and property maintenance. Overall, MIAA gave an assessment of high assurance confirming that there is a strong system of internal control which has been effectively

	designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
MIAA Review Medical Devices 2023/2024	During 2023/2024, MIAA have undertaken an audit to assess the processes and controls around the management of medical devices including procuring new medical devices, safe and effective use and maintenance of existing devices and disposal of devices. Overall, MIAA gave an assessment of substantial assurance confirming that there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently. Areas for improvement relate to following established processes for procurement of equipment and updating of the Medical Devices Management Group Terms of Reference. An action plan is underway.
UKCA Medical Device Certification 2023	The Trust was subject to a UKCA Medical Device Certification Audit Report by SGS United Kingdom Ltd (December 2023). SGS United Kingdom Ltd recommended that, based on the results of the audit, the system's demonstrated state of development and maturity and the demonstrated level of adequacy for the quality management system was such that it systematically meets the agreed requirements for UKCA Medical Device Certification.
Clean Air Solutions Ventilation Review 2023	An annual compliance audit was completed in accordance with the requirements of Health Technical Memorandum 03-01: Specialist Ventilation for Healthcare Premises Part B, Operational management and performance verification. This was undertaken by Clean Air Solutions Europe Ltd on 7th October 2023 and assessed compliance as satisfactory.
Medical Gas Pipeline Systems Review 2023	The audit reviewed the suitability and adequacy of the operational management arrangements in place for medical gas pipeline systems (MGPS) installed. HTM 02-01 Part B is the guidance document for this audit. Overall, Merkland Design & Engineering Consultancy Ltd considered the MGPS operational management arrangements as being of a satisfactory standard with the frequency of the audit requirement to remain annually.

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:**	1st February 2024
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert
Purpose of Report			

Part I	✓	**Part II**			
For assurance	☒	**For decision**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Board of Directors with an update in relation to the safety and quality programmes of work within the maternity and neonatal services up until and including December 2023. Perinatal performance metrics are displayed on the quality surveillance table each month to provide greater oversight of clinical outcomes and key safety indicators for oversight and assurance.

Progress against key maternity national priorities recommendations have also been included in the report. An updated position against the requirements of the maternity self-assessment, the overarching Ockenden and the three-year single delivery plan for maternity and neonatal services has been included, detailing the progress against ongoing action plans for improvement. The report also details the intention to centralise workstreams into an updated maternity improvement and transformation plan. This will enable more efficient oversight and timely proportionate action to address any concerns identified.

NHS Resolution continues to operate in year 5 of the Maternity Incentive Scheme (MIS). This report reconfirms that, following quarterly validation of the evidential requirements, by the Local Maternity and Neonatal System/Integrated Care Board that the service will be declaring achievement of all ten Clinical Negligence Scheme for Trusts (CNST) safety actions. Final sign off by the Chief Executive Officer for the Trust and the Accountable Officer for the ICB has been completed and the declaration will be submitted during the required window between the 25th January and the 1st February 2024.

The committee should note that the governance review, commissioned in response to the Care Quality Commission (CQC) national inspection of maternity service on the 2nd and 3rd July 2023 was completed by the Local Maternity and Neonatal System (LMNS) ICB in December 2023. The review did not identify any immediate actions or cause for concern and concluded that a robust maternity governance team structure was evident, with accountability and line management to the Divisional Midwifery and Nursing Director and Clinical Director. All key roles were identified, and structures clearly defined with links to corporate governance. The review will be presented to the committee in February with a supporting action plan.

To note a formal letter was also received in December 2023 from NHS Resolution letter to inform the service that a thematic review into cases referred under the Early Notification (EN) scheme in response to concerns following the CQC downgraded the 'overall 'safe' rating for maternity at the Royal Preston Hospital from "Good," to "Requires Improvement" in November 2023. In addition, the number of incidents reported to the EN scheme from the Trust has increased significantly, with an EN incidence rate (by birth rate) for 2022/23 is 0.19%, greater than twice the national rate of 0.06% and the regional rate of 0.07%. The review will be completed in February 2024 and the outcome will be shared with the committee once received.

To demonstrate detailed oversight of the outcomes measures the perinatal quality surveillance dashboard (PQSD) (Table 2) triangulates workforce information with safety, patient experience, and clinical effectiveness indicators to enable the committee to maintain oversight of the maternity and neonatal services. Following discussion with members of the Safety and Quality Committee in early January 2024, changes to reporting formats are underway and will present the PQSD in SPC charts where appropriate.

The fill rates for Registered Midwives (RM) (84%) and Maternity Support Workers (MSW) (71%) in December 2023 demonstrates a sustained, lower than planned fill rate, which is reflected in the year-to-date projection. The outstanding 2023 Birthrate plus safe staffing uplift continues to present a risk to the service. The external assessment has been validated as being an accurate assessment of need. At this time there is not a resolution to this given the financial position of the organisation, this is highlighted as a gap on the strategic risk and will form part of 2024 financial planning considerations.

The perinatal quality surveillance dashboard indicates some areas of ongoing and increasing pressure. Ongoing reduced performance related to antenatal booking performance and the antenatal screening Key Performance Indicators remains a cause for concern and despite meeting the standard for the first time in December 2023, the Trust is an outlier when compared to other Trusts within the region. Staffing pressures in Quarter 2, Quarter 3 and into Quarter 4 because of midwifery vacancies, long-term sickness absence and rising maternity leave have had a detrimental impact on the ability to achieve and sustain performance. Consequently, the ability to achieve antenatal screening for sickle cell and thalassemia is also affected. The service is exploring alternative approaches to addressing this issue. As part of responding to the staffing establishment within the unit, the service continues to utilise divert arrangements when appropriate to do so, whilst this mitigates the risk to women, when it occurs, it adversely affects the experience of women who live locally and have chosen to give birth in Lancashire and south Cumbria.

Recommendations

The Board of Directors are asked to:

I. Receive the Maternity Service Update including safe staffing position
II. Note the CNST update report and recommendations.
III. Receive the update in relation to Maternity and Neonatal Improvement plan
IV. Receive the associated action plans for information oversight and assurance.

Appendix Catalogue

1. Action Plan Progress Tracker
2. PMRT Cases
3. Overarching PMRT Action Plan
4. Saving Babies Lives Progress Tracker
5. HSIB/MNSI Cases

6. Ockenden 2 Action Plan
7. Maternity Self-Assessment
8. Red Flags
9. Safety Champions Action Log

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 and Quality Committee Jan 24

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programme of work within the maternity and neonatal services including those relating to the ten maternity safety actions included in year five of the NHS Resolution Clinical Negligence Scheme for Trusts maternity incentive scheme (CNST MIS). The report also triangulates workforce information with safety, patient experience and clinical effectiveness indicators for Board assurance and oversight.

2. MATERNITY INCENTIVE SCHEME (MIS)

Following quarterly external validation of the evidential requirements by the LMNS/ICB and presentation of the minimum requirements, action plans and evidence to the Trust Safety and Quality Committee monthly and to the Board of Directors, the service will declare 100% compliance (10/10) compliant with CNST MIS year 5 safety standards. Final sign off by the Chief Executive Officer for the Trust and the Accountable Officer for the ICB has been completed and the declaration will be submitted between the 25th January and the 1st February 2024.

A summary of the final position for CNST MIS year 5 regarding the attainment of all ten safety actions is detailed below. (Table 1)

Table 1: Progress Tracker

Safety Action	Progress Update	RAG Rating
Safety Action 1 - PMRT	Evidential Requirement met	
Safety Action 2 - MSDS	Evidential Requirement met	
Safety Action 3 - ATAIN	Evidential Requirement met	
Safety Action 4 – Clinical Workforce planning	Evidential Requirement met	
Safety Action 5 – Midwifery workforce staffing	Evidential Requirement met	
Safety Action 6 – SBLV3	Evidential Requirement met	
Safety Action 7 – Maternity and Neonatal Voice Partnership (MNVP)	Evidential Requirement met	
Safety Action 8 – Training Core Competency Framework	Evidential Requirement met	
Safety Action 9 – Board Assurance	Evidential Requirement met	
Safety Action 10 – MNSI (formally HSIB)	Evidential Requirement met	

Mandated updates for MIS safety action 1 detailing the deaths reviewed, any themes identified and the consequent action plans (Appendix 2 and 3), safety action 6 including the updated Saving Babies Lives Version 3 compliance (SBLV3) (appendix 4) and safety action 10 pertaining to referrals to the Maternity and Newborn Safety Investigations programme, (appendix 5) including action plans for MIS are included in appendices for continued oversight.

3. 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 2 details the performance over time from January 2023 to December 2023.

Table 2: Perinatal Quality Surveillance Model Safety Outcomes Table (Formally maternity specific safety and quality matrix check)

Metric	Red flag		Green flag		Jan 23	Feb 23	March 23	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
CNST 10 Key safety actions (Year 5 scheme updated in 31st May 2023)					**100%**	**100%**	**100%**	**100%**	**100%**	**40%**	**40%**	**60%**	**60%**	**80%**	**90%**	**100%**
Births					350	304	376	298	339	371	362	369	352	344	327	315
Total stillbirths represented as a number. New Dec 23															3	1
Total stillbirth rate (per 1,000 births)	>	4.9	≤	4.9	5.7	0.0	5.3	3.4	2.9	0.0	2.8	5.4	2.8	2.9	9.2	3.2
Stillbirth rate excluding termination for fetal abnormality					2.9	0.0	5.3	3.4	2.9	0.0	2.8	5.4	2.8	2.9	9.2	3.2
Examination of the newborn completed within 72 hours	<	95%	≥	95%	95.1%	95.7%	94.7%	95.6%	96.2%	95.7%	96.7%	96.5%	92.6%	95.1%	93.5%	95.2%
Breastfeeding initiation	<	70%	≥	70%	73.9%	76.3%	82.9%	79.8%	76.3%	77.6%	79.8%	77.9%	76.1%	78.4%	74.7%	80.3%
Booked by 9+6	<	50%	≥	50%	32.6%	38.7%	47.3%	42.2%	51.5%	51.3%+	47.4%	48%	30.3%	32.5%	35.1%	52%
Booked by 12+6	<	90%	≥	90%	88.0%	90.8%	88.9%	83.3%	92.7%	90.3%	48%	85.5%	81.5%	83.1%	87.3%	92.3%
Women giving birth in a midwife-led setting	<	25%	≥	30%	17.5%	16.6%	15.1%	16.6%	14.2%	15.8%	15.2%	14.2%	12.5%	14.8%	16.3%	11.9%
Home birth	<	1.7 %	≥	2.0%	2.3%	3.3%	2.1%	3.7%	3.2%	2.4%	2.5%	3.3%	2.3%	2.9%	3.7%	1.6%
Incidence of severe tears grade 3 and above	≥	2.4 %	<	2.4%	2.4%	2.1%	2.8%	2.3%	1.5%	2.7%	2.6%	1.8%	2.9%	3.0%	4.6%	1.1%
One-to-one care in labour in Delivery Suite.	<	100 %	=	100%	99.6%	98.4%	99.7%[$]	99.2%	97.6%	100%	100%	100%	99.5%	100%	100%	100%
One-to-one care in labour in Preston Birth Centre	<	95%	=	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
One-to-one care in labour in Chorley Birth Centre	<	95%	=	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HDU trained per shift.	<	89%	=	90%					99.57%	99.57%	100%	100%	98%	98%	98%	97%
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%	93%	94%	96%	99%	98%	99%	97%	97%	95%	97%	98%
Annual competency (K2 Training Package)	<	90%	≥	90%	99%	99%	99%	97%	97%	96%	95%	94%	95%	96%	99%	99%
GAP/GROW (Growth Assessment Protocol Training)	<	90%	≥	90%	82%	82%	87%	83%	80%	82%	83%	80%	80%	90%	92%	93%
Emergency skills Training (PROMPT – Practical Obstetric Multi-Professional Training)	<	90%	≥	90%	93%	93%	94%	93%	96%	94%	94%	86%	83%	95%	96%	96%
Pool Evacuation Training Midwives (CQC requirement) new Dec 23. Parameter for standard not set		90%		90%												66%
Incidents of moderate harm and above	--		--		1	2	2	0	0	3	0	3	2	3	6	3
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened.	--		--		0	2	1	0	0	0	0	0	2	2	1	0
Complaints	--		--		2	3	2	2	2	2	1	2	2	3	3	1
Prevention of future deaths regulation 28	--		--		0	0	0	0	0	0	0	0	0	0	0	0
CQC Enquiries	--		--		0	0	0	0	0	0	0	0	0	2	1	0
Maternal Death	> 1		<1		0	0	0	0	2	0	0	0	0	0	0	0
Number of Consultant hours on obstetric unit	<70 hrs		=/> 96.5hrs		76.6% hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs

RCOG obstetric benchmarking compliance	<100%	100%	93%	95%	94%	100%	100%	100%	91%	100%	100%	100%	91%	98.4%
24-hour acute obstetric medical staffing fill rate	<95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Births per Funded Clinical Midwife WTE	>28	≤26	23	22	25	21	23	24	26	25	24	23	23	21
Neonatal Nurse Staffing compliance to BAPM (Badger Net report)	<90%	>90%							90%	98%	65%	69%	93%	77%
Staff sickness rate	4%	4%	8.7%	8.6%	8.6%	7.9%	8.47%	8.6%	8.7%	8.8%	8.6%	9%	9.2%	6.9%
Fill rate RM Day	<85%	>85%	82%	81%	81%	82%	NA	93%	95%	91%	74%	79%	84%	84%
Fill rate MSW Day	<85%	>85%	77%	72%	71%	73%	NA	93%	90%	86%	76%	74%	79%	71%
Fill rate RM Night	<85%	>85%	95%	94%	90%	97%	92%	90%	84%	82%	82%	81%	87%	87%
Fill rate MSW Night	<85%	>85%	95%	94%	95%	100%	94%	89%	91%	100%	94%	98%	100%	98%
Registered Midwife shifts sent to agency per month.	--	--	122	143	152	107	110	110	127	127	146	146	151	152
Registered Midwife Agency hour fill rate percentage.	--	--	58%	51%	51%	51%	46%	45%	39%	49%	42%	42%	52%	51%
Red flags reported.			5	12	126	44	71	218	187	105	205	103	90	17
Maternity Diverts	> 1	<1	0	0	0	0	0	0	1	0	2	0	0	0
In- utero transfers declined to accept from other units (maternity)	--	--	1	2	2	0	2	5	4	5	5	5	3	2
In- utero transfers declined to accept from other units (NICU)	--	--	0	4	0	2	1	1	2	0	4	10	4	4
In- utero transfers from LTHTR to another Trust (Antenatal)	--	--	0	0	0	0	10	0	0	1	1	0	0	0
NICU Closure	--	--	0	3	2	5	13	1	1	0	1	2	0	2
Maternity Triage BSOT standard (15min)	--	--	90%	89%	86%	94%	90%	91%	93%	89%	91%	92.4%	89.4%	94.6%
Maternity Triage NICE standard (30 min)	90%	90%	97%	97%	94%	99%	98%	98%	98%	98%	97%	97%	97%	100%

3.1 BOOKING BY 9+6 WEEKS

Key performance related to booking by 9+6- weeks' gestation has been variable and the service continues to be an outlier when compared to other Trusts within the region. Staffing pressures in Quarter 2, Quarter 3 and into Quarter 4 because of midwifery vacancies, long-term sickness absence and rising maternity leave have had a detrimental impact on the ability to achieve and sustain performance. Intermediate actions to mitigate the risk to the service have been implemented to include additional booking clinics scheduled on bank, community hub rationalisation and utilisation of the continuity teams to support when appropriate. However, despite ongoing actions this has not resulted in improvement.

Reduced compliance to booking in line with NICE guidance is also impacting on Antenatal Screening Key Performance Indicators (KPI's) relating to timeliness of antenatal screening and most recently on available screening choices for Downs, Edwards and Patau's syndrome. The service is mapping alternative approaches that could be utilised to improve outcomes for a trial period, specifically considering an early bird appointment led by a maternity support worker (MSW). This will be considered by the service.

3.2 THIRD- AND FOURTH-DEGREE TEARS

The service continues to monitor the incidence of third- and fourth-degree perineal tears monthly and notes that in December 2023 the rate was reported as 1.1%. Statistical process control (SPC) analysis of the data continues to be undertaken which demonstrates no concern and common cause variation within the expected range.

3.3 ROYAL COLLEGE OF OBSTETRICS AND GYNAECOLOGIST CONSULTANT ATTENDANCE AUDIT

As the most experienced clinician, consultant obstetricians are required to be physically present, including out-of-hours, to support the care of more complex women or during high levels of activity. As such the Royal College of Obstetrics and Gynaecologist (RCOG) have published a definitive list of clinical scenarios and situations when consultants should be informed and when they should attend in person and services must monitor compliance to the standard, reporting exceptions from 100% to the Trust Board. An audit of compliance is therefore undertaken monthly and in December 2023, 98.4% of eligible cases were compliant to the standard. 1.6% of cases did not have a consultant present. This equated to 1/61 cases in the category of Postpartum Haemorrhage (PPH) >2L. Reasons for non-attendance have been explored and actioned by the Clinical Director for Obstetrics.

3.4 SICKNESS ABSENCE MANAGEMENT

Sickness absence in December 2023 has reduced for the first time in 12 months to 6.9 %. In view of the higher rates within the division, each speciality has been working with workforce partners to better understand the reasons for the high sickness rates and to revisit support plans to more effectively manage absence and timely return to work. The divisional people plan, and work force targeted action are also ongoing.

The committee should note that the higher sickness rates within maternity are comparable to North West regional rates which are on average 9.5%, with the most common reason for absence being wellbeing and mental health related. This elevated figure is also mirrored with MSW staff with an average of 9.5% of colleagues across the region experiencing absence from their work place.

3.5 RESTORATIVE SUPERVISION AND TRAUMA INFORMED SUPPORT FOR COLLEAGUES

The maternity service acknowledges the impact of trauma to staff following a difficult clinical situation or a poor outcome. Despite wide evidence which correlates trauma with poor mental health, support for teams has not always been readily available. Part of the role of the Professional Midwifery Advocate (PMA) is to provide restorative supervision and support. However specific training on how to do this well. is not offered routinely.

In response to high levels of sickness absence and to the rising complexity of cases mix, the service has commissioned a training programme for the 14 PMA's and other future PMA's to undertake a psychological peer support training, using the Trauma Risk Management (TRiM) model This model works through focused conversations with colleagues who have been exposed to trauma, focusing on identifying individuals at increased risk of developing a post-trauma mental illness. Those identified as at higher risk are re-interviewed around a month later, and if still at increased risk are assisted to access wellbeing support or professional help. It has been agreed that this programme will also include hot debrief training. Dates are awaited and it is anticipated that the first course will be in March 2024.

3.6 SAFE STAFFING

The service has a current registered midwifery vacancy rate as of the 31st December 2023 was 16.07 WTE (including maternity leave). Despite an ongoing advert to recruit, filling all vacances remains a challenge. Recruitment to maternity leave vacancy continues and all vacant shifts are sent to bank and agency. To forward plan, work is ongoing with the local universities to focus future allocations around geographical placements for

students (local placement for local communities) across the education providers. The service has also agreed to invest in offering elective places for Edge Hill students starting their 3rd year from September 2024, who have expressed an interest in working for us who live locally in the PR postcodes.

3.7 FILL RATES

The fill rates for Registered Midwives (RM) (84%) and Maternity Support Workers (MSW) (71%) demonstrates a sustained, lower than planned fill rate year to date. In December 2023, reduced fill rates in fill rates for daytime shifts across midwifery and MSW staffing continues to reflect the establishment gaps associated with maternity leave and ongoing sickness absence.

The outstanding 2023 Birthrate plus safe staffing recommendation continues to present a risk to the service. The external assessment has been validated as being an accurate assessment of need to maintain safety. At this time there is not a resolution to this given the financial position of the organisation. Whilst, the service continues to carry a vacancy, and recruitment has been challenging, the maternity support uplift recommended by birthrate plus should now be considered to support safe staffing. This will be considered as part of the financial planning for 2024.

3.8 NEONATAL (NICU) NURSE BAPM FILL RATES

In December 2023, the British Association of Perinatal Medicine (BAPM) compliance was 77%. When the activity and acuity was reviewed, whilst the neonatal admission numbers were decreased (total of 29 admissions and 27 discharges), acuity was higher than the previous month particularly for intensive care. All vacant shifts are sent to bank to mitigate the shortfall and the service reports a 0% nurse vacancy. The Children and Young People staffing report provides a comprehensive overview of Neonatal outcomes for the safety and quality committee.

3.9 INTRAUTERINE TRANSFER (IUT) NEONATAL AND MATERNITY

Two intrauterine transfers were declined by the maternity service in December 2023 due to acuity, four transfer requests were declined by the neonatal service. There were two occasions in December 2023 where the neonatal unit was required to close. The reason for the closures was attributed to decreased cot capacity due electrical failure at three cot spaces. During the periods of neonatal unit closure, there were no instances of women (antenatal) from LTHTR requiring transfer to another organisation.

3.10 UNIT CLOSURES OR DIVERTS

In the month of December 2023 there were no maternity diverts however, there were two instances of neonatal unit closure as discussed above.

3.11 RED FLAGS

The incidence of maternity red flags continues to be monitored by the maternity service. The breakdown of red flags by category is detailed in Appendix 9. There was a reduction in red flag reporting observed in December 2023, however, there was no reduction in Datix incident reporting overall. No incidents of direct harm have been associated with any maternity red flag incident and all reports are linked to the active risks on the risk register for ongoing oversight by the division.

3.12 REFERRALS TO MNSI (FORMALLY HSIB)

There were no incidents reported to the maternity and newborn safety investigation (MNSI) programme. There were no MNSI investigations concluded in December 2023.

3.13 INCIDENTS OF MODERATE HARM OR ABOVE

There were 3 cases of moderate harm or above report in the month of December 2023. All 3 cases were instances of Post Partum Haemorrhage (PPH) with one case requiring hysterectomy and admission to the critical care unit. Duty of Candour has been applied in all cases and appropriate review and action has been agreed in line with the PSIRF governance framework.

3.14 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 can continue to be delivered safely without impacting on the safety of the service. However, until staffing has stabilised, following risk assessment, triangulation of safety intelligence and when considering the current vacancy, there will be no further expansion of MCoC. The service continues to seek innovative ways 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.

In addition, the service has been accepted to undertake the NHS Race and Heath Observatory has partnered with the Institute for Healthcare Improvement (HI) and the Health Foundation (HF). The aim of the work is to deliver a Learning in action network which aims to tackle and close the gap seen in maternal mortality and morbidity between women from different ethnic backgrounds. Delivered over 15 months, the initial focus will be around data interrogation and ethnicity, specifically for one of 4 clinical outcomes. It is anticipated that this data analysis will then be utilised to expand datasets considering other clinical indicators collected on the maternity dashboard and will provide opportunity to review and consider most appropriate pathways into continuity for women in the lowest deciles, with the poorest clinical outcomes from Black and Asian and mixed ethnic groups.

4. GOVERNANCE REVIEW

Following the national maternity CQC inspection in July 2023, the Trust received a letter of intent under Section 31a. As a result of the response provided by the Trust and evidence submission no further action was taken. However, for assurance, and after discussion with NHS England regional chief midwife, the LMNS undertook a 3- month review of maternity governance**.** The outcome of this review has now been received and an action plan based on the recommendations will be collated. The review was positive and confirmed that the LMNS were assured that there was:

- Positive open and transparent culture of reporting
- Evidence of continuing quality improvement
- MDT approach to all incident management
- Strong links and working in partnership with the Corporate Governance Team, Patient Experience, PALS and Continuous Improvement Team
- Evidence of appropriate check and challenge from colleagues within and from outside the maternity team.
- The service is responsive to and has requested external support for reviews appropriately when required.
- Consistently triangulates data and intelligence from various sources, Serious Incidents, complaints, compliments, safety champion walk arounds.

5. EARLY NOTIFICATION

A letter was received in December 2023 from NHS Resolution to inform the service that a thematic review into cases referred under the Early Notification (EN) scheme in response to concerns following the CQC downgraded the 'overall 'safe' rating for maternity at the Royal Preston Hospital from "Good," to "Requires Improvement" in November 2023. In addition, the number of incidents reported to the EN scheme from the Trust has increased significantly, with an EN incidence rate (by birth rate) for 2022/23 of 0.19%, greater than twice the national rate of 0.06% and the regional rate of 0.07%. The review will be completed in February 2024 and the outcome will be shared with the committee once received.

6. MATERNITY IMPROVEMENT AND TRANSFORMATION

The provision of maternity services is complex in any organisation. By definition, maternity services are a high-risk clinical speciality, which require ongoing oversight by the service to coordinate and manage safety drivers, national maternity review progress and safety improvement initiatives. As such and in response, both the Safety and Quality Committee and the Board of Directors must receive regular updates detailing the progress being made against national work streams and actions taken.

It should be acknowledged that oversight of work streams is significant and therefore to ensure that appropriate improvement and progress is made, a centralised Maternity Improvement Plan (MIP) will be collated by the service, and this will be utilised to provide high level feedback, detail progress, and identify risks to outcomes or delivery of care.

7. BOARD ASSURANCE

To demonstrate detailed oversight of the outcomes measures the perinatal quality surveillance dashboard (PQSD) (Table 2) triangulates workforce information with safety, patient experience, and clinical effectiveness indicators to enable the committee to maintain oversight of the maternity and neonatal services. Following discussion with members of the Safety and Quality Committee in early January 2024, changes to reporting formats are underway and will present the PQSD in SPC charts where appropriate.

8. OCKENDEN UPDATE

Local Maternity and Neonatal system and Integrated Care Board level continue to be jointly responsible with providers for implementation, monitoring, and oversight of progress against national agenda, independent reviews, safety initiatives and care bundles to ensure that maternity and neonatal care is safer, more personalised, and more equitable for women, babies, and families. Whilst it was anticipated that the Three-Year Single Delivery plan was designed to combine national review findings and avoid duplication, an updated standardised approach is awaited from the LMNS. The Ockenden oversight and assurance processes have continued in 2023 and until a joint plan is confirmed, the service has continued to monitor the actions from the Ockenden final recommendations. An updated position on the monitoring and assurance associated with the Three-Year Delivery Plan will be shared once confirmed.

9. MATERNITY SELF ASSESSMENT

One of the actions recommended as part of the LMNS governance review was to revisit the maternity self-assessment toolkit. The safety self-assessment tool has been designed for NHS maternity services to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and keep the trust board and commissioners aware of their current position. An updated toolkit is anticipated, however a date for publication has not been confirmed. Therefore, an updated tracker is included in table 3. (The full tool is available in appendix 7)

Table 3 Updated Tracker Maternity Sellf Assessment Tool

Maternity Self-Assessment Tool	Total recommendation (158)	Deadline Extended not closed	Full Compliance	Action delivered awaiting evidence	Partial compliance	Non-Compliance	Regional consideration	National Requirement
December 2023	**158**	0	0	132	26	0		

10. SAFETY CHAMPIONS

The Executive safety champions continue to engage with and visit the service to provide an opportunity for staff to see and speak with members of the Board and for them to explore whether safety intelligence presented at Trust Board triangulates with the 'work as done' in practice. The Maternity and Neonatal Board Safety Champions also continue to support the perinatal quadrumvirate in their work focusing on positive cultures within the services. In addition to the Safety Champions meetings, the Board Safety Champion(s) Perinatal 'Quad' leadership team meetings have now been established and are arranged bi-monthly in line with the schedule for safety Champions. The ongoing action log is included in appendix 9.

11. CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report confirms progress against the ten new workstreams set out by the CNST NHS Resolution for year 5 of the maternity incentive scheme with 100% compliance to date.

The perinatal quality surveillance dashboard indicates some areas of ongoing and increasing pressure. Ongoing reduced performance related to antenatal booking performance and the antenatal screening Key Performance Indicators remains a cause for concern. The inability to accept IUT's by maternity and neonatal services continue to present a risk to the delivery of services and whilst considerable effort is made to mitigate against this, the impact on the overall service provision remains evident.

The outstanding 2023 Birthrate plus safe staffing recommendation continues to present a risk to the service. The cessation of the international midwifery recruitment strategy will now lead to further work on the model of the delivery of safe maternity services. The external assessment of Birthrate plus has been validated as being an accurate assessment of need to maintain safety. At this time there is not a resolution to this or the medical staffing gaps identified given the financial position of the organisation. Whilst, the service continues to carry a vacancy, and recruitment has been challenging, the maternity support uplift recommended by birthrate plus would mitigate some of the risks presented and will be considered as part of the 2024 financial planning round.

12. RECOMMENDATIONS

The Board of Directors are asked to:

I. Receive the Maternity Service Update including safe staffing position
II. Note the CNST update report and recommendations.
III. Receive the update in relation to Maternity and Neonatal Improvement plan
IV. Receive the associated action plans for information oversight and assurance.

APPENDIX 1 OVERARCHING OCKENDEN ACTION PLAN PROGRESS TRACKER

Immediate and Essential Actions Ockenden 2	Total recommendation (92)	Deadline Extended not closed	Full Compliance	Action delivered awaiting evidence	Partial compliance	Non-Compliance	Regional consideration	National Requirement
September 2022	**92**		13		59	16	2	4
March 2023	**92**		50	13 (new parameter)	23	2	2	4
December 2023	**92**	19	66	8	12	0	2	4

APPENDIX 2 – PMRT CASES CNST MIS YEAR 5

ID (Datix/ PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report drafted within 4 months	Actions ongoing
125023	33+1	Neonatal death	IUT from BVH. Antenatally diagnosed fetal anomaly.	Yes	88023	Yes	Yes	PMRT has been completed, care graded as B, B, C. Ongoing work with the LMNS advocate to develop a SOP for when PMRT review is shared between organisations.
125969	24+5	Neonatal death	Multiple pregnancy – Significant antenatal haemorrhage, emergency caesarean section performed.	Yes	88146	Yes	Yes	Second twin survived.
127505	33+1	Antepartum stillbirth	Multiple pregnancy – fetal heart seen to slow during routine USS. Transferred for emergency caesarean section from scan but unsuccessful resuscitation.	Yes	88277	Yes	Yes	Second twin survived.
130650	26+6	Antepartum stillbirth	Multiple pregnancy – twin one	Yes	88804	Yes	Yes	Emergency caesarean section performed for the health of the second twin.
131848	26+6	Neonatal death	Multiple pregnancy – twin two	Yes	88804	Yes	Yes	
133056	24+1	Antepartum stillbirth	Early onset fetal growth restriction. Antenatally Trisomy 18 suspected.	Yes	89093	Yes	Yes	
135345	28+4	Antepartum stillbirth	Early onset fetal growth restriction -declined delivery at earlier gestation.	Yes	89276	Yes	Yes	
138212	37+4	Neonatal death	Suspected vasa praevia. Baby born in poor condition. Therapeutic cooling commenced but decision made to stop cooling and compassionately reorientate care to palliative.	Yes	98958	Yes	Yes	Referred to HSIB in accordance with referral criteria. StEIS reported. Formal DOC provided to the family. Referred to CDOP.
138783	38+1	Neonatal death	SROM, declined IOL. Absconded from the unit following commencement of IOL process. When returned to the unit terminal CTG pattern. Initially declined emergency caesarean section (CS). CS later accepted. Baby born in poor condition. Resuscitated and transferred to NICU however, decision made for compassionate reorientation of care to palliative.	Yes	89944	Yes	Yes	Referred to HSIB in accordance with referral criteria. StEIS reported. Formal DOC provided to the family. Referred to CDOP. Referred to SUDCI. JAR meeting held; home office postmortem requested from JAR.
140588	33+6	Antepartum stillbirth	Type one diabetic, uncontrolled blood sugars in pregnancy. Admitted unwell in DKA and stillbirth diagnosed on admission.	Yes	90218	Yes	Yes	Rapid incident performed. PSII not indicated.
141893	36+3	Antepartum stillbirth	Admitted following antepartum haemorrhage. Fetal death inutero diagnosed on admission. Emergency caesarean section performed under general anaesthetic for maternal indications.	Yes	90390	Yes	Yes	Rapid incident review performed. Duty of candour provided due to maternal blood loss 5500mls in total.
142732	32+5	Antepartum stillbirth	Admitted following antepartum haemorrhage. Fetal death diagnosed on admission. Emergency caesarean section performed under general anaesthetic for maternal indications. Couvelaire uterus identified.	Yes	90548	Yes	Yes	Rapid incident review performed. No issues identified.
143530	28+6	Antepartum stillbirth	Seen in maternity assessment suite with reduced fetal movements. Fetal death inutero diagnosed on admission. Labour induced.	Yes	90662	Yes	Yes	Rapid incident review performed. No issues identified.

APPENDIX 3 PMRT OVERARCHING ACTION PLAN. CNST MIS YEAR 5

Action Plan – PMRT overarching action plan.

Version	*Date*
V1	18.09.2023
V2	14.11.2023
V3	16.01.2024

Organisation:	Lancashire Teaching Hospital NHS Foundation Trust
Lead Officer:	Emma Holden
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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 Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
TF 106111 StEIS 2023/365 PMRT 85133						
1	Ockenden safety action – maternity services must ensure women and their families have their voice heard.	Debrief meeting to be organised to feedback the investigation findings to the family.	Matron for safety and quality	30.06.2023	Specialist midwife for bereavement to organise family meeting once investigation is finalised. 16.05.2023 ACTION COMPLETED.	
		PMRT review to be completed and provided to the family.	Matron for safety and quality	30.05.2023	16.05.2023 – PMRT review held for the case, care graded as D and C. Family feedback meeting held on 23.05.2023 and PMRT report provided.	
2	Ockenden safety action – incident investigations must be meaningful for families and staff, and lessons	To share the case at the next stillbirth special interest group for wider system level learning	Divisional midwifery clinical governance and risk management midwife	30.05.2023	16.05.2023 Presented at May 2023 regional stillbirth special interest group.	

	must be learned and implemented in practice in a timely manner.	Regional meeting to be organised regarding the NWAS current position regarding the presentation of neonates to the emergency department in resuscitation situation.	Matron for safety and quality	30.01.2023	Meeting held on 20.01.23. Action completed.	
		To present the case for discussion at the LMNS quality assurance panel for wider system level learning	Divisional midwifery clinical governance and risk management midwife	30.06.2023	Action completed presented at LMNS serious incident overview panel.	
		Learning template to be generated and shared with all staff relating to threatened preterm labour, template to include discharge advise.	Matron for safety and quality	30.06.2023	Learning template generated and action completed.	
3	Clinical guidelines should be up to date and evidence based.	Clinical guideline EBG00140 telephone triage – maternity, should be updated to include the BSOTS processes which have been adopted by the department, including the triage algorithms which are in use.	Matron for safety and quality	30.06.2023	30.05.23 Guideline has been reviewed and is currently in the ratification process. Action completed.	
		Task and finish group to be established to review the Trust SOP for babies born in the emergency department.	Deputy divisional midwifery and nursing director	30.04.2023	Guideline reviewed, ratified and published March 2023. Action completed.	
4	Point of care testing for assessment of preterm labour risk should be available.	Until a reliable supply of fFN can be assured, MAS should continue to stock Actim Partus as an alternative to fFN.	Maternity assessment suite manager	30.05.2023	30.05.2023 Stock of Hologic fFN received May 2023 however, only 75 units can be guaranteed therefore MAS will continue to stock Actim partus as an alternative. ACTION COMPLETED.	
5	Ockenden safety action – bereavement care. Trusts must	Bereavement support to be provided to the family for as long as required.	Specialist midwife for bereavement.	30.05.2023	30.05.2023 the specialist midwife for bereavement continues to support the family. Action completed.	

	ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Referral to the reproductive trauma service to be offered to the family.	Matron for safety and quality	30.06.2023	30.5.2023 – updated from the bereavement midwife – the mother is already being supported by RTS.	
RD 101722 StEIS 2022/24747 PMRT 84476						
1	Ockenden safety action – maternity services must ensure women and their families have their voice heard.	Arrange family meeting to feedback the investigation findings to the family.	Divisional Midwifery Clinical Governance and Risk Manager	30/05/2023	Action completed; family meeting organised by the specialist midwife for bereavement.	
2	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.	Review and update the pre-eclampsia and hypertension in pregnancy guidelines to include a plan for increased pre-eclampsia surveillance for mothers with uterine artery notching.	Consultant obstetric lead for Delivery Suite	30/11/2023	18.09.2023 EH – action ongoing. 13.11.2023 FGR guideline under review. 16.01.2024 EH – FGR guideline has been updated and ratified to reflect SBL version three recommendations. Action completed.	
		Share learning with the midwifery team regarding the significance of uterine artery doppler notching.	Divisional Midwifery Clinical Governance and Risk Manager	30/04/2023	Learning template generated and shared. Action completed.	
		NWAS consultant midwife to review the prehospital care.	NWAS Consultant Midwife	31/12/2022	NWAS consultant midwife contributed to the investigation process. NWAS records obtained for the investigation. Action completed.	
		Use the mother's atypical presentation in pre-eclampsia/ eclampsia skills drills taught on the multi-disciplinary PROMPT study day.	Midwifery practice educator	30/08/2023	18.09.2023 EH – case included in the TNA for PROMPT 2024. Eclampsia to be included in the drills on PROMPT in 2024. Atypical presentation to be used as part of the drill.	
3	Ockenden safety action – complex antenatal care. Trusts must follow national	Clinical guideline EGB00176 Nausea and vomiting in pregnancy and hyperemesis gravidarum should be reviewed	MAS lead midwife	30/10/2023	18.09.2023 EH – action ongoing.	

	guidance for managing women with hypertension in pregnancy.	to include a section relating to management of onset of vomiting in the second and third trimesters of pregnancy.				
		Establish a failsafe process to ensure that attendance in antenatal clinic, for ultrasound scan review, can be monitored and non-attendance identified and actioned.	Matron for Complex Midwifery Care	~~30/12/2023~~ 28/02/2024	18.09.2023 EH – a working party has been convened and development of a SOP is ongoing. 13.11.2023 BadgerNet referral created to alert ANC when unplanned scan review is required. 16.01.2024 Audit of compliance to be undertaken	
		Make a CleverMed change request for the Aspirin compliance question to be added to the midwifery led antenatal appointment templates and the obstetric specialist review antenatal appointment templates on the BadgerNet system.	Digital lead midwife	~~31/10/2023~~ 31/01/2024	18.09.2023 Change request to be made to Clevermed. 14.11.2023 EH – update requested from HR digital lead midwife. Deadline extended.	
		Review the current arrangement of offering universal uterine artery doppler scanning at the anomaly ultrasound scan and advise if this practice, outside RCOG (2014) recommendations, should continue.	Fetal medicine consultant obstetrician	31/12/2023	31.07.2023 Awaiting specialist consultant to commence in post with the Trust. Recruitment has been successfully completed. 18.09.2023 EH – consultant now in post. Process to be reviewed. 13.11.2023 FGR policy being review and to apply for TOMMY's trial to support recommendations. 16.01.2024 EH – FGR guideline has been reviewed and updated to reflect the recommendations of SBL version three care bundle. The agreement is to continue to offer universal uterine artery doppler scanning to identify women at risk of early onset FGR.	

		Until the universal offer for uterine artery doppler scanning has been reviewed, all women that have uterine artery doppler notching identified at the anomaly ultrasound scan, should have their blood pressure measured and recorded at 20 weeks gestation (at the scan review) and an additional antenatal appointment for measurement of blood pressure and urinalysis at 25 weeks gestation. Update schedule of antenatal appointments guideline.	Matron for safety and quality	~~30/11/2023~~ ~~31.12.2023~~ 31.01.2024	31.10.2023 EH – action is ongoing. 16.1.2024 Awaiting confirmation that this has been actioned.	
4	Ockenden safety action – bereavement care. Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Bereavement support to be provided to the family.	Specialist Midwife for Bereavement	20/11/2022	20.11.2022 The specialist midwife for bereavement continues to support the family. Action completed.	
		PMRT investigation	Divisional Midwifery Clinical Governance and Risk Manager	30/04/2023	02.08.2023 PMRT review held, and report provided to the family along with the StEIS investigation report. Action completed.	
5	HSIB national learning investigation report – Telephone triage services should support 24-hour access to a systematic structured risk assessment of pregnant people's needs. Telephone triage services should be	Clinical guideline EBG00140 telephone triage – maternity, should be updated to include the BSOTS processes which have been adopted by the department, including the telephone triage algorithms which are in use.	Safety and quality maternity matron	30/04/2023	11.04.2023 Guideline updated and ratified action completed.	
		The MAS phone should be relocated to an area away from the MAS environment. The investigation team recommends that the completion of this action be prioritised to remove the risk	Deputy Divisional Midwifery and Nursing Director (DMND)	~~30/01/2023~~ 1.06.2024	30.05.2023 – action is ongoing as part of the antenatal services development plan. Deadline extended to reflect the size and scope of the action.13.11.2023 Action ongoing.	

	operated by appropriately trained and competent clinicians who are skilled in the specific needs required for effective telephone triage.	of unconscious bias affecting decision making when performing telephone triage assessments.			16.01.2024 EH – action is ongoing. Deadline for completion further extended due to the scope of the action.	
		The investigation team recommends that the maternity service works towards full implementation of the BSOTS system in accordance with the actions detailed on the risk register.	MAS lead midwife/ matron for complex midwifery care.	~~30/01/2024~~ 1.06.2024	30.05.2023 – action is ongoing as part of the antenatal services development plan. Deadline extended to reflect the size and scope of the action.13.11.2023 Action ongoing. 16.01.2024 EH – action is ongoing. Deadline for completion extended due to the scope of the action. Audit data from December 2023 reflects that 95% of women attended MAS were seen within 15 minutes of arrival and 100% within 30 minutes of arrival.	
HF 105125 HSIB MI-019756 StEIS 2022/27283 PMRT 85135						
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	31.12.2022	HSIB investigation completed, and final report received. Action completed.	
		StEIS report	Clinical governance and risk management midwife	15.12.2022	StEIS number obtained when 72-hour report submitted. Action completed.	
		Formal duty of candour	Clinical governance and risk management midwife	15.12.2022	Verbal and formal DOC provided to the parents prior to discharge from hospital. Action completed.	
		Perinatal Mortality Review Tool (PMRT) review	Clinical governance and risk management midwife	13.04.2022	PMRT reported on 23/12/2022 review completed on 27.07.23 following receipt of final HSIB report. Graded as C and B. HSIB involved in the PMRT review and agree with the grading. Action completed.	

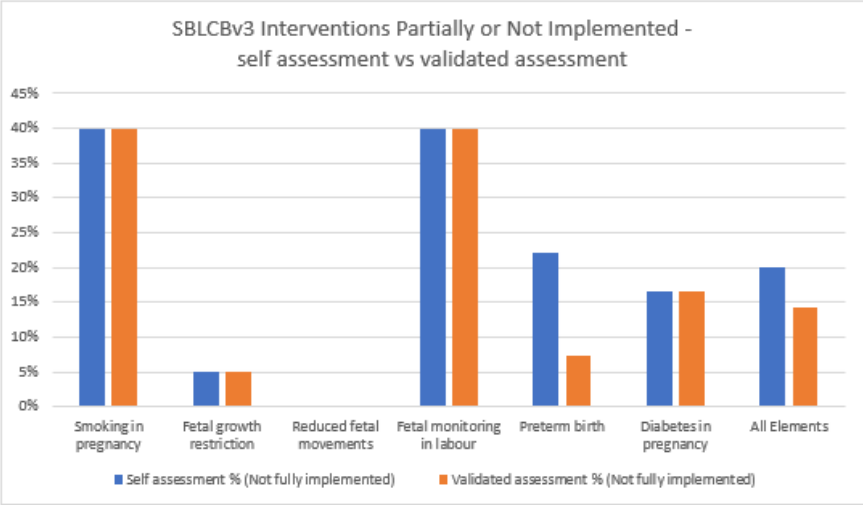
2	**HSIB safety recommendation:** The Trust to ensure that staff are supported to complete a comprehensive risk assessment for each mother at the beginning of, and at least hourly throughout her labour to ensure place of birth is in line with national guidance.		Deputy divisional nursing and midwifery director	Action completed	Hourly holistic reviews and hourly CTG peer reviews implemented into practice. Action completed.	
3	**HSIB safety recommendation:** The trust to ensure all members of the clinical team undergo training in Human Factors, including the risks of normalisation and expectation.	Implementation of Human Factors within the mandatory PROMPT and Fetal Monitoring Training.	Practice Education Midwife/Fetal Monitoring Lead Midwife	Action Completed	Human Factors training included in PROMPT and Fetal Monitoring training. Action completed.	
4	**Trust Action:** Transferring Midwife to reflect on the documentation of the neonatal resuscitation with the matron for midwifery led services		Matron for Midwifery led services	30.01.2023	Action has been completed.	
HH 117009 PMRT 86858						
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in	Ability for the mother to add communication notes to the Badger record to be removed as this is an unmonitored function.	Digital lead midwife	30.11.2023	18.09.2023 EH – action ongoing by the maternity digital team. 14.11.2023 EH – action has been reviewed by the division and has been stood down as unable to deactivate the function locally. Communication has been shared with all staff regarding the functionality of the	

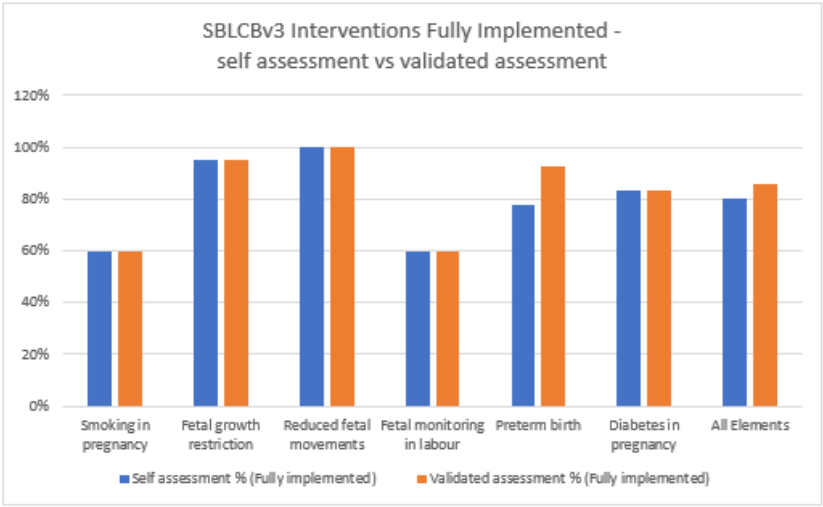
	practice in a timely manner				feature and the advice to be given to women about the feature.	
MC125023 PMRT 88023						
1	**Ockenden safety action – bereavement care.** Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	To work with the LMNS advocate and BVH to agree the roles and responsibilities of each Trust when PMRT investigations are shared across organisations.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023. 14.11.2023 EH – working party was convened and process agreed with BVH for the management of joint cases between the two organisations. Action completed.	
		Review the PMRT card for LTHTR to align with the recently published tools on the MBRRACE website.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023. 14.11.2023 EH – letter updated and approved by the Trust patient experience lead. Action completed.	
		Review the PMRT letter for neonatal deaths to include information on the CDOP process.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023. 14.11.2023 EH – letter updated and approved by the Trust patient experience lead. Action completed.	
		Develop a PMRT letter for use when care is shared between two organisations. The letter should give information regarding the named family liaison person for the family at both organisations.	Maternity matron for safety and quality	30.11.2023	18.09.2023 EH – action ongoing meeting planned for 20.09.2023. 14.11.2023 EH – working party was convened and process agreed with BVH for the management of joint cases between the two organisations. Letter drafted and content agreed jointly by the two organisations. Letter approved by the Trust patient experience lead. Example of the good practice/ joint working shared at the October 2023 LMNS quality assurance panel. Action completed.	

APPENDIX 4 IMPLEMENTATION PROGRESS OF SAVING BABIES LIVES VERSION 3 CNST MIS YEAR 5

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	78%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	80%	Partially implemented	86%	CNST Met





APPENDIX 5 MNSI/HSIB CASE SUMMARY CNST MIS YEAR 5

MI number	Case Summary	Early Notification applicable	Early notification completed	Status of HSIB investigation	Final HSIB report sent to legal team.	Duty of Candour
019756	Spontaneous onset of labour, admitted to birth centre. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. Post cooling MRI showed severe HIE. Decision made for compassionate withdrawal of care.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
020352	Induction of labour. Transferred to delivery suite once labour established. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. At 24 hours cooling stopped by the neonatal team as baby clinically very well. MRI performed and did not show evidence of HIE.	Not applicable – confirmed by legal department. Cooling not completed, no HIE on MRI and HSIB declined to investigate.	Not applicable – confirmed by the Trust legal department.	HSIB declined to investigate as referral criteria not met – based on MRI and the parents had no concerns with care.	Not applicable	Yes
021966	Severe shoulder dystocia (22 minutes) following instrumental birth. Therapeutic cooling treatment initiated. Post cooling MRI showed moderate HIE.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	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	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
024639	Induction of labour. Abnormal fetal heart rate auscultated; Therapeutic cooling treatment initiated. Post cooling MRI showed mild HIE.	Yes	Yes	Completed – final report received.	Yes. Early notification investigation proceeding.	Yes
032957	Spontaneous onset of labour, admitted to birth centre. Progressed to normal birth, baby born in poor condition. Resuscitated and transferred to the neonatal unit for therapeutic cooling. Post cooling MRI showed moderate to severe HIE	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes
34308	Spontaneous onset of labour at term. Admitted to birth centre and transferred to delivery suite following a delay in the second stage of labour. Following transfer to delivery suite decision made for assisted birth. Sequential instrument used on repeat occasions. Assisted birth abandoned and transferred to theatre, baby born by emergency caesarean section in poor condition, significant subgalea haemorrhage identified at birth. Therapeutic cooling treatment initiated. Post cooling MRI showed mild HIE.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes
35266	Seen in maternity assessment suite at term with vaginal bleeding and irregular uterine activity. Following spontaneous rupture of membranes, significant antepartum haemorrhage occurred. Transferred to theatre for emergency caesarean section. Baby born in poor condition, resuscitated and transferred to NICU. Cooling commenced; however, decision made to stop cooling and reorientate care to palliative. Baby died shortly after the reorientation of care.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes

35563	SROM at term, declined IOL. Absconded from the unit following commencement of IOL process. When returned to the unit terminal CTG pattern. Initially declined emergency caesarean section (CS). CS later accepted. Baby born in poor condition. Resuscitated and transferred to NICU however, decision made for compassionate reorientation of care to palliative.	Not applicable neonatal death incident. MNSI declined to investigate as mother did not consent to investigation. Legal team confirmed that early notification referral not indicated.	Not applicable neonatal death incident.	Referred to MNSI as a term neonatal death investigation. MNSI declined to investigate as mother did not consent to investigation. Investigation returned to the Trust. Trust undertaking level 3 StEIS investigation.	Not applicable	Yes
36455	Induction of labour at term for reduced growth velocity and raised blood pressure. Delay in the progress of the first stage of labour, decision made for category two caesarean section. Constriction ring identified at caesarean section, deeply impacted fetal head. Thirteen-minute period between knife to uterus and delivery of baby. Baby born in poor condition. Resuscitated and transferred to NICU. Therapeutic cooling treatment initiated. Post cooling MRI showed moderate HIE	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes

APPENDIX 6 OCKENDEN 2 ACTION PLAN

Version	*Date*
1	05.04.2022
2	*18.06.2022*
3	*03.03.2023*
4	*12.01.2023*

Action Plan – Ockenden 2 2024 Action Plan

Organisation:	Lancashire Teaching Hospitals NHS Foundation Trust
Lead Officer:	Emma Ashton/Jo Lambert
Position:	Divisional Midwifery and Nursing Director
Email:	Emma.Ashton@lthtr.nhs.uk

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

	Standard (Total = 15)	Key Actions (Total = 94)	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	Essential action – financing a safe maternity workforce. The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	The investment announced following our first report was welcomed. However, to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.			National action – not local	
		Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Divisional nursing and midwifery director	31.10.2022	5/4/22 - Currently undergoing a Birth Rate + assessment, expecting this to be completed by August 2022. 30.10.22 – Birth Rate + assessment completed. New app in use.	
					5/4/22 Recruitment and retention action plan ongoing.	
		Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	Senior divisional workforce advisor	~~31.03.2023~~ 31.12.2024	5/4/22 - Needs reviewing with HR, current uplift 23% (embed email 26.1.22) 03.03.22 – assurance evidence requested from workforce. 12.01.23 Requested 3 year forecast to understand uplift required to meet this action. Action extended.	
		The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.			National action – not local	

	Essential action – training We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	Deputy divisional midwifery and nursing director	30.05.2022	5/4/22 - Preceptorship lead midwife appointed, commenced in post 4/4/22. Preceptorship booklet and programme developed by LMNS in place. 30.09.22 preceptorship lead in post, preceptorship curriculum developed and cohort 1 have commenced in post.	
		All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.	All Matrons	30.05.2022	5/4/22 - Matrons to review rotational plan. 6/6/22 Planning meetings ongoing on a weekly basis and draft roster and rotation plan developed.	
		All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Divisional nursing and midwifery director	~~30.06.2023~~ 1.06.2024	5.4.22 - Need to identify appropriate course and identify funding stream. 30.06.23 – course still needs to be identified; deadline extended. 12.1.24 As yet no specific course identified. Letter received from Chief Midwifery Officer for England confirming a framework for labour ward coordinators had been published. Work ongoing to review. No identified funding or course confirmed. Changed to regional action	
		All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Matron for complex midwifery care	~~30.04.2023~~ 31.03.2024	5.4.22 – Delivery Suite lead midwife to develop this alongside preceptorship lead midwife. 03.03.2023 – induction package is in draft awaiting review and approval. 12.1.24 Orientation package developed Action closed	
		All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Matron for complex midwifery care	30.04.2023	13.4.22- Identify which coordinators have undertaken HDU training and establish training requirements, funding, and timescale for remaining cohort. Consider core band 6 team to undertake HDU training and scope current provision. 03.03.2023 deadline for completion extended. 12.01.24. There is at least 1 HDU trained RM on shift and further training is ongoing. Compliance included in perinatal surveillance tracker monthly to Trust S&Q	

		All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.	Divisional nursing and midwifery director Senior divisional workforce advisor Clinical director for Obstetrics	30.05.2023	13.4.22- Trust Shining star leadership programme available. Adapt Trust Strategy to include maternity specific workforce planning for leadership. 12.1.24 ILM courses running for aspiring leaders. Trust policy supports development	
					GAP analysis of all leadership and management roles including specialist midwives and obstetric consultants to look at succession plans and workforce development action plan including work experience. 12.1.24 Gap analysis to be undertaken utilising the RCM strengthening midwifery leadership: a manifesto for safer maternity care.	
					New CD induction programme started in June 2022. Consultant leadership programme for all new consultants. Consultant Stretch programmes for all consultants wishing to further their leaderships into more senior management roles	
		The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.			National action – not local	
2	Essential action All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.			13.4.22 Update the maternity unit bleep holder policy. Update the current escalation policy. Awaiting regional policy update. 31.08.22 Unit escalation policy has been updated in line with the LMNS escalation guideline – Opel levels have been adopted. Trust also dials into the daily LMNS gold call.	
					Update and review safety huddle tool to ensure that mitigations, risks and delays are communicated and captured.	
		In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of	Clinical director for Obstetrics	~~30.05.2023~~ 31.03.2024	This has been added to the Maternity staffing risk.	

		competing workload. This must be agreed at board level.			It has also been identified in the external review with the necessary staffing identified to accommodate. A work-stream is in discussion to review the rota to review the obstetrics and gynaecology on call to review this risk to ensure separate on call rotas to prevent competing pressures. 03.03.2023 deadline extended.	
		All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Matron for complex midwifery care	01.07.2022	13.4.22 Review labour ward coordinator JD and person spec 01.07.22 JD has been updated throughout ongoing recruitment. Action completed.	
		All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	Divisional nursing and midwifery director	01.06.2022	13.4.22 Review current service provision and develop a critical decision-making log in relation to staffing pressures which should include current CoC offer. Risk benefits and alternatives risk analysis paper submitted to Maternity Safety and Quality Committee and updates on position reported to Board of Directors bi-monthly	
		The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	Divisional nursing and midwifery director	01.06.2022	13.4.22 Review current service provision and develop a critical decision-making log in relation to staffing pressures which should include current CoC offer. Risk benefits and alternatives risk analysis paper submitted to Maternity Safety and Quality Committee and updates on position reported to Board of Directors bi-monthly	
		The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change	Clinical director for Obstetrics	31.10.2022	18/5/22 Mandatory training time provided in consultant Core SPA time on job plans. With monthly updates on LTC SCF Job plan includes admin time. Review of SCF and clinical research fellow rota to include SPA time (JR/KR 6/6/2022). Prompt allocated to all Middle grades by rota master.	
		All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Divisional nursing and midwifery director	~~30.06.2023~~ 31.03.2024	13.4.22 Review current provision of clinical skills facilitators and how this can be achieved across all settings. This will require additional funding and resource. 03.03.2023 – deadline extended. 12.01.24 Action presents risk as this is not currently included in the midwifery establishment.	

		Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Deputy divisional midwifery and nursing director	~~30.06.2023~~ 31.03.2024	13.4.22 Establish peer mentorship in practice. 03.03.2023 – deadline extended. 12.1.24 Action assigned to matron for safety and quality and practice development lead to action	
		All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Sextumvirate	31.10.2022	13.4.22 Maternity Strategy to incorporate bi- directional pathways for high quality care and communication between community and hospital settings. Pathways in place as part of operational guidelines for CBC and homebirth. Safety huddles held daily with representation from all areas including Midwifery led services to escalate concerns and ensure channels of communication. Guidance and pathways available throughout pregnancy, birth and postnatal journey.	
		All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.	Clinical director for Obstetrics	31.10.2022	6.6.2022 Locum pre-employment checks and induction included on staffing policy. Time provided at onset of post for mandatory training. Maternity staffing levels http://lthtr-documents/current/P87.pdf	
3	Essential action Staff must be able to escalate concerns if necessary, There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not, resident there must be clear guidelines for when a consultant obstetrician should attend.	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	Deputy divisional midwifery and nursing director	31.05.2023	13.4.22 Scoping exercise to determine current polices, national work streams and develop policy/guideline. 03.03.2023 guideline in draft deadline extended. 12.01.24 Action completed and guideline published	
		When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Clinical director for Obstetrics	31.05.2023	6.6.2022 Information for escalation included in the Induction orientation and escalation processes. All trainees or post CCT managing the maternity unit have an identified consultant in the unit to support them in this role. Consultant role guideline amended to reflect. Trainee training Risk 1346 updated. 03.03.2023 – role of the consultant obstetrician guideline has been updated and published.	
		Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Clinical director for Obstetrics	31.12.2022	13.4.22 Business case developed for obstetric staffing and recent obstetric staffing review by K&B	

		There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.	Clinical director for Obstetrics	01.06.2022	13.4.22 Consultant role when on duty for obstetrics guideline. http://lthtr-documents/current/P1901.pdf Audit included in cycle of business	
		There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Matron for complex midwifery care	31.10.2022	13.4.2022 Undertake review of the current escalation policy and consider draft regional policy. 31.08.22 Unit escalation policy has been updated in line with the LMNS escalation guideline – Opel levels have been adopted. Trust also dials into the daily LMNS gold call.	
4	Essential action Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.	Deputy divisional midwifery and nursing director	~~31.05.2023~~ 31.3 2024	13.4.22 Transformation Board in place. Current stood down. Capture Action plan progress at maternity Safety and Quality committee. 03.03.2023 deadline extended. 12.1.24 Maternity national policy recommendations all have an action plan assigned which are reviewed regularly by safety and quality committee. Exception reports should be shared at Divisional committees and transformation meetings. Established process for review of key programmes of work via LMNS QAP board. Further consideration to wider MIP.	
		All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Deputy divisional midwifery and nursing director	~~31.05.2023~~ 31.05.2024	13.4.2022 Maternity Self-Assessment tool started which includes governance. 03.03.2023 deadline extended. 12.1.24 Self-assessment tool re-completed. Action assigned to complete a paper and share update with the Trust Board. Awaiting new tool.	
		Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Deputy divisional midwifery and nursing director	~~31.05.2023~~ 31.03.2024	03.03.2023 deadline extended. 12.1.24 Matron for Safety and quality in post	
		All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Clinical director for Obstetrics	31.05.2023	13.4.22 Obstetric Governance lead allotted in Job plan, in Accordance with the Maternity Services Systems Learning Maternity assessment Tool.	

		All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	Divisional nursing and midwifery director	31.08.2022	13.4.2022 Midwifery and obstetric Governance Lead attending 5-day training in July 22 01.12.2022 Divisional clinical governance and risk management midwife has attended both the 5 day and 2-day Cranfield university maternity investigators courses	
		All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Deputy divisional midwifery and nursing director Consultant lead for guidelines	~~31.05.2023~~ 31.03.2024	13.4.22 Review guideline development process and agree MQIT. 12.1.24 Action assigned to CD to allocate new consultant lead. Deadline extended.	
		All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Clinical director for Obstetrics	01.07.2022	Audit lead established with time allocated on job plan. Safety and Quality audit midwife in place.	
5	Essential action Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	Divisional clinical governance and risk management midwife	01.07.2022	13.4.2022 Templates for SI's reviewed as a Trust. Changes reflect use of simple explanations and terminology.	
		Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Divisional clinical governance and risk management midwife	01.07.2022	13.4.22 Develop Trust based learning platform for uploading learning briefs. Practice Educator embedded from clinical incidents into PROMPT and live skills drills. MQUIP team to be developed. 01.07.2022 learning templates developed from incident investigations and learning incorporated into PROMPT and maternal AIMS	
		Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Deputy divisional midwifery and nursing director	01.07.2022	13.4.22 Develop audit schedule that aligns with all new action plans as appropriate. 01.07.2022 action plans are monitored through action plan cycle of business held by the maternity safety and quality committee. Audit is included as an action when identified as being indicated in the individual incident action plan – example is cervical suture change of practice and audit.	

		Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Divisional clinical governance and risk management midwife	01.07.2022	13.4.22 Governance team to embed process of oversight and review of ongoing action plans. 01.07.2022 incident action plans are monitored through action plan cycle of business held by the maternity safety and quality committee	
		All trusts must ensure that complaints which meet SI threshold must be investigated as such.	Divisional clinical governance and risk management midwife	01.07.2022	13.4.22 Embedded process and provide audit of completion. 01.07.2022 Trust has an incident investigation guideline and a complaints policy and procedure.	
		All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Deputy divisional midwifery and nursing director	~~30.05.2023~~ 31.03.24	13.4.22 Review complaints response process with MVP and have standing agenda item at MVP committee. 31.12.2022 Trust revised and published the complaints policy and procedures SOP in December 2022. Deadline extended to obtain information from MVP regarding standing agenda item. 12.1.24 Meeting arranged with Patient Experience Lead to consider this action.	
		Complaint's themes and trends must be monitored by the maternity governance team.	Divisional clinical governance and risk management midwife	01.07.2022	13.4.2022 Ongoing complaints oversight included in the weekly W &C Divisional team meeting. Quarterly complaint assurance report added to agenda for maternity safety and quality committee.	
6	Essential action Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.			National action – not local	
		This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.			Regional Action	

	case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	Divisional clinical governance and risk management midwife	01.07.2022	13.4.22 Governance team to embed process of oversight and review of ongoing action plans. 03.03.2023 – LMNS quality assurance panel now established for presenting learning from serious incidents.	
7	Essential action Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	All members of the multidisciplinary team working within maternity should attend regular joint training, governance, and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.	Clinical director for Obstetrics	01.10.2022	13.4.2022 All staff attending PROMPT, CTG updates and Skills drills.	
		Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Deputy divisional midwifery and nursing director	01.06.2022	13.4.22 Relaunch of the SBAR process undertaken. Handover of care guideline http://lthtr-documents/current/P1006.pdf 2/2/22 SBAR embedded into all training. Ongoing audit of compliance being undertaken.	
					20.6.2022 MatNeoSIP deterioration workstream to include SBAR, AID, teach and Treat and team of the day.	
		All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Deputy divisional midwifery and nursing director	01.06.2022	13.4.22 Human factors to be completed by all staff that is protected and funded. Compliance to K2 monitored. Delivery suite coordinators have all completed a 2-day human factors training as well as attending in house training for half day update.	
					20/6/22 MatNeoSIP deterioration workstream to include SBAR, AID, teach and Treat and team of the day.	
		There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Education and practice development midwife	01.06.2022	13.4.22 Schedule of skills drills embedded	
		There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well	Matron for complex midwifery care	01.10.2022	13.4.22 PMAs in place Preceptorship Midwife in post	

		supported staff teams are better able to consistently deliver kind and compassionate care.			01.10.22 PETALS support information provided to staff involved in serious incidents	
		Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Education and practice development midwife	01.10.2022	13.4.22 Lead midwife and lead Obstetrician in post. CTG skills included in PROMPT. K2 in place for education Plan to introduce fetal monitoring full day. 01.10.2022 full day CTG study day established. PROMPT training compliance achieved.	
		Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	Fetal monitoring specialist midwife	01.10.2022	13.4.22 CTG Trajectory and skills drills to be developed and plan for CTG and full day training commenced. 01.10.2022 full day CTG study day established, and medical staff booked on to attend. PROMPT training compliance achieved across all staff groups	
					Aim to be compliant with this by June 2022 by which time all staff providing intrapartum care will have the appropriate level of training. 01.10.2022 full day CTG study day established, and medical staff booked on to attend. PROMPT training compliance achieved across all staff groups.	
8	Essential action Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	Obstetric Team	~~30.05.2023~~ 31.3.2024	ANC clinics exist for diabetic women. Newly established clinic for epilepsy due to start July 2022. Process of referral ongoing work for epilepsy/haematology ongoing with IT through Qmed and for the future intended through Badgernet. Links with specific clinicians when needed for haematology, cardiology, and neurosurgery. Preconceptual counselling provided ad hoc through Thursday pm clinic also Direct communication from local GP through 'Advice and Guidance' communication. Communication for planned Introduction and Educational Meetings with Local GPs through CCG lead intended for Sept 2022 Work ongoing for management of high-risk women within the LMS through the CRG pathways. Weekly Obstetric MDT with Obstetric and anaesthetists and obstetricians established discussing high risk women including preconceptual if known to service. 03.03.2023 deadline extended.	

	hypertension in pregnancy				12.1.24 Establishing maternal medicine centre who will undertake ad-hoc preconceptual care	
		Trusts must have in place specialist antenatal clinics dedicated to accommodating women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Deputy divisional midwifery and nursing director	~~30.05.2023~~ 30.06.2024	Due to Repetitive strain injury sonographer dedicated multiple pregnancies spread between 2 antenatal clinics on Wed and Friday am with named consultant. Ongoing work with TAMBA Twins Trust with quarterly meetings. Twins Guideline to be updated. 03.03.2023 deadline extended. 12.1.24 work ongoing	
		NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.	Continuity team leader	30.05.2023	13.4.22 Benchmark our current guidelines against the NICE guideline. 03.03.2023 deadline extended. 1.12.24 Guideline benchmarking completed as part of SBLV3	
		When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	~~Continuity team leader~~ Lead Midwife for Diabetes	~~30.05.2023~~ 31.03.2024	13.4.22 – Audit maternity records to ensure joint discussions around birth planning are documented. Consider development of an information leaflet to support discussions. 03.03.2023 deadline extended. 12.1.24 Action assigned to lead midwife for diabetes for review.	
		Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment.	Clinical Director for Obstetrics	~~30.05.2023~~ 31.05.2024	No specialist Hypertension clinic at present Plans to incorporate into Renal Thursday pm clinic – however if severe SGA to be reviewed in the Wed placental clinic. Obstetric staffing review as part of KB. 12.1.24 Action assigned to CD for consideration and review in line with maternal medicine centre.	
		Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Deputy divisional midwifery and nursing director		03.03.23 Women are assessed for Aspirin and commenced on this according to Aspirin in pregnancy guideline.	
					3.03.23 Audit compliance against this guideline Compliant achieved. Audit included in the cycle of business	
9	Essential action the LMNS, commissioners and trusts must work collaboratively to	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Lead Midwife and clinician for preterm birth	01.07.2022	13.4.22 – Guideline has been written for threshold of viability but not yet published. 01.07.2022 birth at the threshold of viability guideline now published.	

	ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Fetal monitoring specialist midwife	01.07.2022	13.4.22 – Check current guidelines. Add to preterm birth guideline/birth at threshold of viability. Look at electronic records to see if there is a proforma. 01.07.2022 birth at the threshold of viability guideline now published.	
		Discussions must involve the local and tertiary neonatal teams, so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Divisional clinical governance and risk management midwife	01.07.2022	13.4.22 – Antenatal MDT pathways have been agreed across LMS and \NWNODN – guideline has been written for threshold of viability but not yet published. 01.07.2022 birth at the threshold of viability guideline now published.	
		There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Deputy divisional clinical governance and risk management midwife	01.07.2022	13.4.22 – Partly not applicable as we are a tertiary unit. Audit of all IUT within the unit. Data captured on tool in intra and ex uterine transfers. Documented on Ockenden dashboard	
10	Essential action Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	Matron for midwifery led services	01.07.2022	13.4.22 – Care in labour audit includes risk assessments.	
		Midwifery-led units must complete yearly operational risk assessments.	Matron for midwifery led services	~~31.05.2023~~ 31.03.2024	13.4.22 – Develop an operational risk assessment. Consider any national guidance relating to this. 03.03.2023 – deadline extended. 12.1.24 Operation policy due for update and assigned to MLS and consultant midwife	
		Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Matron for midwifery led services	01.07.2022	13.4.22 – These are done as part of the timetable of MDT skills drills. Planner to be shared with staff so they can attend across all areas and covering different scenarios	
		It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information	~~Matron for midwifery led services.~~ Consultant Midwife	~~30.05.2023~~ 31.3.2024	13.4.22 - Need to look at this with NWAS and decide how we will present this information and provide it to women. 03.03.2023 – deadline extended. 12.1.24 Action re-assigned to consultant midwife for review.	

		working together and in agreement with the local ambulance trust.				
		Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Divisional clinical governance and risk management midwife	30.05.2023	13.4.22 - Need a develop/review IOL pathway and processes for if IOL is delayed and develop a SOP for this. Explore if there are any national guidelines regarding this. 03.03.2023 – deadline extended; flow co-ordinator has been appointed. Guideline is currently being reviewed. 1.12 24 Pathways updated to include escalation flow chart for delay in IOL	
		Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Deputy divisional clinical governance and risk management midwife	01.06.2022	13.4.22 - Currently have centralised surveillance system.	
11	Essential action in addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by	Conditions that merit further follow-up include, but are not limited to, postural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Consultant anaesthetic lead for obstetrics	01.10.2022	11.5.22: Follow up guideline updated last year, compliant. Badgernet is in the process of being amended to include option to select and book anaesthetic outpatient follow-up appointment. Post-natal anaesthetic clinic slots are available for this (since Nov 2019)	
		Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Consultant anaesthetic lead for obstetrics	01.10.2022	11.5.22: As above. We also have a weekly MDT where we can pick up these situations and book follow up appointments as appropriate.	
		All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Consultant anaesthetic lead for obstetrics	01.10.2022	11.5.22: Anaesthetic chart documentation audit completed in 2019 – due again this year. Detailed template for documentation available on badgernet. Plan to survey the requirements for the dataset and then audit compliance based on this	

	obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.	Consultant anaesthetic lead for obstetrics	01.10.2022	11.5.22 There are national guidelines produced by the AAGBI regarding minimal monitoring standards for anaesthesia 2021	
		Obstetric anaesthesia staffing guidance to include the role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	Consultant anaesthetic lead for obstetrics	01.10.2022	11.5.22: Annual staffing report available and reported to S&Q. Anaesthesia clinical services accreditation (ACSA) – we hold current ACSA accreditation relating to staffing as per gpas guidelines. https://rcoa.ac.uk/gpas/chapter-9	
		Obstetric anaesthesia staffing guidance to include the full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	Consultant anaesthetic lead for obstetrics	01.10.2022	11.5.22: We hold current ACSA accreditation relating to staffing. Also relates to a number of local guidelines: http://lthtr-documents/current/P1116.pdf http://lthtr-documents/current/P1942.pdf Attendance at MDT training is mandatory for all permanent members of staff covering obstetrics on an annual basis and is advisable as part of the obstetric anaesthesia training modules. Consultant obstetric anaesthetists attend governance meetings, and this is captured in the minutes.	
		Obstetric anaesthesia staffing guidance to include the competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments.	Consultant anaesthetic lead for obstetrics	~~01.06.2023~~ 31.3.2024	11.5.22: E-learning package being designed for their annual appraisal / CPD. CPD evenings are also run within the department. 03.03.2023 deadline updated. 12.1.24 Action deadline extended, and update requested.	
		Obstetric anaesthesia staffing guidance to include participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report.	Consultant anaesthetic lead for obstetrics	01.10.2022	11.5.22: Compliant. As part of attendance at MDT handover – attendance record is kept	

12	Essential action Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non-maternity ward.	Clinical director for Obstetrics	~~01.06.2023~~ 31.3.2024	13.04.22 -Need to review current guidelines and audit this. 03.03.2023 – audit data needed for assurance that action is completed.	
		Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Clinical director for Obstetrics	01.10.2022	11.6.22 Included in Duties of consultant on call guideline. Unwell postnatal women included on the Labour ward handover board.	
		Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	Safety and quality audit midwife	~~01.06.2023~~ 31.3.2024	Recent audit demonstrates only 6/14 readmissions over 4-week period reviewed by consultant within 14 hours. FS discussed at recent consultant meeting. PN manager devised ward round proforma for sick postnatal women. PN readmissions on labour ward handover board with time of breaching Included in Audit schedule with Reaudit planned for August 2022 03.03.2023 – audit data needed for assurance that action is completed. 12.1.24 Update requested	
		Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Divisional nursing and midwifery director	01.07.2022	13.04.22 -Review this against safe staffing levels. Birth rate plus assessment ongoing 31.10.2022 Birth rate plus assessment has been completed, successful recruitment undertaken.	
13	Essential action Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday	Deputy divisional clinical governance and risk management midwife	31.3.2024	13.04.22 - Review bereavement team and look at expanding current service provision. 03.03.2023- deadline extended. 12.1.24 Bereavement nurse and midwife to be moved into the corporate bereavement team to widen access to bereavement 7/7. Awaiting funding to be provided for additional support to be drawn down. Bereavement champions identified	
		All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the	Deputy divisional clinical governance and risk	01.10.2022	13.04.22 - Review current service provision and uplift as necessary 20/5/2022: Bereavement midwives and Trust team all trained in counselling for post-mortem. External course available	

		purpose and procedures of post-mortem examinations.	management midwife		03.03.2023 additional staff have been booked onto PM consent training to increase the number of staff available to complete PM consent.	
		All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome	Deputy divisional clinical governance and risk management midwife	01.06.2023	13.04.22 - Current process that appointment is offered and review guidelines to ensure this is included	
		Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	Deputy divisional clinical governance and bereavement team	~~01.06.2023~~ 31.3.24	13.04.22 - Currently working on NBCP. 03.03.2023 – deadline extended regarding NBCP. 12.1.24 Work ongoing with NBCP. Peer review undertaken July 23.	
14	Essential action There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Consultant neonatologist – Neonatal ODN lead	01.06.2022	13.04.22- As per NCCR consultation process with NWNODN, Specialist Commissioners and provider	
		Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarter	Consultant neonatologist – Neonatal ODN lead	01.06.2022	13.04.22- As per quarterly ACD review and NWNODN exception reporting process reviewed at MatCEG/ MNAB	
		Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Consultant neonatologist – Neonatal ODN lead	01.06.2022	13.04.22- Agreed IUT/ Antenatal pathways across NWNODN	
		Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example, senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Consultant neonatologist – Neonatal ODN lead	01.06.2022	13.04.22- More applicable to LNUs, but working with NWNODN Workforce and Education leads to promote participation with education activities for all Neonatal staff	

		Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	Consultant neonatologist – Neonatal ODN lead	01.06.2022	13.04.22- As per provider agreements in contracts to Spec Comm to engage with ODN and LMS – this has been confirmed	
		Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Consultant neonatologist – Neonatal ODN lead	01.06.2022	13.04.22 All consultants are available via direct mobile contact in hours on NICU hot weeks and out of hours when on call	
		Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	Consultant neonatal lead for clinical governance	01.08.2022	13.04.22- This is included in standard NLS teaching on current courses. Katie Noble has printed posters to publicise the changes to NLS algorithm (displayed in Delivery suite). Neonatal Simulation team to consolidate practice through simulation sessions	
		Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Clinical director for neonatology	01.10.2022	13.04.22- Recruitment to Tier 3 consultants posts completed. Tier 2 (middle grade) recruitment progressing to enable one in 7 rotas	
15	Essential action Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Specialist midwife for perinatal mental health	01.10.2022	13.04.22 - Have MMH service which has just started. Have specialist midwife for perinatal mental health.	

	must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	Specialist midwife for perinatal mental health	01.10.2022	13.04.22 - Have MMH service which has just started. Have specialist midwife for perinatal mental health.	
		Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.	Specialist midwife for perinatal mental health	01.10.2022	13.04.22 - Have MMH service which has just started. Have specialist midwife for perinatal mental health.	

APPENDIX 7 MATERNITY SELF ASSESSMENT UPDATE

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically led triumvirate**	Trust and service organograms showing clinically led directorates/care groups	G	Organisational charts for leadership triumvirate, governance and midwifery leadership available
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	G	Roles and responsibilities agreed with the QUAD
	Director of Midwifery (DoM) in post **(Current registered midwife with NMC)**	DoM job description and person specification clearly defined	G	Job Description
		Agenda for change banded at 8D or 9	G	Job description
		In post	G	DMND in post
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate	G	Organisational Charts available
		Clinical director to executive medical director	G	Job Description organisational structure
		DoM to executive director of nursing	G	Job Description and organisational Charts
		General manager to executive chief operating officer	G	Job Description

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		NEW 2021 Maternity services standing item on trust board agenda as a minimum three- monthly. Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups. • Clinical outcomes such as SB, NND HIE, ATAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions	G	Serious incident report presented quarterly to Trust Board Training compliance reported monthly via staffing or maternity service update paper. Perinatal Quality Surveillance model metrics dashboard presented monthly to S&Q Trust Board and bi- monthly to Executive Board.
		NEW 2021 Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	G	As above Board and Trust SQ minutes and papers with PQSM dashboard
		There should be a minimum of three PAs allocated to clinical director to execute their role	A	Confirm PA allocation with AB
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	G	Divisional and organisational structures
		NEW 2021 Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate. Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy, and maternity leave	G G	Monthly workforce and finance meetings held with area leads

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		New 2021 Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	G	Finance BP in post
		NEW 2021 Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	G	Monthly performance meeting notes and action plan. CIF meetings to commence.
		New 2021 Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	G	Compliment of specialist and managerial roles aligns with BR+ recommendations 2021.
		From governance and senior management meetings that all clinical decisions are made collaboratively by multi-professional groups	G	Representation from MDT at speciality and Divisional Board
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, e.g. senior midwifery leadership assembly	G	Safety Champions meetings established. Bi-monthly Band 7 forum held. Maternity Safety and Quality Committee chaired by Deputy DMND.
		NEW 2021 Leadership culture reflects the principles of the '7 Features of Safety'.	A	SCORE survey planned for 2024. Behaviour workshops developed in line with 7 features of safety
		Trust-wide leadership and development team in place	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Leadership development opportunities	Inhouse or externally supported clinical leadership development programme in place	G	OD team supportive of leadership development. CPD offered. Aspiring HOM and leadership modules by regional team
		Leadership and development programme for potential future talent (talent pipeline programme)	G	Rising STAR programme
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	G	OD process in place
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy	G	Organisational structure in place.
		Organisational vision and values in place and known by all staff	G	Strategy updated and shared
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	G	Policies in place for professional behaviour management
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years	G	Maternity Strategy collated in 2021 and updated in 2023
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	G	Maternity Strategy collated in 2021 and updated in 2023

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		NEW 2021 Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	G	Maternity Strategy collated in 2021 and updated in 2023
		NEW 2021 Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]	G	MVP minutes TOR, 15 steps.
		New 2021 Maternity strategy aligned with trust board LMNS and MVP's strategies	G	Maternity Strategy collated in 2021 and updated in 2023. Centred around the requirement of 3-year plan.
		New 2021 Strategy shared with wider community, LMNS and all key stakeholders	A	To Be shared
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	G	Appointment letter. Job Description TOR Safety Champions
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	G	Maternity Safety Walkaround Safety Champions
		All Safety champions lead quality reviews, e.g., 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	G	MNVP attends safety Champions and 15 steps revisited

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	G	Trust Board minutes Safety Champions
		NEW 2021 A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	G	Safety intelligence pathway. Established Quality Surveillance process
Multi-professional team dynamics	**Multi-professional engagement workshops**	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e., quarterly audit days, strategy development, quality improvement plans	A	Big Plan annual cycle of business ASF strategy includes triumvirate. Intelligence from Safety Walk - around
		Record of attendance by professional group and individual	G	Held via maternity training team on local trajectory
		Recorded in every staff member's electronic learning and development record.	G	Held via maternity training team on local trajectory
	Multi-professional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	G	TNA updated – meets all the requirements of CCFV2. CNST year 5 toolkits completed.
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	G	CCFV2 toolkit details hours required for training.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All staff given time to undertake mandatory and job essential training as part of working hours	G	Agreed and in place. Included in BR + 2022
		Full record of staff attendance for last three years	G	Health roster Training Trajectory and records.
		Record of planned staff attendance in current year	G	Health roster and Training figures
		Clear policy for training needs analysis in place and in date for all staff groups	G	TNA Policy in line with CCFV2
		Compliance monitored against training needs policy and recorded on roster system or equivalent	G	Recorded on e-roster and held on the local
		Education and training compliance a standing agenda item of divisional governance and management meetings	G	Recorded locally and held on MS teams data base.
		NEW 2021 Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	G	PROMPT and fetal monitoring training MDT Skills drills scheduled annually. Escalation toolkit improvement work ongoing

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		NEW 2021 Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal.	G	Appraisal process in place
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	G	Job Descriptions as required.
		Compliance with annual appraisal for every individual	G	Training compliance report
		Professional validation of all relevant staff supported by internal system and email alerts	G	
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	G	
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	G	Organisational diagrams detailing meets and lines of accountability
	Multi-professional clinical forums	HR policies describe multi professional inclusion in all processes where applicable and appropriate, such as multi professional involvement in recruitment panels and focus groups	G	
	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	G	
		Multi professional inclusion in clinical and HR investigations, complaint and compliment procedures	G	
		Standard operating procedure provides guidance for multi professional debriefing sessions following clinical incidents or complaints	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		NEW 2021 Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	G	Supported by psychology services. TRIM planned for 2024
		NEW 2021 Schedule of attendance from multi professional group members available	G	
	Multi-professional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multi professional attendance.	G	TOR Minutes
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	G	Website Gap analysis
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	G	MNVP joint workplan in place
	Collaborative multi-professional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility	A	Road Map for 2024 to be developed. Transformation lead in post
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	A	Updated QIP to be developed
		NEW 2021 Identification of the source of evidence to enable provision of assurance to all key stakeholders	A	MS Teams
		NEW 2021 The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access	G	MS Teams to be collated and updated

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		New 2021 Clear communication and engagement strategy for sharing with key staff groups	A	
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	G	
		NEW 2021 Weekly/monthly scheduled multi professional safety incident review meetings	G	
	Multi professional approach to positive safety culture	NEW 2021 Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	G	Held at network level. Local maternity summit held in 2023
		Positive and constructive feedback communication in varying forms	G	
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	G	All info graphics are following safety 2 approach
		NEW 2021 Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]	G	
		NEW 2021 Schedule of focus for behavioural standards framework across the organisation	G	Civility Work
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	G	
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All policies and procedures align with the trust's board assurance framework (BAF)	G	
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance	G	Matron for Safety and Quality and governance framework aligned with Ockenden
		Staff across services can articulate the key principles (golden thread) of learning and safety	G	Infographic learning required EH. Safety Boards
		Staff describe a positive, supportive, safe learning culture	A	Civility added to 2024 training programmes
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	G	Governance structures

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support	G	Governance team structure aligned with Ockenden recommendations.
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	G	
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales	G	
		New 2021 In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	G	PSIRF
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF	G	PSIRF policy

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	G	Risk management strategy and perinatal quality Surveillance SOP
		Mechanism in place for trust-wide learning to improve communications	G	Safety and Learning Group. LMNS serious incident learning groups
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication	G	Safety 2 learning templates
		Governance communication boards	G	All areas- Safety Boards and governance Boards
		Publicly visible quality and safety boards outside each clinical area	G	All areas- Safety Boards and governance Boards
		Learning shared across local maternity system and regional networks	G	Quality Assurance Panel and NMBA Board. Serious incident group LMNS
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	G	
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	G	
		Multi-agency input evident in the development of the maternity specification	G	
		Approved through relevant governance process	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Application of national standards and guidance	**Maternity specification in place for commissioned services**	In date and reflective of local maternity system plan	G	
		Full compliance with all current 10 standards submitted	G	10 standards submitted year 4 and 5
	Application of CNST 10 safety actions	New 2021 A SMART action plan in place if not fully compliant that is appropriately financially resourced.	G	MS teams evidence folders in place since year 4 Validation Paper submitted to Board
		New 2021 Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	G	Established QAP
		NEW 2021 Clear process for multi professional, development, review and ratification of all clinical guidelines	G	Established guideline
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 month programme.	G	Cycle of business and AMAT clinical effectiveness
		All guidance NICE complaint where appropriate for commissioned services	G	Clinical audit and effectiveness report
		All clinical guidance and quality standards reviewed and updated in compliance with NICE	G	Tracked via AMAT
		All five elements implemented in line with most updated version	G	
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	A	Delivered SBVL2 Ongoing to SBLV3. On track
		New 2021 Trajectory for improvement to meet national ambition identified as part of maternity safety plan	G	10 standards declared

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All four key actions in place and consistently embedded		
	NEW 2021 Application of the four key action points to reduce inequality for BAME women and families	NEW 2021 Application of equity strategy recommendations and identified within local equity strategy	G	LMNS E&E strategy ongoing
		NEW 2021 All actions implemented, embedded and sustainable.	G	
	NEW 2021 Implementation of 7 essential learning actions from the Ockendon first report	NEW 2021 Fetal Surveillance midwife appointed as a minimum 0.4 WTE	G	Job Description
		NEW 2021 Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	G	Job Plan
		NEW 2021 Plan in place for implementation and roll out of A-EQUIP	G	PMA's in place
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	G	
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered	G	
		Service provision and guidance aligned to national bereavement pathway and standards	A	SANDS peer review undertaken Maternity compliant work ongoing with NN, gynaecology and ED
		Bereavement midwife in post	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity bereavement services and support available	Information and support available 24/7	G	Bereavement part of the wider bereavement structure
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	G	Maternity complete
		Quality improvement leads in place	G	
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	G	
		Recognised and approved quality improvement tools and frameworks widely used to support services	G	
		Established quality improvement hub, virtual or otherwise	G	
		Listening into action or similar concept implemented across the trust	G	
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.	G	
	MatNeoSip embedded in service delivery	New 2021 MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	G	
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	G	
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees	G	
		FTSU guardian in post, with time dedicated to the role	G	Need maternity representative

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post	A	Needs clarity- Not currently achieved
	Human factors training available	Human factors training part of trust essential training requirements	G	e-learning for maternity team and embedded in PROMPT and Fetal monitoring training
		Human factors training a key component of clinical skills drills	A	e-learning for maternity team and embedded in PROMPT and Fetal monitoring training
		Human factors a key area of focus in clinical investigations and formal complaint responses	G	Response letters on request

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		NEW 2021 Multi professional handover in place as a minimum to include. Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.	G	Audit of compliance with handover attendance
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	NEW 2021 Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern	G	
		NEW 2021 A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's	G	
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date	G	SOP
		Audit of compliance against above	A	Audit of compliance with huddle

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Annual schedule for Swartz rounds in place	G	Trust level
	Trust wide Swartz rounds	Multi professional attendance recorded and supported as part of working time	G	
		Broad range of specialties leading sessions	G	
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse	G	
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit	G	
		Annual or biannual trust-wide learning to improve events or patient safety conference forum	G	
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	G	
		In date business plan in place		
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance	A	
		Business plan supports and drives quality improvement and safety as key priority	A	
		New 2021 Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	A	
		NEW 2021 Consultant job plans in place and meet service needs in relation to capacity and demand	G	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Local Maternity System plan)		NEW 2021 All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	G	Need to confirm the PAs from CD
		Business plans ensures all developments and improvements meet national standards and guidance	A	
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.	A	
		NEW 2021 Business plans include dedicated time for clinicians leading on innovation, QI and Research	G	
		NEW 2021 That service plans and operational delivery meets the maternity objectives of the Long-Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	A	
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.	A	

APPENDIX 8 RED FLAGS

Red flag Reporting Metrics	Dec -22	Jan -23	Feb -23	Mar -23	Apr-23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
Delay in time critical activity	1	2	13	54	22	17	17	50	43	34	38	23	10
Missed or delayed care> 60 mins in washing or suturing	0	0	0	1	0	0	1	2	0	0	0	0	1
Failure for women to receive the medication required.	0	0	0	1	0	0	0	0	0	0	0	1	0
>30-minute wait for pain relief.	0	0	0	1	0	0	0	3	2	3	0	1	0
Lack of full examination when woman presents in labour.	0	0	0	1	0	0	0	0	1	1	1	1	0
>2-hour delay in induction?	1	1	0	10	1	6	4	30	10	16	10	7	0
Delay in recognition of and action of abnormal signs.	0	0	0	2	2	0	0	0	2	0	0	4	0
Inability to provide one to one care in labour?	0	0	0	2	0	0	0	7*	0	1	2	1	0
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS													
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)									5	21	18	13	1
>30-minute wait for obstetric triage.	0	1	1	40	15	15	15	29	29	25	11	10	5
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	0	0	0	0	0	0	0	1	0	0	0	1	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)	0	1	0	7	3	5	3	24	5	15	8	19	0
Was there a delay in transfer once labour was established? (New parameter Oct 22)	0	0	0	1	0	0	1	3	1	1	1	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)	0	0	0	0	0	0	0	0	1	0	0	1	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	0	0	0	0	0	1	0	0	1	0	0	1	0

Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	0	0	0	2	0	1	0	7	1	3	1	1	0
Has there been any cancelled or delayed community work? (New parameter Oct 22)	0	0	1	4	1	27	177	31	4	85	14	5	0
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)													0
Total numbers of red flags	**2**	**5**	**15**	**126**	**44**	**72**	**218**	**187**	**105**	**205**	**103**	**90**	**17**

APPENDIX 09 ACTION LOG SAFETY CHAMPIONS

Date	Decision/action agreed	Forum	Action Owner	Actions	RAG
Carried over	Charitable bid to be submitted for PBC, delivery suite and main corridor in SGU for staff rest areas.	Safety Champions Walk round	Area Leads and Matrons	17.8.2023 PBC delivery suite and main corridor bids approved. Work awaiting start dates. 21.12.2023 Delivery suite rest area completed, 12.1.24 Ground Floor ongoing and dates awaited early January 24 from D&G PBC work to commence.	
8/8/2023	Neonatal Safety Champion to contact network to consider whether additional clinical SBAR can be provided when IUT is requested to aid decision making.	Safety Champions forum	Neonatal Safety Champion	9.8.2023 Email sent and plans in place to review process. 21.12.2023 Feedback provided to the North West Connect Team. Action closed	
8/8/2023	Consider whether training budget can train core midwives on maternity B and Birth centres to support capacity and flow	Safety Champions forum	Matron for Safety and Quality	17.08.2023 Training budget to be reviewed with practice educator. Applications to be submitted for maternity B. Email to Birth centre managers to confirm names from midwifery led services. 21.12.2023 Core staff allocated funding to undertake NIPE training. Action closed.	
8/8/2023	Review arrangement for postnatal wellbeing checks for women whose baby is on NICU or for women in Bowland house	Safety Champions forum	Matron for Complex Care	17.8.2023 Meeting to be arranged to consider relocation of postnatal appointments to day unit once service has been relocated. 21.12.2023 Postnatal clinics relocated to ANC. Action completed.	
8/8/2023	Documentation key themes learning template to be generated by the audit midwives to ensure key information is documented in the right place within the EPR	Safety Champions forum	Matron for Safety and Quality	17.8.2023 Matron for Safety and Quality to liaise with specialty audit and IT to create a PowerPoint and learning template for sharing with obstetric and midwifery teams. 12.1.2024 Work ongoing with Digital team to create update user guides for documentation and a working party will be convened to agree a plan	
8/8/2023	Training for Badger| Net and key themes to be added to agenda for clinical audit.	Safety Champions forum	Matron for Safety and Quality	17.8.2023 Matron for Safety and Quality to liaise with specialty audit and IT to create a power point and learning template for sharing with obstetric and midwifery teams. 21/12/2023- Completion of Badger Net process mapping to update operational guides to improve consistency of documentation and any inaccuracies are being flagged to system C.	
8/8/2023	ANC clinic templates to be reviewed with CD to consider type of clinic allocated	Safety Champions forum	Clinical Director and Matron for Complex care	17.8.2023 Email to CD detailing action sent. To review whether clinic organisation can be reviewed. 21.12.2023 Wider actions in relation to ANC templates ongoing with CD and consultant team. Action extended. 12.1.24 ANC to be considered for MCA programme	

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):	12 December 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 November 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. Key points to note included appraisal compliance was 88.8% (target 90%), medical device compliance was 85.46 (target 90%), 9 mandatory training metrics were currently below compliance target and 4 new metrics had been added in September 2023 relating to the Patient Safety Incident Response Framework (PSIRF).

The Committee reviewed the education quality surveillance report, which provided a performance update by education programme outlining divisional performance against measures included within the multi-professional Education Service Level Agreements. Performance within Undergraduate Medical Education and Apprenticeships was strong with mixed feedback across Nursing Midwifery and Allied Health Professions (NMAHP). Several areas were subject to internal and external quality intervention within Postgraduate Medical Education as detailed within the November Quality Surveillance report. NMAHP had three areas requiring support - Ward 17 in the Division of Medicine subject to a Nursing and Midwifery Council (NMC) Exception Report by the University of Bolton following withdrawal of learners from this area due to low staffing negatively impacting the learner placement experience.

The Committee was presented with the education annual report strategy update (interim review), which detailed the interim Education & Training Strategy for 2023-24. This was the final year of the Education & Training Strategy 2020-24 (noting that a one-year extension was implemented for 2023-24 as approved at ETR Committee in October 2022), and the objectives detailed were those that remained active in the current business year (2023-24). Each objective had been reported in terms of status either as complete, in progress or obsolete. In summary, there was a total of 61 active objectives for 2023-24 of which 45 had been completed, 12 were in progress and 4 were obsolete.

The Committee received the research and Innovation plus Edovation update, which provided an update on the progress within the R&I department year to date 2023/24, and specifically within that a) Edovation and b)

The National Institute of Health and Care Research (NIHR) Lancashire Clinical Research Facility (LCRF) Annual Report. Unfortunately, this had not been circulated at the time of writing and would be included in a subsequent ETR report.

The Committee considered and agreed the strategic risk rating should remain at 16.

The Committee noted positive and negative escalations from the ETR feeder groups - Apprenticeships Strategy & Assurance Committee, Training Compliance and Assurance Sub-committee and Research and Innovation Sub-committee.

Items for the Board's attention
Positive escalation
None.
Negative escalation
None.
Committee to Committee escalation
The 'deep dive' review of mandatory training would be referred to Workforce Committee.
Items recommended to the Board for approval
None.
Committee Chairs reports received
a) Training Compliance and Assurance Sub-committee b) Education Quality & Performance Sub-committee c) Research and Innovation Sub-committee
Items where assurance was provided and/or for information
a) Core skills training report b) Education Quality Surveillance report c) Education annual report strategy update (interim review) d) Research and Innovation plus 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 13 February 2024 using Microsoft Teams.

Recommendation:

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

Appendix 1 – Education, Training and Research Committee agenda (12 December 2023)

Education, Training and Research Committee

12 December 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 8 November 2023	1.03pm	✓	Decision	P O'Neill
5.	Matters arising and action log	1.05pm	✓	Decision	P O'Neill
6	Strategic risk register review	1.20pm	Verbal	Assurance	P O'Neill
7.	PERFORMANCE				
7.1	Core skills training report	1.25pm	✓	Assurance	L O'Brien
7.2	Quality surveillance report	1.40pm	✓	Assurance	L O'Brien
8.	STRATEGY AND PLANNING				
8.1	Education annual report strategy update (interim review)	1.55pm	✓	Decision	L O'Brien
8.2	Research and Innovation plus Edovation update	2.15pm	✓	Assurance	P Brown
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic risk register review	2.35pm	✓	Decision	S Regan
9.2	Items for referral to the board or items to/from other committees	2.45pm	Verbal	Information	P O'Neill
9.3	Reflections on the meeting and adherence to the Board Construct	2.50pm	✓	Assurance	P O'Neill
10.	ITEMS FOR INFORMATION				
10.1	Feeder group Chair's reports negative/positive escalations: a) Apprenticeships Strategy & Assurance Committee	2.55pm	✓	Information	L O'Brien / P Brown

№	Item	Time	Encl.	Purpose	Presenter
	b) Training Compliance and Assurance Sub-committee c) Education Quality & Performance Sub-Committee d) Research and Innovation Sub-committee				
10.2	Date, time, and venue of next meeting: 13 February 2024, 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):	9 January 2024
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 14 November 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 a presentation on future opportunities efficiency review, which gave a refreshed view on workforce efficiencies and referred to 13 areas of potential opportunity.

The Committee was presented with the annual partnership update report, noted the local key achievements over the last 12 months, along with further developments planned for the year ahead.

The Committee was provided with an update on the one LSC collaborative.

The Committee reviewed the workforce social and corporate responsibility update and noted the progress made over the last year.

The Committee scrutinised the staff survey report and action plan, which provided early insight into the 2023 national staff survey results, highlighted potential workforce risk, and informed the Committee of the next steps. The results were currently embargoed and so could not be published or communicated formally until March 2024, date TBC.

The Committee reviewed the strategic risk register and agreed the risk rating should remain at 16.

Items for the Board's attention

Positive escalation

The positive work achieved within the workforce social and corporate responsibility update.
Negative escalation
None.
Committee to Committee escalation
None.
Items recommended to the Board for approval
None.
Committee Chairs reports received
EDI group.
Items where assurance was provided and/or for information
Workforce and organisational development integrated performance report review Future opportunities efficiency review Annual partnership update report One LSC collaborative update Workforce social and corporate responsibility update Staff survey report and action plan Exception report from the DIFs
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 March 2024 using Microsoft Teams

Recommendation:

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

Appendix 1 – Workforce Committee agenda (9 January 2024)

Workforce Committee

9 January 2024 | 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 14 November 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	✓	Assurance	K Downey
7.2	Future opportunities efficiency review	1.25pm	Pres	Information	N Pease
8. TO DELIVER A RESPONSE, FUTURE FOCUSSED AND ENABLING SERVICE					
8.1	Annual partnership update report	1.35pm	✓	Assurance	R O'Brien
8.2	One LSC collaborative update	1.45pm	Verbal	Information	N Pease
9. TO BE INCLUSIVE AND SUPPORTIVE					
9.1	Workforce social and corporate responsibility update	2.00pm	✓	Assurance	L Graham
10. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
10.1	Staff survey report and action plan	2.10pm	✓	Assurance	L Graham
11. GOVERNANCE AND COMPLIANCE					
11.1	Gender pay gap report	2.25pm	To follow	Decision	L Graham
11.2	Strategic risk register review	2.35pm	✓	Decision	J Whitaker

№	Item	Time	Encl.	Purpose	Presenter
11.3	Reflections on the meeting and adherence to the Board construct	2.40pm	✓	Information	J Whitaker
11.4	Items for escalation to the Board or items to/from other committees	2.42pm	Verbal	Information	J Whitaker
12. ITEMS FOR INFORMATION					
12.1	Exception report from the DIFs	2.43pm	✓	Information	
12.2	Feeder group Chair's reports: a) EDI group	2.44pm	✓	Information	
12.3	Date, time, and venue of next meeting: *12 March 1.00pm via Microsoft Teams*	2.45pm	Verbal	Information	J Whitaker

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Gender Pay Gap Report

Report to:	Board	**Date:**	1st February 2024
Report of:	Chief People Officer	**Prepared by:**	A Davis
Part I	*X*	**Part II**	

Purpose of Report

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

Executive Summary:

The purpose of this report is to present the findings and recommended actions based on the Gender Pay Gap report for 2023. The gender pay gap for our Trust is below the threshold for immediate action as specified by the Equality and Human Rights Commission, and so should be regularly monitored.

In summary it was found that 76% of our workforce is female, with women occupying 77% of the lowest paid jobs and 69% of the highest paid jobs. The median gender pay gap was found to be at 3.2% which is significantly lower than 6.8% reported in 2022, an explanation for the change is as a result of using the national reporting data set produced automatically using a formatted template in the Electronic Staff Record (ESR). The Equality and Human Rights Commission set out in their criteria that where a pay gap is greater than 3% but less than 5% difference, the position should be regularly monitored,

The ability for us as an organisation to take targeted action is limited due to being bound by NHS terms and conditions, the fact that we encourage colleagues to take up flexible working opportunities which then reduces salary levels and the pipeline of newly qualified individuals who are seeking to obtain posts with us such as higher proportion of females wanting a consultant position, higher proportion of males seeking employment in agenda for change caring professions.

This report details the findings analysis and subsequent proposed actions.

It is recommended that Board

I. Receives and notes the report.
II. Approve the report for publishing on our Trust internet site by 30 March 2024

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	☒
	☐	Deliver Value for Money	☐

To drive health innovation through world class education, teaching and research		Fit For The Future	☒
Previous consideration			
Workforce Committee – January 2024			

INTRODUCTION

From April 2017, gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations each year showing how large the pay gap is between their male and female employees at the end of March. Employers must publish their gender pay gaps both on their own website as well as a government website.

Gender pay reporting is different to equal pay; equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value whereas the gender pay gap shows the difference in the average pay between all men and women in a workforce. The Equality Act 2010 sets out that men and women in the same employment, performing equal work, must receive equal pay, it is unlawful to pay people unequally because of gender. If a workforce has a particularly high gender pay gap, this can indicate that there may be a number of issues to deal with, and the six mandated calculations may help to identify what those issues are.

Lancashire Teaching Hospitals as an employer must publish six calculations showing our:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay

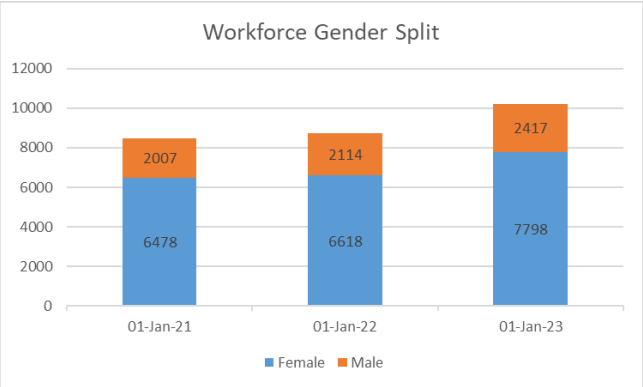
The Equality and Human Rights Commission has the power to enforce any failure to comply with the regulations. The Equality and Human Rights Commission states that where there is a difference in pay related to the gender of an employee, the following applies:

- Less than 3% difference, no action is necessary,
- Greater than 3% but less than 5% difference, the position should be regularly monitored,
- Greater than 5% difference, action should be taken to address the issue and close the gap.

The average gender pay median is the figure which will be used as the most accurate indicator of pay to determine if further action is required.

THE WORKFORCE PROFILE

OUR WORKFORCE IS 76% FEMALE AND 24% MALE



The gender profile of our workforce (Figure 1) continues to be predominantly female. The current (31 March 2023) split within the overall workforce remains consistent with the previous four Gender Pay Gap reports: **76% female, 24% male**.

WOMEN OCCUPY 77% OF THE LOWEST PAID JOBS AND 69% OF HIGHEST PAID JOBS

Table 1 – Proportion of females and males when divided into four groups from lowest to highest pay (full-pay relevant employees only)

Quartile	2023		2022		2021	
	No. Male | Female	% Male | Female	No. Male | Female	% Male | Female	No. Male | Female	% Male | Female
1 – Lower	582 |1968	23% | 77%	502 | 1,681	23% | 77%	467 | 1,654	22% | 78%
2 – Lower middle	579 | 1976	23% | 77%	494 | 1,689	23% | 77%	457 | 1,665	22% | 78%
3 – Upper middle	469 | 2084	18% | 82%	379 | 1,804	17% | 83%	385 | 1,736	18% | 82%
4 – Upper	787 | 1770	31% | 69%	739 | 1,444	34% | 66%	698 | 1,423	33% | 67%
Total	**2,417 | 7,798** (10,215 total)	**24% | 76%**	**2,114 | 6,618** (8,732 total)	**24% | 76%**	**2,007 | 6,478** (8,485 total)	**24% | 76%**

To determine the proportion of employees in each quartile pay band, the following steps were used:

1) List all employees and sort by hourly rate of pay.
2) Divide the list into four equal quarters.
3) Express the proportion of male and female employees in each quartile band.

When analysing the percentage split of each gender workforce by quartile, it is evident that a greater proportion of the male workforce occupies the upper quartile (31%) compared to the lower quartiles. The female workforce is weighted almost equally across both the lowest quartile (Quartile 1 – 77%) and the highest quartile (Quartile 4 – 69%).

OUR GENDER PAY GAP

	Women's earnings are:
Mean gender pay gap in hourly pay	**21% lower**
Median gender pay gap in hourly pay	**3.2% lower**
Difference in **mean bonus** payments	**45.9% lower**
Difference in **median bonus** payments	**0%**
Women earn 79p for every £1 earned by Men	

Table 3 - Average gender pay gap as a mean average for Trust overall

Mean Hourly Rates	Male	Female	Difference	% Difference
2023	£21.68	£17.13	£4.55	21.0%
2022	£24.69	£16.87	£7.81	31.7%
2021	£22.14	£16.00	£6.14	27.7%
2020	£21.79	£15.51	£6.29	28.8%
2019	£20.73	£15.11	£5.62	27.1%

Looking at the 2023 figures, male staff members earn on average £4.55 per hour more than female staff, which is a £3.26 decrease on 2022s figures. As a percentage, men earn 21% more than women; a decrease of 10 percentage points from 2022.

Table 4 – Average gender pay gap as a median average for Trust overall

Median Hourly Rates	Male	Female	Difference	% Difference
2023	£15.92	£15.41	£0.51	3.2%
2022	£15.64	£14.57	£1.07	6.8%
2021	£15.04	£14.02	£1.02	6.8%
2020	£14.45	£13.65	£0.79	5.5%
2019	£14.27	£13.34	£0.93	6.5%

Looking at the 2023 figures, the difference in the median pay for males and females is 3.2%. This is a marked change from 2022 and now falls within the bracket for 'regular monitoring'.

PROPORTION OF ELIGIBLE MALE AND FEMALE STAFF WHO RECEIVED A BONUS (CEA)

1.15% OF WOMEN AND 7.58% OF MEN WERE PAID A BONUS

The data presented in tables 5, 6 and 7 details the clinical excellence bonuses paid to staff split by gender and provides the mean and median bonuses paid. The data also shows the proportion of males and female overall who received a bonus.

The findings presented indicate a mean bonus pay gap between males and females of 45.9% in 2023, an increase from 34.0% the previous year. Since COVID, the usual CEA application and selection process for medical consultants has been set aside, with all eligible consultants being awarded an equal payment of £2,316.00. This has resulted in no median bonus pay gap in 2023.

Table 5 - Bonus paid as a mean average split by gender

Mean Bonus	Male	Female	Difference	% Difference
2023	£8,534.87	£4,621.28	£3,913.59	45.9%
2022	£10,441.88	£6,888.05	£3,553.83	34.0%
2021	£15,721.28	£11,812.87	£3,908.42	24.9%
2020	£16,134.24	£10,900.69	£5,233.55	32.4%
2019	£16,057.62	£11,625.67	£4,431.95	27.6%

Table 6 - Bonus paid as a median average split by gender

Median Bonus	Male	Female	Difference	% Difference
2023	£2,316.00	£2,316.00	£0.00	0.0%
2022	£3,818.66	£3,818.66	£0.00	0.0%
2021	£9,145.29	£6,032.04	£3,113.25	34.0%
2020	£12,063.96	£6,032.04	£6,031.92	50.0%
2019	£9,801.99	£5,991.50	£3,810.50	38.9%

Table 7 - Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment

2023	Total head count paid Bonus	Total No. of relevant employees	% paid bonus
Male	230	3035	7.58%
Female	111	9622	1.15%
2022	**Total head count paid Bonus**	**Total No. of relevant employees**	**% paid bonus**
Male	233	2,203	10.6%
Female	101	7,195	1.4%
2021	**Total head count paid Bonus**	**Total No. of relevant employees**	**% paid bonus**
Male	109	2,072	5.3%
Female	31	6,926	0.4%

FINANCIAL IMPLICATIONS

None

LEGAL IMPLICATIONS

None

RISKS

The gender pay gap is below the threshold for immediate action (as specified by the Equality and Human Rights Commission) however regular monitoring is recommended.

IMPACT ON STAKEHOLDERS

Not applicable

RECOMMENDATIONS

The gender pay gap is 3.2% which means no immediate action is required, however we need to regularly monitor, as specified by the Equality and Human Rights Commission. It is a challenge to identify clear actions to make a tangible difference, as in part our policies and processes (in some cases) work against us achieving a fairer gender pay balance. For example, we actively encourage our colleagues to work flexibly and, aligned to the NHS People Plan, we advertise all our vacancies as having access to flexible working opportunities from day one. Given flexible working is seen as an employee benefit, we want colleagues to take advantage of this, however it may have a negative impact on the gender pay gap, due to the higher proportion of our workforce being female overall and with females tending to work more within part time roles.

Other challenges we face as an organisation is the pipeline of newly qualified candidates coming through degree courses and seeking employment with us. If Universities are unable to attract higher numbers of males into

agenda for change professions and higher numbers of females into medical and dental professions then it makes it more challenging for us to be able to alter our gender split and ultimately the gender pay gap.

In spite of this, as an organisation we are seeking to encourage a more diverse pool of candidates to apply for our unregistered professions such as HCA, roles in Estates and Facilities at bands 2 and 3, as this is something we as an organisation can take positive action towards, specifically in the recruitment of a higher proportion of males into more 'traditionally female' roles, given the fact that males in our organisation in an agenda for change role earns less than females. We have created a diverse multimedia campaign for HCA roles, where we use staff stories to help illustrate what colleagues enjoy about their work to enable potential candidates of different genders, ages, sexual orientation and ethnic backgrounds to see themselves in our teams.

More widely, actions we are planning on taking which for part of Our People Plan 2023 – 2026 include a refreshed talent management offer to accommodate different development needs, particularly for those colleagues' bands 8a or above, or for those who have been identified as a rising star over several years but have yet to secure a more senior position for whatever reason. We are also raising the visibility of the different challenges women may face such as via the menopause programme of work, working towards becoming an endometriosis friendly employer, promoting awareness around colleagues who have caring responsibilities alongside their employment to help demonstrate that we are accepting, and accommodating of different needs women may have and how these will hopefully not be a barrier to women seeking career progression within our organisation.

It is recommended that Board

I. Receive and note the report
II. Approve the report for publishing on our Trust internet site by 30 March 2024

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Equality Diversity and Inclusion Strategy – Annual Report			
Report to:	Board of Directors	**Date:**	1 February 2024
Report of:	Chief People Officer	**Prepared by:**	A Davis
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to provide an annual update against the principles and aims of the Equality, Diversity and Inclusion (EDI) Strategy 2021 – 2024. This report forms part of our public sector duties as set out in the Public Sector Equality Duty and the Equality Act (2010).

This report details the actions which have been completed in the last 12 months against the five principles set out in this strategy for our communities, patients and colleagues. The report highlights achievements, some of which are;

- The range of new methods deployed to better engage patients in providing their lived experience which has enabled us to take forward impactful service improvements.
- The breadth of work being undertaken to tackle health inequalities and is aligned to the Core20PLUS5 framework.
- The collective commitment to EDI being demonstrated across the organisation from the inclusion of EDI objectives in Board Members appraisal processes, the increased appetite of colleagues to learn more about inclusion and understand about diversity through to the increased drive to understand our data through an intersectional lens.
- The focus towards being a zero-tolerance organisation which is aligned to our commitments to be an Anti-Racist Organisation, the principles set out in the Sexual Safety Charter and in direct response to colleagues lived experienced as reported in both the Workforce Race and Disability Equality Standards.
- The focus placed on improving the health and wellbeing needs of minority groups along with further actions taken to support colleagues with disabilities and long-term conditions to receive reasonable adjustments.
- The development of increased educational resources, integration of awareness sessions and importance of inclusion in all aspects of our leadership and management development offer, organisational development programmes of work.
- The increased prominence of EDI as delivered through the inclusion calendar of events.

The report outlines the measurable impact and presents the current demographic information on our workforce. It highlights our performance and current benchmarks reported in other mandated reports such as the Workforce Race Equality Standard, Workforce Disability Equality Standard, National Staff Survey and Gender Pay Gap, alongside other intervention level evaluation measures where applicable. It describes the future focus to ensure we continue to deliver the strategic aims, this includes:

- Increasing the participation rates of colleagues and patients with protected characteristics in local and national surveys, engagement groups and ambassador forums to ensure their views are heard, acted upon through influencing the strategic actions we deliver.
- Increasing the disclosure of protected characteristics of patients and colleagues to enable improved reporting ability and understanding of the impact we have when providing quality care and an inclusive working environment.
- To further increase both colleague and leaders understanding of their role in enabling equality, diversity and inclusion as well as bringing about improvements in health inequalities.
- To review process and approaches across the colleague lifecycle to understand how we can create more inclusive practices which support the recruitment, retention, staff satisfaction and career progression of colleagues with protected characteristics.

It is recommended that the Board approve the report for external publication.

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

Together

NHS
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EQUALITY, DIVERSITY & INCLUSION STRATEGY – ANNUAL REPORT 2023

Being consciously inclusive in everything we do for colleagues and our communities

INTRODUCTION

The Equality Diversity and Inclusion (EDI) Strategy was launched 2 years ago, this is the second annual update highlighting the progress we have made against the five strategic aims underpinning our vision which is to be **"consciously inclusive in everything we do for colleagues and our communities"**. The five strategic aims are:

1. Demonstrating Collective Commitment to EDI.
2. Being Evidence Led and Transparent.
3. Recognising the Importance of Lived Experience
4. Being Representative of Our Community.
5. Bringing About Change Through Education and Development.

The ambition for this strategy was to be transformational, to take a systemic approach to delivering improvements. We wanted to go deeper than surface level actions, seeking to bring patient and colleague experience together, utilising and capitalising on the opportunity that the two are inextricably linked, finding new ways to understand our data and to reflect on the health equalities in our system and the disparities experienced by colleagues, taking decisive action to bring about change.

After the first year which was focused on setting firm foundations and raising the profile of EDI across the organisation, this year has been about how we consciously start to build EDI into our processes, strategies, education and data gathering mechanisms. There's lots of work to do, however progress has been made through a purposeful consideration of how we can apply an EDI lens to our areas of work.

The firm foundations set in year one have most definitely enabled an interest, an enhanced visibility and more open conversations in respect of EDI. Delivery this year has been about building upwards from those firm foundations by focusing more deeply on some distinct pieces of work in order to make a more positive (and sustained impact) for example; exploring a more holistic approach to the delivery of workplace adjustments as well as embedding the zero tolerance approach through a multi-faceted approach.

In the last 12 months we have continued to see improvements in some of the data i.e. some movement on our workforce equality standard reporting for race and disability, also with regards to National Staff Survey results. Some areas fluctuate, so our focus will be around how we can elicit a trend of sustained improvement over a longer period of time.

The information in this report represents the action and progress undertaken in compliance with our public sector duties as set out in the Public Sector Equality Duty and the Equality Act (2010), which requires public bodes to have due regard for the need to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity; and to foster good relations between people who share a protected characteristic and those who do not.

Externally, there has been the publication of the NHS equality, diversity and inclusion improvement plan which was published by NHS England in June 2023. The plan details six high impact actions which are:

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 staff.

6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

The High Impact Actions are being delivered via the EDI strategy action plan, this report will detail our progress with regards to what has already been implemented as well as further detail our future plans to ensure we deliver upon these recommendations and achieve the success metrics defined by NHS England.

The following report highlights many of our achievements, provides a breakdown of our data for patients and colleagues and sets out our future focus to continue to progress this vital agenda.

PRINCIPLE 1 – DEMONSTRATING COLLECTIVE COMMITMENT TO EDI

This principle seeks to hardwire EDI into all aspects of the way we provide care and go about our business within our organisation, to ensure we are consciously inclusive. At a strategic level we made a pledge that every strategy published from the EDI strategy's launch would contain a section on equality, diversity and inclusion in order to support an increased momentum and collective focus for improvement. As well as this we would ensure that adequate consultation and involvement has taken place with minority groups through colleague Ambassador Forums and Patient Involvement Groups.

Over the past year we have undertaken a number of actions which include:

- Continuing to support Divisions to develop their own EDI plans as part of their Divisional People Plan, which contains specific actions to help drive improvements for patients and colleagues with protected characteristics.
- Reviewing all organisational strategies and associated action plans to determine the extent to which they reference EDI including dedicated actions to support the delivery of improvements.
- Creating a guidance document for strategy authors to ensure the EDI and Health Inequality Agendas are considered as a golden thread at the point of strategy development – focused on bringing about improvements for people with protected characteristics.
- Revised the approach to Quality Impact Assesments to include equality impact to encourage and promote wider consideration of the impact of changes to minority groups.
- Introducing 'core objectives' for all leaders across our organisation, including our Board, which includes an EDI focused objective. All leaders, in discussion with their appraiser, can choose to select the EDI objective listed under the Big Ambition – Great Place to Work titled 'Undertake a project which helps to improve equality, diversity and inclusion for patients and/or colleagues'. This then enables the individual to further tailor the objective to their area of work in partnership with their appraiser.

FOR PATIENTS AND OUR COMMUNITIES

COLLECTIVELY TAKING ACTION TO BRING ABOUT IMPROVEMENTS FOR PATIENTS FROM MINORITY GROUPS

The Patient Experience and Involvement Strategy is into its second year; centred on engaging with people who use our services by providing opportunities for them to share their views, identify areas for change and shape our services. Our overall ambition continues to be the delivery of excellent care through promoting positive patient experiences, improving outcomes, and reducing harm. The strategy has set the tone to listen more and act on patient experiences, which means really listening to the experience of patients and families when they do not go well, in addition to when they do go well. We have actively sought the views of patient groups who represent those with protected characteristics and recognise the importance of intersectionality when considering their feedback.

The Patient Experience and Involvement Strategy 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.

Some of the progress which has been achieved over the past year is detailed below;

- The recruitment of patient champions is a pivotal enabler for the Patient Experience and Involvement Strategy and this work is now complete, with every clinical department (and a growing number of administrative areas) in the organisation benefitting from at least one patient experience champion who has been trained and belongs to part of a patient experience champions network.
- 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.
- 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 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.
- Finney House opened as an alternative for patients who do not meet the criteria to reside.
- 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.
- Renal service opened a new unit in Blackburn, Burnley and Ulverston improving the experience of our renal dialysis patients. Continued improvement in leaflet standards by increasing the languages available, introduction of QR codes and size of font.

Each Division has a nominated representative who attends our EDI Strategy Group meetings; the role of the representatives is to attend the Strategy Group, to coordinate the development of an EDI Annual Plan against the principles set out in the strategy and to ensure there is sustained focus on EDI within the Division through their Divisional Board and

Divisional Workforce Committees. The following departments and divisions are represented at the EDI Strategy Group meetings; Medicine, Surgery, Women and Children, DCS, Finance, IT, Education, Nursing Directorate, Estates and Facilities, Workforce, Education and Organisational Development.

Several Divisions have continued to **include colleague or patient stories** as a standing agenda item in these meetings which provides a focus on their experience of care or work with the aim of learning what we can take from their experiences to bring about improvements. The lived experiences of patients with protected characteristics (as well as more general patient and other stakeholder experiences) continue to be routinely used to focus improvement activity as part of each of the Flow Coaching Academy Big Rooms too.

ENGAGING DIVERSE COMMUNITIES, PATIENTS, FAMILIES AND CARERS IN ALL NEW SERVICE DEVELOPMENTS

Across the Divisions, patient and public involvement groups are supporting the co-production of services. Here is a flavour of some of the work which has been co-produced over the last 12 months, illustrating our commitment to engaging our communities and patient groups in line with our EDI strategy aspirations;

- The new 'Patients as Partners' role has been launched within the organisation with three Patient Safety Partners now inducted into the organisation, linked to the Always Safety-First strategy.
- Work has continued with local health partners such as Galloway's, Healthwatch and NCompass. We have also reached out to Diabetes UK to try to commence a new family forum for the diabetes groups.
- A well-established Carers forum is in place, run in collaboration with Lancashire Carers Service which continues to support our carers, this forum (along with the Cancer Patient forum) has helped change policies within the Trust.
- The Youth Forum have been engaged in developing Patient Contribution to Case Notes (PCCN) in addition to working with teams to improve the waiting areas and develop an environment which is 'young person friendly'.
- The renovation of the multifaith area and Muslim prayer room at Royal Preston Hospital has provided a calm, respectful, culturally appropriate area for patients and colleagues to pray.
- Launch of trained way finders to support the Blind and visually impaired in the hospital setting.

ENHANCING OUR SERVICES TO WORK AS ONE AROUND THE PATIENT

Several service developments have been introduced to improve the experience of receiving care easier, to ensure we are joined up around our most vulnerable patients and the care we provide happens in the best environment for their needs. Some examples of actions delivered in the last 12 months include:

- Neurology rehabilitation have been working collaboratively with patients and carers to develop a 'Getting to Know Me' booklet for patients with neurological conditions. This will

be utilised as a nursing tool in respect of how to support and manage patients whilst in hospital, taking into consideration the patient's likes, dislikes, behavioural triggers and what activities/therapies are required, encompassing holistic patient centred care.

- Elderly Medicine have been working alongside the Dementia Lead Practitioner to enhance overall awareness of supportive approaches in de-escalation and distress; training colleagues to a minimum level of Dementia Champions and having a member of the team allocated to support with activities and the completion of Forget-Me-Not documentation.
- Multifaith resources have been created to support the end-of-life CARING campaign to help make it easier to understand and subsequently respond to the spiritual needs of patients at the end of life.
- All wards are promoted to utilise the reasonable adjustments tab within Harris Flex for patients with Dementia, learning disabilities and/or Autism to further improve patient experience and safety within the division.
- The 'Our Health Day' has been reestablished which aids to; increase knowledge of specialist teams and interventions, reduce anxieties, increase access to healthcare and reduce health inequalities. Individuals with learning disabilities, as well as their families and carers, were involved in the planning of the day.
- The Kidney Care big room is a multi-professional enhanced supportive clinic that champions shared decision making, ensuring patients have the opportunity to participate in advanced care planning and address their needs before hospitalisation. The clinics aims to improve symptoms over time for patients receiving conservative management and honours the preferred place of care and providing good palliative and end of life care for patients and support for relatives.

FOR COLLEAGUES

The principles contained in this strategy demonstrate a clear commitment to actively ensure EDI is a core part of all organisational business, led from Board and cascaded across all roles and levels in the wider organisation. One of the ways in which this has been demonstrated over the last year is through consideration of how we assess knowledge, skill and experience of equality, diversity and inclusion, particularly in the recruitment of senior colleagues. We have recruited to several executive level posts over the last twelve months including our Chief Executive, our Chief People Officer and our Chair and we know leadership is pivotal in helping us shift the dial relating to equality, diversity and inclusion within the organisation - the move to **mandate at least one question in the interview relating to equality, diversity and inclusion as a requirement for all posts from 8a and above**, was a positive way of signalling the importance we place on this agenda.

As signalled, in June 2023 NHS England published the NHS equality, diversity and inclusion improvement plan detailing six high impact actions which include the requirement for Chief Executives, Chairs and Board members to have specific and measurable EDI objectives to which they will be individually and collectively accountable. Under each one of these actions are a set of sub-actions which set out activities NHS organisations and ICBs must complete. Specifically in relation to this first high impact action, NHSE also defined the following;

a. Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (by March 2024).
b. Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025).
c. NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).

Achievement of which would be evidenced through the annual chair and chief executive appraisals as well as the Board Assurance Framework.

The EDI Strategy Group and Ambassador Forum members have been consulted in the process of setting out what they believe the focus for Board objectives should be and the following objectives have been agreed for use:

Draft Objective	**EDI Strategy Alignment to Principal**	**NHS EDI Improvement Plan Alignment**
To create a positive organisational culture which improves the experience of work of colleagues with protected characteristics as measured by the NHS Staff Survey.	Demonstrate collective commitment to EDI Recognising the importance of lived experience	High Impact Action 1
To champion a zero-tolerance approach across the organisation to reduce levels of violence, aggression, bullying and abuse experienced by colleagues.	Bringing about change through education and development Recognising the importance of lived experience	High Impact Action 6
To work in partnership to reduce specific health inequalities.	Being Evidence Led and Transparent	High Impact Action 4
Create a workforce that is proportionally representative of the communities we serve at all levels and professions.	Being representative of our community	High Impact Action 2
Commit to being an intentionally anti racist organisation.	Demonstrate collective commitment to EDI	High Impact Action 6
Understand the lived experience of our colleagues and communities taking positive action to remove barriers and inequalities.	Recognising the importance of lived experience	High Impact Action 4
Ensure EDI is reflected in all strategies and strategic action plan/measurable outcomes	Demonstrating collective commitment to EDI	High Impact Action 1

The draft list of objectives are planned to be used in Executive and Non-Executive Director 2024 appraisals, allowing the appraisee in partnership with their appraiser to select a relevant EDI objective before identifying the SMART actions they will take (appropriate to their portfolio of work) to deliver EDI related performance improvements. The next step will be to publish the Board members objectives to illustrate to all colleagues the focus, attention and dedicated action senior leaders are taking. It is hoped this both creates greater energy for others to also commit to delivering on EDI actions alongside demonstrating to our workforce the importance improving equality, diversity and inclusion is for our colleagues and communities.

COMPASSIONATE APPROACH TO SUPPORTING WORKPLACE ADJUSTMENTS

Over the last year, we have undertaken a significant amount of work and delivered a consistent and sustained narrative around the creation of a compassionate culture to support a more seamless implementation of workplace (reasonable) adjustments for colleagues. **Workplace adjustments** are changes made to remove (or reduce) any disadvantage related to a colleague's disability or long-term condition when doing their job, or to remove (or reduce) any disadvantage related to a job applicant's disability or long-term condition when applying for a job. This has been supported by a number of actions;

Education – we have delivered training to colleagues in our Recruitment team to help them support recruiting managers with workplace adjustments as part of the recruitment and selection process. We have also undertaken a number of educational sessions with line managers; through the Managers Update sessions in addition to presenting at several Workforce Committee meetings. Moving forwards, the session recording and slides will be built into the Core People Management Skills programme as part of the Recruitment through to Induction module.

Simplifying the pathway – we have worked collaborative with colleagues across Finance, Procurement, our Partnership team and the Living with Disability forum chair to understanding the pathway for colleagues to agree and subsequently procure workplace adjustments. As part of this process we have sought to identify and minimise any barriers encountered throughout the process to ensure colleagues received the necessary support as soon as possible to enable them to work effectively within our organisation. A pathway has been developed and will be shared as part of a user guide which is being created and will subsequently be available on our Intranet pages.

Supporting Disability Agreements – the EDI team have provided a number of 1:1 support sessions with individuals and/or line managers to aid them to have effective, supportive conversations which enable a shared understanding of how an individual's disability or long term condition affects them in the workplace and to agree what workplace adjustments would be beneficial.

RAISING AWARENESS AND LIVING OUR COMMITMENT TO CREATING AN INCLUSIVE WORKPLACE

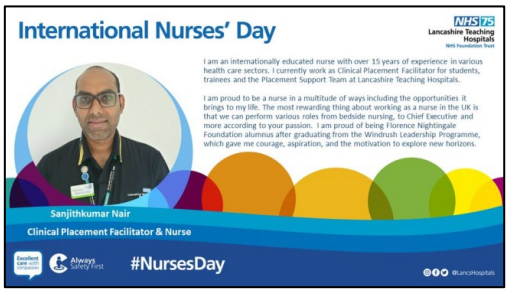
To ensure EDI remains a prominent part of our organisational narrative across the year, we support the promotion of several **key inclusion calendar events**. The focus of the inclusion calendar is to identify which events we will actively promote across the year to create interest, raise awareness, share colleague/patient or community member experiences, educate

colleagues, bust myths, or break down stereotypes or negative assumptions. Our approach enables us to align the focus of teams to ensure a consistent approach to the events we are promoting, across catering, health and wellbeing, library services, organisational development, communications, and EDI to create greater scale, spread and cascade. Selected events are promoted in the HeaLTH matters newsletter sent to all colleagues via email.

Examples over the last 12 months include;

International Nurses Day

On International Nurses Day we held a hybrid event with the aim to engage with all internationally educated nurses acknowledging their essential role in supporting the delivery of excellent care with compassion to our patients. The event was positively vibrant, with cultural dancing and singing included. Our Recruitment Manager spoke about the dedication and commitment of internationally educated nurses, and our forum chairs affirmed the support we provide for internationally educated colleagues.



Black History Month

We celebrated throughout the month of October with sessions including; an opening event with our Interim Chief Executive who spoke about what Black History Month means to her, an educational session led by the Ethnicity Forum Chairs about Black History Month whilst also promoting awareness of the forum. We learned from two external speakers representing Preston Black History Group and Preston Windrush Generation and Descendants, and we rounded the month off with a closing ceremony attended by carnival dancers, our guest speakers, and our Mayor.

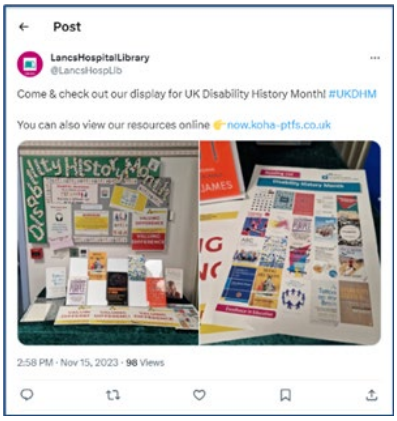
Disability History Month

The middle of November marked the start of Disability History Month; our aims were to increase forum membership in addition to promoting neurodiversity. A face-to-face event was held which included guest speakers such as the NHS Northwest Dyslexia Network Chair, who shared his story and experiences relating to hidden disabilities, as well as the benefits of becoming an accredited dyslexia workplace assessor. We had attendance from our Chief Nurse who shared her story about having a hidden disability.

There were a number of other events throughout the year including; LGBTQ+ history month, Windrush Day, Transgender Awareness Day, South Asian Heritage Month, Staff Networks Day, where all three inclusion forums came together to share ideas as well as information about what staff networks or (inclusion forums) are and more besides.

The annual **Inclusion Event Calendar** is planned, on an annual basis, in conjunction with the Inclusion forum leads ensuring a focus on important events which represent minority groups

whilst also aiming to shine more of a spotlight on what matters to colleagues. There are so many inclusion days/weeks/months, it would be impossible for us to mark every event corporately, however we actively encourage teams and individuals to celebrate the events which are significant to them, their work colleagues or their patient population such as religious festivals and/or events relating to specific long-term conditions.



Our Library colleagues continue to support the promotion of inclusion calendar events by undertaking **displays across both libraries** showcasing authors or literature which supports the topic area. They signpost calendar events through the library newsletter which is circulated to around 2000 colleagues, and they also promote through their social media channels.

To enhance support for colleagues with neurodiverse conditions to be able to engage with library resources more fully Read and Write software has now been installed on PCs, coloured overlays and noise cancelling headphones are also available across both Preston and Chorley libraries.

We also attended a number of **community events** in 2023, namely, Preston Caribbean Carnival, Preston Health Mela and the Windrush Festival To maintain our promise to raising our profile within the community, and actively engaging with community members, celebrating diversity and illustrate our commitment to being an inclusive employer. These events provided a fabulous opportunity to interact with members of our community, gather feedback in respect of our services, communicate information in respect of the New Hospitals programme and increase the diversity of our membership.

Due to improvement works taking place in respect of the Harris Library this year, there were restrictions on the spaces available for organisations to participate in the council-organised Pride event. This meant we were sadly unable to attend **Preston Pride** for the first time in several years; this was a massive disappointment to the LGBTQ+ Inclusion forum members and EDI colleagues yet we will refocus on securing our attendance in 2024.

EMBEDDING A ZERO TOLERANCE APPROACH TO DISCRIMINATION AND RACISM

To continue with our aim to be an antidiscrimination and anti-racist organisation we signed up to the **Organisational Sexual Safety Charter** in November; this signals our intent to take and enforce a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace. There are ten core principles and actions set out to help us achieve this. The sexual safety charter is very much in line with our existing Zero Tolerance approach and toolkit, it is supported by our zero tolerance statement in addition to an animation explaining what it is, the principles and points to consider as individuals but also within our teams.

In the latter half of the year we have delivered training sessions to over 100 colleagues to increase awareness and understanding of every colleagues' responsibility to support a **zero-tolerance approach**. Sessions have been created for both leaders and team colleagues to explore how they can uphold a culture of zero-tolerance and civility in their teams, considering how their own attitudes, actions and/or behaviours can support an effective zero-tolerance approach in their daily work and across their teams. The session also encourages leaders and colleagues to raise their own awareness of appropriate ways to address and challenge negative behaviour from others and guides them where they can seek further support from if needed.

Across 2023, we have also delivered several lightening sessions for c.130 line managers in respect of **"Banter – when it's definitely not a laughing matter"** to explore what banter is and when (or why) we might use it to support us in the workplace but also to guard against when it may cross the line towards more negative behaviours. The session revisits cases which have progressed to Employment Tribunals to help provoke discussion around instances where banter crosses the line towards bullying, harassment or discrimination and encourages line managers to consider their role in creating a safe environment for all colleagues alongside a collective commitment to "Call it Out".

We have made a commitment to embrace becoming an **actively anti-racist organisation**. This has started with completing an initial review and benchmarking ourselves against each level of the North West Black, Asian and Minority Ethnic Assembly Anti-racist framework (Bronze, Silver, Gold) to understand where our existing gaps are. We have drafted an anti-racist statement which will shortly be circulated across the Ethnicity Inclusion forum members for comment and review. Our aim for this year is to attain Bronze level before working towards the achievement of Silver.

OUR FUTURE FOCUS

- Include EDI measures within the STAR quality assurance process.
- Commit to achieving Bronze level of the North West Black, Asian & Minority Ethnic Assembly Anti-racist framework.
- Agree an anti-racist statement which will be published on our website.
- Ensure all new estate developments incorporate a consciously inclusive approach i.e., always consulting with patient groups and ambassador forums to ensure design principles support patients and colleagues with disabilities to navigate around the site with ease and to ensure facilities have gender neutral toilets as standard.

- Continue to use our position within the community as a healthcare provider and as a larger employer to help influence wider community change by actively tackling discrimination and inequality faced by people with protected characteristics when receiving care or working for us.
- To publish Board members objectives in relation to EDI.
- Drive to increase the number of patients from diverse backgrounds responding to national patient surveys.
- Increase the diversity of feedback in national surveys to better reflect the experiences of the community demographic.
- Agree the approach to the measurement and analysis of the 9 protected characteristics as part of all Trust defined audits and clinical reviews, so experience, health outcomes and inequalities can be understood and improved.

PRINCIPLE 2 – BEING EVIDENCE LED AND TRANSPARENT

This second principal is centred around using evidence to help inform our focus and our decision making, enabling us to recognise where the experience of patients and colleagues who belong to protected characteristic/minority groups is not where we would want it to be and empowering us to create focused actions to make the right difference. Equally this principle sets out the importance of using our data to help us reflect, understand and measure the impact we are having through the steps we are taking.

BEING TRANSPARENT WITH OUR WORKFORCE EDI DATA

This second report continued to demonstrate our commitment to deliver against this principle by having a **comprehensive annual report** which sets out where our focus has been, what we have delivered in the last 12 months and future actions we are going to take. It forms part of our Trust's public sector statutory duties under the Equality Act 2010 to report on performance and delivery against equality objectives annually alongside the breakdown of protected characteristics detailing the diversity of our workforce.

Our Workforce Diversity Headlines 2023

Headcount
10,348 (*9593*)

Ethnic Minorities
26.2% (*25%*)

Disability
4.9% (*4%*)

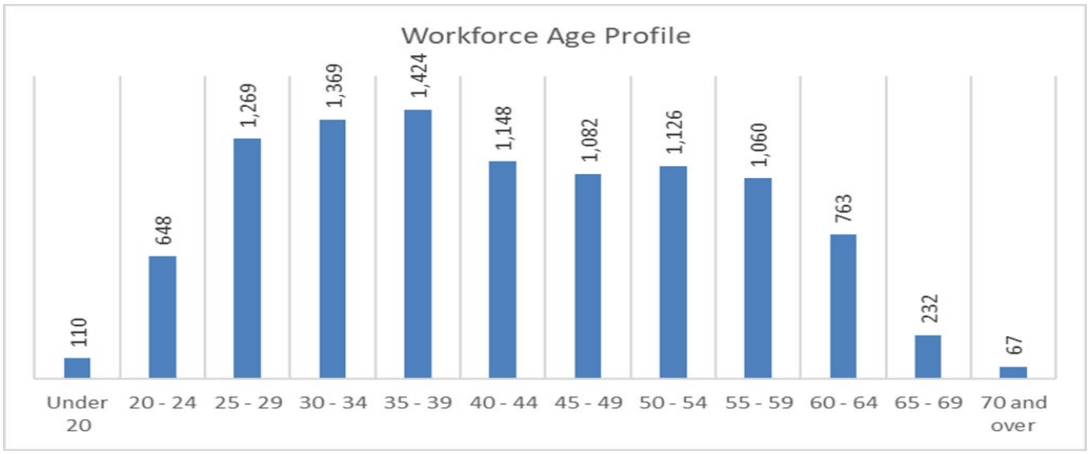
LGBT+
2.4% (*2%*)

Women
76.2% (*76%*)

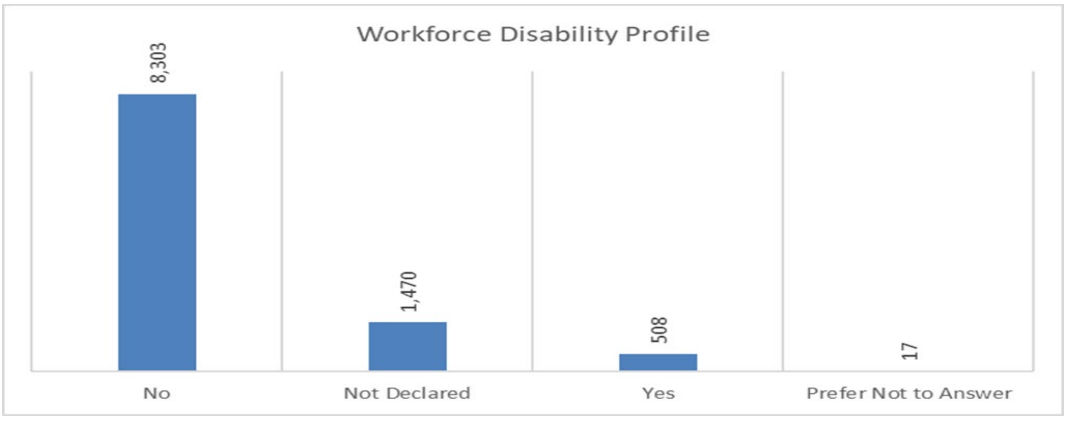
Married
53.3% (*53%*)

(2022 data shown in brackets)

Graph 1 - Age Profile

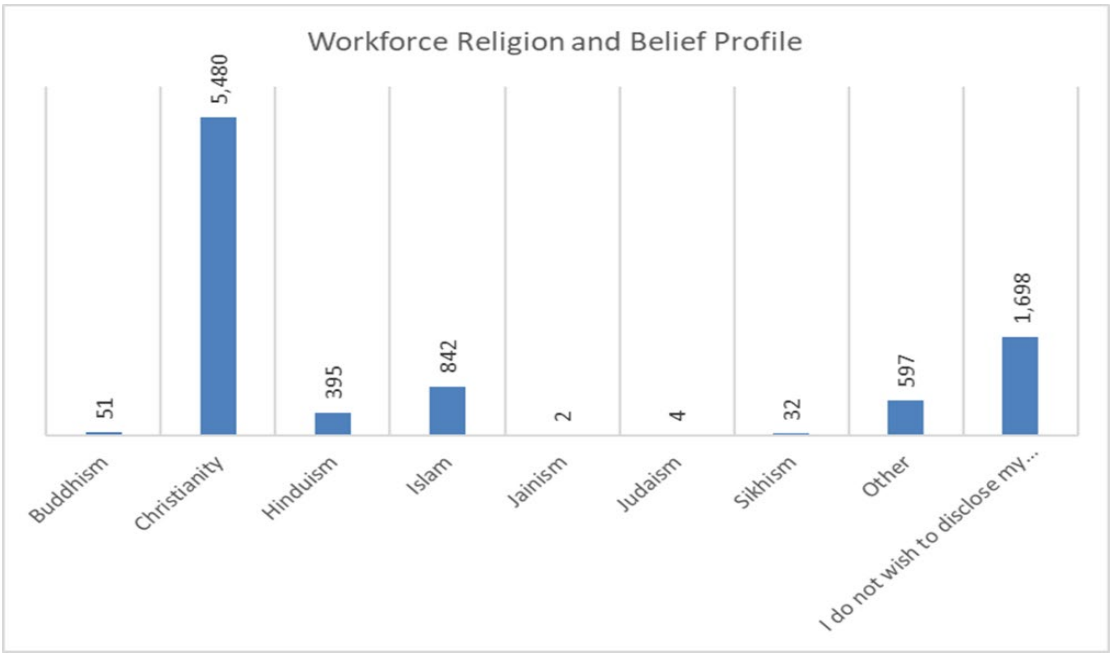


Graph 2 - Disability Profile

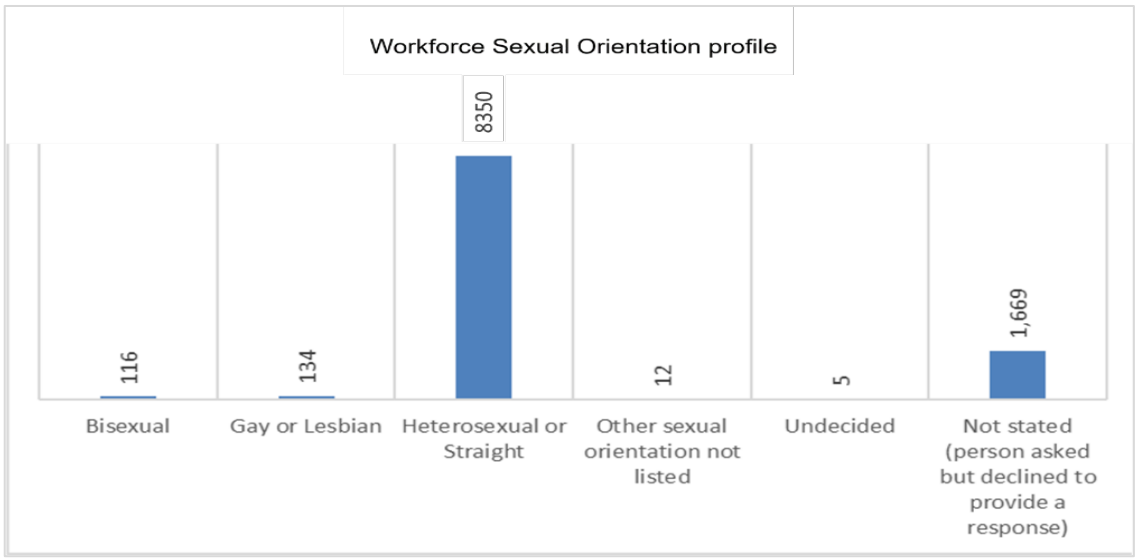


Graph 3 - Ethnicity Profile

Graph 4- Religion and Belief Profile



Graph 6 - Sexual Orientation Profile



Appendix 1 and Appendix 2, displays infographics displaying our annual WRES and WDES returns for 2023. The full reports can be found here.

Further actions to support the transparency of our approach with regards to delivering improvements for EDI as defined by the public sector equality duties is to undertake the annual **Equality Delivery System** (known as EDS2022) self-assessment process via coproduction with colleagues, patients and members of our community from minority groups. The purpose

of EDS it to support NHS organisations to improve the services they provide for local communities and provide better work environments whilst meeting the requirements of the Equality Act 2010. The completion of EDS2022 is mandated as part of our NHS Standard Contract. It is reported separately to Board outside of this annual update. The approach to completing EDS 2022 in 2024 is to work on a system level with colleagues across the Lancashire & South Cumbria Integrated Care System (L&SC ICS) whilst consulting, engaging and involving colleagues with protected characteristics via the Inclusion Ambassador Forums, with patients via the Patient Experience group as well as divisional engagement with colleagues supporting the delivery of EDI Actions. To understand our performance against last year's EDS22 assessment, the report can be found here.

FOR COLLEAGUES

USING DATA AND LIVED EXPERIENCE TO IMPROVE CULTURE

A number of the sub actions detailed under the first of NHSEs High Impact Actions relate to the use of EDI data by the Board, in order to understand lived experience, culture, priorities and progress we are making to reduce inequality. As it stands the Board already receives the following data sets/reports:

- Workforce Race Equality Standard
- Workforce Disability Equality Standard
- Gender Pay Gap
- Equality Delivery System (EDS) 2
- NHS Staff Survey results broken down by protected characteristic
- Annual EDI Report

With the exception of this report, all other reports are discussed within Workforce Committee, with escalation (and in some cases approval) by Board to enable the national publication of our data set. In addition to the suite of reports noted above, Workforce Committee also receive the annual strategy update for the Our People Plan strategic aim – to create a positive organisational culture.

Equality impact assessments have been undertaken on all workforce policies which have been reviewed or updated throughout 2023, to understand whether the application of our employee relation policies may lead to an adverse impact for colleagues with protected characteristics, and if so, then undertake actions which mitigate against any adverse impacts. Those policies were;

- Banding/re-banding Policy and Procedure
- European Working Time Directive Policy & Procedure
- Parenting Policy
- Qualifications and registration checks policy and procedure
- Retirement policy

A policy review and approval process has also been developed which sets out the need for an equality impact assessment to be undertaken for all policies in addition to the requirement for Inclusion Ambassador forums to be consulted with when a policy is being developed or reviewed. 2024 will see action taken to roll out additional guidance and training to workforce policy authors to further build on this work and make it more robust.

As a part of our **Workforce Disability Equality Standard (WDES)** and **Workforce Race Equality Standard (WRES)** analysis it was found that with regards to the formal capability process, disabled colleagues are more likely to be engaged in this process (being 1.9 times more likely to enter into the formal process), however this has reduced from the previous year (3.28 times more likely) and the number of cases entering a formal capability process overall remains very low (averaging under 10 each year), therefore care must be taken when drawing any conclusions. With regards to the formal disciplinary process, we have seen no movement in the percentage of colleagues from a minority ethnic background (compared to white colleagues) entering the formal stages with the results indicating that ethnic minority colleagues are less likely to enter the process (0.76 times less likely) a figure which has remained static over the last couple of years.

We continue with our commitment to enhance the level of reporting, analysis and assurance we provide around the **Workforce Race Equality Standard** (WRES), **Workforce Disability Equality Standard** (WDES) and **Gender Pay Gap**, all of which we publish externally here. The key findings from the WRES and WDES reports are provided in the Appendix, as the data forms part of our impact measures to assess the improvements delivered through this strategy. The associated strategy action plans contain actions designed to bring about improvements and reduce any adverse impacts experienced by these minority groups.

The **National Staff Survey** results are reviewed annually to understand if there are any differences in the experience of work for any of our minority groups. Through completing this analysis, we found a number of themes which include:

Bullying, Abuse, Violence and Aggression

- Colleagues who have a disability or long-term condition reported experiencing greater levels of bullying, harassment, violence and abuse from patients, their relatives or members of the public than colleagues without a disability or long-term condition. Similarly, it was found that colleagues with a disability of long-term condition reported experiencing higher levels of bullying or abuse from colleagues and managers. In addition, colleagues with this protected characteristic indicated that they felt less secure in raising concerns and less confident that, as an organisation, we would address them when compared with the Trust average.
- It was found that colleagues from a Chinese background and colleagues who identified as Irish experienced the highest levels of bullying, harassment, violence and abuse from patients, their relatives or members of the public. Colleagues who identified as Chinese also reported the highest levels of harassment, bullying or abuse from managers whereas colleagues from an Arab background noted the highest levels of harassment, bullying or abuse from other colleagues (all when compared to the wider Trust average).
- Colleagues below the age of 30 reported more experiences of bullying, harassment, violence and abuse from patients, their relatives or members of the public. Colleagues

between 41-50 reported experiencing greater levels of harassment, bullying or abuse from other colleagues.

The actions which have been taken to bring about improvements in these results are detailed elsewhere in this document and form part of Our People Plan strategic action plan, in summary this has involved the delivery of dedicated zero-tolerance training sessions in addition to a Banter "When it's not a laughing matter" lightening session and is supported by a bystander intervention toolkit. It is aligned with the actions being delivered through the Freedom to Speak Up Strategy and the Reducing Violence and Aggression Strategy.

Colleague Engagement

- Colleagues aged between 21-30 have the lowest engagement levels (overall score of 6.8), the most engaged groups are those aged 16-20 and 31-40 (score of 7.0), with those aged 66 and over having this greatest levels of engagement with a score of 7.3.
- Colleagues with a disability were found to have lower levels of engagement (6.5) compared to those without a disability (7.1) and in comparison to the organisational average (6.9). Looking at the 2022 results we can see the overall engagement level has slightly increased from a score of 6.4 however the gap has remained the same.
- Colleagues who identified as being Indian or Chinese had the highest engagement scores at 7.6 closely followed by colleagues who are African at 7.4 and Caribbean at 7.3. These scores are higher than the organisation average and also higher than white colleagues (score of 6.8). Colleagues with lower staff engagement levels were those from mixed or multiple ethnic groups (score of 6.0).
- Males and females had similar levels of engagement with males scoring slightly lower (6.8) to females 7.0). Colleagues who identify as non-binary had the lowest staff engagement levels at 4.6 with individuals who prefer to self-describe at 5.9
- Levels of staff engagement were lowest for colleagues who are gay, lesbian, bisexual or other, with a score of 6.2 (all 10 areas had a red RAG rating when compared against the organisation average) in comparison to heterosexual colleagues at 6.9.
- With regards to religion, colleagues who stated they had no religion had the lowest staff engagement scores and had 7/9 areas measure rated as red RAG when compared with the organisation average. Colleagues whose religion is Hindu or Sikh had the highest engagement levels (7.6) followed by colleagues whose religion is Buddhist (7.5).

Staff Satisfaction

- Colleagues between 21-30 years reflected experiencing higher levels of work-related stress and found work more exhausting and tiring than other age groups. With colleagues over the age of 51 years experiencing the greatest levels of satisfaction across the items measured in the National Staff Survey.
- Disabled colleagues report far lower levels of satisfaction across the majority of the questions in the National Staff Survey, including factors relating to their job such as ability to make suggestions to improve the work of their team/department, manage conflicting demands on time, feeling valued for their work. Through to how they feel working in their team; levels of respect and kindness demonstrated from colleagues and line managers and ability to access training and development opportunities.
- Across all the staff satisfaction questions, Pakistani colleagues, colleagues from any other mixed/multiple ethnic background and colleagues from any other white ethnic minority

background had the highest number of red RAG rated items compared with other ethnic minority groups and the Trust average.

- Across all the staff satisfaction indicators, colleagues who identify as gay, lesbian or 'prefer not to say' had lower levels of satisfaction than heterosexual or bisexual colleagues. Colleagues who identify as 'Other' had the greatest number of green RAG rated responses.

This year, we are hoping to be able to obtain our Staff Satisfaction results by protected characteristic group, cut by Division and Band so we can start to explore the experiences of colleagues at a more granular level and understand whether colleague experience varies depending on band/level of seniority, length of service or Division.

As always, we explore ways in which we may bring about improvements in the levels of engagement and staff satisfaction experience for colleagues with protected characteristics, we continue to involve the Inclusion Ambassador Forums to help define the actions which will make a difference.

The actions identified to date include dedicated development opportunities for colleagues with protected characteristics; increased awareness and understanding by team colleagues and line managers as to what inclusion means and how they can help support positive action. Greater analysis of data such as talent management categories, appraisal scores and attendance at leadership development opportunities is also an area for further exploration in 2024.

FOR PATIENTS

ENHANCING THE ROUTINE MONITORING OF PROTECTED CHARACTERISTICS OF OUR PATIENTS

A programme of work is ongoing through the Digital and Health Inequalities EDI Subgroup, focusing in on how we can **increase the routine monitoring of the protected characteristics** of our patients, to capture information across all 9 protected areas on patient records to enable deeper analysis and understanding of health inequalities. We understand we need to reduce the proportion of patient records which currently have a percentage unknown for a number of protected characteristics.

Through initial benchmarking it was found that we regularly record the following protected characteristics for our patients; age, marriage/civil partnership, pregnancy/maternity, race, religion/belief, disability and sex. Since that time, sexual orientation has been added and disability data is now used to prompt the clinician to discuss and identify whether reasonable adjustments are required to support the patient's ongoing care.

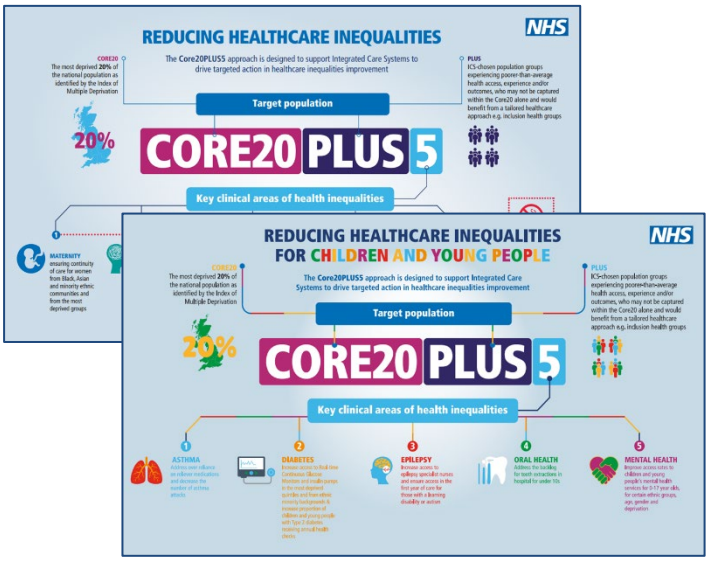
To increase the accessibility for patients to provide information on their protected characteristics work is underway to create a patient portal, this will enable those patients who are able and willing to self-disclose their personal information, rather than having to verbally state at an outpatient's reception desk for example deeply personal information. For those

patients such as the elderly or with disabilities we will ensure suitable alternatives are in place to support patients who wish to share this information so we can capture it on their behalf.

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.

HEALTH INEQUALITIES – Core20PLUS5

The Trust are in the early stages of defining an LTH Health Inequality delivery plan to tackle health inequalities in our locality. The NHSE Core20PLUS5 framework is a national approach to inform action to reduce healthcare inequalities at both national and system level based on the theory of social determinants of health. The Trust's delivery plan is structured around the ICB health inequalities programme and will link closely with the Preston and Chorley health and wellbeing partnership Boards, of which we are a member.



There are several projects underway to target specific groups of the population to reduce 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 undertake deep dive root cause, focused engagement with patients co-creating interventions around access and awareness.

- **Outpatient Did Not Attend (DNA)/Was Not Brought (WNB) (NHS England)** - review of DNAs through a 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 as well as ways in which 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.

- **Peer Support in Emergency Department –** Recognising the adverse experiences that may occur when a patient uses drugs and/or 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, drug and alcohol abuse and teenage pregnancy. The next stage 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, 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 –** work has commenced with the prison service to understand how health inequalities relating to prisoner access can be reduced.

The Macmillan Cancer team have undertaken a project working with ethnic minority community members, as data showed 97% of people that access their services are White British. Members of the Macmillan team visited the Sahara Centre in Preston, which is a voluntary organisation working predominantly for the benefit of the black and minority ethnic (BME) community members, to engage with their members and seek to understand any potential barriers. A few reasons have already been highlighted including the absence of translators at the appointment or not having the correct information. This work links in with a wider community project which has been established, working with Lancashire BME Network, focused on ethnic minority community members accessing Macmillan Care, the project is called **MPACE (Macmillan Preston Area Cancer Engagement)**.

Health Literacy: "The personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services, to make decisions about health" (World Health Organisation).

The organisations Library and Knowledge Management Service have delivered interactive sessions titled **"Health Literacy Awareness: A Pathway to reducing Health Inequalities"** which promises to help attendees recognise the impact of low health literacy, recognise the connections between health literacy and health inequalities in patient outcomes, recognise how patient experience is impacted by the understanding of health information and learn techniques and tools to support better health communication, and therefore, better health outcomes.

OUR FUTURE FOCUS

- Take an intersectional approach to evaluation and reporting, enabling us to identify unwarranted variations in experience for both patients and our workforce.
- Improve our methods of understanding barriers to social mobility and career progression of colleagues from all social class backgrounds by seeking to measure the socio-economic background of our workforce and benchmark our position and progress against the Social Mobility Employer Index.
- Have a clear measurement strategy for all patient facing engagement and involvement groups so we are able to understand impact and improvements delivered through this approach, as well as demonstrating to patients how we have taken forward actions to address their views and experiences.
- Each service will develop the ability to view outcome measures through the lens of protective characteristic data so we have the capability to understand our performance, incident and feedback data through the lens of protected characteristics and take action to reduce systemic inequalities.
- Through understanding the system and Integrated Care Partnership 'system' data, approaches to prioritising services will consider health inequalities that affect outcomes for our communities.
- To design and deliver equality impact assessment training, to enable those who produce patient and colleague facing policies, processes and standard operating procedures to competently complete impact assessments and improve the documented evidence of mitigations taken where impacts are recognised and confirm these are sufficient with colleague and community groups.
- To undertake equality impact assessments for appraisal and talent ratings, turnover, sickness absence, training evaluation and education metrics.
- To deliver a campaign which encourages colleagues to update their personal data sets to enable more accurate reporting of protected characteristics.

PRINCIPLE 3 – RECOGNISING THE IMPORTANCE OF LIVED EXPERIENCE

This principle emphasises the importance of understanding, valuing, and responding to the lived experience of our communities and colleagues. To provide excellent services and a great place to work we recognise that we need to engage with all groups but ensure the voices of minority groups in particular are engaged to co-produce and co-design as equal partners the shape of our services and type of organisation colleagues wish to work within. To implement Principle 3 the following actions have been taken forward to ensure we consciously recognise the lived experience or patients, our communities and colleagues:

FOR PATIENTS

The new '**Patients as Partners'** role has launched , linked to the Always Safety First strategy. This role builds on the concept of patient leadership, working to disrupt the 'them and us' relationship dynamic in healthcare and develops the capability for shared working by fostering a different relationship with our patients and our community members.

To learn from the lived experience of our patients in making improvements from our services we have sought to engage relevant patient groups in the design of services, to share their stories so we can reflect, learn and make impactful changes. As already mentioned in an earlier section of this report, patient stories continue to be a golden thread throughout a number of board, divisional, patient and committee meetings as a means of conveying the importance associated with understanding the lived experiences of our patient and carers, appreciating impact, learning and striving to embed best practice across their areas.

To further understand the needs of patients who present to hospital with self-harm the Medicine division has actively engaged with patients a part of their individualised care plans, to recognise how the hospital can be made to feel a calmer and safer place. Matrons are also reviewing any incidents of self-harm which take place within the division to ensure that comprehensive plans are in place to support and protect vulnerable patients.

Within Elderly Medicine, day room activities are being re-established and encouraged on Rookwood A and Ward 17, promoting use of activities for patients with dementia by music therapy, games and group sessions where families and carers are encouraged to attend. Relatives are also encouraged to bring items from home to make patients feel secure with recognisable possessions.

Neuro Rehabilitation have arranged for Headway (a charity which supports individuals who have been affected by a brain injury) to come onto the unit to meet with patients and families and offer support and guidance.

The expectation of wards and departments within the Medicine Division, is that a Learning Disability and Autism champion is identified. The champion is expected to attend bespoke training sessions, often co-delivered by people with lived experience and then to cascade information locally, at departmental level. The aim for the next quarter is for all wards and departments to have a champion, in keeping with the Learning Disability Plan 2023-26.

A number of ward areas are demonstrating a proactive approach to EDI through adopting bespoke bed boards called 'About Me' boards which communicate individual preferences, needs and personal care. For those on rehabilitation pathways, therapy boards have also been developed which details the patient's goals and achievements.

The Ear Nose and Throat Team invited a local primary school, which caters for deaf children, into clinic to visit and engage with patients and staff as a means of raising awareness. The team also promote the laryngectomy choir to patients and have updated their colleague display boards with information relating to dementia awareness and learning disabilities awareness.

We continue to look at ways in which we can make accessibility a priority across all our procedures, policies, documentation, web sites, internal/external communication and ways of working (e.g. by achieving the NHS England Accessible Information Standard), through utilising audio leaflets, providing different colour paper copies, and using different font sizes to support visually impaired and/or neuro diverse communities.

FOR COLLEAGUES

INCLUSION AMBASSADOR FORUMS

As noted in last year's report, we have three Inclusion Ambassador forums which have been established since 2019; Ethnicity, Living with Disability and LGBTQ+. The Inclusion Ambassador Forums are each chaired by a member of the community group, with support from the EDI team and with sponsorship from members of our Board and Executive Team. In addition to the inclusion forums, we have three support groups which are also aligned to the health and wellbeing agenda; a Menopause Group, a Carers Group and, within the last quarter we have also developed an Endometriosis Awareness group.

Membership and attendance across the forums has been variable again this year in spite of strengthened promotion, clarity of purpose and governance. Forum chairs have worked incredibly hard to **increase their visibility, foster greater awareness amongst colleagues and secure more engagement**, both internally (through events, corporate communications, emails and MS Teams channels) and externally, through social media channels, community events and cross system working.

There has been a notable **increase in the number of colleagues reaching out** (particularly to the ethnicity forum Co-Chairs) which illustrates a growing sense of trust among colleagues. Open discussions are encouraged around problems, challenges and any instances of discrimination colleagues feel they are encountering within the Trust. While this reflects positively on the forum's approachability, it also highlights enduring challenges within the organisation which we will collectively work to address.

Several of the forum chairs have been **strong advocates for Inclusive Recruitment** practices, particularly across the number of Board and Executive posts recruited for over the past few months; forum chairs were part of the assessment processes in respect of the Chief Executive and the Chief People Officer roles in addition to Non-Executive Director posts. In support of this, each of the forums have Chairs who have undertaken the Equality Diversity Representatives training which supports them to participate in panels as a champion promoting inclusive recruitment practices.

Every forum has made a concerted effort to **broaden their networks** – both internally by working on more of an intersectional basis, whilst also strengthening relationships externally across the ICS. This enables cross sharing, a deeper understanding of each other's workstreams and demonstrates their collective commitment to inclusion and the wider EDI agenda. All forums have welcomed presentations from the New Hospitals Programme teams and have engaged colleagues in discussions to ensure the provision of inclusive facilities as part of any new build.

The LGBTQ+ Inclusion forum has been working as part of the Lancashire & South Cumbria ICS LGBTQ+ group, they've also helped to set up Blackpool Hospital's LGBTQ+ staff network and they've reached out to other network chairs.

UTILISTING THE LIVED EXPERIENCE OF COLLEAGUES TO SHAPE HOW WE DO THINGS

As part of the EDI Strategy we continue to **co-produce our workforce and organisational development policies with the Inclusion Ambassador Forums**, by sharing details of proposed policy changes for discussion, circulating drafted policies for feedback, seeking views on completed equality impact assessments and understanding the impact of how our policies are applied on their lived experience.

We continue to seek the views of our Inclusion Ambassador Forums in reflecting on the findings from WRES, WDES, and our annual National Staff Survey results to identify if this reflects their experience of working with us, what would make the difference and bring about improvements. Their feedback has helped to shape the direction we take and what areas are given priority.

INVITING COLLEAGUES TO SHARE THEIR EXPERIENCES

The library, the EDI team and the Inclusion Ambassador forums are continuing to encourage staff to sign up as 'books' for our **Living Library**. The principle behind the Living Library is that the 'books' are colleagues with lived experience who generally belong to a minority group and the 'readers' of the books are colleagues who are interested in learning more about other people's lived experiences, maybe also their challenges, and it enables more of a shared understanding of how others experience life, or our working environment. It also helps to challenge negative stereotypes or generalisations and busts myths, encouraging colleagues to consider how they may be able to utilise their learning to support others.

As mentioned, we hold regular events which are scheduled as part of the EDI Inclusion calendar, to support colleagues with protected characteristics – on these occasions members of our **Inclusion Ambassador Forums** to come together and share their experience around different topics, examples include International Nurses Day, Discrimination aligned to Black History Month, Transitioning in the Workplace as part of Trans Awareness Day or Workplace Adjustments aligned to Disability History Month.

INTERNATIONALLY EDUCATED COLLEAGUES (IEN)

International Recruitment is where a healthcare professional moves to the UK from all over the world to practice. We have recruited over 650 internationally educated nurses to join our workforce and are actively recruiting for other healthcare professionals including Midwives, Occupational Therapists, Speech and Language Therapists and other AHP's.

Internationally Educated Nursing colleagues have been supported over the last year by our Pastoral Support Officer. An evaluation has been undertaken to gauge the experience of IEN colleagues with the majority reporting a positive experience in respect of recruitment and onboarding (4.36/5).

Once in receipt of their NMC pin, 87% of IEN colleagues noted they felt supported in their ward environment, to work independently which is an important aspect to aid retention. There are some inconsistencies with a small percentage of colleagues reporting they do not feel supported or highlighting they have experienced unfair treatment – this is an area which needs further action. To foster more positive relationships between line managers, team colleagues and IEC, a **Cultural Awareness training session** has been developed which aims to bridge some of the gaps. This training session was piloted with Band 7s across Surgery and received very positive evaluation feedback, this will be rolled out further across the organisation.

To further support IEC in building on their communication skills, we now also offer an **English Communication Course** with Runshaw College. The course not only supports development of communications skills but also leadership and team-working skills too.

A **new Ward Managers guide** has also been created, which is available via the new International Recruitment intranet page. The guide provides information for Ward Managers and Senior Colleagues on how to monitor the progress of Internationally Educated Colleagues as well as FAQ's.

The **new International Recruitment Intranet page** also has all of our resources available for colleagues to access to help them in supporting our Internationally Educated Colleagues on the wards. There are a range of resources including important Home Office Visa updates, English Language resources and Pastoral Support Resources. This also helps to manage expectations after they have received their NMC pins including the consideration of patient safety, completing and signing off competencies etc.

Our focus for next year is to **support career progression and career aspirations** of our internationally educated colleagues through concentrating on talent management, career development pathways, progression and effective appraisal conversations. From the evaluation feedback provided, 75.3% of this group of colleagues reported they have had an appraisal with their line manager and discussed career development and progression as part of that conversation however, 24.7% have reported that they have not.

RESPONDING TO HEALTH AND WELLBEING BEING NEEDS OF MINORITY GROUPS

As already noted, over the last year we have undertaken a significant amount of work and delivered a consistent and sustained narrative around the creation of a compassionate culture to support a more seamless implementation of workplace (reasonable) adjustments for colleagues. **Workplace adjustments** are changes made to remove (or reduce) any disadvantage related to a colleague's disability or long-term condition when doing their job, or to remove (or reduce) any disadvantage related to a job applicant's disability or long-term condition when applying for a job.

As measured through the annual Workforce Disability Equality Standard, we found that 75.1% of colleagues who have a disability or a long-term condition said the organisation has made **reasonable adjustments** to enable them to carry out their work. This is above the national average for this measure (71.8%) and marks an increase from 72.6% in the previous year.

A new **Endometriosis Awareness group** has been formed, with a view to enabling the organisation to become an Endometriosis Friendly Employer. As an organisation who has a 76.2% female workforce, this is an area colleagues have signposted would be beneficial for us to consider from a health and wellbeing perspective. Even though the group is still relatively new plans are underway to launch a communications campaign in conjunction with Endometriosis Awareness month in March 2024. We are also exploring how we can develop interventions to assist in raising awareness of the condition across the organisation whilst busting any myths, as well as how we can educate line managers too, ensuring a compassionate and supportive line management approach is adopted.

Alongside this there have been a number of health and wellbeing campaigns designed to help address health inequalities in the workforce, support colleagues with protected characteristics to feel well at work as well as provide guidance to colleagues who may have financial challenges or being experiencing deprivation. These have included:

- 204 blood pressure checks were completed in support of national campaigns such as South Asian Heritage Awareness month and Diabetes Awareness month, with 22% of participating colleagues referred to their GP due to high blood pressure readings. This has supported individuals to access early intervention for a potentially serious health concern they may not have previously been aware of.
- Delivered 106 health check appointments for colleagues at higher risk of serious illness from Covid-19, including BMI calculation, cholesterol testing, lifestyle advice etc.
- Mini Health Checks and Complementary Therapy Appointments were offered to Estates colleagues during Men's Health Week as a way to support males to access wellbeing support and engage them in the health and wellbeing offer when historically this group from this area of the Trust have been harder to reach in this regard.
- Health and Wellbeing team collaborated with Chaplaincy and EDI team to support colleague wellbeing during Ramadhan.
- Worked with Vivup salary sacrifice and employee assistance provider to incorporate ethnic minority group uptake within utilisation reporting.

- To provide financial support to colleagues the Health and Wellbeing Team have engaged with HSBC regarding potential future support available for colleagues as part of their community engagement offer, advertised to colleagues how to access advice from Utilities Warehouse Household utility bills free assessment for potential cost savings and promoted how to access the Household Support Fund available within Preston and Chorley.

OUR FUTURE FOCUS

- To improve the experience of work for our temporary workforce with protected characteristics to reflect that of our substantive colleagues.
- Further evidence targeted health promotion interventions in protected characteristic groups to improve outcomes related to obesity, alcohol and tobacco.
- Review the effectiveness of Supporting Disability in the Workplace Agreement with every colleague who has a disability or long-term condition.
- To review Core People Management Skills Programme in partnership with the Inclusion Ambassador Forums to shape content in which to build the competence and confidence of line managers to have conversations with colleagues about their protected characteristics such as during a return-to-work conversation, as part of appraisal, when considering a range of factors which could be impacting on an individual's performance.
- For every structural estate change, or new building development we will commit to engaging with individuals with protected characteristics, specifically those patients who are living with the condition in the design and layout of our physical estate from conception stage to build sign off.
- Work with diverse groups of patients, their families, carers and service users to shape wayfinding and signage to make it easier to navigate when in hospital and transferring care between hospital and community services. This should include accessible interventions for those with additional needs.
- Ensure all new software and equipment goes through a procurement, EIA or accessibility check before it is piloted or purchased.
- All pathway and service redesign will involve the patient voice, providing opportunity for co-design and consultation.
- Explore the use of social prescribing to promote health and wellbeing in community groups.
- Undertake a "Sharing not declaring your disability" campaign to increase disclosure rates.

PRINCIPLE 4 - BEING REPRESENTATIVE OF OUR COMMUNITY

This principle focuses inward and sets out our ambitions to increasing the diversity of our workforce so it is proportionally representative of our communities. Within the EDI Strategy we have set out ambitious goals which includes increasing the representation of colleagues with protected characteristics, publicly demonstrating our support to recruiting individuals with protected characteristics or who are from more disadvantaged backgrounds or from deprived areas through to supporting colleagues with protected characteristics to reach their full potential and climb the career ladder should they wish.

INCREASING REPRESENTATION OF COLLEAGUES WITH PROTECTED CHARACTERISTICS

Through the series of annual reports we produce as part of our NHS Contract, we understand our current position with regards to representation for a number of protected characteristics, specifically:

- We have seen **some increases in the percentage of disabled colleagues across our workforce**, with 4.7% of our non-clinical workforce and 4.8% of our clinical workforce who identify as disabled. It is positive to note an increase in representation in our clinical colleagues at bands 2, 3, 4, 6, 7 and VSM, as well as an increase in representation across our non-clinical colleagues at bands 2, 4, 5, 8a, 8b, 8c and VSM. Despite these increases we know we still have a significant disparity between the number of colleagues who have shared their disability on our Employee Staff Record system i.e., as at 31 March 23, 481 colleagues recorded they had a disability or long-term condition yet we understand from our National Staff Survey data that 996 colleagues who completed the staff survey recorded they had a disability or long term condition. Given the proportion of people who take part in the survey is typically 50% of total workforce, we could be looking at many more than this.
- Through the annual Workforce Race Equality Standard report we found in the last 12 months that across the majority of the agenda for change bands for clinical and non-clinical colleagues we had seen **an increase in the representation of ethnic minority colleagues within our workforce**. There was a slight decrease in representation of clinical ethnic minority colleagues at bands 8b, 8c and 8d as well as a decrease for non-clinical ethnic minority colleagues at band 8c.
- The greatest representation of ethnic minority colleagues in non-clinical roles are in bands 2 and below (below band 1 tend to be apprentices) and in band 8c (16.7% of band 8c colleagues are from and ethnic minority background). Across all bands with the exception of apprentices and 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, this could in part be due to extensive international recruitment in the last couple of years. With the exception of band 5 clinical roles, again ethnic minority colleagues are underrepresented in all other bands when compared against the Trust wider ethnic minority workforce.
- The majority of our workforce (53.2%) is aged over 40 years. The workforce is fairly evenly distributed across age groups with most groups making up around 10-13% of the workforce.

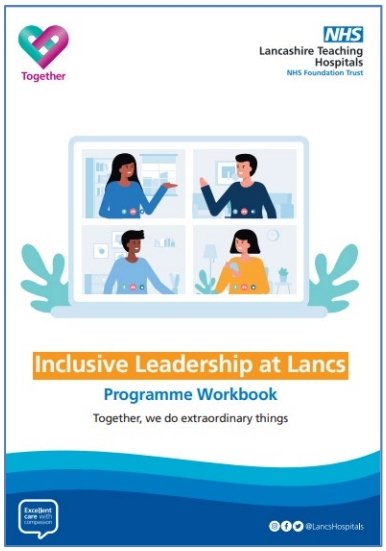
The groups that are lower in representation are the under 25s and over 60s meaning those colleagues are in the minority groups.

- The predominant gender is female at 76%, which is typical for NHS organisations.

Within both WRES and WDES reports we measure the likelihood of disabled candidates and ethnic minority candidates being shortlisted. There has been an improvement in the last 12 months in relation to the likelihood of disabled candidates being appointed from shortlisting (moving from 1.21 to 1.13), showing a levelling of experience between disabled candidates compared against the experience of non-disabled candidates. However, for ethnic minority candidates the race disparity ratio for this indicator has deteriorated from the previous 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 an ethnic minority background. The disparity ratio is above the range of 0.8 – 1.2, which means there is likely to be an adverse impact experienced by ethnic minority candidates, therefore further action needs to be taken.

DEMONSTRATING OUR COMMITMENT TO CREATING A DIVERSE WORKPLACE

Over the past twelve months we have continued to provide a series of focused pastoral support sessions to assist our **internationally educated nurses**. Sessions have focused on providing guidance and support in areas such as; cost of living advice, family visas, education support and connecting cultures. There has been a great uptake within the community and attendance at events with over 180 members in the WhatsApp community group. A focus over the next 12 months will be in respect of career development sessions or clinics to enhance knowledge in respect of career development opportunities and encourage retention of colleagues.



In November we celebrated the graduation of colleagues from the **Inclusive Leadership at Lancs** programme. The programme had been co-designed with colleagues specifically to support our talented ethnic minority clinical and non-clinical aspiring leaders of the future who occupy band 5-8a posts, as data shows there is likely to be some social, organisational and psychological barriers which restrict ethnic minority talent from progressing up the career ladder. The programme contained several elements including a RADA model in respect of personal impact, talent management, management development and continuous improvement - it was designed to help bridge the gap between where colleagues currently were and where they wanted (or needed) to be, in order to progress into a more senior role. 38 colleagues started the programme and 26 colleagues successfully completed 2 or more elements. Early evaluation data indicates that 8 colleagues have subsequently been promoted internally which equates to approximately 27%. Further evaluation is set to take place with programme participants to look at what the next steps might be.

Our Leadership Development team have engaged with each of the Inclusion forums in order to **promote the leadership, management and talent management development opportunities** we have in existence here at the Trust and to encourage colleagues to apply.

A proportionate number of places have started to be ringfenced across accredited leadership development programmes as part of a positive action approach.

To lay down the right foundations we have committed to several pledges, charters and covenants. The purpose of undertaking these actions has been to assess our own current position against the standards set by external bodies, to reflect on what more we should be doing, to show our commitment to our current workforce and externally to our future workforce alongside patients and the communities we serve.

In the last 12 months we have:

Maintained **Disability Confident Employer at Level 2** which signals that we think differently about employing disabled people in our organisation; we recognise that disabled individuals are a hugely diverse group of people with amazing skills and experience, in addition to qualities our organisation needs.

We continue to believe in the five steps set out in the **Dying to Work Charter**, which was led by our Staff Side colleagues.

In January 2023 we signed up to participate in the **Care Leavers Covenant** which is a national inclusion programme supporting care leavers aged 16-25 to live independently. The Covenant is a promise made by our organisation that we will support Care Leavers through providing opportunities to enter the world of work, through offering access to our Pre-Employment Programme and our Reboot programme. The goals of the Covenant are to better prepare Care Leavers to live independently; to improve access to Employment, Education and Training; to support care leavers to experience stability in their lives and feel safe and secure; give improved access to health and emotional support and help them to achieve financial stability.

In response to our **Working Smarter Pledge** to ensure flexible and agile working is firmly embedded within our organisation, it has been great to see our staff survey results in response to the question “Satisfied with opportunities for flexible working patterns” increase year on year, with our latest figures (60.2%) reflecting the highest result in the last 5 years as well as being above the national average score.

The idea behind the Working Smarter pledge is to reaffirm the importance of **encouraging and supporting agile and flexible working**, which can positively support elements such as colleague wellbeing and compassion towards others. It’s a marked shift in focus from “presenteeism” and can act as a supportive mechanism for colleagues with a disability or long-term condition if their role enables them to work productively from home, as well as for other colleagues who need greater flexibility due to demands in their home life such as caring responsibilities.

The **renovation of the multifaith area and Muslim prayer room** at Preston has provided a calm, respectful, culturally appropriate area for patients and colleagues to pray. Prayer facilities at Chorley will be the next area of focus.

DEVELOPING A TALENT POOL AND SUPPORTING CAREER PROGRESSION

Our WRES and WDES data, submitted in July 2023, tells us that:

- 52.4% of colleagues with a disability and 61.4% of colleagues without a disability believe 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.
- 48.5% of ethnic minority colleagues and 62% of white colleagues believe our organisation provides equal opportunities for career progression and promotion. This is an improvement on results from the previous year, however the disparity ratio falls outside the 0.8-1.2 guidelines, indicating a potentially adverse impact for ethnic minority colleagues and warrants further discussion and action.
- Colleagues from ethnic minority groups are just as likely (1.02) to be able to access non mandatory and continuous professional development than their white counterparts. This is a significant improvement on the previous year and we need to ensure this parity is maintained as far as is possible.
- 0% of the Board's voting membership had an ethnic minority background, compared with an overall workforce of 26.2%. This indicates we had no representation of ethnic minority members on the board of directors and therefore we were not proportionately representative of our workforce.
- With 10.5% of the Board's voting membership identifying as having a disability, this is greater than the NHS average of 3.7% as well as an increase from our position of 7.14% in the previous 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.

To bring about improvements and ensure colleagues with protected characteristics have greater opportunity to access development, are supported in their talent and career aspirations, as well as trying to create greater diversity in colleagues who obtain more senior, executive and non-executive director level posts, we have continued to undertake several programmes of work which include:

Leadership to the Disabled NHS Directors Network

Kate Smyth, one of our Non-Executive Directors, co-founded the Disabled NHS Directors Network in October 2020 alongside Peter Reading, Chief Executive of Yorkshire Ambulance Service. The network is open to Executive and Non-Executive Directors with disabilities on the Boards of NHS Trusts, CCGS, ICSs, NHS Arms-Length Bodies and Community Interest Companies and Public Sector Mutuals providing NHS services. It was created to strengthen

the collective impact and voice of disabled leaders and, through them, of disabled staff within the NHS and to provide a peer support network for disabled NHS directors. Some examples of the work Kate has undertaken so far are;

Worked closely with the national WDES team on aspects such as WDES strategy and funding support
Undertaken a number of presentations at conferences i.e. NHS Confederation, NHS Providers, NHS Employers Disability Summit
Produced content to raise awareness and support Disability History Month – nationally (NHS England, NHS Employers, NHS Providers) and locally (trust boards) presentations,
Undertaken mentoring for recently recruited disabled NEDs and aspiring NEDs (funded by NHSE/I)

ENCOURAGING SOCIAL MOBILITY AND WIDNENING ACCESS

The Widening participation team continues to provide career inspiration and opportunities for employment to our local community, through provision of programmes and events designed to support those who are at a disadvantage and aspire to a career in the NHS.

In the last 12 months, 11 individuals have completed the **Pre-Employment Programme** the purpose of which is to help long-term unemployed individuals to gain employment with us, 19 candidates took part in the two week **Reboot Programme**, with 7 obtaining employment in our organisation. We offer a 3 day **Ready, Steady, Apply** course which is designed to support candidate who are already employed but struggle with the application process, 27 candidates completed the programme and 14 of which secured employment with us.

Preston Widening Access Programme has been delivered annually since 2014, providing disadvantaged students in our local area with the knowledge and experience necessary to pursue medicine at the University of Manchester. This year, we welcomed 19 students to the January 2023 cohort, of which 18 successfully completed the programme and applied for the course: we're awaiting confirmation of interviews.

The **Work Familiarisation Programme** is designed to provide students with learning difficulties and disabilities an insight into the world of work. Following completion of the programme, students can participate in work experience for two hours a week over six weeks in an area they found interesting. In 2023, 16 students completed this programme and will proceed to complete work experience in early 2024.

ENSURING OUR COLLEAGES AND COMMUNITY MEMBERS SEE THEMSELVES REFLECTED IN THE CONTENT WE PROMOTE

We continue to ensure that all images, videos, leaflets, training resources, written publications and animations use images which reflect the full diversity of the communities we serve and the colleagues we employ. We consciously ensure images reflect our diversity across protected characteristic groups, professions and areas of the organisation.

Over the last year, **Multifaith resources** have been created to support the end-of-life CARING campaign to help make it easier to understand and respond to the spiritual needs of our patients at the end of life.

OUR FUTURE FOCUS

- Review our recruitment and selection processes from end to end, this includes having as standard diverse recruitment panels and the presence of an equality representative who has the authority to stop selection processes if deemed unfair.
- Take further steps to increase the representation of minority colleagues to ensure the diversity makeup across all minority and socioeconomic groups is broadly representative of the communities we serve at all levels of our organisation.
- Develop a talent pool database of individuals across the organisation who are identified as Rising Stars and agree the positive action we will take to fill promotion opportunities with colleagues from underrepresented groups.
- Continue to prioritise and promote the widening access work and programmes in the organisation in order to further enable social mobility through our attraction, recruitment, retention efforts.
- Understand disparities in performance management in colleagues with protected characteristics, specifically in relation to formal performance management processes, appraisal ratings, talent management ratings and ability to access training and development opportunities beyond mandatory training.
- Ensure wider engagement from our diverse communities across all services and divisions, in co-production, listening to feedback and taking actions based on feedback.

PRINCIPLE 5 – BRINGING ABOUT CHANGE THROUGH EDUCATION AND DEVELOPMENT

Education and raising awareness is an essential part of the strategy, as it helps to inform, change mindsets and create a force for change. This section details how we are using training, education and development to support colleagues with protected characteristics, through to detailing how we are using education and awareness to raise the wider workforce understanding of their role in supporting us to deliver the aims of this strategy.

Some of the progress under this aim, has already been reported under other aims including; the Inclusive Leadership in Lancs Programme, the Bystander Toolkit and Zero Tolerance implementation.

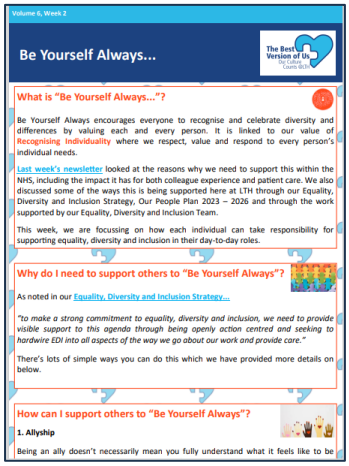
IMPROVED EXPERIENCE FOR COLLEAGUES WITH PROTECTED CHARACTERISTICS

As already covered within this report, we have embarked on rolling out an organisation wide programme affirming **Our Zero Tolerance Approach** to all colleagues. The programme is intended to ensure all colleagues understand their personal responsibility to uphold a Zero Tolerance approach to abuse within our organisation through looking at our organisational approach and by exploring leadership and colleague responsibilities to take action.

Over the past quarter we have developed **additional EDI training sessions** to help us respond to organisational needs; Banter – When it's Definitely not a laughing matter and Cultural Awareness which explores culture, stereotypes, cultural differences in communication all of which positively support a multicultural workplace, generate discussion and increase knowledge or awareness. These are in addition to other masterclasses already developed including; Unconscious Bias, Microaggressions and Inclusive Language.

This year also saw the launch of a **mandatory Learning Disability, Autism and Neurodiversity online learning module**, developed to help colleagues understand the different aspects of learning disability, autism and neurodiversity. It aims to give people an insight into various conditions along with some guidance about how adjustments could be facilitated.

We believe culture is everyone's responsibility and throughout 2023, we have been supporting all colleagues to explore how they can put the principles of **The Best Version of Us** into practise in their day-to-day roles.


Volume 6, Week 2

Be Yourself Always...

What is "Be Yourself Always..."?

Be Yourself Always encourages everyone to recognise and celebrate diversity and differences by valuing each and every person. It is linked to our value of Recognising Individuality where we respect, value and respond to every person's individual needs.

Last week's newsletter looked at the reasons why we need to support this within the NHS, including the impact it has for both colleague experience and patient care. We also discussed some of the ways this is being supported here at LTH through our Equality, Diversity and Inclusion Strategy, Our People Plan 2023 – 2026 and through the work supported by our Equality, Diversity and Inclusion Team.

This week, we are focussing on how each individual can take responsibility for supporting equality, diversity and inclusion in their day-to-day roles.

Why do I need to support others to "Be Yourself Always"?

As noted in our Equality, Diversity and Inclusion Strategy...

"to make a strong commitment to equality, diversity and inclusion, we need to provide visible support to this agenda through being openly action centred and seeking to hardwire EDI into all aspects of the way we go about our work and provide care."

There's lots of simple ways you can do this which we have provided more details on below.

How can I support others to "Be Yourself Always"?

1. Allyship

Being an ally doesn't necessarily mean you fully understand what it feels like to be

Each month we have focused on one aspect of the framework and we have released a weekly communication via the HeaLTH Matters Newsletter which includes ideas, resources, activities, and events that colleagues can access and use personally and within their teams. At the end of each month, we have shared a newsletter for leaders which has additional guidance, case studies and engagement activities to support the delivery of cultural improvement within our teams.

A number of the communications have had an inclusion theme, such as **"Two Ears and One Mouth – Listening for Inclusion".** The topic of "Be Yourself Always…Recognising and celebrating diversity and differences by valuing each and every

person" contained four separate newsletters which focused on Our Approach, Allyship, Increasing Awareness and Supporting Difference, Our Role as Leaders and Learning & Development opportunities.

An action from last year was to **implement a Bystander Intervention Kit** which includes values based and civility resources to help colleagues to tackle uncivil behaviours, discrimination, bullying and harassment – this has been achieved.

INCLUSIVE, ACCESSIBLE BLENDED LEARNING AND LIBRARY SERVICES

In the last 12 months we have taken the steps to enhance accessibility in respect of our online learning content; all new videos and animations have captions to support learners with impaired hearing. In addition, all mandatory Core Skills Framework courses have an MS Word version available to support colleagues who would find a printable document a more accessible form of learning. There is an option to translate the Core Skills Framework content into other languages too.

LEADERSHIP AND MANAGEMENT SKILLS

We have undertaken a significant amount of education and communication in support of **Workplace Adjustments**; supporting managers and leaders to understand their responsibilities and requirements in line with legislation, our Supporting Disability in the Workplace policy and our Trust Values. A member of the EDI team has been identified who can support Workplace Adjustment requests or queries and we have detailed a pathway for colleagues and line managers to follow if they require (or require support with) Workplace Adjustments.

As promised in last year's report, we have finalised the review of current EDI training available to all colleagues to ensure everyone understands their personal responsibility to promote equality, work in line with inclusive practices, challenge inappropriate behaviours and remove any unfair barriers. This includes raising awareness of expected behaviour, terminology, relevant good practices and where to access further guidance and support. In support of this we undertook a **Training Needs Analysis** across the organisation as a means of understanding how colleagues were educating themselves around inclusion matters and where they felt they required additional support. Responses were very low however the information gathered from those colleagues who did respond has been used to formulate an initial training plan for the coming year.

COLLABORATIVE WORKING WITH EDI COLLEAGUES ACROSS THE INTEGRATED CARE SYSTEM (ICS)

EDI Colleagues from across Lancashire & South Cumbria ICS have assembled to explore ways in which we can work more collaboratively for collective benefit, particularly as a means of gaining some pace and traction in respect of particular programmes of work.

At present, seven projects have been identified for us to move forwards, which are;

- Cultural Awareness
- Reasonable Adjustments
- Inclusive Recruitment
- Delivering on Anti-Racism
- Staff Network Chair Development
- Reciprocal Mentoring
- EDS2022

An initial scoping exercise has been started in respect of each of the projects which will progress throughout 2024.

OUR FUTURE FOCUS

- Deliver Equality Impact Assessment Training for all colleagues and teams who draft policies, guidelines, patient information and colleague communication.
- To ring fence a proportionally representative percentage of apprenticeships, accredited (e.g. Institute of Leadership and Management Level 2, Consultant Leadership Development etc.) non-accredited (e.g. Continuous Improvement Programmes, Core People Management Skills, Senior Leadership Development etc.) taught programmes for colleagues with protected characteristics.
- To foster a restorative, just and learning culture by integrating learning from concerns and complaints made by patients, families, carers and colleagues into the organisations learning to improve processes.
- Embed a talent management strategy which targets under-representation and lack of diversity, which specifically addresses the issues around attracting and retaining younger talent, as well as equity of career progression opportunities for colleagues with protected characteristics, particularly for internationally recruited colleagues.
- Develop and deliver a comprehensive induction, onboarding and development programme for internationally educated colleagues which encompasses both professional and pastoral support.
- Deliver Equality Diversity Representatives training to colleagues to support recruitment, performance, disciplinary and grievance processes.
- Analyse data from appraisal in relation to the number of colleagues who have a completed Supporting Disability in the Workplace agreement, as well as conducting an assessment to determine the effectiveness of the agreements with colleagues who have an identified long-term condition or disability.
- Work with EDI colleagues across Lancashire & South Cumbria to progress the seven agreed collaborative projects.

FINANCIAL IMPLICATIONS

Whilst there are limited direct financial implications associated with this report, there are a number of indirect costs which could be incurred if we are unable to progress against the strategic aims outlined. These include:

- Costs associated with missed appointments from patients who may have lower health literacy skills, from a poorer demographic background, or minority group.
- Increased treatment costs for patients with health inequalities.
- There is no celling for the maximum amount which could be awarded from a potential employment tribunal with a discrimination claim.
- The associated costs for colleague turnover, this includes impact on team morale which can impact on levels of productivity, impact on reputation, time to hire and needing to use temporary worker colleagues, as well as time spent recruiting and upskilling.

LEGAL IMPLICATIONS

As a public sector body, we are governed by the Public Sector Equality Duty which came into force in 2011 alongside the Equality Act 2010. As part of this we are obliged to meet the objectives set out which include:

a. eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b. advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c. foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

To ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require public authorities to publish:

- equality objectives, at least every four years,
- information to demonstrate their compliance with the public sector equality duty.

This annual report and the EDI Strategy supports the transparency with regards to the objectives we are taking to improve diversity and inclusion alongside our data profile. In conjunction with this report, the Workforce Race Equality Standard, Workforce Disability Equality Standard and the Gender Pay Gap report support further transparency with regards to our data and experience of colleagues from certain protected characteristics.

RISKS

The risks to not progressing against the EDI strategy are in part documented within the financial and legal implications. Further to this wider risks include:

- Ability to analyse our patient data by all 9 protected characteristics is limited due to system limitations, this makes it more challenging to understand any health inequalities that may exist, alongside measure any impact through actions taken in delivering the strategic aims.
- Negative impact on the experience of work for colleagues with protected characteristics leading to challenges with retention.

- Increased discrimination claims.
- Reduction in overall levels of colleague engagement and satisfaction as measured by the National Staff Survey and the National Quarterly Pulse Survey.
- Reduced reputation as an inclusive employer.
- A workforce that is not representative of the communities we serve, across all levels and professional groups.
- A workforce which is not consciously inclusive, or who possess the skills, knowledge, confidence and competence to tackle discrimination and deliver inclusive working practices within an increasingly more diverse workforce.
- Inability to progress social value work through increasing the diversity of our workforce which in turn supports our communities to thrive.
- Increased health inequality gap(s).
- Services are designed which do not meet the unique needs of our local populations.
- Inability to achieve CQC standards around equality, diversity and inclusion of the services we offer.
- Inability to deliver on the NHS People Plan and the NHS People Promise Element - We Are Compassionate and Inclusive.
- Failure to deliver the NHSE High Impact Actions.
- Not keeping up with developments in diversity and inclusion from a patient, community and workforce perspective.

IMPACT ON STAKEHOLDERS

The stakeholders are patients, their families, the wider community, our current and future workforce. All these groups could be negatively impacted if we fail to deliver on all aspects of the EDI strategy.

RECOMMENDATIONS

It is recommended that Board approve the paper for external publication.

APPENDIX 1

Together

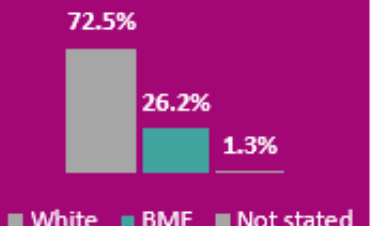
THE WORKFORCE RACE EQUALITY STANDARD 2023

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

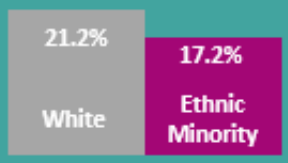
DISCIPLINARY PROCESS

Ethnic minority colleagues are **0.76** times less likely to enter a formal disciplinary process than **white** colleagues

TRAINING AND DEVELOPMENT

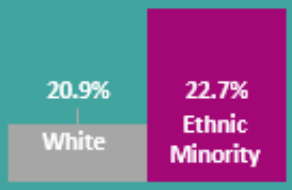
White colleagues are **1.02** times more likely to access non-mandatory training and CPD compared to ethnic minority colleagues

BULLYING AND HARRASSMENT FROM PAITENTS AND THE PUBLIC



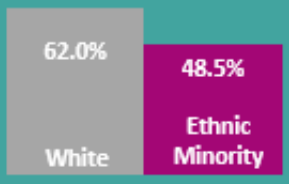
17.2% of Ethnic Minority colleagues experienced harassment, bullying or abuse from patients, relatives or public in the last 12 months

BULLYING AND HARRASSMENT FROM COLLEAGUES



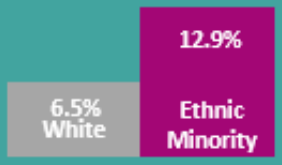
22.7% of **Ethnic Minority** colleagues experienced harassment, bullying or abuse from other colleagues in the last 12 months

CAREER PROGRESSION



48.5% of **Ethnic Minority** colleagues believe 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 19 Board Members

APPENDIX 2

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.

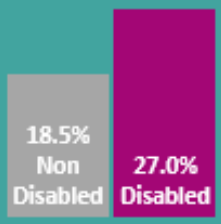
SHORTLISTING

Non-disabled colleagues are **1.13** times more likely to be appointed from shortlisting.

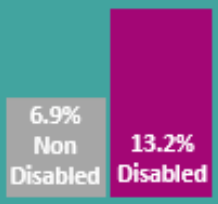
CAPABILITY PROCESS

Disabled colleagues are **1.9** times more likely to enter the formal capability process.

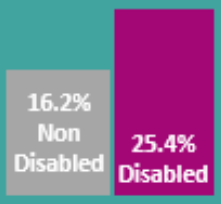
BULLYING, HARRASSMENT AND ABUSE



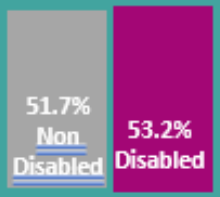
Colleagues experiencing harassment, bullying or abuse from patients, relatives or public



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 61.4% 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 18.4% of Non-Disabled colleagues.

FEELING VALUED

33% of Disabled colleagues are satisfied with the extent to which their organisation values their work, compared with 48.4% 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

Chair's Report

Committee:	Charitable Funds Committee
Chairperson and role:	Kate Smyth, Non-Executive Director
Date(s) of Committee meeting(s):	19 December 2023
Purpose of report:	To update the Board on the business discussed by the Charitable Funds Committee on 19 December 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

Hospitals' Charity Update including Baby Beat Appeal:
The report provided updates on LTH's Charity activities, including Baby Beat Appeal. The Charity's Christmas activity, raising gifts and funds, showcased the community's generosity. Fundraising efforts, reaching £456,000 year-to-date, demonstrated the impact of community support.

The Committee APPROVED proposals for a video telemetry application and alternatives to tap-to-donate facilities. A strategic discussion highlighted the Committee's agreement to utilise funds for patient experience improvements, with emphasis on due process and operational considerations.

Rosemere Charity Update:

The report highlighted Rosemere Cancer Foundation's exceptional fundraising, surpassing expectations with over £1,000,000 raised.

The Committee APPROVED funding applications, discussed terms of reference updates, and emphasised financial reviews. Trustees expressed interest in self-assessment reviews and sought reassurance on research investments.

The Committee APPROVED the report, emphasising transparency, accountability, and measurable impacts from research investments.

Financial Update including Review of Spending Plans and Balances:

The financial update noted a reduction in available funds due to new commitments, especially from Rosemere. Despite sector challenges, the combined charity positions showed a net income ahead of plan.

Items for the Board's attention

Positive escalation
Rosemere's outstanding fundraising and charitable fund approvals.
Negative escalation
(a) None
Committee to Committee escalation
1. To remind Safety & Quality Committee of the availability of and process of applying for charitable funds. 2. To inform Education, Training and Research Committee of the approval of research funding
Items recommended to the Board for approval
Committee Chairs reports received
(a) Rosemere Management Committee Chair's report
Items where assurance was provided and/or for information
The Committee expressed assurance in the finance report, acknowledging legacies, investment income, and bank interest rates contributing to positive results.
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 19 March 2024 on Microsoft Teams

Recommendation:

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

Appendix 1 – Charitable Funds Committee agenda (*19 December 2023*)

Charitable Funds Committee

19 December 2023 | 10.30am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chairman and quorum	10.30am	Verbal	Information	K Smyth
2.	Apologies for absence	10.31am	Verbal	Information	K Smyth
3.	Declaration of interests	10.32am	Verbal	Information	K Smyth
4.	Minutes of the previous meetings held on 19 September 2023	10.33am	✓	Decision	K Smyth
5.	Matters arising and action log	10.34am	✓	Decision	K Smyth
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Baby Beat	10.35am	✓	Decision	D Hill
6.2	Rosemere Charity update	10.45am	✓	Decision	D Hill
7.	FINANCE AND PERFORMANCE				
7.1	Finance update including review of spending plan and balances	10.55am	✓	Assurance	B Patel
8.	GOVERNANCE AND COMPLIANCE				
8.1	Items for referral to the Board or from/to other committees	11.05am	Verbal	Information	K Smyth
8.2	Reflections on the meeting and adherence to the Board Compact	11.10am	✓	Information	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Rosemere Management Committee Chair's report		✓		
	Date, time and venue of next meeting: *19th March 2023, 1.30pm, MS Teams*	11.15am	Verbal	Information	K Smyth

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside, Non-Executive Director
Date(s) of Committee meeting(s):	28 November 2023
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 28 November 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 23rd October 2023 and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

Strategic Risk Review: Discussed risks aligned with 'Deliver Value for Money' strategic aim, emphasising productivity-related work, SLIP impact on productivity, difficulties in measuring outcomes, resource allocation and financial considerations.

Financial Performance: Highlighted Trust's financial performance, concerns about income targets, deficit explanations, and measures to address deficit drivers within a recovery plan.

Operational Performance:

- **Performance Assurance Progress:** Reviewed Trust's performance up to October 2023, focusing on Urgent and Emergency Care, discharge readiness, and discussed strategies for managing winter demands.

Strategy and Planning

- **Planning Framework Update and Review**: Updates on the Programme Management Office, fragile services assessment, and discussions on addressing missing perspectives within reports for comprehensive assurance.

- **Continuous Improvement & Transformation**: Feedback on the Chair's report, request for more visibility into trajectory, and ongoing work's impact.

- **Recovery and Transformation Plan**: Discussed financial improvements, income strategies, and concerns about balancing patient safety with financial targets.

In addition, the Committee received reports for consideration/discussion for:

EPRR Core Standards Annual Assurance 2023/24 Update: Reviewed EPRR compliance across network providers, emphasising action plans for improvement and clarifying compliance statements within the Board Assurance Framework.

Annual Operating Plan: Highlighted the need for structured planning tools and concerns regarding the timeline alignment with decisions impacting 2024/25.

Pathology Business Case: Outlined key elements, funding challenges, stakeholder management, and concerns about financial payback and differing clinical opinions.

Cyber Security Update: Reviewed cybersecurity measures, challenges, and recommendations for addressing them.

Items for the Board's attention

Positive escalation

- Positive Cyber security position
- Approach to fragile services – seeking to sure up and eradicate sensitivities.
- Continuing to work through methodologies for improvement to drive change across the organisation.

Negative escalation

- Continued financial pressure around deficit plans. Oversight framework will be re-reviewed by the ICB and NHS England.
- Further assurance sought on improvement plans.
- Non-compliance with EPRR standards
- Pathology Business Case – insufficient capital funds. Seeking further assurances around the vision of a future Pathology; continuing to work with the ICB.

Committee to Committee escalation

None

Items recommended to the Board for approval

None

Committee Chairs reports received

a) Capital Planning Forum
b) New Hospitals' Programme flash report
c) ICS, ICP, PCB system update
d) Digital & Information Strategy and Review
e) Transformation Board

Items where assurance was provided and/or for information
• Exception Reports from Divisional Improvement Forums • Contract Performance • Controls Overview
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 18 December 2023 using Microsoft Teams

Recommendation:

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

Appendix 1 – Finance and Performance Committee agenda (*28 November 2023*)

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside, Non-Executive Director
Date(s) of Committee meeting(s):	18 December 2023
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 18 December 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 28th November 2023 and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

Strategic Risk Review: The report provided updates on risks aligned with the 'Deliver Value for Money' strategic aim. Discussions highlighted ongoing conversations regarding SOF ratings and concerns about unchanged narratives regarding risks, especially financial matters. The importance of a balanced risk narrative was emphasised.

Financial Performance: The financial performance up to Month 8 was presented. Caution was advised due to potential challenges ahead, despite recent positive outcomes. Concerns were raised about nursing agency spend, operational challenges, and pressures in various care pathways.

Operational Performance:

- **Performance Update (inc. Performance Assurance Report, Winter Plan Update and Activity Improvement Plan):** Emergency care improvements were noted, but challenges persisted. Mental health funding cuts posed risks. The Winter Plan's comprehensive strategies were reviewed, emphasising the need for ongoing vigilance.

Strategy and Planning

- **Planning Framework Update and Review**: Focus on system planning, challenges in transitioning horizons, and alignment with partners were discussed. Governance matters for external programmes and considerations regarding EPR implementation were highlighted.

- **Transformation Update**: Discussions focused on integrating reports, streamlining updates, and enhancing visibility in the Transformation Report. The need for a comprehensive five-year plan and better delineation of the current year, the 3-year and 5-year plans was emphasised.

- **Recovery and Transformation Plan**: The Value Based Improvement approach and plans for financial recovery were presented. Concerns were raised about meeting targets and the complexity of change management.

In addition, the Committee received reports for consideration/discussion for:

- **Drivers of Deficit and Operational Performance:** Challenges included fixed caps on services, excess demand, and the need for robust partnerships to navigate healthcare complexities. Aligning the operating plan with the New Hospital Programme was discussed.

Items for the Board's attention

Positive escalation

- Good progress against revised year end forecast noted, whilst also acknowledging the significant risks and challenges ahead.
- Assurance received on the winter plan with increasing focus on driving up vaccination rates (staff & Public) and working with Place and system partners to address local community communications.
- Clarification given and growing positivity surrounding the transformation processes and value-based improvement approaches to bring about financial balance.
- Greater confidence and evolution in planning approaches.

Negative escalation

- Continued need for dual operation during the settling of the new Opal national framework.
- Further reductions required to achieve the shift in exit run rate.
- Improvements in framing the top-down financial allocations to local population needs sought (underfunded vs unfunded; tertiary vs hospital vs other services)

Committee to Committee escalation

A referral to the Safety & Quality Committee regarding EPR readiness risk (especially in light of reported external events, where avoidable harm due to staff readiness and understanding of a new system launch.)

Items recommended to the Board for approval

None

Committee Chairs reports received

a) New Hospitals' Programme flash report
b) ICS, ICP, PCB system update
c) Transformation Board

Items where assurance was provided and/or for information

- Exception Reports from Divisional Improvement Forums
- Contract Performance
- Corporate Benchmarking Report

• Deficit Protocol Controls Overview
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 22 January 2024 using Microsoft Teams

Recommendation:

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

Appendix 2 – Finance and Performance Committee agenda (*18 December 2023*)

Finance and Performance Committee

28 November 2023 | 9.00 am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9.00m	Verbal	Information	T Whiteside
2.	Apologies for absence	9.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	9.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 28 November 2023	9.03am	✓	Decision	T Whiteside
5.	Matters arising and action log	9.04am	✓	Decision	T Whiteside
6	Strategic Risk Review	9.05am	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M7 Finance Report	9.20am	✓	Assurance	C McGourty
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Assurance Progress Report • Winter Plan • Activity Improvement Plan	9.35am	✓	Assurance	I Devji
8.2	EPRR Core Standards Annual Assurance 2023/24 Update	9.45am	✓	Assurance	I Devji
9.	STRATEGY AND PLANNING				

9.1	Recovery & Transformation Plan • Challenging Decisions • Revised Deficit Protocol - matters arising	9.50am	✓	Assurance	J Wood
9.2	Planning Framework Update	10.05am	✓	Assurance	G Doherty
9.3	a) Annual Operating Plan b) 5-year Integrated Business Plan	10.20am	✓ ✓	Assurance	G Doherty
9.4	Pathology Business Case	10.35am	✓	Information	G Doherty
9.5	Digital and Information Strategy and Review	10.50am	✓	Assurance	S Dobson
9.6	Continuous Improvement/Transformation Update	11.05am	✓	Information	A Brotherton
10.	GOVERNANCE AND COMPLIANCE				
10.1	Cyber Security Update	11.20am	✓	Information	S Dobson
10.2	Items for escalation to the Board or items to/from other Committees	11.30am	Verbal	Information	T Whiteside
10.3	Reflections on the meeting and adherence to the Board Compact Items for escalation to the Board or items to/from other Committees	11.40am	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Chairs' reports**: (a) New Hospitals Programme flash report (b) ICS, ICP, PCB System update (c) Capital Planning Forum		✓		
11.4	Controls Overview		✓		

11.5	Date, time and venue of next meeting: *18 December 2023 1pm-4pm* *Microsoft Teams*	11.50am	Verbal	Information	T Whitesid e

Finance and Performance Committee

18 December 2023 | 1.00 pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	T Whiteside
2.	Apologies for absence	1.01pm	Verbal	Information	T Whiteside
3.	Declaration of interests	1.02pm	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 28 November 2023	1.03pm	✓	Decision	T Whiteside
5.	Matters arising and action log	1.04pm	✓	Decision	T Whiteside
6	Strategic Risk Review	1.10pm	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M8 Finance Report	1.25pm	✓	Assurance	C McGourty
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Update • Performance Assurance Report • Winter Plan Update • Activity Improvement Plan	1.40pm	✓	Assurance	I Devji
8.2	Drivers of Deficit and Operational Performance	2.10pm	Verbal	Assurance	J Wood
9.	STRATEGY AND PLANNING				
9.1	Financial Recovery & Transformation Update • Value Based Improvement	2.25pm	✓	Assurance	J Wood

9.2	Transformation Update	2.40pm	Verbal	Information	A Brotherton
9.3	a) Planning Framework Update b) Planning Framework Review	2.55pm 3.10pm	✓ ✓	Assurance Assurance	G Doherty
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items for escalation to the Board or items to/from other Committees	3.25pm	Verbal	Information	T Whiteside
10.2	Reflections on the meeting and adherence to the Board Compact	3.35pm	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	Model Hospital Update (purchase Price Index & Benchmarking)				
11.4	Corporate Benchmarking Report		✓		
11.5	**Chairs' reports**: (a) New Hospitals Programme flash report (b) Digital & Health Informatics Divisional Board (**stood down**) (c) ICS, ICP, PCB System update (d) Capital Planning Forum (**deferred**) (e) Transformation Board				
11.6	Deficit Protocol Controls Overview				
11.7	Date, time and venue of next meeting: *22 January 2024 12.30-3.30pm* *Microsoft Teams*	4.00pm	Verbal	Information	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:**	1st February 2024		
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 December 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 December, 396 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, an increase of 126 from last month. 207 patients waited over 60 minutes to be handed over from NWAS to the Trust in December. Ambulance handover delays remain a high priority and a local improvement collaborative is in place.

4 Hour ED performance is showing an improved position, with December at 68.0%, an increase in compliance compared to November at 66.5% and on target compared against the internal improvement trajectory. The Trust is just below the national average position of 69.4% and 7th out of the acute trusts in the North West.

Performance relating to the number of patients waiting over 12 hours (admitted and non-admitted) in ED for December remains consistent at 11.1%.

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 December at 94.7%, 0.6% below last month's position.

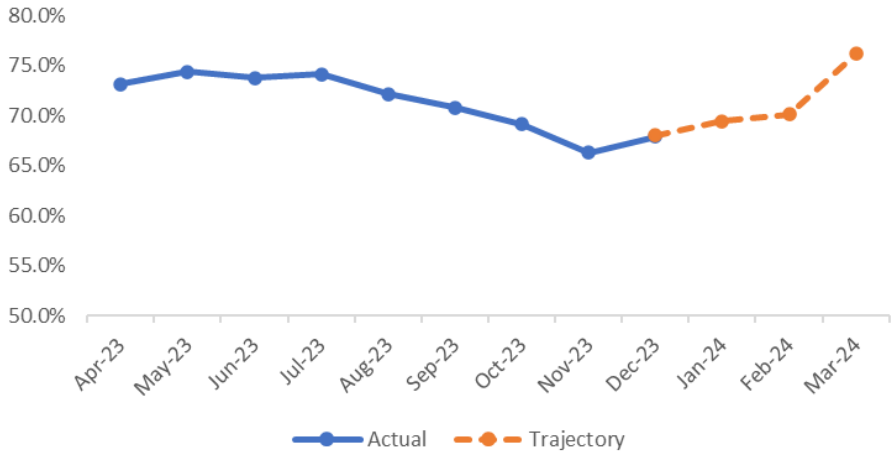
As part of the Trust Escalation Plan in response to operational pressures, patient boarding has been implemented to facilitate the safe movement of patients requiring ward admission as additional patients on a ward. This is based on clinically led risk assessment per ward receiving additional patients. This approach helps to reduce congestion in the emergency department (ED) enabling timely handover of ambulance patients in ED resulting in the release of ambulance crews to respond to emergency calls in the community. The clinical risk of ED congestion is mitigated through managing the pressure across the organisation with additional staffing support where required for the provision of safe care for patients. This cohort of patients are predominantly medical requiring admission to an acute

medical ward. On average, 22 patients were boarded each day during December, with 697 associated bed days. The Trust monitors the number of patients boarded on wards as additional patients on a daily basis with clinical oversight led by the Chief Nurse, Chief Medical Officer and the Chief Operating Officer with the divisional senior team. The Trust is reviewing its capacity plan with a system based approach for a more sustainable position taking into account both the clinical and financial context with executive oversight. The Safety and Quality committee will receive an assurance report relating to the safety of patients who are boarded in March.

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 increased slightly from last month's position of 8.6% to 8.9% in December. There has been good utilisation of available capacity in the Home First service, and the Community Healthcare Hub (CHH) at Finney House. The CHH has had a significant positive impact on the movement of patients who are medically fit for discharge from an acute to community bed setting.

A recovery trajectory in relation to the 4-hour ED performance target has been developed, with an expected improvement to 76% compliance by March 2024. The trajectory is based on an improvement plan, and includes the assumption of a recovery of Urgent Care Center (UCC) performance delivered by Go To Doc (GTD). Overall performance for December is in line with the trajectory. However, the risk to delivering the trajectory remains considering the continued operational pressures consistent with the national and local position. Internal operational programmes of work are in place with a focus on inflow (attendance to ward admission) and flow (admission to discharge) with teams across the organisation working together to improve processes and streamline business as usual activity. An Urgent and Emergency Care (UEC) Performance Recovery Group has been established, replicating effective arrangements already in place for our Elective and Cancer care oversight.
The Trust trajectory and actual position to date for the 4 hour emergency care standard is presented below.

All services 4 Hour Trajectory:



Unfunded capacity and operational changes:

There have been a number of changes to processes and services, including Finney House, improved utilisation of 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	Completed – require COO/CMO approval to open
Closure of acute ward	Reduction of 17 G&A beds	Jul-23	Completed
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
Closure of additional acute ward	Reduction of 11 G&A beds	October-23	Emergency pathway pressures have delayed delivery – currently reviewing plans for implementation in Q4.
Co-location of Mental Health Urgent Access Centre (MHUAC)	Reduced cubicle space in ED, improved environment for patients awaiting MH assessment/treatment	Nov-23	Initial capital bid unsuccessful – joint LSCFT/LTH proposal being developed
MAU/SAU Development	Right-sizing MAU and SAU to improve UEC pathways and increase direct access	2024/25	Capital bid successful – delivery 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, including Care ConneXion and Virtual Ward, the Trust has its own internal programme of improvement being delivered through the Urgent Care Transformation Board.

Quarter 4 operational performance focus

The areas below will be the key priority areas of focus outlining the actions and support required.

Key areas	Actions/Support required
Quality and Safety	• Continued focus on C.*diff* reduction, pressure ulcers an • Managed boarding on wards ensuring safety checks • ED corridor care (supported by SoP)
Tertiary Capacity	• Ringfenced capacity • Out of ICS area repatriation support by System Co-ordi
UEC (Ambulance handover, 12 hrs Total Time In Department (TiD) and 4 hr emergency care trajectory)	• Ambulance handover duration reduction • Accelerated inflow and flow improvement programmes • Weekend discharge support • Protected Virtual Ward, Care Connexion, Frailty, ED, Same Day Emergency Care (SDEC), Acute Admissions Unit (AAU) and ward decision making Resources 7 days a week • Support with out of hospital model of care • Support with MH pathways from ED • Support with GTD performance
>65 week clearance	• Focus on ensuring eliminating the 78 week wait by end of March 24 • Continued clearance capacity • Maximum cap at 64 weeks wait from April 24 • Protected elective care capacity • Deliver the DM01 updated trajectory
>62 day clearance to 180 by March 24; 28 day FDS at >75% by March 24	• Continued cancer backlog clearance • Protected cancer capacity
Manage financial run rate to priority areas	• Continued Financial Recovery Plan underpinned by key priority areas as above • PMO oversight and anticipated escalation of risks • Corporate resource to support the FRP ensuring efficiency, cash and cost release/reduction • Performance accountability framework to be implemented

Cancer recovery:

The table below shows how the Trust compares with England averages by tumour group for 62 day performance at week ending 31st December:

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)
Lower Gastrointestinal	665	87	12	13.1%	10	14	10.8%	15
Haematological	4	4	0	100.0%	4	3	18.2%	3
Urological	221	40	3	18.1%	5	5	16.6%	3
Lung	58	10	6	17.2%	-3	0	14.4%	2
Children's	3	0	0	0.0%	0	0	6.4%	0
Gynaecological	109	11	3	10.1%	1	-14	9.7%	0
Other	10	1	0	10.0%	0	0	7.7%	0
Breast	136	4	2	2.9%	0	-6	3.9%	-1
Brain/Central Nervous System	44	0	0	0.0%	-1	-2	4.3%	-2
Sarcoma	29	2	1	6.9%	-1	-3	13.9%	-2
Upper Gastrointestinal	106	6	3	5.7%	-6	-4	8.8%	-3
Head & Neck	149	9	1	6.0%	-5	-3	8.4%	-4
Skin	423	32	26	7.6%	-9	-9	9.4%	-8
All Suspected Cancers	1,957	206	57	10.5%	-5	-19	10.1%	3

2023/24 Cancer National targets:

Performance against the tumour group specific trajectories for the Cancer 62 day recovery plan, to March 24 is outlined below:

Speciality		Recovery period	Apr 23	May 23	Jun 23	Jul 23	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	1	1	3	1	0	0			
	Breast	Trajectory	8	7	7	7	7	6	6	6	6	6	6	6
		Actual	4	6	2	8	13	6	3	6	4			
	Colorectal	Trajectory	53	52	50	48	46	44	42	41	42	44	40	38
		Actual	42	39	51	41	42	67	95	82	87			
	Gynaecology	Trajectory	28	27	26	25	24	24	23	22	22	24	21	20
		Actual	34	27	29	34	23	17	12	8	11			
	Haematology	Trajectory	10	9	9	9	9	8	8	8	8	8	8	7
		Actual	4	7	7	5	3	1	1	0	4			
	Head & Neck	Trajectory	25	24	23	22	21	21	20	19	20	21	19	18
		Actual	13	15	22	22	20	18	12	11	9			
	Lung	Trajectory	13	13	12	12	12	11	11	10	11	11	10	10
		Actual	12	10	6	13	11	7	7	7	10			
	Sarcoma	Trajectory	4	4	4	4	4	4	4	3	4	4	3	3
		Actual	3	9	8	9	3	5	6	4	2			
	Skin	Trajectory	25	24	23	22	21	20	20	19	20	20	19	18
		Actual	22	23	37	47	26	48	30	30	32			
	Upper GI	Trajectory	8	8	7	7	7	7	6	6	6	7	6	6
		Actual	8	12	19	15	8	11	15	10	6			
	Urology	Trajectory	74	72	71	68	65	63	60	58	59	63	56	53
		Actual	71	87	76	50	42	37	35	36	40			
	Total	Trajectory	**250**	**242**	**234**	**226**	**218**	**210**	**202**	**194**	**200**	**210**	**190**	**180**
		Actual	**221**	235	257	245	192	220	217	194	205	0	0	0

There was underperformance against the trajectory to the end of December. The target for 2023/24 backlog for >62 days wait is 180 and is achievable with resource support from the Cancer Alliance, driven by the agreed tumour site specific trajectory improvement plans for the 28 day Faster Diagnosis Standard (FDS).

62-day backlog performance increased marginally in December to 205 from a November position of 194. The December performance is slightly above trajectory (205 actual versus 200 trajectory). The tumour site specific improvement action plans are monitored weekly with senior oversight and reported through the Transformation Board for assurance.

Cancer FDS actual position against trajectory to December 2023:

	Apr-23			May-23			Jun-23			Jul-23			Aug-23			Sep-23			Oct-23			Nov-23			Dec-23		
Tumour Group	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var	Trajectory	Actual	Var
Brain	40.8%	41.5%	0.7%	46.3%	64.1%	17.8%	52.6%	56.8%	4.1%	62.1%	57.6%	-4.5%	70.5%	42.0%	-28.5%	75.8%	53.1%	-22.7%	75.8%	62.4%	-13.4%	75.8%	64.0%	-11.8%	75.6%	78.9%	3.3%
Breast	93.0%	98.2%	5.2%	93.0%	96.6%	3.6%	93.0%	95.1%	2.1%	93.0%	97.8%	4.9%	93.0%	96.8%	3.8%	93.0%	95.8%	2.9%	93.0%	98.0%	5.1%	93.0%	96.5%	3.5%	93.0%	93.9%	0.9%
Breast Symptomatic	94.3%	94.6%	0.2%	94.3%	96.6%	2.3%	94.3%	98.9%	4.6%	94.3%	99.0%	4.7%	94.3%	95.1%	0.8%	94.3%	100.0%	5.7%	94.3%	96.6%	2.3%	94.3%	97.1%	2.8%	93.6%	92.5%	-1.1%
Colorectal	50.0%	50.0%	0.0%	55.6%	44.0%	-11.5%	61.1%	59.0%	-2.1%	66.7%	52.3%	-14.3%	72.2%	22.5%	-49.7%	75.1%	10.1%	-65.0%	75.1%	32.4%	-42.7%	75.1%	20.4%	-54.7%	75.2%	22.7%	-52.6%
Gynaecology	49.5%	46.4%	-3.1%	52.2%	55.8%	3.6%	54.9%	67.5%	12.5%	60.4%	65.9%	5.5%	65.9%	52.8%	-13.1%	71.4%	67.9%	-3.5%	75.3%	77.2%	1.9%	75.3%	82.8%	7.5%	75.0%	80.9%	5.9%
Haematology	0.0%	20.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Head and Neck	70.9%	77.5%	6.6%	71.8%	74.6%	2.8%	72.7%	76.9%	4.1%	73.6%	83.0%	9.4%	74.5%	80.1%	5.5%	75.0%	80.0%	5.0%	75.0%	81.1%	6.1%	75.0%	78.0%	3.0%	75.0%	82.1%	7.1%
Lung	65.2%	67.4%	2.2%	68.1%	73.2%	5.1%	71.0%	74.0%	3.0%	73.9%	93.3%	19.4%	73.9%	75.8%	1.8%	73.9%	82.5%	8.5%	75.4%	76.9%	1.6%	75.4%	81.3%	5.9%	75.0%	90.6%	15.6%
NSS	75.0%	80.0%	5.0%	75.0%	80.0%	5.0%	75.0%	85.7%	10.7%	75.0%	25.0%	-50.0%	75.0%	72.7%	-2.3%	75.0%	56.5%	-18.5%	75.0%	50.0%	-25.0%	75.0%	85.7%	10.7%	75.0%	0.0%	-75.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	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%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%	75.0%	88.9%	13.9%	75.0%	68.8%	-6.3%	75.0%	100.0%	25.0%	75.0%	100.0%	25.0%
Sarcoma	59.5%	68.2%	8.7%	61.9%	52.0%	-9.9%	64.3%	60.7%	-3.6%	66.7%	62.5%	-4.2%	69.0%	76.7%	7.6%	71.4%	62.9%	-8.6%	76.2%	71.8%	-4.4%	76.2%	48.3%	-27.9%	76.2%	75.0%	-1.2%
Skin	90.0%	93.4%	3.4%	90.0%	95.7%	5.7%	90.0%	94.3%	4.3%	90.0%	91.1%	1.1%	90.0%	86.5%	-3.5%	90.0%	52.0%	-38.0%	90.0%	74.2%	-15.8%	90.0%	87.7%	-2.3%	90.0%	83.4%	-6.6%
Upper GI	75.4%	69.6%	-5.8%	75.4%	71.8%	-3.6%	75.4%	66.1%	-9.3%	75.4%	72.5%	-2.9%	75.4%	69.5%	-5.8%	75.4%	71.4%	-3.9%	75.4%	76.0%	0.7%	75.4%	79.8%	4.4%	75.2%	77.8%	2.6%
Urology	45.8%	44.9%	-0.9%	51.9%	38.7%	-13.2%	55.7%	46.2%	-9.5%	61.1%	25.6%	-35.5%	67.2%	36.6%	-30.6%	72.5%	27.3%	-45.2%	75.6%	29.2%	-46.4%	75.6%	44.6%	-31.0%	75.2%	33.7%	-41.5%
Grand Total	**70.1%**	**72.7%**	**2.7%**	**72.4%**	**73.4%**	**1.1%**	**74.4%**	**77.7%**	**3.3%**	**75.0%**	**75.8%**	**0.8%**	**75.0%**	**68.6%**	**-6.5%**	**75.0%**	**56.3%**	**-18.7%**	**75.0%**	**68.3%**	**-6.7%**	**75.0%**	**72.1%**	**-2.9%**	**75.0%**	**68.7%**	**-6.3%**

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. A small residual number of 78 week waits remained in December due to the impact of the ongoing industrial action, and a day zero PTL approach is being applied in pressured specialties.

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.

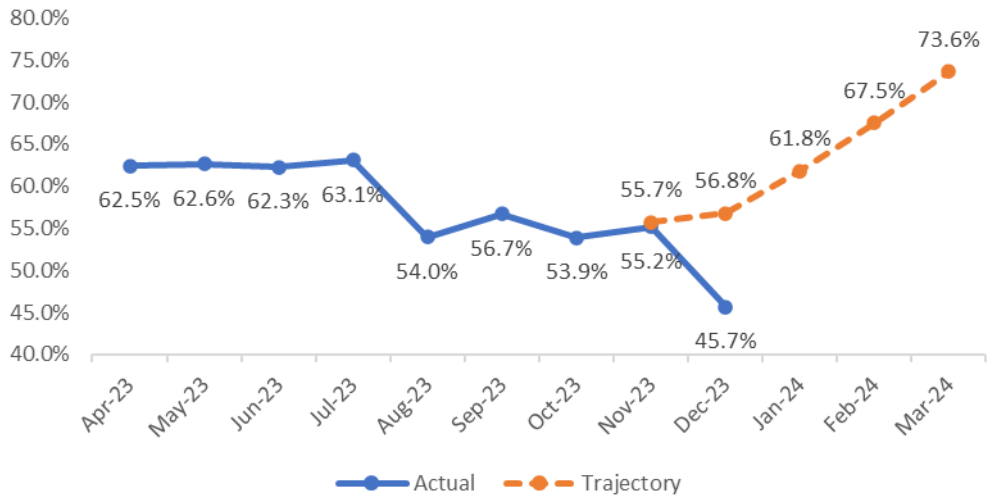
The following summary provides an outline for performance and actions in December:

- Plans are in place to ensure dating of all potential 78 week waiter patients by the end March 2024. Daily assurance touch point meetings provide the required grip and control across the services ensuring any risks to delivery are mitigated.

- Diagnostics performance beyond 6 weeks was 54.3% for December. Urgent and cancer patients are seen within 2 weeks. There is a trajectory in place reflecting DM01 performance improvement, with performance to the end of December under target. The highest volume contributors to the DM01 position are non-obstetric ultrasound (NOUS) and echocardiography. 1.0 WTE sonographer is commencing in January 2023 and to support NOUS capacity in the short term outsourcing arrangements are in place. There is a plan in place to support backlog clearance for echocardiography with a mixture of weekend working, mutual aid and additional capacity.

- Endoscopy remains pressured. Agreed capital bids will provide additional capacity on the Preston site. A recovery trajectory has been developed to reflect improvements to the Diagnostics 6 week performance to 73.6% by March 2024:

DM01 Under 6-week Improvement Trajectory:



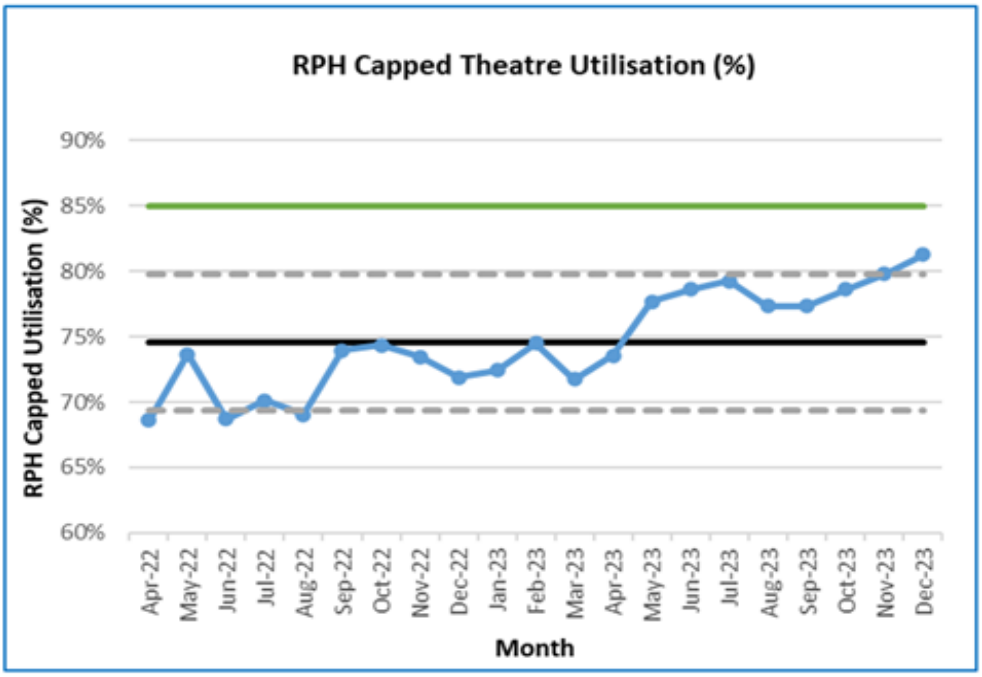
- Elective and outpatient activity has been significantly affected by periods of industrial action, with strike action that took place in Dec 2023 (3 days) and Jan 2024 (6 days) resulting in the cancellation of a total of 159 elective IP/DC and 1702 outpatient appointments over both periods. This is in addition to capacity not booked into during the strike periods.

- The current capped theatre utilisation rates are shown below indicating an improving and consistent capped performance: Paediatric Surgery has successfully moved to CDH and the national team has commended this achievement.

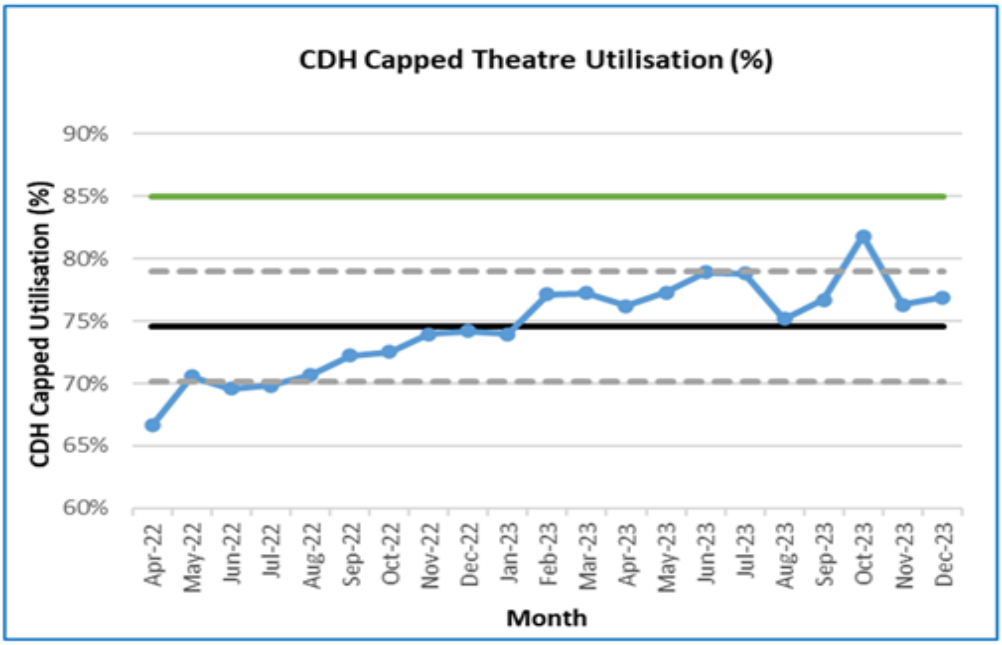
- The team at CDH carried out a Perfect Week in the week commencing 4th Dec 2023, resulting in a capped utilisation rate of 84.7% during the period. Practice improvement and learning is being implemented to sustain this level of improvement.

- Below is the monthly capped theatre utilisation performance (Capped – utilisation *within* scheduled capacity):

	RPH Capped Theatre Utilisation (%)
Apr-22	68.61%
May-22	73.66%
Jun-22	68.70%
Jul-22	70.12%
Aug-22	69.04%
Sep-22	73.94%
Oct-22	74.36%
Nov-22	73.47%
Dec-22	71.87%
Jan-23	72.44%
Feb-23	74.52%
Mar-23	71.73%
Apr-23	73.58%
May-23	77.67%
Jun-23	78.63%
Jul-23	79.28%
Aug-23	77.33%
Sep-23	77.36%
Oct-23	78.60%
Nov-23	79.79%
Dec-23	81.26%



	CDH Capped Theatre Utilisation (%)
Apr-22	66.63%
May-22	70.55%
Jun-22	69.58%
Jul-22	69.83%
Aug-22	70.68%
Sep-22	72.24%
Oct-22	72.53%
Nov-22	73.97%
Dec-22	74.19%
Jan-23	73.96%
Feb-23	77.14%
Mar-23	77.26%
Apr-23	76.21%
May-23	77.30%
Jun-23	78.93%
Jul-23	78.83%
Aug-23	75.20%
Sep-23	76.72%
Oct-23	81.84%
Nov-23	76.31%
Dec-23	76.89%



The current 65-week specialty cohort month end trajectories to March 2024 are detailed below with actual end of December position:

		30/04/2023			31/05/2023			30/06/2023			31/07/2023			31/08/2023			30/09/2023			31/10/2023			30/11/2023			31/12/2023		
Division	**Specialty**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**	**Plan**	**Actual**	**Var**
DCS	C Immunology	846	787	-59	762	718	-44	670	628	-42	582	540	-42	447	468	-22	285	380	52	191	326	135	138	262	124	69	191	122
DCS	Pain Management	766	664	-102	690	576	-114	606	473	-133	526	410	-116	403	337	-105	256	264	-30	171	220	49	123	171	48	61	152	91
Medicine	Cardiology	1185	1036	-149	1068	820	-248	938	612	-326	815	464	-351	625	335	-350	398	232	-228	266	154	-112	191	99	-92	95	63	-32
Medicine	Diabetes	74	59	-15	67	51	-16	59	39	-20	51	25	-26	39	20	-23	25	12	-15	17	9	-8	12	5	-7	6	3	-3
Medicine	Elderly Care	48	37	-11	43	23	-20	38	12	-26	33	8	-25	26	6	-22	16	1	-17	11	1	-10	8	1	-7	5	0	-5
Medicine	Endocrinology	588	572	-16	530	485	-45	466	371	-95	405	321	-84	311	235	-106	198	114	-47	133	58	-75	96	14	-82	49	3	-46
Medicine	Gastroenterology	1059	964	-95	954	791	-163	839	590	-249	729	422	-307	560	275	-339	357	179	-235	239	109	-130	174	60	-114	87	32	-55
Medicine	General Medical	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1
Medicine	General Medicine	1787	1752	-35	1610	1556	-54	1415	1338	-77	1229	1133	-96	943	861	-173	601	688	11	402	482	80	291	285	-6	146	151	5
Medicine	Neurology	4891	4613	-278	4407	3762	-645	3874	3086	-788	3365	2536	-829	2583	1968	-864	1645	1423	-402	1102	792	-310	797	465	-332	399	222	-177
Medicine	Rehabilitation	24	17	-7	22	10	-12	19	6	-13	17	6	-11	13	2	-12	8	2	-10	6	2	-4	4	1	-3	2	1	-1
Medicine	Renal	213	113	-100	192	76	-116	169	55	-114	147	33	-114	113	8	-116	72	3	-95	49	2	-47	36	1	-35	18	0	-18
Surgery	Clinical Oncology	206	189	-17	186	164	-22	164	134	-30	143	133	-10	110	116	-5	71	83	14	48	72	24	36	19	-17	19	18	-1
Surgery	Colorectal Surgery	1560	1455	-105	1406	1220	-186	1236	991	-245	1074	803	-271	825	677	-227	525	519	-72	352	418	66	255	298	43	128	188	60
Surgery	Dermatology	490	426	-64	442	359	-83	389	189	-200	338	104	-234	260	69	-216	166	45	-169	111	36	-75	81	11	-70	41	7	-34
Surgery	ENT	1235	1064	-171	1113	850	-263	978	583	-395	850	480	-370	652	373	-342	416	281	-216	278	197	-81	201	141	-60	101	94	-7
Surgery	General Surgery	924	795	-129	833	701	-132	732	554	-178	636	276	-360	488	388	-147	311	311	-57	208	266	58	150	130	-20	75	95	20
Surgery	Maxillo-Facial	426	411	-15	384	316	-68	338	264	-74	293	197	-96	225	164	-83	143	121	-42	96	66	-30	70	39	-31	35	24	-11
Surgery	Medical Oncology	35	25	-10	32	25	-7	28	20	-8	24	19	-5	18	15	-5	11	13	-1	7	10	3	5	4	-1	3	4	1
Surgery	Neurosurgery	2842	2637	-205	2561	2163	-398	2252	1724	-528	1956	1336	-620	1502	1094	-553	957	838	-282	641	625	-16	465	464	-1	233	320	87
Surgery	Ophthalmology	1940	1780	-160	1748	1442	-306	1536	1090	-446	1334	874	-460	1024	634	-488	651	500	-308	436	384	-52	314	261	-53	157	152	-5
Surgery	Oral Surgery	341	295	-46	307	216	-91	270	175	-95	234	143	-91	180	108	-89	114	46	-57	76	32	-44	55	23	-32	28	10	-18
Surgery	Orthodontics	241	250	9	217	240	23	191	234	43	166	220	54	128	214	74	81	204	99	55	191	136	40	161	121	20	136	116
Surgery	Orthopaedics	1432	1277	-155	1290	1015	-275	1134	811	-323	985	647	-338	756	525	-304	482	378	-175	322	254	-68	233	155	-78	117	80	-37
Surgery	Plastic Surgery	1581	1492	-89	1424	1241	-183	1252	1069	-183	1087	938	-149	835	857	-58	531	709	87	356	608	252	257	506	249	129	365	236
Surgery	Surgical Dentistry	1481	1445	-36	1334	1253	-81	1173	1137	-36	1019	989	-30	783	887	29	499	709	168	334	531	197	242	406	164	121	324	203
Surgery	UGI	473	457	-16	426	379	-47	374	313	-61	325	243	-82	249	196	-77	159	146	-32	106	123	17	76	95	19	38	67	29
Surgery	Urology	1799	1734	-65	1621	1460	-161	1425	1227	-198	1237	1071	-166	950	863	-178	604	599	-5	404	446	42	292	315	23	146	210	64
Surgery	Vascular Surgery	1677	1640	-37	1511	1404	-107	1329	1133	-196	1155	1138	-17	888	825	-148	566	630	-3	380	519	139	276	427	151	139	304	165
WCS	Breast Surgery	57	56	-1	51	53	2	45	45	0	39	36	-3	30	31	-2	19	28	3	13	23	10	10	17	7	5	16	11
WCS	Gynaecology	619	550	-69	558	451	-107	490	363	-127	426	309	-117	327	214	-144	208	128	-83	139	61	-78	100	29	-71	50	17	-33
WCS	Neonatology	1	1	0	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1
WCS	Paed. Cardiology	72	59	-13	65	40	-25	57	18	-39	50	12	-38	38	10	-32	25	7	-26	17	2	-15	12	0	-12	6	0	-6
WCS	Paediatrics	805	737	-68	725	591	-134	637	411	-226	553	268	-285	424	212	-253	270	147	-175	180	99	-81	130	76	-54	65	55	-10
Total	**Total**	**31719**	**29389**	**-2330**	**28581**	**24451**	**-4130**	**25125**	**19695**	**-5430**	**21825**	**16134**	**-5691**	**16757**	**12987**	**-5382**	**10672**	**9740**	**-2350**	**7148**	**7118**	**-30**	**5172**	**4941**	**-231**	**2595**	**3304**	**709**
	Monthly reduction				-3138			-3456			-3300			-5068			-6085			-3524			-1976			-2986		

- The 65-week snapshot position on 8th January 2024 was 1,026, with a cohort (end March 2024) position of 3,142 – 1,398 admitted and 1,744 non-admitted cases

- The 65-week cohort position on the 30th November was 4,941 – 1,959 admitted and 2,982 non-admitted. The position now shows a reduction of 1,637 during the 4 week period to the 31st December.

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 Junior Doctor and Consultant industrial action that took place December and January impacting on activity, with further strikes expected during the current financial year
- Workforce - sickness and vacancies
- Anaesthetist capacity
- Urgent care pressures – COVID, Flu, NMCTR and poor patient flow
- Number of complex cases and particular pressures in Urology, Colorectal and Orthodontics.

Outpatient transformation

Progress on the Outpatient Transformation Programme is reported through the Transformation Board and is focussed on reducing follow ups, reforming triage before appointment bookings and digital to support patients' portal.

Safety and Quality

Pressure Ulcers

The pressure ulcer data demonstrated a positive shift in April 2023 with 7 data points below the median, this has been maintained. New national guidance relating to the management and prevention of pressure ulcers has been published and the teams are working through the changes in guidance with the aim of further reducing the incidence of pressure ulcers. This remains a priority area of work within the Always Safety First strategy.

Falls

The falls data demonstrated a positive shift in April 2023 with 7 data points below the median, this has been maintained. Whilst the target reduction has not yet been achieved, this level of improvement work moves closer to the target reduction. The improvement work is focused standardising best practice. This remains a priority area of work within the Always Safety First strategy.

HSMR

Mortality metrics remain stable and within expected parameters. In recognition of the mortality data continuing to demonstrate performance within expected range, the Safety and Quality committee have requested and received for assurance, a data quality deep dive review for both adult and paediatric mortality and confirmed it is assured of the data quality and approach to mortality.

STAR

STAR Quality assurance accreditation awards of silver and above is consistently higher than target. Analysis of this identifies an opportunity to undertake some further focused improvement work in ward areas where there is the most opportunity to improve. This data will be separated in future reports to ensure greater oversight of the ward metrics. The STAR accreditation programme has been reviewed following the CQC inspection and increased scrutiny has been placed on both the weekly and deep dive accreditation visits to ensure the quality assurance system drives improved outcomes.

Clostridium *difficile*

The data is demonstrating continued elevated levels of C. *difficile* this consistent with a noted northwest increase. The chart continues to show increased variation. This month has shown a decrease on the previous month however it is too early to evaluate this as a success. Enhanced executive oversight meetings continue given the increased risk and the Board considered the IPC BAF issued by NHS England at its last meeting.

Actions taken to date include:

a) Removal of cefuroxime for treatment of unexplained sepsis in July 2023
b) Introduction of a sporicidal agent for general cleaning on wards in September 2023
c) Refresh of ward staff cleaning checklists and implementation of national cleaning standards for nursing
d) Gradual roll out of national cleaning standards by domestic services, 13 areas are now fully compliant, a further 27 areas require implementation.
e) New system to track fogging compliance and bed movement
f) Refresh of mattress audit process
g) Strengthened assurance of IPC/cleaning standards through the “STAR” assurance framework
h) New IPC risk flag for estates remedial work requests from wards
i) Improvements in electronic “Side-room audit” which lists everyone in hospital who is in a side-room and why they were placed in the side-room

Registered Nurse and Midwifery Fill Rates

The RN fill rates continue to reflect positive staffing levels at >95% overall, there continues to be fluctuations day to day. Staffing is closely monitored on a three times daily basis with mechanisms to escalate and request support when required. The Safety and Quality committee continue to review the detail of this on a monthly basis.

A Great Place to Work

Sickness absence has exceeded 7% in both October and November with a rise in short-term absence episodes compounding a long-term absence rate of around 4.40%. Whilst seasonal absence is likely to be a contributing factor, it is unusual to see these levels quite so early in the winter period, and this may be reflective of the disappointing response we have had to the winter vaccination campaign. Flu vaccination uptake currently stands at 33% of the overall workforce, with COVID-19 vaccination uptake at 21%. We will continue to offer vaccinations throughout January, however the low interest we have observed this year reflects the regional and national trend. The Workforce team are supporting managers to address long-term sickness absence and they are raising awareness through Divisional Workforce Committees of the need for improved compliance with the short-term sickness absence procedure.

We continue to take a proactive approach to addressing mental health and musculoskeletal related absence. The psychological wellbeing service has experienced an increase in referrals in recent months and we have introduced self-booking of appointments for initial contact with the service. We are also developing a new team stress risk assessment tool in conjunction with Lancaster University. Demand for the Occupational Health physiotherapy service exceeds capacity, and we are therefore exploring support from a neighbouring trust, in addition to offering remote access support through Physiomed for less complex cases.

It is encouraging to see a recent reduction in violence and aggression incidents, compared to the peak we observed over the summer, although incident numbers are still high. During the last few weeks, the 'Violence Prevention and Reduction Big Room' have liaised with the safeguarding and security teams around a review of the processes for zero tolerance letters and violence markers, and a colleague survey is currently live to help us gather further feedback from our workforce around their experience and the support they need in this area.

Agency use has continued to reduce in November (down 427 shifts from 2,795 in October). From 4 December 2023, the lead time for shifts being cascaded to agency was reduced for general areas from 28 days to 14 days. The lead time for critical care areas (i.e. ED, critical care, theatres, paediatrics and maternity) remains at 28 days currently. There continues to be no off-framework agency usage within the organisation, nor non-clinical agency usage. Agency rates are above the national price cap for some shifts, however, there is an established rate-reduction plan in place to address this for nursing staff across the ICS. A maximum rate card was implemented across the acute trusts within the ICS in April 2023. This rate card has the potential to deliver £5.5m across the ICS, assuming no escalation. Total year-on-year savings on agency spend at LTHTr associated with demand reduction and rate card is over £3.5 million. This has been predominately driven by the reduction in usage. It should be noted that we are now within the normal winter/seasonal pressure period, although it is not currently anticipated that any escalated rates will be required for nursing.

Recognising the financial position, a vacancy pause is now in place. New vacancy control criteria have been developed, which categorise posts as falling into 1 of 3 categories: safety critical; if not filled it will require bank/agency to cover; or other exceptional circumstances. Where posts are rejected at any stage, a full Equality and Quality Impact Assessment will be completed so that risks are fully considered and appropriate mitigation put in place. Additional ICB level vacancy controls also remain in place for some posts.

Delivering Value for Money

Income and Expenditure

The Trust reports a YTD Month 9 deficit position for 2023/24 of £37.0m against a £17.6m deficit plan, this gives a YTD Variance on Plan of £19.4m. This can be explained mainly by the £12.3m System Support Gap (£18.5m for the year) and £8.5m under-delivery of CIP. There are a number of operational financial pressures associated with industrial action, double running of international nurses and funding

Capital Position

Capital expenditure in the year to date is ahead of plan as a consequence of expenditure on externally funded projects which were not in the original plan. Excluding such projects the internally funded plan is behind plan. This is management of projects in the early part of the year to create capacity to deal with emergency requirements as they arise during the year. Projects are planned for the latter part of the year to deliver the plan in full by the year-end. No issues are anticipated with achieving the plan for the year.

Cash Position

The Trust has drawn down cash support amounting to £41.7m in the year to date with a further amount of £30.9m requested for Quarter 4 which is subject to NHSE/DHSC approval.

Cost Improvement Programme

'The Trust's core 2023/24 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 total FIP target is £67m which includes the system gap of £18.5m.

As at Month 9 (December 2023), YTD delivery of FIP is £24.3m against a plan of £32.8m, an adverse variance of £8.5m. Slippage in delivery of FIP programmes is mainly due to the planned closure of beds, covid defund from ED, procurement schemes and divisional schemes all impacted by the operational challenges relating to industrial action. Full year delivery currently stands at £33m and the full year

Use of Resources

The Trust is in Segment 3. This may be reviewed in light of the Trust's re-forecast.

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 9 was £16.6m against an Agency Ceiling of £14.9m, 3.7% of pay expenditure. This is an overspend of £1.7m mainly due to slower than expected benefits from international recruitment, the cost of industrial action cover 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 December 2023

INTRODUCTION

Performance to 31st December 2023

Mission

To provide excellent care with compassion

Strategic Aim

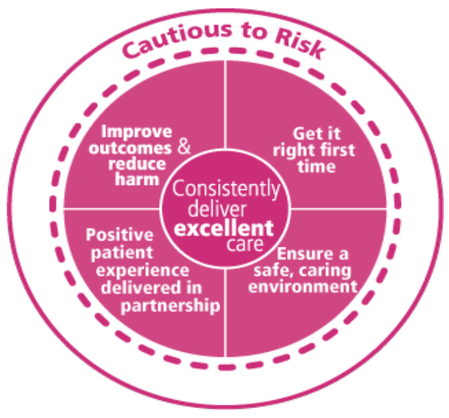
To provide excellent healthcare to our local communities

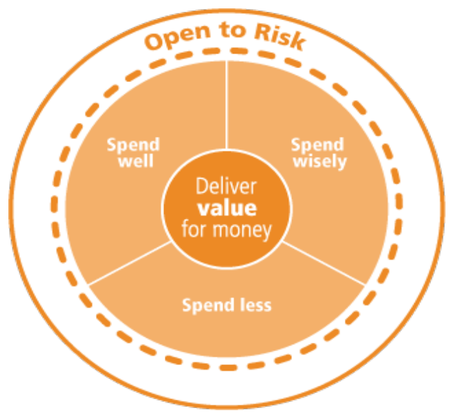
Strategic Aim

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			-	-	-	-	-	-
Pressure Ulcers	**Key Metric**	**Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days (Rate per 1000 beddays)**	M | T-D-S | TB-SQ | SC	No				1.68	2.90	3.00
	Big Plan	Reduce the number of device related pressure ulcers by 10% - per 1000 bed days (Rate per 1000 beddays)		No				0.21	0.55	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		Delivery Plan in place						
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				63.5	-
Access Standards	**Key Metric**	**Achieve the Emergency Department within 4 hours target**	M | T-D | FPC | FB	No				76%	68.0%	74.2%
	Key Metric	**Reduction in patients waiting +12 hours in Emergency Department**	M | T-D | FPC | FB	No				2%	11.1%	9.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 15 minutes**	M | T-D | FPC | FB	No				65%	35.9%	52.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 30 minutes**	M | T-D | FPC | FB	No				95%	76.3%	86.2%
	Key Metric	**Reduction in ambulance turnaround times - 60 minutes**	M | T-D | FPC | FB	No				98%	91.9%	96.0%
	Key Metric	**Achieve agreed trajectory for reducing 52 week waiters**	M | T-D-S | FPC | FB	No				3881	3112	3898
	Key Metric	**Eliminate waits over 65 weeks for elective care by March 2024**	M | T-D-S | FPC | FB	No				172	883	912
	Key Metric	**Eliminate waits over 78 week waiters**	M | T-D-S | FPC | FB	No				0	62	88
	Key Metric	**Achieve Cancer - 28 day FDS**	M | T-D-S | FPC | FB					81%	68.6%	68.7%
	Key Metric	**Number of patients waiting over 62 days**	M | T-D-S | FPC | FB	No				200	206	147
	Key Metric	**Moving or discharging 5% of outpatient attendances to a PIFU pathway**	M | T-D-S | FPC | FB	No				5%	4.98%	4.24%
	Key Metric	**Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels - @ November 2023**	M | T-D-S | FPC | FB	No				-25%	10.37%	-1.36%
	Key Metric	**Reduce adult general and acute (G&A) bed occupancy to 92% or below**	M | T-D-S | FPC | FB	No				92%	95%	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				5.00%	8.93%	8.69%
	Key Metric	**Reduce length of stay to next best quartile**	M | T-D-S | FPC | FB	Logic Under Review						
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	2542	2417
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	0.24	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	0.42	0.66
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				3.3	2.8	3.1
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%	40.00%	36.07%
	Big Plan	Full implementation of Teledermatology in the suspected skin cancer pathway	M | T-D-S | FPC | FB	No				80%	83.16%	58.49%
	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
B = Bi-annual	D = Division	W = Workforce Committee	JW = Jonathan Wood	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	FB = Faith Button	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	SC = Sarah Cullen	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee		

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
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
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	3.82	4.55
Infection	**Key Metric**	**Achieve less than the annual tolerance for C.difficile**	M | T-D-S | SQ | SC-GS	Yes	F			10	16	16
	Big Plan	Achieve zero MRSA bacteraemia	M | T-D-S | SQ | SC-GS	No	-	-	-	0	0	Last reported case Sept 2023
Safety	Big Plan	Maintain 90% staff trained in level 1 safety training	M | T-D-S | ETR | NL	No	P		-	90%	98.5%	97.3%
	Big Plan	Achieve 90% executive and senior leaders safety training	M | T-D-S | ETR | NL	No	P		-	90%	95.1%	93.6%
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	23	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%	88.9%	90.7%
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%	88%	96%
Safe Staffing	Big Plan	Maintain Registered Nurse and Midwife fill rates of > 90%	M | T-D-S | SQ | SC-GS	No		+	-	95%	97%	93%

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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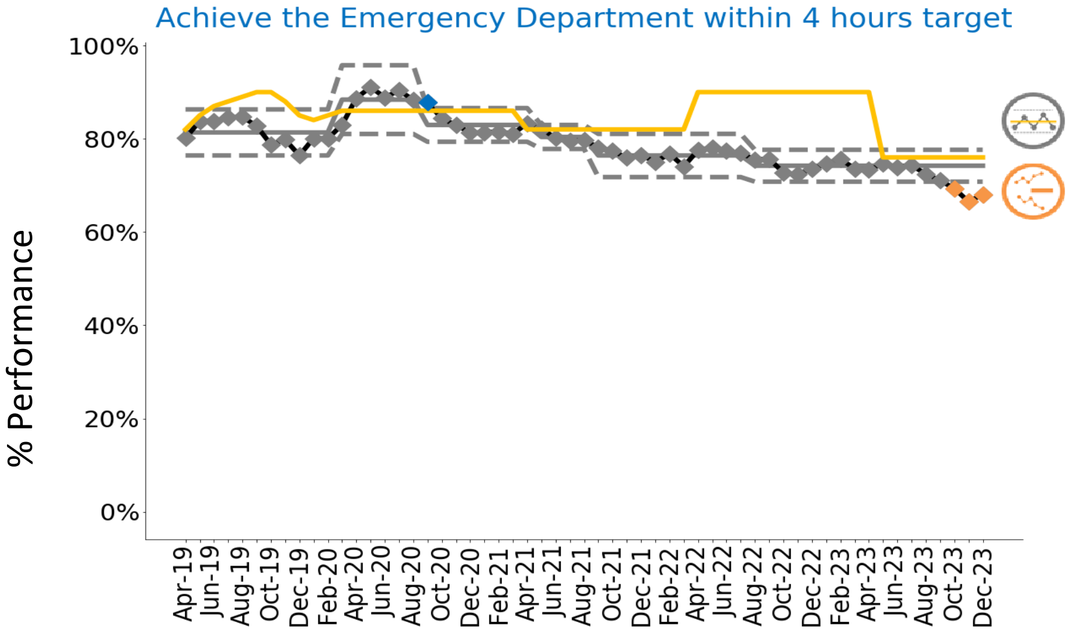
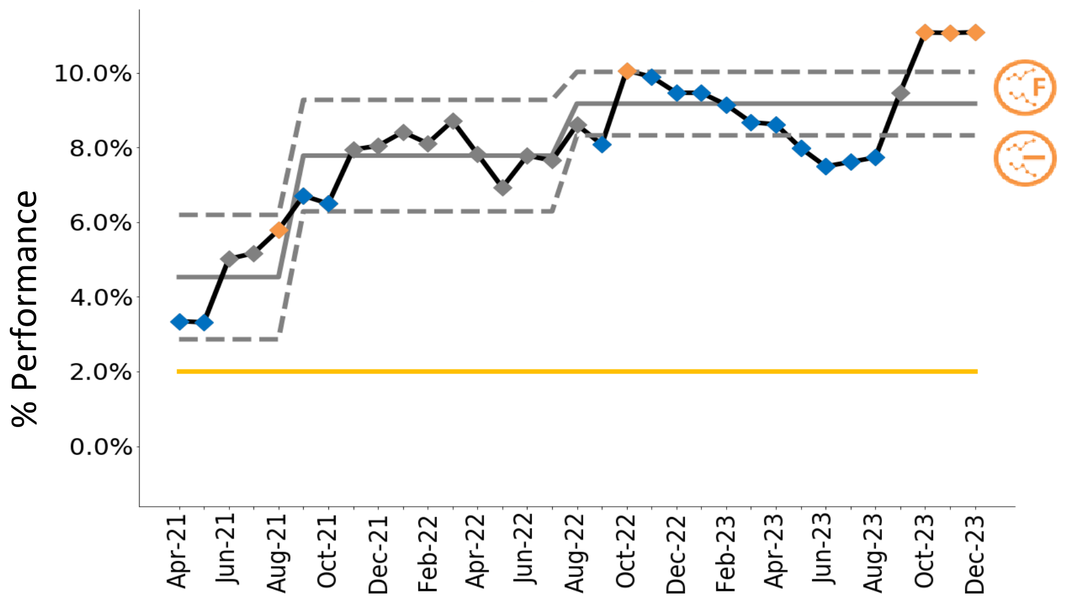
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	SC = Sarah Cullen	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee	NL = Nicki Latham	

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*
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
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

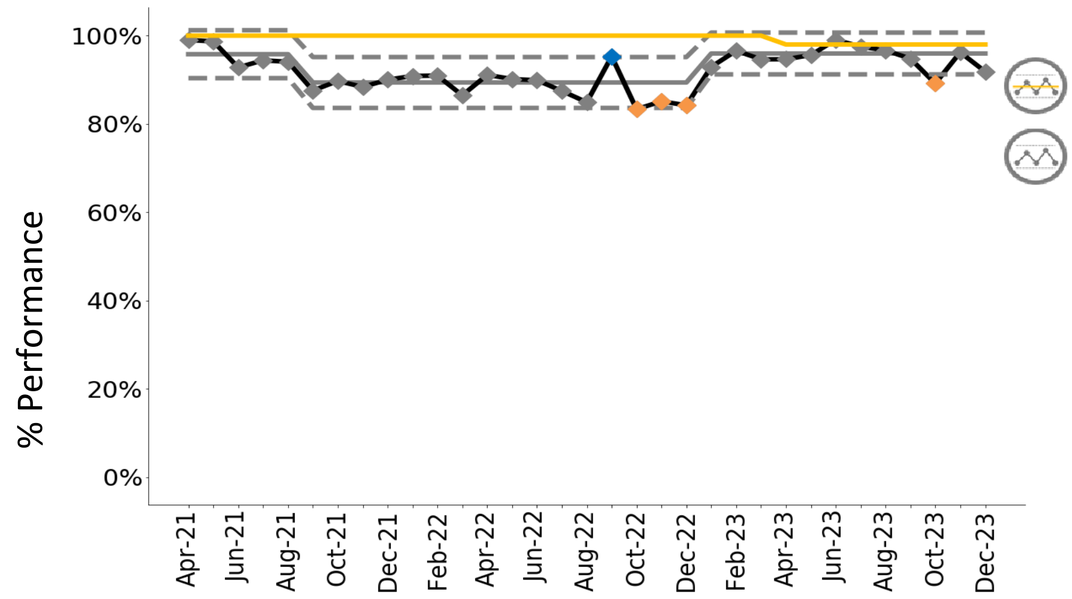
Achieve the Emergency Department within 4 hours target



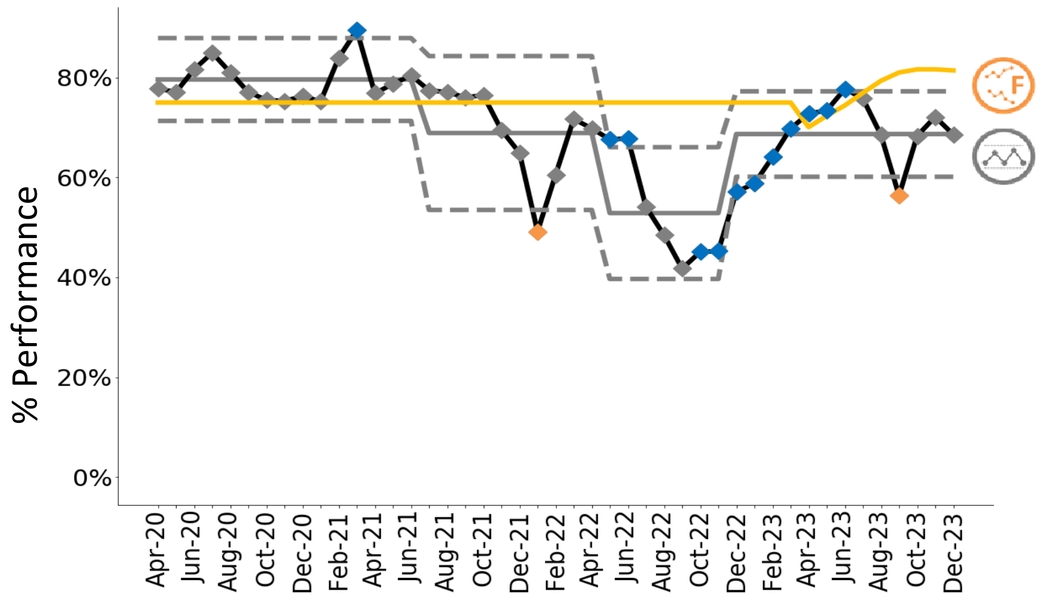
Reduction in patients waiting +12 hours in Emergency Department



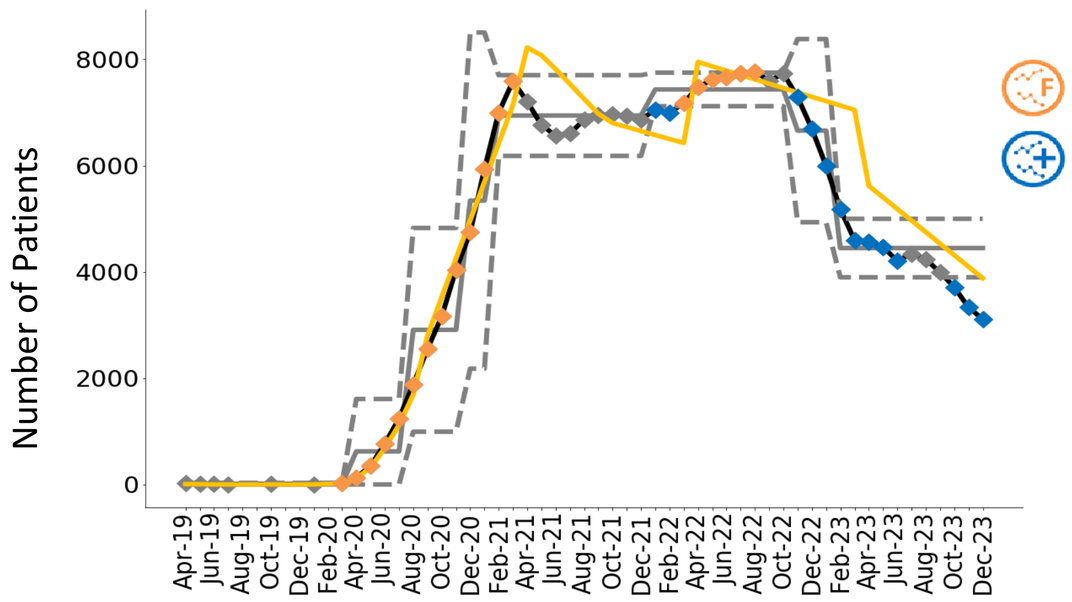
Reduction in ambulance turnaround times - 60 minutes



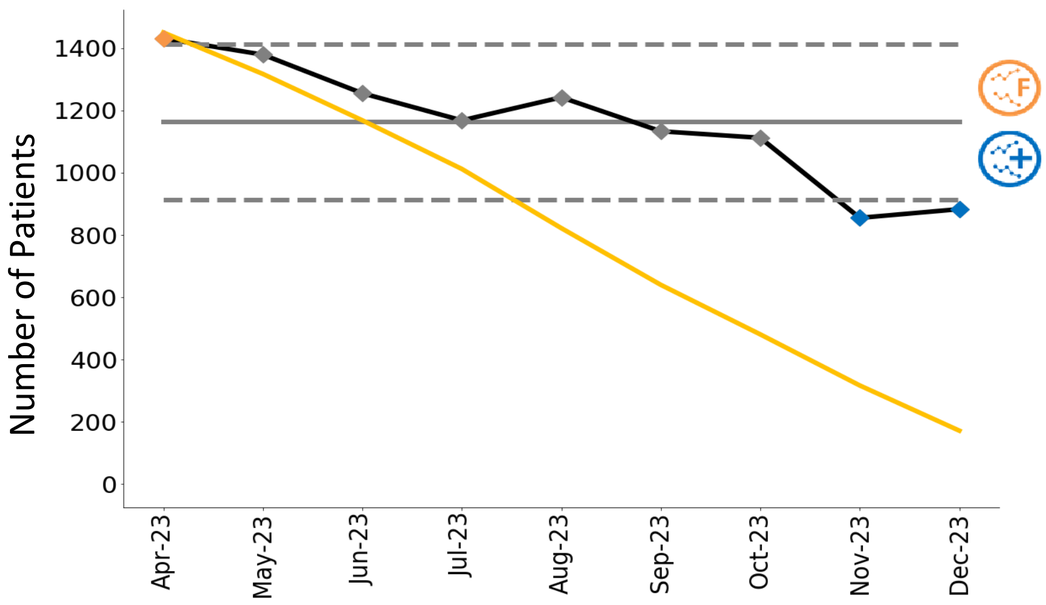
Achieve Cancer - 28 day FDS



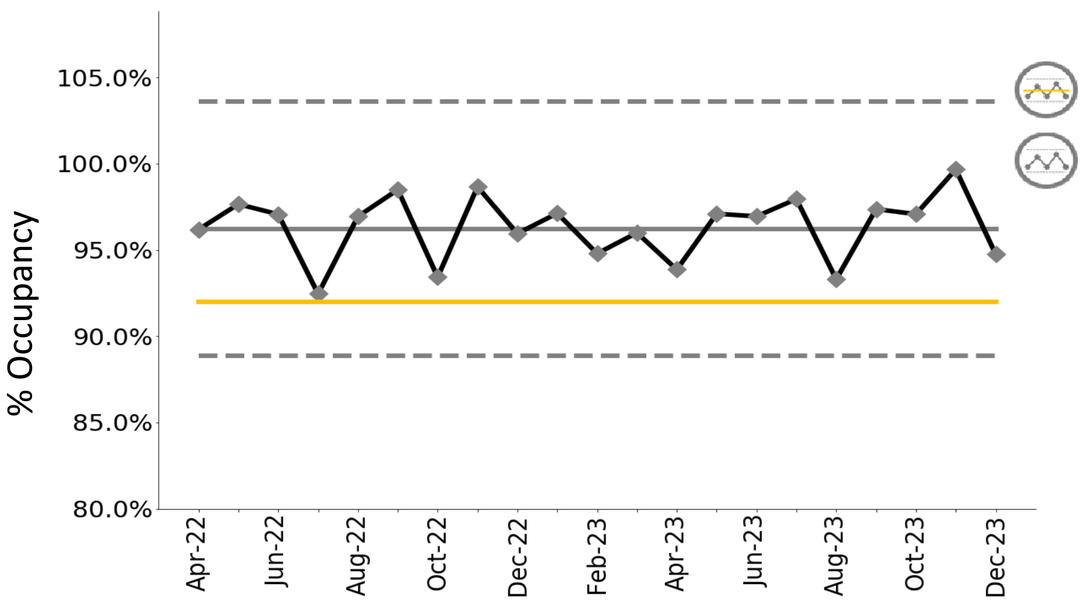
Achieve agreed trajectory for reducing 52 week waiters



Eliminate waits over 65 weeks for elective care by March 2024



Reduce adult general and acute (G&A) bed occupancy to 92% or below



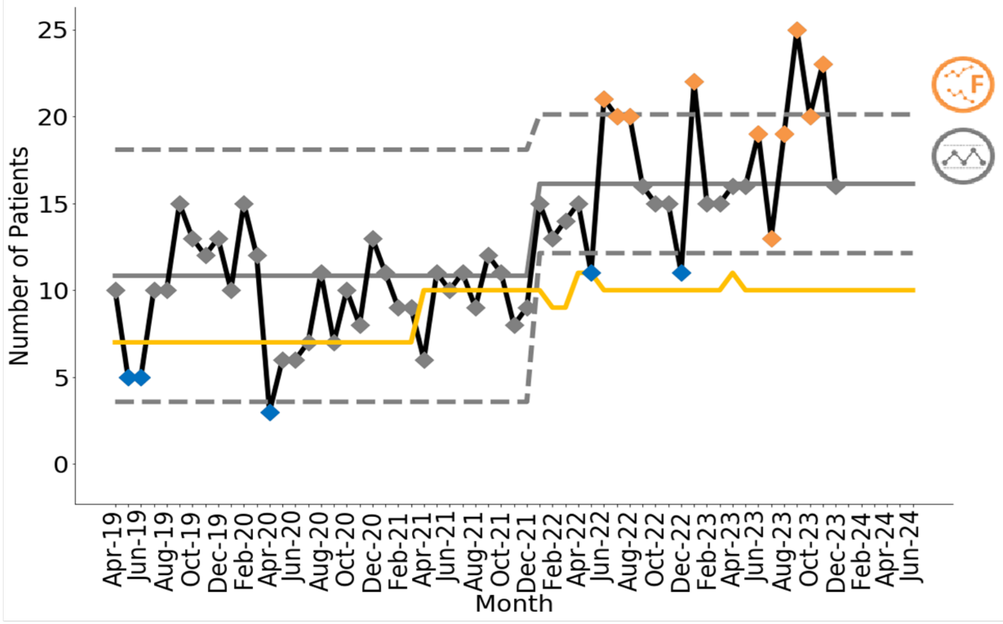
Assurance Icons – How likely are we to hit the set target in future?

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*

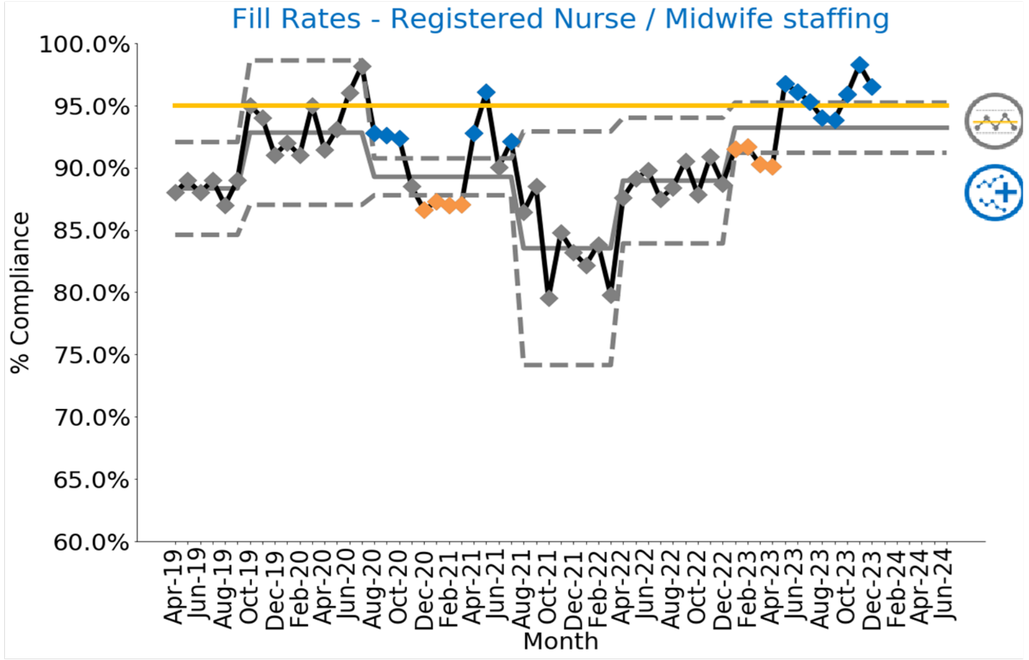
Variation Icons – Is the measure showing signs of change over time?

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*

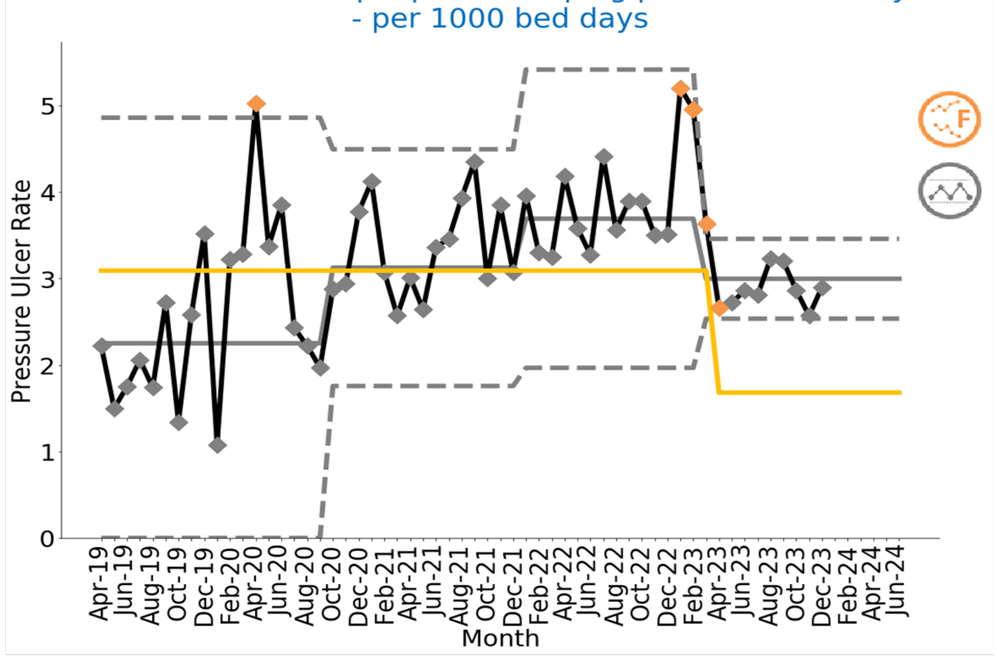
Achieve less than the annual tolerance for C.difficile



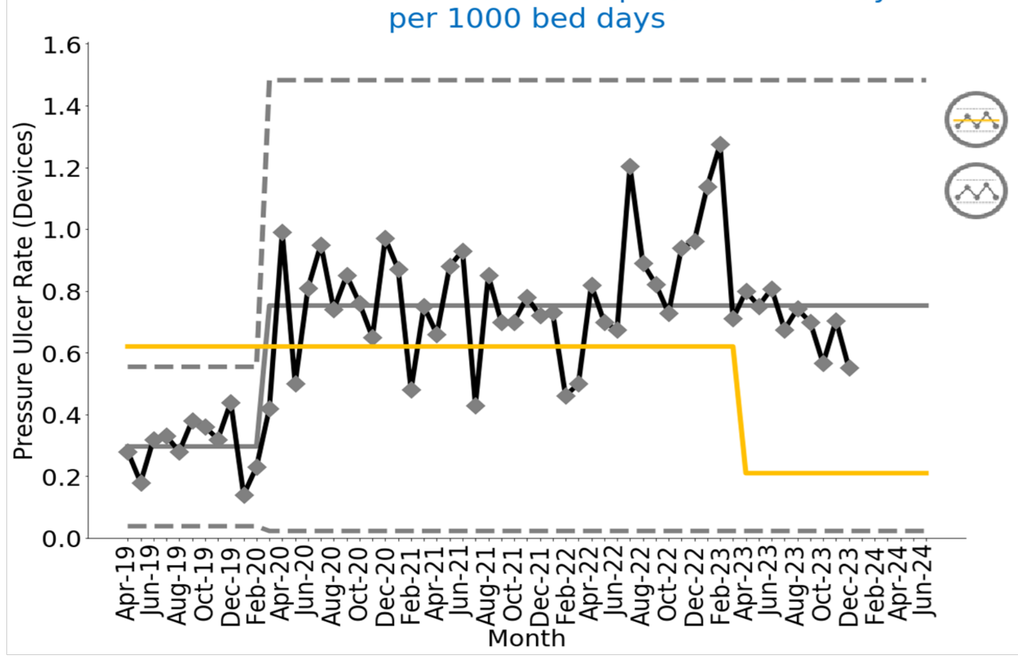
Fill Rates - Registered Nurse / Midwife staffing



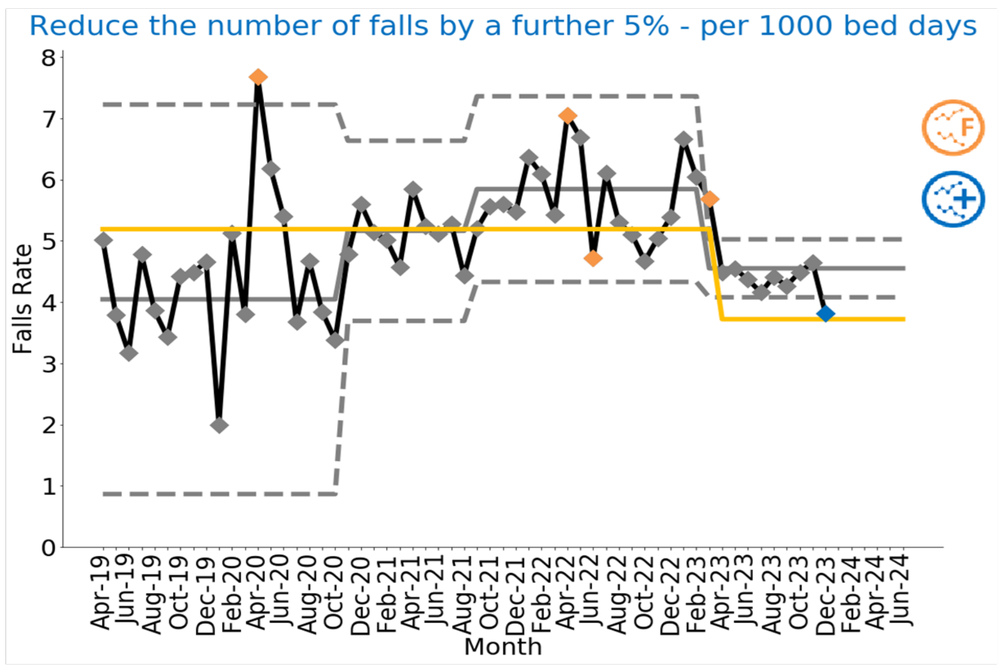
Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days



Reduce the number of device related pressure ulcers by 10% - per 1000 bed days



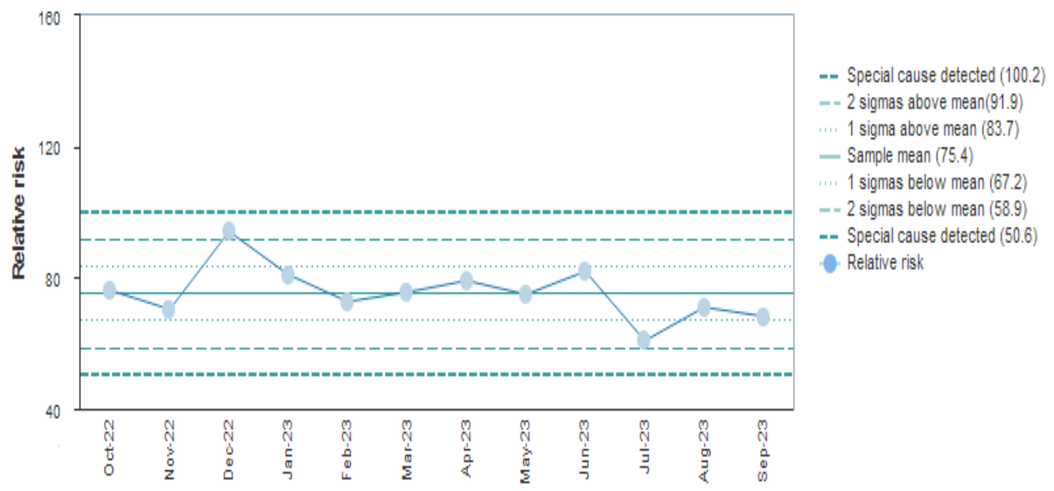
Reduce the number of falls by a further 5% - per 1000 bed days



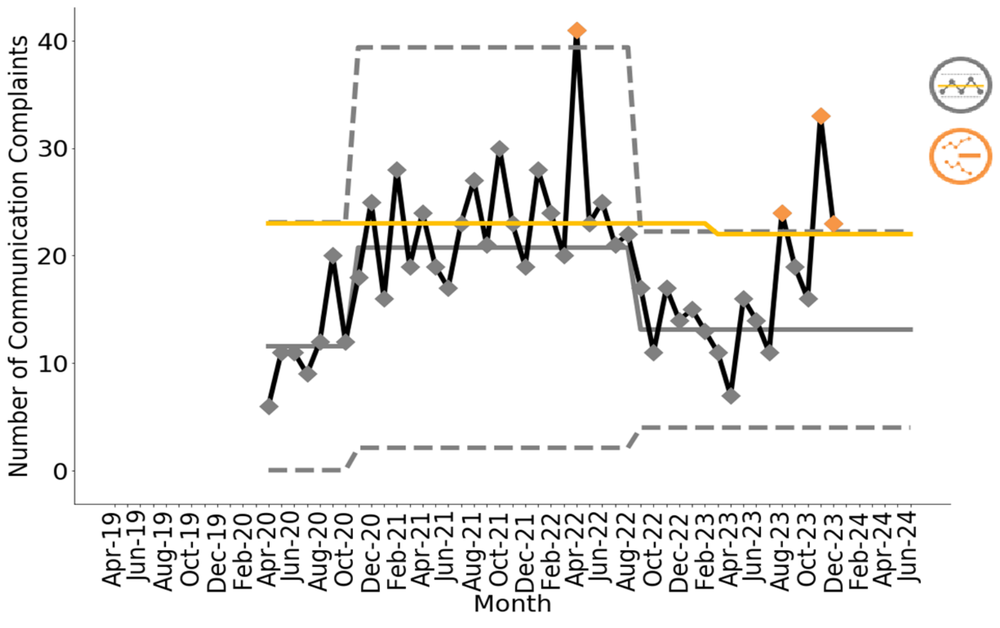
Diagnoses - HSMR | Mortality (in-hospital) | Oct-22 to Sep-23 | Trend (month)

Age (adult/child): 'Adult'

Period: **Month** *Measure*: **Relative risk** *Additional measure*: **No additional measure**



Reduce the number of complaints relating to communication



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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*

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	-	F		-	≤ 5%	6.82 %	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%	2.42 %	1.99 %
	Reduce long-term sickness absence to 3.25% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	F		-	≤ 3.25%	4.40 %	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	36.09	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	25.69	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	-	F		-	≤ 73	85	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	-	P		-	≤ 6%	5.31 %	9.05 %
Appraisals	Maintain 90% HC compliance rate for appraisals	M | T-D-S-C | W | KS	-				≥ 90%	87.90 %	
Mandatory Training	Maintain 90% HC compliance against all core skills training requirements (module compliance reported)	M | T-D-S-C | ETR | KS	-				≥ 90%	94.32 %	
Medical Devices	Achieve 90% HC compliance with medical device training	M | T-D-S-C | ETR | KS	-				≥ 90%	84.53 %	
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	-	F		-	≥ 17	6	7.92
	Ensure 60% of our staff would recommend us as a place to work	Q | T-D | W | KS	-			-	≥ 60%	58.09 %	61.79 %

Assurance Icon / Variation 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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Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive
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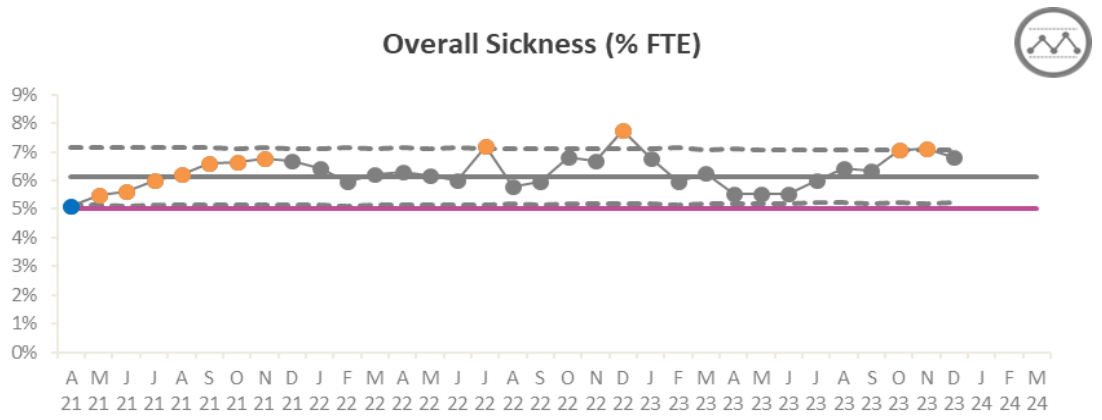
Q = Quarterly	C = Cost Centre		

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)
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
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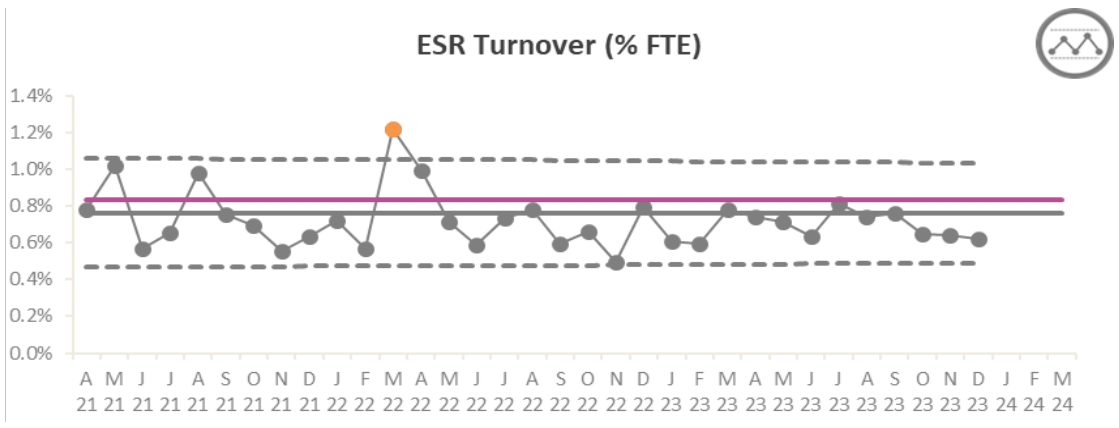
ESR Turnover (% FTE)
1.4%
1.2%
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
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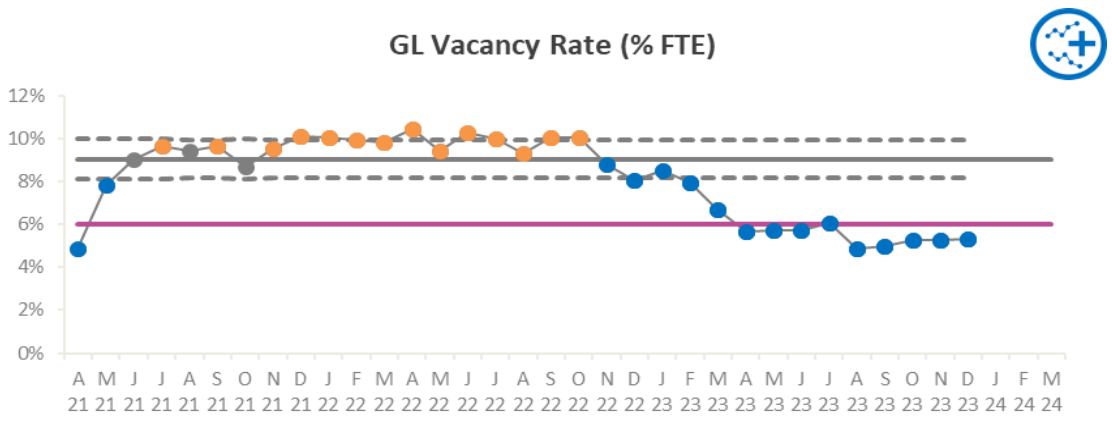
GL Vacancy Rate (% FTE)
12%
10%
8%
6%
4%
2%
0%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
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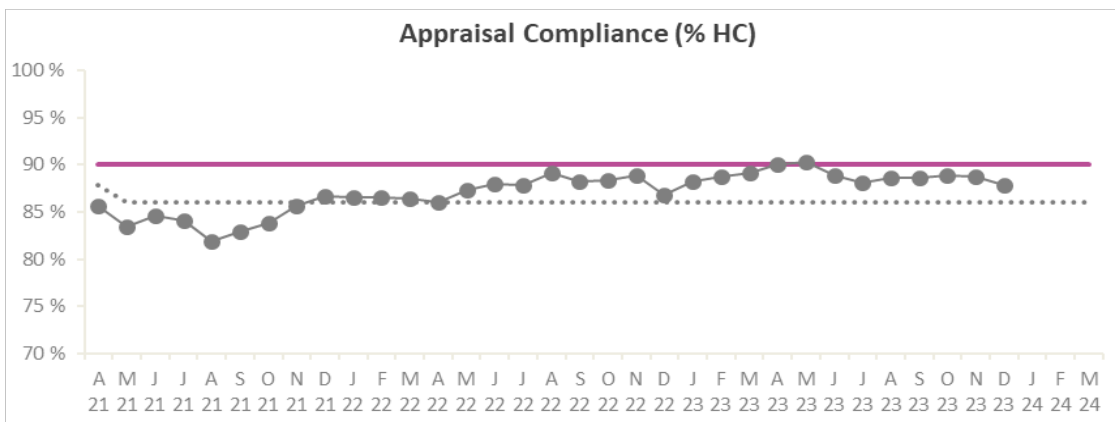
Appraisal Compliance (% HC)
100 %
95 %
90 %
85 %
80 %
75 %
70 %
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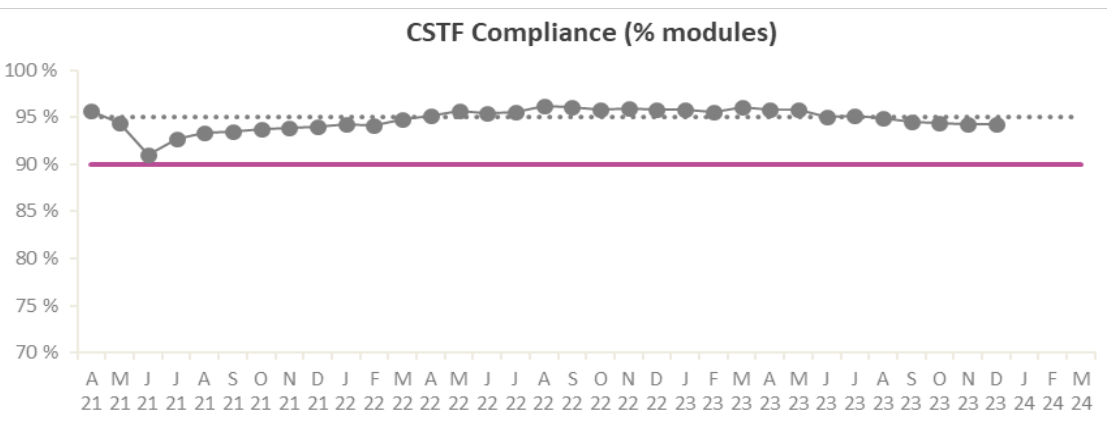
CSTF Compliance (% modules)
100 %
95 %
90 %
85 %
80 %
75 %
70 %
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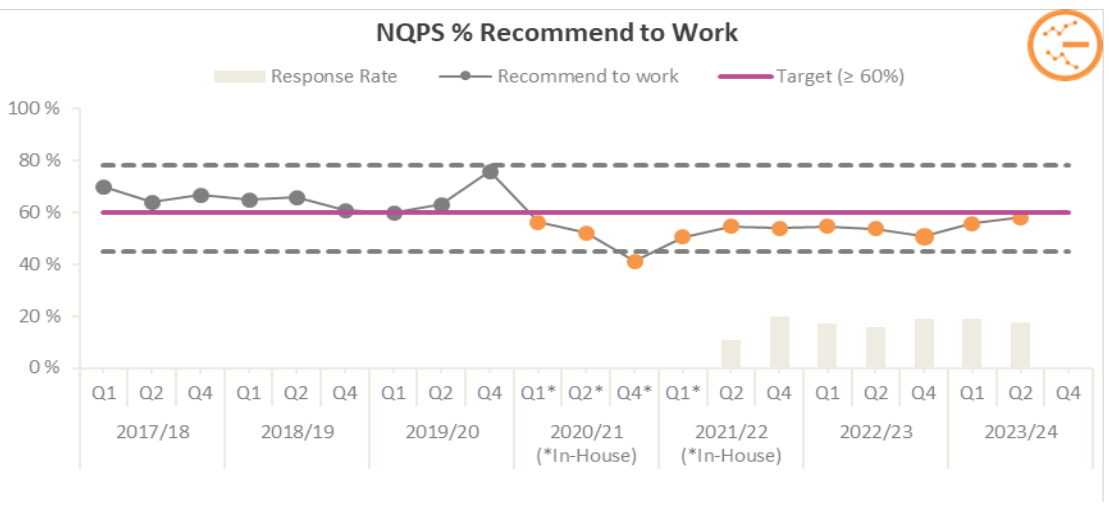
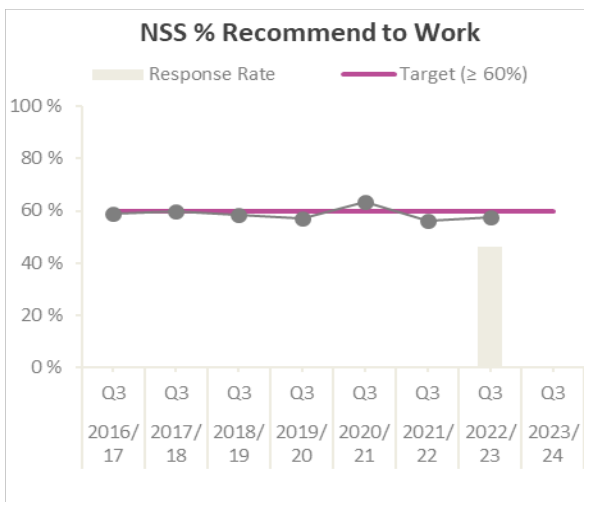

NQPS % Recommend to Work
Response Rate
Recommend to work
Target (≥ 60%)
100 %
80 %
60 %
40 %
20 %
0 %
Q1 Q2 Q4 Q1 Q2 Q4 Q1 Q2 Q4 Q1* Q2* Q4* Q1* Q2 Q4 Q1 Q2 Q4 Q1 Q2 Q4
2017/18 2018/19 2019/20 2020/21 (*In-House) 2021/22 (*In-House) 2022/23 2023/24

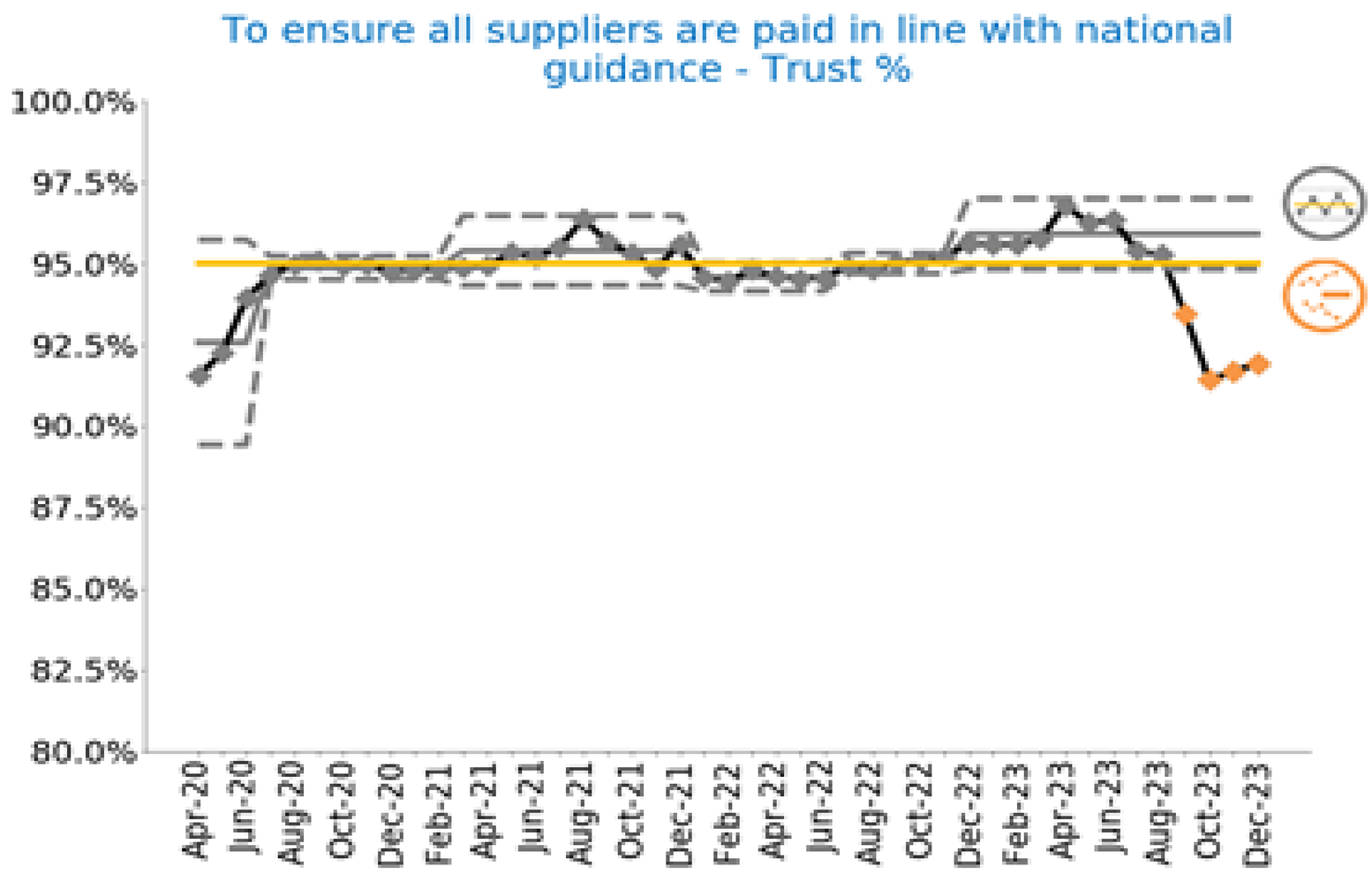

NSS % Recommend to Work
Response Rate
Target (≥ 60%)
100 %
80 %
60 %
40 %
20 %
0 %
Q3 Q3 Q3 Q3 Q3 Q3 Q3 Q3
2016/17 2017/18 2018/19 2019/20 2020/21 2021/22 2022/23 2023/24

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	-	-	-	5217	3453	-
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				90%	91.7%	94.3%
Theatre Efficiency	Big Plan		RPH - Theatre capped utilisation rates are no lower than 80%	M | T-D-S | FPC | FB	No	-	-	-	80%	81.6%	-
	Big Plan		CDH - Theatre capped utilisation rates are no lower than 85%	M | T-D-S | FPC | FB	No	-	-	-	85%	76.9%	-
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 outpatient follow ups by a minimum of 25% against 2019/20 activity levels - **November 2023**	M | T-D-S | FPC | FB	No				-25%	10.4%	-1.4%
Supplier payments (BPPC)	Big Plan		To ensure all suppliers are paid in line with national guidance	M | T | FPC | JW	No			-	95%	91.9%	-
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%	4.14%	-
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	-	-	-	-17553	-36796	-
Capital	**Key Metric**		To ensure 100% delivery of the Trust's Capital programme	M | T | FPC | JW	No	-	-	-	16279	20099	-

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	KS = Karen Swindley	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	JW = Jonathan Wood	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	FB = Faith Button	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee	SC = Sarah Cullen	

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
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
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



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*

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 | ID							
			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							This programme has been replaced with the Value Based Improvement Programme
			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								

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
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								

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
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			▲	▲	▲	▲		JFP signed off by the ICB Board
			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			▭	▭	▭	▭		Variation between programmes
			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			▲	▲	▲	▲		
Digital Northern Star / EPR Convergence	Big Plan	FFTF-12	Deliver the 23/24 actions and outcomes from the agreed Digital/EPR work plan	M | T | FPC | SD-GD		▭	▭	▭	▭		
			EPR tenders evaluated, and preferred supplier awarded			▼	▲	▲	▼		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			▭	▭	▭	▭		L&SC data lake created and populated with draft data. North west programme progressing.
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

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		SQ = Safety & Quality Committee		

Green Delivering actions and outcomes

Amber On track to recover actions & outcomes

Red Significantly off track with actions & outcomes

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

NHP – Board Assurance for next stage			
Report to:	Board of Directors	**Date:**	1 February 2024
Report of:	Company Secretary	**Prepared by:**	J Foote
Part I	✓	**Part II**	

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

Executive Summary:

As reported to the Board at the meeting in December 2023, we are entering a new phase of the NHP as part of the cohort 4 projects. Responsibilities for the delivery of the final business case will now shift towards the Trust and its Board. Whilst the ICB as a commissioner and a strategic lead will still have an important role in the programme, new governance models and assurance frameworks need to be developed to support the programme in its next stage (Minute No. 233/23 refers). This report details proposals for the establishment of a new committee of the Board with the oversight remit of the New Hospital Programme, as it relates specifically to the Trust as a statutory body and the associated Scheme of Reservation and Delegation (SoRD).

The Board is recommended to establish a new committee of the Board for the oversight of the New Hospital Programme with the Terms of Reference and Scheme of Reservation and Delegation as set out as appendices to the report.

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

Trust Board 7 December 2023

1. Current Position

To date the governance and assurance of the New Hospitals Programme has been undertaken at a system level with reports to trust boards for information. The Lancashire and South Cumbria NHP (with proposals for new facilities at both UHMB and LTH) has been successful in its bid to be included in cohort 4 of the Government's national New Hospitals Programme.

This means that, whilst some statutory responsibilities, such as consultation and system wide oversight, remain with the ICB, both UHMB and LTH as the statutory bodies to sit behind decisions involving, for example, the acquisition of land and submission of the business case, will need to shift to a more focussed oversight and assurance model.

To ensure a consistency of approach both UHMB and LTH have worked together to draft proposals for the establishment of board committees to sit within each trust. The terms of reference of these committees are consistent with each other to maintain a parity of process. The terms of reference are complimented by a SoRD drafted to cover only the very specific circumstances surrounding the new hospital programme as it relates to LTH (with the same in place as it relates to UHMB).

2. Key Principles

With any material new build project, board oversight needs to be nimble enough to respond to matters as they arise but also allow sufficient scope for the project to progress operationally. The ToR/SoRD have been carefully drafted to ensure that oversight and assurance is maintained within the wider umbrella programme whilst also giving a degree of flexibility and delegation to maintain momentum as the project runs within the trust. This approach has been mirrored by UHMB.

It is anticipated that the new committee will meet at least quarterly, but more often should the need arise. Again, it is planned that the UHMB and LTH committees will (at least in the first instance) meet on or around the same date to allow for an efficiency of reporting.

The membership of the committee is yet to be allocated but custom and practice allows for this to be at the discretion of the Chair for NED members.

3. Significant Transaction

A significant transaction is defined within the constitution as:

"any transaction determined by NHSE to be significant according to the *Transactions Guidance* … as may be updated from time to time."

The NHSE Transactions Guidance was last updated in October 2022 and lists significant transactions as: mergers, acquisitions, dissolutions, separations, and transfer schemes.

Whilst the new hospital programme falls outside this technical definition and is not therefore a significant transaction requiring the approval of Council, in the spirit of recognising the significance of the project for the communities of central Lancashire it is proposed that the endorsement of Council, at the appropriate time, is sought to evidence that a robust process has been followed in the production of the final business case.

4. Financial implications

No additional costs

5. Legal implications

Evidence of oversight at board level is a requirement of the national NHP during the next phase.

6. Risks

As part of its assurance remit, the new committee will need to understand the overall project risk assurance process and the governance of the project in its entirety, including how the decision-making requirements of the trust are managed within this.

7. Impact on stakeholders

Enabling the continuance of the NHP will have a positive impact.

8. Recommendations

The Board is recommended to establish a new committee of the Board for the oversight of the New Hospital Programme with the Terms of Reference and Scheme of Reservation and Delegation as set out as appendices to the report.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

New Hospital Committee

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the New Hospital Committee. The Committee is a non-executive body and therefore has no executive powers, save as may be expressly provided within these terms of reference.

1.2 In these terms of reference:

i. "the Board means the Board of Directors as specified in the Trust's Constitution
ii. "director" means those directors appointed to the Board by virtue of paragraph 12.2 of the Trust's Constitution.
iii. "member" refers to a member of the Committee as specified at paragraph 3.1 of these terms of reference.

2. PURPOSE

2.1 The overall purpose of the Committee is to direct and provide assurance on the progress of the new hospital project to the Board of Directors.

2.2 Specifically, the Committee shall:

i. Lead/direct on behalf of the Board of Directors the successful delivery of the project including development and implementation of products.
ii. Provide assurance to the Board of Directors on the development of the capital business cases (strategic outline case, outline business case and full business case), construction, operational commissioning and realisation of benefits.
iii. Ensure that appropriate products are submitted to the National team(s) which meet the requirements of both the Trust and the national programme.
iv. Ensure alignment of the NHP Programme objectives with the strategic direction of the Trust.
v. Ensure calibration of the NHP Programme to system commissioner intentions.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

Members;

- 3 Trust, Non-Executive Directors
- Trust, Chief Finance Officer (Senior Responsible Officer)
- Trust, Chief Medical Officer
- Trust, Chief Operating Officer

Attendees;

- Trust, Chief People Officer
- Trust, Chief Nursing Officer
- Trust, Director of Strategy and Planning
- Trust, Director of Estates
- Trust, Director of Communications and Engagement
- Trust, Company Secretary
- Trust, Chief Information Officer
- NHP, Programme Director

3.2 Such officers of the Trust shall attend as required by the Committee for the furtherance of its business, including an expectation of attendance of representatives of operational areas of the Trust. The Trust Chair and CEO may attend meetings at their discretion. Only members of the Committee shall be permitted to vote.

3.3 The Committee can instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3.4 ***Quorum***: The Committee will be deemed quorate when three members are present, including at least one Non-Executive Director.

3.5 ***Frequency of meetings***: Meetings shall be held quarterly with additional meetings held on an exceptional basis as directed by the Chair.

3.6 ***Minutes***: The minutes of meetings shall be formally recorded at the direction of the Company Secretary.

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board to make decisions in line with the levels of authority as set out in the Scheme of Reservation and Delegations and;

Business case;

i. Provide assurance to the Board of Directors that the project is being managed effectively to support the successful achievement of the projects objectives (investment objectives) and the realisation of the benefits from the business case. The Committee will at times direct items of consideration or work to the following Board Committees:
    - Finance and Performance Committee
    - Workforce Committee; and the
    - Safety and Quality Committee

ii. Review draft business cases and checklists and make recommendation to the Board of Directors for approval.

iii. Advise the Board of Directors on readiness for Government project gateway reviews.

Product development;

iv. Direct/lead on compliance with National New Hospitals Programme responsible, accountable, consulted and informed (RACI) matrix for product development, specific documents held in the 'Scheme of Reservations and Delegations.

v. Challenge and seek assurance on the options. Provide escalation to the Board of Directors where material increase in option cost (i.e. greater than 10%) or any reduction in the bed base.

Delivery;

vi. Direct/lead on the implementation of the model of care, demand and capacity modelling, transformation assumptions and workforce planning, as identified in the 'Scheme of Reservations and Delegations. Provide escalation to the Board of Directors where fundamental deviation occurs.

vii. Ensure that a robust communications and engagement plan is in place and delivered effectively to support the NHP.

viii. Provide assurance to the Board of Directors that the new site is safe to receive patients into the new building alongside other necessary clinical configuration including community services.

Project management;

ix. Direct/lead on the delivery against key timelines set out in the overall master project plan, including risks and mitigations these maybe subject to the exploratory deep dive processes and learning from others NHP experiences. Provide escalation to the Board of Directors where the timeline may exceed nationally agreed milestones.

x. Ensure that risks relevant to the Committee's purpose are minimised through the NHP and Trust risk management processes. This will include, but not be restricted to, the consideration of significant risks to the delivery of the Trust's strategic objectives, through review and scrutiny of the relevant risks from the BAF and the project risk register.

xi. Provide assurance to the Board of Directors on the material dependencies.

xii. Direct/lead and approve informal submissions and data collection exercises for the National New Hospitals Programme.

xiii. Advise on exploratory deep dives in relation to Government project gateway reviews and risks using experts to inform those reviews.

xiv. Provide assurance to the Board of Directors on the effective commercial management of the project working with the National New Hospitals Programme Team.

xv. Receive reports via the New Hospital Project Group on project delivery.

5. RELATIONSHIP WITH THE BOARD/REPORTING ARRANGEMENTS

5.1 The Committee will report in writing to the Board the basis for its recommendations. The Board will use that report as the basis for its decisions but shall remain accountable for taking the decision. Minutes of meetings of the Board shall record such decisions.

5.2 The Committee shall receive regular reports from the New Hospital Project Group.

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NHS Lancashire Teaching Hospitals NHS Foundation Trust

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

NEW HOSPITAL PROGRAMME

RESERVATION OF POWERS AND SCHEME OF DELEGATION

1. Background

1.1. Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust were included in the Government's 2019 Health Infrastructure Plan as wave 2 schemes (referred to as "HIP2"), superseded by the New Hospitals Programme (NHP) in 2021.

1.2. The Lancashire and South Cumbria New Hospitals Programme is part of Cohort 4 of the Government's commitment to build circa 40 new hospitals by 2030 with a rolling investment plan ongoing into the future.

1.3. In May 2023, the Secretary of State for Health and Social Care announced two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital as part of a rolling programme of national investment in capital infrastructure beyond 2030.

2. Introduction

2.1. The purpose of this document is to clarify the powers reserved to the Board of Director, generally matters for which they are held accountable to their regulators. The Board remains accountable for all its functions, even those delegated to individual staff and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2.2. This New Hospitals Programme, Reservation of Powers and Scheme of Delegation details administrative practice and procedure and records the delegations and reservations of powers and functions adopted by the New Hospitals Programme, the "Programme".

2.3. They should be read in conjunction with the Lancashire Teaching Hospitals Trust, Reservation of Powers to the Board and Scheme of Delegation and used in line with the Trust Constitution and the Standing Financial Instructions.

3. Decisions reserved for the Board

Governance;

3.1. Approving the Programme governance arrangements and decision-making models.
3.2. Approving the terms of reference and reporting arrangements for the New Hospital Committee.

Business cases;

3.3. Approving Strategic Outline Cases, Outline Business Cases and Full Business Cases for Capital Investment.

Land;

3.4. Approving proposals for acquisition, disposal or change of use of land and/or buildings.

Finance;

3.5. Approving budget.
3.6. Approving expenditure for goods and services over £1,000,000.
3.7. Authorise contracts for expenditure over £1,000,000.

Note: Any matter listed above considered to be a significant transaction will also require the approval of the Council of Governors.

Workforce;

3.8. Appointing the Senior Responsible Officer.

4. <u>Decisions / duties delegated to the New Hospital Committee</u>

Business cases;

4.1. Approving Enabling Business Cases for Capital Investment.
4.2. Approving five cases – commercial, economic, financial, management and strategic.
4.3. Project management;
4.4. Approving demand and capacity modelling
4.5. Approving model of care
4.6. Approving schedules of accommodation
4.7. Approving project option
4.8. Approving site option
4.9. Approving Royal Institute of British Architect (RIBA) stage reports
4.10. Approving digital plan
4.11. Approving estates and facilities management plan
4.12. Approving workforce plan
4.13. Approving operational readiness plan
4.14. Approving project execution plan (PEP)
4.15. Approving programme timeline
4.16. Monitoring benefits realisation
4.17. Approving risk register
4.18. Approving informal submissions and data collection exercises for the National New Hospitals Programme

Finance;

4.19. Obtaining outside legal or other independent professional advice, if it considers this necessary.

4.20. The Committee is authorised by the Board to investigate any activity within its terms of reference.

5. Decisions / duties delegated to the Appointments, Remuneration and Terms of Employment Committee

Workforce;

5.1. Approving the arrangements for the appointment and remuneration of very senior management NHP staff.

6. Delegated authority relating to Senior Responsible Officer

Finance;

6.1. Budget setting (budgets approved by Board).
6.2. Submitting financial plans (budgets).
6.3. Approving expenditure for goods and services up to £500,000.
6.4. Authorise contracts for expenditure up to £500,000.

Workforce;

6.5. Adding staff to the agreed establishment with Chief People Officer (subject to vacancy control processes).

Risk management;

6.6. Ensuring the Programme has a Risk Management Strategy.

7. Delegated authority relating to Programme Director

Finance;

7.1. Monitoring budgets.
7.2. Ensuring compliance with requisitioning/ordering/payment system.
7.3. Approving expenditure for goods and services up to £200,000.
7.4. Authorise contracts for expenditure up to £200,000.
7.5. Approving proposals for the use of management consultants in consultation with the Chief Finance Officer.
7.6. Ensuring that best value for money is demonstrated for all services provided under contract;
7.6.1. £10,000-30,000 - obtain at least 3 written quotes.
7.6.2. £30,000-100,000 - obtain at least 3 written competitive tenders.
7.6.3. £100,000 - comply with Public Procurement Regulations.

Workforce;

7.7. Recruiting/appointing to funded establishment (Programme Team)
7.8. Appointing to a vacancy within the Programme Team (subject to vacancy control processes)
7.9. Renewing fixed-term contracts

Risk management;

7.10. Developing systems for the management of risk

8. Review

8.1. This document will be reviewed inline with the New Hospital Committee, Terms of Reference.

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Updated Risk Management Strategy (2024-2027)			
Report to:	Board of Directors	**Date:**	1st February 2024
Report of:	Chief Nursing Officer	**Prepared by:**	S. Regan
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this paper is to:

- Present the updated Risk Management Strategy (2024-2027).
- Give an update in relation to the implementation of the new Risk Management Group.

Risk Management Strategy

In pursuit of excellence in its risk management arrangements, the Trust developed a Risk Management Strategy which was discussed and approved at the Board of Directors meeting in October 2023, subject to the strategy being updated to provide greater clarity around the control framework.

In line with the discussion at the Board of Directors meeting, the strategy has been updated to include an annual review of the key controls and assurances through Committees of the Board to ensure appropriate internal and external scrutiny.

Some additional amendments have also been made including minor wording changes and changes to images to include alternative text (alt text) in line with NHS digital accessibility standards. The timeframe for the strategy has also been updated to 2024-27 to reflect this as the final version. A copy of the final strategy can be found at Appendix 1.

Risk Management Group

A full review of the Risk Management Policy was undertaken in 2023 and a revised policy was approved at the Board of Directors meeting in October 2023.

One of the main changes was the planned introduction of a new Risk Management Group from November 2023. However, a decision was made to pause the start date of the new group in view of the appointment of a new Chief Executive and an imminent start date.

In the interim period, Risk Management has continued to be overseen through the Senior Leadership Team (SLT) meetings and the Divisional Improvement Forums (DIFs) and this will continue until the implementation of the new Risk Management Group.

The new Chief Executive started in post at the beginning of January 2024, and it has been agreed that the first meeting of the Risk Management Group will be held in March 2024 and take place monthly thereafter.

It is recommended that the Board of Directors:

I. Note the updates to the Risk Management Strategy.
II. Note the revised start date for the new Risk Management Group.

Appendix 1 – Final Risk Management Strategy 2024-27

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

Audit Committee – September 2023
Board of Directors Meeting – October 2023

1. Background

1.1 The purpose of this paper is to:

- Present the updated Risk Management Strategy (2024-2027).
- Give an update in relation to the implementation of the new Risk Management Group.

1.2 A new Risk Management Strategy was developed and discussed at the Board of Directors meeting in October 2023. The strategy was approved and as part of the discussion, there was a request made for the strategy to be updated to provide greater clarity on the control framework and for this to be included on the Board agenda in February 2024.

1.3 The new Risk Management Group was planned to start in November 2023. However, this was paused due to the appointment of a new Chief Executive.

1.4 The new Chief Executive started in post at the beginning of January 2024, and it has been agreed that the first meeting of the Risk Management Group will be held in March 2024.

2. Discussion

Risk Management Strategy (2024-27)

2.1 In pursuit of excellence in its risk management arrangements, the Trust developed a Risk Management Strategy which was discussed and approved at the Board of Directors meeting in October 2023, subject to the strategy being updated to provide greater clarity around the control framework.

2.2 In line with the discussion at the Board of Directors meeting, the strategy has been updated to include an annual review of the key controls and assurances through Committees of the Board to ensure appropriate internal and external scrutiny.

2.3 Some additional changes have also been made including minor wording changes and changes to images to include alternative text (alt text) in line with NHS digital accessibility standards. The timeframe for the strategy has also been updated to 2024-27 to reflect this as the final version.

2.4 The strategy is framed upon the consistent principles adopted within the Trust's Always Safety-First Strategy, and the Patient Experience & Involvement Strategy:

i. Insight
ii. Involvement
iii. Improvement

2.5 It sets out the approach to further enhancing Risk Management at Lancashire Teaching Hospitals over the next three years after consultation with members of the Senior Leadership Team (SLT), the Board of Directors and wider groups.

2.6 The strategy will be overseen by the Risk Management Group, with progress presented annually to the Audit Committee.

2.7 A copy of the final strategy can be found at Appendix 1.

Risk Management Group

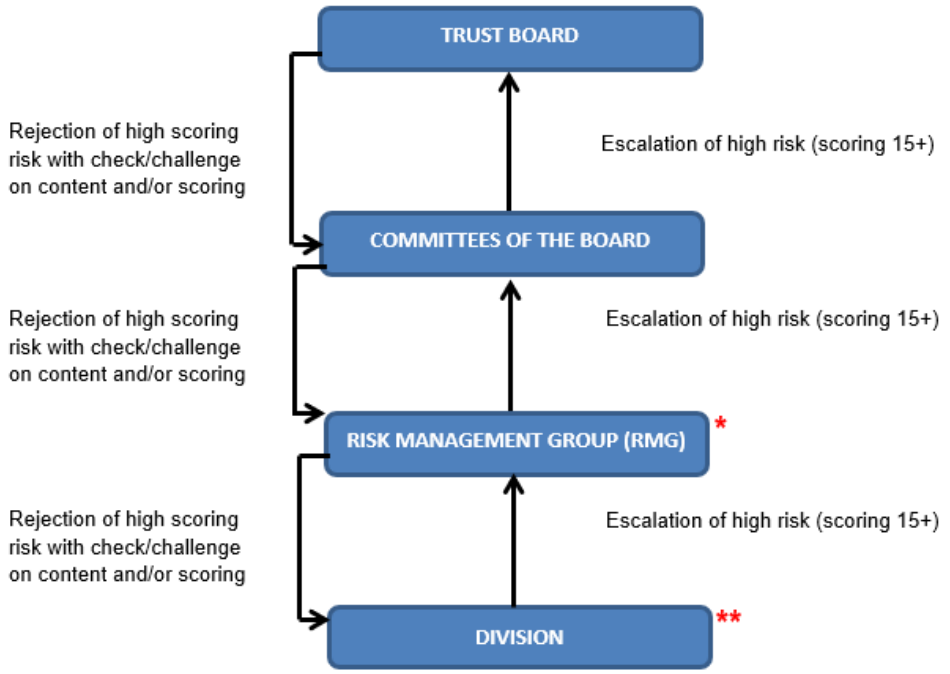
2.8 A full review of the Risk Management Policy was undertaken in 2023 and a revised policy was approved at the Board of Directors meeting in October 2023.

2.9 One of the main changes was the planned introduction of a new Risk Management Group from November 2023. However, a decision was made to pause the start date of the new group in view of the appointment of a new Chief Executive and an imminent start date.

2.10 In the interim period, Risk Management has continued to be overseen through the Senior Leadership Team (SLT) meetings and the Divisional Improvement Forums (DIFs), and this will continue until the implementation of the new Risk Management Group.

2.11 The new Chief Executive started in post at the beginning of January 2024, and it has been agreed that the first meeting of the Risk Management Group will be held in March 2024 and take place monthly thereafter.

2.12 An overview of the planned governance and escalation arrangements are shown below:



* In the absence of the Risk Management Group meeting, urgent risk escalations can be made via the Senior Leadership Team (SLT) meeting to Committees of the Board.

** This could include escalation from Divisional Board, Divisional Safety and Quality Committee, Divisional Finance and Performance Committee or Divisional Workforce Committee

3. Financial implications

3.1 There are no identified financial implications to introducing the strategy or amending the policy.

4. Legal implications

4.1 There are no identified legal implications to introducing the strategy or amending the policy.

5. Risks

5.1 The paper is risk focussed and introduces the new Risk Management Strategy, the updated Risk Management Policy and the new Risk Management Group with the intention to further improve governance and risk management within the organisation.

6. Impact on stakeholders

6.1 The Risk Management Group will change the meeting requirements for stakeholders and any impact of this will be monitored and minimised as far as is reasonably practicable.

7. Recommendations

I. Note the updates to the Risk Management Strategy.
II. Note the revised start date for the new Risk Management Group.

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Risk Management Strategy
2024–2027

Excellent care with compassion

Always Safety First

@LancsHospitals

Contents

Foreword

At Lancashire Teaching Hospitals NHS Foundation Trust we believe in establishing an organisational culture that ensures risk management is an integral part of corporate objectives, business plans and management systems.

As a large and complex organisation delivering a range of services, in a challenging operational and financial environment, we recognise that risks are an inherent part of the day-to-day life in the delivery of healthcare. However, the Board are fully committed to ensuring that risks are identified and managed, so that they are reduced to an acceptable level, or eliminated as far as reasonably practicable.

As a Board, we place particular emphasis on having robust and effective controls in place to mitigate clinical and non-clinical risks. We have an effective framework in place that supports the identification and mitigation of risks as they may present themselves over time, but that also enables us to be agile when emerging risks present themselves through the course of the Trusts' day-to-day activities. Assurance is provided to the Board through the Board Assurance Framework (BAF). The BAF provides a structure and process to enable us to identify those strategic and operational risks that may compromise the achievement of our high level strategic objectives.

In developing this strategy our teams have reviewed the Trust's Risk Management Policy alongside recommendations and learning from external reviews conducted by the Care Quality Commission (CQC), NHS England/Improvement (NHSE/I), the Good Governance Improvement (GGI) and Mersey Internal Audit Agency (MIAA).

Through this strategy and implementation plan, in conjunction with the Trust's Risk Management Policy, we will aim to ensure Risk Management processes are embedded at every level of the organisation. This is important to ensure there is a culture that supports active and consistent management of risks, where staff feel confident to speak up and raise concerns about issues that affect safety and quality outcomes, finance and performance, and staff and patient experience.

We believe that whilst compliance with legislative requirements is important, we see this as a minimum standard only. Through implementation of this strategy, we will strive for excellence and innovation in risk management to empower and enable our teams with the right education, framework and platform to resolve complex issues, and deliver 'Excellent Care with Compassion' for our patients.

Strategy overview

Our three year strategy (2024–2027) is designed to further improve and refine our approach to risk management across the organisation, with the aim of fostering a proactive and responsive culture in mitigating threats that may affect safety, quality, performance and finance to the detriment of patients and their families, staff, services and the sustainability and future viability of the organisation. In doing so, this strategy supports us in working towards the achievement of the strategic Aims and Ambitions within Our Big Plan.

Developing the strategy

Previous iterations of the Risk Management Strategy have also incorporated elements of the Risk Management Policy and this strategy marks a shift in approach. The Risk Management Strategy sets out our organisational plans over the next 3 years and should be read in conjunction with our Risk Management Policy, which sets out our policy requirements and processes in detail.

In developing this strategy, we looked at previous external reviews related to governance and risk, at different levels of the organisation including by:

- The Care Quality Commission (CQC).
- NHS England/Improvement (NHSE/I).
- The Good Governance Improvement (GGI).
- Mersey Internal Audit Agency (MIAA).

We also looked at:

- Risk management approaches both in the NHS and in other sectors.
- The Health and Social Care Act 2012.
- CQC Guidance for Providers, encompassing the Essential Standards of Quality and Safety.
- NHS Foundation Trust Code of Governance.
- The NHS Oversight Framework.
- National Guidance from the National Quality Board on Quality Risk Response and Escalation in Integrated Care Systems.

We asked Executive Directors, Non-Executive Directors, Divisional and Departmental Leads and Governance Professionals to contribute to building the strategy and will continue to work in partnership with stakeholders to review progress and constantly look for ways to enhance and develop organisational Risk Management and Board Assurance processes.

We have developed this 3 year plan to build on the solid foundations in place and drive Risk Maturity forward within the organisation.

Defining our approach to Risk Management

In undertaking Risk Management activity there are two key approaches that the Trust takes: the top down and the bottom-up approach.

Top Down **(Identifying Strategic Risks)**	The Trust undertakes Strategic Risk Management through Executive Management and Committee structures that enables the identification, assessment and recording of strategic risks which threaten the achievement of the Trust's Strategic Objectives. The management of Strategic Risks also consider the implementation and monitoring of controls and mitigating actions. (Strategic Risks may also be identified through the monitoring and reporting of operational risks).
Bottom Up **(Identifying Operational Risks)**	The Trust undertakes Operational Risk Management activity through staff working in adherence to the Trust's Risk Management Policy. Operational Risks are those that sit on the divisional and corporate risk registers and may affect and relate to the day to day running of the organisation. Operational Risks may present themselves via incidents, complaints, claims, patient feedback, safety inspections, external review and ad hoc assessments etc., which may impact on the Trust's ability to meet its objectives and targets.

Risk Management Activity – Top down and Bottom up approach

The Board Assurance Framework

The Board Assurance Framework (BAF) 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 and is made up of two parts the Strategic Risk Register and the Operational Risk Register.

- Strategic Risks are those risks that threaten the delivery of the strategic objectives and are not likely to change over time.
- Operational Risks are those that sit on the divisional and corporate risk registers and may affect and relate to the day to day running of the organisation. They mainly affect internal functioning and service delivery and are managed at the appropriate level within the organisation.

The BAF records organisation wide strategic risks that include risks identified in relation to the business objectives, corporate objectives and the Care Quality Commission Standards. The BAF enables the Board to demonstrate the key controls in place and the assurances for each strategic risk. Every strategic risk on the BAF is assigned to an Executive Director who is responsible for reporting on progress to the Board of Directors via Committees of the Board. The BAF is presented to the Board of Directors meeting on a bi-monthly basis.

Risk Scoring

Risks are scored utilising a matrix which was derived from the National Patient Safety Agency Risk Matrix and compares likelihood and consequence.

	Likelihood Score				
Consequence Score	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

The overall score determines the level of risk and monitoring within the Trust.

Risk Monitoring and Escalation

As a 'Clinically Led Organisation' we believe that operational risks are best managed by clinical staff and those that are closest to the risk and can affect it positively. However, we recognise that support and guidance can often be required, along with appropriate oversight from Departmental, Divisional and Corporate Management teams, and the Board of Directors..

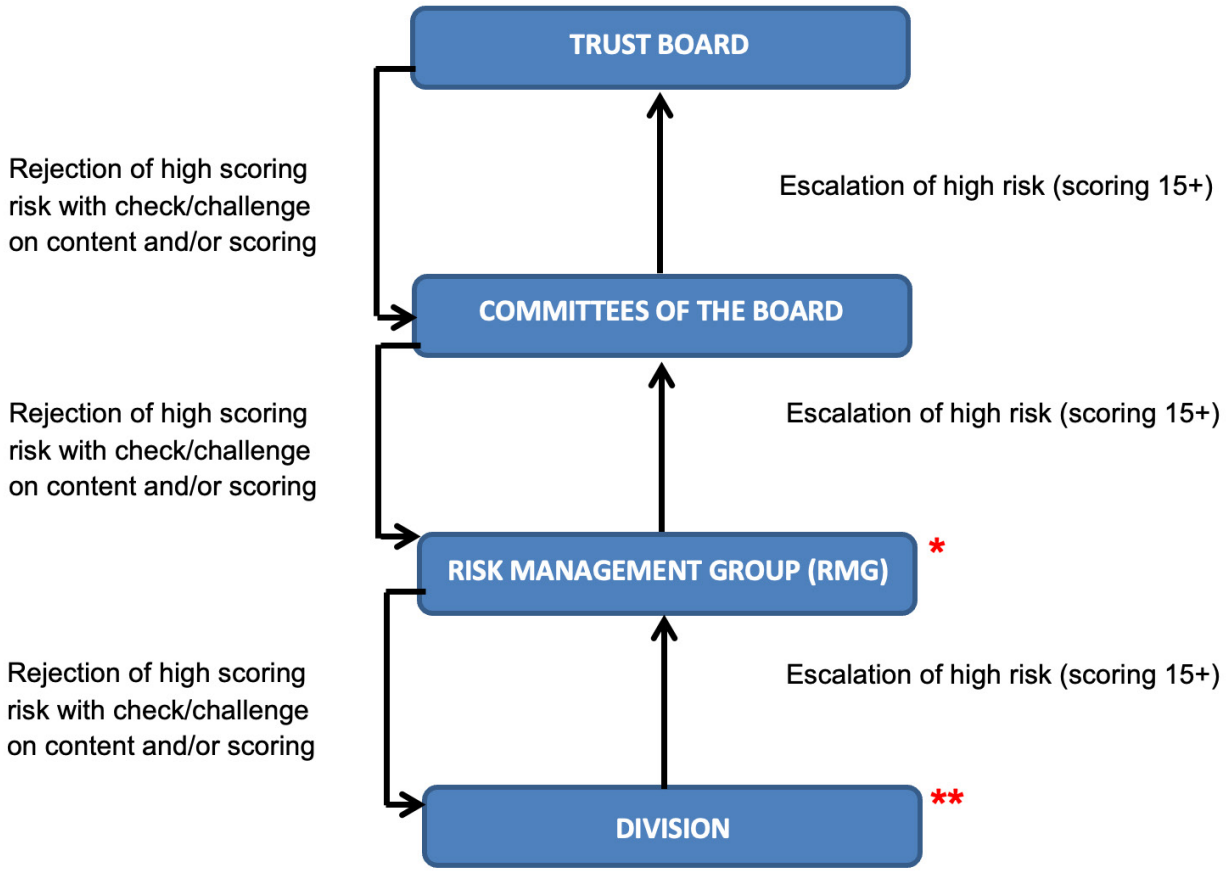
The frequency at which a Risk should be reviewed is determined by the risk score with higher scoring risks requiring more frequent review.

- Risks rated as 'High' (15-25) must be reviewed monthly
- Risks rated as 'Significant' (risk score 8-12) or 'Moderate' (score of 4-6) must be reviewed on at least a quarterly basis
- Risks rated as 'Low'(risk score 1-3) must be reviewed at least annually.

The monitoring and escalation processes will ensure that risks are not managed by staff without sufficient authority, experience and knowledge to mitigate the risk and that significant and serious risks are identified and escalated as quickly as possible.

The high risks to the organisation are overseen by Senior Leaders, Committees of the Board and Trust Board using the following escalation process:

Route of escalation for high risks



* In the absence of the Risk Management Group meeting, urgent risk escalations can be made via the Senior Leadership Team (SLT) meeting to Committees of the Board.

** This could include escalation from Divisional Board, Divisional Safety and Quality Committee, Divisional Finance and Performance Committee or Divisional Workforce Committee

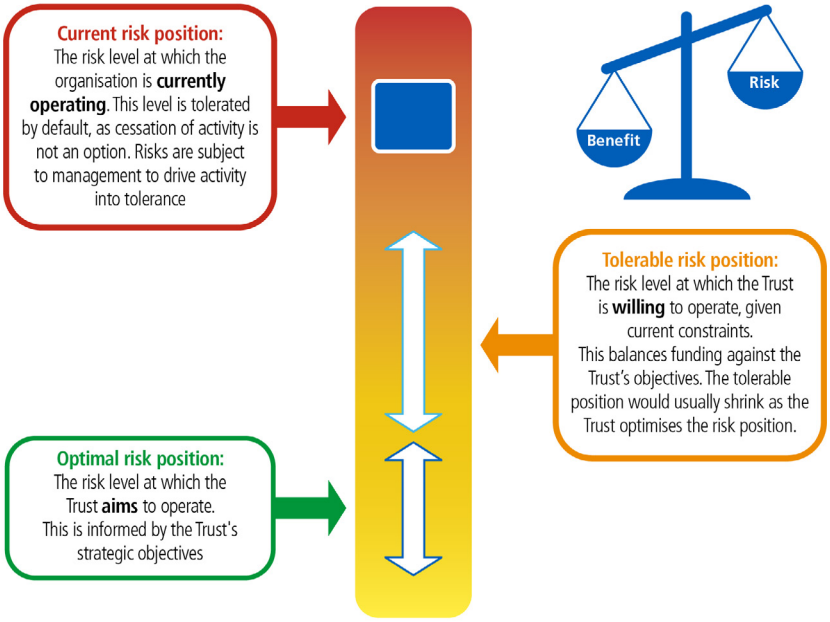
Risk Appetite & Risk Tolerance

The UK Corporate Governance Code states that 'the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'. This means that at least once a year, we should consider the types of risk we may wish to exploit and/or can tolerate in the pursuit of objectives.

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.

The infographic below provides a high-level overview of the journey of a risk from its current risk position to its optimal risk position, recognising some risks may be tolerated in line with the level of risk the Trust is willing to operate within.



Risk Appetite Scale

As part of considering our appetite to risk, we have used the following Scale to support the development of our Risk Appetite Statement which outlines our appetite and tolerance to risk when pursuing our Strategic Aims and Ambitions.

The Trust seeks to manage risks in accordance with our Risk Appetite Statement.

Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust
Seek	Eager to be innovative and to choose options offering higher rewards, despite inherent business risk
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Cautious	Preference for safe delivery options which have a low degree of residual risk and only a limited reward potential
Minimal	Preference for very safe delivery options which have a low degree of inherent risk and only a limited reward potential
None	Avoidance of risks is a key organisational objective

Risk Appetite Statement

In 2022/23, we reviewed and updated our Risk Appetite Statement in conjunction with the Good Governance Improvement (GGI) and this was endorsed by the Board. This was reviewed again for 2023/24 as part of the annual cycle, and approved with no changes at the Board of Directors Meeting in June 2023.

We will use this Risk Appetite Statement to support our strategic decisions and to monitor progress with the Strategic Risks to the delivery of our Aims and Ambitions.

We also want our operational teams to feel confident in using the Board-approved Risk Appetite and Tolerance to give confidence when making decisions about how much risk to take (appetite) and how much risk we can operate with (tolerance).

The Risk Appetite Statement* set by the Board is as follows:

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.

**This may be subject to change in the three year cycle of this strategy*

Strategic Risks

In developing the Risk Appetite Statement, we have reviewed each of our Strategic Risks to determine the level of risk that we aim to operate with (appetite) and the level that we are prepared to operate with (tolerance). The risk appetite and tolerances shown below were approved by the Board of Directors in June 2023.

Strategic Risks - Appetite*

Strategic Risks		Risk Appetite Statement	Rationale
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	Cautious	Our Trust has an Always Safety First strategy. In pursuit of this strategy, we recognise there may an be adverse impact on other aims but we are not open to risking non-compliance with regulatory standards.
	Risk to delivery of Strategic Ambition: A Great Place to Work	Open	We are willing to accept some risk where there is a potential to improve recruitment, retention and employees' personal development.
	Risk to delivery of Strategic Ambition: Deliver Value for Money	Open	We are willing to accept quantifiable and well-controlled financial risk where there are tangible benefits and opportunities to restore financial balance, e.g. invest to save programmes.
	Risk to delivery of Strategic Ambition: Fit for the Future	Seek	We are willing to consider all possible solutions to providing sustainable healthcare for local communities, while maintaining a low tolerance for risks to quality or patient safety.
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		Seek	We are willing to pursue innovative options in pursuit of world class education, training and research. By its nature, innovation involves stepping away from tried and tested options.
Risk to delivery of Strategic Aim to offer a range of high quality specialist services to patients in Lancashire and South Cumbria		Open	We are willing to take risks where there are clear opportunities to streamline and modernise services, whilst retaining our own tertiary status.

Strategic Risks - Tolerance*

Strategic Risks		Risk Tolerance Level	Rationale
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	1-6	We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the fullest range of safety measures being put in place.
	Risk to delivery of Strategic Ambition: A Great Place to Work	4-8	Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority and we are guided by our shared values.
	Risk to delivery of Strategic Ambition: Deliver Value for Money	8-12	Acute trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk.
	Risk to delivery of Strategic Ambition: Fit for the Future	8-12	To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk.
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		9-12	We recognise that investments in education, training and research can take time to generate the expected benefits for the trust, and that new ways of working have a higher inherent risk than established methods.
Risk to delivery of Strategic Aim to offer a range of high quality specialist services to patients in Lancashire and South Cumbria		6-9	We are willing to take risks where there are clear opportunities to streamline and modernise services but are unwilling to lose our own tertiary status.

**These may be subject to change in the three year cycle of this strategy*

Risk Maturity

As part of our Risk Management Policy, we use a bespoke risk maturity matrix, building on a respected Institute of Internal Audit model. This tool is recognised by our Internal Auditors Mersey Internal Audit Agency (MIAA) and considers the following factors as part of the review to provide an assessment of the embeddedness and effectiveness of the risk management processes being applied.

- Leadership, management & culture.
- Roles & Responsibilities.
- Processes.
- Monitoring & feedback.

The overall conclusions can broadly be made against the following risk maturity definitions:

Level 5
Risk enabled

Driven by the Board, staff at all levels actively consider issues of risk in all areas of activity and develop control and assurance processes to manage those risks / risk management and internal controls fully embedded into the operations.

Level 4
Risk managed

Staff throughout the organisation are aware of the importance and the organisations response to risk Enterprise approach to risk management developed and communicated.

Level 3
Risk defined

The organisation has considered risk management, and put in place strategies led from a risk management team / strategy and policies in place and communicated. Risk appetite defined.

Level 2
Risk aware

The organisation is aware of risk management responsibilities, and needs to embed systems/ scattered silo based approach to risk management.

Level 1
Risk naive

The organisation has little or no awareness of the importance of risk management / no formal approach developed for risk management.

As part of this Strategy, our ambition is to achieve Level 5 of Risk Maturity in the next three years and we will conduct annual assessments to monitor our progress.

The Strategy

The strategy has been divided into three sections:

(i) **Insight**: Improve our understanding of Risk Management at the Trust by drawing intelligence from multiple sources, internally and externally.

(ii) **Involvement**: Supporting, training, and involving key staff groups will enhance their understanding and maturity in Risk Management and we will use this as a vehicle to improve how we manage risk within the organisation.

(iii) **Improvement**: The Trust will support continuous and sustainable improvement, with everyone learning to improve Risk Management within the organisation, to reduce risk to patients, staff and stakeholers.

Through this strategy we recognise the opportunity to shape a forward-thinking culture that supports the Trust to enhance its key controls and mitigate strategic and operational risks for our patients, staff and other stakeholders.

Our ambition is to become an organisation that achieves the highest level of Risk Maturity (Level 5 – Risk Enabled).

This is important to ensure there is a culture that supports active and consistent management of risks, where staff feel confident to speak up and raise concerns about issues that affect safety and quality outcomes, finance and performance, and staff and patient experience.

Key enablers and stakeholders are identified within the strategy, specifically creating the infrastructure for improving Risk Management, which will enhance the arrangements to assure the Board through the Board Assurance Framework (BAF).

The successful delivery of this strategy is underpinned by culture, leadership, engagement and education programmes of work.

Measurement

The improvement measures are identified within the insight section of the strategy and these will be monitored through the review of data and information at the new Risk Management Group. These include:

- Improved Risk Management training
- Introduction of Risk Management Workshops
- Reduction in long-standing risks
- Reduction in operational high risks
- Reduction in confidential risks
- Improvements in Risk Maturity ratings

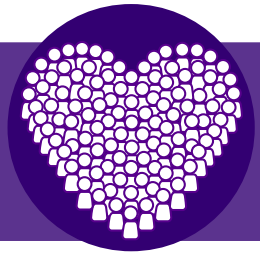
Our Big Plan strategy

Our Values

Our aim is to always provide excellent care with compassion from all of our sites including:

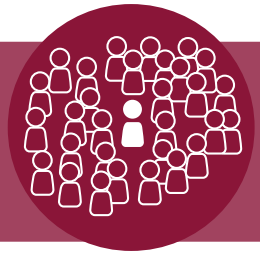
- Chorley and South Ribble Hospital
- Royal Preston Hospital
- The Specialist Mobility and Rehabilitation Centre (SMRC)
- Finney House Community Healthcare Hub (CHH)
- Our community and satellite sites.

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



Compassionate

A culture where we treat patients and colleagues with compassion, understanding and with kindness.



Respectful

A culture where all roles or backgrounds are valued and equal, ideas are welcomed, we feel respected and supported.

Empowered

A culture where we are empowered and enabled to act to the full remit of our roles, we understand what we can do and feel able to act without permission.

Collaborative

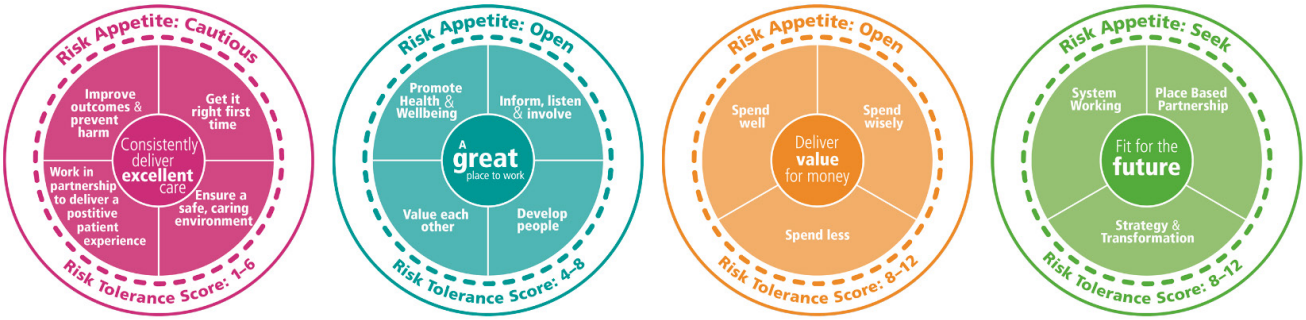
A culture where we recognise we are part of a bigger team, willing to work across boundaries to support others to achieve their aims.

Performance Focussed

A culture which is performance focussed, we strive to be the best. We are happy to be held and hold others to account in a positive, supportive manner, we are reflective and do not seek to blame.

Alignment to Trust Objectives

The objectives in this plan are derived from the Trust's core objectives. Currently all risks on the active Risk Register at the Trust are aligned to a Trust Ambition or Aim to ensure there is a structure and process in place to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives. This Strategy looks to support the refinement of the Trust's approach to managing all risks aligned to the Trust's Aims and Ambitions.



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**

How will we work differently?

Through this strategy the role of leaders will be defined across our organisation. This section of the strategy contains an outline of how this will be achieved and how our teams will work together to build our Insight, Involve and learn from best practice, and Improve our risk profile and maturity. Through development of the new Risk Management Group, we intend to capture and share learning and become a centre of excellence for our risk and assurance processes.

Our clinical and corporate teams will work together to implement this strategy.

Insight: Teams will work together to improve our understanding of Risk Management at Lancashire Teaching Hospitals by drawing intelligence from multiple sources internally and externally. Risk data and information will be scrutinised in different ways through the new Risk Management Group. This will ensure a shared understanding of our key strategic and operational risks, and provide a platform to resolve complex cross-divisional/cross-Trust/cross-boundary issues, to support organisational and system-based controls and solutions.

Involvement: Our strategy has been designed to involve staff through workshops and provide them with the right education to improve their skills, understanding and confidence to tackle risks. The draft strategy was circulated widely amongst divisional and corporate teams to ensure the final product identifies what matters most. The strategy will remain responsive as each year progresses with the ability to add to and take away as priorities change.

Improvement: The Board of Directors have committed to adopting a robust improvement methodology across our organisation. The strategy will be underpinned by underpinned by this and our teams will work together to deliver effective and sustainable change in our highest risk areas. Learning from improvements in our risks will be shared widely with staff.

Delivering the Plan

The new Risk Management Group, with representation from Executive Directors, Corporate and Divisional Leadership Teams and Multi-disciplinary Governance Professionals, will oversee the implementation of this Strategy, the group will focus on the three major areas of work: insight, involvement and improvement.

The new group will aim to create a flattened hierarchy to identify improvement priorities ('insights'), further improving the involvement of our staff and stakeholders in designing the improvements required ('involvement') and overseeing the improvements in the organisational risk maturity ('improvement').

The deliverables outlined in this strategy will be delivered through the Risk Management Group, who will use the intelligence created to inform future priorities of 'Our Big Plan'.

Progress will be monitored through the Risk Management Group and an annual report will be produced.

The Risk Maturity Assessments will be a key vehicle to test the deliverables of the strategy and an overview will be reported to the Risk Management Group

The strategy is applicable to all areas of the organisation and we will support teams to mature their risk arrangements.

The strategy will be considered as a fundamental part 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.

The 3 Year Risk Management Implementation Plan

1. INSIGHT	AIM	
Improve our understanding of Risk Management at Lancashire Teaching Hospitals by drawing intelligence from multiple sources internally and externally. Adopt and promote key risk management principles by: • implementing a risk management group to enable a deeper understanding of the organisational risks, and to support cross-divisional, cross-Trust and cross-boundary learning and improvements. • gaining an understanding on how risk management software can improve organisational governance and risk management. • supporting the development of patient safety priorities through learning from incidents, complaints, claims, patient feedback, safety inspections, external reviews and events and other ad hoc assessments etc, which may impact on the Trust's ability to meet its objectives and targets. • carrying out deep dives into organisational risks..		
Year 1	**Year 2**	**Year 3**
Driving improvement Implementation of a Risk Management Group to oversee and monitor risk management across the Trust.	**Driving improvement** Use intelligence from the Risk Management Group to inform improvement priorities.	**Driving improvement** Review and refine approach.
Governance Embedding and fully utilising Risk Management KPIs through the Governance Dashboard on the BI portal, with the aim of sustained compliance (≥80%) with KPIs across the Trust.	**Governance** Divisional and Trustwide focus on Risk Management KPIs through the Governance Dashboard on the BI portal with the aim of sustained compliance (≥90%) with KPIs across the Trust.	**Governance** Speciality focus on Risk Management KPIs through the Governance Dashboard on the BI portal with the aim of sustained compliance (≥95%) with KPIs across the Trust.
Deep Dives Completion of thematic reviews on 10% (circa 50) of active risks to support the understanding and development of organisational and system-based controls and solutions.	**Deep Dives** Based on learning from Year 1, complete thematic reviews on a further 10% (circa 50) of active risks to support further refinement and development of organisational and system-based controls and solutions.	**Deep Dives** Based on learning from Year 1 and 2, complete thematic reviews on a further 10% (circa 50) of active risks to support further refinement and development of organisational and system-based controls and solutions.
Key controls Annual Review of Key Controls & Assurances through Committees of the Board to ensure appropriate internal/ external scrutiny	**Key controls** Annual Review of Key Controls & Assurances through Committees of the Board to ensure appropriate internal/ external scrutiny	**Key controls** Annual Review of Key Controls & Assurances through Committees of the Board to ensure appropriate internal/ external scrutiny
Risk-based Priorities Review of all operational High Risks to support a systems-based approach to the development of the Trust's Patient Safety Priorities in line with the National Patient Safety Strategy.	**Risk-based Priorities** Annual Review of all operational High Risks to support a systems-based approach to the identification of organisational priorities and programmes of work, aligned to the Strategic Aims and Ambitions.	**Risk-based Priorities** Annual Review of all operational High Risks to support a systems-based approach to the identification of organisational priorities and programmes of work, aligned to the Strategic Aims and Ambitions.
Understanding National Risks Annual Review of National Risk register issued by the Government to ensure that Local risks align to National Risks, as appropriate.	**Understanding National Risks** Annual Review of National Risk register issued by the Government to ensure that Local risks align to National Risks, as appropriate.	**Understanding National Risks** Annual Review of National Risk register issued by the Government to ensure that Local risks align to National Risks, as appropriate.
Technology Review of Risk Management Software available on the market to ensure the Trust is utilising the best possible software package to support and enhance risk management and risk maturity across the Trust.	**Technology** Annual Software review to ensure format and structure of system supports the Trust's Risk Management and Risk Maturity processes.	**Technology** Annual Software review to ensure format and structure of system supports the Trust's Risk Management and Risk Maturity processes.

2. INVOLVEMENT	AIM	
Supporting, training, and involving key staff groups will enhance their understanding and maturity in Risk Management and we will use this as a vehicle to improve how we manage risk within the organisation. Plans include: • a refreshed organisational approach to Risk Management training • targeted training for specialist groups • risk management workshops with divisional leads, departmental leads and the Board to listen, learn and evolve Risk Management in the organisation.		
Year 1	**Year 2**	**Year 3**
Risk Management Education and Training Refresh the requirements for Risk Management Training with an organisational Training Needs Analysis.	**Risk Management Education and Training** Implementation of an E-Learning Risk Management Training package, with data reported through the Trust's educational data reporting in line with the Training Needs Analysis.	**Risk Management Education and Training** Achieve sustained ≥90% compliance with E-learning Risk Management Training Package.
Targeted training for specialists Enhanced Deep Dive training for Multi-Disciplinary Governance Professionals to enable cascade of Deep Dive reviews across Trust.	**Targeted training for specialists** Evaluate the additional training for Multi-Disciplinary Governance Professionals from Year 1 and develop new/enhanced training for year 2.	**Targeted training for specialists** Evaluate the additional training for Multi-Disciplinary Governance Professionals from the first two years and develop new/ enhanced training for year 3.
Learning and Evolving Together Roll out of Risk Management Workshops for Divisional and Departmental Leads to listen, learn and improve on how we tackle risk, together.	**Learning and Evolving Together** Refine and improve Risk Management Workshops building on year 1 learning.	**Learning and Evolving Together** Evaluate Risk Management Workshops learning and determine any further staff groups that would benefit from Risk Management Workshops.
Board Development Annual Board Workshop to review the Risk Appetite and Tolerances.	**Board Development** Annual Board Workshop to review the Risk Appetite and Tolerances.	**Board Development** Annual Board Workshop to review the Risk Appetite and Tolerances.

3. IMPROVEMENT	AIM	
The Trust will support continuous and sustainable improvement, with everyone learning to improve Risk Management within the organisation, to reduce risk to patients, staff and stakeholders. **Improvement' work aims to develop and support Risk Management improvement programmes that prioritise the most important issues with risk mitigation, utilising effective improvement methods where this is possible**		
Year 1	**Year 2**	**Year 3**
Risk-based Decisions Creation of a Decision Support Tool to support decision making in line with the Trust Risk Tolerance and Risk Appetite statement.	**Risk-based Decisions** Review learning from year 1 and revise as necessary. Further embed the use of the Decision Support Tool to ensure Risk Appetite and Risk Tolerance is used to support decision making.	**Risk-based Decisions** Review learning from year 1 and 2, and revise as necessary. Further embed the use of the Decision Support Tool to ensure Risk Appetite and Risk Tolerance is used to support decision making.
Improved Triangulation Evolving the Risk Register to ensure that financial cost and impact is documented on each risk.	**Improved Triangulation** Evolving the Risk register to enhance learning from Risk Management and to enable easier triangulation with learning from other Governance processes (.i.e Incident Management, Patient Experience & Patient Advice and Liaison Service (PALS) etc).	**Improved Triangulation** Review the learning from year 1 and 2, and further refine as indicated.
Improved Reporting Evolving and developing more intuitive and informative Risk Management reports to Divisional Improvement Forums, Risk Management Group and Committees of the Board.	**Improved Reporting** Annual review of risk report content and format to ensure the most intuitive and informative reports in place.	**Improved Reporting** Annual review of risk report content and format to ensure the most intuitive and informative reports in place.
Confidential Risks Evolve and embed the confidential risk process to ensure tracking of confidential cultural risks.	**Confidential Risks** Aim to reduce the total confidential risks at the end of year 1 by 10% (amount TBC at end of year 1).	**Confidential Risks** Aim to reduce the total confidential risks at the end of year 2 by a further 10% (amount TBC at end of year 2).
Long-standing Risks Reduce long standing risks (risks active for 5 years or more) by 15% (reduce by 13).	**Long-standing Risks** Reduce long standing risks (risks active for 5 years or more) by a further 15% (reduce by 11).	**Long-standing Risks** Reduce long standing risks (risks active for 5 years or more) by a further 15% (reduce by 10).
Operational High Risks Reduce operational high risks (scoring ≥15) by 15% (reduce by 15).	**Operational High Risks** Reduce operational high risks (scoring ≥15) by a further 15% (reduce by 13).	**Operational High Risks** Reduce operational high risks (scoring ≥15) by a further 15% (reduce by 11).
Defining key programmes of work Implementation of an annual Divisional and Trust-wide Risk Maturity Assessment with documented tracking of each year's outcomes, presented to the Risk Management Group.	**Defining key programmes of work** All Specialities and Divisions to achieve level 4 rating (Risk Managed) of Risk Maturity.	**Defining key programmes of work** All Specialities and Divisions to achieve level 5 rating (Risk Enabled) of Risk Maturity.

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NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

New Hospitals Programme Quarter 3 Board Report

Report to:	Board of Directors	**Date:**	1 February 2024
Report of:	Finance Director / Deputy Chief Executive (LTHTr NHP SRO)	**Prepared by:**	R Malin, Programme Director
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 on the Lancashire and South Cumbria New Hospitals Programme for the Quarter 3 period: October to December 2023.

This quarterly report is presented to the following Boards:

- NHS Lancashire and South Cumbria Integrated Care Board
- Lancashire Teaching Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Blackpool Teaching Hospitals NHS Foundation Trust
- Provider Collaborative

The report includes the progress against plan for October to December 2023, in particular providing an update on work to support site acquisition and the outcome of the Programme governance review.

It is recommended the Board:

- Note the progress undertaken in Quarter 3.
- Note the activities planned for the next period.

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

N/a

NEW HOSPITALS PROGRAMME Q3 BOARD REPORT

1. Introduction

1.1 This report is the 2023/24 Quarter 3 update from the Lancashire and South Cumbria New Hospitals Programme (L&SC NHP).

2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) were included in the Government's Health Infrastructure Plan in 2019 (renamed to New Hospitals Programme [NHP] in 2021). The Lancashire and South Cumbria NHP is part of cohort 4 of the Government's national New Hospital Programme for England.

2.2 The L&SC NHP offers a once-in-a-generation opportunity to develop cutting-edge facilities, offering the absolute best in modern healthcare. The New Hospitals Programme aims to address significant problems with our ageing hospitals in Preston (Royal Preston Hospital) and Lancaster (Royal Lancaster Infirmary). We also need to invest in Furness General Hospital's infrastructure in the context of its strategic importance and geographically remote location. This will provide patients with high-quality, next generation hospital facilities and technologies. Hospital buildings will be designed in a way to meet demand, while remaining flexible and sustainable for future generations. The aim is to support local communities, bringing jobs, skills and contracts to Lancashire and South Cumbria businesses and residents.

2.3 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. Following the May 2023 statement to the House of Commons from the Secretary of State for Health and Social Care, the local NHS was delighted to welcome the announcement of two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital 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.

3 National New Hospital Programme

3.0 **National guidance** – as part of cohort 4 of the national New Hospital Programme, L&SC NHP will be a full adopter of national guidance e.g. Hospital 2.0, an integrated systems approach built on best practice standards and delivery solutions, enabling best-value procurement and Modern Methods of Construction (MMC). The aim of this is to drive an accelerated programme, creating transformative environments that

will benefit patients and the public as a whole. A critical part of this system will be the ability to create prototypes to enable quick learning, collaboration and validation of hospital design, including new greener and safer ways of building. Further guidance regarding Hospital 2.0 is expected in Q4 2023/24 and Q1 2024/25.

3.1 During Quarter 3, the L&SC NHP team have continued to support the national New Hospitals Programme team and worked to inform the new RACI (responsible, accountable, informed and consulted) matrix being developed for all NHP projects. The L&SC NHP team also have supported an early adopter project to test the benefits of intelligent lighting in an operational hospital environment to inform our adoption of Hospital 2.0.

4 Progress against plan (for the period October to December 2023)

4.0 **Governance** - a review was undertaken in December 2023 in response to the programme transitioning from an options appraisal phase to a business case phase for the two separate projects (Royal Preston Hospital and Royal Lancaster Infirmary). The governance review acknowledged the leadership, delivery and governance requirements for the service change / consultation phase and then the capital business case phase needs to recognise the clear statutory accountabilities for the Trusts and Integrated Care Board. The Trust Boards will receive papers in February 2024 seeking approval to establish the new governance and decision-making structures.

4.1 **Potential new sites** – advisors have been appointed to progress work to determine the viability of potential new sites for a new Royal Preston Hospital and Royal Lancaster Infirmary and the L&SC NHP team has developed draft enabling works business cases focused on land acquisition. The Programme is working closely with the national NHP to understand the detailed requirements and assurance to support completion of the business cases. In parallel, the L&SC NHP team continues to consider and assess any further sites put forward against the existing criteria.

4.2 **Public consultation planning** – the L&SC NHP team have worked with the ICB and Trust Communications and Engagement colleagues to start to scope the tasks and resource required for future pre-consultation engagement and public consultations. This includes the overarching approach to consultation, a communications and engagement strategy, and consultation and pre-consultation engagement plans. The timeline for such consultations will ultimately be determined by the critical dependencies of sites and model of care.

5 Public, patient and workforce communications and engagement

5.0 Patient representatives have been working with the Lancashire and South Cumbria NHP clinical workstream. This currently includes representation from people living in Barrow, Chorley, Kendal, Lancaster, Morecambe and Preston. The LSC NHP Clinical workstream met with patient representatives on 29 November 2023 to provide a programme update. The Programme team are looking to recruit additional patient representatives in 2024/25, working with the ICB on an approach to joint recruitment as part of the ICB citizen's reference group, with the intention of recruiting an additional 15 to 20 people.

5.1 The LSC NHP team has attended the following Trust inclusion forums in Quarter 3 of 2023/24:

- LTHTr Living with Disabilities Forum (4 October 2023)
- LTHTr Carers Forum (1 November 2023)
- UHMBT joint forum, including Carers network, BAME (Black, Asian and Minority Ethnic) network, LGBT (Lesbian, Gay, Bisexual and Transgender) network, Women leaders, and the Disability network (7 November 2023).

5.2 The LSC NHP team is in liaison with the ICB Communications and Engagement team regarding primary care involvement and engagement and is in the process of arranging attendance at upcoming sessions. The Programme team met with primary care colleagues in Central and West Lancashire on 22 November 2023, with further sessions scheduled for Quarter 4.

5.3 Interaction with L&SC NHP digital communication channels continues to grow, with focus on driving traffic to the New Hospitals Programme website and providing information via Facebook and Twitter, with a LinkedIn channel launched in August 2023. Social media toolkits continue to be shared with Lancashire and South Cumbria NHS Communications teams on a regular basis, with ongoing sharing of NHP content through partner channels.

5.4 The following new website content was published in Quarter 3:

- Join the national NHS New Hospital Programme Engagement Intensive Care Unit Workshop (10 October 2023)
- Kevin Lavery on the New Hospitals Programme (19 October 2023)
- Join the national NHS New Hospital Programme Engagement Hospital Facilities Workshop (8 November 2023)
- Phil Woodford on the New Hospitals Programme – video (6 November 2023)
- Join the national NHS New Hospital Programme Engagement Car Parks Workshop (20 December 2023).

6 Next period – Q4 2023/24

6.0 **Governance** - the L&SC NHP team and statutory bodies will implement the recommendations of the external governance review and establish the new governance structure once approved by Boards in February 2024.

6.1 **Site due diligence** - the Programme will focus on undertaking the technical due diligence assessments for the potential new sites and in parallel, progress site acquisition. The L&SC NHP team will continue working with the national NHP team to understand the business case process for site acquisition.

6.2 **Model of care –** the Programme will undertake wider engagement on a draft model of care and further discussions will take place with the clinical senate regarding the timing of expert reviews.

7 Conclusion

7.0 This paper is a summary of progress on the Lancashire and South Cumbria New Hospitals Programme throughout Quarter 3 of 2023/24.

8 Recommendations

8.0 The Board is requested to:

- Note the progress undertaken in Quarter 3.
- Note the activities planned for the next period.

Rebecca Malin
Programme Director
January 2024

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Register of Interests

Report to:	Board of Directors	**Date:**	1 February 2024
Report of:	Company Secretary	**Prepared by:**	K Brewin
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

The Board of Directors have a responsibility to declare relevant interests as defined in section 14 of the Trust Constitution. The register (appendix 1) has been updated throughout 2023-24 to include or remove declarations following confirmation of interests by relevant Board members.

The register is published on the Trust's website following periodic updates throughout the year should further interests be declared or changes be notified to the Office of the Company Secretary. The Corporate Affairs Team also ensures that declarations are registered on MES Declare, the tool available on the website for public scrutiny.

The report identifies declarations made by Board members at a point in time and will be incorporated into new ways of working and in line with the NHS England Fit and Proper Person Test framework for Board members published in September 2023. Over the coming months the Board (Non-Executive and Executive Directors) will be required to sign a range of documents which will be completed prior to the start of each financial year.

It is recommended that the Board of Directors:

I. Note the Register of Interests compiled as at 25 January 2024**.**
II. Note their responsibility to notify the Office of the Company Secretary of any changes to their individual interests.

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. **Background**

   All Directors have a responsibility to declare relevant interests as defined in section 14 of the Trust Constitution. A list of interests declared is published on the Trust's website, is included within the MES Declare electronic register, and is also available on request from the Office of the Company Secretary. Information on how to access those details is also included in the Trust's Annual Report.

   The latest information held by the Office of the Company Secretary as at 25 January 2024 is attached as appendix 1.

   The register will be updated periodically throughout the year should any further interests be declared or changes be notified to the Office of the Company Secretary.

2. **Financial implications**

   There are no financial implications in respect of the contents of this report.

3. **Legal implications**

   Failure to declare interests is a breach of the Trust's Code of Conduct and could result in disciplinary action being taken.

4. **Risks**

   There is a risk to the Board undertaking its statutory business and adhering to its governance processes if changes to individual interests are not declared or communicated in a timely manner.

5. **Impact on stakeholders**

   There is no impact on stakeholders in respect of the contents of this report.

6. **Recommendations**

   It is recommended that the Board of Directors:

   I. Note the Register of Interests compiled as at 25 January 2024**.**
   II. Note their responsibility to notify the Office of the Company Secretary of any changes to their individual interests.

Board of Directors: Register of Interests as at 25 January 2024

Lancashire Teaching Hospitals NHS Foundation Trust

Name	Position	Declared Interest
NON-EXECUTIVE DIRECTORS		
Dr Tim Ballard	Non-Executive Director	• Care Quality Commission National Clinical Advisor for General Practice, Independent Primary Care, Digital Health and Environmental Sustainability • GP locum at Slaidburn Country Practice • Chair of the Brabin's Trust • Fellow of the Royal College of General Practitioners
Ms Victoria Crorken	Non-Executive Director	• Director of Lancashire Hospitals Services (LHS) Ltd • Group Head of Risk, Compliance and Security – The Co-op Group Ltd • Vice Chair, Board of Governors – Co-op Academy Leeds • Stepdaughter on 12-month pre-registration placement (pharmacist)
Professor Paul O'Neill	Vice Chair/Non-Executive Director	• Emeritus Professor at University of Manchester • General Medical Council Associate – Medical Education
Ms Kate Smyth	Non-Executive Director	• Lay Leader at the Yorkshire and Humber Patient Safety Translational Research Centre • Member and volunteer at Calderdale and Huddersfield Foundation Trust • Spouse is a Non-Executive Director of East Lancashire Hospitals NHS Trust • Member of the Cabinet Office Disability Unit - North-West Regional Stakeholder Network • Co-chair of the Disabled NHS Directors Network • Member of the ICB People Board
Mr Tim Watkinson	Non-Executive Director/Senior Independent Director	• Independent Member of the UK Statistics Authority's Audit and Risk Assurance Committee
Mr Jim Whitaker	Non-Executive Director	• Director of Lancashire Hospitals Services (LHS) Ltd • Employed by BT Enterprise as Head of Strategic Health Programmes, delivering Digital Healthcare Solutions
Mr Peter White	Chair	• Chair of North West Ambulance Service NHS Trust • Director of Bradley Court Thornley Limited

Mrs Tricia Whiteside	Non-Executive Director	• Daughter working for North-West Ambulance Service • Member of the Integrated Care Board (ICB) Patient Involvement and Engagement Advisory Committee • Member of the Lancashire Constabulary Ethics Advisory Committee
ASSOCIATE NON-EXECUTIVE DIRECTORS (NON-VOTING)		
Mr Uzair Patel	Associate Non-Executive Director	• Natwest Group employee *(with effect from 29 January 2024)* • Trustee of Torus Foundation • Director of Papa Love Mango Limited (non-trading company) • Director of Pehlwani Limited (non-trading company)
Mr Michael Wearden	Associate Non-Executive Director	• Managing Director of Red Rose Recovery Lancashire
Mr Peter Wilson	Associate Non-Executive Director	• No interests to declare
EXECUTIVE DIRECTORS (VOTING BOARD MEMBERS)		
Ms Faith Button	Chief Operating Officer	• No interests to declare
Ms Sarah Cullen	Chief Nursing, Midwifery and Allied Health Professionals Officer	• Son is a member of the Administrative Bank • Sister is Clinical Business Manager in the Women's and Children's Division • Trustee at St Catherine's Hospice
Mr Silas Nicholls	Chief Executive Officer	• Partner is General Counsel at Liverpool University Hospitals Trust • Visiting Professor of the University of Bolton
Dr Geraldine Skailes	Chief Medical Officer	• No interests to declare
Mr Jonathan Wood	Chief Finance Officer/Deputy Chief Executive	• Spouse is Director of Finance for Northwest Ambulance Service NHS Trust • Chair of the Finance Committee at Blackburn Cathedral • Chair of the NHS Supply Chain's Northern Customer Board • University of Central Lancashire Medical School Guest Speaker
CORPORATE DIRECTORS (NON-VOTING BOARD MEMBERS)		
Mrs Ailsa Brotherton	Director of Continuous Improvement	• Daughter is a member of the Medical Bank • Honorary Professorial role at University of Central Lancashire
Mr Imran Devji	Interim Chief Operating Officer	• No interests to declare
Mr Stephen Dobson	Director of Information Management and Technology (CIO)	• Honorary contract with the University of Manchester • Independent Member of the Audit and Ethics Committee for Lancashire Police

Mr Gary Doherty	Director of Strategy and Planning	• Director of Lancashire Hospitals Services (LHS) Limited • Spouse works for NHS England and NHS Improvement
Mrs Naomi Duggan	Director of Communications and Engagement	• Son is Regional Editor North-West at Newsquest
Mrs J Foote MBE	Company Secretary	• No interests to declare
Dr Neil Pease	Chief People Officer	• Director of Dr Neil Pease & Associates