Board of Directors

4 April 2024 | 1.00pm | Lecture Room 1, 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 1 February 2024	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.	Patient Story	1.25pm (10mins: Pres) (10mins: Q&A)	Pres	Assurance	S Cullen
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) Bi-annual Safe Staffing Review for Nursing	2.05pm (10mins: Q&A)	✓	Assurance	S Cullen
11.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
11.1	Education, Training and Research Committee Chair's Report	2.15pm (10mins: Q&A)	✓	Information	P O'Neill
11.2	Workforce Committee Chair's Report	2.25pm (10mins: Q&A)	✓	Information	J Whitaker
11.3	**Report recommended for assurance**: (a) 2023 Staff Survey Report	2.35pm (10mins: Q&A)	✓	Assurance	N Pease
12.	**FIT FOR THE FUTURE** (STRATEGY AND PLANNING)				
12.1	2024-25 Single Improvement Plan	2.45pm (10mins: Q&A)	✓	Decision	S Nicholls
12.2	Clinical Services Strategy	2.55pm (10mins: Q&A)	✓	Assurance	G Doherty
12.3	Green Plan	3.05pm (10mins: Q&A)	✓	Assurance	G Doherty
13.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
13.1	Charitable Funds Committee Chair's Report	3.15pm (10mins: Q&A)	✓	Information	K Smyth

№	Item	Time	Encl.	Purpose	Presenter
13.2	Finance and Performance Committee Chair's Report	3.25pm (10mins: Q&A)	✓	Information	T Whiteside
13.3	Integrated Performance Report as at 29 February 2024 including Finance update – *(considered by appropriate Committees of the Board)*	3.35pm (10mins: Pres) (10mins Q&A)	✓	Assurance	I Devji
14.	**GOVERNANCE AND COMPLIANCE**				
14.1	Appointment of Internal Auditors	3.55pm (5mins: Pres)	✓	Decision	J Foote
14.2	Board Visibility Review 2023-24 and Plan for 2024-25	4.00pm (10mins: Q&A)	✓	Decision	S Cullen
15.	**ITEMS FOR INFORMATION**				
15.1	Data Quality Assurance Report		✓		
15.2	Use of Common Seal		✓		
15.3	2024 Governor Election Report		✓		
15.4	Maternity and Neonatal Services report		✓		
15.5	Date, time and venue of next meeting: *6 June 2024, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital*	4.10pm	Verbal	Information	P White

Board of Directors

1 February 2024 | 1.00pm
Lecture Room 3, 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	P
Dr T Ballard				P	P	P
Ms V Crorken	P	P	P	A	P	A
Professor P O'Neill	P	P	Chair	P	P	P
Ms A Pennell *(until 31 May 2023)*	P					
Ms K Smyth	P	P	P	P	P	P
Mr T Watkinson	P**	P	P	P	P	P
Mr J Whitaker	P	P	A	P	A	P
Mrs T Whiteside	P	P	P	A	P	P
EXECUTIVE DIRECTORS						
Ms F Button Chief Operating Officer *(Interim CEO 1 Oct – 8 January)*	P	P	P	P	P	A
Ms S Cullen Chief Nursing, Midwifery and AHP Officer	P	P	P	P	P	P
Professor N Latham Interim Chief People Officer *(until 30 November 2023)*		P	P	A		
Mr K McGee Chief Executive Officer *(until 30 September 2023)*	P	P	P			
Professor S Nicholls Chief Executive Officer *(from 8 January 2024)*						P
Dr G Skailes Chief Medical Officer	P	P	P	P	P	A
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	P
IN ATTENDANCE						
Mrs K Brewin (minutes) Associate Company Secretary	P	P	P	P	P	P
Mrs A Brotherton Director of Continuous Improvement	P	P**	P	P	A	P
Mr S Canty Divisional Medical Director (Surgery)						D
Mr I Devji Interim Chief Operating Officer				P	P	P
Mr S Dobson Chief Information Officer	A	A	A	P	P	A
Mr G Doherty Director of Strategy and Planning	P	P	A	P	P	P
Mrs N Duggan Director of Communications and Engagement	P	P	P	P	P	P

Mrs J Foote MBE Company Secretary	P	P	P	P	P	P
Dr N Pease Chief People Officer					P	P
ASSOCIATE NON-EXECUTIVE DIRECTORS						
Mr U Patel				P	P	A
Mr M Wearden	A	A	P	P	P	A
Mr P Wilson	A	P	A	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: Dr M France, S Heywood, J Miller, F Robinson, and P Spadlo

Observers in attendance: Martyn Jones

IN ATTENDANCE TO PRESENT THE BOARD ASSURANCE FRAMEWORK (Minute ref 8/24)	
Simon Regan	Associate Director of Risk and Assurance

IN ATTENDANCE TO PRESENT THE STAFF STORY (Minute ref 9/24)	
Dr Lloyd Gemson	Principal Clinical Psychologist
Dr Chris Jefferson	Consultant Clinical Psychologist
Dr Thomas Rozwaha	Principal Clinical Psychologist

IN ATTENDANCE TO PRESENT THE MATERNITY AND NEONATAL SERVICES REPORT (Minute ref 12/24)	
Joanne Lambert	Deputy Divisional Midwifery and Neonatal Nursing Director

1/24 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.

2/24 Apologies for absence

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

3/24 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.

4/24 Minutes of the previous meeting

The minutes of the meeting held on 7 December 2023 were approved as a true and accurate record, subject to amendment to minute 214/23, Safety and Quality Committee Chair's Report in that it was noted that PSIRF had launched on 6 November 2023 (not 2024).

In respect of minute 210/23, Board Assurance Framework, it was observed that whilst risks were being scrutinised by Committees of the Board, the Fit and Proper Person and Specialist Services risks were reviewed directly by the Board not a specific Committee.

5/24 Matters arising and action log

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

6/24 Chair's opening remarks and report

The report provided a summary of work and activities undertaken during December 2023 and January 2024 by the Trust Chair including a resume of the items discussed in the part II Board meeting on 7 December. The following key points were highlighted:

- The Chair welcomed the Chief Executive to his first Board meeting since joining the Trust on 8 January 2024. Congratulations were also extended to the Chief Executive on the recent award of the title Professor of Leadership and Healthcare Management to the Institute of Medicine within the University of Bolton.
- On behalf of the Board, the Chair had recognised and thanked Governor Lynne Lynch at the Council of Governors meeting on 23 January for her nine years' dedicated service to the Trust as a governor.
- The Provider Collaborative was now moving into greater collaborative system transformation therefore work would be undertaken to review governance, engagement, and communication processes to ensure they were fit for purpose.
- Following the agreed six-month review and a recommendation by the Nominations Committee, the Chair expressed his gratitude that the Council of Governors had ratified its original decision on his appointment as Chair for a term of office of three years with effect from 1 August 2023.

7/24 Chief Executive's report

The report provided an overview on matters of interest since the previous meeting.

Having reflected on his first month in the role, the Chief Executive thanked all colleagues in the Trust for the warm welcome. It had been an incredibly busy winter season which had continued throughout January including periods of industrial action. Tribute was paid to the entire workforce who had gone above and beyond to ensure patients were safe and cared for and the continuing pressures both locally and across the wider system were acknowledged.

The Chief Executive had undertaken a range of visits to various areas across both hospital sites and whilst the poor environment within which staff were operating was recognised, it was encouraging to hear the views of staff and see the positive work being delivered under difficult circumstances. It was noted there was a lot of potential within the organisation and it would be important to ensure robust plans were in place to co-ordinate and deliver improvements.

There were some significant risks within the organisation and it was encouraging that the Risk Management Strategy had been revised to include the introduction of a Risk Management Group which would be important in terms of how the Trust conducted and managed its business. One key risk was around urgent and emergency care and the constant pressures at the front door. There had also been occasions when patients had

been boarded on ward areas and the Executive Management team was keen to eradicate that practice at the earliest opportunity and revert to business as usual.

Some improvements had been seen in the Trust's financial position although there remained a significant amount of work to be delivered for the Trust to return to financial sustainability. There was a risk around the in-year position and the Executive Management team had discussed the three-year recovery plan which was being developed to ensure improvements were delivered safely and did not compromise patients or staff.

Finally, the Chief Executive paid tribute to the Chief Operating Officer (Faith Button) who would be leaving the Trust in the coming weeks to take up a new role as Chief Delivery Officer within the Birmingham and Solihull Integrated Care Board (ICB).

A question was raised regarding the funding that had been provided to support the Medical and Surgical Assessment Units and when it was expected those areas would be fully operational. The Chief Finance Officer confirmed that the contractors had commenced on-site and the work should be completed for both areas to be operational in the latter part of the year.

8/24 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 relevant Committees of the Board, apart from the Fit for the Future and specialist services risks which were reviewed by the Board. 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 December Board meeting. Three operational risks remained escalated to the Board relating to exit block (risk ID 25); elective restoration (risk ID 1125); and ongoing strike action (risk ID 1182).

Attention was drawn to the strategic risks to deliver tertiary services which had a risk score of 8, although when looking at broader services, the financial status of the ICS and reconfiguration, it was suggested the risk score should be higher. It was felt there was a need to stand back and look at the overall Board Assurance Framework from time to time to determine whether clear actions had been captured to improve all the risk scores. The Chief Executive advised that from now until the Risk Management Group convened in March 2024 work would be undertaken to look at the high-level risks in the organisation and consider/align them with relevant strategies. There would be focus on the next three years therefore the time was appropriate to refresh the organisation's long-term strategy given the changes in the NHS landscape, the new structure at the ICS, the New Hospitals Programme, and looking ahead to the next 10 years.

Reference was made to the difficult balance to be achieved in respect of the decisions around boarding patients and clarification was requested on when it was expected that boarding would cease. It was explained that having patients boarded was not acceptable from a patient care and experience perspective. Whilst acknowledging that the Trust needed to reduce its spending each month, it was important also to direct resources to ensuring a better patient and staff environment. The Chief Operating Officer, Chief Nursing Officer and Chief Medical Officer had been tasked with developing

the plan to decongest ward areas considering patient safety, staff health and wellbeing, and potential regulatory sanctions. It was anticipated that the operational plan would be introduced in the next six weeks although that would be reliant on a piece of work being undertaken by the Director of Continuous Improvement and colleagues around length of stay. It was explained that a standard operating procedure for boarding patients was in place which involved daily checks from ward managers and matrons with actions to maintain safety. Discussions were also being held with patients and a duty of candour letter had been produced to ensure patients were aware that the Trust would move away from boarding as soon as practicable.

It was further confirmed there were continuing pressures in the system and there were 80 patients not meeting the criteria to reside who were waiting for social care, crisis care, or crisis intervention. There were also patients on the acute frailty pathway not meeting the criteria to reside and work was ongoing to determine additional actions that could be introduced to relieve capacity pressures. There was a need to balance the average number of decisions to admit and remove some to provide headroom for the improvement plan to ensure there was inflow and outflow to allow for sustainability. There was also a need to look at the financial position and manage one-wards-worth of patients in a case management way. Work was being completed to look at an area dedicated to case management for patients fit for discharge and the resources to support that would need to be identified, including the possibility of reintroducing Fell View. A meeting was also planned with social care to see what could be provided to support the Trust in the immediate and longer-term. It was noted a range of patients were going to care homes on trolleys, therefore potentially introducing Avondale for patients not meeting the criteria to reside would create capacity in other areas.

The Chair thanked the Executives for the detailed responses and confirmed that discussions on boarding patients had been undertaken in the appropriate assurance Committees. It was noted that the governors had also raised boarding patients as a concern at the Council meeting on 23 January.

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

9/24 Staff Story: Clinical Health Psychology Service

Board was advised that the previous Chief Executive had invited members of the Clinical Psychology team to attend a future Board meeting to outline the invaluable services provided to both patients and staff. The Chief People Officer introduced the item noting the psychology service was well-established and far-reaching and whilst the service was predominantly for patients there was also a staff offering.

Drs Clare Jefferson, Lloyd Gemson, and Thomas Tozwaha joined the meeting and shared a slide presentation entitled *'Our Role in Supporting Multidisciplinary Teams (MDTs) and Enhancing Patient Care'*. The presentation outlined the services provided, including a range of case studies, examples of patient and colleague feedback about the service provided, and an overview of planned service developments. An example was provided of the work the team had undertaken to help a young man with mental health issues to overcome a fear of needles and injections which allowed him to benefit from a lifesaving organ transplant that may otherwise have been impossible for him, given the intervention involved. It was explained that many people suffered from 'white coat syndrome' although for some patients with mental health needs, learning difficulties, and

autism hospitals could present a particularly hostile environment. Helping those patients to overcome such feats assisted with reducing health inequalities for the most vulnerable patients. The Clinical Psychology team also helped and supported colleagues with their own resilience which, given the ongoing pressures, was a critical support for staff.

The Board recognised the importance of the clinical health psychology service, recalling a previous patient story to the Board from a patient who had experienced significant trauma and the value the patient had placed on the psychological support they had received which had aided their recovery.

In terms of supporting colleagues within the Trust, reference was made to mental health illness which was a core reason for sickness absence and clarification was requested on whether the team had identified any themes that could be shared with the Board. It was explained that the team did recognise burnout from a caring workforce and the fast pace of roles, meaning staff would deal with successive distressing issues with no time to reflect or take learning opportunities.

Discussion was held regarding the ambition for the team to grow their services. Board members recognised the value the team provided to a range of patients and specialties, particularly major trauma. In response to a suggestion that links be developed with other clinical specialties, the team welcomed the suggestion as they were attempting to embed psychology across the organisation.

The Chair referred to the Trust's financial situation and the ambition to grow the service and asked whether key performance indicators (KPIs) were used to evidence the positive impact of the service, which would help to inform decisions around progressing the service in the future. It was confirmed that the team was currently working with the finance team as it was recognised that the value of the service needed to be demonstrated. In terms of developing KPIs and any supporting business information, the team confirmed they would value details of who to contact for a discussion in this regard.

The Chair thanked the team for attending the meeting and delivering the presentation, recognising the important work that was being undertaken. Information would be provided to the team on the most appropriate contact to progress on developing KPIs and supporting business information.

10/24 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee meetings on 24 November 2023 and 5 January 2024 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- The positive forecast position relating to compliance with the 10 safety action standards in the Clinical Negligence Scheme for Trusts year-five maternity incentive scheme.
- Assurance received in relation to perinatal mortality data quality.
- Implementation of the Patient Safety Incident Response Framework (PSIRF) in line with the organisational plan.
- Compliance with the complaints response rate in line with Trust policy.

- Improvements to the patient safety repositioning documentation and the ongoing work on the pressure ulcer reduction plan.
- Sustained improvement to the fluid balance and vital signs compliance.
- Discussion on the additional data requested by the Committee in relation to boarded patient occupancy across inpatient areas, length of stay and care provision. It was noted that assurance had been provided that eradicating boarding patients was a key priority for the Executive team.

Reference was made to the major incident declared in December regarding an outbreak of measles and a query was raised regarding whether information had been presented to the Safety and Quality Committee. It was confirmed that the team was working through the plans around the measles outbreak and once finalised they would be presented to the Committee.

11/24 Health and Safety Annual update

The report provided an overview of the management of health and safety at the Trust during 2022-23 in line with legislative requirements as overseen by the Health and Safety Governance Group. In addition, the report summarised the prevailing legislative framework within which health and safety concerns were managed and outlined and addressed the local governance arrangements underpinning health and safety management within the organisation. It was noted that whilst a range of assurances could 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 were evident. To address those challenges the health and safety teams (corporately and within estates and facilities) were working collaboratively to revisit the health and safety governance arrangements to ensure ongoing compliance with all relevant legislation within the current financial envelope. The report had been scrutinised by the Safety and Quality Committee and an overview of key points was presented for information.

Board members recognised the challenges with the ageing estate although agreed there were actions within the Trust's control that could be delivered. Reference was made to the increase in the number of people coming to harm through manual handling practices and the increase in sharps injuries. It was confirmed that discipline around training and awareness would need to be strengthened in both cases. It was noted that whilst the Waste Management team had directed focus to sharps injuries, the issue appeared to relate to staff not following policy. It was agreed the Executive team would reinforce with managers the importance of ensuring staff followed agreed policies and procedures.

A question was raised regarding the current restraints with the ageing estate and finances and the balance between having to accept a certain position or whether further mitigations could be introduced whilst waiting for the new hospital. It was agreed that an analysis of the position would be undertaken and information included in the next update report to the Board in six months' time. A suggestion was made regarding further improvements being driven by the STAR framework and the Chief Nursing Officer agreed to review the elements contained within STAR to see whether anything further could be included as a measure for improvement. As the new hospital build was a number of years away then a detailed piece of work would be undertaken on how the planning programme was better aligned to allow triangulation of higher risk areas.

The Board RESOLVED that:

- **it was assured of the actions being taken to reduce the risks associated with health and safety despite the various challenges.**
- **the further update at the Board meeting on 1 August 2024 on assurance on the areas that required further improvement be supported.**

12/24 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 December 2023. The Deputy Divisional Nursing and Midwifery Director joined the meeting and provided an overview of the contents including other high level service updates. Reference was also made to the presentation of evidence to the Safety and Quality Committee in January 2024 relating to the CNST Validation (Year 5) position. It was noted the final Local Maternity and Neonatal System validation and assurance visit took place on 3 January 2024 following which it was confirmed that the evidence provided by the service had met the standards required for compliance for all 10 safety actions. It was therefore recommended that the Board instruct the Chief Executive to declare compliance with the 10 CNST safety action standards and sign the declaration to allow the report to be submitted by 1 February 2024.

Reference was made to the Birthrate plus safe staffing uplift and clarification was requested on whether the Trust had been unable to recruit or whether the establishment was not what it should be due to financial constraints. In addition, clarification was requested on the actions being taken to ensure any risks that arose due to staffing challenges were managed/mitigated outside of requests for mutual aid or deflection to other organisations. In relation to the Birthrate plus staffing calculation, the national picture for funding midwives meant that there were insufficient numbers to recruit, both nationally and regionally, and work was being undertaken with local Universities to attempt to improve the position. Birthrate plus showed there was a need for a further number of midwives in addition to the current 16.07 wte vacancies to ensure a sustainable model, and consideration would be needed on how the service was staffed to the recommended establishment. With regard to managing and mitigating risks, there were safety huddles held in the unit twice per day, overseen by the matron, to look at issues such as acuity and staffing levels, and resources would be redeployed as required. The team monitored safety metrics on a daily and monthly basis. Support had also been provided by the Board for recruitment of midwives from bank and agency therefore some of the risks were being mitigated through the use of agency midwives. In relation to mutual aid or deflection to other organisations, such considerations were undertaken through a measured approach with safety at the forefront and sensitivity to the needs and considerations of the mother.

A question was asked regarding to what extent the team was able to secure agency midwives and the risk associated with that. The Board was advised that the maternity service used regular agency workers and had key professionals returning to the service to provide the required support meaning the agency worker was known to the service and had worked at the Trust previously. The service reported agency fill rates on a monthly basis and 50% of shifts placed with agencies were filled. There was close monitoring of agency workers who were supported during their period of work at the Trust and avoidance of moving the agency worker from their preferred work area to mitigate against the lack of familiarisation of an area, service, and processes. Discussion was also held regarding where regular agency staff were returning to take up

shifts, whether there was potential for them to consider a substantive post. It was explained that the team did explore permanent employment with agency workers, however, some people preferred the flexibility of agency work therefore there had been limited turnaround of people wanting to join the team on a permanent basis.

Board members recognised a range of positive information in the report. Reference was made to some concerns raised by governors at the Council meeting on 23 January and it was pleasing to note positive improvements had been made on the points that had been raised. The maternity team was commended on having been accepted to undertake the NHS Race and Health Observatory partnered with the Institute for Healthcare Improvement and the Health Foundation, a learning in action network aiming to tackle and close the gap seen in maternal mortality and morbidity between women from different ethnic backgrounds.

The Chair asked that the Board's appreciation be passed to the maternity and neonatal services teams and confirmed that assurance had been taken from the report and the supplementary information provided during the discussion.

The Board RESOLVED that:

1. **the safe staffing position within maternity services and the maternity and neonatal improvement plan and associated action plans provided assurance.**
2. **The CNST update and validation report (year 5) circulated to all Board members prior to the meeting be approved and the Chief Executive be instructed to sign the declaration for the report to be submitted by 1 February 2024.**

13/24 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee meeting on 12 December 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 Committee Chair referred to the discussion on the Education and Training Strategy and the need to ensure education, training and research were woven into the overall strategy for the Trust. There were opportunities for the Trust to be a beacon for the ICS and further opportunities in the plans for the new hospital build. The views were supported by the Chief Executive who communicated the ambition for the Trust to work to achieve University hospital status, emphasising the importance of training and recruiting doctors in the future.

14/24 Workforce Committee Chair's report

The Chair's report from the Workforce Committee meeting on 9 January 2024 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 workforce and organisational development performance report. It was noted that sickness absence rates had increased during the reporting period and violence and aggression continued to be an area of focus for the Committee.

- There had been a reduction in agency usage as more international nurses were starting to work independently.
- A presentation on actions and potential opportunities to improve efficiency.
- The Committee recognised the One LSC collaborative programme would be a significant change and felt communications could be improved to reduce staff anxieties.
- Review of the workforce social and corporate responsibility update and progress during the last year.
- Early insights from the 2023 national Staff Survey results which were currently embargoed. Once the results had been published then a report and action plan would be presented to the Board.

Reference was made to the potential opportunities to improve efficiency and it was suggested the work be extended to include productivity. It was proposed that a conversation was required by the Board in the future on how the Trust was bearing down on efficiency and productivity through the work being undertaken by the Continuous Improvement team.

15/24 Gender Pay Gap report 2023

The report presented the findings and recommended actions based on the Gender Pay Gap report for 2023. It was noted the gender pay gap for the Trust was below the threshold for immediate action as specified by the Equality and Human Rights Commission, and therefore should be regularly monitored. The report detailed the findings analysis and subsequent proposed actions and an overview of the report was provided for information.

Discussion was held regarding the mean bonus differential between male and female gender and queries were raised regarding the large difference which had grown since the previous year. It was explained that the differential related to the substantive Consultant body and there had been changes in how Clinical Excellence Awards were allocated. Historically, the Trust received funding and invited applications from the Consultant body following which a panel would determine how the funds would be awarded against set criteria as a special recognition payment. Since the onset of the Covid pandemic, the Trust distributed the funding allocation across the entire Consultant body as it was felt that was the most fair and equitable approach, although that action had skewed the position with a small amount of money set against such a large organisation. It was agreed that the Chief People Officer would undertake a deep dive into the bonus differential and report the findings through the Workforce Committee.

The Chair recognised the Trust needed to report against a national framework in respect of the gender pay gap. However, if there was a fundamental issue in relation to progression of females and minority staff, then it would be important to develop an improvement plan. It was confirmed that whilst the Trust was legislated to produce the gender pay gap data, more could be done to demonstrate a positive impact to close the gender pay gaps.

The Board RESOLVED that the report be approved for publishing on the Trust website by 30 March 2024.

16/24 Equality, Diversity and Inclusion Annual Report 2023-24

The report provided an annual update against the principles and aims of the Equality, Diversity and Inclusion (EDI) Strategy 2021-24 which formed part of public sector duties as set out in the Public Sector Equality Duty and the Equality Act (2010). The report detailed the actions which had been completed in the last 12 months against the five principles set out in the strategy for communities, patients, and colleagues, along with highlighting achievements during the year.

The Board commended the work that was being undertaken around EDI and the importance of ensuring the whole depth and breadth of communities had been captured. It was confirmed that the Executive Management team had recently discussed their objectives on EDI and the question would also be taken into the next round of the EDI strategy review. It was also confirmed that all Board Directors (Executive and Non-Executive) would have an EDI specific appraisal objective for 2024/25.

Reference was also made to the positive steps that had been taken on a joint patient and staff strategy. However, this could be strengthened in the next iteration of the strategy, including staff and patient representation for matters such as learning disabilities and autism.

The Board RESOLVED the report for external publication be approved.

17/24 Charitable Funds Committee Chair's report

The Chair's report from the Charitable Funds Committee meeting on 19 December 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:

- Receipt of the regular update reports on the Rosemere and Lancashire Hospitals' charities including the Baby Beat Appeal and the significant funds raised as at the year-to-date.
- Approval of proposals for a video telemetry application and alternatives to tap-to-donate facilities from the Lancashire Hospitals' charity.
- Approval of funding applications from the Rosemere charity.
- Receipt of the financial update including spending plans and balances.

The Board acknowledged the immense support for the charities and the generosity of the community particularly during such a pressured economic climate. The need to ensure people were aware of the charitable funding available and how to make application for funds was also emphasised and this was part of the Trust's communications plan.

18/24 Finance and Performance Committee Chair's report

The Chair's reports from the Finance and Performance Committee meeting on 28 November and 18 December 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:

- In months 8 and 9 there had been a deterioration in the forecast financial performance although actions were in place to recover the trajectory.
- A discussion on the new methodology adopted by the Trust on drivers of deficit. Assurance was provided on the value-based improvement approach (a systematic view of all services and how clinical and financial performance of those services was ensured, using Model Hospital and GIRFT data, to drive areas and opportunities for improvement).
- Further assurance was provided on the winter plan at the December meeting.
- The planning framework was evolving with significant focus on the transformation agenda both internal and external recognising the need to have the appropriate governance construct in place and that the Trust's controls' structure was appropriate and robust.
- The Committee looked at flow and scrutinised the plans and approach from the front to the back of the pathway.

A question was raised regarding the new OPEL framework and whether it had become a distraction. The Board was advised that the Trust was using the new national OPEL framework alongside the Trust's local framework when responding to escalation. It was noted that during the last week, it had been identified that the national OPEL framework was consistent with the Trust's internal processes therefore no real difference had been seen in practice.

19/24 Integrated Performance Report as of 31 December 2023

The integrated performance report as of 31 December 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.

(a) ***Consistently Deliver Excellent Care*** – ambulance handover continued to be an area of focus to ensure release of ambulance crews as soon as possible and work was ongoing on the wider urgent and emergency care improvement programme of which ambulance handover formed a part. Particular challenges were being faced around patients not meeting the criteria to reside and plans had been developed to manage the position. The Trust continued to work around elective care and cancer treatment. In terms of cancer, a point had been reached where sustainability would be essential particularly in terms of colorectal, urology and skin cancer tumour groups. Signs of improvement had been seen on the colorectal cancer pathway and at the next Board meeting it was expected to have a drill down on those metrics within the report.

With regard to safety and quality issues, pressure ulcers remained a priority area of work within the Always Safety-First Strategy. C.*difficile* continued with elevated levels which was consistent with an increase across the northwest. There had been a decrease of C.*difficile* infection on the previous month however it was too early to confirm whether the improvement would be sustained. Enhanced Executive oversight meetings were taking place given the increased risk and the Board considered the Infection Prevention and Control BAF issued by NHS England at the December Board meeting.

Reference was made to haematological cancer and whilst the number of patients waiting for treatment was small (4 patients) all were waiting more than 62-days and

clarification was requested on the plans to improve the position. It was explained that looking at the pathways for haematological cancer the patients were usually those with complex conditions requiring inter-specialty input and all cases were being managed appropriately. Capacity issues across the system were being looked at and the position was not unique to the Trust as haematology had been identified as one of four fragile services across Lancashire and South Cumbria therefore work was being completed as a system. The Interim Chief Operating Officer agreed to look at the impact of the delay on the patients and during the coming weeks work would be completed to understand what could be introduced to reach a sustainable position. A report on the outcome of the work would be presented to the Safety and Quality Committee.

Attention was drawn to the two graphs on pages 2 and 7 relating to all services 4-hour trajectory and DM01 6-week improvement trajectory for diagnostics and clarification was requested on whether the plans were realistic to achieve the March targets. In terms of the DM01 data, it was confirmed that the key constraint was sonography and an element was linked to colorectal capacity. Originally, support had been committed by an external provider (Remedy) who were scheduled to commence in November although the timeline had slipped. The ICB introduced controls had caused further delays. In addition, non-obstetric ultrasound was a cause for concern. The Endoscopy team had been asked to review the end position for March 2024. whilst recognising the scale of remedial work required. Reference was made to a deep dive on cancer tumour groups which had been undertaken around October 2023 and covered a range of the points highlighted during the discussion and a further update could be provided at a forthcoming Finance and Performance Committee meeting.

(b) ***Great Place to Work*** – the work undertaken in the Big Room on violence and aggression prevention had helped to reduce the number of incidences. Vacancy pause controls had been introduced which had been driven by the equality quality impact assessment approach to ensure risks were mitigated and managed which was particularly important in terms of safe staffing when posts were not approved.

(c) ***Deliver Value for Money*** – the Trust was reporting a month 9 deficit position for 2023-24 of £37m against a £17.6 deficit plan with the £19.4m variance attributable, in the main, to the system support gap and under-delivery of the Cost Improvement Plan. There were a range of operational financial pressures associated with industrial action and double running of international nurses. An overview was provided of the capital and cash positions, cost improvement programme, and use of resources as outlined in the report. Once the forecast position as at month 10 was known work would be undertaken to look at whether efficiency schemes could be brought forward to mitigate the position by year end. It was acknowledged the bed reduction plan would not materialise during 2023-24 therefore a clear plan would be needed to escalate other schemes where possible. It was acknowledged that the Trust needed to be responsive to the needs of its services and understand how the bed base was optimised.

The Chair emphasised the need for the Non-Executive Directors to be confident that the data presented was clear on whether the cited position was an ambition or was achievable. There was a need for the Board to receive assurance that targets were being achieved and were within the gift of the Trust to deliver.

As a general point, the Chair confirmed that the style and structure of the Board Assurance Framework and the Integrated Performance Report needed to be reviewed for ease of reading and clarity of understanding.

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

20/24 New Hospitals Programme – Governance and Assurance

As reported at the December Board meeting, the Trust was entering a new phase of the New Hospitals Programme (NHP) as part of the cohort 4 projects. Responsibilities for the delivery of the final business case would now shift towards the Trust and its Board. Whilst the ICB, as a commissioner and a strategic lead, would still have an important role in the programme, new governance models and assurance frameworks would need to be developed to support the programme in its next stage (minute 233/23 refers). The report presented to Board detailed proposals for the establishment of a new Committee of the Board with the oversight remit of the NHP, as it related specifically to the Trust as a statutory body and the associated Scheme of Reservation and Delegation (SoRD).

It was noted that, whilst the programme represented a significant shift for the delivery of services by the organisation it was not within the defined term of significant transaction for the purpose of the Constitution. However, Council would be engaged as the business case was developed and the NHP itself would continue with its public engagement and consultation remit.

Reference was made to quoracy and whether there was sufficient representation for the magnitude of the project. Additionally, with regard to clinical building blocks and the decision and design brief, it was felt that element should be held in totality by the Trust and should be clarified in the document. A request was also made to ensure education, training and research were clearly articulated in the document. It was agreed that quoracy would be amended to include two Non-Executive Directors and two Executive Directors. It was acknowledged that reporting arrangements would need to align for both organisations (Lancashire Teaching Hospitals and University Hospitals of Morecambe Bay) to ensure a consistent approach and reporting to both Boards and the national NHP team at the same time. With regard to the design brief, it was noted there would be several players in that space and it would be important that the Trust voice was heard.

During discussion on quoracy and membership it was confirmed that the University Hospitals of Morecambe Bay had specifically included their Trust Chair on the NHS Assurance Committee. Therefore, it was agreed that the Non-Executive Directors would be Mr P White (acting as Committee Chair), Professor P O'Neill and Mrs T Whiteside, and the terms of reference would be amended accordingly.

The Board RESOLVED that the establishment of a new Committee of the Board for the oversight of the New Hospital Programme and the Terms of Reference and Scheme of Reservation and Delegation be approved.

21/24 Items for information

The following reports were received and noted for information:

(a) Risk Management Strategy
(b) New Hospitals Programme Q3 report
(c) Register of Interests

22/24 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 4 April 2024 at 1.00pm in Lecture Room 3, Education Centre 1, Royal Preston Hospital.

Signed: ________________________________
Chair

Date: ________________________________

Action log: Board of Directors (part I) – 1 February 2024

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update

COMPLETED ACTIONS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	9/24	1 Feb 2024	*Clinical Health Psychology Service* – information to be provided to the psychology team on the appropriate contacts within the Trust to progress developing service KPIs and supporting business information.	Interim Chief Operating Officer	4 Apr 2024	**Completed** **Update for 4th April 2024** - Offer of KPI support provided. Awaiting service lead to confirm what data and KPI is required.
2.	14/24	1 Feb 2024	*Workforce Efficiency and Productivity* – a Board discussion to be scheduled at a future date on how the Trust was focused on efficiency and productivity through the work being undertaken by the Continuous Improvement team.	Director of Continuous Improvement	To be confirmed	**Completed** **Update for 4th April 2024** - This will be incorporated into a future board development session for discussion. In the interim, The Trust has signed up to test EVO, a new programme which is focused on calculating the financial benefit of its improvement work, which will start in April 2024. The CI team is also supporting the work to improve efficiency and productivity through both the improvement programmes and transformation programmes. This work will align to the Single Improvement Plan in 2024/25.
3.	8/24	1 Feb 2024	*Board Assurance Framework* – the tertiary services risk to be reviewed to ensure the actions and mitigations were sufficient and the risk score was correct.	Director of Strategy/ Chief Medical Officer	4 April 2024	**Completed** **Update for 4 April 2024 -** The Chief Medical Officer and Director of Strategy and Planning have reviewed the Risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services, and proposed the risk remains focused on the commissioning of specialist services rather than delivery as was the Trust's original aim

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
						when developed. The strategic risk to the delivery of the Trust's Strategic Objective to Consistently Deliver Excellent Care reflects the fragile services that exist within specialist and local specialties and includes the ICS work underway to address this.
4.	11/24	1 Feb 2024	*Health and Safety Annual Report* – work to be undertaken on how the planning programme was better aligned to allow triangulation of higher risk areas.	Director of Strategy	To be confirmed	**Closed** **Update for 4 April 2024** - The newly formed Risk Committee will allow us to undertake the triangulation more effectively.
5.	4/24	1 Feb 2024	*Minutes of the previous meeting* – amendment to minute 214/23 to confirm that PSIRF had launched on 6 November 2023 (not 2024).	Associate Company Secretary	4 Apr 2024	**Completed** **Update for 4 April 2024** – minutes amended and filed on 2 February 2024.
6.	8/24	1 Feb 2024	*Board Assurance Framework*: (a) Review of the BAF contents to be undertaken in line with the work being completed on the Trust's overall strategy. (b) Review the structure and style of the report.	Associate Director of Risk and Assurance	To be confirmed	**Closed** **Update for 4 April 2024** – picked up as part of the risk review work being undertaken.
7.	11/24	1 Feb 2024	*Health and Safety Annual Report*: (a) Reinforce with managers the importance of ensuring staff followed agreed policies and procedures, particularly around sharps injuries. (b) Analysis to be undertaken to determine any further mitigations that could be introduced for the ageing estate with the outcome being reported to the Board in the next update report. (c) A review of the STAR framework to be undertaken to determine whether any further checks could be added as health and safety improvement measures.	Executive Directors Chief Nursing Officer Chief Nursing Officer	4 Apr 2024 1 Aug 2024 1 Apr 2024	**Completed** **Update for 4 April 2024**: (a) Included in the Monday Message on 4 February. STAR framework to be reviewed to include any items that are reflected as areas that require improvement within the health and safety portfolio. (b) To be completed as part of the risk review and focused attention through the Risk Management Group due to commence March 2024. (c) To be completed as part of the STAR review process that will be taking place in 2024/25.
8.	15/24	1 Feb 2024	*Gender Pay Gap Report 2023* – deep dive to be undertaken into the bonus differential with a report on	Chief People Officer	Referred to Workforce	**Closed** **Update for 4 April 2024** – referred to the

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
			the findings being presented through the Workforce Committee.		Committee	Committee for a deep dive.
9.	19/24	1 Feb 2024	*Integrated Performance Report – Consistently Deliver Excellent Care* – review to be undertaken on the impact of the current delay for haematological cancer patients and what could be introduced to reach a sustainable position. Outcome of the review to be presented to the Safety and Quality Committee.	Interim Chief Operating Officer	Referred to Safety and Quality Committee	**Completed** **Update for 4 April 2024**: Haematology is one of the top four fragile services identified across Lancashire and South Cumbria ICS provided by Blackpool Teaching Hospitals NHS Foundation Trust. This programme of work is led by the Provider Collaborative Board's Clinical Programme Board. Lancashire Teaching Hospitals has a small volume of patients referred for ongoing care such as Radiotherapy. This cohort of patients are often complex and referred close to or over the 62-day pathway from Blackpool resulting in the small number within the Trust (4 patients currently) breaching the standard. The Chief Operating Officer at Blackpool is the lead for Haematology services with support from all the acute organisations and in this case, the cancer alliance ensuring he safe and timely management of pathways. All cancer pathway patients exceeding the 104-days have a Root Cause Analysis with clinical review of potential harm due to delays. The findings are shared as part of the cancer alliance to ensure learning and improvement of pathways. The Trust continues to be a part of this arrangement and an active partner towards improving the haematology pathway with Blackpool as the lead provider.
10.	19/24	1 Feb 2024	*Integrated Performance Report – Consistently Deliver Excellent Care* – an update to be provided to the Finance and Performance Committee on the deep	Interim Chief Operating Officer	Referred to Finance and Performance	**Closed** **Update for 4 April 2024** – referred to the Committee for an update on the previous deep

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
			dive undertaken around October 2023 on all cancer tumour groups.		Committee	dive.
11.	19/24	1 Feb 2024	*Integrated Performance Report* – the style and structure of the report to be reviewed for ease of reading and understanding.	Interim Chief Operating Officer	To be confirmed	**Closed** **Update for 4 April 2024** – picked up by the appropriate team. The Operational performance section has been reviewed in the interim period. The overall review including data alignment with the single improvement plan will be scheduled for Q1 2024/25.
12.	20/24	1 Feb 2024	*New Hospitals Programme: Governance and Assurance* – terms of reference to be amended to identify the Trust Chair as Committee Chair, with two Non-Executive Directors and two Executive Directors as members of the Committee.	Company Secretary	4 Apr 2024	**Completed** **Update for 4 April 2024** – terms of reference updated on 1 February 2024. Diary invites for the quarterly meetings issued.

Trust Headquarters

Board of Directors Report

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System Collaborative Business Manager</td></tr>
<tr><td>Part I</td><td colspan="2">✓</td><td>Part II</td><td colspan="2"></td></tr>
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<tr><td>For assurance</td><td>☐</td><td>For decision</td><td>☐</td><td>For information</td><td>☒</td></tr>
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<tr><td colspan="6">The purpose of this report is to provide a summary of work and activities undertaken during February and March by the Trust Chair.

It is recommended that the Board receives the report and notes the contents for information.</td></tr>
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<tr><td>To provide outstanding and sustainable healthcare to our local communities</td><td>☒</td><td colspan="3">Consistently Deliver Excellent Care</td><td>☒</td></tr>
<tr><td>To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria</td><td>☒</td><td colspan="3">Great Place To Work</td><td>☒</td></tr>
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<tr><td colspan="6">None</td></tr>
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Chair's Report

1. Introduction

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

Departmental Visits
Following a powerful and emotional presentation by the Bereavement and Tissue Donation team in December, I was able to personally visit the department and meeting the wider team and see the hard work and challenges that are taking place in the organisation. I have also had the chance to visit our Elective Surgical Hub and the Lancashire Eye Centre at Chorley Hospital with Lisa McKenna who kindly took time out of her day to show me the fantastic departments.

I shall be undertaking further walkabout sessions this year across the organisation and look forward to seeing the ongoing work that is taking place to improve that care and support that we give to our patients and their families.

Council of Governor Elections
The elections to the vacancies on the Council of Governors closed on 21 March and I am very pleased to report that all twelve positions have been filled. The details of the successful candidates are set out in the report on the election later on this agenda. Welcome to our new governors who will attend their first Council meeting in April. Sean Barnes and Piotr Spadlo were current governors who were unsuccessful in being re-elected for a further term of office. In addition Paul Wharton-Hardman has recently submitted his resignation as a governor. I would like to recognise the hard work and commitment given by all three governors during their tenure and wish them well for the future.

Provider Collaborative
Discussions are ongoing around the governance, engagement and communication processes as the collaborative develops. Our CEO is supporting this work given his previous expertise around collaborative working. Specific subjects that are being discussed relate to the move towards joint central services and the potential for clinical and pathology collaboration.

Non-Executive Director Appraisals
I have commenced the appraisal process with Non-Executive colleagues throughout March and April; once completed the outcome of these will be reported to Nominations Committee in April and confirmed at the meeting of Council shortly afterwards before being reported through to NHSE.

New Hospital Programme
The first of the new governance process meetings has taken place as we enter a different phase for the planning of our new hospital.

Part II Board of Directors' meetings – February 2024

The items discussed at the February part II Board meeting are outlined below along with a brief resume of the discussions. The Board also held a Special part II meeting in February and the items discussed have also been summarised below.

1 February 2024:

1. **Electronic Patient Record (EPR) Procurement** – the Board was assured on the current situation regarding system procurement of an EPR in Lancashire and South Cumbria and approved proposals on the way forward.
2. **ONE LSC Briefing** – an update was provided on the creation of ONE LSC and the Board held a detailed discussion regarding governance arrangements and the planning process.
3. **Single Improvement Plan (SIP)** – the Board received a presentation on the approach the Trust proposed to adopt for its journey to transition to an improved National Operating Framework rating through development of a SIP. The Board supported the plan and the direction of travel.
4. **Financial Recovery Plan (FRP)** – the Board received the draft FRP detailing the key financial challenges faced by the Trust, details of the underlying financial gap, and the three-year financial plan projections.
5. **Contract Award** – the Board received a recommendation and approved the annual renewal of a contract award for 2024/25.
6. **2023/24 Financial Forecast** – assurance was provided on the Trust's full-year 2023/24 financial improvement plan and risk adjusted financial forecast for the year.
7. **Value Circle Review** – the Board endorsed the proposal to convene a Task and Finish Group to form an action plan on the recommendations contained in the recent governance review report.
8. **Confidential Risk Report** – the Board received an update on the confidential risk process implemented by the Trust and was assured that there was an effective and comprehensive process in place.
9. **Ward 8 Report** – the Board received the report presented to the Safety and Quality Committee, for information.
10. **Minutes of meetings** – the Board received copies of relevant approved minutes from meetings of Committees of the Board.

27 February 2024:

1. **Tendering for services** – the Board endorsed an options appraisal and the proposed approach to a tender.
2. **North West Regional Support Group** – the Board considered a letter received from the NHSE Regional Team.
3. **New Hospitals Programme (NHP)** – the Board received a briefing on progress with land acquisition.

2. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during February and March 2024.

Date	Activity
February 2024	
1st February	Board of Directors
6th February	1:1 Chief Executive
6th February	1:1 Chair, ICB
6th February	Departmental Visit – Bereavement and Donation Team
6th February	Health Inequalities Meeting
8th February	1:1 Company Secretary
8th February	Corporate Governance Review Committee
8th February	1:1 Lead Governor
8th February	1:1 Chair, LSCFT
13th February	1:1 Chief Executive
13th February	Provider Chairs Discussion
15th February	Provider Chair Meeting
15th February	Provider Collaboration Board
15th February	1:1 Chief People Officer
15th February	1:1 Chief Executive, ICB
20th February	1:1 Chief Executive
20th February	System Recovery and Transformation Board
21st February	Departmental Visit – Elective Surgical Hub and Lancashire Eye Centre
22nd February	Board Visibility Session
27th February	1:1 Chair, LSC Provider Collaborative
27th February	Board Agenda Setting
27th February	Non-Executive Monthly Catch Up
27th February	Board Workshop
27th February	Board Meeting – Part 2
29th February	1:1 Company Secretary
29th February	One LSC mtg
29th February	New Hospitals Programme – Partnership Forum
March 2024	
1st March	1:1 Chief Executive
14th March	Provider Collaboration Board
15th March	Joint Council and Board Development Session
20th March	Non-Executive Director – Appraisals
20th March	1:1 Chair, LSC Provider Collaborative
21st March	Consultant Interview Panel

21st March	Appointments, Remuneration and Terms of Employment Committee (ARTE)
21st March	1:1 Chief Executive
22nd March	Non-Executive Director – Appraisals
25th March	COO Shortlisting Panel
25th March	Chairs, Deputy Chairs and Lead Governor Meeting
26th March	Non-Executive Director – Appraisals
26th March	1:1 Interim Chair, ICB
26th March	1:1 Executive Medical Director
26th March	Non-Executive Director – Appraisals
28th March	Non-Executive Director - Appraisals

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.

Board of Directors Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	4 April 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

As we enter a new financial year, I would like to begin by acknowledging the exceptionally hard work and achievements of colleagues across our hospitals under what have been very challenging circumstances. Despite a year filled with prolonged and ongoing Industrial Action, an ageing estate, ever increasing demand for our services, a large historic financial deficit and the high levels of waiting lists that many major tertiary centres carry post pandemic, we have, amongst many other achievements: delivered unprecedented levels of financial savings; implemented innovative award winning services; improved staff survey scores; gained accreditation status for our Surgical Hub at Chorley and continued to make huge inroads into reducing our waiting lists for elective procedures and for cancer treatment. I am impressed by and proud of all that colleagues have achieved and am looking forward to working with them in the year ahead.

I'd like to say we are entering a less pressured period, however Trusts across Lancashire and South Cumbria, and the wider NHS, continue to experience extremely high demand for our services. This has resulted in long waiting times for some of our patients accessing Urgent and Emergency Care as well as the boarding of patients on our wards. We are grateful for the patience and understanding from our communities who are incredibly supportive and to our colleagues who are adaptable, resourceful, and resilient – both deserve better. We apologise to all those who have experienced over-crowding and we continue to work with our partners to improve this situation for our colleagues, patients, and their families.

There have been positive signs in our improvement work, with the recently formed Admission Avoidance Therapy Team helping to ease pressure across departments as well as providing better care for our patients. Initially a five-day therapy service, this increased to a seven-day service between 8am-6pm from February. In their first two months the team avoided 68 admissions, with 62 patients returned directly home and six stepped up into the Community Healthcare Hub. In addition, the team provided therapy input to an additional 126 patients who required an admission for a medical reason.

Construction work is well underway on our new Day of Surgical Assessment (DOSA) unit which is relocating to enable us to expand our Surgical Assessment Unit (SAU) which will increase both our efficiency and the experience of our patients. We hope this will be completed by the Autumn.

We have been 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. Results have been encouraging and those involved will attend a special session on 5 April to discuss the findings and look at whether this work can now be scaled up across our hospitals. Many thanks to all colleagues who have taken part in this important project so far.

Towards the end of March, the Acute Assessment Unit at Royal Preston Hospital (RPH) celebrated its first birthday. This opened as a dedicated 20-bed assessment area to cohort appropriate medical patients for rapid multi-disciplinary assessment, diagnosis and management within a length of stay of between 24-48 hours. As of mid-March, the unit had received a total of 3,460 patients through its doors, with an average length of stay of 46 hours. Of the patients admitted to the unit, 47% have gone on to be discharged from the hospital. This unit has brought together a new team who are making a tangible difference to improving patient flow.

New step-up pathways to the Community Health Care Hub (CHH) are now in place to support admission alternatives for 2 hour Urgent Care Response (2Hr UCR). Care Connexions is a new programme set up to look at reduction of admissions from a nursing /residential home setting and this is being led by our Integrated Care Board (ICB) colleagues

With regard to our financial position, the Trust has met its agreed year end deficit, and continues to work on our three year financial plan and our single improvement plan which will provide a road map for all colleagues so that amongst our many competing priorities, we focus on the areas that will make the most difference to patient outcomes and experience, and staff morale and well-being.

It is going to take a herculean effort to achieve the necessary cost reductions this year and to this end we have engaged an experienced financial turnaround specialist to work with the Executive team and Divisions for an initial period of six months to provide external challenge and intensive support to help us achieve our Cost Improvement Plans. We have also put in place a dedicated Project Management Office to ensure that we keep on track no matter what competing operational challenges we may face.

We continue to innovate and utilise the latest technology to improve patient care. The cardiorespiratory department have introduced a state-of-the-art Butterfly IQ handheld scanner which provides ultrasounds at a patient's bedside. Funded by our Charity, this is connected to a tablet or smartphone and provides instant images, and is more convenient, effective and affordable than regular machines. You can read about it here. A digital pathology open day event was held in mid-March, showcasing new technologies that are set to be introduced in our pathology laboratories from April 2024. New digital imaging equipment and DP600 scanners will be introduced in our laboratories at RPH which will not only transform patient care, but will also improve clinical decision-making, and pathology workflow.

As always there have been several special days and events within our hospitals since our last Board meeting. As part of LGBTQ+ History Month in February, the LGBTQ+ Forum held a face-to-face event, with Barrie Morgan-Scrutton, the founder of Inclusive Thinking, as guest speaker, while external organisations and NHS England Health Leads also spoke at a separate online session.

Our first Maternal Medicine Centre Study Day was held at RPH early in February, with over 85 delegates in person, and a further 50 online, coming together to listen to lectures and case studies from colleagues in the region working in maternal medicine, on a wide range of issues, including cardiology, neurology, endocrinology, perinatal mental health, and immunology.

We also marked NHS Overseas Workers Day on 3 March, and it was fantastic to see so many different wards and departments across Preston and Chorley sites getting involved and celebrating overseas workers in their teams.

As a part of the Magnet4Europe research programme, we have recently hosted a three-day site visit from our USA twin hospital team from Hackensack University Medical Centre, allowing them to see how our Organisation works, with a focus on nursing and to share recommendations and learning to improve in line with the Magnet principles for nursing excellence. The team visited several different departments across the Trust at Royal Preston and Chorley Hospitals and Finney House. For convenience you can access this link to their website to learn more about their hospital and here to find out more about the Magnet4Europe research programme.

On 25 March we launched the Patient Safety Incident Response Framework (PSIRF) published by NHS England, replacing the Serious Incident Framework (SIF) established in 2015. The new framework outlines how NHS organisations respond to patient safety events to help promote learning and improvement. PSIRF removes the 'serious incident' criteria, providing a framework for other incidents to be investigated, and for learning response resources to focus on areas with the greatest potential for learning and patient safety improvement. A big thank you to the eighty or so colleagues who attended the launch on Microsoft Teams.

We continue to improve our cancer pathways and this along with much of our research work is gaining external interest and recognition. Sky News recently featured improvements within our colorectal pathway, and our Surface Guided Radiation Therapy (SGRT) and interviewed Lynne Pelly, who is receiving treatment for breast cancer. As well as this, Professor Alison Birtle and our Oncology team received a formal letter of thanks from the Medical Research Council for their hard work in recruiting and following up patients to a trial aimed at improving survival and quality of life for men with prostate cancer. Also, the Medical Research Council-based STAMPEDE (Systemic Therapy in Advancing or Metastatic Prostate Cancer: Evaluation of Drug Efficacy) study has looked at the best way of treating men with newly diagnosed advanced prostate cancer, and the team recruited 302 patients, putting the Rosemere Cancer Centre in the top 20 recruiters globally. You can read about it here.

Congratulations also to our Data Science Team, who are celebrating winning a Health Data Research UK Award for their work in turning data into research, to help improve patient care and health outcomes for the region. The team, led by Consultant Surgeon, Professor Vishnu Chandrabalan, including Emergency Medicine Specialist Registrar, Dale Kirkwood, and Quinta Ashcroft and Tim Howcroft from the Trust, alongside Professor in Applied Data Science at Lancaster Medical School Jo Knight, were presented with their prizes during the 2024 HDR UK Conference in Leeds by Chair of the Board, Dame Julie Moore.

Also on the awards front, congratulations to Martin Keeney, Portering Services Assistant Manager, who was a finalist in the Unsung Hero Awards 2024 in the Estates and Ancillary - Individual Award category.

Last but certainly not least, I was pleased to meet with Toni Sutcliffe-Whyte of the LGBTQ+ Forum and Emma Wright of the Living with Disabilities Staff Ambassador Forum to learn more about their work. Our ambassador forums actively help to contribute towards the Trust's equality, diversity and inclusion (EDI) strategy. I am absolutely committed to a culture of EDI and am pleased to see we are continuing to build a workforce which reflects the communities we serve.

1. Recommendations

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

Trust Headquarters

Board of Directors Report

Board Assurance Framework (BAF) Risk Report					
Report to:	Board of Directors		**Date:**	4th April 2024	
Report of:	Associate Director of Risk and Assurance		**Prepared by:**	K Clay	
Part I	✓		**Part II**		
Purpose of Report					
For assurance	☐	**For decision**	☒	**For information**	☐

Executive Summary:

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

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

Strategic Risks

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

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

There has been no change in score for:

- 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/De-escalation

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.

Following discussion at the Executive Management Team (EMT) meeting, and Safety & Quality Committee in February 2024, it was agreed that Risk ID 1157 (Increased cases of *clostridioides difficile* (C.*difficile*) Infection) would be referred to the Board of Directors meeting in April 2024, to consider accepting this as an escalated risk for oversight as the Trust continues to see higher than planned rates of C.*difficile* infection.

The new Risk Management Group (RMG) held its first meeting in March 2024, chaired by the Chief Executive. The group discussed Risk ID 1182 - Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, and agreed that the Trust's response to the ongoing strikes has been well-managed and whilst it remains a risk, the score should be reduced to 16 from 20, and Safety & Quality Committee should consider recommending that Risk ID 1182 is formally de-escalated from the Board of Directors as the impact is seen in other risks. Safety & Quality Committee agreed, and therefore recommend that Risk ID 1182 is de-escalated from the Board of Directors.

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

Risk Management Group
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 Following discussion at the Board of Directors meeting in February 2024, the Chief Medical Officer and Director of Strategy and Planning have reviewed the Risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services, and proposed the risk remains focused on the commissioning of specialist services rather than delivery as was the Trust's aim when developed. The Risk to delivery of the Trust's Strategic Objective to Consistently Deliver Excellent Care reflects the fragile services that exist within specialist and local specialties and includes the Integrated Care System (ICS) work underway to address this.

2.2.3 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.

2.2.4 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 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 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 Following discussion at the Executive Management Team (EMT) meeting, and Safety & Quality Committee in February 2024, it was agreed that Risk ID 1157 (Increased cases of *clostridioides difficile* (C.*difficile*) Infection) would be referred to the Board of Directors meeting in April 2024, to consider accepting this as an escalated risk for oversight as the Trust continues to see higher than planned rates of C.*difficile* infection.

2.3.3 The new Risk Management Group (RMG) held its first meeting in March 2024, chaired by the Chief Executive. The group discussed Risk ID 1182 - Probability of ongoing strike action and the impact of strikes on patient safety following announcement of national pay award, and agreed that the Trust's response to the ongoing strikes has been well-managed and whilst it remains a risk, the score should be reduced to 16 from 20, and Safety & Quality Committee should consider recommending that Risk ID 1182 is formally de-escalated from the Board of Directors as the impact is seen in other risks. Safety & Quality Committee agreed, and therefore recommend that Risk ID 1182 is de-escalated from the Board of Directors.

2.3.4 The RMG also discussed Risk ID 499 - Failure to effectively manage staff absence and achieve Trust and National target rates. The score was proposed to be increased to 20 from 16, based on the sickness rates and that the Trust is an outlier regionally and nationally. It was agreed that this should be escalated to Workforce Committee to consider escalating to the Board of Directors but due to the timings of meetings, this will be recommended to the next Workforce Committee meeting in May 2024 and any subsequent recommendations to Board (if required) will be made in June 2024.

2.3.5 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.

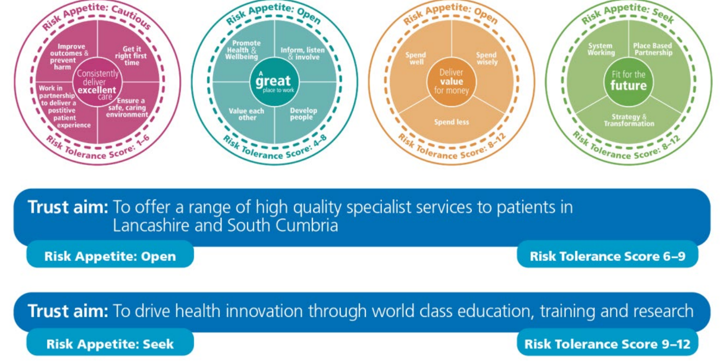
7. Recommendations

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

Trust Aims and Ambitions



Current principal risks on the Strategic Risk Register – April 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	Feb 2023 Score	Apr 2023 Score	June 2023 Score	Aug 2023 Score	Oct 2023 Score	Dec 2023 Score	Feb 2024 Score	Apr 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	20	20	20	20	20	16	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	16	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

Strategic Risk Summary

<table>
<tr><th colspan="2">Risk</th><th>Risk ID</th><th>Risk Summary</th></tr>
<tr><td colspan="2">Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research.</td><td>860</td><td>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.</td></tr>
<tr><td colspan="2">Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service</td><td>859</td><td>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.</td></tr>
<tr><td rowspan="4">Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities</td><td>Risk to delivery of Strategic Ambitions.. Consistently Delivering Excellent Care</td><td>855</td><td>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.</td></tr>
<tr><td>Risk to delivery of Strategic Ambitions.. Great Place to Work</td><td>856</td><td>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.</td></tr>
<tr><td>Risk to delivery of Strategic Ambitions.. Deliver Value for Money</td><td>857</td><td>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.</td></tr>
<tr><td>Risk to delivery of Strategic Ambitions.. Fit For the Future</td><td>858</td><td>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.</td></tr>
</table>

See next slides for key operational risks that are escalated, or for de-escalation to/from Board.

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

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Key Operational Risk Summary for Escalation to the Board

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

Escalated Risks

- **Impact of Emergency Department Block on Patient Safety (Risk ID 25 – Initial Score 20, Current Score 20)** – The data measured through the Emergency Department (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, some of the unfunded General & Acute escalation beds have reduced, however, due to increased occupancy, inpatient and ED boarding has deteriorated and patients have spent longer in the ED leading to increased safety and quality risk. As a result of this the bed reduction programme has been paused at this time. The Chief Operating Officer is leading a review of the current approach and further information will be presented to safety and quality in March 24 on next steps.

- **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 on track to achieve the 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) making good progress reducing the number of patients waiting over 78 weeks. Achievement of the plan and performance against the trajectory is reviewed daily as we reach year end. 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

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 and Consultants, which is having an impact on the hospital's activity. 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. In February 2024, further strike action by junior doctors was announced for 5 days from 24th February 2024. The new Risk Management Group (RMG) held its first meeting in March 2024, chaired by the Chief Executive. The group discussed this risk and agreed that the Trust's response to the ongoing strikes has been well-managed and whilst it remains a risk, Safety & Quality Committee should consider recommending that Risk ID 1182 is formally de-escalated from the Board of Directors as the impact is seen in other risks. **Safety & Quality Committee agreed, and therefore recommend that Risk ID 1182 is de-escalated from the Board of Directors.**

New Escalation

The Executive Management Team (EMT) and Safety & Quality Committee recommended in February 2024 that the Board of Directors accept the following risk as a newly escalated risk for oversight and scrutiny:

- **Increased cases of clostridioides difficile (C.*difficile*) Infection (Risk ID 1157 – Initial score 16, Current score 20)** - The Trust continues to see higher than planned rates of C. *difficile* infection, reviewing the data on a monthly basis via the safety and quality dashboard and whilst a number of actions have been taken and remain ongoing the number of cases continues to place LTHTR as an outlier nationally by 6% (nationally rates have increased by 40% LTHTR have increased by 46% when comparing last year data. Despite the interventions the risk is not stabilising and leading to further material actions taking place including exploring the requirement to fully implement the national cleaning standards at a cost of £1.2m and a structural review of sewage systems within the organisation that may lead to the requirement to evaluate if works in the region of £10m could be required to prevent the current leaks associated with a single stack system. NHS England Infection Prevention and Control team are raising the estate as a significant concern at this time affecting the ability to control infection. The EMT and Safety & Quality Committee recommended in February 2024 that the Board of Directors accept the following risk as a newly escalated risk for oversight and scrutiny.

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: 13th March 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

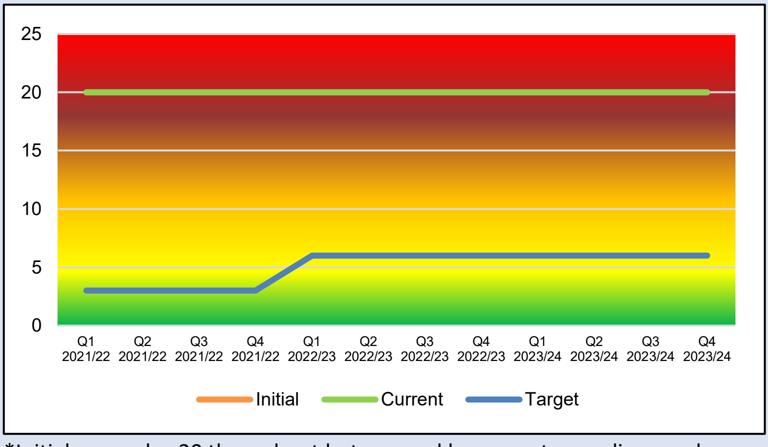
1-6

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 of stay in the ED and additional patients boarding on inpatient 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 risk score now at 20 associated with 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'.
- There are some specialty services that are considered fragile and this presents a risk to consistent delivery.

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 fragile 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 • Planned programme of work commenced focused on fragile services across the ICS.	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups ***(Ref CDEC 020)***. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection ***(Ref CDEC 019).*** • 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)*** (02/24 - 25% compliant for domestic standards, 100% compliant for nursing standards.) • The capital required to address backlog maintenance is not sufficient. ***(CDEC 019)***	**Internal** • 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 • Director of Strategy and Planning reports updates on clinical reconfiguration programmes to Finance and Performance Committee. **External** • National Surveys • Clinical Negligence Schemes for Trust • External regulators and benchmarking • Medical Examiner's Office, Perinatal Mortality Tool • Internal Audit • External system assurances, PLACE based arrangements, ICB and PCB • NHS England performance monitoring	• 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~~ 30 November 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~~ 30 April 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 017	Bi annual safe nurse staffing assessment to be undertaken given the time elapsed since previous assessment and changes in operating environment.	Chief Nursing Officer	~~30 May 2024~~ 30 April 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~~ 31 August 2024		Ongoing	Control	• The implementation of the national cleaning standards is not yet complete. 25% compliant for domestic standards, 100% compliant for nursing standards.
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. • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection.
DVFM 031	Refine approach to making risk-based strategic decisions	Chief Nursing Officer	30 April 2024		Ongoing	Assurance	• Enhanced approach to risk-based decision making
CDEC 020	To develop a plan in conjunction with the Director of Public Health, that aligns with the Health and Wellbeing Board's Health Inequalities Plan	Chief Nursing Officer	31st May 2024		NEW	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.

Summary of review – February and March 2024

- Rationale for current score updated to note that the C.Difficile risk (ID 1157) was reviewed at Infection Prevention and Control and assessed as having increased further on the basis that the numbers of cases continue to remain elevated, the increased occupancy is further impeding the ability to clean effectively and the non-compliance with national cleaning standards. This risk has been escalated to Safety & Quality Committee in February 2024 with the recommendation the risk is escalated to Board in April 2024.
- Cleaning standards compliance is 25% in domestic services and 100% compliance in nursing services. Further recourse is required to move to a compliance position and is a priority action given the increase in C.Difficile risk.
- Additional gaps in control have been linked to CDEC 019.
- Following discussion at the Board of Directors meeting in February 2024, the Chief Medical Officer and Director of Strategy and Planning have reviewed the Risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services, and proposed the risk remains focused on the commissioning of specialist services rather than delivery as was the source of the original aim of the organisation when developed. The CDEC strategic risk reflects the fragile services that exist within specialist and local specialties and includes the ICS work underway to address this. Updates on reconfiguration of clinical services are provided at Finance and Performance Committee by the Director of Strategy & Planning. However, consideration should be given to whether Safety & Quality Committee require any further updates and how often.
- CDEC 014 - The date for the delivery of the new SAU and MAU has been adjusted to reflect the current full completion date on 30 November 2024. The SAU is planned for completion by 31 July 2024, however the MAU will not be completed until November 2024.
- CDEC 016 – Following the inability to identify the funding to support the Chief Nursing Officer safe staffing recommendations, these have been reassessed and a proposal will be considered by Board in April 2024. The decision to fund this will be made as a part of the cost pressures discussion at Board in April 2024.
- CDEC 017 – action changed in relation to the Chief Nursing Officer safe staffing recommendations in February 2024, given the time elapsed and the safe nurse staffing recommendations not implemented due to financial constraints. As a mitigating action, divisional adjustments to staffing take place on a daily basis in response to risk. Due date brought forward in March 2024, the bi annual safe nurse staffing will be completed and considered by Board in April 2024.
- CDEC 018 – The date for delivery of the national cleaning standards has been adjusted to reflect the financial consideration that is required as part of the cost pressures discussion. An options analysis has been undertaken and a recommendation to prioritise the implementation of the ward cleaning standards agreed as a risk mitigated proposal for consideration by the Board.
- A new action has been developed (CDEC 020) which reflects the developing work and agreement with the Director of Public Health to develop a secondary care plan that compliments that which is being developed through the Health and Wellbeing Boards.

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: 8th March 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

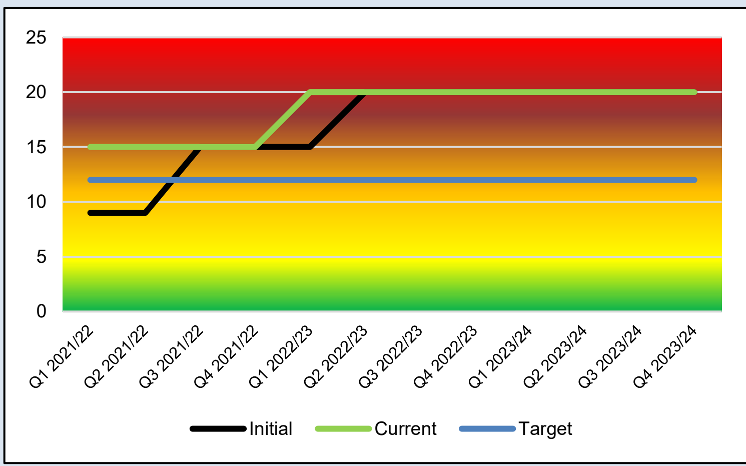
8-12

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 NOF 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	Future Opportunities
	• **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.	• 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	Gaps in Assurance
• Workstream related strategies in place ○ Workforce and OD Strategy, ○ Continuous Improvement Strategy ○ Clinical Strategy ○ Financial Strategy ○ IM&T Strategy, ○ Estates Strategy, ○ Our Big Plan, Annual Business Plan Planning framework established to track delivery of schemes. ○ Always safety first • Scheme of delegation/Standing Financial Instruction • Accountability Framework • Long term case for change the New Hospitals Programme • CCG funding for additional plans in Stroke and Palliative care	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • Service disruption due to ongoing industrial tensions (Managed through operational risk ID 1182 (probability of strike action) escalated to Board) • Inability to sufficiently influence externally impacting directly on services provided by LTH (e.g., partner organisation strategies and decision taking, financial rules for NHS services, NHS wide workforce development and investment and some processes and decision making at system and PLACE such as priority setting in development and deployment of system and PLACE Urgent and Emergency Care Strategy)	**Internal** • Specialty Performance meetings • Divisional Improvement Forums • Integrated Performance reporting at Finance and Performance Committee and Board • Audit Committee assurance processes to test effectiveness of financial infrastructure and internal control system • Temporary monitoring of undertakings internally (The Trust has been placed in segment three for the System Oversight Framework (SOF)). • Use of Resources assessments now reported through Finance & Performance Committee. • Regular embedded cycle of sharing information relating to the wider programme of change in place • Report on elective productivity and plans for improvement completed to better understand the impact on elective productivity together with movements in the underlying drivers together with plans for improvement.	• The Trust needs to identify how it will return its services to financial balance and deliver a challenging cost improvement programme whilst closing unfunded infrastructure or securing the associated funding. ***(DVFM 010)*** • 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)*** • 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)*** • Enhanced approach to risk-based decision making ***(DVFM 031)***

• 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.	• 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)***	• 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 has been reintroduced. • Improved governance arrangements in place with strengthened executive oversight of transformation and reporting of transformation progress to Finance & Performance Committee, along with the evolution of the Performance Accountability Framework. • Temporary Workforce Controls have been reviewed by internal audit and gained substantial assurance. In addition, review of adequacy of controls in regard to budgetary control completed and reported into FPC Q3 23/34. **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. • Improved oversight of the reporting of actions relating to the Improvement and Assurance Group with the Integrated Care Board via sharing of minutes and actions of IAG meeting with FPC	• There is a need to develop a single improvement plan which supported the Trust to improve its NOF rating. This will incorporate the three year financial recovery plan ***(DVFM 032)***

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. To be signed off by the Board of Directors in April 2024. This plan will be a key component of the Single Improvement Plan (see below).	Chief Financial Officer and Director of Strategy and Planning	~~31.01.24~~ 04.04.24		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	Ongoing	Assurance	The Trust needs to ensure that each of its strategies will contribute to delivering sustainable financial balance or better.
DVFM 017	Income strategy	Chief Financial Officer	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 022	Develop a 'value add' reporting for collaborative arrangements	Reporting to be developed via ICS Recovery and Transformation Board					
DVFM 023	Review of effectiveness of internal controls (e.g. budget constraint) relating to temporary workforce	Chief People Officer	~~31.01.24~~ 29.03.24	08.03.24	Complete	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~~ 30.04.24		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~~ 04.04.24		Ongoing	Assurance	Gaps are mitigated adequately within the Financial Recovery Programme
DVFM 030	Share minutes and actions of IAG meeting with FPC	Secretariat	30.04.24	12.02.24	Complete	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
DVFM 032	Development of a Single Improvement Plan to improve Board Assurance	Director of Improvement and Transformation	04.04.24		Ongoing	Assurance	There is a need to focus on the actions which will lead to an improvement in the Trusts NOF rating.

Summary of updates to risk – February and March 2024

- Correction of a spelling mistake in rationale for current score – "SOF" amended to "NOF".
- Action DVFM 023 updated to be completed, leading to the removal of a gap in assurance and identification of a new assurance.
- Completion of Action DVFM 030 leads to the removal of a gaps in assurance and identification of a new assurance measure regarding the sharing of minutes and action plans to improve oversight of actions relating to the Improvement and Assurance Group.
- New gap in assurance identified regarding need to develop a single improvement plan which supported the Trust to improve its NOF rating, leading to the identification of a new action DVFM 032 – Development of a Single Improvement Plan. The Boad approval of the Single Improvement Plan and the Financial Recovery Plan will be undertaken on 04/04/24.
- Extension to the due dates for actions DVFM 010 and DVFM 029.
- Extension to the due date for action DVFM 026. Work has been undertaken with finance colleagues to quantify the benefits of each transformation programme and the benefits are now reported in the programme documentation. Work has also been undertaken with finance colleagues to agree a methodology to calculate the financial benefits of the improvement programmes, with pressure ulcers being the first programme to be costed. This standardised methodology will be used for the improvement programmes for 24/25 and beyond. Additionally, EVO (a new patient level data framework) will be used to prioritise improvement programmes to capture both the clinical benefits and financial benefits, with a plan to test this approach with three projects initially, adopting a rapid 16 week cycle.

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: 1st March 2024

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.

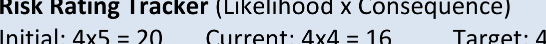
Risk Appetite:
Open to Risk – willing to consider all potential delivery options and choose while also providing an acceptable level of reward.

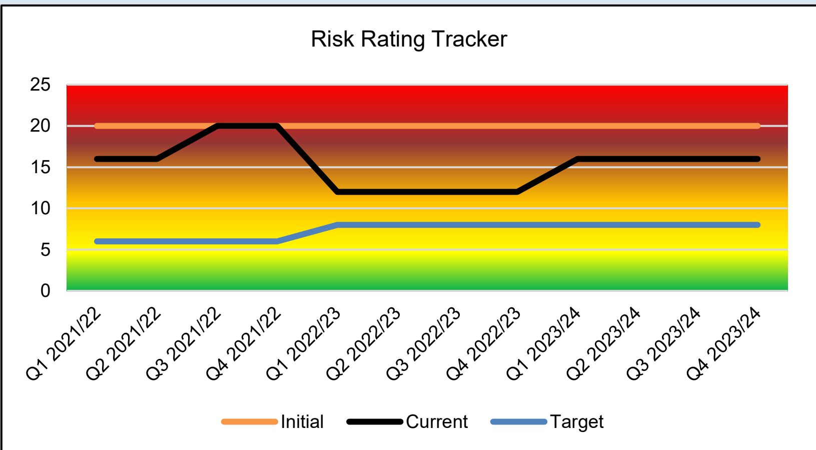
Risk Tolerance
4-8

Rationale for Current Score

- Workforce shortages and some 'hard-to-recruit-to' posts 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.
- Physical environment and colleague facilities (catering) cited as a concern by departments and teams for having an impact on feeling valued, 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 presenting cost and capacity issues.
- Gap between the desired and the current culture indicates improvements are needed.
- The impact of uncertainty and clear direction from One LSC 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 One LSC programme and ICS -led plans.
- 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 agenda for change pay scales not offering reward for colleagues with additional experience leading to staff feeling the only option is to negotiate locally.
- We are seeing an increased appetite for the establishment of an engagement with 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.

Risk Rating Tracker (Likelihood x Consequence)


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



	Future Risks	Future Opportunities
	• 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 delivery of financial turnaround on staff morale • The lengthy leading time for delivering the New Hospital Programme impacting on ability to utilise available workforce effectively. • Efficiencies anticipated through One LSC are not currently evidence based and pose a risk to the ongoing delivery of corporate services. • One LSC collaboration may de-stabilise some of the Trust's current and existing processes • Continued deterioration of the working environment and hygiene factors impacting on staff satisfaction • Fragility of some services within Workforce and OD identifying potential single points of failure should staff leave.	• Optimising the ability to develop contract flexibility and reciprocal help across Lancashire & South Cumbria footprint. • 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. • 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. • Optimisation of "Anchor Institution" status.

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
  ○ 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
	• 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-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
		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
		• 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
		
		External
		• 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)
			• Enhanced approach to risk-based decision making ***(DVFM 031)***

• 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		• 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.
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

Risk updates – February and March 2024

- Narrative regarding rationale for current score, future risks and future opportunities updated.

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: 12th March 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.

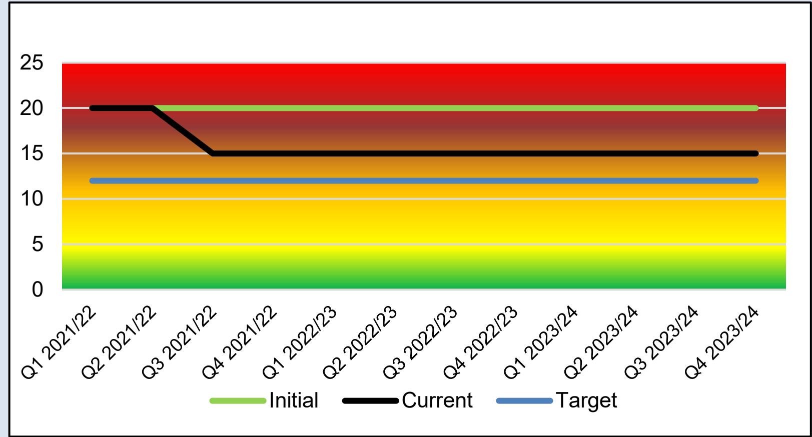
Risk Tolerance
8-12

Rationale for Current Score

- System working continues to develop but further progress is needed at pace in relation to both the governance of decision making and the clarity and confidence in expected benefit delivery. In order for LTH and the wider system to be fit for the future major transformational change is needed. A number of programmes (e.g. Fragile Services, Central Services) are moving forward but challenges and complexity remain in terms of governance, expected benefit plans and programme delivery. The development of a clear system clinical strategy, a clear set of system commissioning intentions and a robust set of LSC transformational programmes are critical to the mitigation of our fit for the future risk.
- Place based working continues to develop, with discussions underway regarding potential budget devolution for 2024/25 and a number of governance pillars/programmes now established such as the Central Lancashire Executive Oversight Group and the Central Locality Community Services Transformation Programme Board. However, there is still significant work to do for LTH and our partners to fully establish transformational Place based governance and work programmes
- Digital transformation will be a major enabler for partnership working, pathway/service integration and ensuring we are fit for future. We have an ambitious Digital Northern Star strategy but delivering this will be a major challenge and for a number of reasons our transformational programmes in this are not progressing at the rate we had 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.

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

	• 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	

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

• 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
  ○ 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.
	• Integration of services and pathways. ***(FFTF 001, FFTF 003, FFTF 004, FFTF 005, FFTF 006, FFTF 008)***
	• Effective Place and system based working. 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. ***(FFTF 001, FFTF 005, FFTF 007, FFTF 008)***
	• Single Improvement Plan approach still under development. (***FFTF 008)***
	• Fragile Services programme currently still focussed on a “deficit model” and needs to rapidly develop a robust expected benefits plan ***(FFTF 001)***
		<u>Internal</u>
		• Executive Transformation Group
		• Planning Framework updates to Finance and Performance Committee.
		• New Hospitals Programme assurance to Board
		• Audit Committee assurance processes to test effectiveness of infrastructure and internal control system.
		• Strategic element of Board discussions has been strengthened with dedicated sessions to focus on specific strategies
		• Northern Star Programme shared approaches developed leading to £1M in cash realising or cost avoidance savings
		• Online presence seen to increase over the period March 2023 – May 2023 with 23,000 new users to the Trust website in that period demonstrating continuing upward trend of engagement with the local population. Increase in Twitter and Facebook interaction and internal intranet interaction also.
		
		<u>External</u>
		
		• New Hospitals Programme Oversight Group
		• ICS Digital Board
		• Clinical Programme Board
		• Central Services Board
			• Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim ***(FFTF 001, FFTF 003, FFTF 004, FFTF 008)***

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~~ 30th September 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working. • Fragile Services programme currently still focussed on a "deficit model" and needs to rapidly develop a robust expected benefits plan
FFTF 002	Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters	Director of Strategy and Planning	31st March 2024	28th February 2024	Complete	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~~ 30th September 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~~ 30th September 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~~ 30th September 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 006	Establish new governance arrangements to support the development of the PCBC in conjunction with the programme office and the ICB	Executive Leads	30th September 2024		Revised and ongoing	Control	• Integration of services and pathways
FFTF 007	Deliver our Social Value Strategy	Chief People Officer	~~31st March 2024~~ 30th September 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~~ 30th June 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working. • Single Improvement Plan approach still under development

Updates – March 2024

Risk content reviewed and no change to content required at the current time. Action Plan updates:

- **FFTF 001 - link LTHTR strategies with Place, Provider Collaborative and ICS Strategies and FFTF 003 Ensure maximum LTH influence on/contribution to Place and System working** - Positive discussions underway with LSCFT and the ICB regarding service integration – though significant consideration needs to be given to both the complexity/challenge of getting agreement as to the way forward but also the resource required to deliver/realistic timescales. Place based working is being strengthened following successful meetings regarding Urgent Care. External support has been commissioned and project teams are being set up to taken forward the development of a clinical "blueprint" and the team have reviewed existing documents/strategies – however, the timeline for this work is very challenging and it is difficult to be assured at this stage. Financial benefits have been calculated for each of the 4 fragile services and the other clinical service reconfigurations , through these are not yet at the stage where they could be incorporated into the LTH plan. The LTH CEO is working with the PCB to carry out a review of governance which will strengthen our capacity to work at system level going forward. As such, the due date is extended by 6 months for each action.
- **FFTF 002 - Strengthen Board discussions on key strategic issues** - A Board Workshop was held on the 28th of February which included a planning update and a detailed session on the Single Improvement Plan. The action is therefore marked as completed.
- **FFTF 004 Develop and deliver Digital Northern Star strategy** - ICS wide technical infrastructure governance has been updated to align with government digital data services, to include Digital, Data and Technology design authorities. All major projects with digital components will have to report through one or all of these design authorities before being implemented to programmes have appropriate digital engagement, ensuring best value alignment to existing architecture, to prevent generation of silos and ensure movement to the northern star. LTH's data science team led by Professor Vishnu Chandrabalan, is rapidly gaining national and international recognition with collaborations up and down the country and has won the Health Data Research UK team of the year through its work on the Secure Data Environment. This provides endorsement of the L&SC SDE strategy and approach. L&SC is in early discussions with the Federated Data Platform to ensure it can take advantage of the application market places associated with this platform. As such, the due date of the action is extended by 6 months as work remains ongoing.
- **FFTF 005 Deliver staff engagement/comms strategy (including reputation monitoring/management)** - due date extended by 6 months at the request of the Chief People Officer, as work remains ongoing.
- Action **FFTF 006** reworded upon request of the Chief Finance Officer to reflect the need for Trust response to New Hospital Programme developments, as the delivery of the New Hospital Programme in its entirety is not for the Trust to own.
- **FFTF 007 Deliver our Social Value Strategy** - ownership has been realigned to the Chief People Officer and the due date extended due to work remaining ongoing.
- **FFTF 008 - strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change** - Aim to have the PMO established by the 18th of March (within existing resources). The Trust Single Improvement Plan is progressing well. Programme and project leads for all areas of the SIP have been agreed and detailed milestone plans are currently being completed. Improvements in Strategy and Planning are part of the Well Led component of the SIP. A paper on developing and agreeing the Trust strategy will go to the April Board meeting. As such, the due date is extended by 3 months for this action.

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: 7th March 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.

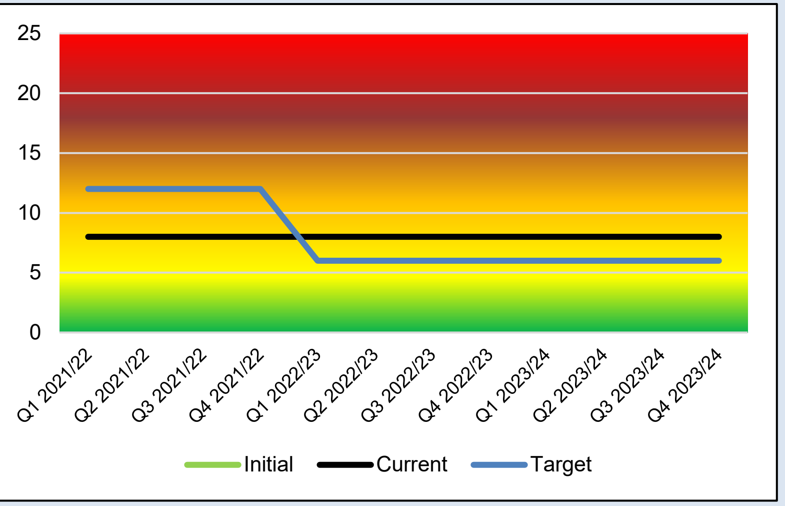
Risk Appetite: Open to Risk - prepared to consider all delivery options and select those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

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	Future Opportunities
	• Risk of New Hospital Programme not progressing. • Commissioning risks to lower volume/low priority services. • Potential risks associated with changes in specialised commissioning arrangements.	• 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~~ 30th September 2024		Ongoing	Control	• Services being compliant with the service specification

Updates to risk – February and March 2024

- Action SPEC 002 due date extended by 6 months to allow for an ICB/PCB commissioned clinical blue print of service reconfiguration to be developed.
- The risk score was reviewed in response to Action 1 within the Board Action Log from February 2024 and felt to be correct at the time of review. The Specialised Services strategic risk is regarding the risk to commissioning of specialised services delivered by the Trust, which at the current time is not felt to be a high risk. At the review, it was acknowledged that "specialised" services differ from "fragile" or "vulnerable services. There are ongoing ICB/PCB system wide workstreams to reconfigure and expand services currently considered "fragile" or "vulnerable" services with a view to improving patient safety and quality, which aligns to the strategic risk for Consistently Deliver Excellent Care, overseen by Safety & Quality Committee.

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 (with input from Deputy Director of Education and Deputy Director of Research & Innovation)

Date last reviewed: 31st January 2024

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

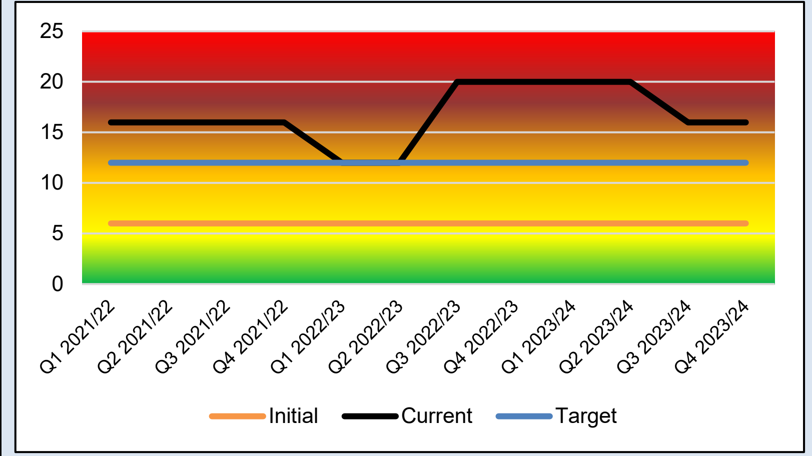
9-12

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	• 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
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	31.03.24		Ongoing	Control	• Lack of research leads embedded in divisions.
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 – January 2024

- Review of the risk carried out by Chief People Officer, Deputy Director of Education and Deputy Director of Research & Innovation and no substantive updates to be made at the current time.
- 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.

Chair's Report

<table>
<tr><td>Committee:</td><td>Safety and Quality Committee</td></tr>
<tr><td>Chairperson and role:</td><td>Kate Smyth, Non-Executive Director</td></tr>
<tr><td>Date(s) of Committee meeting(s):</td><td>26 January 2024 and 23 February 2024</td></tr>
<tr><td>Purpose of report:</td><td>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.</td></tr>
<tr><td colspan="2">Committee Chair's narrative</td></tr>
<tr><td>26 January 2024</td><td>23 February 2024</td></tr>
<tr><td>Following the meeting held on the 26 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

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.
- Health Inequalities Delivery Plan 6 Month Update
- Bi-annual Sepsis Report
- Equality Impact Assessment Update
- National Maternity Survey Results
- Annual Health and Safety Review
- CQC Action Plan</td><td>Following the meeting held on the 23 February 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.
- Bi-annual AHP's Staffing Report
- Quarterly Serious Case Thematic Review and Learning Report
- Inquest Conclusion Regulation 28 Report – Datix 121144</td></tr>
<tr><td colspan="2">Items for the Board's attention</td></tr>
<tr><td>The Committee received the Health Inequalities Delivery Plan update on the work carried out to</td><td>The Bi-annual AHPs Staffing report provided detailed findings of the Lancashire Teaching Hospitals bi-</td></tr>
</table>

tackling health inequalities at Lancashire Teaching Hospitals. Over the last 6 months the Chief Nursing Officer and Health Inequality Group had been scoping work already underway within the Trust related to tackling health inequalities, improving internal knowledge on health inequalities and developing the priorities and a Trust approach to tackle health inequalities. The Committee confirmed its assurance in respect of the continued requirement to develop a deeper internal knowledge of current practice that contributes towards CORE20PLUS5 delivery and the developing links with the new PLACE and ICB health inequalities teams. The Bi-annual Sepsis Report provided an update on sepsis care in Lancashire Teaching Hospitals since the previous report in June 2023. The report described the continuous improvement work being undertaken with regards to the management of patients with suspected sepsis, explored some of the challenges with providing excellent quality sepsis care. The CQC Action Plan report provided an update on the action plan following the Care Quality Commission's (CQC) Inspection of Lancashire Teaching Hospitals NHS Foundation Trust that took place on 31 May 2023, 1 June 2023, 12 June 2023, 13 June 2023, 26 June 2023, 27 June 2023, 28 June 2023, 29 June 2023, 3 July 2023 and 4 July 2023 and the publication of their findings on 24 November 2023. A summary of findings from the published report was provided to the Committee in November 2023.	annual Allied Health Professionals workforce safeguards review for the reporting period of June 2023 to November 2023. The report evidenced an improving picture in relation to AHP workforce. The Committee resolved to receive a further update in line with the workforce safeguards in 6 months' time. 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. The Committee confirmed its assurance in respect of the management of serious incidents and endorsed the new governance meeting structures, reporting arrangements and associated terms of references under PSIRF. The Committee received the Inquest Conclusion Regulation 28 Report which provided the information of a Regulation 28 report issued to the Trust by HM Coroner for South Manchester on conclusion of an inquest into the death of a patient on 20.12.23. It outlined the details of the case, matters of concern raised and the action plan created in response. The Committee confirmed its assurance in respect of the actions being taken to prevent future deaths.
Positive escalation	
26 January 2024	**23 February 2024**
- The Committee were assured of the process and outcomes of EQIA management within the organisation and had seen evidence of Executive scrutiny and approval. - The total number of PALS requests had reduced during December and the complaints response rate compliance had met the internal target with the backlog now recovered. - There is now >50% of areas achieving gold status in STAR, the focus will now move to driving improvements at ward level, acknowledging the pressures faced in relation to occupancy in these	- The Committee noted the overall improving picture in relation to the AHP workforce developments and opportunities. - The Committee were assured of the measles preparation noting that the Trust had a working group in place with workforce, infection control and clinical operational staff representation. - The Thrombectomy service was now operating 7 days a week on a 9am to 5pm basis, noting some fragility in the delivery of this service that was being managed by the team.

areas currently and the less positive outcomes in ward areas. - The maternity survey results indicate a positive outcome for the organisation, these will be published publicly in the coming weeks.	
Negative escalation	
26 January 2024	**23 February 2024**
- The Clostridium Difficile Infection rates continued to exceed the trajectory. There was weekly Executive oversight of the action plans, sharing best practice learning from peers and working collaboratively with the multidisciplinary team. - The Trust continued to see a significant increase in occupancy across the inpatient areas relating to boarded patients. The creation of a robust mechanism to capture boarded patients was being developed. - The Birthrate Plus safe staffing assessment remains outstanding due to the funding required to enact this. The prioritised approach to this is based on addressing the existing vacancy gap for Registered Midwifes in year 1 and focusing on support staff and retention of existing workforce. - The Committee referred the health and safety training compliance data to the ETR Committee for oversight and monitoring on the Committee's cycle of business.	- The Committee agreed to escalate risk ID 1157 for the increased cases of Clostridium *difficile* infection as an operational high risk of significant concern to the Board of Directors in April 2024 via the BAF. The Clostridium d*ifficile* Infection rates continued to exceed the trajectory. There was a bi weekly Executive oversight group to ensure focus on the delivery of the plan to address this. - The Trust continued to see a significant increase in occupancy across the ED and inpatient areas that had led to adverse outcomes and patient experiences. - Birthrate Plus safe staffing requirements remain outstanding due to the financial position and the difficulties in recruiting midwives. - The planned industrial action by junior doctors. The Committee discussed the regulation 28 that had been received from the Coroner and confirmed it was assured of the actions being taken to prevent future deaths.
Committee to Committee referral	
26 January 2024	**23 February 2024**
The Safety and Quality Committee referred For ETR Committee to have an oversight and monitor health and safety training data on the Committee's cycle of business.	Escalation of risk ID 1157 for the increased cases of C.*difficile* infection as an operational high risk of significant concern to the Board of Directors in April 2024 via the BAF. Escalation to Workforce for a review of psychological support for staff involved in incidents and hearings such as this.
Items recommended to the Board for approval	
26 January 2024	**23 February 2024**
None	None
Committee Chairs reports received	

26 January 2024	23 February 2024
(a) Infection, Prevention and Control Committee (b) Medicines Governance Committee (c) Safety and Learning Group (d) Health and Safety Governance	(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 Care Committee (g) Health Inequalities Group (h) Health and Safety Governance
Items where assurance was provided and/or for information	
26 January 2024	**23 February 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 December 2023. The Annual Health and Safety Review provided 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 summarised the prevailing legislative framework within which Health and Safety concerns were managed and addressed and outlined the local governance arrangements that underpin Health and Safety management within the Trust. The Committee resolved to confirm its assurance of the actions being taken to reduce the risks associated with Health and Safety. The Equality Impact Assessment Update provided an assurance update on the status of Equality & Quality Impact Assessments (EQIA) for 2023/24 year-to-date. Following a review in May 2023 of the	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 January 2024 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. 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 confirmed its assurance in respect of the mitigating actions that were in place and the escalation of risk ID 1157 for the increased cases of Clostridium difficile infection as an operational high risk of significant concern to the Board of Directors in April 2024 via the BAF.

EQIA policy, EQIA's use had been expanded to include decisions related to service changes as well as Cost Improvement Projects (CIP). EQIA's were undertaken by the Trust as defined in the EQIA policy. The Committee confirmed its assurance in respect of the process and outcomes of EQIA management within the organisation.	
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 March 2024 using Microsoft Teams.	

Recommendation:

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

Appendix 1 – Safety and Quality Committee agenda (26 January 2024)

Appendix 2 – Safety and Quality Committee agenda (23 February 2024)

Safety and Quality Committee

26 January 2024 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 5 January 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	1.00pm	✓	Assurance	J Lambert
7.3	Children and Young People Staffing Report	1.10pm	✓	Assurance	S Cullen
7.4	Health Inequalities Delivery Plan 6 Month Update	1.20pm	✓	Assurance	S Cullen
7.5	Bi-annual Sepsis Report	1.30pm	✓	Assurance	C Roberts
7.6	Equality Impact Assessment Update	1.40pm	✓	Assurance	I Ward
7.7	National Maternity Survey Results	1.50pm	✓	Assurance	J Howles
8.	GOVERNANCE AND COMPLIANCE				
8.1	Annual Health and Safety Review	2.00pm	✓	Assurance	H Ugradar
8.2	CQC Action Plan	2.10pm	✓	Assurance	H Ugradar
8.3	Strategic risk register review	2.20pm	✓	Decision	K Smyth

№	Item	Time	Encl.	Purpose	Presenter
8.4	Items for referral to the Board or to/from other Committees	2.25pm	Verbal	Information	K Smyth
8.5	Reflections on the meeting and adherence to the Board Compact	2.30pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums – **(no meeting)**				
9.2	Terms of Reference: Patient Experience and Involvement Group		✓		
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board – **(no meeting)** c) Always Safety First Committee – **(no meeting)** d) Medicines Governance Committee e) Safety and Learning Group f) Patient Experience and Involvement – **(no meeting)** g) Health and Safety Governance		✓		
9.4	Date, time and venue of next meeting: *23 February 2024, 12.30pm, Microsoft Teams*	2.35pm	Verbal	Information	K Smyth

Safety and Quality Committee

23 February 2024 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 26 January 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	1.00pm	✓	Assurance	J Lambert
7.3	Children and Young People Staffing Report	1.10pm	✓	Assurance	S Cullen
7.4	Bi-annual AHP's Staffing Report	1.20pm	✓	Assurance	C Granato
8.	GOVERNANCE AND COMPLIANCE				
8.1	Quarterly Serious Case Thematic Review and Learning Report	1.30pm	✓	Assurance	H Ugradar
8.2	Inquest Conclusion Regulation 28 Report – Datix 121144	1.40pm	✓	Assurance	G Skailes
8.3	Strategic risk register review	1.50pm	✓	Decision	K Smyth
8.4	Items for referral to the Board or to/from other Committees	1.55pm	Verbal	Information	K Smyth
8.5	Reflections on the meeting and adherence to the Board Compact	2.00pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums		✓		

№	Item	Time	Encl.	Purpose	Presenter
9.2	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) Always Safety First Committee – **no meeting** d) Medicines Governance Committee e) Safety and Learning Group f) Patient Experience and Involvement g) Mortality and End of Life Care Committee h) Health Inequalities Group i) Health and Safety Governance		✓		
9.3	Date, time and venue of next meeting: *22 March 2024, 12.30pm, Microsoft Teams*	2.05pm	Verbal	Information	K Smyth

Trust Headquarters

Board of Directors

Annual Safe Staffing Review – Nursing 2023/2024			
Report to:	Board of Directors	**Date:**	4 April 2024
Report of:	Chief Nursing Officer	**Prepared by:**	S Cullen, C Gregory, N Ross

Purpose of Report

For assurance	☐	For approval	☒	For information	☐

Executive Summary

The purpose of this report is to detail the findings of the Lancashire Teaching Hospitals NHS Foundation Trust 2023/24 nurse staffing review to set nurse staffing establishments for 2024/25. This review was carried out during January and February 2024 and conducted as a desktop review revisiting the previous year's outcome data with staffing levels, feedback from leaders and staff and the professional guidelines associated with safe staffing.

The recommendations of the annual 2022/2023 nurse staffing review reported to Safety and Quality committee in February and April 2023 and to Trust Board in August 2023, have not been funded substantively and therefore, the recommendations of the Chief Nursing Officer have not been transacted. However, it should be noted that where there are patient safety risks, in line with the safe staffing policy, bank and agency staff are used to provide additional staffing in response to acuity.

The 2023/2024 review included 51 clinical areas which include the Emergency Departments, assessment areas, adult inpatient areas, neonates and children and young people areas.

There continues to be areas that require improvement, these correlate with the CQC areas of focus during the inspection and mostly linked to large wards, areas with increased occupancy and leadership challenges in a small number of areas.

Escalated beds have increased the number of patients across the organisation with circa 60 additional beds used when operational pressures occur. There are no additional staff in place for these beds hence when this happens the nurse to patient ratio is diluted. In addition to this, the practice of boarding has further diluted the nurse to patient ratio in ED and the wards. Positively, the registered nurse fill rate has improved and is consistently over 94% in the majority of areas compared with 90% 12 months ago. This is helping to mitigate some of the escalation and boarding risks described in reports received by committee.

Despite this, the review has identified the positive impact of the international nurse strategy leading to a reduction in agency spend. Based on 2022/2023 there has been a reduction of £5,342m to end of February 2024.

The outcome of the review has revised the last staffing recommendation made in August 2023 to focus on what is considered, safety critical recommendations. The report includes a recommendation for progressing the Birthrate plus recommendation for maternity services, however, the report will not explain the detail of this review as the maternity neonatal report previously considered by Board contained this information.

The impact of the March 2024 biannual safe staffing review is within table 1.

Area	Increase /Decrease budget establishment	WTE change in totality	Run rate impact WTE	Run rate impact Budget	Justification
Birthrate plus	£478k	9.91	+9.91 WTE	£478k	Implement Twin CMS, AMP and address support staff component of Birthrate plus to stabilise safety concerns and turnover within the service whilst recruiting to the vacant 15WTE RM.
Gynaecology	£173k	2.2	+1 WTE	£82k	Addresses 50% increase in demand for EPGAU and baby loss weekend provision (patient safety risk) as evidenced in prior review.
Medicine	£528k	9.69	No	£0	Addresses inequity in staffing in stroke rehabilitation ward, CDH MAU increase in activity and areas, ward 17 safety concern, plus CQC areas of concern.
Surgery	£11K	-3.33	Yes -3.33	£0k	Changes to address priorities, inaccurate headroom and consistency over 7 days.
Critical care	£0	0	No	£0	Staffing assessed as being compliant with guidance. No changes required.
Finney House	£0	0	No	£0	Staffing assessed as being compliant with guidance. No changes required.
CYP	£0	0	No	£0	Changes made to strengthen leadership within existing budget.
ED	£0	0	No	£0	Staffing as assessed as appropriate, maintaining the investment from the pandemic and the ability to respond to increases in acuity through the use of bank and agency. No changes at this time.
Total	**£1.190m**	**+18.47WTE**	**7.58WTE**	**£560k**	

The areas the review has not included that were contained within the previous recommendation relate to;

1. **Birthrate plus** - The Registered Midwifery component of the Birthrate plus review. The service has 15 Registered Midwife vacancies currently; therefore, the focus is to retain those midwifes by providing the appropriate level of support and attract new midwifes to fill the existing vacancies. This is predicted to take at least one year and therefore a phased approach to birth rate plus would allow phase 1 (2024) to focus on support staff and phase 2 (2025) to focus on Registered Midwifes, pending approval.
2. **Enhanced Levels of care** - Addressing the increasing requirement to provide enhanced supervision to patients is an important component of safe staffing reviews. There are mechanisms in place to do this on as required following formalised acuity assessments and oversight by the matrons three times daily to determine what staffing is required to maintained to safety. This decision will not prevent this and provides time to consider how this part of the previous review can be addressed moving forward.
3. **HealthCare Support worker's banding** – There is a national programme of work underway relating to this and the difference between a band 2 and 3 and therefore this will be addressed as part of that work.

There are a number of improvement programmes of work that have delivered this year including;

- International nurse recruitment- with only 30 colleagues now working in a supervisory capacity, all are expected to become independent by June 24.
- The increase in the number of Trainee Nurse associates being trained in our organisation, taking a grow our own approach to the recruitment of Nurse Associates and future registered Nurses. To date 143 Nurse Associates have joined the programme.
- The focus on healthcare support workers which will continue into 2024, focused on valuing and retaining these colleagues recognising their critical contribution to safe and quality care and addressing the persistent 15% vacancy.

The focus of 2024 will be on reducing sickness, strengthening clinical leadership, achieving increased STAR rated green wards and attracting and retaining healthcare assistants.

The overall budget increase associated with the safe staffing review is £1.190m (18.47WTE) with a run rate increase of £560k (7.58WTE).

The safe staffing review and recommendations have been considered and endorsed by Safety and Quality committee in March 2024.

Overall, the establishments recommended by the Chief Nursing Officer as part of this review will deliver safe, effective and sustainable staffing levels for the organisation and meet the requirements of the NICE Safe Staffing Guidelines (2014) and the National Quality Board (NQB) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016).

It is recommended that the Board of Directors:

i. Note financial impact of the outcome.
ii. Approve the staffing review to set establishments for 2024/5 and agree to seek ICB approval to support the investment in line with the triple lock procedure.
iii. Note, in line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Chief Nursing Officer confirms they are satisfied with the outcome of the annual safe staffing assessment and that whilst risks remain present staffing is safe, effective and sustainable.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

1.0 INTRODUCTION

The purpose of the nursing safe staffing review is to set an appropriate staffing resource, to deliver safe care within the inpatient bed base, using a robust, systematic process. This includes escalation areas and clinical areas not recurrently funded but which have consistently remained open during the review period.

This process has been led by the Chief Nursing Officer and deputy.

51 clinical areas across Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR), have been reviewed as part of the 2023/24 nursing and midwifery safe staffing review.

This report details the findings of triangulating workforce information with safety, patient experience and clinical effectiveness indicators in order to review the appropriate staffing requirements to provide safe and effective care for patients.

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

- Improvement and Assessment Framework for Children's and Young People's (CYP) health services (2016)
- Safe, Sustainable and productive staffing: An improvement resource for neonatal, children and young people services (2017)
- Safe, sustainable and productive staffing – adult inpatient wards in acute hospitals (2018)
- Safe, sustainable and productive staffing an improvement resource for urgent and emergency care (2017)

An overview of these guidelines are presented in Appendix 4 and 5.

The expectations of safe staffing are further strengthened by NHS Improvement, Developing Workforce Safeguards. Organisations will be assessed annually for Trust's compliance with the guidance. Provider performance will be monitored against five themes:

- Service quality
- Finance and resources
- Operational performance
- Strategic change
- Leadership and improvement capability

Appendix 7 contains a list of the guidance and recommendations and LTHTR response to each standard.

2. SCOPE

The review will triangulate staffing and outcome data for 51 clinical areas which include assessment areas, adult inpatient areas, neonates, children and young people areas and community services.

Medicine Division	Surgical Division	Women's and Children	Diagnostic and Clinical Support (DCS)
ED (RPH) including ED Children's	Neuro High Care	Ward 8	Critical Care Unit (CrCU)
Acute Assessment Unit	Ward 2a	Paediatric Assessment Unit (PAU)	Buttercup (CHH)
Acute Frailty Assessment Unit	Ward 2b	Paediatric Day case	Meadow (CHH)
Bleasdale Ward	Ward 2c	Neonatal Unit (NNU)	Orchard Residential
NRU (Barton)	Ward 3	Gynae Ward RPH	
MAU (RPH)	Ward 4	Gynaecology Early Pregnancy Assessment Unit	
CCU RPH	Ward 10		
Ward 5	Ward 11		
Ward 17	Ward 12		
Ward 18	Ward 14		
Ward 21	Ward 15		
Ward 23	Ward 16		
Ward 24	Major Trauma Ward		
Ward 25	Ribblesdale Unit		
Enhanced High Care Unit	Surgical Assessment Unit		
ED (CDH)	Surgical Enhanced Care Unit (SECU)		
MAU (CDH)	Surgical Unit (CDH)		
Brindle	Leyland Ward		
CCU CDH			
Rookwood A			
Rookwood B			
Hazelwood			
Cuerden			

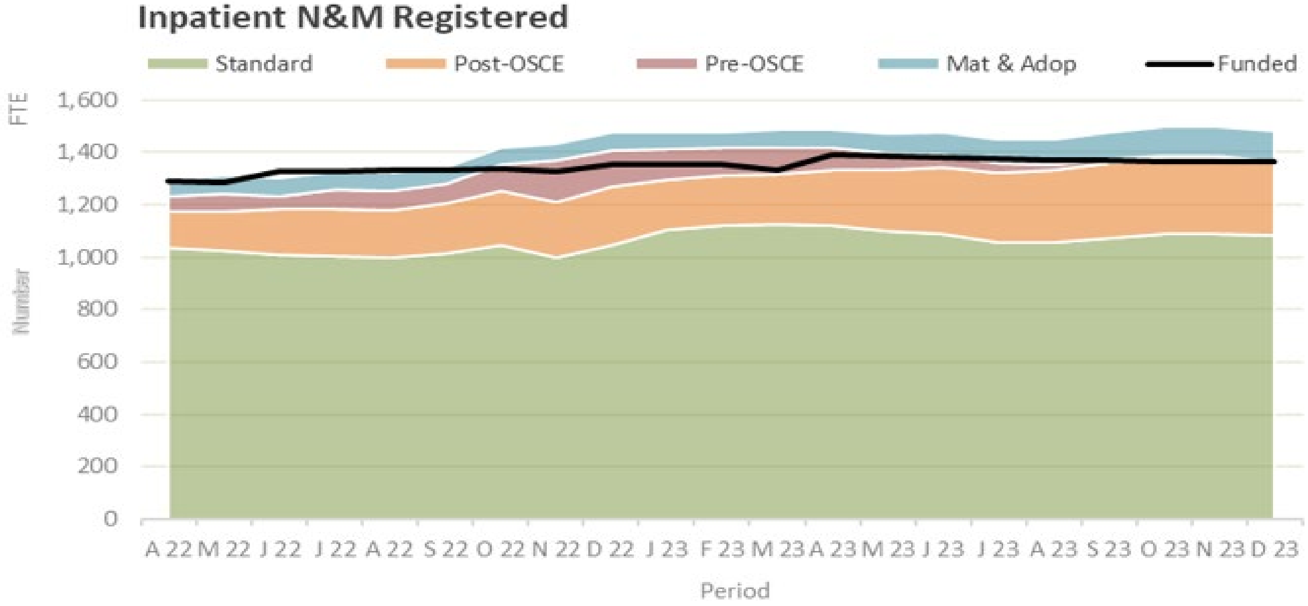
3. CONTEXT

The establishments are set annually with the Ward Manager, Matron and Divisional Nurse/Midwifery Leader. This review follows on from the previous annual review from 2022/2023 which was considered by the Board in August 2023 where the previous annual review was not funded. This review has followed the desk top review approach and has prioritised the safety critical components of the review presented in the previous year. The ward managers have approval to:

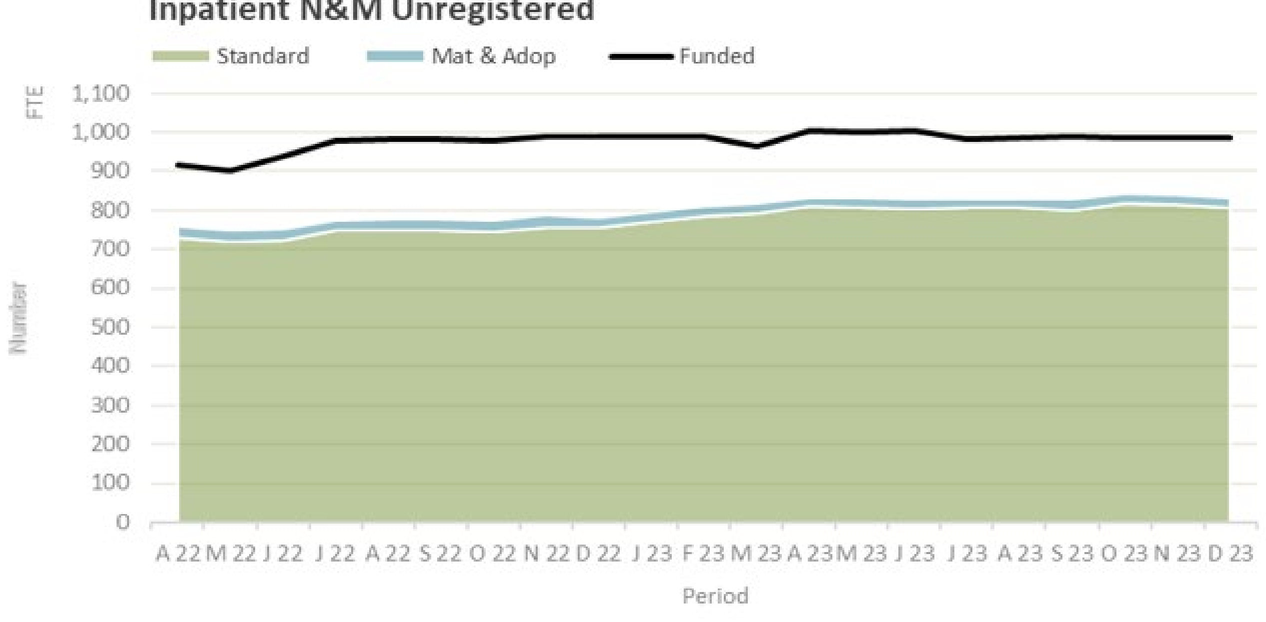
- Recruit substantively to maternity leave for registered (RN) and Health Care Assistants (HCA).
- Request immediate bank and agency in response to changes in patient acuity or dependency (with approval control for long term use in place)
- Request an establishment review at any time if the assessment by the ward manager, matron and Divisional Nurse Director (DND) is not meeting the needs of the patients.

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

Graph 1 Registered Nurse establishment versus staff in post April 22- Dec 23



Graph 2 Healthcare Assistant establishments versus staff in post April 22 – Dec 23



Despite high volume recruitment the vacancies for Band 2 and 3 HCA remain high at 15.2% (c197.53 FTE). HCA recruitment continues to be an area of focus with continued investment in recruitment campaigns.

3.1 Actions taken to date to recruit and retain include:

- Stay interviews are in place across the organisation for all new starters. Managers can access support in undertaking Stay interview via the intranet, or the workshop 'Let's Talk'
- Fresh Eye Forums have taken place centrally, as well as divisional New Starter forums, to gather feedback from new starters and to provide an opportunity for them to meet each other and share their experiences.
- Leadership development opportunities through the Organisational Development team.
- An annual new starter survey provides valuable information to analyse and plan activity to support colleague experience, supplemented by national staff survey and new starter forum feedback.
- Focused work on known or anticipated challenges, for example: health care assistants, newly qualified nurses, and international nurses, looking at aspects such as a consistent buddy system, strong local induction, and recognition.

- Training existing HCAs as trainee nurse associates (TNAs) has improved staff retention.
- TNA applicants who are not successfully recruited to our limited TNA places, are supported to gain the criteria to help them be successful in a TNA application in the future.
- Open day recruitment both in person and on teams for registered nurse recruitment.
- TNA vacancies are promoted through the CEO brief and on the intranet to encourage staff interested in progression are aware of opportunities available.
- Successful bids awarded through NHS Improvement to increase resources and materials to support recruitment to HCA positions.
- A series of webinars in the evenings have been run for interested candidates to find out more about the role of a HCA and the career opportunities available with representatives from Recruitment and Education leading them.
- Direct working with Indeed who have been funded by NHS England to support Trusts –gain wider audiences for our roles using their multi-national jobs board platform.
- Continued investment in social media advertisement, branding, better together campaign, #WeAreHCSWs and #WeAreTheNHS national campaigns.
- Successful monthly Saturday interview days for HCAs – recruiting between 35 – 40 staff members per month.
- Introduction of a HCA recruitment and retention group to specifically focus discussions and actions.
- Internal transfer window approach.
- International Nurse recruitment – There are 30 of 261 international colleagues currently progressing through the supervised phase of practice with a plan to work independently by 30 June 2024. The review has evidence the positive impact of the international nurse strategy leading to a reduction in agency spend. Based on 2022/2023 there has been a reduction of £5,342m to end of February 2024.

3.2 Areas that require Improvement

Healthcare Support Workers

The HCA vacancy rate continues to run at 15%. This has not improved significantly in the last year. This presents a risk to providing high quality care and a number of actions are being tested to explore how an improved career option and experience can be provided to HCA. This is critical to ensure we are retaining high quality HCA and growing nurses of the future.

Sickness

Sickness rates in all inpatient units exceed the 4% target. This is multifactorial and has been above the target for the last year. Influencing factors in the clinical environment include: enhanced levels of care, violence and aggression, stress, increased occupancy levels, complex health and home circumstances. Ensuring staffing establishments are fit for purpose is an essential contribution to managing sickness levels. Staff frequently report the adverse experiences that lead to prolonged periods of sickness, this should be considered a fundamental link to safe staffing. The lack of consistently when delivering care to complex people in teams impacts on the quality of patient care and on the experience of those delivering it, often having further compounding impacts on the sickness rates. 2024 will see a renewed focus in this area and will depend on the outcome of the staffing review to contribute towards that work.

Roster Key Performance Indicators

The management of rosters is key to delivering safe care. The ability to monitor and track this for assurance is key and a number of agreed roster metrics have been agreed that will allow greater oversight and scrutiny on roster management to ensure the best care possible is delivered within the allocated resource. The outcome of this work will be feedback to workforce committee.

3.3 Areas not included in the March 2024 review

Areas the review has not included that were contained within the previous recommendation relate to;

1) **Birthrate plus** - The Registered Midwifery component of the Birthrate plus review. The service has 15 Registered Midwife vacancies currently; therefore, the focus is to retain those midwifes by providing the appropriate level of support and attract new midwifes to fill the existing vacancies. This is predicted to

take at least one year and therefore a phased approach to birth rate plus would allow phase 1 (2024) to focus on support staff and phase 2 (2025) to focus on Registered Midwifes, pending approval.

2) **Enhanced Levels of care** - Addressing the increasing requirement to provide enhanced supervision to patients is an important component of safe staffing reviews. The mechanisms in place currently follow a formalised acuity assessments and have oversight by the matrons three times daily to determine what staffing is required to maintained to safety. This decision will not prevent this current process from continuing and provides time to consider how this part of safe staffing can be addressed moving forward.
3) **HealthCare Support worker's banding** – There is a national programme of work underway relating to this and therefore this will be addressed as part of that work.

4. EFFECTIVE WORKFORCE PLANNING

The NQB (2018) recommend the annual workforce reviews consider the following:

- Patient acuity and dependency using an evidence-based tool (where available)
- Activity levels
- Seasonal demand
- Service developments
- Contract commissioning
- Service changes
- Staff supply
- International recruitment
- Temporary staffing above the set planned establishment
- Patient and staff outcome measures

Each of the 10 areas described were considered within each divisional review.

5. MONTHLY REPORTING

A comprehensive monthly report is presented to the Safety and Quality Committee as part of the safety and Quality dashboard and provides assurance in relation to the planned versus actual Nurse staffing, triangulated with the ED dashboard, Trust wide patient experience and safety indicators.

In recognition of the risks associated with Maternity and Children these staffing reports are disaggregated to ensure clear line of sight in these services.

Staffing levels are represented as percentage fill rates for each ward as submitted to NHS Choices each month. The fill rate is calculated from the number of actual hours worked by staff as a percentage of the number of hours required. The required hours are as agreed through the regular staffing and skill mix reviews. The sickness and maternity leave levels are also included in the analysis. This analysis is then converted to Care Hours per patient day (CHPPD).

6. ANNUAL REVIEW

The review is presented for approval to Board which is in line with the National Quality Board guidance following scrutiny at Safety and Quality committee.

7. METHODOLOGY

A triangulated multidisciplinary approach by the Chief Nursing Officer and deputy has been used to undertake the safe staffing reviews. The review included evidence-based tools, such as National Institute for Clinical Excellence (NICE) guidance, National Quality Board (NQB) safe staffing guidance alongside the professional judgement of those leading the services and a review of the key performance outcome measure for each area.

The review provided leaders with the opportunity to scrutinise quality, safety and workforce metrics alongside staff and patient feedback and any additional concerns or good practice associated with staffing and the wider provision of delivering excellent care with compassion.

The outcome of the review has been confirmed as being appropriate by the Divisional Nurse and Midwifery Directors for each division.

The NBQ (2018) Developing Workforce safeguards, recommends the following elements are considered for effective workforce planning. These include:

- Leadership
- Technology
- Information, method and governance
- Engagement and integration
- Strategy

The methodology of the review included analysis of the current establishment, beds, sickness levels, fill rates, activity, safety risks, feedback and analysis of quality outcomes including pressure ulcers, falls, start quality assurance outcomes, leadership performance and CQC feedback as part of their 2023 report.

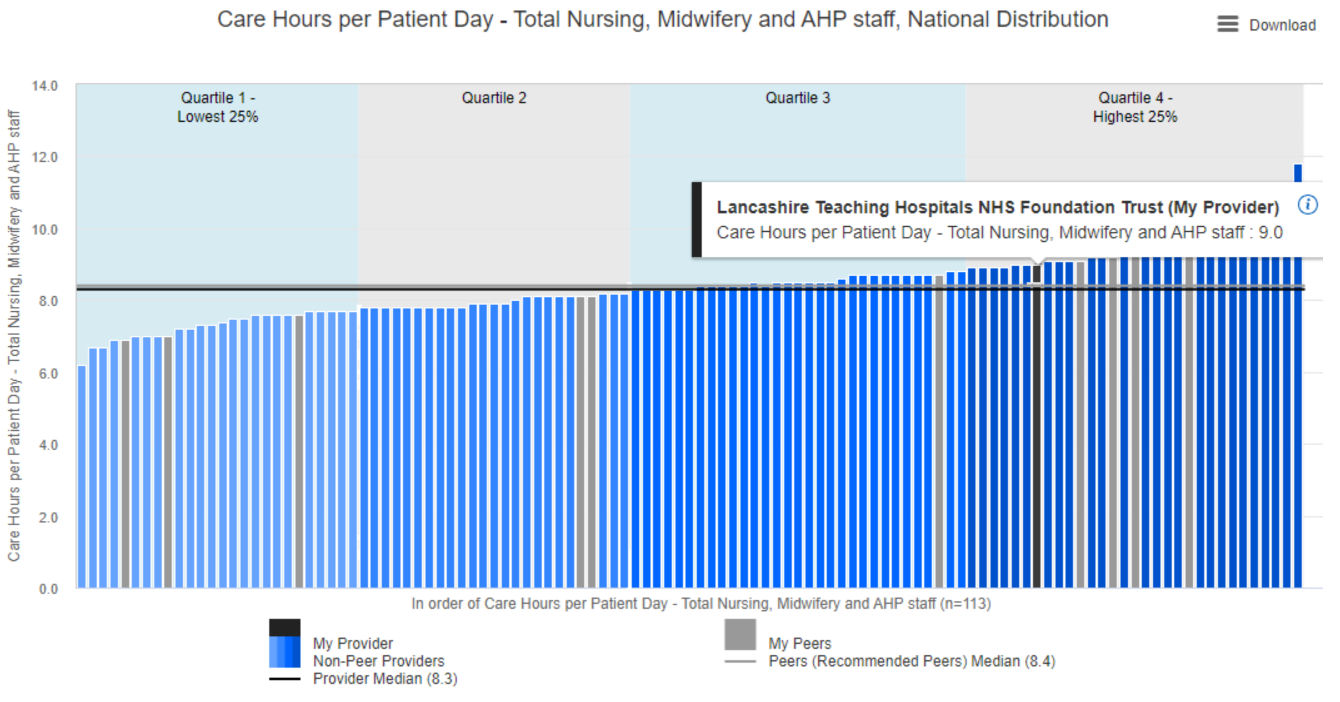
It is important to note, there will always be patients that require a significant level of care and this is not built into the establishment routinely given the cost associated with doing this. It was agreed that the autonomy to make additional requests in response to individual needs of patients would remain part of the ward managers role.

Using workforce information, patient safety, patient experience and clinical effectiveness indicators provides insight into the clinical areas/ services indicating stability, improvement and services that require additional support.

8. PROFESSIONAL JUDGEMENT AND PEER COMPARISON

The NICE (2014) and NHS Improvement staffing guidelines recommend the use of informed professional judgement to make the final assessment of the nursing needs of each clinical area. This review enacts the judgement of a number of senior nurses, considering professional guidance and safety and quality indicators to reach an agreement.

Graph 3 – Model Hospital Lancashire Teaching peer comparison using CHPPD – February 2024



Establishment Care Hours Per Patient Day (CHPPD) are the number of hours of care combining nurses and HCA divided by the number of beds in the hospital.

It is a high level, national proxy for staffing to bed ratios, some assurance can be gained from the positioning of the organisation against peer, however, contextual information such the number of enhanced care areas (7 at LTHTR) relating to providing tertiary services and the significant fluctuation of escalation beds which are not reflected in the model hospital return, (at their peak an additional 61extra beds) in addition to patients in non-designated bed spaces (boarded) that range between an additional 1-3 patients per ward in non high care areas, are relevant to this. It is important to note this also includes the double running associated with the international nurses and the position is expected to return to quarter 3 in 2024.

The data in graph 3 reflects Model hospital data from (February 2024) and places Lancashire Teaching Hospitals in the 4th quartile for CHPPD.

Table 1 – CHPPD compared to neighbouring and recommended peer organisations. (February 2024)

Peers	CHPPD Feb 24
Lancashire Teaching Hospitals NHS FT	9.0
East Lancashire Hospitals NHS	8.3
University Hospitals of Morecambe Bay NHS Foundation Trust	9.1
Blackpool Teaching Hospitals NHS FT	8.5
Mid Yorkshire Teaching NHS Trust	6.9
University Hospitals Plymouth NHS Trust	7
Royal Cornwall Hospitals NHS Trust	7.6
University Hospitals Coventry and Warwickshire NHS Trust	8.1
Torbay and South Devon NHS Foundation Trust	8.1
Dudley Group NHS Foundation Trust	8.7
North Bristol NHS Trust	9.2
South Tees Hospitals NHS Foundation Trust	9.3
Stockport NHS Foundation Trust	9.7

*It is important to note this data demonstrates hours worked and includes the double running associated with the international nurses and the position is expected to return to quarter 3 in 2024. It is reassuring that against peers LTH is broadly comparable.

9. LEADERSHIP

The role of the ward manager is pivotal to the delivery of safety and quality outcomes for patients. The roles impact and influence on the effectiveness of the day to day running of a ward cannot be underestimated. The ward manager role in ensuring quality, safety and the patients experience is critical, The roles have protected 80% time to lead and 20% working clinically as part of the team. (60% time to lead for the units with equal to or less than 10 beds or where there are 2 ward managers, this applies to the wards with equal to or more than 28 beds)

Time to lead can be defined as any duty that contributes to the delivery of safety, effectiveness and experience. This may include but not be exclusive to mentoring, clinical supervision, roster management, responding to clinical incidents, implementing improvements and supporting staff. However, it should be noted that although time to lead is allocated, on wards where vacancies are high, the ward manager will often need to work clinically to bridge gaps in safe staffing. This can compromise their ability to deliver the leadership requirements.

9.1 Assessment area leadership

The workforce review includes all assessment areas within the terms of reference. During the 2022/2023 review it was recognised that all assessment areas, with the exception of gynaecology and early pregnancy, have a ward manager to lead the service and 24/7 band 6 nurse presence ensuring sufficient senior nursing leadership is in place and retained to ensure that safety, quality and experience metrics are achieved.

The review has therefore given some additional scrutiny into the requirements of gynaecology, through the lens of early pregnancy and experiences of women and families. The gynaecology ward base currently provides inpatient care, day case and Same Day Emergency Care (SDEC) for benign gynaecology, early pregnancy, endometriosis, urogynaecology, ambulatory, menopause, endocrine disorders, vulval conditions and termination of pregnancy. In addition, they also provide tertiary gynaecological oncology services for Lancashire and South Cumbria (LSC) with a specialist team of gynaecology oncologists.

The Gynaecology Ward previously has 14 beds but due to Opel level escalation pressure within the Trust the bed base has the ability to increase to 18 beds in order that elective and emergency cases are accommodated. The elective and day case area is also staffed by the gynaecology ward and has 4 Trolleys for elective work with up to 7 admissions per day, Monday to Friday.

In addition, Gynae Assessment Unit (GAU) and Early Pregnancy Assessment Area (EPAU) falls under the remit of the gynaecology ward and the single ward manager. This is a 24/7 service accepting all urgent gynaecology and early pregnancy referrals. The average attendance is 30 patients each weekday. The activity data is demonstrating a sustained increase in attendances since 2021, with a 47% increase in attendances to the GAU/EPAU in the last two years.

The current staffing model is one band 7 across the ward (18 beds) elective work, the Day of surgery Admissions area (DOSA) the GAU/EPAU and SDEC Same Day Emergency Care service for gynaecology and early pregnancy. It is therefore proposed within the review and plan going forward that a second band 7 is required to manage the assessment areas.

10. EMERGENCY DEPARTMENT

The Emergency Department has maintained an increase in nurse staffing levels since the pandemic of 40WTE and 27WTE HCA. The staffing review identified the ED is continuing to experience high levels of occupancy and boarding and the substantive staffing in place is not sufficient to meet the demands on some days owing to peak pressures. The ED follow the same approach to safe staffing arrangements and have the ability to request bank and agency staff when patient safety may be compromised. A strategic approach to staffing the ED has been undertaken during 2023 with the aim of reducing the number of vacancies and improving the experience of staff in the department leading to less turnover. Due to the pressure of working in this environment sickness and turnover remain above the expected levels and it will be necessary to review the staffing levels again once some decisions are made regarding addressing the operational pressures.

In recognition of this, the ED dashboard is reviewed by the Safety and Quality committee and in March the committee also considered the additional steps taken to reduce the risk in ED by boarding additional patients on inpatient wards. The indicators are demonstrating a service under sustained pressure with specific areas of improvement required in average time to see a clinician, total length of time in the department and the STAR quality assurance outcomes. This triangulates with the CQC 2023 report findings and is the reason the exit block continues to remain escalated to the Board.

The professional judgement for ED is that the staffing levels are considered appropriate with the addition of the flexibility described to respond to peaks in activity and expansion of the department to maintain patient safety.

11. CHILDREN AND YOUNG PEOPLE EMERGENCY DEPARTMENT

Paediatric nurses are in place at RPH in line with RCN and NHS Improvement guidance and monitored along with child specific outcome measures as part of the Children and Young People Safety and Quality monthly papers. The indicators are demonstrating a stable service both in the ED and on the children’s ward.

The paediatric areas have been reviewed and a number of changes made to address skill mix deficit identified specifically relating to the leadership presence within the units to ensure robust supervision arrangements are in place. Appendix 3 provides the associated outcome measures relating to children and young people.

The professional judgement for children is that the staffing levels set in ED and in the paediatric areas are sufficient to meet the needs of the service.

12. CRITICAL CARE

Critical care beds increased in response to the covid pandemic from 28 to 34 beds. These beds have now been funded. A new critical care delivery group has been formed to oversee the enhanced care and critical care areas in line with good practice recommendations. This is a positive step forward and will enable additional insight into high care areas based on the peri operative care standards and will aim to ensure patients who are in their most acute phase receive the appropriate standards of care.

The professional judgement for critical care is that the staffing levels set are sufficient to meet the needs of the service.

13. FINNEY HOUSE

Finney House has now reached its first year. The staffing model was reviewed in October 2023 and a new staffing judgement determined. The unit is performing positively with low levels of incidents and complaints. An annual report to provide greater insight into Finney House outcomes is being drafted and will be shared in due course.

The professional judgement for Finney House is that the staffing levels set are sufficient to meet the needs of the service.

14. SURGERY

The recommended changes in surgery relate to standardising staffing over 7 days per week. Historic reduced occupancy within surgical wards on a weekend no longer occur. This increase in budget requested correlates with Wards 10 and 12 being key overspending cost centres as well as additional unqualified bank usage above funded establishment. Failure to uplift the funded establishment across these areas will result in a continued budgetary overspend. The financial increase of this change is largely offset by reductions in areas linked to underspending ward areas, and proposed changes agreed with respective Ward Managers and Matron, or with standardised safe staffing principles across the smaller clinical areas.

The professional judgement for the surgery division is that the staffing levels set require changes to address inaccurate headroom and consistency over 7 days. The review has led to a reduction of 3.33WTE in the surgical division overall.

15. WOMEN AND CHILDREN'S

The recommended increase within Womens relate to

- Birthrate plus - the Twin specialist midwife, Advanced Midwifery Practitioner for triage and the support element of the birthrate plus proposal. Total 9.91WTE. (The report does not explain the detail of the Birthrate plus review as the maternity neonatal report previously considered by Board contained this information).
- Gynaecology – Addressing the gap in leadership for the Early Pregnancy Gynaecology Assessment Unit and band 5 cover for the EPGAU at weekends to respond to the risk of early pregnancy loss on the unit. Total 2.20WTE.

It is not possible to enact these changes within existing budget. The changes suggested are safety critical.

The changes would then enable sufficient staffing levels to meet the needs of the service with continued use of agency within maternity services until the Registered Midwife position improves.

16. MEDICINE

The recommended increase in medicine relates to address safe staffing on MAU CDH following the extension of the assessment area (increase from 29 to 32 beds / trolleys) plus seating in the waiting room. Skill mix review on RWB due to acuity and complexity of the patients being managed in the unit and a skill mix review on ward 17 to provide band 6 support over 24hours as standardised for large ward. The financial increase of this change is offset by reductions in areas linked to underspending ward areas, and proposed changes agreed with respective Ward Managers and Matron, or with standardised safe staffing principles across the smaller clinical areas.

Total 9.69WTE in totality for the division.

It is not possible to enact these changes within existing budget, however, these posts all feature within the existing run rate as they are gaps in templates that would lead to safe staffing compromises and are therefore filled on a temporary basis. By filling these permanently the risk of turnover and adverse outcomes will be reduced.

The changes would then enable sufficient staffing levels to meet the needs of the service and minimise further the requirement for agency and bank.

17. FINANCIAL IMPLICATIONS

It is not possible to enact these changes within existing budget, the proposal is to realign budget across various departments to address staffing priorities and mitigate highest risk safety concerns, which in turn will allow areas to recruit into substantive posts at assessed and appropriate revised staffing models based on risk and the triangulated methodology. The expenditure is already being incurred in the run rate to provide safe levels of staffing, but increasing the fill-rate of substantive postholders should result in a reduction in bank and agency premium expenditure in due course, and reduce the gaps in staffing templates that would lead to safe staffing compromises.

The impact of the acuity review is a proposed recurrent budgetary increase of £1.190m and 18.47WTE.

Table 2 – Budget based on reviews recommendations vs current run rate. Divisional overview (*excluding maternity)

Division	Area	Recurrent Additional / Reduction In Budget Being Requested	Budget Required Based On Professional Judgement	Forecast Run Rate For FY23/24	Difference Run Rate vs. Professional Judgement
Medicine	Total	£528,317	£20,081,359	£25,311,206	(£5,229,846)
Surgery	Total	£11,310	£24,458,994	£31,239,491	(£6,780,496)
W&C's	Total	£173,184	£1,986,166	£1,904,432	£81,734
Total		**£712,810**	**£46,526,519**	**£58,455,128**	**(£11,928,609)**

The only areas where the budget is not within current run rate is Gynaecology, the impact on run rate for this area is £82k overall. Combining this with the maternity recommended increase would increase the run rate by £560k.

Table 3 - Overview and summary per areas / division

Area	Increase /Decrease budget establishment	WTE change in totality	Run rate impact WTE	Run rate impact Budget	Justification
Birthrate plus	£478k	9.91	+9.91 WTE	£478k	Implement Twin CMS, AMP and address support staff component of Birthrate plus to stabilise safety concerns and turnover within the service whilst recruiting to the vacant 15WTE RM.
Gynaecology	£173k	2.2	+1 WTE	£82k	Addresses 50% increase in demand for EPGAU and baby loss weekend provision (patient safety risk) as evidenced in prior review.
Medicine	£528k	9.69	No	£0	Addresses inequity in staffing in stroke rehabilitation ward, CDH MAU increase in activity and areas, ward 17 safety concern, plus CQC areas of concern.
Surgery	£11K	-3.33	Yes -3.33	£0k	Changes to address priorities, inaccurate headroom and consistency over 7 days.
Critical care	£0	0	No	£0	Staffing assessed as being compliant with guidance. No changes required.
Finney House	£0	0	No	£0	Staffing assessed as being compliant with guidance. No changes required.
CYP	£0	0	No	£0	Changes made to strengthen leadership within existing budget.
ED	£0	0	No	£0	Staffing as assessed as appropriate, maintaining the investment from the pandemic and the ability to respond to increases in acuity through the use of bank and agency. No changes at this time.
Total	**£1.190m**	**+18.47WTE**	**7.58WTE**	**£560k**	

18. SAFE STAFFING GOVERNANCE

Safety and Quality Committee continue to receive monthly safe staffing papers for adults, children and maternity. The papers are separated to ensure sufficient detailed oversight of the specialties is achieved and the introduction of medical staffing fill rates is evolving first through the maternity staffing paper.

Safe staffing policies are in place for each area and the DND's retain accountability for ensuring the deployment of staff in response to patient demand. The matrons operationalise these moves with site management arrangements in place 24/7 to ensure clear lines of escalation and support are available as situations change.

19. CHANGES TO ESTABLISHMENT

Appendix 1 outlines the specific changes made as a result of the annual review.

20. CONCLUSION

The staffing review for 2022/23 that should inform the establishments for 2024/25 have complied with the requirements of the NQB guidance detailed within the appendix.

As part of this review the Chief Nursing Officer confirms they are satisfied with the outcome of the safe staffing assessment and that whilst risks remain present as detailed within the strategic and operational risk register, staffing is safe, effective and sustainable. (Workforce Safeguards 2018).

The review has evidenced the positive impact of the international nurse strategy leading to a reduction in nurse agency of £5.3m year to date.

The overall budget increase associated with the safe staffing review is £1.190m (18.47WTE) with a run rate increase of £560k (7.58WTE).

The focus of 2024 will be on reducing sickness, strengthening leadership, achieving increased STAR rated green wards and attracting and retaining healthcare assistants to close the persistent 15% vacancy gap.

The safe staffing review and recommendations have been considered and endorsed by Safety and Quality committee in March 2024.

21.RECOMENDATION

It is recommended that the Board of Directors:

i. Note financial impact of the outcome.
ii. Approve the staffing review to set establishments for 2024/5 and agree to seek ICB approval to support the investment in line with the triple lock procedure.
iii. Note, in line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Chief Nursing Officer confirms they are satisfied with the outcome of the annual safe staffing assessment and that whilst risks remain present staffing is safe, effective and sustainable.

Appendix 1 Staffing Establishment - wards analysis Beds, WTE and financial impact. **(areas highlighted in green are included as a safety critical requirement)**

Division	Ward	Beds				WTE		Financial impact					
		Beds 2021	Beds 2022	Difference	Recurrently funded	22/23 WTE Funded (Recurrent & Non Recurrent)	Professional Judgement Nov22	Sum of Proposed Change to Funded WTE 22/23	Sum of Proposed change to Recurrent Funded WTE	Annual Budget 22/23 £	Proposed inc/(dec) In Year budget 22/23 £	Proposed incr/(dec) Recurrent budget £	Reasons for change
W&C's	Gynaecology Ward (RPH)	14	14	0	18	40.51	42.18	1.67	2.20	1,824,373	161,793	173,184	Currently established for 14 beds however continually escalated to 18 beds for some time, so professional judgement uplifted to support this. 47% increase in GAU activity over the last 2 years - Ward manager added to GAU, band 6 head room added as band 6 24/7 for pregnancy loss. The use of additional band 3 is currently being filled by Band 2 staff and will need reviewing as part of the annual staffing review 2024 - Additional Band 3 to be considered as Enhanced Level of Care at later stage. Removed band 2 as not required in this area currently staff member in post not to be replaced.
W&C's Total						40.51	42.18	1.67	2.20	1,824,373	161,793	173,184	
Surgery	ENT Ward 3 (RPH)	14	14	0	14	31.35	31.12	(0.23)	(0.23)	1,188,980	(11,456)	(8,209)	Standardised 2wte band 6, as per revised principles.
	Gen Surgery Ward 10 (RPH)	29	29	0	29	43.67	47.14	3.47	3.47	1,684,046	91,962	130,886	Addition of Band 2 HCA on night shift (increase of 1 to 2/shift) to ensure safe staffing levels, plus 1 additional B2 HCA on 12hr shift Friday - Sunday for consistent staffing numbers across 7days. Headroom allocated to B6s, in-line with principles for 28 beds and above. Hospital occupancy levels are now consistently above 95%, 7 days per week.
	Gen Surgery Ward 12 (RPH)	33	33	0	33	46.72	49.89	3.17	3.17	1,750,540	95,399	117,924	Addition of Band 3 HCA on night shift (increase of 1 to 2/shift) to ensure safe staffing, plus band 3 short shift on days converted to long shifts. Headroom allocated to B6s, in-line with principles for 28 beds and above. Hospital occupancy levels are now consistantly above 95%, 7 days per week.
	Leyland Wd (CDH)	25	15	-10	15	25.45	24.81	(0.64)	(0.64)	999,888	(34,502)	(18,835)	Removal of B5 short shift Monday - Wednesday (7.5hrs), and 0.79wte B2 HCA vacant post.
	Major Trauma Ward	10	10	0	10	31.26	29.68	(1.58)	(1.58)	1,294,679	(47,407)	(40,304)	Removal of 2 x B3 short shifts Monday - Sunday, partly offset by creation of 1 x B4 Monday - Friday long day shifts and B3 additional weekend long day shifts. Headroom allocated to B6s, in-line with revised principles for high-care areas.
	Neurosurgery Ward 2a(RPH)	17	17	0	17	29.07	35.83	6.76	6.76	1,437,926	(285,912)	205,106	Wards split into 4 areas - 2a, 2b, 2c, NHC. 2a, b, c standardised staffing model. Neuro wards should be considered as a whole, the changes are cost neutral across the 4 areas.
	Neurosurgery Ward 2b(RPH)	27	17	-10	17	44.16	35.83	(8.33)	(8.33)	1,799,532	(572,786)	(269,280)	Wards split into 4 areas - 2a, 2b, 2c, NHC. 2a, b, c standardised staffing model. Neuro wards should be considered as a whole, the changes are cost neutral across the 4 areas.
	Neurosurgery Ward 2c(RPH)	17	17	0	17	33.57	35.83	2.26	2.26	1,294,169	65,480	91,666	Wards split into 4 areas - 2a, 2b, 2c, NHC. 2a, b, c standardised staffing model. Neuro wards should be considered as a whole, the changes are cost neutral across the 4 areas.
	Orthopaedics Ward 14(RPH)	24	24	0	24	45.20	45.81	0.61	0.61	1,676,205	2,706	18,078	Additional HCA B2 on Short Saturday and Sunday shifts, and standardised 2wte band 6 for ward size, ward manager clinical time adjusted. Hospital occupancy levels are now consistently above 95% 7 days
	Orthopaedics Ward 16(RPH)	24	24	0	24	46.20	46.81	0.61	0.61	1,747,095	2,916	3,423	Additional HCA B2 on Short Saturday and Sunday shifts, and standardised 2wte band 6 for ward size, ward manager clinical time adjusted. Hospital occupancy levels are now consistently above 95% 7 days
	Plastics Ward 4 (RPH)	8	11	0	22	42.14	41.94	(0.20)	(0.20)	1,610,764	(21,405)	(342)	Skill mix between B3 and B4 levels due to increased theatre lists and the needs for specialised post operative care. RN added to Sunday to standardised staffing 7 days per week.
	SECU	4	4	0	4	13.60	11.55	(2.05)	(2.05)	582,023	(69,372)	(69,064)	Creation of B7 ward manager, offset by skill mix changes at B5 and B6 levels.
	Surgical Assessment Unit(SAU)	10	10	0	10	53.51	53.27	(0.24)	(0.24)	2,011,691	2,015	27,374	Surgical Ambulatory Care Unit is actually the Surgical Assessment Unit (cost centre name updated in the ledger effective M10 22/23). Headroom changes between B5 and B6 levels, in-line with revised principles for Assessment areas.
	Surgical Unit	16	16	0	16	35.10	30.16	(4.94)	(4.94)	1,212,912	(158,579)	(157,776)	Reduction in B2 A&C Ward Manager support.
	Upper GI Ward 11 (RPH)	8	11	0	22	37.77	38.58	0.81	0.81	1,360,186	6,207	39,253	Standardised 2wte band 6, as per revised principles, partly offset by creation of 1 x B5 on long day shifts (increase from 2 to 3/shift). Offsetting reduction for Ward Manager clinical shift on Fridays. Occupancy level now
	Vascular Ward	33	33	0	33	61.75	58.96	(2.79)	(2.79)	2,395,390	(97,001)	(58,404)	Headroom allocated to B6s, in-line with principles for 28 beds and above. Reduction in 1 x B3 short shift Monday - Thursday and at weekends, and B4 short shift Tuesday - Thursday.
	Neuro Enhanced High Care	0	10	10	10	30.84	30.83	(0.01)	(0.01)	733,999	710,703	(187)	Wards split into 4 areas - 2a, 2b, 2c, NHC. 2a, b, c Staffing set as per high care principles. Neuro wards should be considered as a whole, the changes are cost neutral across the 4 areas.
Surgery Total					18.69354839	651.36	648.03	(3.33)	(3.33)	24,780,026	(321,032)	11,310	
Medicine	Bleasdale Ward (RPH)	20	21	1	20	42.58	41.34	(1.24)	(0.24)	1,598,329	(51,118)	(18,165)	Time adjusted for ward managers clinical time.
	Brindle Ward - Gastro	30	30	0	30	51.28	49.89	(1.39)	(1.39)	1,947,789	(73,438)	(54,464)	B5 adjusted for Ward Manager undertaking clinical shifts. Headroom allocated for B6, in-line with principles for 28 beds and above. Band 5 short shifts removed.
	Cardiology Ward 18 (RPH)	28	28	0	28	58.23	53.65	(4.58)	(4.58)	2,205,681	(180,731)	(158,872)	Time adjusted for clinical shifts undertaken by the ward manager. Headroom allocated for B6, in-line with principles for 28 beds and above. Staffing need for enhanced care to be reviewed as part of the annual staffing review 2024.
	Elderly Rookwood A (CDH)	24	24	0	24	51.51	49.60	(1.91)	(0.91)	1,866,393	(56,039)	(28,259)	Standardised 2wte band 6, as per revised principles. band 5 short day converted to long, band 2 HCA short shift removed. Increased patient complexity.
	Elderly Rookwood B (CDH)	24	24	0	24	41.90	49.60	7.70	7.70	1,641,647	259,086	279,584	B3's moved to long days. Additional RN on days to support acuity and complex patient needs. Standardised 2wte band 6, as per revised principles. Increase HCA on nights to maintain safety.
	Gen/Med Elderly Ward 17	32	32	0	32	52.07	52.65	0.58	0.58	2,044,210	21,385	65,023	Headroom allocated for B6, in-line with principles for 28 beds and above. Skill mix reviewed to ensure safety between band 2 and band 3 staff needed. Staffing need for enhanced care to be reviewed as part of the annual staffing review 2024.
	Hazelwood	19	19	0	19	36.86	35.83	(1.03)	(1.03)	1,486,292	(80,191)	(66,148)	Ward manager clinical time adjusted. Skill mix enacted between B2 / B3 colleagues. Standardised 2wte band 6, as per revised principles.
	MAU (CDH)	29	29	0	29	59.46	71.09	11.63	12.63	2,376,531	525,610	560,034	Headroom added to templates. Extension to assessment area has increase beds & trolleys to a total of 32 (previously 29) plus the waiting room. Skill mix review of band 2 and band 3 need for an assessment unit undertaken.
	Respiratory Ward 23	34	34	0	34	60.00	59.27	(0.73)	(0.73)	2,244,848	(25,704)	(2,312)	Headroom allocated for B6, in-line with principles for 28 beds and above. Skill mix altered between B2 / B3. Time adjusted for ward manager clinical shifts.
	Stroke Ward 21 (RPH)	24	24	0	24	63.37	61.02	(2.35)	(2.35)	2,407,003	(76,225)	(48,103)	Headroom allocated to B6. Additional funding provided to facilitate the creation of 5 enhanced high care beds.
Medicine Total					26.4	517.26	523.95	6.69	9.69	19,818,723	262,636	528,317	
Grand Total				-0.32247557	21.42996743	1,209.13	1,214.16	5.03	8.56	46,423,122	103,397	712,810	

Appendix 2 – Triangulation of workforce, safety, quality and experience data

Ward/Dept	No of Beds 2024	No of Beds 2022	No of Beds 2021	% Fill Rate RN Days (6months - July - December)	% Fill Rate UnReg Days (6months - July - December)	% Fill Rate RN Nights (6months - July - December)	% Fill Rate UnReg Nights (6months - July - December)	Falls (6months - July - December)	Pressure Ulcers (6months - July - December)	Clostridium difficile (6months - July - December)	Sickness % FTE (6months - July - December)	Turnover % FTE (6months - July - December)	STAR rating (last accreditation audit)	Friends and family Good % (6months - July - December)	Friends and family Poor % (6months - July - December)	Friends and family Responces (6months - July - December)	Medication Errors with Harm (6months - July - December)	Incident reports relating to Staffing (6months - July - December)	Red Flags raised (6months - July - December)	Formal complaints (6months - July - December)
ED (RPH) (adult)	46	53	33	102%	93%	104%	95%	46	25	0	5.00 %	2.56 %	Bronze (86%)	58%	32%	1555	113	2	0	17
ED (RPH) (children)	4	4	N/A	87%	93%	92%	93%	0	0	0	0%	0%	Bronze (88%)	76%	16%	165	Not seperated			
AAU	18	N/A	N/A	92%	88%	90%	87%	10	6	1	11.87 %	4.62 %	Bronze (87%)	100%	0%	1	25	0	5	0
Acute Frailty	10	10	10	99%	95%	97%	85%	10	3	0	8.34 %	3.18 %	Silver (96%)	94%	3%	33	5	0	8	0
Bleasdale Ward	21	21	20	85%	108%	100%	112%	25	10	0	3.83 %	5.07 %	Silver (92%)	82%	9%	11	21	10	5	0
NRU (Barton)	16	16	13	167%	115%	103%	171%	2	2	1	2.46 %	1.02 %	Gold (96%)	66%	0%	23	9	0	2	1
MAU (RPH)	29	30	28	91%	82%	84%	97%	43	15	3	7.96 %	2.67 %	Bronze (86%)	100%	0%	25	41	3	45	3
CCU RPH	6	6	6	99%	62%	101%	N/A	3	1	0	6.32 %	0%	Silver (91%)	98%	2%	46	3	0	7	0
Ward 5	28	28	28	101%	84%	100%	100%	29	35	2	7.27 %	4.27 %	Silver (92%)	75%	17%	36	16	1	30	1
Ward 17	32	32	30	109%	110%	106%	129%	33	18	2	8.02 %	4.87 %	Silver (94%)	81%	15%	27	14	9	56	4
Ward 18	28	28	28	98%	94%	99%	101%	13	17	4	7.41 %	3.09 %	Silver (95%)	80%	16%	55	8	0	8	1
Ward 21	24	24	25	98%	87%	98%	97%	26	5	0	9.68 %	0%	Silver (92%)	84%	4%	45	22	0	21	2
Ward 23	34	34	34	92%	91%	103%	118%	27	16	2	5.96 %	0%	Silver (93%)	85%	10%	52	24	8	53	3
Ward 24	32	32	32	103%	87%	100%	103%	37	21	1	7.43 %	2.99 %	Silver (93%)	66%	15%	41	13	0	8	3
Ward 25	23	23	23	109%	87%	94%	105%	14	4	8	8.84 %	2.15 %	Silver (91%)	78%	11%	54	11	0	17	2
Enhanced High Care (Ward 20)	22	22	12	93%	86%	92%	103%	11	23	2	7.06 %	1.64 %	Silver (94%)	100%	0%	6	30	3	19	1
ED (CDH)	17	17	17	100%	120%	N/A	N/A	2	1	0	8.10 %	9.33 %	Silver (91%)	89%	6%	1426	22	3	1	2
MAU (CDH)	29	29	29	104%	139%	101%	145%	35	19	4	7.86 %	1.68 %	Silver (90%)	71%	20%	80	68	7	18	7
Brindle	30	30	30	92%	103%	100%	121%	16	19	4	12.84 %	0%	Bronze (89%)	76%	8%	79	15	0	13	3
CCU CDH	10	10	10	95%	98%	101%	105%	6	5	0	5.83 %	2.61 %	Gold (95%)	No data	No data	No data	28	5	31	0
Rookwood A	24	24	24	116%	91%	117%	107%	27	5	1	6.29 %	4.10 %	Silver (93%)	79%	7%	85	31	2	59	1
Rookwood B	24	24	24	109%	104%	104%	113%	21	8	0	10.29 %	2.28 %	Silver (90%)	69%	22%	32	16	0	36	1
Hazelwood	19	19	19	95%	84%	104%	106%	12	6	0	5.06 %	0%	Silver (91%)	85%	7%	110	19	0	6	2
Cuerden	24	24	N/A	105%	89%	117%	93%	19	2	2	11.63 %	6.20 %	Silver (93%)	89%	8%	126	25	1	19	1
Neuro High Care	10	10	N/A	102%	101%	107%	257%	7	5	1	10.81 %	1.08 %	Gold (93%)	No data	No data	No data	23	2	27	0
Ward 2a	17	17	17	94%	118%	100%	139%	11	10	4	7.87 %	2.56 %	Silver (97%)	100%	0%	58	9	0	2	1
Ward 2b	17	17	27	96%	95%	102%	134%	20	6	1	2.91 %	0%	Silver (93%)	83%	17%	12	18	1	9	1
Ward 2c	17	17	17	93%	91%	100%	115%	14	5	2	9.14 %	5.60 %	Gold (96%)	100%	0%	22	12	0	4	0
Ward 3	14	14	14	101%	93%	113%	117%	1	4	1	10.83 %	0%	Gold (94%)	91%	5%	102	7	0	16	1
Ward 4	26	26	22	118%	87%	113%	120%	9	2	1	7.76 %	1.47 %	Gold (97%)	88%	6%	109	15	0	9	0
Wrad 10	29	29	29	95%	122%	94%	139%	21	3	3	5.27 %	2.08 %	Gold (93%)	89%	9%	154	22	1	5	2
Ward 11	22	22	18	96%	85%	98%	96%	9	5	2	10.13 %	2.47 %	Silver (92%)	84%	9%	67	16	0	1	0
Ward 12	33	33	32	103%	104%	99%	134%	16	12	2	4.97 %	1.96 %	Silver (96%)	73%	17%	93	28	0	6	1
Ward 14	24	24	24	102%	112%	100%	125%	15	24	1	6.27 %	0%	Gold (94%)	83%	13%	40	14	5	40	2
Ward 15	33	33	33	102%	78%	102%	96%	38	18	8	9.99 %	2.60 %	Bronze (85%)	81%	9%	58	15	0	6	1
Ward 16	24	24	24	103%	106%	102%	117%	14	11	3	4.21 %	0%	Gold (93%)	93%	2%	41	5	1	23	1
Major Trauma Ward	10	10	10	93%	101%	100%	115%	8	6	0	5.78 %	1.38 %	Gold (94%)	100%	0%	5	11	0	0	1
Ribblesdale Unit	24	24	24	102%	91%	120%	95%	30	29	7	9.17 %	3.45 %	Silver (91%)	74%	15%	34	25	0	41	2
Surgical Assessment Unit RPH	17	17	17	86%	83%	94%	92%	2	1	0	6.05 %	0%	Gold (93%)	68%	26%	286	19	0	4	3
SECU	4	4	4	96%	N/A	93%	N/A	0	1	0	7.67 %	0%	Gold (96%)	100%	0%	44	5	1	0	0
Surgical Unit (CDH)	16	16	16	83%	67%	96%	68%	1	0	0	12.97 %	1.68 %	Gold (97%)	No data	No data	No data	5	0	1	0
Leyland Ward	15	15	25	87%	68%	90%	72%	6	5	0	6.99 %	0%	Gold (97%)	96%	3%	229	10	0	0	0
Ward 8	30	30	30	91%	88%	92%	91%	4	0	1	9.88 %	1.70 %	Bronze (89%)	89%	7%	357	57	5	0	1
PAU	10	10	10	93%	95%	100%	97%	1	0	0	8.85 %	8.29 %	Gold (95%)	96%	3%	120	6	7	0	0
Pead Day case	7	7		94%	89%	N/A	N/A	0	0	0	5.86 %	11.99 %	Gold (99%)	100%	0%	17	2	3	0	0
NNU	28	28	28	75%	87%	76%	69%	0	3	0	12.31 %	1.80 %	Silver (97%)	100%	0%	59	47	35	0	1
Gynae Ward RPH	18	18	14	95%	98%	99%	90%	3	2	2	6.35 %	0%	Gold (91%)	89%	8%	287	13	1	13	8
GAU				81%	124%	N/A	N/A	0	0	0	-	0%	Gold (93%)	30%	40%	10	1	1	0	1
Critical Care	28	28	28	90%	86%	97%	76%	6	57	8	7.75 %	3.14 %	Gold (93%)	100%	0%	5	69	49	0	0
Buttercup (CHH)	32	N/A	N/A	104%	99%	99%	105%	37	14	0	7.76 %	0.97 %	Silver (94%)	95%	5%	19	40	0	0	1
Meadow (CHH)	32	N/A	N/A	90%	106%	105%	106%	35	11	0	4.04 %	7.21 %	Silver (93%)	89%	4%	47	50	0	0	1
Orchard	32	N/A	N/A	127%	97%	203%	101%	14	2	0	4.73 %	8.80 %	Bronze (80%)	N/A	N/A	N/A	31	0	0	0

Appendix 3 Children's and young People Dashboard

Indicator	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-23
Senior review within 4 hours weekday %	97%	95%	95%	86%	96%	93%	93%	97%	92%	88%	81%	93%	94%
Senior review within 4 hours weekend %	91%	86%	95%	98%	91%	100%	96%	95%	100%	88%	92%	93%	97%
Consultant review within 14 hours weekday %	80%	81%	77%	70%	81%	88%	82%	88%	92%	72%	64%	91%	75%
Consultant review within 14 hours weekend %	79%	96%	79%	76%	65%	62%	80%	64%	81%	65%	75%	68%	74%
Discharges against medical advice	2	5	5	1	3	2	3	3	3	8	5	0	3
Safe and secure handling of medicines	76%	79%	68%	86%	72%	84%	87%	92%	83%	83%	81%	68%	81%
Monthly inpatient STAR	79%	77%	87%	81%	81%	85%	97%	94%	78%	73%	62%	66%	78%
PEWS compliance	98%	98%	95%	98%	96%	96%	85%	98%	97%	100%	95%	100%	93%
mattress audit	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%
hand hygiene	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Intra vascular devices	87%	93%	91%	97%	100%	100%	95%	100%	88%	100%	93%	100%	95%
Management of suspected infection	97%	98%	98%	100%	100%	100%	100%	96%	100%	100%	98%	100%	100%
Monthly commode audit	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%
CCOT PEWS 3 monthly	92%	#	#	#	100%	100%	#	#	95%	#	#	95%	100%
CD audit 3 monthly	90%	#	#	90%	#	#	70%	#	#	90%	#	#	90%
Local CD audit	92%	100%	100%	100%	100%	100%	92%	98%	100%	98%	100%	100%	96%
Number of incidents	82	154	155	134	83	75	59	79	90	97	114	75	69
No harm	73	130	130	95	74	65	51	50	71	82	101	61	50
Near miss	11	30	29	3	12	2	3	10	10	7	4	10	3
Harm (low)	9	12	25	11	7	8	13	17	17	14	9	11	9
Harm (moderate and above)	0	1	0	1	1	2	1	2	2	1	4	3	2
Number of child deaths	0	0	0	0	0	1	0	0	0	0	0	0	0
Number of complaints	1	2	0	1	1	2	0	0	0	2	2	2	1
Number of PALS	5	7	7	9	3	11	13	3	4	13	7	4	6
Friends and family Inpatient	90	94	82	88	86	92	95	87	82	90	89	76	87
Friends and family day case	90	91	94	97	96	96	95	100	95	87	92	85	88
Friends and family Outpatients	95	96	99	94	92	96	93	97	94	90	85	90	88
Appraisal rate	76%	82%	78%	84%	84%	84%	86%	90%	92%	91%	80%	77%	81%

Safeguarding children level 3	94%	92%	96%	97%	94%	94%	95%	98%	90%	96%	97%	95%	96%
Prevent	97%	96%	96%	97%	97%	97%	97%	97%	94%	97%	95%	95%	97%
PBLS	92%	92%	84%	90%	87%	87%	87%	89%	86%	83%	77%	95%	84%
APLS	89%	88%	88%	55%	71%	71%	62%	62%	50%	50%	50%	38%	28%
Moving and handling	94%	94%	97%	97%	97%	97%	92%	85%	81%	74%	65%	63%	63%
ANTT	92%	92%	94%	97%	98%	98%	100%	98%	95%	97%	98%	98%	97%
Ward 8 Registered Nurse Day	89%	91%	93%	93%	92%	94%	91%	88%	89%	93%	93%	90%	90%
Ward 8 Un registered Nurse Day	75%	66%	82%	78%	81%	79%	93%	90%	85%	89%	88%	86%	82%
Ward 8 Registered Nurse Nights	90%	94%	94%	97%	93%	94%	92%	94%	93%	93%	92%	89%	92%
Ward 8 Unregistered Nurse Nights	85%	90%	90%	85%	90%	91%	95%	93%	90%	84%	87%	94%	91%
Roster publishing 100%	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
RCN Compliance ward 8	93%	88%	89%	100%	100%	98%	95%	98%	85%	82%	unav	94%	93%
ward 8 Vacancies WTE band 5	7	11	11	6	7	7	13	5	5	4	6	5	5
ED Registered Nurse Day	97%	87%	86%	91%	85%	81%	85%	91%	89%	85%	89%	89%	88%
ED Un Registered Nurse Day	93%	90%	87%	94%	81%	91%	96%	92%	95%	90%	94%	94%	93%
ED Registered Nurse Night	96%	87%	79%	75%	73%	76%	92%	92%	89%	95%	97%	89%	89%
ED Un Registered Nurse Night	79%	90%	96%	93%	99%	95%	95%	97%	94%	99%	92%	94%	99%
PAU Registered Nurse Day	88%	93%	91%	94%	96%	93%	88%	93%	100%	99%	94%	89%	87%
PAU Un Registered Nurse Day	94%	93%	91%	93%	100%	99%	97%	90%	97%	99%	97%	92%	100%
PAU Registered Nurse Night	100%	97%	97%	100%	100%	100%	93%	98%	101%	103%	100%	97%	100%
PAU Un Registered Nurse Night	97%	101%	97%	92%	97%	97%	100%	97%	98%	99%	102%	87%	100%

Appendix 4 Staffing Guidelines

This seeks to provide a broad overview of the guidance consulted and considered when applying the speciality guidance available.

Speciality	Guideline's	High level Overview of Recommendations
Adult inpatient areas	NICE Safe Staffing Guidelines	There is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. Each ward should determine its nursing staff requirements to ensure safe patient care. It then recommends on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met throughout a 24-hour period. Recommends the use of Shelford Safer Care Tool and endorses the use of Health Roster and safe care.
Adult Inpatient	NHS Improvement (March 2021) Care Hours Per Patient Day (CHDDP) Guidance for all inpatients Trusts	Ward establishments are set using NICE endorsed evidence based tools such as the Safer Nursing Care Toll or Birthrate plus in maternity. These are in line with the NQB and underpinned by clinical judgement. The set establishment as signed off at budget setting by finance, workforce, operational and clinical leads are being expressed in terms of care hours (and could be therefore convertible to CHPPD) to enable comparison and triangulation with national reported CHPPD.
Children's and Young Peoples Service	RCN standards (2013)) Defining staffing levels for children and young people's services	Children < 2 years of age 1:3 registered nurse: child, day and night. Children > 2 years of age 1:4 registered nurse: child, day and night The ward staffing complement must also have a supervisory ward sister/charge nurse and unregistered staff, who are not included in the above baseline bed side establishment. The following standards should be applied for all general inpatient wards as a minimum: • one Band 7 ward sister/charge nurse • one ward receptionist +/- admin support for sister • minimum of one health play specialist • one housekeeper • +/- one hostess. Skill mix should be balanced to meet the needs of the service and dependency/acuity of the children and young people requiring nursing care. In addition to the Band 7 ward sister/charge nurse, a competent, experienced Band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team. This will provide an experienced nurse to advise on clinical nursing issues relating to children across the organisation 24-hours a day. **High dependency care** The nursing requirements for infants and children in NICU and PICU requiring high dependency care have been defined above. However, high dependency care is often provided outside of the intensive care unit in both specialist wards in tertiary hospitals and general wards in district general hospitals. The expertise and support for staff in these settings varies considerably, necessitating staffing for high dependency care to be based on local requirements as well as national guidance. While use of a children's high dependency care
		assessment tool can assist the assessment of staffing requirements for high dependency care, the following registered nurse-to-patient ratios should be applied regardless of the setting: • 0.5:1 registered nurse: patient for children requiring close supervision and monitoring following surgery, those requiring close

		observation for mental health problems or with single system problems. • 1:1 registered nurse: patient, where the child is nursed in a cubicle, has mental health problems requiring close supervision, or where the condition of the child deteriorates and requires intensive care. This higher ratio will also be required during the admission process until the child is fully admitted and stable.
Coronary Care units	British Cardiology Society (2011)	Recommends BACCN standards Staffing in the acute cardiac care unit should not fall below a ratio of one registered nurse to two patients.
Critical Care Units	British Association of Critical Care Nurses 2009 Standards for nurse staffing in critical care. (BACCN)	Critical Care units also require a number of staff to support the delivery of care to patients through: 1. Management of the unit by a designated lead matron, 2. Coordination of each shift by a supervisory/supernumerary senior critical care qualified nurse. 3. Additional supervisory/supernumerary support for every 10 beds. (BACCN/ICS recommendation: 21 – 30 beds = 2 additional supernumerary registered nurses). This is the minimum recommended. The support includes assistance with admissions, transfers, ensuring patient care is driven forward to reduce length of stay or time spent at level 3 e.g. that there are no delays in weaning plans 4. Education and Training for staff - the recommended service specification is that 50% of staff on critical care units should be in possession of a post registration award in Critical Care Nursing. The BACCN/ICS recommendation is 1 for every 75 staff. Each Critical care unit should have a dedicated clinical educator. 5.Technical support – The vast amount of medical devices within the unit requires a level of technical expertise to maintain the day to day integrity of the machines in the clinical environment. 6.Care support workers are required to support the provision of care in each area of the unit.
Critical Care Units	Guidelines for the Provision of Intensive care services Core Standards for Intensive care units 2013	Level 3 patients (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum 1:1 to deliver direct care Level 2 patients (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum 1:2 to deliver direct care Supports BACCN standards
Emergency Departments	RCN Baseline Emergency Staffing Tool (2013)	BEST recommends minimum nurse to patient ratios when planning nursing establishments or for use on a shift-by-shift basis. The BEST tool reflects the following ratios. One registered nurse to four cubicles in either “majors” or “minors” One registered nurse to one cubicle in triage One nurse to two cubicles in the resuscitation area. 1 band 7 (or equivalent) registered nurse on every shift at all times Major trauma (2 registered nurses to 1 patient) Cardiac arrest (2 registered nurses to 1 patient) Priority ambulance calls (1 registered nurse to 1 patient) Family liaison (1 registered nurse to 1 patient’s family/carers) 1 Registered Children’s nurse per shift
Major trauma Network	Regional Networks for Major Trauma 2010	Major Trauma Peer review recommends one Band 7 RN per shift in the ED 24/7 to maintain Major Trauma status. Geography is also an important factor that affects the number of nurses required to provide visual observation of acutely unwell patients. A children’s nurse should be present in the departments during

		opening hours. In the Major Trauma Centre, patients with multiple injuries should be located within dedicated trauma wards. Some patients with single system injuries may have their care needs best met by the appropriate speciality ward. Crucial to the delivery of safe, high quality care for trauma patients is the establishment of a critical mass of experienced staff. This requires a highly trained and experienced nursing workforce with the appropriate staffing levels, skills mix, ongoing education and leadership.
Neonatal Services	British Association of Perinatal Medicine (2011) Department of Health (2009)	The recommended staffing levels for neonatal services, minimum nurse to child ratio Intensive Care 1:1 High Dependency 1:2 Special Care 1:4 The DOH also produced best practice guidance for neonatal staffing which recommend a nurse co-ordinator on every shift (additional to those providing direct clinical care) and that units have a minimum of two registered staff on duty at all times (one which holds a qualification in the speciality)
Neuro Rehabilitation	NICE 2015 Specialised Neurorehabilitation Service Standards Updated 30.4.2015	Specialised rehabilitation services for Neurorehabilitation services per 20 beds require Hyper acute phase - 65-75% RN Level 1a -50-60% RN Level 1b – 35-40% RN At least 40% of nurse should have specific rehab training
Older People	RCN Safe Staffing for Older People's Wards (2012)	Recommends 1:5 – 1:7 nurse to patient ratio to deliver ideal, good quality care. 65:35% registered to un- registered skill mix.
Stroke	British Association of Stroke Physicians 2014 BASP	The Acute Stroke Unit provides sufficient trained nursing staff to provide high quality nursing care. In the first 72 hours of an acute stroke patient's admission, they will require more intensive monitoring and nursing input, requiring a minimum Level 2 nursing staff numbers to manage the acute stroke patient (2.9 WTE nurses per bed; 80:20% trained to untrained staffing ratio) is recommended. Thereafter a level of 1.2 WTE nurses per bed is appropriate.

Appendix 5 - NHS Improvement staffing improvement resources

Area for Improvement	Description	Sources	Hight level Overview of Recommendations
National Quality Board (2016) Improvement and Assessment Framework for Children's and Young People's health services			
Nurse Staffing Level	Right staff Right Skills Right time and place	Supporting NHS providers to deliver the right staff with the skills at the right time. (National Quality Board 2016)	• Evidence-based workforce planning. • Professional judgement. • Compare staffing with peers. • Mandatory training, development and education. • Working as a multi-professional team. • Recruitment and retention. • Productive working and eliminating waste. • Efficient deployment and flexibility. • Efficient employment and minimising agency.
National Quality Board (2017) Safe, Sustainable and productive staffing: An improvement resource for neonatal, children and young people services			
Nurse Staffing Level	Safe, Effective, caring, Responsive and Well-led care	National Quality board (Nov 2017)	• Boards must ensure there is a strategic multi-professional staffing review at least annually (or more frequently if service changes are planned or quality or workforce concerns are identified), which is aligned to the operational planning process. In addition a mid-year review should provide assurance that neonatal services are safe and sustainable. This should assess whether current staffing levels meet the recommended levels and are likely to do so in future. • Skill mix should be regularly reviewed to ensure that the most suitable staff are undertaking the correct roles and that they are available in sufficient numbers. • Professional judgement should be used together with appropriate workforce and acuity tools. • Data collected using BadgetNet and the neonatal nurse staffing tool (Dinning) should be used to calculate the required establishment according to the level of activity. This should be shared with the neonatal ODN. • Training and development must be linked to annual individual appraisals and development plans and must be provided within the resources available to the team, to meet service needs. • Organisations should recognise the increasing need for flexible working patterns to meet the fluctuating needs in neonatal services. All neonatal units should adhere to the pathways agreed with the ODN and specialised commissioning teams to ensure efficient working across the network. All neonatal units should input data into BadgerNet to enable national benchmarking. • Areas of concern highlighted by parents/families or staff using workforce planning and analysis methods must be carefully scrutinised and appropriate actions taken to address them.
National Quality Board (2018)Safe, sustainable and productive staffing – adult inpatient wards in acute hospitals			
Nurse Staffing Levels	Safe, Effective, caring, Responsive and Well-led	National Quality board (Jan 2018)	• A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers. • A strategic staffing review must be undertaken annually or

	care		sooner if changes to services are planned. • Staffing decisions should be taken in the context of the wider registered multi-professional team. • Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process. • Action plans to address local recruitment and retention priorities should be in place and subject to regular review. • Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit the use of temporary staff. • A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making. • Organisations should ensure they have an appropriate escalation process in cases where staffing is not delivering the outcomes identified. • All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff. • All organisations should investigate staffing-related incidents and their outcomes on patients and staff, and ensure action and feedback.
National Quality Board (2017) Safe, sustainable and productive staffing An improvement resource for urgent and emergency care			
Nurse Staffing Levels	Leading change, adding value.	National Quality board (Nov 2017)	• A strategic staffing review must be undertaken annually or sooner if changes to services are planned. • A systematic approach should be adopted using an evidence-informed decision support tool cross-checked with professional judgement and comparison with comparable peers. • Safe staffing requirements and workforce productivity should be considered as an integral part of the operational planning process. • Acuity and dependency may vary considerably within UEC settings. Staffing reviews should use decision support tools for the assessment and measurement of acuity, dependency and workload. • Demand in UEC settings fluctuates through 24 hours, the week and with the season. Workforce planning should allow for this and reflect trends in activity. Contingency plans should enable flexibility of staffing to meet unexpected demand. •Workforce planning should allow for role development/expansion and new ways of working while ensuring that fundamental care remains a priority. • Staffing decisions should be taken in the context of the wider multi-professional team. • A local dashboard should be used to assure stakeholders that staffing is safe and sustainable. The dashboard should include department-level quality indicators to support decision-making. • Organisations should ensure they have an appropriate escalation process in case staffing is inadequate. •Action plans to address local recruitment and retention priorities within UEC settings should be in place and subject to regular review. • Flexible employment options and efficient deployment of staff should be maximised to limit the use of temporary staff. • All organisations should have a process to determine additional uplift requirements based on the needs of patients and staff.

			• All organisations should investigate staffing-related incidents and the outcomes for patients and staff, ensuring action and feedback.

Appendix 6 - NQB Safe sustainable and productive staffing recommendations 2016

Supporting NHS providers to deliver the right staff, with the right skills in the right place at the right time

	Recommendation	LTHTR Response
	Right staff	
1	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.	Daily meetings for staffing, operationally managed by divisional matrons and escalated through chain of command.
	Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.	Annual staffing reviews undertaken using professional judgement, model hospital comparisons, CHPPD and predicted CHDDP , workforce data , nurse sensitive indicators and financial impact Monthly staffing reports provided to Safety and Quality committee.
	Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations.	Monthly in-depth staffing papers to Safety and Quality committee for adult inpatient, maternity / neonates and paediatrics
1.1	Evidence based workforce planning	Workforce reviews include benchmarking against professional and national Standards. SAFECARE to calculate acuity scores CHPPD / predicted CHPPD/ peer and national CHPPD
1.2	Professional judgement	Annual workforce review – all ward managers included in the discussion to establish professional judgement
1.3	Compare with peers	Clinical quality dashboard Service level peer reviews Model hospital comparisons
	Right Skills	
2	Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.	Quarterly reports (Schedule 6) to ICB. ICB Executive in attendance at Safety and Quality committee
	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multi-professional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services.	Core people management skills. Leadership and development programmes. Leadership and OD strategy. Leadership focus as part of the annual review. Flow Coaching Academy. Micro Coaching Academy.
	Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.	Skill mix, extended roles, introduction of AP/ NA role, Discharge facilitators/ Non - medical prescribing, Advanced nurse practitioners, Non- medical consultants, Clinical specialists.
2.1	Mandatory training, development and education	Study leave included in headroom

		calculations. Mandatory training and appraisal targets. Time to lead incorporated into ward managers role
2.2	Working as a multi -professional team	Integrated allied health professionals within traditional workforce. Pharmacy Technicians supporting medication round pilot
2.3	Recruitment and retention	Quarterly recruitment and retention committee reports directly to Chief Peoples Officer. Retire and return scheme Attendance at regional university recruitment fairs. International recruitment. Local divisional retention plans. On boarding as part of local induction
	Right place and times	
3	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.	Roster publishing compliance. Escalation through chain of command. Monthly safety and quality committee. Daily staffing meetings.
	Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations	Annual workforce planning. Clinical capacity and skill mix are aligned to the needs of the patient.
3.1	Productive working and eliminating waste	DF role to increase patient flow. Risk register. DATIX. Productive ward principles. Daily staffing meeting, escalation through chain of command. Opening of CHH to increase patient flow.
3.2	Effective deployment and flexibility	Effective use of e-rostering and SAFE CARE for re-deployment .Flexible working polices Increased staffing for predicted demand i.e. seasonal illnesses in paediatrics
3.3	Effective employment, minimising agency use	Capped agency rates and master vend agreement. Large internal bank. HEE submissions for registered staff training. Multi Area Support Team

Appendix 7 - Developing Workforce Safeguards

Recommendations

NQB's guidance states that providers:

- Must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- Must use an approach that reflects current legislation and guidance where it is available.

Meeting NQB's expectations helps providers comply with CQC's fundamental standards on staffing – for example, in the well-led framework3 – and related legislation.

No.	Recommendation	LTHTR response
1	Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	See appendix 2
2	Trusts must ensure the three components are used in their safe staffing processes: – Evidence-based tools (where they exist) – Professional judgement – Outcomes	Introduction of the Safer Nursing Care tool to assess acuity and dependency. Professional judgement forms part of the acuity review process. Patient outcomes are considered including STAR, experience and harms.
3	Trusts will be required to confirm their staffing governance processes are safe and sustainable.	Included within annual governance statement
4	Review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.	Included within annual governance statement
5	As part of the safe staffing review, the director of nursing and medical director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Statement included from the Chief Nursing Officer in the annual paper.
6	Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting.	Monitored through Workforce Committee.
7	They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.	Quality dashboard reported monthly to Safety and Quality committee.
8	An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance5 and NHS Improvement resources.	Annual staffing report reported to Board with monthly staffing reports to Safety and Quality committee.

	This must also be linked to professional judgement and outcomes.	
9	There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	Clear training recorded with validation during the audit period in line with implementation guidance.
10	As stated in CQC's well-led framework guidance (2018)6 and NQB's guidance 7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review	EQIA policy reviewed and in place.
11	Given day-to-day operational challenges, we expect Trusts to carry out business-as usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments	Daily staffing meetings used to assess nurse staffing levels. Reported and escalated through chain of command process
12	Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	Risks managed on daily basis by senior nursing and medical team. Long term decisions regarding bed numbers/ward configuration and escalation reported to board.

Chair's Report

Committee:	Education, Training and Research Committee
Chairperson and role:	Professor Paul O'Neill, Non-Executive Director
Date(s) of Committee meeting(s):	13 February 2024
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 December 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 Trust appraisal compliance was 87.8% (target 90%), medical device compliance was 84.5% (target 90%), 10 Mandatory Training metrics were currently below compliance target and 4 new metrics had been added to the mandatory group 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). Nursing, Midwifery and Allied Health Professions (NMAHP) response rates had increased during the last quarter with most divisions seeing improved feedback across multiple themes. Performance within Undergraduate Medical Education remained strong with mixed feedback across Apprenticeship programmes received within the last quarter. The number of specialities subject to internal and external quality intervention within Postgraduate Medical Education (PGME) was unprecedented with nine specialities across three divisions requiring support. Poor feedback from Year 4 Undergraduate Medical Education (UGME) students in Neurology had raised concerns following triangulation with poor feedback received from postgraduate doctors in training. NMAHP had three areas requiring support, however, Delivery Suite had now been removed from enhanced monitoring following completion of all actions and improved feedback received during the last quarter.

The Committee was presented with the NIHR CRF annual report and feedback, which updated on the progress within Research and Innovation of the National Institute for Health and Care Research (NIHR) Lancashire Clinical Research Facility (LCRF) for the period 1 September 2022 to 31 March 2023.

The Committee received the research and innovation update, which identified progress made within the department year to date 2023/24, and specifically within R&I and its ongoing strategy.

The Committee considered the MIAA apprenticeship funding review and acknowledged that overall, the system met Ofsted and ESFA expectations, and with minor adjustments, the Trust could strengthen its effectiveness further. The department was given an overall assurance opinion of "substantial", which meant there was a good system of internal control designed to meet the system objectives, and that controls were being applied consistently.

The Committee received an update on the expansion plans within Rosemere for the BSc Adult Nursing Practice-based Pathway Clinical Learning.

The Committee was presented with the review of education sub-committee effectiveness including terms of reference.

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 - Education Finance & Business Sub-Committee, Training Compliance and Assurance Sub-committee and Education Quality & Performance Sub-Committee.

Items for the Board's attention

Positive escalation

- NIHR CRF annual report and feedback.
- Development of the learning environment space within Rosemere for the BSc Adult Nursing Practice-based Pathway Clinical Learning.

Negative escalation

None.

Committee to Committee escalation

None.

Items recommended to the Board for approval

None.

Committee Chairs reports received

a) Education Finance & Business Sub-Committee
b) Training Compliance and Assurance Sub-committee
c) Education Quality & Performance Sub-Committee

Items where assurance was provided and/or for information

a) Core skills training report
b) Education Quality Surveillance report
c) NIHR CRF annual report and feedback
d) Research and Innovation update
e) MIAA apprenticeship funding review
f) BSc Adult Nursing Practice-based Pathway Clinical Learning
g) Review of education sub-committee effectiveness including terms of reference.

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 9 April 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 (13 February 2024)

Education, Training and Research Committee

13 February 2024 | 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 12 December 2023	1.03pm	✓	Decision	P O'Neill
5.	Matters arising and action log	1.05pm	✓	Decision	P O'Neill
6	Strategic risk register review	1.15pm	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.	GOVERNANCE AND COMPLIANCE				
8.1	NIHR CRF annual report and feedback	1.50pm	✓	Assurance	P Brown
8.2	Research & Innovation update	2.00pm	✓	Assurance	P Brown
8.3	MIAA apprenticeship funding review	2.10pm	✓	Assurance	H Juwale
8.4	BSc Adult Nursing Practice-based Pathway Clinical Learning	2.20pm	✓	Information	H Juwale
8.5	Review of education sub-committee effectiveness including terms of reference.	2.30pm	✓	Information	L O'Brien
8.6	Strategic risk register review	2.40pm	✓	Decision	S Regan
8.7	Items for referral to the board or items to/from other committees	2.45pm	Verbal	Information	P O'Neill
8.8	Reflections on the meeting and adherence to the Board Construct	2.50pm	✓	Assurance	P O'Neill

№	Item	Time	Encl.	Purpose	Presenter
9.	ITEMS FOR INFORMATION				
9.1	Feeder groups Chair's reports negative/positive escalations: a) Education Finance & Business Sub-Committee b) Training Compliance and Assurance Sub-committee c) Education Quality & Performance Sub-Committee	2.55pm	✓	Information	L O'Brien
9.2	Date, time, and venue of next meeting: 9 April 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

Board of Directors Report

National Staff Survey Benchmark					
Report to:	Board of Directors		**Date:**	4th April 2024	
Report of:	Chief People Officer		**Prepared by:**	Head of OD Programmes	
Part I	X		**Part II**		
Purpose of Report					
For assurance	☒	**For decision**	☐	**For information**	

Executive Summary:

This report outlines our National Staff Survey results compared with the national benchmarks.

In our 2023 Staff Survey results we can see that we are above the national average for all elements of the People Promise Themes except one (Staff Engagement Measure) for which we have met the national average.

Trust Level

When looking at the Trust level data, out of the 97 comparable questions, 83 have shown improvements, 2 remained the same and 12 declined. The report provides an analysis to help identify areas for improvement by looking at both the questions which have shown a decline and presents these alongside the different sub theme scores which make up each of the People Promise Elements along any national benchmark comparisons.

Colleagues who completed the National Staff Survey were invited to provide any additional comments about working in this organisation, with a free text answer option. The report includes an analysis of the free text comments and the high level themes identified which are Health, Safety & Wellbeing, Staff Engagement/Morale/Hygiene Factors, Culture/Leadership/Inclusion and team working.

The recommended priority areas for action are to:

- Address the different perceptions of the quality of care and find ways to increase feelings of advocacy across teams for provision of high-quality care.
- Address the level of burn out and wellbeing concerns reported and explore how our corporate offer can further support improvements for colleagues experiencing this.
- Continue to embed our new recognition offers at a corporate level and increase local level recognition to support all colleagues to feel rewarded, recognised and valued despite internal resourcing/financial challenges.
- Explore and scope options there may be to improve key hygiene factors such as access to kitchen, break areas, car parking solutions, catering, dilapidated estate etc.
- Support key manager practices such as 1:1s, appraisals and involving teams in decision making and continue to invest in leadership and management development.
- Continue work to support more positive team cultures, calling out behaviours and incivility that doesn't support this and further embed 'Our Best Version of Us' to help address behavioural challenges.

- Address experiences of personal safety i.e. discrimination, bullying, harassment, aggression by further embedding our Zero Tolerance approach to support colleagues to feel safe at work.
- Implement the NHS' Sexual Safety Charter which will support addressing experiences seen through the new question set which focus on unwanted sexual behaviour.
- Continuing to utilise TED, to support team members to feel involved in changes, manage team dynamics, integrate colleagues as well as to empower and upskill team leaders to be able to facilitate team improvements.
- Promoting ways in which we can support teams and colleagues to overcome relationship challenges.

This report details the next steps which include the development of our corporate level action plan to address the priority areas discussed and align this to continue our work within the People Plan 2023 – 2026 strategic actions.

Divisional Level

To continue taking a more proactive and direct approach and bring about organisation-wide improvements, the teams which have lower levels of satisfaction and engagement have been identified. This list of teams identified as areas of concern have also been shared with the relevant Divisional Workforce Committees as part of our offer to provide enhanced support and agree which areas the Organisational Development (OD) team should prioritise.

It is recommended that the Board of Directors

I. Receive and note the results and next steps
II. Discuss the results and consider the implications

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

INTRODUCTION

This report details the national benchmarking for our National Staff Survey results, which are available publicly as of the 7th March 2024 now the embargo has been lifted. It also includes the analysis of the free text comments, themes identified and the key priority areas for action.

The report highlights at a Divisional Level the teams with the lowest satisfaction and may require supportive intervention and the recommended next steps.

OUR PERFORMANCE AGAINST THE NATIONAL BENCHMARK

There are 122 organisations in our benchmarking group, with a mean response rate of 45%, internally our response rate was 45%.

In Graph 1 detailing the benchmarking against the People Promise elements displays our position (navy blue bar) shows that we are **above** the national average for **all elements** except one (Staff Engagement Measure) for which we have met the national average.

Within the context of pressure facing the organisation, teams and managers, these results are very positive. We have been able to sustain our levels of engagement whilst demonstrating improvements across the majority of the People Promise measures.

In Table 1 it shows that across 4 of the national measures we have seen an increase of 0.1 points, ('We each have a voice that counts', 'We are safe and healthy', 'We are a team' and 'Morale').

Across 3 of the elements, we have seen an increase of 0.2 points ('We are rewarded and recognised', 'We are always learning' and 'We work flexibly') and we have remained the same for the measures 'We are compassionate and inclusive' and overall Staff Engagement.

We have overall sustained the gap between our average and the 'Best' score for each of the People Promise Elements with the difference between our average and the best ranges remaining between 0.3 – 0.5 points. We can see good progress in the theme 'We are recognised and rewarded' closing the gap between ourselves and the best by 0.2 points and we can see a increase in the gap for overall Staff Engagement between ourselves and the best by 0.1 points.

It is pleasing to see that some of the corporate level action taken following last year's results appear to be demonstrating impact in this year's results. Examples include an increased focus on recognition (details of which can be seen in the November Workforce Committee report), further work to embed our flexible working policy and toolkit, the new focus on zero tolerance training and toolkit and increased promotion of our learning and development offer across the Trust and Divisional workforce committees.

Looking at the data over the last three years (since the People Promise was launched) Graph 2 demonstrates that we are showing a positive trend across all the People Promise measures, Staff Engagement and Morale.

Graph 2 indicates that 'We are always learning', and 'We work flexibly' are the areas we are showing the most overall progress (+0.3 points) followed by 'We are safe and healthy', 'We are a team' and over Morale which have all improved by 0.2 points.

GRAPH 1 – National Benchmark Findings for All People Promise Elements

People Promise elements and themes: Overview

Survey Coordination Centre NHS

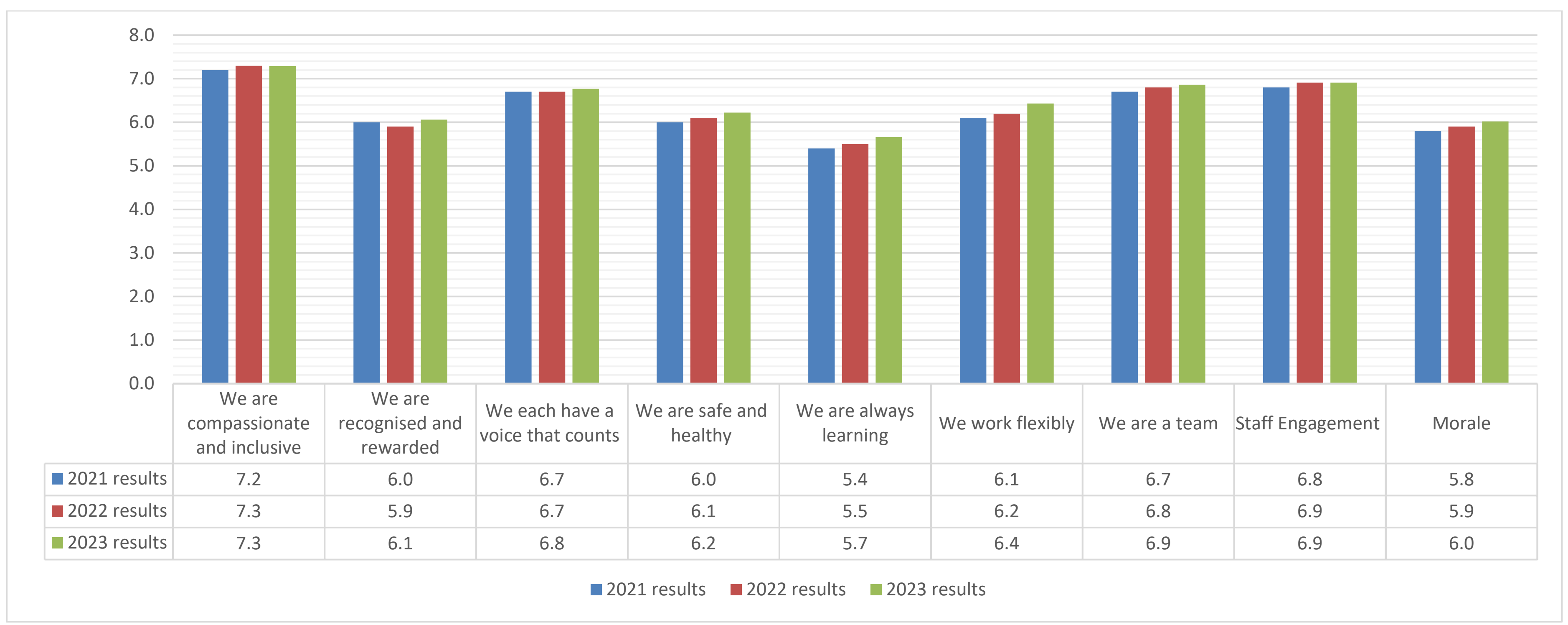
People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.29	6.06	6.77	6.22	5.66	6.43	6.86	6.91	6.02
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	4527	4529	4496	4496	4258	4508	4525	4533	4535

TABLE 1 – People Promise Results Comparison 2022 - 2023

People Promise Measures	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2022 results	7.3	5.9	6.7	6.1	5.5	6.2	6.8	6.9	5.9
2023 results	7.3	6.1	6.8	6.2	5.7	6.4	6.9	6.9	6.0
Differences	**0**	**+0.2**	**+0.1**	**+0.1**	**+0.2**	**+0.2**	**+0.1**	**0.0**	**+0.1**

GRAPH 2 People Promise Measure Results - 2021-2023



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
2021 results	7.2	6.0	6.7	6.0	5.4	6.1	6.7	6.8	5.8
2022 results	7.3	5.9	6.7	6.1	5.5	6.2	6.8	6.9	5.9
2023 results	7.3	6.1	6.8	6.2	5.7	6.4	6.9	6.9	6.0

SUB SCORES AND QUESTION ANALYSIS IDENTIFYING ITEMS FOR IMPROVEMENT IN 2024

In the January 2024 Workforce Committee paper the Organisational Development team identified the need to improve the way we present the Staff Survey data this year to enable leaders and managers to better understand and engage with their results.

This work is now complete, and we have been able to create simple and clear spreadsheets at Trust, Divisional and Team level which are user friendly. They show each questions results and bring together previous data sets showing the changes to enable comparison and quicker analysis.

When looking at the Trust level data, out of the 97 comparable questions, 83 have shown improvements, 2 remained the same and 12 declined.

The table below looks at both the questions which have shown a decline and presents these alongside the different facets called sub scores which make up each of the People Promise Elements. Where a question has declined, national benchmark comparison has also been included.

The purpose of this table is to help enable us, at an organisational level, to determine what actions we need to take to bring about improvements.

TABLE 2 – SUB SCORE ANALYSIS

SUB SCORE	COMPARISON TO NATIONAL AVERAGE	QUESTION ANALYSIS *Questions which have deteriorated since 2022 results and if applicable below the national benchmark (NA)*
PROMISE ELEMENT 1 – WE ARE COMPASSIONATE AND INCLUSIVE		
Compassionate Culture	Below 0.14	• My role makes a difference to service users **(-0.2%)** **Below NA** • Care of patients/service users is organisation's top priority **(-0.3%)** **Below NA** • If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation **(-1.6%)** **Below NA**
Compassionate Leadership	Above 0.13	All questions improved and all above NA
Diversity and Equality	Above 0.16	• Not experienced discrimination from patients/service users, their relatives or other members of the public **(-0.8%)** • Feel organisation respects individual differences **(-0.1%)**
Inclusion	Slightly Above 0.04	• Feel a strong personal attachment to my team **(-0.8%)**
PROMISE ELEMENT 2 – WE ARE RECOGNISED AND REWARDED		
Recognised and rewarded	Above 0.12	All questions improved and all above NA
PROMISE ELEMENT 3 – WE EACH HAVE A VOICE THAT COUNTS		
Autonomy and control	Above 0.13	• I am trusted to do my job **(-0.3%)**
Raising concerns	Same	All questions improved and all above NA
PROMISE ELEMENT 4 – WE ARE SAFE AND HEALTHY		
Health and safety climate	Above 0.1	• I have adequate materials, supplies and equipment to do my work **(-0.9%)** **Below NA**

		• Last experience of harassment/bullying/abuse reported **(-1.0%)**
Burnout	Above 0.17	• Never/rarely worn out at the end of work **(-0.9%)**
Negative experiences	Above 0.2	• Experienced bullying, harassment and abuse from patients and members of the public **Slightly below NA**
PROMISE ELEMENT 5 – WE ARE ALWAYS LEARNING		
Development	Above 0.11	All questions improved and all above NA
Appraisals	Slightly Above 0.02	All questions improved. (Two questions are below NA - If had an appraisal in last 12 months and helped agree clear objectives)
PROMISE ELEMENT 6 – WE WORK FLEXIBLY		
Support for work-life balance	Above 0.22	All questions improved and all above NA
Flexible working	Above 0.25	All questions improved and all above NA
PROMISE ELEMENT 7 – WE ARE A TEAM		
Team working	Above 0.9	• Enjoy working with colleagues in team **(-1.0%)**
Line management	Above 0.2	All questions improved and all above NA
STAFF ENGAGEMENT		
Motivation	Above 0.11	All questions improved and all above NA
Involvement	Above 0.54	All questions improved and all above NA
Advocacy	Below 0.16	• Care of patients/service users is organisation's top priority **(-0.3%) Below NA** • If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (and below the national average) **(-1.6%) Below NA**
MORALE		
Thinking about leaving	Above 0.14	All questions improved and all above NA
Work pressure	Slightly Above 0.05	I have adequate materials, supplies and equipment to do my work **(-0.9%) Below NA**
Stressors	Above 0.12	All questions improved and all above NA

FREE TEXT THEMES

Colleagues who completed the National Staff Survey were invited to provide any additional comments about working in this organisation, with a free text answer option. A total of 810 free text responses from 4539 total survey responses (=18%) were recorded.

Overall Sentiment

Each comment was themed to identify overall sentiment and tone within the comment. Table 3 shows the overall sentiment found across the comments. Please note some comments expressed both positive and negative sentiment within the narrative.

TABLE 3 – Free text comments overview of sentiment and tone

Overall sentiment and tone	Frequency count
Positive	145
Negative	625
Neutral	62

Comments were analysed further. Table 3 shows the high-level themes and table 4 gives a breakdown of the high-level themes split into sub themes. Th sub themes have been ordered by highest count to help give an indication of where improvements are required to enhance levels of satisfaction and engagement.

TABLE 4 – High Level Themes Frequency Count

High Level Theme	Frequency Count
Culture / Leadership/ Inclusion	379
Health, Safety and Wellbeing/Flexible working	209
Staff engagement / Morale / hygiene factors	314
Team Working	290
Development/Career	84

TABLE 5 – Sub Theme Frequency Count

High Level Theme	Sub Theme	Frequency Count
Culture / Leadership/ Inclusion	**Leadership/Line manager**	211
Team Working	**Resources and Staffing**	180
Team Working	**Team working**	76
Health, Safety and Wellbeing/Flexible working	**Advocacy/Patient Safety**	62
Culture / Leadership/ Inclusion	**Culture**	57
Staff engagement / Morale / hygiene factors	**Car Parking**	57
Health, Safety and Wellbeing/Flexible working	**Workload/work pressures**	50
Staff engagement / Morale / hygiene factors	**Motivation/Morale**	50
Staff engagement / Morale / hygiene factors	**Recognition / Valued**	49
Staff engagement / Morale / hygiene factors	**Pay**	47
Development/Career	**Progression**	46
Staff engagement / Morale / hygiene factors	**Thinking about leaving**	37
Culture / Leadership/ Inclusion	**Raising concerns**	35
Development/Career	**Development**	35
Team Working	**Communication**	34
Culture / Leadership/ Inclusion	**D+E**	33
Health, Safety and Wellbeing/Flexible working	**Health and Wellbeing**	33
Culture / Leadership/ Inclusion	**Personal Safety i.e. Bullying/ Harassment/Violence/Aggression**	28
Staff engagement / Morale / hygiene factors	**Stress/Anxiety**	27
Health, Safety and Wellbeing/Flexible working	**Flexible/Agile Working**	26
Staff engagement / Morale / hygiene factors	**Involvement**	24
Health, Safety and Wellbeing/Flexible working	**Burnout**	20
Health, Safety and Wellbeing/Flexible working	**Work-Life Balance**	18

Culture / Leadership/ Inclusion	**Inclusion**	15
Staff engagement / Morale / hygiene factors	**Recruitment Processes**	11
Staff engagement / Morale / hygiene factors	**Catering**	9
Development/Career	**Appraisals**	3
Staff engagement / Morale / hygiene factors	**Health/ Safety**	3

The qualitative data helps to provide context and richer understanding of why we may have seen a deterioration in the some of the Sub Themes as described in Table 2. Following the thematic analysis, the findings have been grouped into 5 main area of focus with regards to the most common sub themes.

THEME – Line Management and Leadership

- Out of 211 comments, 157 were negative, 52 were positive and 2 were neutral.
- Colleagues experience lack of involvement in decision making and some colleagues feel there is sometimes a lack of understanding of the role from those in more senior roles, which colleagues feel negatively impacts on decision making and priorities. (“*Management make changes but do not consult the staff working out on the wards”, “Disconnect continues between managers and staff in front line”)*
- Colleagues would welcome more visibility from senior leaders, so they truly understand the context they are working in.
- Communications from immediate management could be improved, including colleagues having a firm understanding of their roles and responsibilities.
- Some colleagues reported not feeling valued or supported in their roles and if concerns were raised with management, they were not always addressed, or the feedback loop wasn’t always closed.
- Some colleagues reported concerns over their managers treating staff differently and not displaying the correct values and behaviours expected. *(“My managers appear to exhibit favouritism when it comes to team assignments”)*
- Comments report that some colleagues with less clinical experience have been promoted into management and leadership roles and there is a perceived lack of depth of knowledge, skills, and experience. It is suggested they need more support in ensuring they are effective at their roles including around the basics of team management and communication.

THEME - Staffing and Resources

- Out of 180 comments, 178 were negative and 2 were neutral.
- Widespread recognition of the impact of the current financial challenges. This impacts on adequate resources, fit for purpose working environments and around recruitment, where fixed term contracts or secondments are used, instead of permanent roles.
- Staffing pressures were identified on wards especially but also in non-clinical and administrative areas. There is an emotional and physical impact of staffing levels on morale and concerns over staffing ratios.
- There are feelings of unfairness with the rates of pay for agency colleagues, HCAs and those in lower banded roles.
- There were numerous comments about the lack of effective equipment and low supplies impacting on the ability to carry out roles as well as a feeling in some areas that there is waste and inefficiency. There were also comments around ineffective breakrooms and office space.

(*"Insufficient staff resources to do the role effectively, which puts more stress and pressure on existing staff")*

- Some colleagues feel that their basic hygiene needs are not met within their working environment which impacts on their wellbeing. This also includes issues with car parking and the impact staff feel this can have on their work life balance. Better water facilities, the kitchen on ward 21 is falling apart and there is no water machine. ("*The tap water tastes awful and I have to keep walking to the canteen (if I have time) to get fresh water. Also, there is 1 staff shared toilet on ward 21, which is always busy. The 1 toilet next to the lift is often dirty or busy. These are basic things that can be very frustrating when you are working 12 hour shifts.", "Need to look at staff uniforms - uniform very thick fabric and majority of staff are women. I am going through menopause and find the uniforms worsen my symptoms especially being in work. These are all beneficial for staff and a healthy workforce - preventing sickness.")*
- There was a general consensus that the health and wellbeing packages on offer were useful but due to work pressures, shift patterns, thy were not easily accessible for many colleagues.

THEME - Working in Teams

- Out of 76 comments, 38 were negative, 36 were positive and 2 were neutral.
- There were many positive comments around team dynamics and relationships, with many staff feeling valued and supported by their team. *("I have never worked in such a patient focussed pro-active team. I can't see myself leaving until I retire well in the future.", "I love coming to work and thoroughly enjoy my role. My colleagues are great to work with and we have a great team spirit.")*
- There were different comments around working overtime, including hours not shared fairly, disparity between overtime arrangements within different roles and different bands.
- Sometimes there are challenges in team dynamics between colleagues with longer services and newer colleagues.
- Colleagues describe experiences of favouritism within their teams. This is experienced by how shifts and leave are assigned, in recruitment and in accessing training and promotions.
- Several colleagues raised ineffective performance management, including abuse of sickness absence and grievance policies.
- Colleagues would like to be able to contribute to decision making, especially in those changes that impact on their teams. Lack of communication can create feelings of unsettledness and anxiety. Colleagues would welcome the opportunity to get involved in changes.
- Opportunity to develop clarity of progression between bands including from 2.

THEME – Advocacy/Patient Safety

- Out of 62 comments, 56 were negative and 6 were positive.
- Colleagues describe different perceptions of the quality of care across the Trust and colleagues recognise patient care and services is impacted by lack of staffing and resources.
- Concerns over staff to patient ratios ("*Boarding patients in bays is very unsafe as no emergency equipment at bedsides and call bells. Also, there is not enough space within the bays, inappropriate patients boarded in bays causing additional infection control issues and falls due to how small the bays are and how cluttered they are.",*
- *"I feel that boarding patients 5 in a bay designed for 4 is very wrong and makes staff an patients feel uncomfortable and unsafe - no oxygen, no suction, no privacy curtains, no plugs no space for the resus trolley does someone need to die before this poor practice is stopped! It makes myself and my colleagues feel anxious about being unable to provide safe and effective care and*

feel embarrassed to tell patients they will be squashed into the bay. As a nurse I feel this practice does not provide patients with privacy or dignity and goes against trust values that the organisation preaches but does not practice.")

- Decisions made without consulting staff directly which is felt has a negative impact on patient care and safety.

THEME – Culture

- Out of 57 comments, 52 were negative and 5 were positive.
- Some comments alluded to a lack of professionalism in some areas and issues around civility of both staff and management.
- Some colleagues felt their concerns were dismissed and no feedback given
- Concerns around some managers/colleagues treating staff differently and not adhering to the Trusts values and behaviours. The process around raising concerns is sometimes seen as a tick box exercise only.
- The increases in work pressures and burnout are adding to poor culture in some areas as well as across different teams due to staff feeling stressed and anxious. *("Different staff teams do not necessarily always speak to each other with the appropriate amount of respect when we are all under pressure.")*

PRIORITY AREAS FOR ORGANISATIONAL LEVEL ACTION

Based on the findings reported in the free text comments and the question data the follow areas have been identified as priority areas for improvements to continue our work to enhance levels of staff satisfaction, morale and overall engagement:

- **Health, Safety & Wellbeing**
  - Address the different perceptions of the quality of care and find ways to increase feelings of advocacy across teams for provision of high-quality care.
  - Address the level of burn out and wellbeing concerns reported and explore how our corporate offer can further support improvements for colleagues experiencing this.

- **Staff Engagement/Morale/Hygiene Factors**
  - Continue to embed our new recognition offers at a corporate level and increase local level recognition to support all colleagues to feel rewarded, recognised and valued despite internal resourcing/financial challenges.
  - Explore and scope options there may be to improve key hygiene factors such as access to kitchen, break areas, car parking solutions, catering, dilapidated estate etc.

- **Culture/Leadership/Inclusion**
  - Support key manager practices such as 1:1s, appraisals and involving teams in decision making and continue to invest in leadership and management development
  - Continue work to support more positive team cultures, calling out behaviours and incivility that doesn't support this and further embed 'Our Best Version of Us' to help address behavioural challenges.

- Address experiences of personal safety i.e. discrimination, bullying, harassment, aggression by further embedding our Zero Tolerance approach to support colleagues to feel safe at work.
- Implement the NHS' Sexual Safety Charter which will support addressing experiences seen through the new question set which focus on unwanted sexual behaviour

- **Teamworking**
    - Continuing to utilise TED, to support team members to feel involved in changes, manage team dynamics, integrate colleagues as well as to empower and upskill team leaders to be able to facilitate team improvements.
    - Promoting ways in which we can support teams and colleagues to overcome relationship challenges.

NEXT STEPS – ORGANISATION WIDE

- In April we will cascade Trust-wide a corporate level action plan to address the priority areas discussed above and this will be aligned to continue our work within the People Plan 2023 – 2026 strategic actions.
- Share corporate level communications about our results, the national benchmarks, areas of success, areas for improvement and an all-workforce call to action.
- To deliver manager briefing sessions to help managers use their results and engage their team throughout March and April 2024.
- To carry out further analysis and work with teams who have scored lower in the survey providing enhanced OD support and interventions to create team improvements for which the impact will be measured in next Staff Survey results.
- To develop a corporate communication campaign to create visibility around staff survey action plans and you said we did messages, in response to findings from the staff survey throughout May 2024 and further updates in July 2024.

DIVISIONAL FINDINGS

This section further enhances the high-level information provided in the January 2023 Workforce Committee. Divisional Workforce Committees have been provided with their data set, guidance around the next steps to take and where we are recommending action and Organisational Development (OD) support to be prioritised.

To determine the teams which may require more enhanced OD support, analysis was undertaken (of all 267 Locality Level 4 results in the staff survey) to look at the teams which met these different measures.

We identified the 50 teams who had:

- the lowest average staff survey question score

- declined the most in their average staff survey question score
- the lowest 'We are a team' question scores
- declined the most in their 'We are a team' question scores
- the lowest Engagement and Morale question scores
- declined the most in their Engagement and Morale question scores

The names of these teams have been shared across Divisional Workforce Committees to determine which ones may be a priority area for support or perhaps may already be identified as areas of concern.

The aim of this is for the Organisational Development team to continue to take a more proactive and direct approach, offering enhanced support and by targeting those teams with the lowest satisfaction, the intention is to bring about organisation wide improvements in staff satisfaction as measured across all 9 People Promise Elements and support teams to have improved experience of work.

Whilst the lowest scoring teams have been identified, it is important to note that 34% of teams measured by the staff survey (at locality level 4) did not have enough responses, (less than 10 responses) submitted by team members meaning a team level report is not available for analysis. It is worth noting that whilst this is an improvement from 2022 where we saw 41% of teams did not reach the report threshold, the lack of responses could potentially indicate a colleague satisfaction or cultural concern and without an adequate response rate we are unable to understand if the team are satisfied or need support to improve colleague experience.

Further work will be undertaken to review the teams who have not reached the reporting threshold to understand if other data sets could provide insight as to if these teams are cause for concern. We will also prepare a targeted communication with the managers of these teams to feedback on their response rate and encourage improvement for the 2024 survey.

NEXT STEPS – DIVISIONALLY

By the end of May 2024 we will:

- Agree the priority teams for supportive intervention by Organisational Development.
- Triangulate the staff survey data against a range of other performance metrics (such as sickness absence, turnover, STAR level, Freedom to Speak Up concerns etc) to create a more detailed benchmark for each team.
- Make initial contact with the team leaders to contract and agree the appropriate support and OD interventions.
- Continue to communicate and provide progress updates with Divisional leadership teams.
- Support Division identify and agree their own Staff Survey plans for action. .
- Identify high performing teams from the staff survey results to engage and understand key themes, management practices and activities these leaders undertake as part of an exercise to capture and share best practice across the Trust.

FINANCIAL IMPLICATIONS

Evidence shows that organisations with higher levels of staff satisfaction and engagement have better financial performance. Improving staff experience in our organisation as a whole and within hot spot areas underpins organisational effectiveness and sustainability.

Improvement in team engagement and colleague satisfaction can enable key workforce metrics to improve such as retention and levels of sickness absence. Through improved workforce stability we would hope to see in a reduction in agency reliance, and a reduction in the time and money spent on recruitment for managers and the wider organisational recruitment costs.

Research also demonstrates that higher engaged teams are also higher performing teams, linking strongly to improvement patient experience and outcomes which all can result in an improvement to financial performance.

Whilst our National Staff Survey Results demonstrate progress and improvement, the free text comments and question results indicate dissatisfaction with colleagues feeling undervalued due to resources, staffing levels, working in challenging circumstances such as wards boarding and the associated health and safety issues this brings.

Furthermore, themes from the free text indicate further investment in equipment, supplies and the estate is required to support colleagues to do their jobs with ease. To achieve increased satisfaction will require significant investment.

RISKS

As indicated in the body of the report there are several themes and trends which could create organisational and divisional level risks, these are:

- A perceived and real lack of resources versus demand in patient facing roles which is contributing to levels of dissatisfaction in our colleagues, this is difficult to address through the work of the Workforce and Organisational (OD) department. It will require a whole Trust, local health economy and potentially national/government response to support system wide change.
- Intention to leave the organisation due to pressures, burnout and levels of pay could increase turnover and worsen an already challenging level of vacancies, increasing pressure on those colleagues who remain.
- The pressures in the organisation, level of resources and capability of managers to progress with TED, engage colleagues in conversations about their levels of satisfaction at work may have a negative impact on the ability to deliver on the anticipated outcome measures – the most significant impact on colleague engagement is delivered locally through direct line manager commitment.
- Attendance and ability to commit to development programmes due to other competing demands and operational pressures faced by leaders and managers.
- Application of new skills, knowledge and behaviours in the workplace by leaders and managers due to cultural issues, lack of appreciation of role of leaders/managers, limited holding to account to apply learning to role, meaning that there is limited organisational performance improvements.

- Lack of commitment to ongoing development by some groups of leaders and managers, meaning we are unable to engage them in participating in and taking forward team engagement, reward or retention initiatives locally in their team.
- The volume of teams requiring support rom Organisational Development cannot be underestimated, this will create significant pressure in the team to support team turnaround whilst delivering on other aspects of Our People Plan 2023-2026.
- Failure to visibly progress actions may lead to an inability to achieve national average or above for the National Quarterly Pulse Survey or National Staff Survey 2024. Consequently, this will indicate our colleagues are having a negative experience of work, which could lead to low levels of engagement, morale and increased turnover. It could also indicate wider cultural challenges which may impact upon patient care and safety indicators.

IMPACT ON STAKEHOLDERS

The primary stakeholders are our colleagues, having a highly engaged, satisfied, rewarded and motivated colleagues enables the organisation to achieve its vision. It is well publicised that highly engaged teams are more innovative, resilient, productive and able to deliver compassionate care.

As a large employer we are duty bound to continue to invest in the staff satisfaction and levels of colleague engagement, not only for our current workforce, but also for our future workforce who will want to join an organisation with a positive reputation.

RECOMMENDATIONS

It is recommended that the Board of Directors:

I. Receive and note the results and next steps.
II. Discuss the results and consider the implications.

APPENDIX 1 - 2023 STAFF SURVEY TRUST LEVEL RESULTS WITH COMPARISON TO PREVIOUS YEARS DATA

Q	Question	Trust Results 2023	Trust Results 2022	Changes 2022 v 2023
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	**58.3%**	60.0%	-1.6%
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	**78.2%**	79.6%	-1.4%
q7e	Enjoy working with colleagues in team	**81.2%**	82.2%	-1.0%
q14d	Last experience of harassment/bullying/abuse reported	**51.5%**	52.5%	-1.0%
q12e	Never/rarely worn out at the end of work	**20.6%**	21.5%	-0.9%
q3h	Have adequate materials, supplies and equipment to do my work	**56.5%**	57.4%	-0.9%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	**93.8%**	94.6%	-0.8%
q7i	Feel a strong personal attachment to my team	**64.0%**	64.8%	-0.8%
q25a	Care of patients/service users is organisation's top priority	**72.8%**	73.1%	-0.3%
q3b	Feel trusted to do my job	**92.0%**	92.3%	-0.3%
q6a	Feel my role makes a difference to patients/service users	**87.1%**	87.3%	-0.2%
q21	Feel organisation respects individual differences	**72.9%**	73.0%	-0.1%
q19a	Staff involved in an error/near miss/incident treated fairly	**58.6%**	58.6%	0.0%
q15	Organisation acts fairly: career progression	**59.2%**	59.2%	0.0%
q8c	Colleagues are polite and treat each other with respect	**70.9%**	70.8%	0.1%
q12c	Never/rarely frustrated by work	**23.9%**	23.8%	0.1%
q12a	Never/rarely find work emotionally exhausting	**26.4%**	26.3%	0.1%
q16b	Not experienced discrimination from manager/team leader or other colleagues	**92.3%**	92.1%	0.2%
q12d	Never/rarely exhausted by the thought of another day/shift at work	**38.2%**	38.0%	0.2%

q25e	Feel safe to speak up about anything that concerns me in this organisation	**62.8%**	62.5%	0.3%
q3a	Always know what work responsibilities are	**89.0%**	88.7%	0.3%
q14c	Not experienced harassment, bullying or abuse from other colleagues	**82.2%**	81.8%	0.4%
q14b	Not experienced harassment, bullying or abuse from managers	**91.9%**	91.5%	0.4%
q9e	Immediate manager values my work	**73.8%**	73.4%	0.4%
q13d	Last experience of physical violence reported	**74.1%**	73.6%	0.5%
q9g	Immediate manager listens to challenges I face	**72.8%**	72.3%	0.5%
q13b	Not experienced physical violence from managers	**99.5%**	99.0%	0.5%
q8b	Colleagues are understanding and kind to one another	**70.2%**	69.7%	0.5%
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	**86.1%**	85.6%	0.6%
q13c	Not experienced physical violence from other colleagues	**98.3%**	97.7%	0.6%
q7d	Team members understand each other's roles	**72.5%**	71.9%	0.6%
q5c	Relationships at work are unstrained	**45.7%**	45.0%	0.6%
q11a	Organisation takes positive action on health and well-being	**60.5%**	59.8%	0.7%
q19d	Feedback given on changes made following errors/near misses/incidents	**63.7%**	63.0%	0.7%
q2b	Often/always enthusiastic about my job	**71.2%**	70.5%	0.8%
q25b	Organisation acts on concerns raised by patients/service users	**68.0%**	67.2%	0.8%
q12f	Never/rarely feel every working hour is tiring	**52.4%**	51.6%	0.8%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	**56.2%**	55.4%	0.8%
q20a	Would feel secure raising concerns about unsafe clinical practice	**70.6%**	69.7%	0.9%
q9h	Immediate manager cares about my concerns	**72.1%**	71.2%	0.9%
q5b	Have a choice in deciding how to do my work	**53.9%**	53.0%	0.9%

q8d	Colleagues show appreciation to one another	**68.3%**	67.4%	0.9%
q12g	Never/rarely lack energy for family and friends	**36.9%**	35.9%	1.0%
q7h	Feel valued by my team	**71.2%**	70.2%	1.0%
q26a	I don’t often think about leaving this organisation	**45.5%**	44.5%	1.0%
q19b	Encouraged to report errors/near misses/incidents	**87.6%**	86.6%	1.0%
q7f	Team has enough freedom in how to do its work	**61.3%**	60.3%	1.0%
q7a	Team members have a set of shared objectives	**76.3%**	75.2%	1.1%
q3d	Able to make suggestions to improve the work of my team/dept	**75.1%**	74.0%	1.1%
q3g	Able to meet conflicting demands on my time at work	**49.7%**	48.6%	1.1%
q9c	Immediate manager asks for my opinion before making decisions that affect my work	**61.0%**	59.8%	1.1%
q25f	Feel organisation would address any concerns I raised	**50.1%**	48.9%	1.2%
q3f	Able to make improvements happen in my area of work	**57.4%**	56.3%	1.2%
q3c	Opportunities to show initiative frequently in my role	**76.7%**	75.5%	1.2%
q9f	Immediate manager works with me to understand problems	**70.5%**	69.3%	1.2%
q2c	Time often/always passes quickly when I am working	**75.4%**	74.1%	1.3%
q9a	Immediate manager encourages me at work	**74.8%**	73.5%	1.3%
q18	Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	**67.4%**	66.1%	1.3%
q2a	Often/always look forward to going to work	**56.9%**	55.6%	1.3%
q9i	Immediate manager helps me with problems I face	**69.4%**	68.1%	1.3%
q4b	Satisfied with extent organisation values my work	**46.3%**	44.9%	1.3%
q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	**49.0%**	47.6%	1.4%
q12b	Never/rarely feel burnt out because of work	**33.4%**	32.0%	1.4%

q24a	Organisation offers me challenging work	**69.7%**	68.2%	1.5%
q24d	Feel supported to develop my potential	**58.8%**	57.2%	1.5%
q9d	Immediate manager takes a positive interest in my health & well-being	**72.3%**	70.7%	1.5%
q24b	There are opportunities for me to develop my career in this organisation	**56.8%**	55.3%	1.6%
q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	**73.6%**	72.0%	1.6%
q26b	I am unlikely to look for a job at a new organisation in the next 12 months	**54.6%**	53.0%	1.6%
q7c	Receive the respect I deserve from my colleagues at work	**71.9%**	70.4%	1.6%
q3e	Involved in deciding changes that affect work	**54.2%**	52.5%	1.6%
q23a	Received appraisal in the past 12 months	**82.6%**	80.9%	1.7%
q5a	Have realistic time pressures	**27.6%**	25.8%	1.7%
q4a	Satisfied with recognition for good work	**58.0%**	56.2%	1.8%
q25c	Would recommend organisation as place to work	**59.3%**	57.5%	1.8%
q26c	I am not planning on leaving this organisation	**59.8%**	57.9%	1.8%
q7g	Team deals with disagreements constructively	**57.0%**	55.0%	2.0%
q9b	Immediate manager gives clear feedback on my work	**68.5%**	66.4%	2.1%
q11e	Not felt pressure from manager to come to work when not feeling well enough	**81.0%**	78.9%	2.1%
q3i	Enough staff at organisation to do my job properly	**33.6%**	31.5%	2.2%
q23b	Appraisal helped me improve how I do my job	26.0%	23.7%	2.3%
q8a	Teams within the organisation work well together to achieve objectives	56.2%	54.0%	2.3%
q23d	Appraisal left me feeling organisation values my work	37.3%	34.9%	2.4%
q24c	Have opportunities to improve my knowledge and skills	71.4%	68.9%	2.5%
q11c	In last 12 months, have not felt unwell due to work related stress	62.2%	59.6%	2.6%

q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	61.6%	58.7%	2.9%
q6c	Achieve a good balance between work and home life	59.8%	56.6%	3.3%
q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	57.4%	54.2%	3.3%
q24e	Able to access the right learning and development opportunities when I need to	63.4%	60.1%	3.3%
q6d	Can approach immediate manager to talk openly about flexible working	73.5%	70.1%	3.4%
q31b	Disability: organisation made reasonable adjustment(s) to enable me to carry out work	78.3%	74.9%	3.4%
q4d	Satisfied with opportunities for flexible working patterns	60.2%	56.5%	3.6%
q19c	Organisation ensure errors/near misses/incidents do not repeat	69.9%	66.3%	3.6%
q23c	Appraisal helped me agree clear objectives for my work	34.5%	30.8%	3.7%
q7b	Team members often meet to discuss the team's effectiveness	66.9%	62.4%	4.5%
q6b	Organisation is committed to helping balance work and home life	52.2%	47.3%	5.0%
q4c	Satisfied with level of pay	31.8%	26.4%	5.4%
q17a	Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public	92.3%	*	*
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	96.0%	*	*
q22	I can eat nutritious and affordable food at work	55.7%	*	*

Excellent care with compassion

Trust Headquarters

Board of Directors Report

Development of the Single Improvement Plan			
Report to:	Board of Directors	**Date:**	27 February 2024
Report of:	Chief Executive Officer	**Prepared by:**	A Brotherton and Rachel Mellor
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to inform and update the board on the development and transition to delivery of the Trust's new Single Improvement Plan.

The development of our Single Improvement Plan, discussed with Board members in a Board workshop, has taken the learning from the national Recovery Support Programme (RSP) which is provided to Trusts and Integrated Care Boards (ICBs) in Segment 4 of the NHS Oversight Framework (NOF). Whilst we are not in segment 4, it was felt that it would be good practice to adopt this approach to accelerate the pace of our recovery as an organisation. Liverpool University Hospitals Foundation Trust (LUHFT) has been highlighted as an exemplar in the production of their plan and processes and the Trust has kindly shared their learning with colleagues across our organisation. It is therefore recommended that we adopt this approach and approve the transition to a single improvement plan, focused on mobilisation and delivery from April 2024.

Following discussion in the Board workshop, the Single Improvement Plan has six domains; Well-Led; Safety and Quality; Clinical Effectiveness; People and Culture; Operational Performance and Financial Sustainability. There is also a significant focus on Strategy and Planning within the plan. Executive Directors have been identified to lead each domain as Senior Responsible Officers (SROs) for their respective areas. A new way of working will be adopted to increase the pace of delivery, including executive led weekly improvement huddles focused on ensuring the teams are on track with delivery and offering support to overcome any barriers. Benefits have been identified for each domain against the quadruple aim and work is now underway to build the reporting of the key metrics for our June 2024 Board.

All priority elements of improvement being undertaken across the Trust will be contained within the Single Improvement Plan, providing a streamlined and consistent structure and supporting matrix working which will eliminate silo working and minimise duplication. The aim is that we will work very differently as one wider senior leadership team, supporting the divisions and specialty teams with delivery.

The Board is asked to:

I. Review and discuss the content of the Single Improvement Plan and advise regarding any amendments required

II. Approve the proposed reporting and governance arrangements

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			

1. Context

The development of our Single Improvement Plan has taken the learning from the national Recovery Support Programme (RSP) which is provided to Trusts and Integrated Care Boards (ICBs) in Segment 4 of the NHS Oversight Framework (NOF). Whilst we are not in segment 4, it was felt that it would be good practice to adopt this approach to accelerate the pace of our recovery as an organisation. Liverpool University Hospitals Foundation Trust (LUHFT) has been highlighted as an exemplar in the production of their plan and processes and the Trust has kindly shared their learning with colleagues across our organisation. It is therefore recommended that we adopt this approach and approve the transition to a single improvement plan, focused on delivery from April 2024.

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The purpose of this report is to inform and update the board on the development and transition to delivery of the Trust's new Single Improvement Plan.

2. **Discussion**

The structure and content of our new Single Improvement Plan as outlined above has been developed and shared with senior leaders, board members and governors with work completed to mobilise the delivery of the plan from April 2024.

The following summarises the work undertaken since the Board workshop to ensure the Trust is in a position to commence delivery of the plan with immediate effect:

- ***Finalising the plans and identification of benefits against the quadruple aim:*** in addition to the high-level summary and plan on a page for each element of the programme, detailed project plans have now been developed.
- ***A Check and Challenge discussion has been held*** with the Executive Directors for each domain to ensure that all elements of the project plans are finalised. Please note that the plan will be an iterative document and as new priorities are being identified through engagement with the wider leadership team, these are being added to the plan.
- ***Work underway to design the new reporting of the programme:*** Taking the learning from other organisations, the Single Improvement Plan will be tracked using Project (Microsoft Office) and licences are currently being procured. Work is also underway to adopt Power BI to ensure efficient and streamlined reporting. The reporting structure will ensure 'Board to ward' reporting.
- ***Establishment of a Programme Management Office:*** the Executive Directors have identified programme and project managers within the organisation and a short staff consultation process is underway to establish a Single Improvement Plan delivery unit/Programme Management Office that will provide the capability and capacity required to both support the delivery of the plan and the tracking of the benefits. This team of programme and project managers will initially report into the new Intensive Support Director. Workforce, Finance and IT leads have been identified to support the work.
- ***Initial governance arrangements in place:*** A paper outlining the governance of the programme has been discussed by the Executive team. This included project planning, EQIAs, gateways for approvals (as outlined in our current processes for the existing transformation boards) and measurement and tracking of impact. The proposed governance arrangements are outlined below.
- **Plans for enabling workstreams** such as Digital, Communications, Continuous Improvement and Estates are now in development, on completion of the detailed plans for each domain.

Reporting and Governance structure

It is proposed that the governance and reporting structure is followed as per the diagram attached in Figure 1. This will consist of each programme holding a weekly delivery huddle which would report on progress, issues and successes. It is proposed that each Executive lead will hold a monthly oversight meeting (these will take slightly different formats aligning to existing meetings where possible). The Improvement Plan Portfolio Board will be held monthly and chaired by the Chief Executive. Progress reports on all programmes will be presented at this meeting using a standardised highlight report and an overall dashboard reporting progress at a glance.

It is proposed that the individual domains will be reported to the following committees of the board:

- Well-led – will be reported directly to the Board
- People and Culture – workforce committee
- Safety and Quality – Safety and Quality committee
- Clinical Effectiveness - Safety and Quality committee
- Financial Sustainability – Finance and Performance Committee
- Operational Performance - Finance and Performance Committee

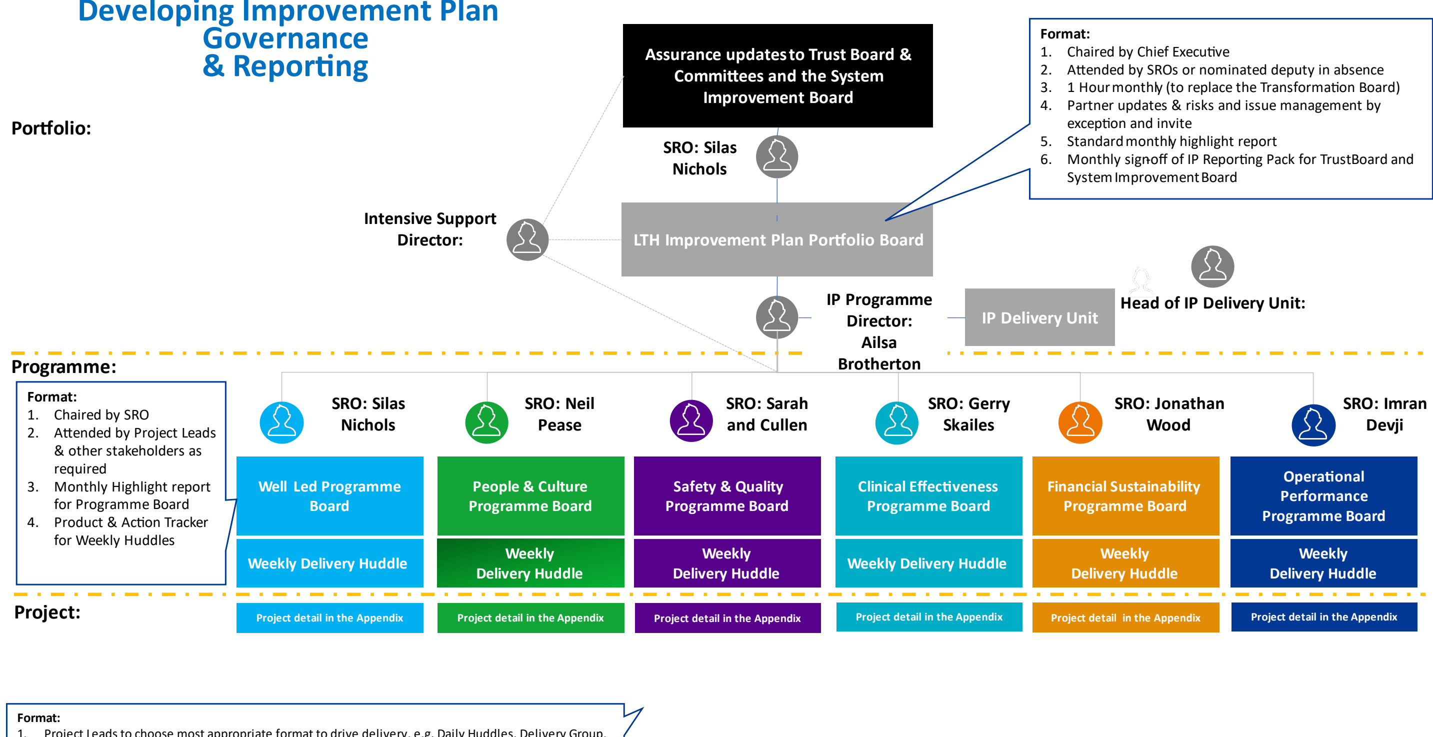


Figure 1: High level governance structure

Delivery Mechanisms

Work is underway to determine the delivery mechanisms for each of the programmes/projects. These include operational delivery (Business as Usual), large scale improvement programmes, existing improvement forums (including the Big Rooms). A formal project management approach will be applied to all the programmes and projects within the Single Improvement Plan.

3. Financial implications

Financial sustainability is a key element of the plan. Some programmes may require additional investment to realise the full benefit, this detail will be developed when the Intensive Support Director commences in post.

4. Legal implications

None

5. Risks

Risks derived from individual projects and plans will be detailed and risk registers developed in line with our risk management policy. Further work will be undertaken to describe the overall single improvement plan risks as it is mobilised and reporting is developed.

6. Impact on stakeholders

A full communications plan will be developed.

7. Recommendations

The Board is asked to:

i) Review and discuss the content of the Single Improvement Plan and advise regarding any amendments required
ii) Approve the proposed reporting and governance arrangements

Appendix 1 – Overview Tiles March 2024

The Lancashire Teaching Hospitals Improvement Journey
Transitioning to an improved NOF rating

Single Improvement Plan

Developing Our Single Improvement Plan

What is the Single Improvement Plan aiming to achieve?

Well Led		Develop and deliver a risk management strategy to address the long-standing high risks/systemic issues that have prevented the Trust getting to good, with a particular focus on financial recovery, elective performance and UEC pathways. Building leadership capacity and capability will be a key part of achieving improvement in well-led.
People & Culture		Continue to demonstrate year on year improvement in all our People Promise domains (currently average or above in each domain).
Safety & Quality		Use of Continuous Improvement (CI) to improve inpatient care, in particular Sepsis, Clostridium Difficile, Risk Assessment completion, Medication Safety and Maternity (triage and induction).
Clinical Effectiveness		To improve clinical effectiveness across the Trust in particular medical staffing, our clinical strategy and models of care (including mental health).
Financially Sustainable		Development and delivery of a Three-Year Plan to improve the financial position of the Trust, with a focus on enabling workstreams, including digital, estates and facilities supporting the clinical service improvements.
Operational Performance		Use of CI to reduce the trust's elective backlog, continued improvement of cancer performance and UEC performance with improved whole system flow.

1. Well Led | 2. People & Culture | 3.Safety & Quality | 4.Clinical Effectiveness | 5. Financially Sustainable | 6. Operational Performance

	1 Stabilising	2 Performing	3 Transforming
AIM	Steadying the ship…	…Delivering improved performance	A leading organisation
OBJECTIVES	• Control and stability is in place. • A single improvement plan is developed and signed off, ready for mobilisation from April 2024.	• Single Improvement Plan is delivered to embed safe, well-led care.	• Designing and delivering the long term vision for LTH, in readiness for the New Hospital. • System leader, collaborating for Central Lancashire Place to thrive
DESIRED OUTCOMES	• Exec Team portfolio clarity • Intensive Support Director sourced • Improvement Plan Delivery Unit established • Exit criteria from NOF rating agreed	• IP projects delivering to plan • Not a NW or L&SC outlier for all areas within the Improvement Plan • Exit from current NOF rating	• Outstanding provision of care • Place of choice to train and thrive in career • Upper quartile performance nationally

Developing Improvement Plan Governance & Reporting

Portfolio:

Assurance updates to Trust Board & Committees and System Improvement Board

SRO: Silas Nichols

Intensive Support Director:

LTH Improvement Plan Portfolio Board

Format:
1. Chaired by Chief Executive
2. Attended by SROs or nominated deputy in absence
3. 1 Hour monthly (to replace the current transformation board)
4. Updates & risks and issue management by exception and invite
5. Standard highlight reports
6. Monthly sign-off of IP Reporting Pack for Trust Board and System Improvement Board

IP Programme Director: Ailsa Brotherton

IP Delivery Unit

Head of IP Delivery Unit/PMO

Programme:

Format:
1. Chaired by SRO
2. Attended by Project Leads & other stakeholders as required
3. Monthly Highlight report for Programme Board
4. Product & Action Tracker for Weekly Huddles

SRO: Silas Nichols	SRO: Neil Pease	SRO: Sarah Cullen	SRO: Gerry Skailes	SRO: Jonathan Wood	SRO: Imran Devji
Well Led Programme Board	People & Culture Programme Board	Safety & Quality Programme Board	Clinical Effectiveness Programme Board	Financial Sustainability Programme Board	Operational Performance Programme Board
Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle	Weekly Delivery Huddle
Project detail on following slides	Project detail on following slides	Project detail on following slides	Project detail on following slides	Project detail on following slides	Project detail on following slides

Project:

Format:
1. Project Leads to choose most appropriate format to drive delivery, e.g. Daily Huddles, Delivery Group, Project Board, Task & Finish Group etc
2. Mandatory for all Projects to update Highlight Report in standard format

Becoming Well Led

The Well Led Programme

The Need for Change 1

- Long standing Requires Improvement
- Challenge within the CQC report on board stability and diversity
- November 2023 CQC rated Trust as Requires Improvement for Well Led (reduction from previous good)
- Lack of progress on resolving long standing risks: finance, UEC, elective recovery and maternity (safe domain)
- The New Hospital programme requires us to be at upper decile of performance in each specialty for demand to match capacity

The Improvement Plan 2

Changing Our Culture

The People & Culture Programme

The Need for Change (1)

Staff survey results show year on year improvement in all domains of 'Our People Promise'

The November 2023 CQC inspection highlighted outstanding practice;

- *"The trust had developed and used a team engagement and development tool (TED) to support improvements in levels of team satisfaction and engagement as measured through the trust annual staff survey. The tool was embedded across the trust in leadership development, continuous improvement, and the Star Ward Accreditation programmes. In 2022-2023 the trust completed 175 TEDS, which engaged with 1,523 colleagues. The tool had been recognised by NHSE as an example of excellent practice and the trust was supporting other organisations to do this"*

However, there is a need to:

- Improve our sickness rates
- Support teams to improve the culture in a number of challenged areas
- Continue to deliver our strategies and roll out of TED

SOURCE: November 2023 LTHTR CQC Report

The Improvement Plan (2)

- Attract, recruit and resource
- Engage, retain, reward and recognise
- Create a positive organisational culture
- Be well led
- Supporting the health and wellbeing of colleagues
- Being consciously inclusive in everything we do
- Education, Training & Research

Safety and Quality

The Safety and Quality Programme

The Need for Change (1)

The Trust is in the lowest quartile of performance for Clostridium Difficile

The CQC reported in the November 2023 inspection:

- *"The service must ensure that risk assessments are fully completed"*
- *"The service must ensure that risk assessments are fully completed with patients attending with mental health needs and mitigating actions to limit identified risks are implemented"*
- *"The service should ensure there is an accurate overview of risks faced, including the monitoring of delays in induction of labour, monitoring of missed telephone calls and telephone call drop off rates within triage and to rate all 3rd and 4th degree tears and post-partum haemorrhages as incidents"*

SOURCE: November 2023 LTHTR CQC Report

The Improvement Plan (2)

- **Deliver annual safe staffing requirements**
- **Maternity and Neonatal**
- **Patient experience and involvement**
- **Childrens Improvement**
- **Safeguarding**
- **Health Inequalities**
- **C Difficile Improvement Programme**
- **Deliver Always Safety First strategy**

Driving Clinical Effectiveness

The Clinical Effectiveness Programme

The Need for Change (1)

November 2023 CQC inspection found:

- “The trust must continue to take actions to improve the number of patients receiving a clinical assessment and daily review by a senior decision maker”
- “The service must ensure that risk assessments are fully completed with patients attending with mental health needs and mitigating actions to limit identified risks are implemented”
- “The service should continue its focus on establishing sufficient numbers of medical staff and managing any risks occurring as a result of staffing lack in medical workforce”
- “The services should ensure that premises are safe for use by patients”

SOURCE: November 2023 LTHTR CQC Report

The Improvement Plan (2)

- Medical staffing improvement
- Outpatient transformation
- Development of a clinical strategy
- Major Trauma
- Medication safety
- Junior Doctors
- Frailty

A Pathway to Sustainability

The Financially Sustainable Programme

The Need for Change 1

November 2023 CQC inspection found:

- “The trust must continue to take actions to improve the number of patients receiving a clinical assessment and daily review by a senior decision maker”
- “The service must ensure that risk assessments are fully completed with patients attending with mental health needs and mitigating actions to limit identified risks are implemented”
- “The service should continue its focus on establishing sufficient numbers of medical staff and managing any risks occurring as a result of staffing lack in medical workforce”
- “The services should ensure that premises are safe for use by patients”

SOURCE: November 2023 LTHTR CQC Report

The Improvement Plan 2

- 3 year recovery – identify and develop
- Budget Holder Allocation and Personal Engagement
- Budget Planning
- Procurement (LPC) & Contracts Hub

Improving Performance

Operational Performance

The Need for Change

1

November 2023 CQC inspection found:

- *"There was progress with performance but there was still much to do to address elective recovery"*
- *"The trust must continue to take actions to improve referral to treatment waiting time performance in line with national standards"*
- *"The trust had significant challenges around elective recovery and performance against the 62- and 31-day cancer treatment targets, this meant the trust was in the lowest 25% of trusts nationally for these metrics"*
- *"The division had performance committees in place, but poor performance was not always dealt with in a timely manner"*
- *"The trust had not yet delivered 6 of the 10 requirements set out by the NHS for cancer waiting lists and although they were making improvements with some of the cancer waiting targets, others were lengthy"*
- Challenges with UEC performance metrics

The Improvement Plan

2

- UEC In-flow
- UEC flow
- UEC outflow/community collaborative
- Elective: general
- Elective: cancer
- Elective: theatre efficiencies
- Strengthening Weekend Discharge in Acute Medicine
- Clinical Reconfiguration (System)
- Thinking Differently about the Medical Take

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors Report

Clinical Strategy Update			
Report to:	Trust Board	**Date:**	4th April 2024
Report of:	Director of Strategy & Planning	**Prepared by:**	Director of Strategy & Planning
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 regarding the development of a revised Clinical Strategy for Lancashire Teaching Hospitals. The paper covers the following key areas:

1. A summary of the key strategic issues that we are currently facing
2. An update with regards to current relevant work streams/activities in Lancashire & South Cumbria
3. The key areas where it is suggested further work is needed to develop and strengthen our existing strategy
4. Additional key areas of focus and proposed model of strategy development
5. Proposed next steps

It is recommended that:

I. The Board receives this report as assurance regarding the planned development of our revised Clinical Strategy

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

The Clinical Services Strategy was approved by the Board in April 2022. A refreshed Clinical Strategy was presented to the Board in December 2023

1. Introduction

Significant work was undertaken during 2022 to develop the Trust Clinical Services Strategy. The Strategy was co-designed with our clinical leaders, frontline staff and operational leaders and was agreed by the Board in April 2022, running until the end of 2024. A refreshed Clinical Strategy was presented to the Board in December 2023, which contained a range of updates particularly in relation to:

- The national planning context (including the very challenging financial context)
- The latest LTH elective and urgent care strategies
- System and collaborative working
- Health inequalities

In summary our current Clinical Services Strategy outlines the following priorities:

- Responding to the national/local planning context as laid out in the NHS Long Term Plan and our Integrated Care Board and Provider Collaborative strategies and priorities
- Delivering our Strategic Clinical priority to provide outstanding and sustainable healthcare to our local communities, including reducing our elective waiting lists and reducing waiting times in our Emergency Department
- Delivering our Strategic Clinical priority services to provide high quality tertiary services to the population of Lancashire and South Cumbria
- Driving health innovation through world class education, teaching and research
- Maximising system working in the new NHS landscape
- Reducing Health Inequalities
- Delivering the New Hospital Programme

The Board requested that a full refresh be brought forward in 2024 to allow a new Clinical Strategy to be agreed. It is proposed that a new strategy is developed that will run until 2030, taking us into a new decade and up to the delivery of the New Hospital Programme. Given the critical importance of being ready to move into our new hospital, for each key component of our new clinical strategy we will lay out where we are now, where we need to get to and how we will get there. The new Clinical Strategy will drive the production of an Estates and Facilities Strategy, which again will lay out the key issues facing LTH in the immediate term as well as the steps needed to prepare us for the move to our new hospital.

2. Key strategic issues facing Lancashire Teaching Hospitals

The Trust faces a wide of strategic challenges and opportunities, most of which are in line with those faced across the NHS, but in many cases our position in Lancashire and South Cumbria (L&SC) is worse than the national picture as can be seen below:

<u>Demand/Demographics</u>

In summary the population of Lancashire is older, sicker and poorer that the England average. This can be seen in a range of key data such as:

- We have a higher percentage of citizens over 65 years old
- We have a higher proportion of adults classed as overweight or obese
- The number of adults with a confirmed diagnosis of depression is higher
- The number of Looked after Children is significantly higher
- The number of Children in absolute low-income families is significantly worse
- Our Life Expectancy at Birth is lower
- Our Healthy Life Expectancy is lower

In addition to the above there are material inequalities in the quality of life and health outcomes for people living in different areas e.g. there is a 22 year difference in healthy life expectancy between the most and the least deprived areas

Looking forward:

- By 2043 there will be a 20% increase in the number of over 65's
- Life expectancy is falling, and falling faster in the most deprived areas
- The number of Children in absolute low-income families is increasing

As shown above, the population we serve faces a range of significant health and wellbeing challenges which on current trends are forecast to worsen over the next 10 to 20 years.

Resources

The NHS faces a range of major resource challenges, including budgets, workforce and buildings/equipment. The Lancashire and South Cumbria health system has a combined reported forecast deficit for 2023-24 of circa £198m. In addition, our system, based on the national funding formula (used to calculate allocated budgets based on population/need), is 'over funded' by a further circa £200m, and in each future national planning round funding will be removed in a process called 'convergence' that seeks to move us to our "fair share" of national funding. As such L&SC and LTH face major budget challenges going forward which, given the national financial position, will not be met by material increases in funding.

Workforce challenges are a resource issue in themselves but are also one of the key drivers for the financial deficits and challenges referred to above. The NHS in England has vacancies totalling over 112,000. The level of national vacancies will be exacerbated by the demographic changes referred to above – without action national demographic change is forecast to result in a shortfall of between 260,000 and 360,000 staff by 2036/37. Within LTH we currently have over 500 vacancies, which equates to a 5% vacancy rate.

Within L&SC nearly a quarter of our health buildings pre-date the NHS, and the current level of backlog maintenance across our provider buildings is nearly £180m, with £108m of this relating to significant, high risk or critical infrastructure. Independent appraisal has confirmed 80% of the Royal Preston Hospital site requires redevelopment or demolition over the medium to long term. The site has backlog maintenance costs totalling around £160m and over 70% of its clinical facilities date from the 1970s to 1990s.

A "Left Shift" and a focus on population health

Responding to the above challenges will require the introduction of new models of care to allow us to achieve what is described as a "Left Shift" in healthcare – a move to increased upstream interventions, whereby instead of treating patients in hospitals once their condition has significantly progressed, we focus on earlier stage treatment in ambulatory and community settings and on maintaining the health, wealth and happiness of our population. This left shift requires identifying disease at an earlier stage, enabling earlier interventions, which would result in better clinical outcomes, better patient satisfaction and a reduced burden on health systems. The NHS Long Term Plan identifies that population demand will continue to outstrip supply unless we make a series of key changes to ensure the NHS can be:

- More joined-up and coordinated in its care: the NHS must break down traditional barriers between care institutions and move away from competition to integration whereby teams and funding streams come together to support the growth in long term health conditions, rather than viewing each encounter with the health service as a single, unconnected 'episode' of care
- More proactive in the services it provides: the majority of initial medical contacts with the NHS occur when a patient calls NHS 111 or 999, or visits their pharmacist, GP practice or A&E but we need to move to a 'population health management' approach, using predictive prevention (linked to new

opportunities for tailored screening, case finding and early diagnosis) to better support people to stay healthy and avoid illness complications
- More differentiated in its support offer to individuals: this is necessary if the NHS is to make further progress on prevention, on inequalities reduction, and on responsiveness to the diverse people who use and fund our health service. More fundamentally, with the right support, people of all ages can and want to take more control of how they manage their physical and mental wellbeing

Clinical Critical Mass

In considering the strategic options and possibilities for hospital services the concept of clinical critical mass is important. Inorder to function as a viable unit a hospital has a minimal level of collocated services/resources that are needed irrespective of the number of patients who may attend. For example, hospitals with Emergency Departments receiving all acute adult patients (an unselective take) need on site acute and general medicine, acute surgery, and critical care. Therefore, such hospitals also need to provide all the supporting clinical services which are required by all or any one of these four core inter-related acute specialties. The concept of clinical critical mass also applies within specialties – particularly specialised services, where the evidence base suggests that inorder to achieve the best clinical outcomes each clinician must undertake a minimum number of procedures/interventions a year. Whilst clinical critical mass is a recognised and accepted part of strategic service planning in the NHS and across the world its detailed application and implications can be contentious particularly in relation to whether colocation is absolutely necessary for a particular circumstance or is desirable, and in relation to the exact number of procedures required for a particular clinician/service to be optimal.

New Hospitals Programme

The New Hospitals Programme gives us a once in lifetime opportunity to address the full range of issues outlined above inorder to ensure we provide high quality, efficient, effective services with optimised service configurations and pathways. Within our New Hospital Business Case we have modelled future demand, which as outlined previously is projected to increase significantly, adding pressure to our services which are currently struggling to give our patients and our staff the experience we would want. We have also modelled the opportunities we have to transform our services to ensure we have the right pathways, capacity, staff and expertise to provide high quality, sustainable services. As we move forward with our Hospitals Programme we must ensure that our Clinical Strategy is reviewed and refined to deliver the new care models and service assumptions that underpin our plans.

3. Current Strategic Clinical Workstreams in L&SC

There are currently a range of strategic clinical workstreams progressing in L&SC which will all have material implications for our Clinical Strategy. The overall programme is led by the Provider Collaborative Board Clinical Programme Board, which is chaired by the Chief Executive of East Lancashire Hospitals and has Medical Directors from each Trust as members. The programme consists of the following 3 main workstreams:

Fragile services

Each Trust in L&SC has undertaken a Fragility Assessment using an agreed scoring system. This required each Trust to score its specialties using 3 headings - workforce, clinical standards and finance. The scores were then added together to get an overall score for the specialty, which was used to calculate a Frailty Priority score. The assessments were discussed at the Provider Collaborative Board Clinical Programme Board before being presented to a Clinical Strategy Workshop in November 2023. The workshop agreed that haematology, orthodontics, stroke and gastroenterology would be the first phase of Fragile services requiring the development and implementation of system networked solutions. Senior Responsible Officers have been appointed for each specialty to develop a strategy and implementation plan to deliver high quality, sustainable services.

Service Reconfigurations

There are four specialties where service reconfiguration is underway to drive new models of care, largely driven by the need to meet NHSE service specifications/standards. The services in question are vascular, head & neck cancer, urology and cardiology. Senior Responsible Officers have been appointed for each specialty and detailed case for change documents have been produced presenting compelling evidence as to the need to reconfigure services.

Clinical service configuration "blueprint"

Following the system wide clinical workshop held in November 2023, agreement was reached that an external partner would be commissioned to develop a clinical configuration blueprint. A company called has been commissioned and the Senior Responsible Officer is the CEO from ELHT. The approach to be taken is summarised below:

- Phase 1: Mobilisation - eg Stakeholder Engagement, Governance Setup, Document Analysis,
- Phase 2: Discovery - eg Strategic Analysis, Patient Segmentation, Capability and Productivity Analysis
- Phase 3: Conversations - building on the analysis, a series of conversations will be orchestrated to develop the clinical services blueprint
- Phase 4: Roadmap - the co-development of a 3-year roadmap with a supporting case for change that maximises L&SC's ability to improve safety, effectiveness, and affordability

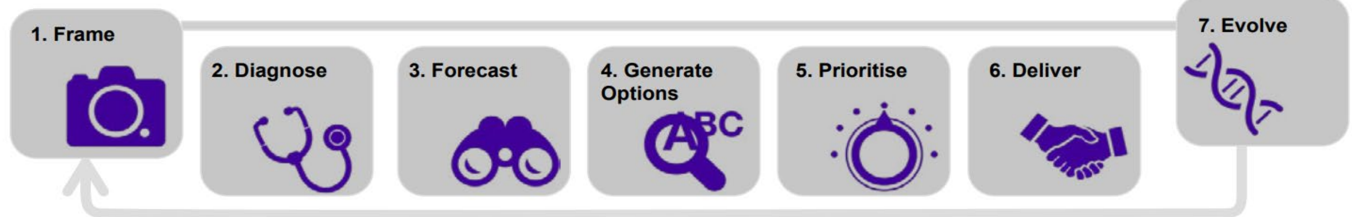
The above programme is timetabled to culminate in the production of the blueprint by the end of July 2024. We will ensure that our teams are fully engaged in the coproduction of the L&SC clinical configuration blueprint and this will be a major factor in developing our Clinical Strategy.

4. Additional key areas of focus and proposed model of strategy development

Our revised Clinical Strategy will seek to address all the challenges/opportunities outlined in sections 2 and 3 of this paper. In addition, with regards to areas not explicitly mentioned, it will seek to focus on:

- Maximising our contribution to population health as an anchor institution
- Opportunities to strengthen our range of tertiary services as part of a coherent cross L&SC service development plan
- Integrating our services and joining up our pathways across community services in partnership with our colleagues in Primary Care
- Opportunities to maximise our elective capacity and treat more patients rather than have those operations being done in the Independent Sector
- Clinical research and development
- Education and training

It is proposed to use the following high level model to develop our new strategy



Each step is summarised below:

Frame: establish the scope of the strategy development process by identifying the important strategic context, choices and challenges

Diagnose: assesses current performance what lies behind it. All aspects of performance are included eg quality, operational, financial and workforce
Forecast: projecting forward to create a clear view of what the future might look like
Generate options and ideas: explore interventions and choices that would change the base case identified above
Prioritise: choosing which strategic initiatives to pursue and build them into a coherent strategy
Deliver: agreeing the high level actions to deliver the strategy and how we achieve them
Evolve: agreeing how we will monitor delivery to ensure the strategy is effective and how and when we will take stock to assess whether the strategy needs to change

5. Next Steps

Detailed action plans have been developed as part of the Trust Single Improvement Plan. The key next steps and timescales to develop our new Clinical Strategy are summarised below:

Review existing Strategy and good practice from other Trusts	March
Agree key issues, strategy duration and approach	April
Signal intent to key external stakeholders and partners	March & April
Establish internal steering group	April
Pull together data for diagnose and forecast steps	April
Consultation and Engagement	April to July
Draft Trust Clinical Strategy & engage on redrafts	July/August
Finalise Clinical Strategy	September
Agree final Strategy at Board	3rd October

6. Financial implications

No direct implications.

7. Legal implications

No direct implications.

8. Risks

A range of risks are present in relation to the development of a new Clinical Strategy. These will be managed, mitigated and reported to the Board as part of our Fit for the Future risk management system.

9. Impact on stakeholders

No direct impact.

10. Recommendations

It is recommended that:

I. The Board receives this report as assurance regarding the planned development of our revised Clinical Strategy

Excellent care with compassion

Trust Headquarters

Board of Directors Report

Green Plan			
Report to:	Board of Directors	**Date:**	4th April 2024
Report of:	Gary Doherty, Director of Strategy and Planning	**Prepared by:**	I. Ward, T. Calvey
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to give assurance to the Board on the progress being made against our agreed Green Plan. The NHS became the world's first health service to commit to reaching carbon net zero in October 2020 ahead of COP26 in response to the increased threat posed by climate change, with the Trust Board approving our 3-year Green Plan in February 2022. This plan is in the process of being updated ahead of submission for Board approval in Q4 2024/25.

The Trusts position is summarised below:

- Good progress is being made to deliver our Green Plan.
- Benchmarking data indicates that we are above the national average in 9 out of 10 areas, with the one we are below the national average reflecting the way the timing of our plan refresh is scored in the national system.
- The Trust's Total carbon dioxide emissions (tCO2e) have reduced by 12.5% against the baseline position.
- Reduction of paper generation by over 2m sheets per year relating to our digital programmes.
- Significant increase in our cloud computing footprint removing 80% of on-site servers by the end of Q1 (2024/25) reducing our overall CO2 emissions.
- Increased utilisation of virtual appointments from around 48k in 19/20 to 134k in 2023/24 (+180%) meaning less patients traveling to hospital.
- Significant improvements in reduction of waste sent to landfill.

Delivering further improvements in our environmental impact will require a range of transformational changes in our services, pathways and behaviours. Additional investment will help to drive such improvements, however given the pressures on our capital programme we will be seeking to maximise access to external sources of capital funding. Our plans for the development of a replacement hospital under the New Hospitals Programme continue with a key requirement that all new hospital builds are net-zero, which will make a game changing contribution to our net-zero journey.

It is recommended that the Board:

I. Note the contents of this paper and receive assurance on progress against our Green Plan

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

Previous consideration
The Trust Board approved our 3-year Green Plan in February 2022

Background

1. In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero. In response to the profound and growing threat to health posed by climate change, the Greener NHS National Programme published its strategy on "Delivering a net zero National Health Service". This report highlighted that left unabated climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma, and cancer. To support the co-ordination of carbon reduction across the NHS and the translation of this national strategy to a local level, the 2021/ 2022 NHS standard contract introduced the requirement for NHS Trusts to develop a "Green Plan" to detail their approaches to reducing emissions.

2. In February 2022 the Trust Board approved our three-year Green Plan, outlining the Trust's organisational approach and commitments in moving towards net zero. This plan is in the process of being updated ahead of submission for Board approval in Q4 (2024/25).

Discussion

3. Our Green Plan was developed utilising the 'Sustainable Development Assessment Tool' (SDAT) to assess our baseline position and to drive action plans for improvement. However, in July 2022 the SDAT was decommissioned and subsequently replaced by the 'Green Plan Support Tool' (GPST).

4. The new self-assessment support tool remains in pilot phase and is primarily intended for use by sustainability leads to:

    - Assess an organisation's performance against key metrics
    - Track progress over time and benchmark against other organisations
    - Understand our organisation's Carbon Footprint Plus
    - Set our own interim targets for improvement

Current Position

5. The self-assessment support tool enables benchmarking against the national average in the ten areas of focus as shown overleaf in Figure 1. The most recent self-assessment shows the Trust benchmarks above the national average in 9/10 areas with 1 area below national average.

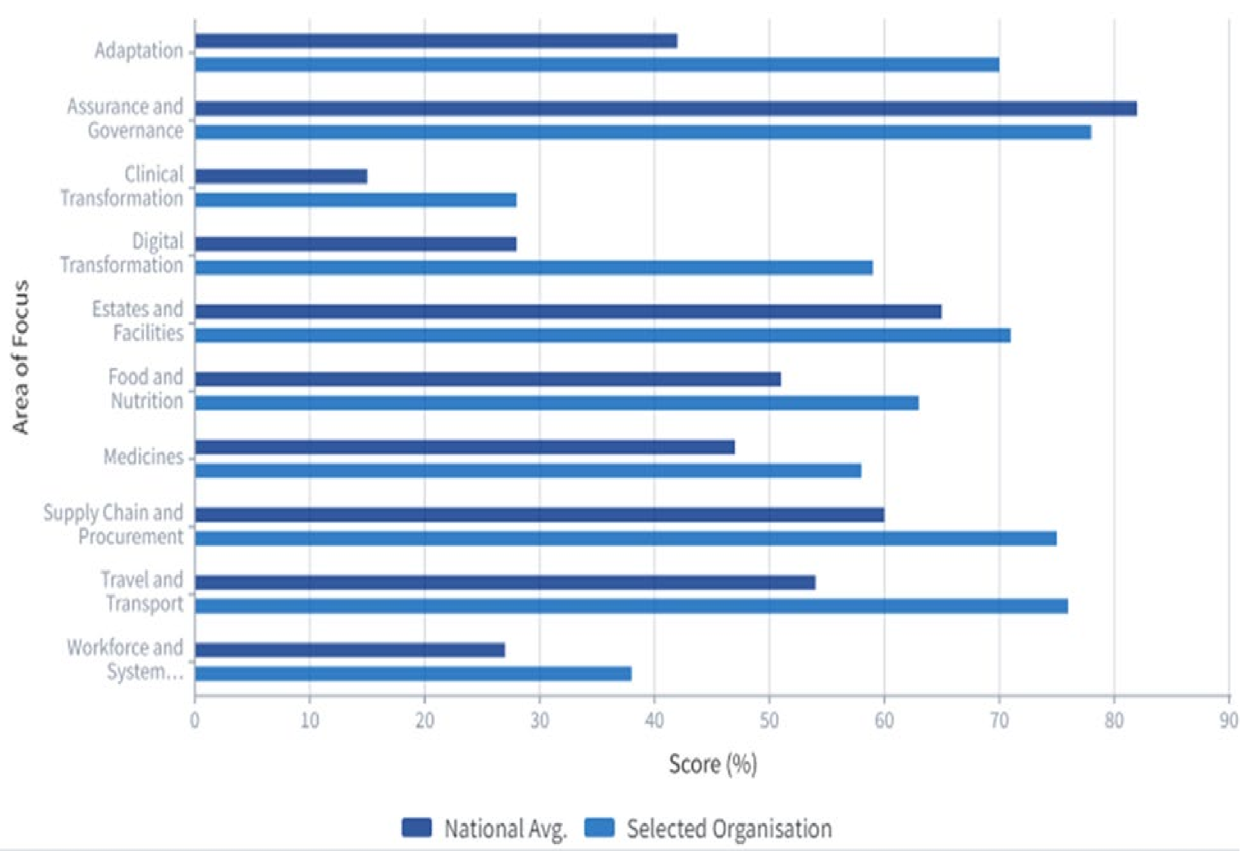


Figure 1: Greener NHS - Green Plan Support Tool (PILOT) for Lancashire Teaching Hospital in Q4 2023/2024

6. The area we are below average (Assurance & Governance) appears as such because our score is reduced as we plan to refresh our green plan in 2024/25 as opposed to updating at the end of 2022/23 – if this scoring element was changed/removed our benchmark would be above average.

7. The latest data published on the Green Plan Support Tool for our Trust's contribution to the NHS Carbon Footprint (tCO2e) is illustrated in Figure 2 below, with the most significant area being attributed to Building energy, business & travel and Anaesthetic gases:

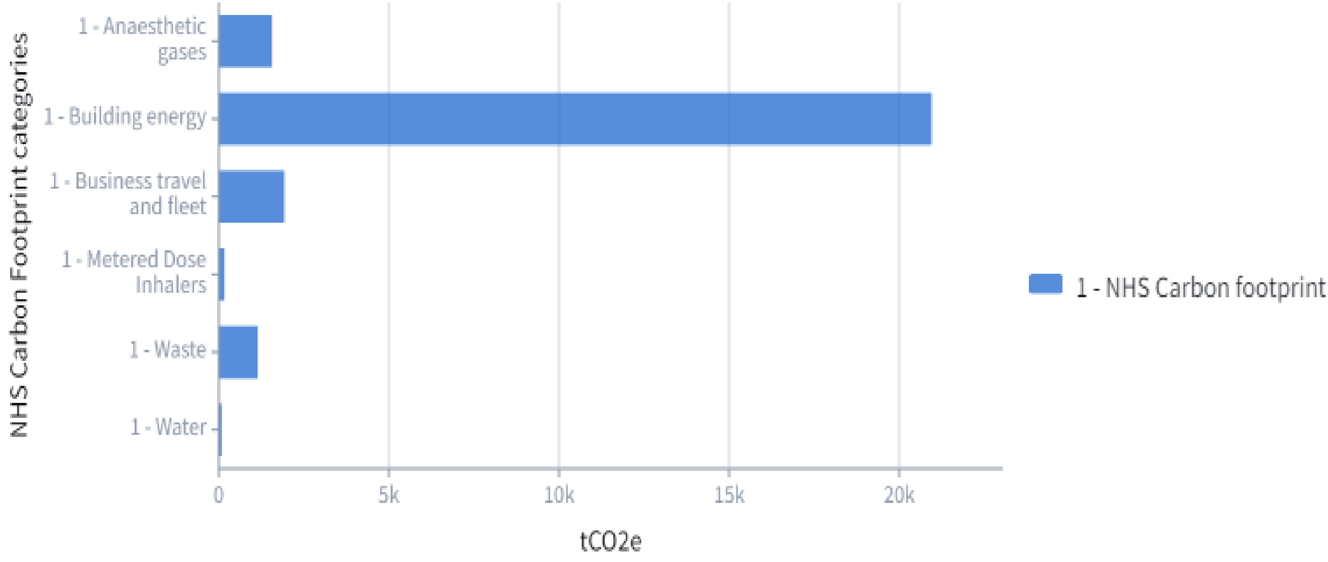


Figure 2

8. Our carbon dioxide emissions are measured in three distinct areas as outlined below:

- Scope 1: Direct emissions sources resulting from owned machinery, facilities, and vehicles.
- Scope 2: Indirect emissions sources associated with the generation of electricity, heat, steam and/or cooling.
- Scope 3: Indirect emissions across all 15 categories including business travel, commuting, waste, and third-party deliveries.

9. Table 1 below shows our total carbon dioxide emissions from the baseline period to latest published 2022 data.

tCO2e	Baseline (2010)	Latest (2022)	Change
Scope 1 emissions	15,814	15,731	-0.5%
Scope 2 emissions	7,032	123	-98.3%
Scope 3 emissions	116,658	106,159	-9.0%
Total	139,504	122,013	-12.5%

Table 1

10. Anaesthetic and medical gases are responsible for around 2% of all NHS emissions and 5% of emissions from acute care, according to the 'Delivering a Net Zero National Health Service' (July, 2022 report). Desflurane has a global warming potential 2,500 times greater than carbon dioxide. In Jan 2023 it was announced that by early 2024 Desflurane will no longer be used by the NHS in England. Figure 3 below shows our reduction in Desflurane.

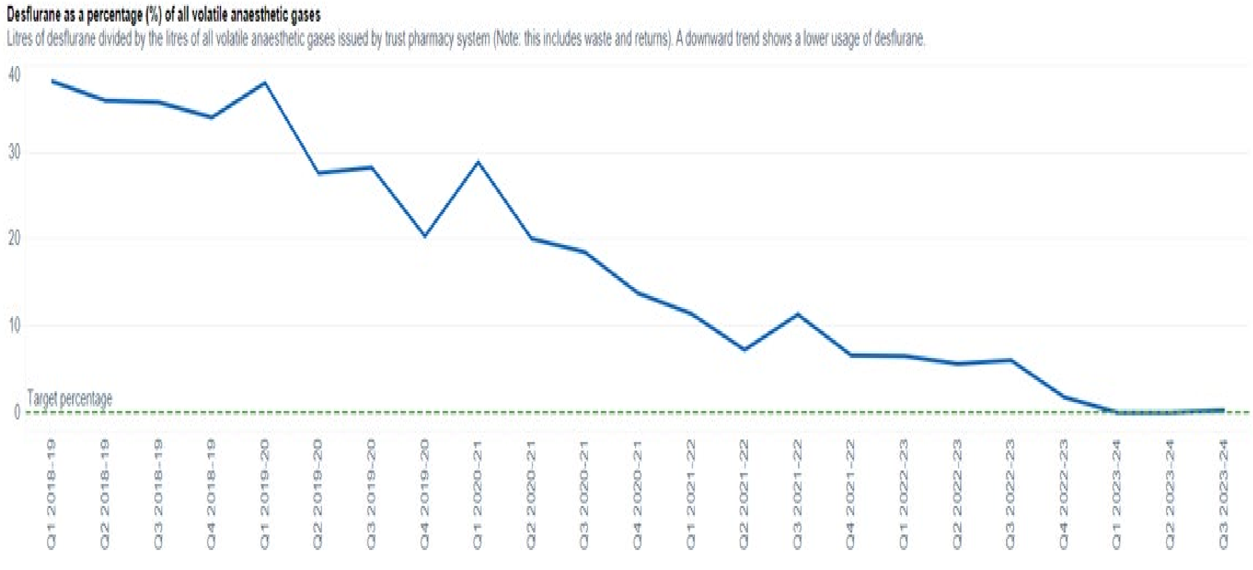


Figure 3

11. Some of the key headlines regarding our green plan achievements include:

- Reduction of paper generation by over 2m sheets per year as a result of digital programmes.
- Significant increase in cloud computing footprint removing 80% of on-site servers by the end of Q1 (2024/25) reducing our overall CO2 emissions.
- Increased utilisation of virtual appointments from around 48k in 19/20 to 134k in 2023/24 (+180%) meaning less patients traveling to hospital.
- Significant improvements in waste sent to landfill with:
    i. 615 tonnes of waste recycled (includes estimated confidential wastepaper recycling).

ii. 5 tonnes of waste composted.
iii. 1,036 tonnes of waste recovered (includes estimated food waste disposed of by anaerobic digestion and other domestic wastes by energy from waste).
iv. 2.5 tonnes of waste re-use (furniture and equipment through the Trust's reuse portal Warp-it).

12. The trusts Green Plan is monitored on a regular basis through the governance arrangements for our Social Value Framework under the 'Planet' theme as illustrated in Figure 4 below, we also report nationally on a quarterly basis via the Greener NHS Data Collection and Greener NHS Fleet Data Collection submissions.

Figure 4

Future Developments

13. Development of the new iteration of our Green Plan has commenced, and we are working with the respective leads of each section to identify key performance indicators in developing how our approach to sustainability can further reduce carbon emissions and support the NHS's goal of moving towards Net Zero.

14. Given the Trusts' challenging financial position, prioritisation of the limited capital available to us is focused on maintaining our clinical areas, therefore access to external sources of funding & investment is crucial to enable material progress to be made in our journey to net zero.

15. The Trust has been successful in securing a £650,000 grant for energy-efficient LED lighting with plans for installation at Chorley District Hospital and Royal Preston.

16. A £16m bid has been made via the Public Sector Decarbonisation Scheme (PSDS) to Salix Finance for heat decarbonisation, which is primarily targeted at the Trust's gas consumption and Solar Photovoltaic (PV) generation. If successful, the Trust share of the funding will be £2m.

17. Training has been developed 'For a Greener NHS - Delivering Net Zero at LTHTR'. Going forward we will consider how to further increase awareness throughout the Trust by either making the eLearning package part of mandatory training or incorporating it into Induction.

18. The New Hospitals Programme gives us a once in a lifetime opportunity to transform both our services and our environmental impact. A new Net Zero Carbon Hospital Standard has been

developed as part of the NHP, and applied across the new hospitals to be built. The standard involves both the use of innovative, low-carbon materials, as well as new design that allows for flexibility and shifts in how care will be delivered in the future. As a result, our new hospital will be fully carbon net zero which will have a significant impact and make a major contribution to reducing our tCO2e.

Financial implications

19. There are no direct financial implications arising from the development and monitoring of the Green Plan – any costs or benefits of the actions contained within the plan are incorporated into our planning/budget setting cycle.

Legal implications

20. There are no direct legal implications arising from this paper.

Risks

21. Without access to external sources of capital funding, progress towards net zero will be challenging given the financial position of the Lancashire & South Cumbria wider-system.

Impact on stakeholders

22. No direct impact on stakeholders arising from this report.

Recommendations

It is recommended that the Board:

I. Note the contents of this paper and receive assurance on progress against our Green Plan

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):	22 January 2024
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 22 January 2024. 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 18th December 2023 and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

Strategic Risk Review: The Committee received an update on risks aligned with the 'Deliver Value for Money' strategic aim. Discussions included funding challenges, risk management concerns, and the need for greater emphasis on controls, linking them to the single improvement plan. The Committee confirmed that risk articulation at level 20 was appropriate.

Financial Performance: An overview of the Trust's financial performance up to Month 9 was provided. Concerns about overspending, challenges in CIP delivery, and the Finney House funding dispute were discussed. Assurance was sought on deficit management and backlog maintenance prioritisation.

Operational Performance:

- **Performance Update** Updates on urgent and elective care, cancer care, and the winter plan were provided. Concerns about operational performance were highlighted and further assurances sought regarding frailty management, DNA metrics and boarding risks.

Strategy and Planning

- **Planning Framework Update and Review**: Updates on the establishment of a Project Management Office and system transformation programmes were provided, with concerns raised about clarity and outcomes. It was resolved that the stroke business case be reconsidered at a future meeting and that a limited level of assurance around fragile services contribution to the quadruple aim be noted.

- **Financial Recovery and Transformation Update:** Efforts to mitigate financial pressures and improve operational efficiency were discussed, with emphasis on the need for clearer action plans.

- **Transformation Update**: Progress and challenges in transformational activities were reviewed, with a call for greater risk focus and specificity in future updates.

- **LTH Planning Update**: The current status of the planning cycle and process was outlined, with concerns raised about engagement and collaboration.

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

- **Drivers of Deficit and Operational Performance (verbal update):** Key changes since August 2021 were discussed, with a focus on addressing deficit drivers and engaging stakeholders effectively.

- **National Cost Collection – Post Submission Report:** The Committee received the post-submission report, discussed its implications, and noted ongoing efforts to improve costing methods.

- **Procurement Update:** Progress and developments in the procurement strategy were presented. Significant savings were achieved, but challenges in insourcing and contract management were noted.

- **Single Tender Waivers Report:** Progress and developments in the procurement strategy were presented. Significant savings were achieved, but challenges in insourcing and contract management were noted. It was resolved that a zero-tolerance approach to waivers within the requirements as set out in Standing Financial Instructions be endorsed.

Items for the Board's attention

Positive escalation

- Recognition of improvements in single tender waivers and mobilised efforts to drive those improvements.
- Spotlight on elderly & frail population as a key area for demographic driven care, including work from Engineering Better Care.
- Continued preparation of a three-to-five-year plan to achieve a sustainable balance in performance across the quadruple aims.

Negative escalation

- Continued financial pressures and potential new headwinds affecting year-end outcomes.
- Lack of clarity and assurance on the PCB-Frailty service Project's contribution to the quadruple aim.
- Challenges in funding the original stroke business case and the need for a retrospective deep dive into benefits realisation.
- Mismatch between the demand for services and the current funding provision, creating specific pressures on the organisation.

Committee to Committee referral

None

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) Capital Planning Forum d) IG Records Committee e) EPRR – stood down due to non-quorate – Committee raised concerns that this meeting keeps being stood down.
Items where assurance was provided and/or for information
• Contract Performance • Corporate Benchmarking Report • Deficit Protocol Controls Overview • ELFS Management Notes
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its Cycle of Business. The next meeting of the Committee will take place on 27 February 2024 using Microsoft Teams

Recommendation:

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

Appendix 1 – Finance and Performance Committee agenda (*22 January 2024*)

Chair’s Report

DRAFT

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside, Non-Executive Director
Date(s) of Committee meeting(s):	27 February 2024
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 27 February 2024. 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 22nd January 2024 and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

Strategic Risk Review: The Committee received an update on risks aligned with the 'Deliver Value for Money' strategic aim. The importance of mitigating factors and controls in the risk profile was emphasised. Further review of the risk profile was planned in line with annual planning cycles. The Committee confirmed that risk articulation at level 20 was appropriate.

Financial Performance:

- **Month 10 Finance Report**: An overview of the Trust's financial performance up to Month 10 highlighted challenges in delivering financial improvement programmes, primarily attributed to operational pressures and industrial action. Efforts to achieve Cost Improvement Programme (CIP) targets showed progress, though risks to CIP delivery remain.

Operational Performance:

- **Performance Update:** Updates on Urgent and Elective Care (UEC) and Elective Care Cancer highlighted progress and challenges in meeting targets and addressing operational issues. The Committee sought further understanding of DNAs and actions being taken to improve performance.

Strategy and Planning:

- **Planning Framework Update:** The report highlighted progress and challenges in system programmes, emphasising consensus on the need for implementation but concerns about timelines and financial viability, particularly in clinical areas. The Committee acknowledged the importance of the PMO and raised questions about selecting appropriate delivery vehicles for the Single Improvement Plan, urging clarity on the Trust's financial contribution to programmes. The need for

scrutiny regarding shortfalls was acknowledged and a loopback process for reassessment was proposed. Plans were outlined to involve project leads in developing detailed delivery plans, considering resources and potential support from regional bodies.

- **Transformation Update:** Efforts to improve performance, particularly in urgent and emergency care, were acknowledged, with emphasis on the need for proactive communication strategies. Further assurance on transformational risk position and alignment with the Single Improvement Plan was sought.

- **LTH Planning Update:** An update was provided on the Trust's planning activities outlining progress made since December in establishing forecast outturns, clear baselines, and anticipated impacts of business cases for the upcoming year. Final guidance for the coming year was still pending. Key issues identified included urgent care, finances, and safety and quality concerns. Ongoing discussions were noted, particularly around maternity, and the need to strengthen planning processes and strategy formulation was highlighted. The Committee sought clarification on the submission process's alignment with Board commitments, emphasising the importance of patient and staff voices in planning.

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

- **Financial Plan Update:** A financial summary was presented indicating a projected deficit of £36.6 million, even after accounting for inflation growth, local pressures, and the delivery of CIPs. Despite efforts to address the deficit, it was emphasised that the position was not satisfactory. Uncertainty was expressed about improving this position given existing CIP risks and pending planning guidance. The need for ongoing monitoring and acknowledgment that the deficit figure is subject to change over the coming weeks and months was highlighted.

- **VBI Update:** VBIs were discussed as the methodology for target setting in the financial recovery plan, with a focus on achieving break-even or better positions within a three-year period. The importance of patient involvement and engagement in planning was emphasised.

- **Digital and Information Strategy and Review:** Progress on digital transformation initiatives was discussed, emphasizing the need for alignment with organisational goals and effective communication strategies. Concerns were raised about protecting intellectual property, suggesting the need for specific legal support in this regard.

- **Use of Resources Deep Dive:** Discussion focused on the Trust's self-assessment and use of resources assessment, highlighting challenges with outdated indicators and the need for more current data. Further clarification on the use of non-clinical space metrics and its impact on the NHP metric was requested.

- **HR Controls:** The Committee expressed satisfaction with control achieved over nurse agency and highlighted plans to improve management of doctors' attendance. Concerns were raised regarding disparity on Bank rates within East Lancashire, emphasising the need for all system partners to work within agreed rate cards.

- **Trading Accounts:** Concerns were raised about losses incurred by non-patient catering services, emphasising the need to balance financial sustainability with essential service provision. Plans were outlined to address deficits in various areas and provide regular reporting on trading accounts.

Items for the Board's attention

Positive escalation

- Improving agency cap position
- Tracking to reforecast the outcome trajectory
- Strong level of assurance on digital strategy and improvements

- Ethical approval obtained for research environment
- Positive assurance around improving workforce controls from recent grip and control actions
- Positive outlook in bringing together the Single Improvement Plan
- Strong approach and launch of VBI aiding financial challenge

Negative escalation

- Scale of financial challenge due to overall size of deficit, and balancing decisions for financial recovery against S&Q and experience
- Deviation from agreed Agency Rate Cards by Trust Partner
- Shortfall of some wider system transformation programmes, despite positive over-delivery in other areas.

Committee to Committee referral

None

Items recommended to the Board for approval

None

Committee Chairs reports received

a) ICS, ICP, PCB system update
b) Capital Planning Forum – no meeting
c) SIRO/AIO Working Group
d) Medical Devices Group

Items where assurance was provided and/or for information

- Contract Performance
- Deficit Protocol Controls Overview
- Action Plans for DIFs

Feeder Group TOR:

- EPRR
- Capital Planning Forum inc. expensive medical equipment

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 March 2024 using Microsoft Teams

Recommendation:

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

Appendix 2 – Finance and Performance Committee agenda (*27 February 2024*)

Finance and Performance Committee

22 January 2024 | 12.30 pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	12.30pm	Verbal	Information	T Whiteside
2.	Apologies for absence	12.31pm	Verbal	Information	T Whiteside
3.	Declaration of interests	12.32pm	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 18 December 2023	12.33pm	✓	Decision	T Whiteside
5.	Matters arising and action log	12.35pm	✓	Decision	T Whiteside
6	Strategic Risk Review	12.40pm	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M9 Finance Report	12.55pm	✓	Assurance	A Mulholland-Wells
7.2	National Cost Collection – post submission report	1.05pm	✓	Assurance	C McGourty
7.3	Procurement Update	1.15pm	✓	Assurance	S Robson
7.4	Waivers	1.25pm	✓	Information	S Robson
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Update • Performance Assurance Report • Winter Plan Update • Activity Improvement Plan	1.35pm	✓	Assurance	I Devji
8.2	Drivers of Deficit and Operational Performance	1.50pm	✓	Assurance	J Wood

9.	STRATEGY AND PLANNING				
9.1	Financial Recovery & Transformation Update • Value Based Improvement	2.00pm	✓	Assurance	J Wood
9.2	Transformation Update	2.15pm	✓	Information	A Brotherton
9.3	Planning Framework Update (to inc. PMO briefing)	2.25pm	✓	Assurance	G Doherty
9.4	Update on National Operational & Contract Guidance	2.40pm	Verbal	Information	J Wood
9.5	Update on LTH Planning	2.55pm	✓	Assurance	G Doherty
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items for escalation to the Board or items to/from other Committees	3.10pm	Verbal	Information	T Whiteside
10.2	Reflections on the meeting and adherence to the Board Compact	3.20pm	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums (stood down)				
11.2	Contract Performance		✓		
11.3	**Chairs' reports**: (a) New Hospitals Programme flash report (b) EPRR Committee (stood down) (c) IG & Records Committee (d) ELFS Management Board (e) ICS, ICP, PCB System update (f) Capital Planning Forum		✓ ✓ ✓ ✓ ✓		
11.4	Deficit Protocol Controls Overview		✓		
11.5	ICBIAG Update		✓		
11.6	Date, time and venue of next meeting: *27 February 2024* *09.00am – 12.00pm* *Microsoft Teams*	3.30pm	Verbal	Information	T Whiteside

Finance and Performance Committee

27 February 2024 | 09.00 am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	09.00am	Verbal	Information	T Whiteside
2.	Apologies for absence	09.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	09.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 22 January 2024	09.03am	✓	Decision	T Whiteside
5.	Matters arising and action log	09.05am	✓	Decision	T Whiteside
6	Strategic Risk Review	09.10am	✓	Assurance	J Wood
7.	FINANCIAL PERFORMANCE				
7.1	M10 Finance Report	09.20am	✓	Assurance	A Mulholland-Wells
7.2	Trading Accounts	09.30am	✓	Assurance	C McGourty
7.3	HR Controls	09.40am	✓	Information	N Pease
7.4	Use of Resources Deep Dive	09.50am	✓	Information	I Ward
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Update • Performance Update • EPRR	10.00am	✓	Assurance	I Devji S Hughes
9.	STRATEGY AND PLANNING				
9.1	Digital & Information Strategy and Review	10.15am	✓	Assurance	S Dobson
9.2	Financial Recovery Plan Update	10.25am	Verbal	Information	J Wood

9.3	VBI Update	10.35am	✓	Information	A Mulholland-Wells
9.4	Transformation Update	10.45am	✓	Assurance	A Brotherton
9.5	Planning Framework Update (to inc. PMO briefing)	10.55am	✓	Assurance	G Doherty
9.6	a) Update on LTH Planning b) Financial Plan Update	11.05am	✓	Assurance	G Doherty
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items for escalation to the Board or items to/from other Committees	11.40am	Verbal	Information	T Whiteside
10.2	Reflections on the meeting and adherence to the Board Compact	11.45am	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Feeder Group TOR:** (a) EPRR (b) Capital Planning Forum inc. expensive medical equipment		✓ ✓		
11.4	**Chairs' reports**: (a) ICS, ICP, PCB System update (b) Capital Planning Forum – **no meeting** (c) SIRO/AIO Working Group (d) Medical Devices Group		✓ ✓ ✓		
11.5	Deficit Protocol Controls Overview		✓		
11.6	Date, time and venue of next meeting: *26 March 2024 09.00am – 12.00pm* *Microsoft Teams*	12.00pm	Verbal	Information	T Whiteside

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors Report

Integrated Performance Report

Report to:	Board of Directors	Date:	4th April 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 February 2024, unless otherwise stated.

- **The report reflects the revised 2023/24 Big Plan measures agreed by each sub-committee.**

Consistently Deliver Excellent Care

Performance commentary

Access Standards - Emergency Care Performance:

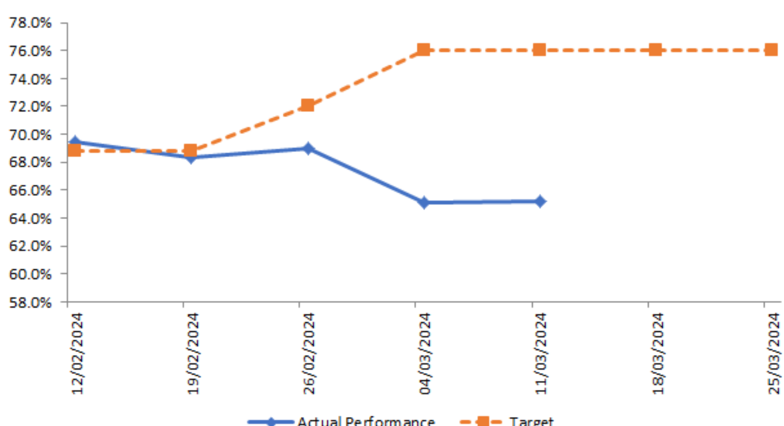
- 4 Hour ED performance is showing a slight improvement, with February 24 at 67.9%, compared to January 24 at 66.6%. The Trust is below the national average position of 70.9% and 7th out of the acute trusts in the North West. There is a plan in place to recover performance and achieve 76% for March 24

- A weekly recovery trajectory in relation to the 4-hour ED performance target has been developed, with an expected improvement to 76% during March 2024. The trajectory runs from 12th February – 31st Mar 2024 (see table below). It is based on an improvement action plan relating to improvements in time to 1st treatment, timely review of diagnostics and investigations and improved access to assessment areas. Overall performance for February 24 is slightly below the weekly improvement trajectory, and achievement of 76% during March is challenging. The Trust continues to experience significant pressure from an urgent and emergency care pathway perspective, which is understandably impacting on performance. Key issues include:
    - IPC issues (side room pressures) including norovirus impacting on bed flow.
    - Lack of assessment space due to escalation and corridor care.
    - Exit block due to lack of G&A beds and patients not meeting the criteria to reside in an acute Trust but unable to leave hospital with the right support.

- Delays in access to mental health bed once assessed (small number of patients but significant staff impact)

4 Hour Trajectory: Feb-Mar 2024

		TrajectoryWeek Beginning						
Service	**Category**	**12/02/2024**	**19/02/2024**	**26/02/2024**	**04/03/2024**	**11/03/2024**	**18/03/2024**	**25/03/2024**
Total Trust	Attends	3815	3815	3688	3682	3682	3682	3682
Total Trust	Breaches	1189	1189	1031	883	883	883	883
	Compliance %	68.83%	68.83%	72.04%	76.02%	76.02%	76.02%	76.02%



- Performance relating to the number of patients waiting over 12 hours (admitted and non-admitted) in ED for February decreased to 10.8% from 11.7% in January.

- In February, 433 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a decrease of 71 from last month. 285 patients waited over 60 minutes to be handed over from NWAS to the Trust in February 24 from 298 in January. Ambulance handover performance reflects increased Urgent and Emergency Care pathway pressures, with limited capacity across the Trust despite increased escalation. Ambulance handover delays remain a high priority and a local improvement collaborative is in place.

- 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 February of 96.2%, a reduction compared to last month's position. This is consistent with the flow pressures experienced.

- On average 41 patients were boarded each day across both sites during February, with 1181 associated bed days. These are predominantly medical patients requiring admission to an acute medical ward.

- 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 10.3% to 11% in February 24. There has been good utilisation of available capacity in the Home First service, and the Community Healthcare Hub (CHH) at Finney House.

Unfunded capacity and operational changes – Bed Capacity:

There have been a number of changes to processes and services, including Finney House, Virtual Ward, reprofiling of space in the Emergency Department to create an Acute Assessment Unit and an update to the organisational response to demand related escalation. This has enabled the following changes to be put in place:

Ward/Area	Impact	Delivery Date	Status
Closure of Avondale	Reduction of 28 G&A beds	Mar-23	Completed
Closure of Cath Lab & RAU	Reduction of 14 G&A beds	May-23	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	Jun- 24	Emergency pathway pressures have delayed delivery – currently reviewing plans for implementation in Q1 2024/25.
Co-location of Mental Health Urgent Access Centre (MHUAC)	Reduced cubicle space in ED, improved environment for patients awaiting MH assessment/treatment	Jun-24	Initial capital bid unsuccessful – joint LSCFT/LTH proposal being developed for Q1 2024/25
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. Several proposals have been submitted against the ICB UEC capacity investment funding for 2024/5 and the following set of system actions has been agreed at Central Lancashire place level:

- Demand management focused on the following streams:
  - top 20 attendances to urgent and emergency care settings by GP Practice
  - top 20 attendances to urgent and emergency care settings by Care Home
  - top 100 frequent users of urgent and emergency care
- Responding to frailty differently through using the outputs of the LSC Engineering Better Care programme for Frailty with a rapid focus on managing long terms conditions within primary and community settings rather than hospital and secondary care settings
- Mobilising and maximising our existing intermediate care capacity (including urgent community response, hospital at home, virtual ward and short term beds) to support both step up as an alternative to hospital admission and accelerate step down and discharge pathways to reduce length of stay, prevent deconditioning, improve outcomes and experience for admitted residents and optimise existing acute bed capacity
- A rapid process review and re-design of disease/condition specific pathways, with pathways to be determined.
- Additional executive level oversight from Chief Officers to ensure focus, pace and supportive leadership.

In addition to system plans, the Trust has its own internal programme of improvement being delivered through the Urgent Care Transformation Board which will inform the Single Improvement Plan for 2024/25

Access Standards - Elective restoration

65 and 78 Week Access Standards

Clearing the 78 and 65-week waits is a priority for the divisional teams with performance under constant review for assurance.
A small residual number of 78 week waits remained in February 24 due to the impact of the ongoing industrial action with daily oversight from the Interim Chief Operating Officer.

- Plans are in place to ensure treatment of all potential 78 week wait patients by the end March 2024 with the exception of some Orthodontic cases. Daily assurance takes place to ensure any risks to delivery are mitigated. Additional focus on identifying next steps for all patients is in place with risks addressed through PTL meetings and Performance Recovery Group.

- Elective and outpatient activity has been significantly affected by periods of industrial action, with strike action that took place in December (3 days) and January (6 days) and February (5 days) resulting in the cancellation of a total of 296 elective IP/DC and 2503 outpatient appointments over all periods. This is in addition to capacity not booked into during the strike periods

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

		30/04/2023			31/05/2023			30/06/2023			31/07/2023			31/08/2023		
Division	**Specialty**	**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
DCS	Pain Management	766	664	-102	690	576	-114	606	473	-133	526	410	-116	403	337	-105
Medicine	Cardiology	1185	1036	-149	1068	820	-248	938	612	-326	815	464	-351	625	335	-350
Medicine	Diabetes	74	59	-15	67	51	-16	59	39	-20	51	25	-26	39	20	-23
Medicine	Elderly Care	48	37	-11	43	23	-20	38	12	-26	33	8	-25	26	6	-22
Medicine	Endocrinology	588	572	-16	530	485	-45	466	371	-95	405	321	-84	311	235	-106
Medicine	Gastroenterology	1059	964	-95	954	791	-163	839	590	-249	729	422	-307	560	275	-339
Medicine	General Medical	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
Medicine	Neurology	4891	4613	-278	4407	3762	-645	3874	3086	-788	3365	2536	-829	2583	1968	-864
Medicine	Rehabilitation	24	17	-7	22	10	-12	19	6	-13	17	6	-11	13	2	-12
Medicine	Renal	213	113	-100	192	76	-116	169	55	-114	147	33	-114	113	8	-116
Surgery	Clinical Oncology	206	189	-17	186	164	-22	164	134	-30	143	133	-10	110	116	-5
Surgery	Colorectal Surgery	1560	1455	-105	1406	1220	-186	1236	991	-245	1074	803	-271	825	677	-227
Surgery	Dermatology	490	426	-64	442	359	-83	389	189	-200	338	104	-234	260	69	-216
Surgery	ENT	1235	1064	-171	1113	850	-263	978	583	-395	850	480	-370	652	373	-342
Surgery	General Surgery	924	795	-129	833	701	-132	732	554	-178	636	276	-360	488	388	-147
Surgery	Maxillo-Facial	426	411	-15	384	316	-68	338	264	-74	293	197	-96	225	164	-83
Surgery	Medical Oncology	35	25	-10	32	25	-7	28	20	-8	24	19	-5	18	15	-5
Surgery	Neurosurgery	2842	2637	-205	2561	2163	-398	2252	1724	-528	1956	1336	-620	1502	1094	-553
Surgery	Ophthalmology	1940	1780	-160	1748	1442	-306	1536	1090	-446	1334	874	-460	1024	634	-488
Surgery	Oral Surgery	341	295	-46	307	216	-91	270	175	-95	234	143	-91	180	108	-89
Surgery	Orthodontics	241	250	9	217	240	23	191	234	43	166	220	54	128	214	74
Surgery	Orthopaedics	1432	1277	-155	1290	1015	-275	1134	811	-323	985	647	-338	756	525	-304
Surgery	Plastic Surgery	1581	1492	-89	1424	1241	-183	1252	1069	-183	1087	938	-149	835	857	-58
Surgery	Surgical Dentistry	1481	1445	-36	1334	1253	-81	1173	1137	-36	1019	989	-30	783	887	29
Surgery	UGI	473	457	-16	426	379	-47	374	313	-61	325	243	-82	249	196	-77
Surgery	Urology	1799	1734	-65	1621	1460	-161	1425	1227	-198	1237	1071	-166	950	863	-178
Surgery	Vascular Surgery	1677	1640	-37	1511	1404	-107	1329	1133	-196	1155	1138	-17	888	825	-148
WCS	Breast Surgery	57	56	-1	51	53	2	45	45	0	39	36	-3	30	31	-2
WCS	Gynaecology	619	550	-69	558	451	-107	490	363	-127	426	309	-117	327	214	-144
WCS	Neonatology	1	1	0	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
WCS	Paediatrics	805	737	-68	725	591	-134	637	411	-226	553	268	-285	424	212	-253
Total	**Total**	**31719**	**29389**	**-2330**	**28581**	**24451**	**-4130**	**25125**	**19695**	**-5430**	**21825**	**16134**	**-5691**	**16757**	**12987**	**-5382**
	Monthly reduction				-3138			-3456			-3300			-5068		

		30/09/2023			31/10/2023			30/11/2023			31/12/2023			31/01/2024			29/02/2024		
Division	**Specialty**	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var	Plan	Actual	Var
DCS	C Immunology	285	380	52	191	326	135	138	262	124	69	191	122	46	149	103	0	76	76
DCS	Pain Management	256	264	-30	171	220	49	123	171	48	61	152	91	38	114	76	0	55	55
Medicine	Cardiology	398	232	-228	266	154	-112	191	99	-92	95	63	-32	60	30	-30	0	6	6
Medicine	Diabetes	25	12	-15	17	9	-8	12	5	-7	6	3	-3	4	1	-3	0	0	0
Medicine	Elderly Care	16	1	-17	11	1	-10	8	1	-7	5	0	-5	4	0	-4	0	0	0
Medicine	Endocrinology	198	114	-47	133	58	-75	96	14	-82	49	3	-46	33	2	-31	0	0	0
Medicine	Gastroenterology	357	179	-235	239	109	-130	174	60	-114	87	32	-55	59	18	-41	0	6	6
Medicine	General Medical	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	0	0	0
Medicine	General Medicine	601	688	11	402	482	80	291	285	-6	146	151	5	97	95	-2	0	39	39
Medicine	Neurology	1645	1423	-402	1102	792	-310	797	465	-332	399	222	-177	264	157	-107	0	85	85
Medicine	Rehabilitation	8	2	-10	6	2	-4	4	1	-3	2	1	-1	1	0	-1	0	0	0
Medicine	Renal	72	3	-95	49	2	-47	36	1	-35	18	0	-18	13	0	-13	0	0	0
Surgery	Clinical Oncology	71	83	14	48	72	24	36	19	-17	19	18	-1	15	2	-13	0	0	0
Surgery	Colorectal Surgery	525	519	-72	352	418	66	255	298	43	128	188	60	86	169	83	0	96	96
Surgery	Dermatology	166	45	-169	111	36	-75	81	11	-70	41	7	-34	29	4	-25	0	1	1
Surgery	ENT	416	281	-216	278	197	-81	201	141	-60	101	94	-7	66	50	-16	0	24	24
Surgery	General Surgery	311	311	-57	208	266	58	150	130	-20	75	95	20	49	40	-9	0	22	22
Surgery	Maxillo-Facial	143	121	-42	96	66	-30	70	39	-31	35	24	-11	24	16	-8	0	7	7
Surgery	Medical Oncology	11	13	-1	7	10	3	5	4	-1	3	4	1	1	0	-1	0	0	0
Surgery	Neurosurgery	957	838	-282	641	625	-16	465	464	-1	233	320	87	156	192	36	0	67	67
Surgery	Ophthalmology	651	500	-308	436	384	-52	314	261	-53	157	152	-5	101	77	-24	0	37	37
Surgery	Oral Surgery	114	46	-57	76	32	-44	55	23	-32	28	10	-18	18	3	-15	0	1	1
Surgery	Orthodontics	81	204	99	55	191	136	40	161	121	20	136	116	14	110	96	0	59	59
Surgery	Orthopaedics	482	378	-175	322	254	-68	233	155	-78	117	80	-37	77	46	-31	0	17	17
Surgery	Plastic Surgery	531	709	87	356	608	252	257	506	249	129	365	236	86	252	166	0	139	139
Surgery	Surgical Dentistry	499	709	168	334	531	197	242	406	164	121	324	203	81	253	172	0	168	168
Surgery	UGI	159	146	-32	106	123	17	76	95	19	38	67	29	23	60	37	0	25	25
Surgery	Urology	604	599	-5	404	446	42	292	315	23	146	210	64	96	136	40	0	53	53
Surgery	Vascular Surgery	566	630	-3	380	519	139	276	427	151	139	304	165	95	198	103	0	71	71
WCS	Breast Surgery	19	28	3	13	23	10	10	17	7	5	16	11	3	14	11	0	12	12
WCS	Gynaecology	208	128	-83	139	61	-78	100	29	-71	50	17	-33	31	7	-24	0	2	2
WCS	Neonatology	1	0	-1	1	0	-1	1	0	-1	1	0	-1	1	0	-1	0	0	0
WCS	Paed. Cardiology	25	7	-26	17	2	-15	12	0	-12	6	0	-6	4	0	-4	0	0	0
WCS	Paediatrics	270	147	-175	180	99	-81	130	76	-54	65	55	-10	41	33	-8	0	12	12
Total	**Total**	10672	**9740**	**-2350**	7148	**7118**	**-30**	5172	**4941**	**-231**	2595	**3304**	**709**	1717	**2228**	**511**	**0**	**1080**	**1080**
	Monthly reduction	-6085			-3524			-1976			-2986			-3455			-1717		

- There is a system level piece of work underway to support the position with Orthodontics and East Lancashire Hospitals Trust have offered mutual aid to system partners to support long waits across Lancashire and South Cumbria. A co-ordinated approach is being taken with HMP to support bookings for prisoners awaiting treatment. All prisoner potential 78 week waiters at year end have all been dated for treatment in March.

- The 65-week snapshot position on 14th March 2024 was 613, with a cohort (end March 2024) position of 725 – 411 admitted and 314 non-admitted cases

- The 65-week cohort position on the 31st January was 2,228 – 1,059 admitted and 1,169 non-admitted. The position now shows a reduction of 1,148 during the 4 week period to the 29th February 24 (weekly removal rate of 287 pathways).

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 industrial action scheduled for February 2024 impacting on activity
- Workforce - sickness and vacancies

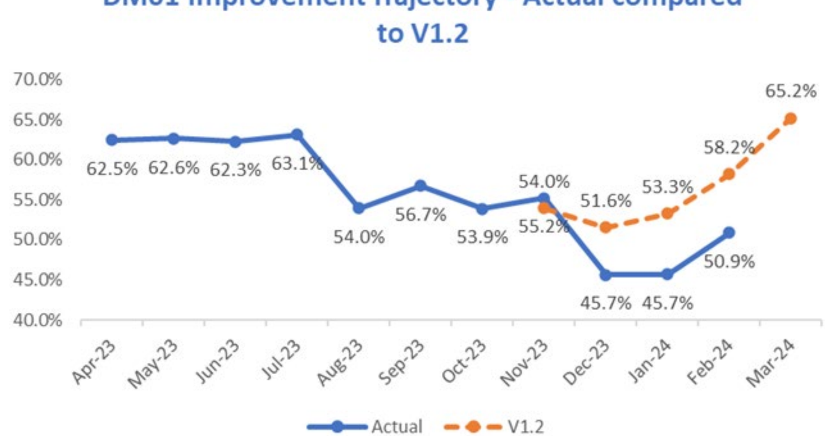
- Anaesthetist capacity
- Urgent care pressures – COVID, Flu, NMC2R and poor patient flow
- Number of complex cases and particular pressures in Orthodontics and with accommodating prisoners.

Access Standards – Diagnostic Waits

- Diagnostics performance beyond 6 weeks was 49.09%, a reduction of 5.17% waiting over 6 weeks compared to the January position of 54.3%. The reduction has predominantly been in the Non Obstetric Ultrasound and MRI modalities. 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 February under target. The highest volume contributors to the DM01 position are non-obstetric ultrasound (NOUS) and echocardiography. 1.0 WTE sonographer commenced 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 with a further delay to Remedy. Agreed capital bids will provide additional capacity on the Preston site. An updated recovery trajectory has been developed to reflect improvements to the Diagnostics 6 week performance to over 65.2% by March 2024. This takes account of additional mutual aid capacity for echocardiography, additional MRI and NOUS throughput in Q4:

  DM01 Improvement Trajectory:



- **Diagnostic Surveillance Patients**

Surveillance diagnostics are tests that are planned for a specific date or need to be repeated at a specific frequency. Patients listed in this way should be booked in for an appointment at the clinically appropriate time and should not have to wait a further period after this time has elapsed. As per national guidance surveillance tests are excluded from the DM01 waiting list position. All Trusts were asked to complete an assessment of the number of surveillance (planned) patients that are currently waiting in excess of 6 weeks past their expected admission date. Trusts were also asked to assess the impact on the DM01 Waiting List if:

- at least 50% of these patients, including all >13-weeks, were moved to the active DM01 list by the end of Qtr 1 2024/25.
- All patients were moved to the active DM01 list by the end of Qtr 2 2024/25.

The Trust identified that 855 patients, (following clinical review) could be moved onto the DM01 waiting list, of which 159 were waiting between 6-<13 weeks and 509 over 13 weeks. Whilst the overall impact on the DM01 performance position will be minimal there will be impact at modality level with the greatest increase in Colonoscopy.

Test	Estimated additions to total WL	...of which waiting >6 - < 13 weeks	...of which waiting >13 weeks
Colonoscopy	504	60	407
Cystoscopy	29	15	14
Flexi Sigmoidoscopy	71	9	26
Gastroscopy	87	18	21
CT	34	5	9
MRI	37	20	4
Non-obs ultrasound	93	32	28
Total	**855**	**159**	**509**

Access Standards - Cancer Recovery:

2023/24 62 Day National Cancer Standard:

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

Speciality		Recovery period	Apr 23	May 23	Jun 23	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	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	7	2	
	Colorectal	Trajectory	53	52	50	48	46	44	42	41	42	44	40	38
		Actual	42	39	51	41	42	67	95	82	87	90	66	
	Gynaecology	Trajectory	28	27	26	25	24	24	23	22	22	24	21	20
		Actual	34	27	29	34	23	17	12	8	11	9	7	
	Haematology	Trajectory	10	9	9	9	9	8	8	8	8	8	8	7
		Actual	4	7	7	5	3	1	1	0	4	4	2	
	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	14	10	
	Lung	Trajectory	13	13	12	12	12	11	11	10	11	11	10	10
		Actual	12	10	6	13	11	7	7	7	10	12	6	
	Sarcoma	Trajectory	4	4	4	4	4	4	4	3	4	4	3	3
		Actual	3	9	8	9	3	5	6	4	2	1	1	
	Skin	Trajectory	25	24	23	22	21	20	20	19	20	20	19	18
		Actual	22	23	37	47	26	48	30	30	32	36	27	
	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	9	10	
	Urology	Trajectory	74	72	71	68	65	63	60	58	59	63	56	53
		Actual	71	87	76	50	42	37	35	36	40	51	57	
		Trajectory	0	0	0	0	0	0	0	0	0	0	0	0
		Actual	0	0	0	0	0	0	0	0	0	1	1	
	Total	Trajectory	**250**	**242**	**234**	**226**	**218**	**210**	**202**	**194**	**200**	**210**	**190**	**180**
		Actual	221	235	257	245	192	220	217	194	205	234	189	0

The performance reflects the actual figure of patients waiting over 62 days against the trajectory to the end of January 24. The target for 2023/24 is 180 and is achievable with financial support from the Cancer Alliance, agreed tumour group specific trajectories for FDS and 62 day are detailed in the report.

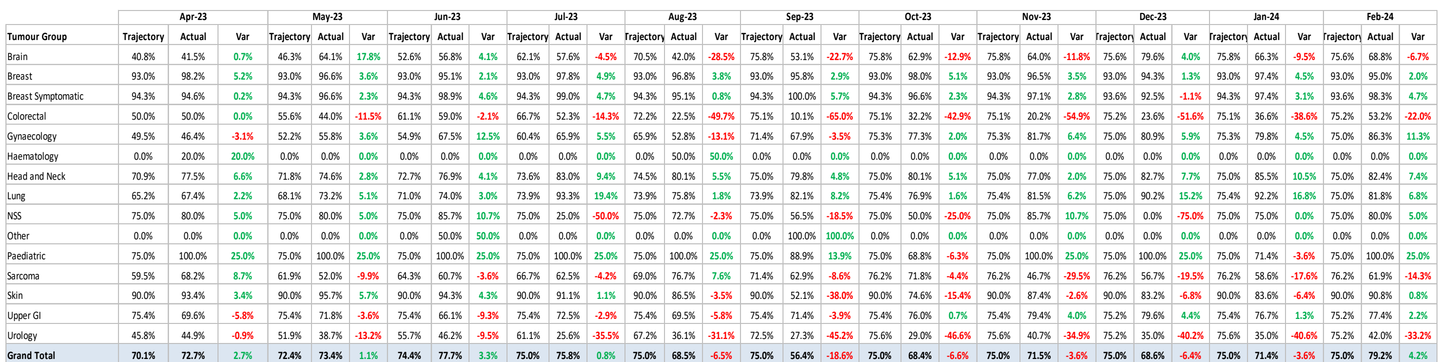
- 62-day performance - the number of patients over 62 days decreased in February 24 to 189 from a January 2024 position of 234. Performance has now moved to under both the locally agreed trajectory (180) and fair share (151). In month March 24 position is at 138 >62 days, exceeding the fair shares. The Trust has tumour site specific actions plans that are monitored weekly, with a daily overview of performance by the Interim Chief Operating Officer.

The table below shows how the Trust compares with England averages by tumour group for 62 day performance at week ending 10th March 2024:

Suspected Tumour Type	Total waiting list	Number past day 62	Number past day 62 - DTT	% of waiting list past day 62	Change in number past day 62 (4 weeks)	Change in number past day 62 (12 weeks)	England % of waiting list past day 62	Distance from England average (>62 days)
Urological	257	48	7	18.7%	-13	11	13.2%	14
Lower Gastrointestinal	556	45	15	8.1%	-31	-32	7.2%	5
Haematological	3	1	0	33.3%	-2	0	13.5%	1
Lung	41	6	3	14.6%	-3	-3	11.3%	1
Other	12	2	0	16.7%	1	2	4.2%	1
Brain/Central Nervous System	75	1	0	1.3%	1	1	2.8%	-1
Sarcoma	21	1	1	4.8%	0	-1	9.6%	-1
Breast	133	1	1	0.8%	-7	-2	2.2%	-2
Head & Neck	186	7	3	3.8%	-8	-4	5.1%	-2
Upper Gastrointestinal	157	7	1	4.5%	-2	-1	6.0%	-2
Gynaecological	153	5	1	3.3%	-1	-8	5.5%	-3
Skin	666	14	12	2.1%	-17	-21	3.6%	-10
All Suspected Cancers	2,260	138	44	6.1%	-82	-58	6.3%	1

2023/24 28 Day Faster Diagnosis Standard:

Performance compared to the Cancer FDS trajectory to February 2024 is shown below, performance for February currently exceeds the 75% standard:



	Apr-23			May-23			Jun-23			Jul-23		
Tumour Group	**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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%
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%

	Aug-23			Sep-23			Oct-23			Nov-23		
Tumour Group	**Trajectory**	**Actual**	**Var**	**Trajectory**	**Actual**	**Var**	**Trajectory**	**Actual**	**Var**	**Trajectory**	**Actual**	**Var**
Brain	70.5%	42.0%	-28.5%	75.8%	53.1%	-22.7%	75.8%	62.9%	-12.9%	75.8%	64.0%	-11.8%
Breast	93.0%	96.8%	3.8%	93.0%	95.8%	2.9%	93.0%	98.0%	5.1%	93.0%	96.5%	3.5%
Breast Symptomatic	94.3%	95.1%	0.8%	94.3%	100.0%	5.7%	94.3%	96.6%	2.3%	94.3%	97.1%	2.8%
Colorectal	72.2%	22.5%	-49.7%	75.1%	10.1%	-65.0%	75.1%	32.2%	-42.9%	75.1%	20.2%	-54.9%
Gynaecology	65.9%	52.8%	-13.1%	71.4%	67.9%	-3.5%	75.3%	77.3%	2.0%	75.3%	81.7%	6.4%
Haematology	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Head and Neck	74.5%	80.1%	5.5%	75.0%	79.8%	4.8%	75.0%	80.1%	5.1%	75.0%	77.0%	2.0%
Lung	73.9%	75.8%	1.8%	73.9%	82.1%	8.2%	75.4%	76.9%	1.6%	75.4%	81.5%	6.2%
NSS	75.0%	72.7%	-2.3%	75.0%	56.5%	-18.5%	75.0%	50.0%	-25.0%	75.0%	85.7%	10.7%
Other	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Paediatric	75.0%	100.0%	25.0%	75.0%	88.9%	13.9%	75.0%	68.8%	-6.3%	75.0%	100.0%	25.0%
Sarcoma	69.0%	76.7%	7.6%	71.4%	62.9%	-8.6%	76.2%	71.8%	-4.4%	76.2%	46.7%	-29.5%
Skin	90.0%	86.5%	-3.5%	90.0%	52.1%	-38.0%	90.0%	74.6%	-15.4%	90.0%	87.4%	-2.6%
Upper GI	75.4%	69.5%	-5.8%	75.4%	71.4%	-3.9%	75.4%	76.0%	0.7%	75.4%	79.4%	4.0%
Urology	67.2%	36.1%	-31.1%	72.5%	27.3%	-45.2%	75.6%	29.0%	-46.6%	75.6%	40.7%	-34.9%
Grand Total	**75.0%**	**68.5%**	-6.5%	**75.0%**	**56.4%**	-18.6%	**75.0%**	**68.4%**	-6.6%	**75.0%**	**71.5%**	-3.6%

	Dec-23			Jan-24			Feb-24		
Tumour Group	**Trajectory**	**Actual**	**Var**	**Trajectory**	**Actual**	**Var**	**Trajectory**	**Actual**	**Var**
Brain	75.6%	79.6%	4.0%	75.8%	66.3%	-9.5%	75.6%	68.8%	-6.7%
Breast	93.0%	94.3%	1.3%	93.0%	97.4%	4.5%	93.0%	95.0%	2.0%
Breast Symptomatic	93.6%	92.5%	-1.1%	94.3%	97.4%	3.1%	93.6%	98.3%	4.7%
Colorectal	75.2%	23.6%	-51.6%	75.1%	36.6%	-38.6%	75.2%	53.2%	-22.0%
Gynaecology	75.0%	80.9%	5.9%	75.3%	79.8%	4.5%	75.0%	86.3%	11.3%
Haematology	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Head and Neck	75.0%	82.7%	7.7%	75.0%	85.5%	10.5%	75.0%	82.4%	7.4%
Lung	75.0%	90.2%	15.2%	75.4%	92.2%	16.8%	75.0%	81.8%	6.8%
NSS	75.0%	0.0%	-75.0%	75.0%	75.0%	0.0%	75.0%	80.0%	5.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Paediatric	75.0%	100.0%	25.0%	75.0%	71.4%	-3.6%	75.0%	100.0%	25.0%
Sarcoma	76.2%	56.7%	-19.5%	76.2%	58.6%	-17.6%	76.2%	61.9%	-14.3%
Skin	90.0%	83.2%	-6.8%	90.0%	83.6%	-6.4%	90.0%	90.8%	0.8%
Upper GI	75.2%	79.6%	4.4%	75.4%	76.7%	1.3%	75.2%	77.4%	2.2%
Urology	75.2%	35.0%	-40.2%	75.6%	35.0%	-40.6%	75.2%	42.0%	-33.2%
Grand Total	**75.0%**	**68.6%**	-6.4%	**75.0%**	**71.4%**	-3.6%	**75.0%**	**79.2%**	4.2%

A Cancer Transformation Plan is in place to support delivery in 2023/24 and reports through the Transformation Board.

Whilst Cancer performance is improving and the Trust is on track to achieve 2 week wait compliance for the first time since 2019, there are a small number of tumour groups with the greatest collective contribution to current performance challenges, an update on progress is detailed below:

- **Colorectal**
  The Colorectal pathway has been redesigned. The front end of the pathway is performing well with a Rapid Diagnostic Clinical triage occurring for each patient by day 6 of the referral being received. The improvement in Colorectal has been the biggest contributor in positive movement against the FDS standards, overall, the standard is currently being achieved in current data for February. There are a residual number of 62 day patients that are currently being resolved. When the remaining 62 day clearance is completed, ongoing, sustained 62 day compliance with trajectory is expected from March 2024.

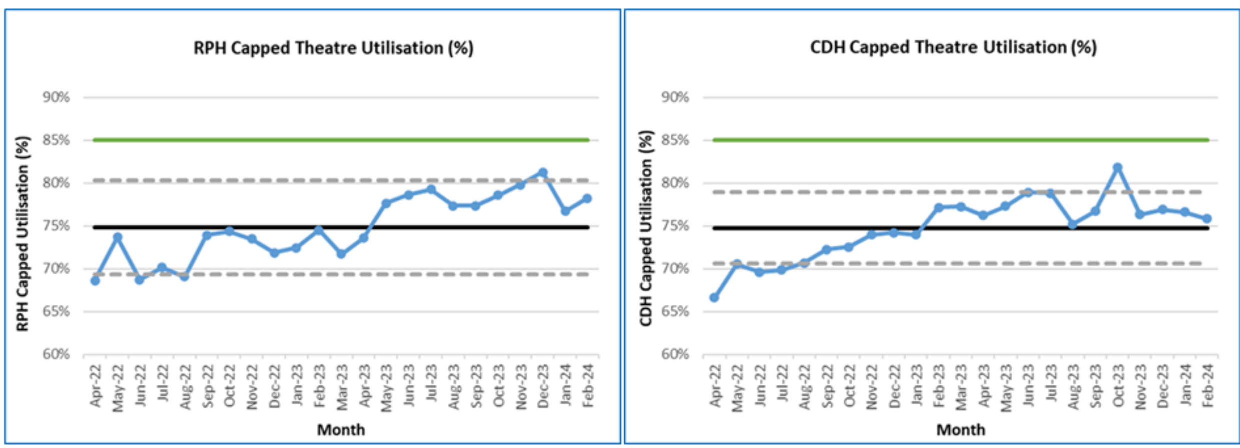
- **Urology**
  The Urology pathway has been redesigned. The one stop model is unable to be fully realised until the scanner has been upgraded, this requires capital funding and a business case is currently in development. Short term sickness in the team has impacted on current performance but is expected to be resolved with improvement against FDS performance in February.

- **Skin**
  The skin pathway has not undergone redesign as yet, though this is planned. Performance against FDS and 2 week waits is good, with the tumour site on target to continue achieving FDS. With a recent high profile diagnosis, referral numbers have increased and this increase has been sustained into February. There is sufficient capacity at the front end of the pathway to meet the increase in demand. The Day Zero Day PTL continues with Skin, maintaining the focus on telling people quickly that they do not have Cancer, the performance output from the PTL continues to be closely monitored. The Cancer Alliance have invested in an eDerma model, however, this is not expected to adversely impact internal Skin pathway plans.

Theatre Efficiency Programme

The 65-week trajectories factor in the impact of improved theatre productivity, utilisation of the independent sector and waiting list initiatives. A Theatre Efficiency Programme reports progress through the Elective Care Transformation Board.

- The current capped theatre utilisation rates are shown below indicating an improving and consistent capped performance at CDH, performance on the RPH site deteriorated slightly in January, but has improved during February: Paediatric Surgery has successfully moved to CDH and the national team has commended this achievement.



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.

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 • 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-o
UEC (Ambulance handover, 12 hrs TiD and 4 hr trajectory)	• Ambulance handover duration reduction • Accelerated inflow and flow improvement programm • Weekend discharge support • Protected VW, Care Connexion, Frailty, ED, SDEC, • Support with out of hospital model of care • Support with MH pathways from ED • Support with GTD performance
>65 week clearance	• Focus on ensuring 78 week dating < end Mar 24 • Continued clearance capacity • Cap at 64 weeks from April 24 • Protected elective care capacity • Deliver DM01 updated trajectory
>62 day clearance to 180 by March 24; 28 day FDS at >75% by March 24	• Continued clearance capacity • Protected cancer capacity
Manage financial run rate to priority areas	• Continued Financial Recovery Plan underpinned by • PMO oversight and anticipated escalation of risks • Corporate resource to support the FRP ensuring effi • Performance accountability framework to be implem

Next Steps

1. Progression of the areas detailed in the Q4 operational performance focus section of the report.
2. Review of the impact of activity lost during February period of industrial action.
3. Continued focus on achievement of performance expectations in relation the cancer and long waiting patients.

1. **Financial implications**
   Noted in the narrative if relevant and included in the update provided in the contract report, and reporting against the impact of the Trust transformation programmes.
2. **Legal implications**
   None to note.
3. **Risks**

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 industrial action
- Workforce - sickness and vacancies
- Anaesthetist capacity
- Urgent care pressures – COVID, Flu, NMC2R and poor patient flow
- Number of complex cases and particular pressures in Orthodontics and with accommodating prisoners.

4. Impact on stakeholders

The Trust continues to work with health and social care organisations across the Central Lancashire system to support improvement to services and pathways that will have a positive impact on performance.

Recommendations

It is recommended that:

I. The committee note the contents of the report and the action being taken to improve performance.

Safety and Quality

Pressure Ulcers

The pressure ulcer data demonstrated a positive shift in April 2023 with 7 data points below the median, this continues to be maintained. Purpose T, the new national guidance relating to the management and prevention of pressure ulcers has been introduced to the organisation and forms part of the improvement plan. The extended length of stay in the Urgent and Emergency pathway is impacting the ability to improve further at this time. The focus of the improvement work is centred on increased compliance with risk assessment and intentional rounding.

Falls

The falls data demonstrated a positive shift in April 2023 with 7 data points below the median, this has been maintained. The improved staffing fill rates are expected to have a positive impact on this metric although this is constrained at this time due to the increase in patients within the UEC pathway and boarding within ward areas and ED.

HSMR

Mortality metrics remain stable and within expected parameters.

STAR

STAR Quality assurance accreditation awards of silver and above is consistently higher than target. Analysis of this identifies an opportunity to undertake focused improvement work in ward areas where there is the most opportunity to improve. This will include mandating compliance with specific metrics (infection prevention and control and risk assessments) in order to progress to a green outcome.

Clostridium *difficile*

The data is demonstrating 3 improved data points compared to the previous quarter. It is too early at this time to conclude improvement, however, the increased focused work has continued.
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

The outstanding action in this scheme of work relates to the implementation of the national cleaning standards in the remaining wards. This has been included in the financial pressures considerations for 2024/25. 75% of ward areas continue to be compliant with the 2017 domestic standards and all are compliant with 2021 nursing cleaning standards.

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.

Care Quality Commission

At the end of February 2024, of the 54 'Must Do's' and 'Should Do's' included in the 2023/2024 CQC Quality Improvement Plan (QIP), there are 24 (44%) recommendations assessed as 'Green' i.e., delivered and 30 (56%) as 'Amber-Green' i.e. ongoing and progress made. Nil are currently assessed as 'Amber-Red' i.e. not currently delivered and risks with delivery or 'Red' i.e. not expected to deliver at any point in time. A deep dive paper was

presented to the January 2024 Safety and Quality Committee which provided further detail on progress with recommendations and actions within the CQC QIP along with rationale for assessments.

A Great Place to Work

Sickness absence remained over 7% in January, with the divisional absence rates in Women's and Children (8.19%) and Estates and Facilities (10.72%), being of greatest concern. Overall, long term absence has started to reduce, and this is in part due to the intense focus of the Workforce Advisers in supporting managers to resolve cases. Short-term absence rose in January, and this is an area where case review indicates that Attendance Management procedures are not being robustly followed. A number of actions are planned, including further training and exploration of digital solutions which will help us better monitor compliance. Ultimately, we need to address the root causes of absence and the staff survey results will help us triangulate measures of colleague satisfaction, engagement and wellbeing in the areas with the highest absence rates. The rise in the average duration of musculoskeletal absence is likely to be partly attributable to the gaps in our Occupational Health physiotherapy services, as colleagues are not receiving the normal levels of rapid access support.

Violence and aggression incidents have shown a gradual rising trend over the last 3 to 4 months. The detailed Annual Violence and Aggression report provides Workforce Committee with a full analysis and summary of actions being progressed.

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 now over £4 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. As a result, we have delivered on the NHSE capped rate target of our agency spend being no more than 3.7% of pay bill for the last 2 months.

New vacancy control criteria remain in place. 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. Between October 23- February 24 a total of 26 posts have been refused at vacancy control.

Delivering Value for Money

Income and Expenditure

There has been a significant movement in the Trust's plan in month due to national funding to reduce the original plan deficit. The Trust's annual plan has reduced from a deficit of £15.3m to a deficit of £0.4m. The variance to plan has remained the same at £35.2m as a result the Trust's forecast deficit is £35.6m.

The Trust reports a YTD Month 11 deficit position for 2023/24 of £31.8m against a £2.6m deficit plan, this gives a YTD Variance on Plan of £29.2m. This can be explained mainly by the £16.4m System Support Gap (£18.5m for the year) and £8.7m under-delivery of CIP. There are a number of operational financial pressures associated with industrial action, double running of international nurses and funding of pay awards that are to some extent offset by operational underspends and financial recovery actions. pay awards that are offset by operational underspends and financial recovery actions.

Capital Position

The level of capital expenditure required in the final month of the year is significant. Projects are planned and are in the process of being delivered by the end of the year to deliver the plan in.

Cash Position

The Trust had drawn down cash support amounting to £58.3m by the end of February. A further £14.3m has been requested for March.

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 11 (February 2024), YTD delivery of FIP is £34.6m against a plan of £43.3m, an adverse variance of £8.7m. 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 £37.6m and the full year forecast as at Month 11 is £38.7m in line with the Trust's recovery plan.t Month 9 now stands at £38.7m

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 six 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 11 was £19.0m against an Agency Ceiling of £18.1m, 3.7% of pay expenditure. This is an overspend of £0.9m 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			

Board of Directors

Performance to February 2024

INTRODUCTION

Performance to 29th February 2024

Mission

To provide excellent care with compassion

Strategic Aim

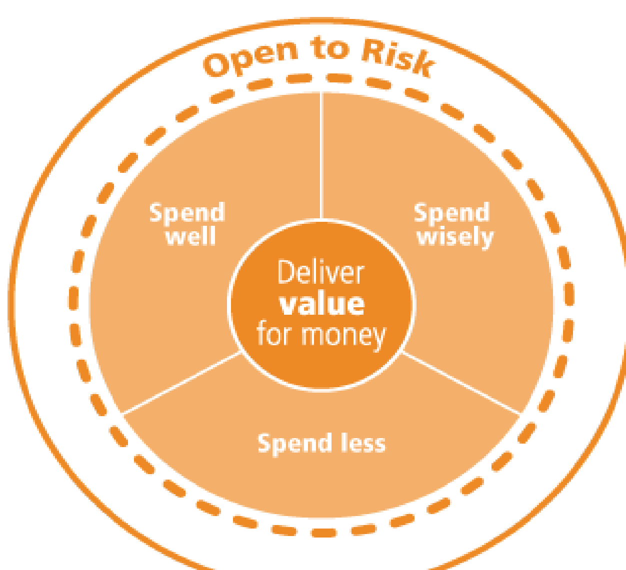
To provide excellent healthcare to our local communities

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*



Seeking to Involve

Being Caring and Compassionate

Recognising Individuality

Taking Personal Responsibility

Building Team Spirit

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

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			-	-	-	-	44.0%	-
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	3.49	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	0.62	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				64.4	-
Access Standards	Key Metric	**Achieve the Emergency Department within 4 hours target**	M | T-D | FPC | FB	No				76%	67.9%	74.2%
	Key Metric	**Reduction in patients waiting +12 hours in Emergency Department**	M | T-D | FPC | FB	No				2%	10.8%	9.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 15 minutes**	M | T-D | FPC | FB	No				65%	28.5%	52.2%
	Key Metric	**Reduction in ambulance turnaround times - seen within 30 minutes**	M | T-D | FPC | FB	No				95%	68.0%	86.2%
	Key Metric	**Reduction in ambulance turnaround times - 60 minutes**	M | T-D | FPC | FB	No				98%	87.3%	96.0%
	Key Metric	**Achieve agreed trajectory for reducing 52 week waiters**	M | T-D-S | FPC | FB	No				3446	2716	3734
	Key Metric	**Eliminate waits over 65 weeks for elective care by March 2024**	M | T-D-S | FPC | FB	No				61	612	1080
	Key Metric	**Eliminate waits over 78 week waiters**	M | T-D-S | FPC | FB	No				0	27	90
	Key Metric	**Achieve Cancer - 28 day FDS**	M | T-D-S | FPC | FB					81%	79.0%	68.7%
	Key Metric	**Number of patients waiting over 62 days**	M | T-D-S | FPC | FB	No				190	189	219
	Key Metric	**Moving or discharging 5% of outpatient attendances to a PIFU pathway**	M | T-D-S | FPC | FB	No				5%	3.76%	2.20%
	Key Metric	**Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels - @ January 2024**	M | T-D-S | FPC | FB	No				-25%	-13.67%	-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%	96%	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%	11.01%	8.69%
	Key Metric	**Reduce length of stay to next best quartile**	M | T-D-S | FPC | FB	Approach to this metric 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	2245	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	0.14	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	0.44	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	Full implementation of Teledermatology in the suspected skin cancer pathway	M | T-D-S | FPC | FB	No				80%	81.80%	82.45%
	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
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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	+	Flag	3.72	4.08	4.55
Infection	**Key Metric**	**Achieve less than the annual tolerance for C.difficile**	M | T-D-S | SQ | SC-GS	Yes	F	+	-	10	8	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%	98.6%	97.3%
	Big Plan	Achieve 90% executive and senior leaders safety training	M | T-D-S | ETR | NL	No	P	Normal variation	-	90%	94.3%	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	Pass/fail	Normal variation	-	22	30	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	Pass/fail	Normal variation	-	90%	89.1%	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	Pass/fail	−	-	90%	89.2%	96.0%
Safe Staffing	Big Plan	Maintain Registered Nurse and Midwife fill rates of > 90%	M | T-D-S | SQ | SC-GS	No	Pass/fail	Normal variation	-	95%	98.2%	95.8%

Reporting Requirements Key

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		SQ = Safety & Quality Committee	NL = Nicki Latham	

Variation Icon / Assurance Icon	F – Will consistently fail target within expected variation	Could both pass or fail target within expected variation	P – 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
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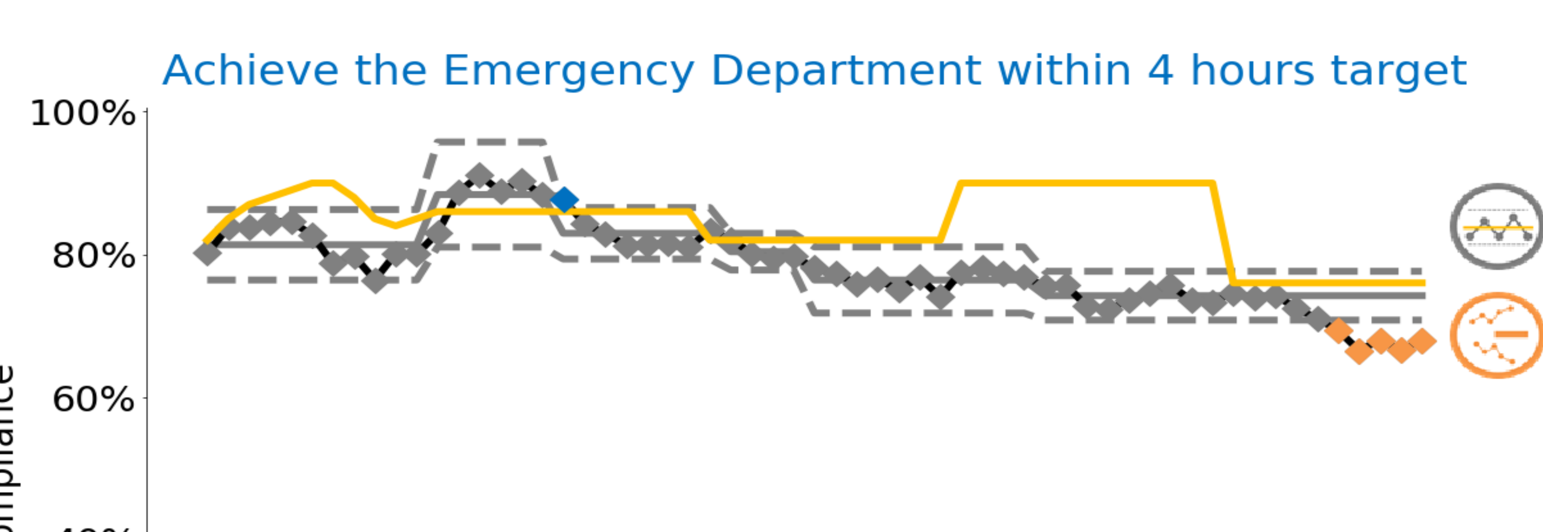
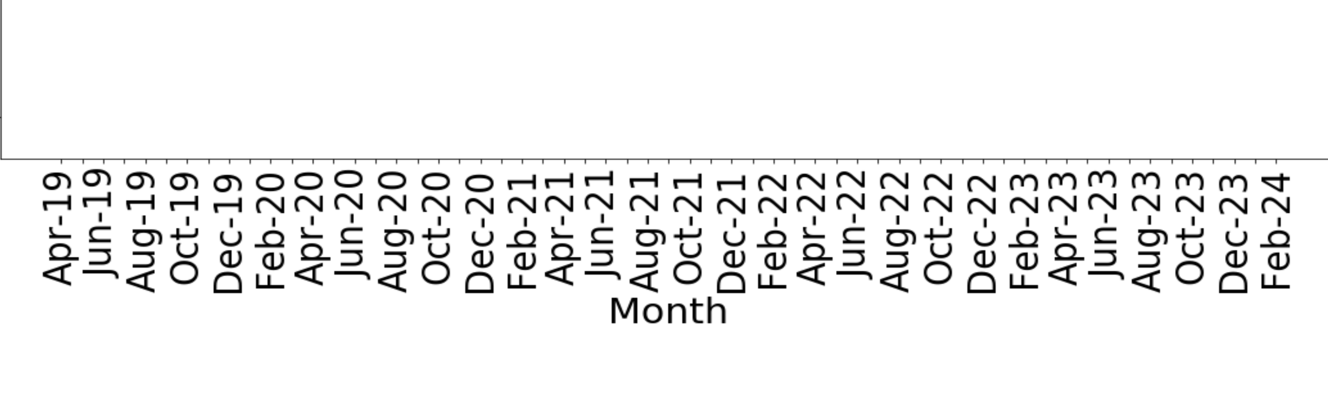
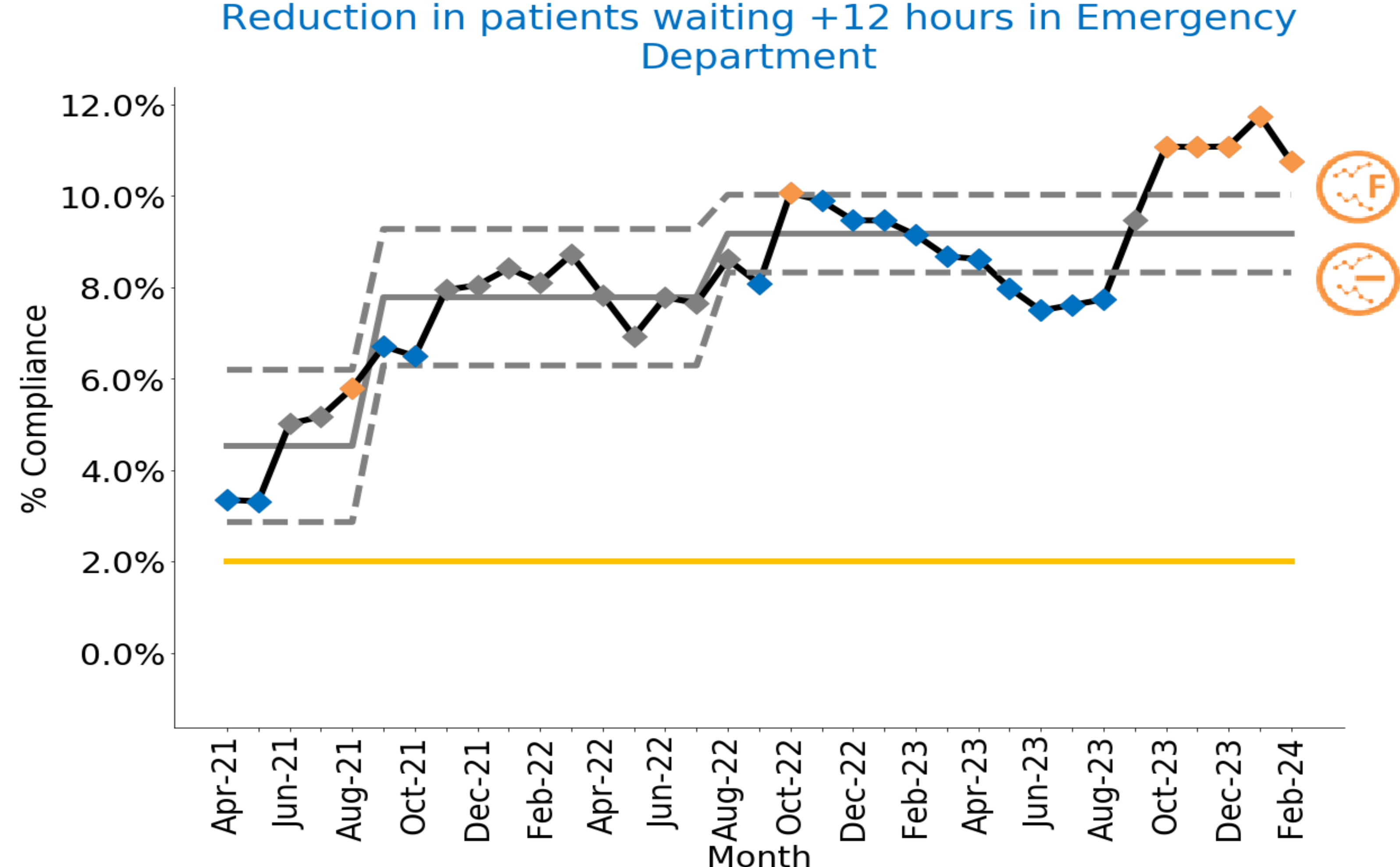
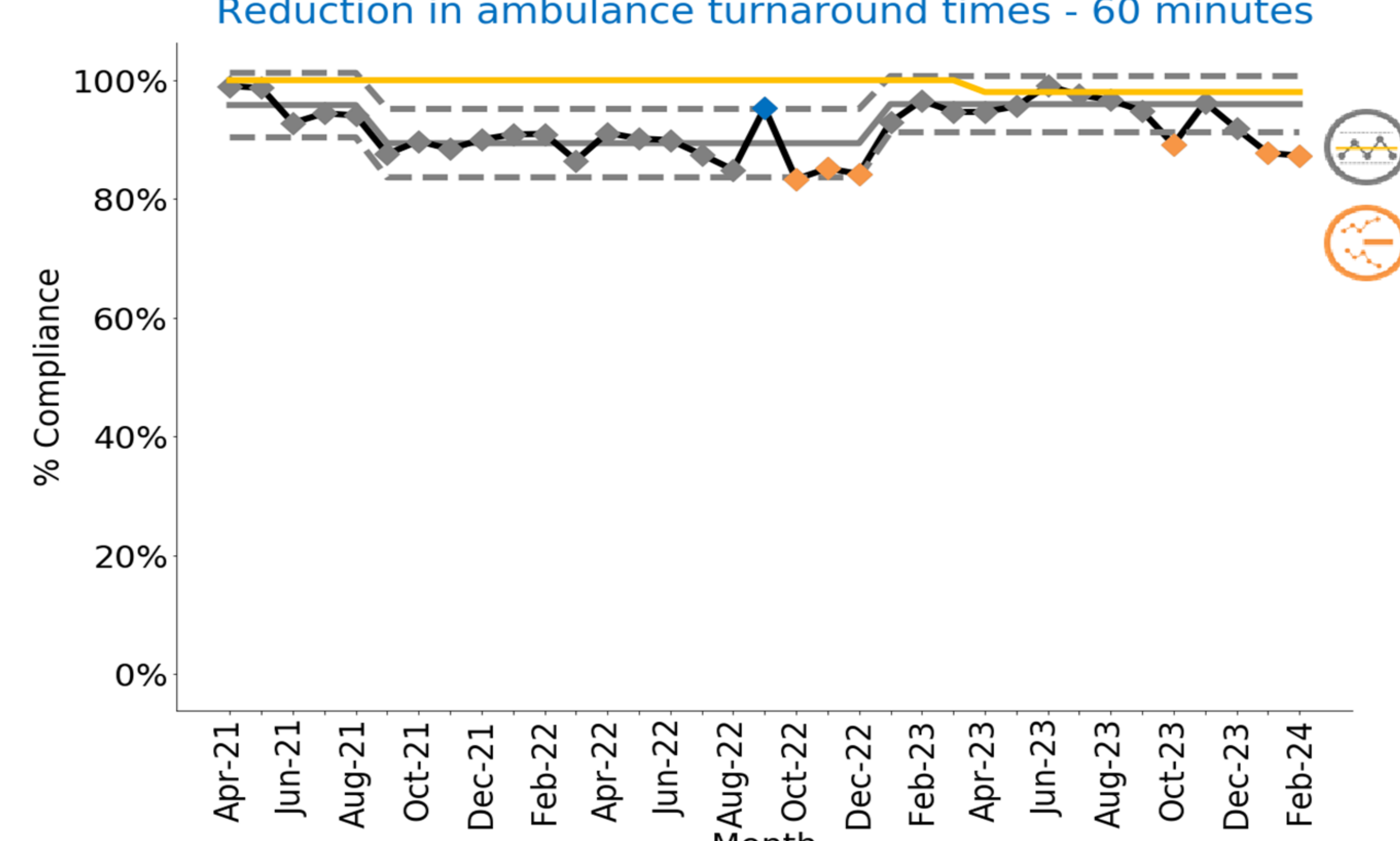
Achieve the Emergency Department within 4 hours target

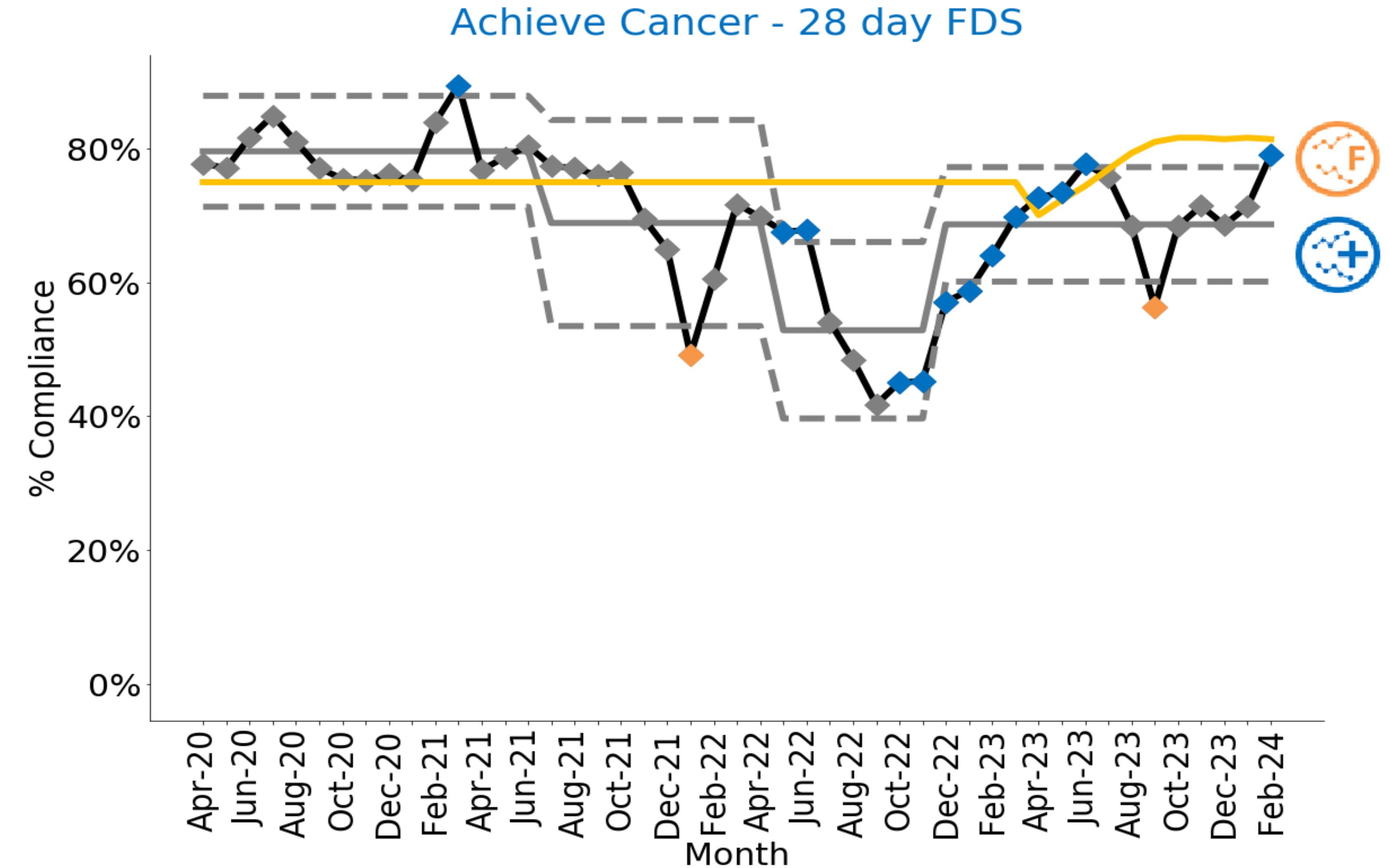
Reduction in patients waiting +12 hours in Emergency Department



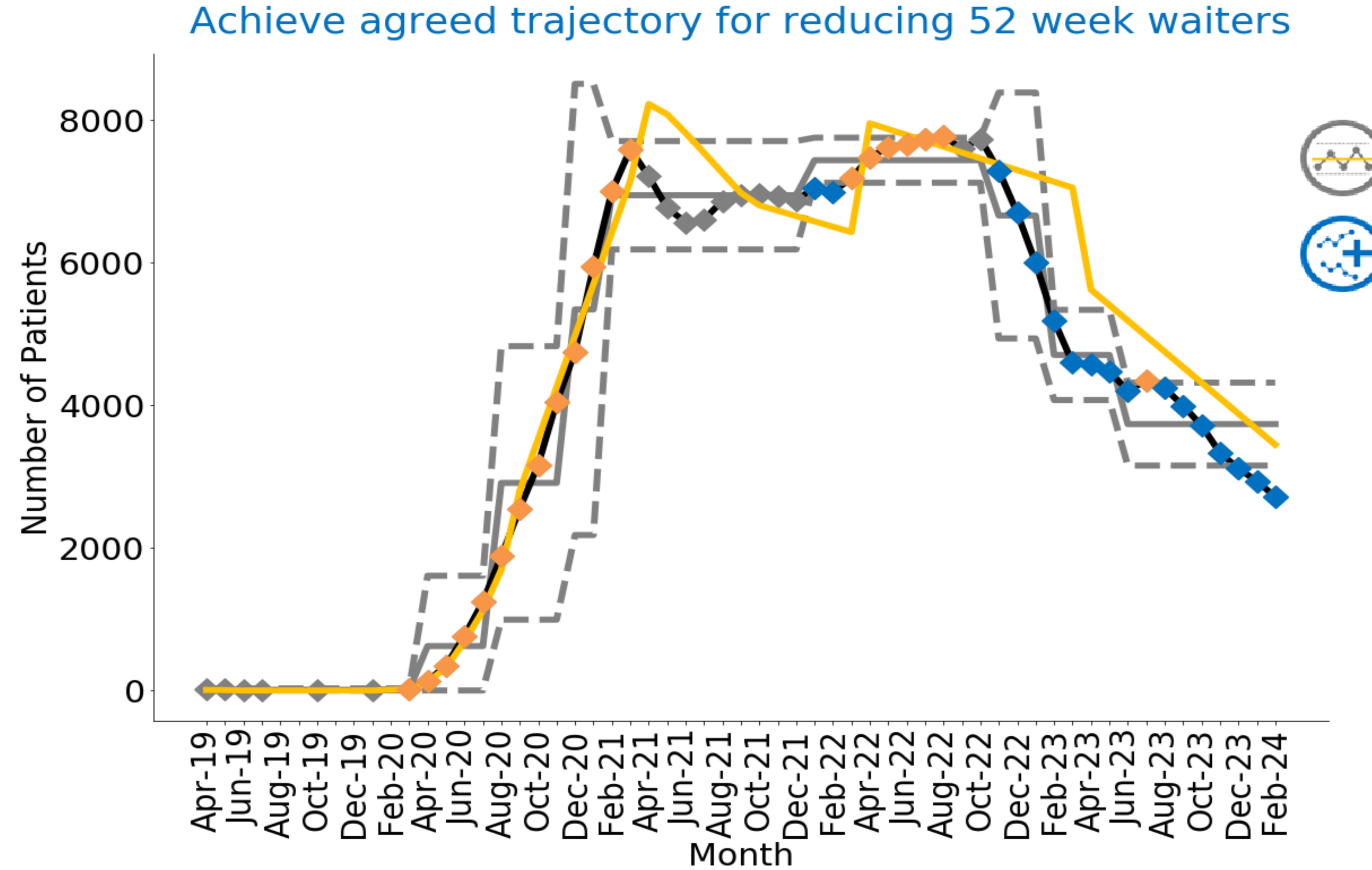
Reduction in ambulance turnaround times - 60 minutes



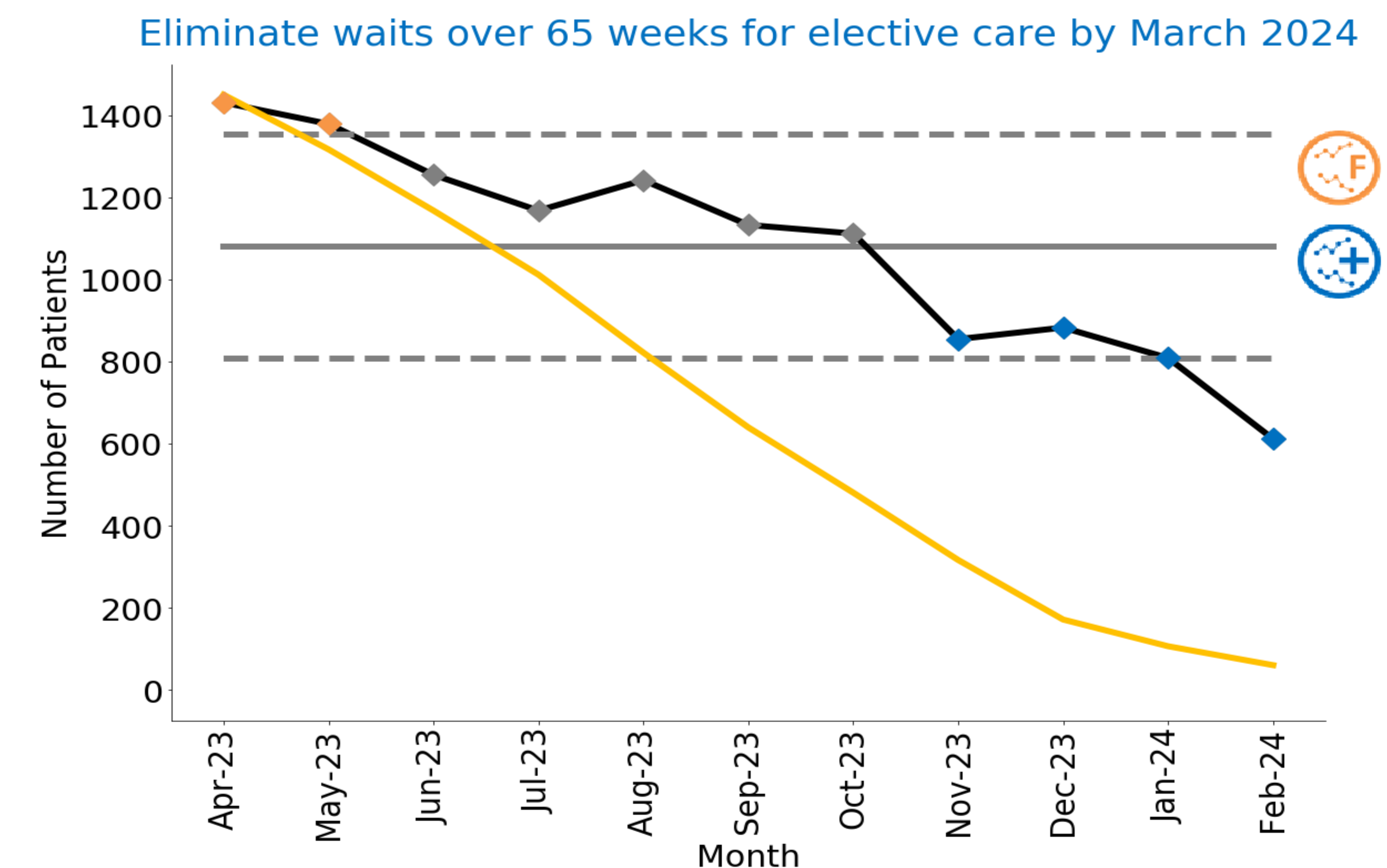
Achieve Cancer - 28 day FDS



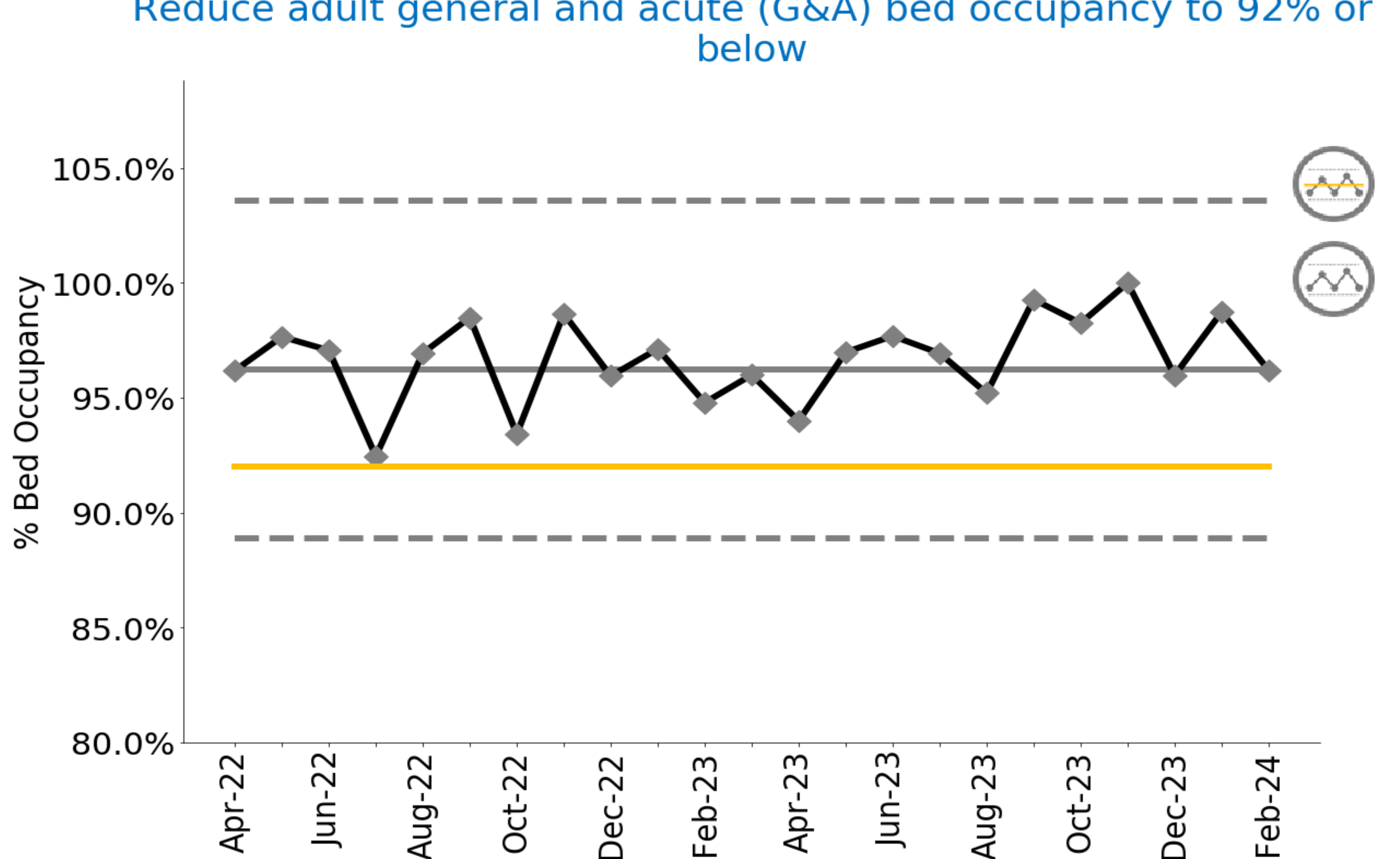
Achieve agreed trajectory for reducing 52 week waiters



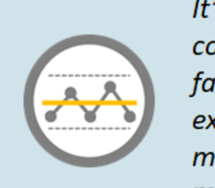
Eliminate waits over 65 weeks for elective care by March 2024



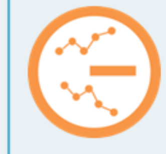
Reduce adult general and acute (G&A) bed occupancy to 92% or below

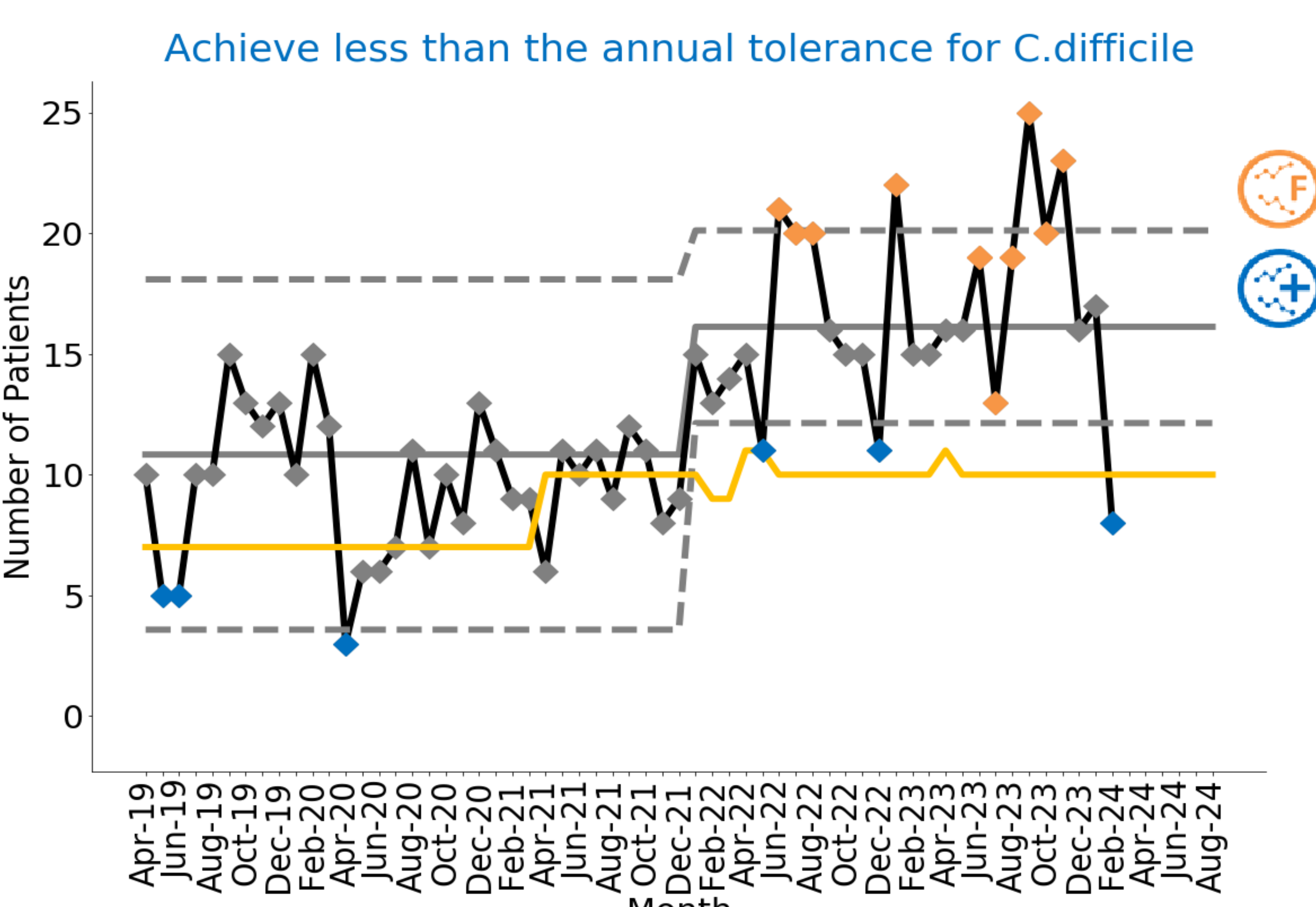


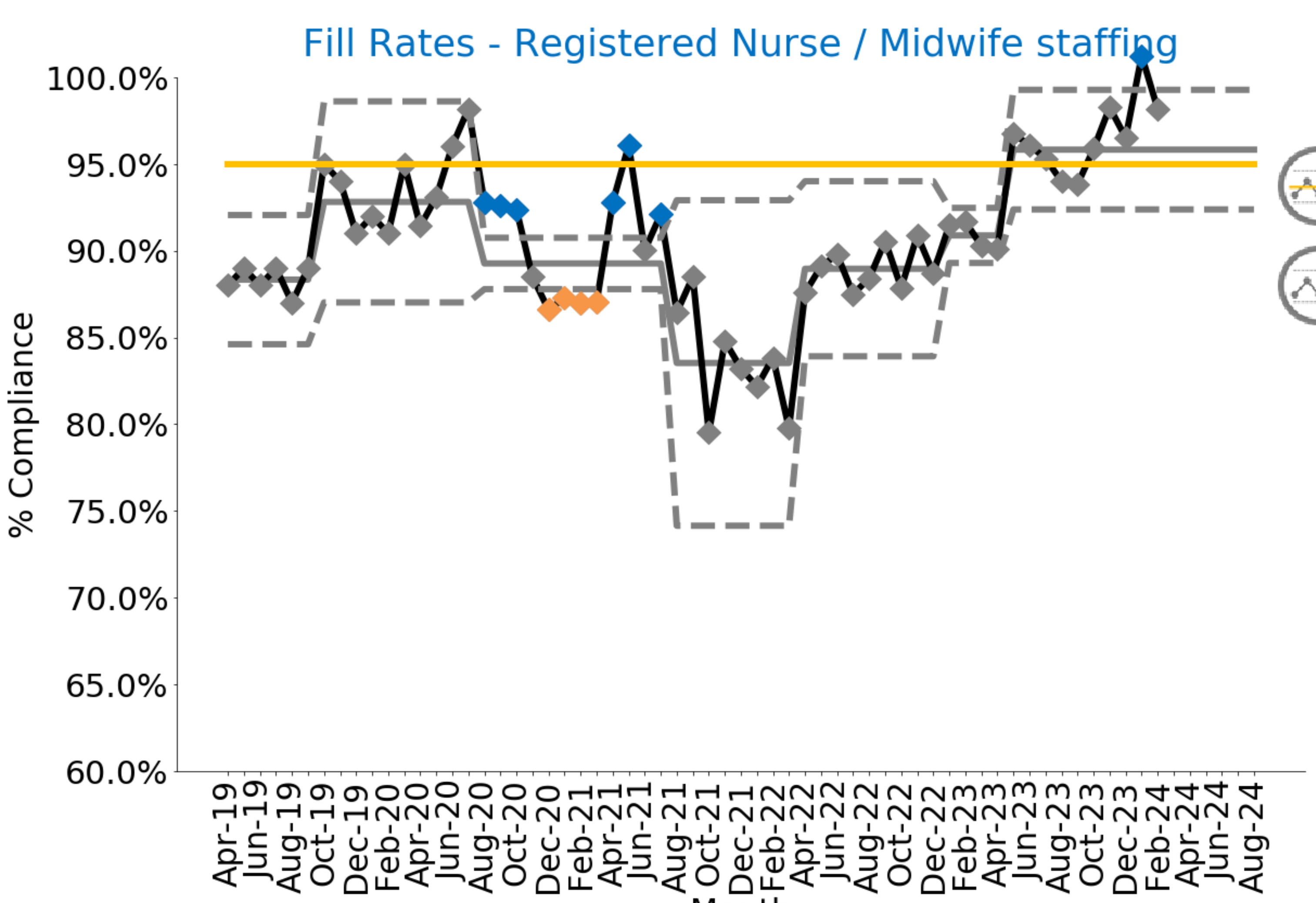
Assurance Icons – How likely are we to hit the set target in future?

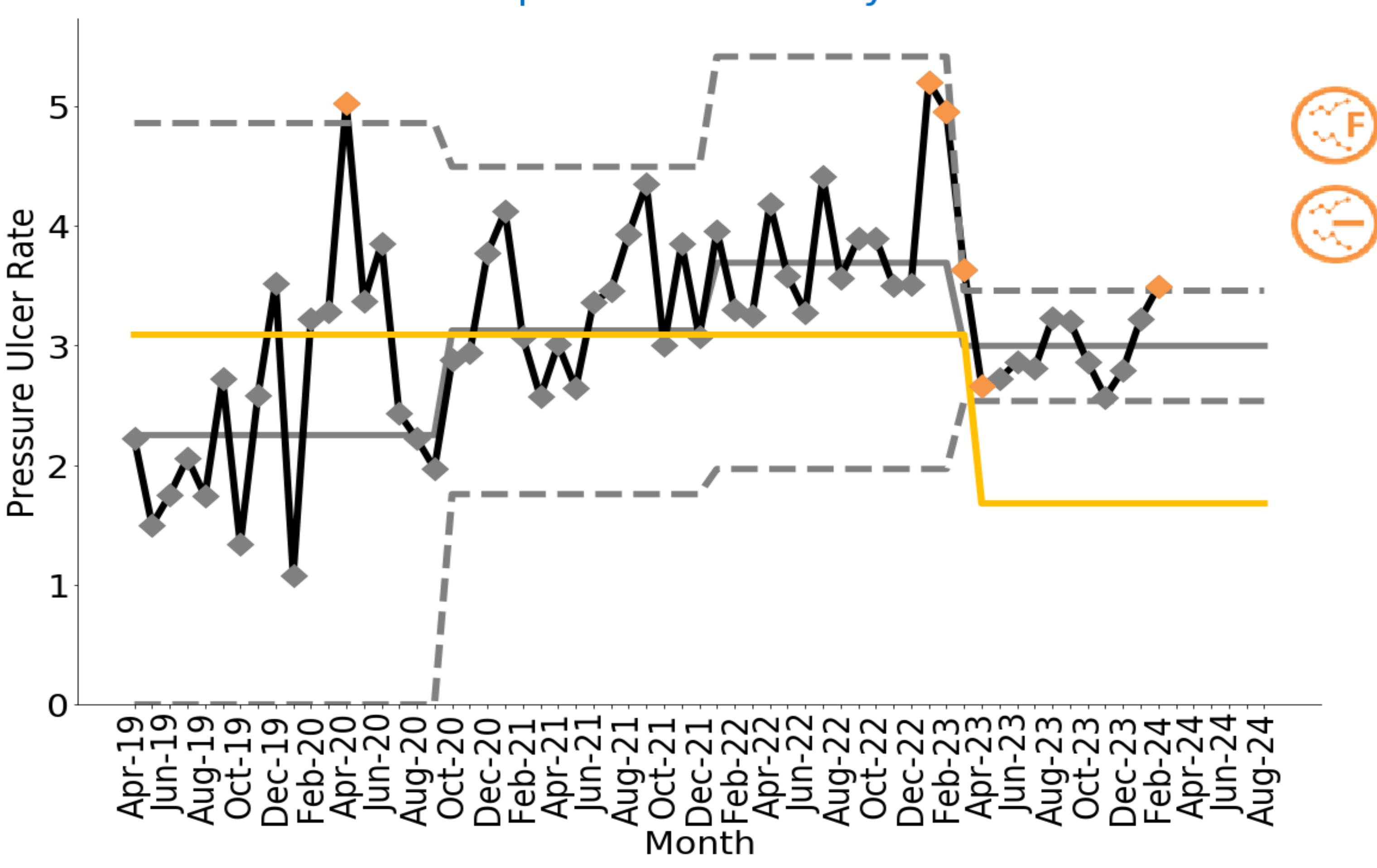
	*It's possible the target could be either passed or failed within the expected month to month variation of the measure*		*The target will be consistently failed within expected variation unless the process is changed*		*The target will be consistently passed within expected variation unless the process is changed*

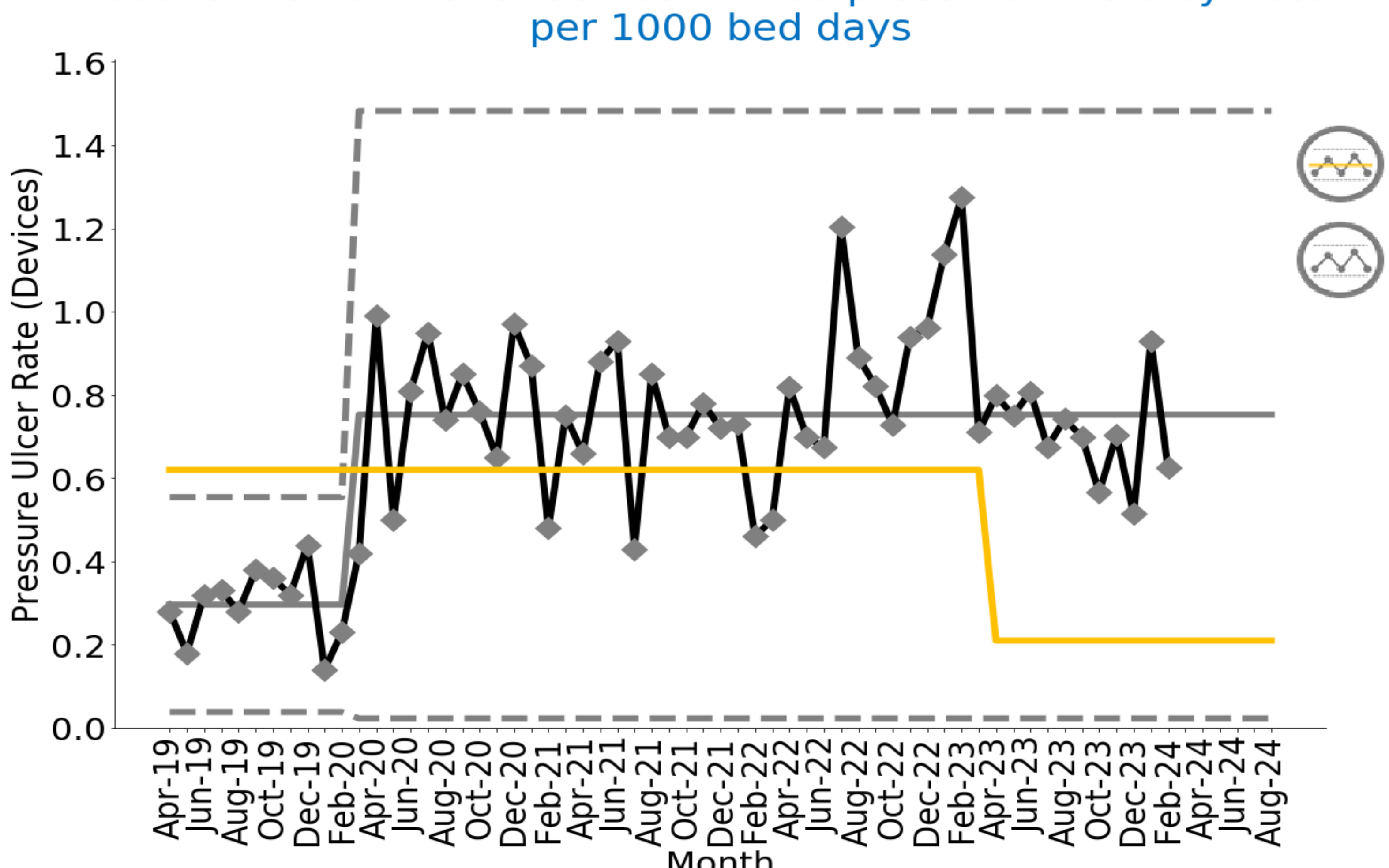
Variation Icons – Is the measure showing signs of change over time?

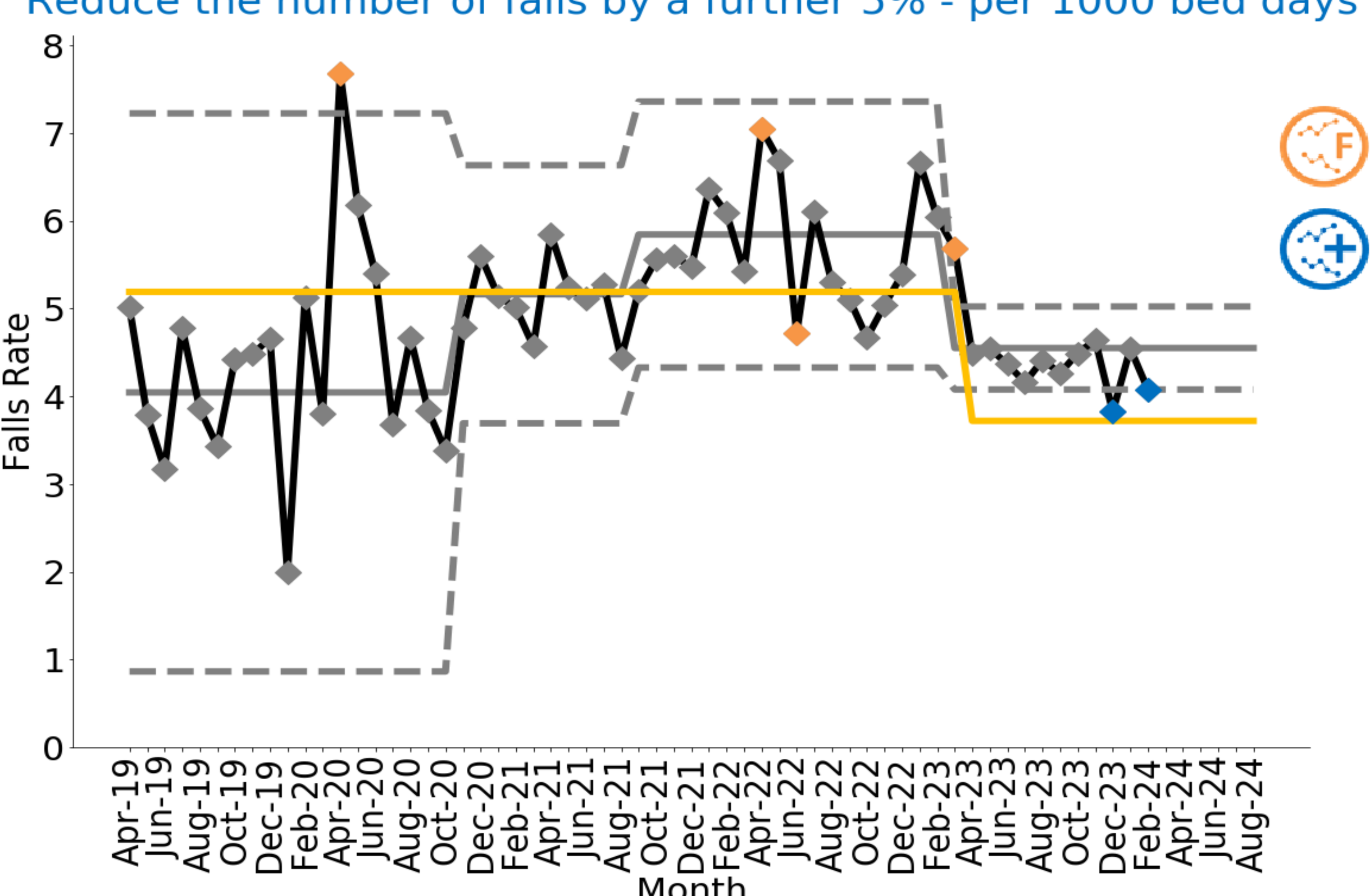
	No signs of change over time evident in recent data		*An example of concerning change is evident in the recent data*		*An example of positive change is evident in the recent data*

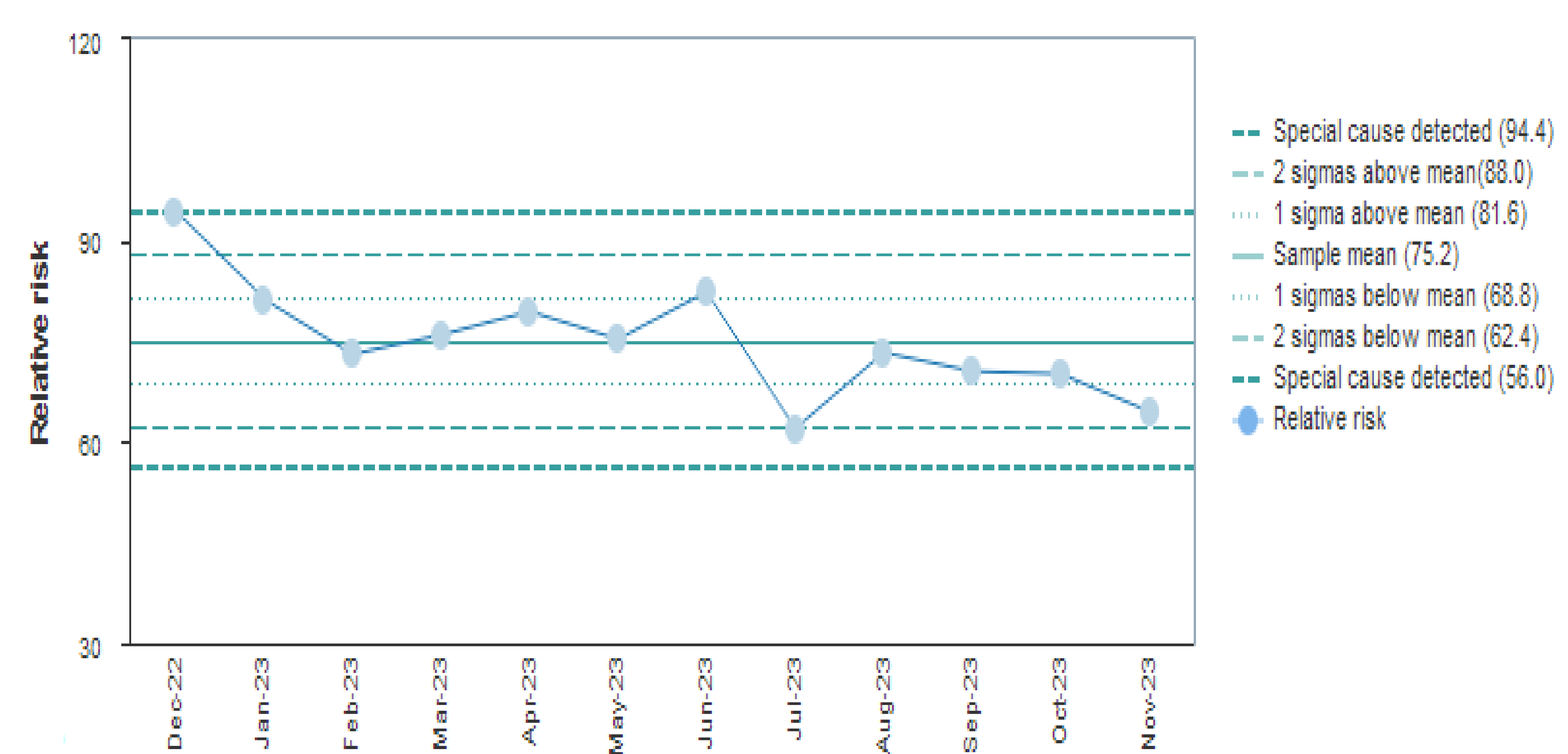


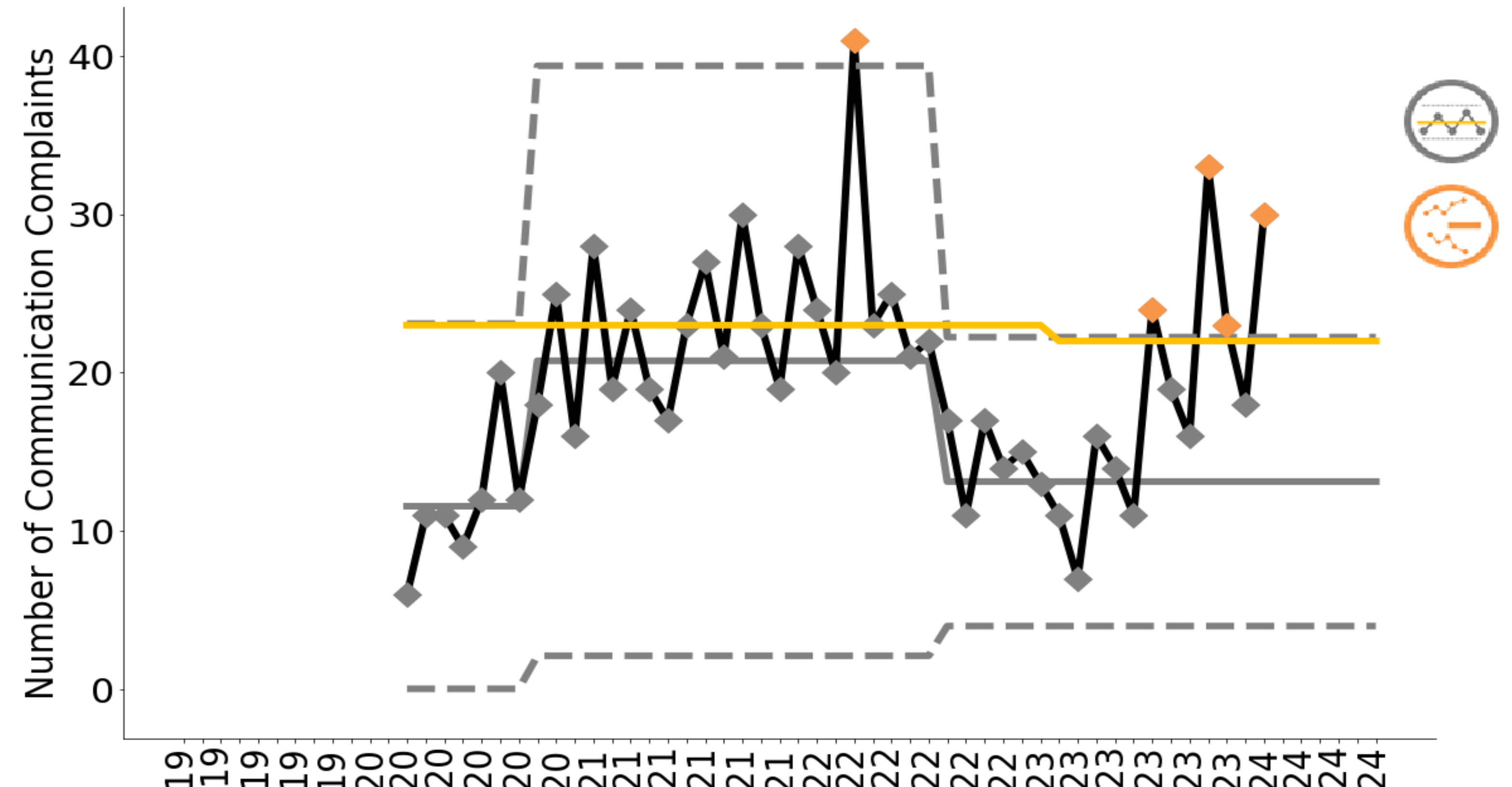


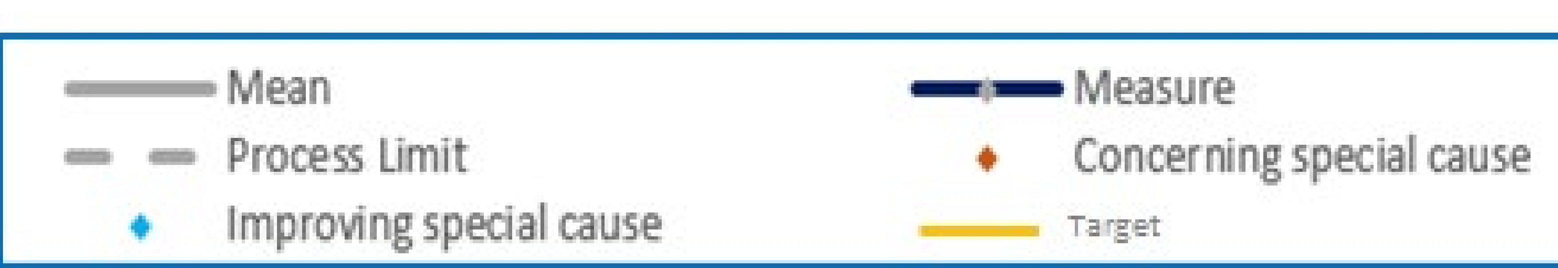












Assurance Icons – How likely are we to hit the set target in future?

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*

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%	6.91 %	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%	2.53 %	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%	4.38 %	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	46.21	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	24.28	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	69	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%	0.48 %	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%	5.16 %	9.05 %
Appraisals	Maintain 90% HC compliance rate for appraisals	M | T-D-S-C | W | KS	-				≥ 90%	89.70 %	
Mandatory Training	Maintain 90% HC compliance against all core skills training requirements (module compliance reported)	M | T-D-S-C | ETR | KS	-				≥ 90%	93.99 %	
Medical Devices	Achieve 90% HC compliance with medical device training	M | T-D-S-C | ETR | KS	-				≥ 90%	84.79 %	
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	5	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 %

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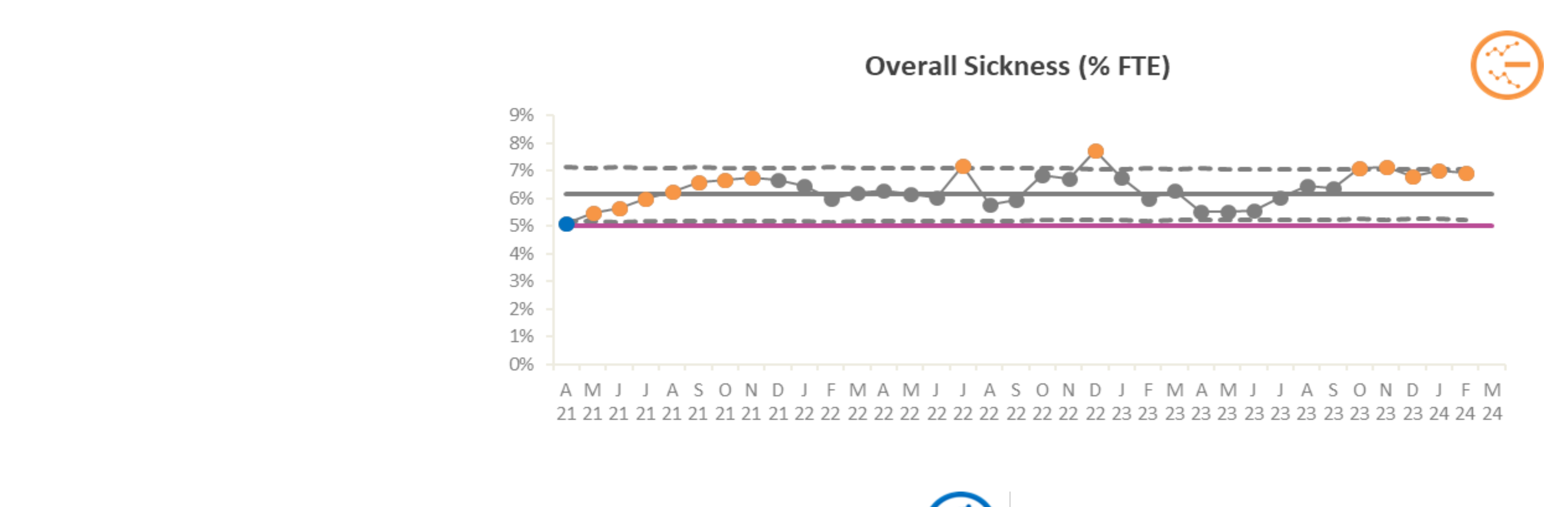
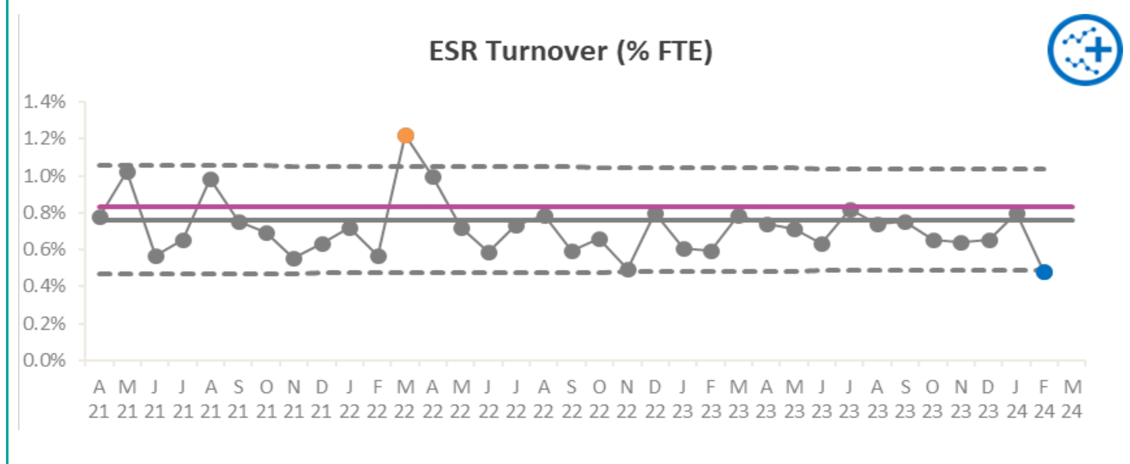
A GREAT PLACE TO WORK
Reviewed via committee cycles of business

Together

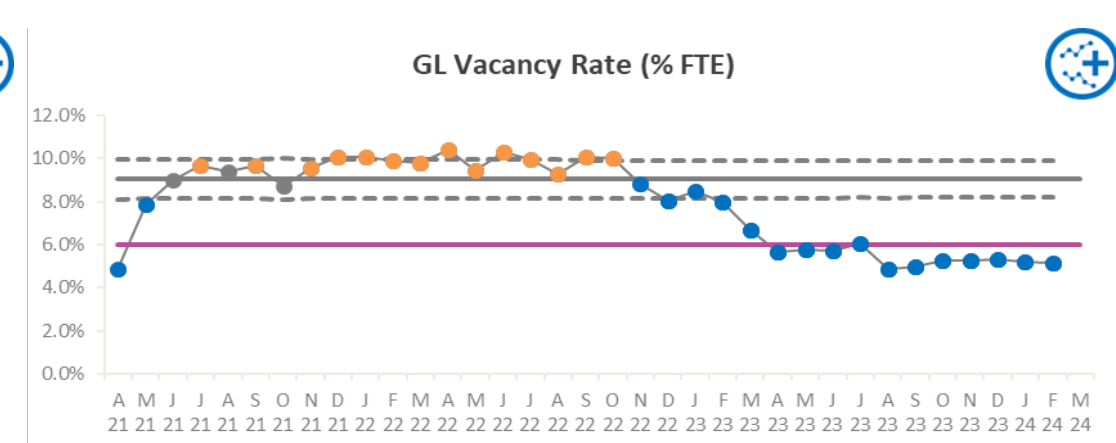
	Metric Description	Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Enivronment	Upgrade a further five local staff rest areas	B | T | W | JW							
	Create five agile activity based workspaces	B | T | W | JW							
	Create outdoor recreational space on both the Chorley and Preston sites	B | T | W | JW							
Health & Wellbeing	Increase staff perception that the organisation takes positive action on health and wellbeing to 40%	A | T-D-S-C | W | KS							
	Support staff to stay well by ensuring adequate rest and recuperation in line with working time regulations	B | T-D-S-C | W | KS							
Develop People									
Appraisals	Improve staff perception of the quality of appraisals by 5%	A | T-D | W | KS							
Inform, Listen and Involve									
Just Culture	Reduce further the number of grievances that are managed through formal processes to monitor the move to a just culture	B | T | W | All							
	Reduce the gap between the scores achieved in the annual culture survey between staff perception of the current and desired culture	A | T-D-S | W | All							
Freedom to Speak Up	Ensure all staff accessing the Freedom to Speak Up team are satisfied with how their concerns were managed	A | T | W | KS							
Staff Engagement & TED	Increase the staff engagement score, as measured by the annual staff survey, to 7 out of 10	A | T-D | W | KS							
	Ensure 50% of our staff complete the annual staff survey	A | T-D | W | KS							
Value Each Other									
Race Equality	Reduce the number of staff from BAME backgrounds that have personally experienced discrimination at work to be in line with that of their white colleagues	A | T | W | All							
	Increase the number of colleagues from a BAME background in senior roles (AfC Band 8a and above)	A | T | W | All							
Disability Equality	Reduce the number of disabled staff that experience harassment, bullying and abuse from managers to be in line with the experience of non-disabled colleagues	A | T | W | All							
Corporate Social Responsibility	Engage with our local communities through a range of workforce and education programmes	A | T | W | KS							



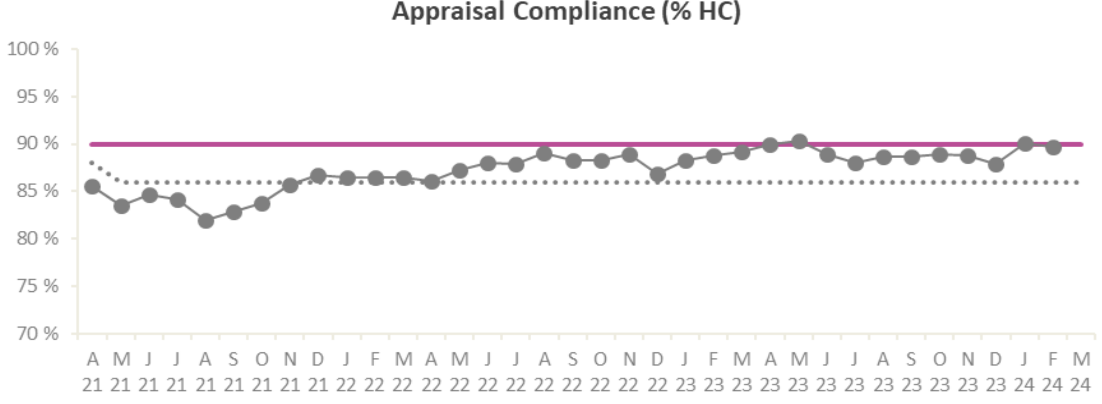
Overall Sickness (% FTE)



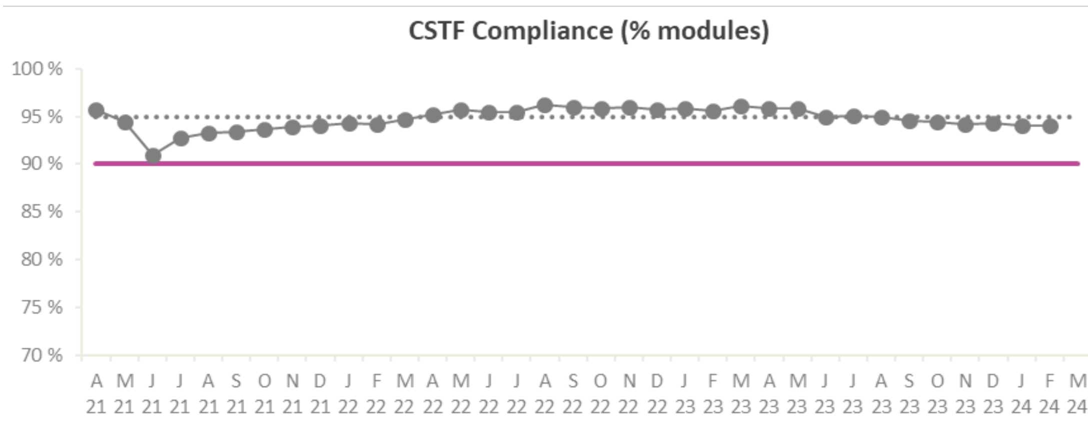
ESR Turnover (% FTE)



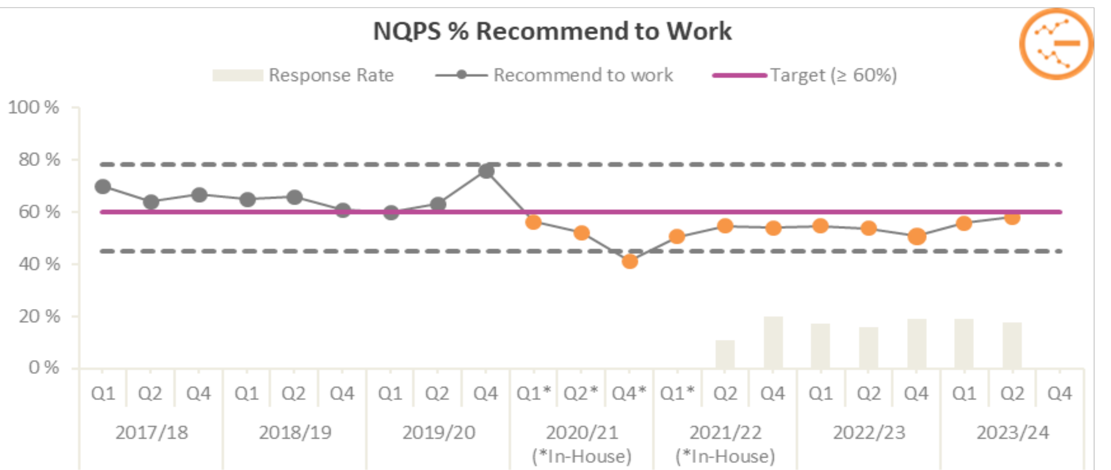
GL Vacancy Rate (% FTE)



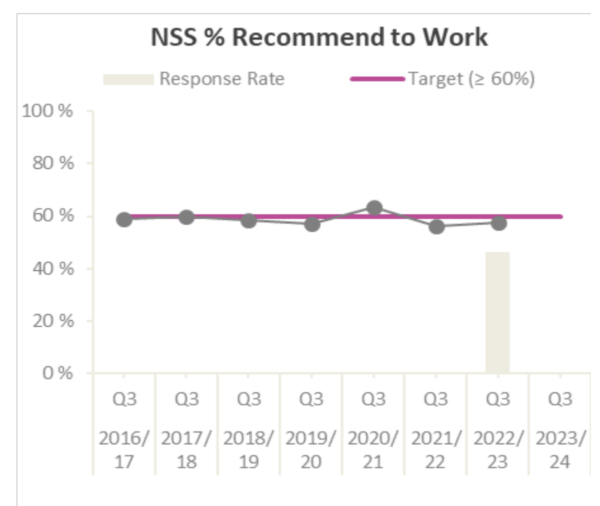
Appraisal Compliance (% HC)



CSTF Compliance (% modules)



NQPS % Recommend to Work
Response Rate
Recommend to work
Target (≥ 60%)

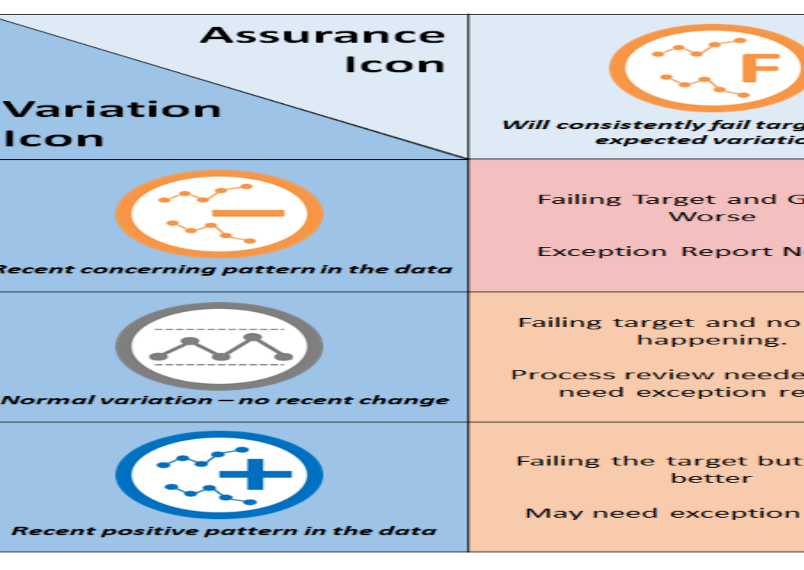


NSS % Recommend to Work
Response Rate
Target (≥ 60%)

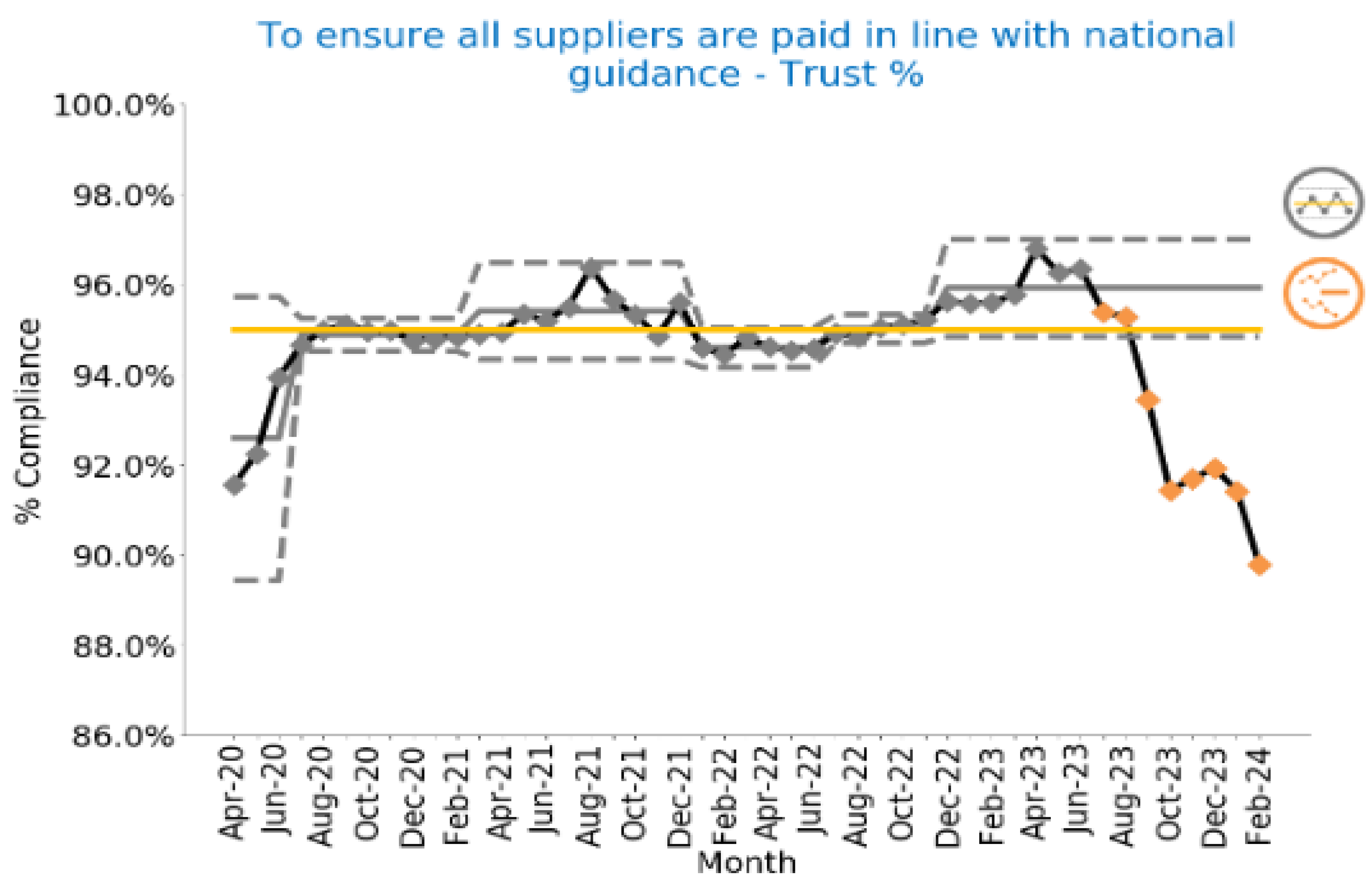
Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One - Spend Less (Economy)											
Agree revenue and capital financial plan with ICB	**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	-	-	-	5224	6171	-
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%	96.2%	94.3%
Theatre Efficiency	Big Plan		RPH - Theatre capped utilisation rates are no lower than 80%	M | T-D-S | FPC | FB	No	-	-	-	80%	80.7%	-
	Big Plan		CDH - Theatre capped utilisation rates are no lower than 85%	M | T-D-S | FPC | FB	No	-	-	-	85%	75.9%	-
GIRFT (Model Hospital)	Big Plan		Achieve 85% day of surgery using BADs Procedures - GIRFT	M | T-D-S | FPC | FB	No			-	85%	84.6%	85.5%
OP Follow Ups	Big Plan		Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels - **January 2024**	M | T-D-S | FPC | FB	No				-25%	-13.7%	-1.4%
Supplier payments (BPPC)	Big Plan		To ensure all suppliers are paid in line with national guidance	M | T | FPC | JW	No			-	95%	89.8%	-
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%	3.88%	-
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	-	-	-	-2561	-31751	-
Capital	**Key Metric**		To ensure 100% delivery of the Trust's Capital programme	M | T | FPC | JW	No	-	-	-	27561	26386	-

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


To ensure all suppliers are paid in line with national guidance - Trust %
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
% Compliance
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22
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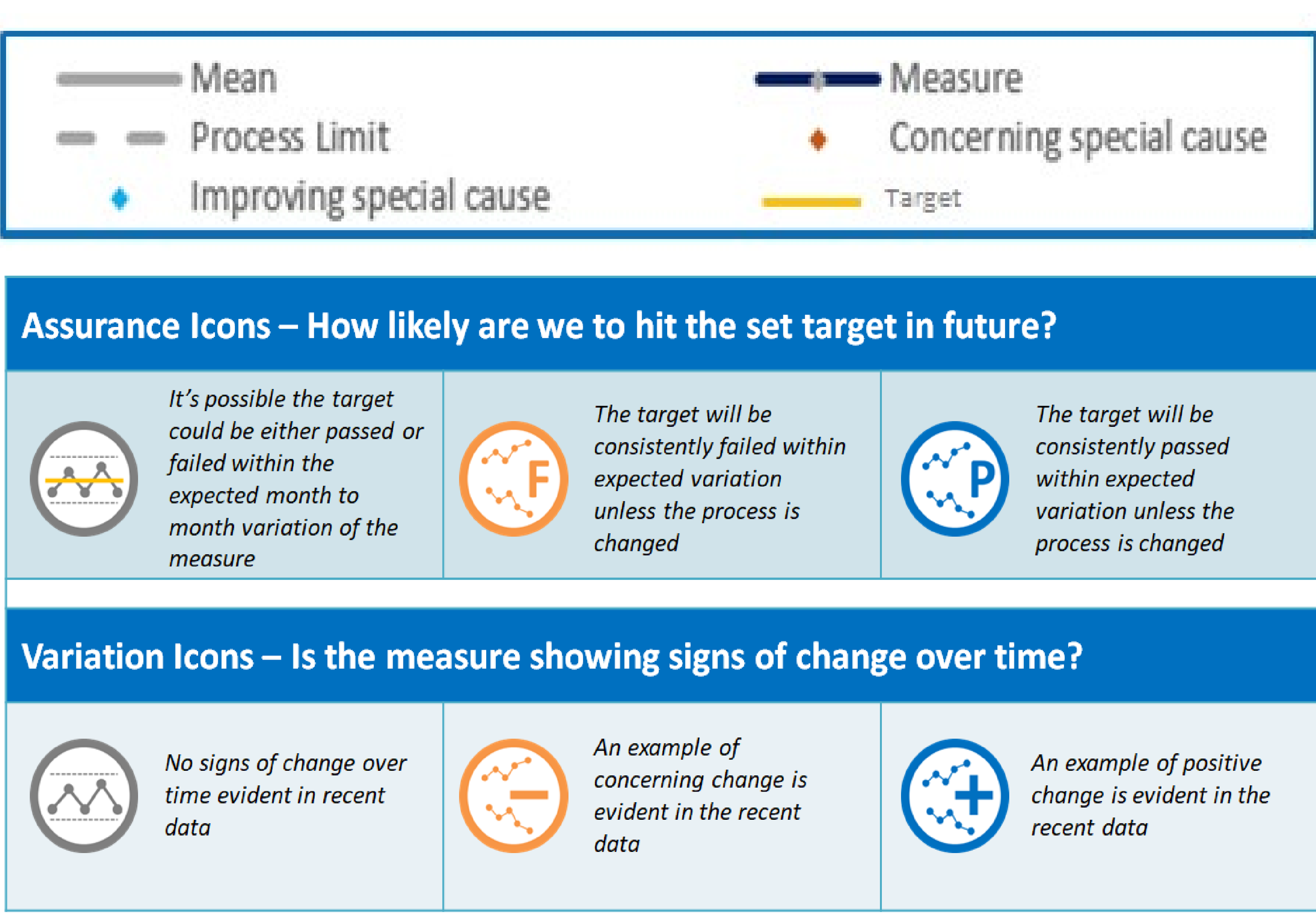
Oct-23
Dec-23
Feb-24
Month


Mean
Measure
Process Limit
Concerning special cause
Improving special cause
Target
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		▬	▬	▬	▬	▬	This is under review and to be aligned with the Trust clinical services strategy.
			Deliver agreed national waiting list improvement targets and productivity benchmarks			▬	▬	▬	▬	▬	Good progress made as part of Tier 1 exit plan.This also aligns with the internal transition from stabilising services to perform and then further transformation through the Single Improvement Plan.
			Develop our elective strategy to include repatriation of activity from the independent sector and other regions, and the maximisation of our surgical hub capacity			▼	▬	▬	▼	▼	This will be incorporated into the service triangulation programme at specialty level to inform capacity for repatriation as we stabilise, perform and transform,
			Deliver our planned care financial targets in support of the Financial Improvement Plan			▬	▬	▬	▬	▬	This is incorporated within the Single Improvement Plan ensuring robust governance through streamlining improvement plans.
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		▬	▬	▬	▬	▬	In progress and aligned to the Single Improvement Plan
			Focus on pre hospital pathway/front door to include integrated mental/physical health services and a 40% reduction in ambulance conveyances			▼	▬	▬	▼	▼	Continued work programme and review of Same Day Emergency Care demand and capacity to improve ambulance flows outside of ED.
			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)			▬	▬	▬	▬	▬	System leadership group relaunched on the 1st March and work programme for place being developed with immediate, medium and long term plans.
			Deliver agreed financial benefits to support Financial Improvement Plan			▼	▬	▬	▼	▼	This is being integrated within the Trust's Single Improvement Plan. Focus on quarter 4 maintained to manage the year end position.
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		▬	▬	▼	▬	▬	Gaps largely related to UEC optimisation
			Fully embed FIP governance & reporting			▬	▬	▬	▬	▬	Further work required to mature plans
			Fully embed FIP delivery framework			▬	▬	▬	▬	▬	Further work is required to build assurance
			Develop and agree 3 year FIP			▬	▬	▬	▬	▬	There remain gaps in the bottom up delivery plans
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		▬	▬	▬	▬	▬	Governance has been established but is currently under review
			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			▲	▬	▬	▲	▲	Update report on April Board meeting
			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		▼	▬	▬	▬	▼	Procurement to be restarted
			EPR tenders evaluated, and preferred supplier awarded			▼	▲	▲	▼	▼	Procurement to be restarted
			Digital Convergence programme governance reviewed and revised			▬	▲	▲	▬	▬	To be reviewed
			Implement Secure data Environment			▬	▬	▬	▬	▬	
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		▬	▬	▬	▲	▬	Actions delivered but due to industrial action targets will not be met
			National waiting times targets			▼	▬	▬	▬	▼	Actions delivered but due to industrial action targets will not be met
			National productivity targets			▲	▬	▬	▬	▲	
			Surgical Hub Strategy			▲	▲	▲	▲	▲	On track to be deleivered/agreed
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

Board of Directors' Report

Appointment of Internal Audit & Counter Fraud Provision

Report to:	Board of Directors	Date:	4th April 2024
Report of:	Company Secretary	Prepared by:	B Patel

Purpose of Report

For assurance	☐	For decision	☒	For information	☐

Executive Summary:

Under clause 2.5.37 of the Trust's Scheme of Reservation and Delegation the appointment of internal auditors is a reserved matter for the Board. The purpose of this paper is to provide an update in relation to the Internal Audit & Counter Fraud contract (referred to as IAS for the purpose of this report) held by the Trust and the wider Lancashire and South Cumbria (LSC) Integrated Care System (ICS).

The Trust's current contract for IAS from MIAA ended on 31st March 2024. Whilst a long-term strategic direction for the engagement of Internal Audit Services is considered, the Trust must have this service in place.

The collaborative intention from the Trust and other provider organisations in Lancashire and South Cumbria is to consider procuring Internal Audit and Counter Fraud Services on a system basis to provide potential economies of scale, efficiencies in the procurement approach and potential quality benefits further into the contract to look at systems wide controls to determine and share best practice.

Should PCB partners agree, then it is anticipated that a market test will be made in a collaborative procurement process in 2025-26 ready for the start of a new contract in 2026-27. As this remains to be agreed by the collaborative it is suggested that and option for a 12-month period is also considered, i.e. make a direct award with an existing framework for a period of 2 years plus 1.

It is recommended that:

i. **The Board approves the appointment of MIAA for Internal Audit and Counter Fraud Services as set out in option 2 for a term of 2 years with an option to extend by a further 1x12 months.**
ii. **the aim to undertake a market engagement exercise in 2025-26, ready for a new contract term from 2026-27 be endorsed.**
iii. **A report for assurance be submitted to the Audit Committee on proposals for a collaborative provision of IAS**

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	☒

<table>
<tr><td>To drive health innovation through world class education, teaching and research</td><td>☒</td><td>Deliver Value for Money</td><td>☒</td></tr>
<tr><td></td><td></td><td>Fit For The Future</td><td>☒</td></tr>
<tr><td colspan="4">Previous consideration</td></tr>
<tr><td colspan="4">N/A</td></tr>
</table>

1. Introduction

The purpose of this paper is to provide an update in relation to the Internal Audit & Counter Fraud contract held by the Trust and the wider Lancashire and South Cumbria (LSC) Integrated Care System (ICS) and decide on a way forward given that the current contract with MIAA for the provision of this service ended on 31 March 2024.

2. Background

The initial intention from Trusts operating in Lancashire and South Cumbria was to consider procuring Internal Audit and Counter Fraud Services on a system basis to provide potential economies of scale, efficiencies in the procurement approach and potential quality benefits further into the contract to look at systems wide controls to determine and share best practice.

Blackpool Teaching Hospitals NHS Foundation Trust (BTH) undertook to prepare an options paper with input from Lancashire Procurement Cluster (LPC). However, the wider options appraisal on the potential for a collaborative long-term solution would require the alignment of current trust IAS contract end dates. Whilst it was anticipated that this would be concluded before the end of LTH's current contract, and therefore allow a seamless transition into a collaborative service (should that be the decision of the member trust boards), this has not transpired in practice.

The appointment of Internal Audit Services is a reserved matter for the Board. The current contract with MIAA ended on 31 March, but as the matter is strategically significant it is appropriate that the decision is put forward for discussion and discussion in open forum rather than written resolution. MIAA are aware of the situation.

3. Procurement options for consideration

There are several options relating to the procurement route although Option 1 (do nothing) is not viable. There is an ambition to align the contract periods across ICB partner Trusts in order that a future market process can be undertaken. This will be coordinated by respective Audit Committees and Chief Financial Officers. Options are as follows:

Option 1 – Do Nothing

This would be non-compliant and leave the Trusts with no benefits and several risks.

- Legal challenge.
- Contract variation.
- Uncompetitive pricing through differential contracts rather than standardising pricing.
- Inability to challenge poor supplier performance.

Option 2 – Direct Award to MIAA via Framework

As all L&SC Trusts are currently contracted with MIAA, these contracts could be renewed by direct award via a framework for several years.

Benefits:

- All Trusts have a current relationship with the supplier.
- The L&SC system can continue to build a positive relationship with MIAA.
- Leveraging spend as a collaborative may allow for a greater discount, achieving value for money across the system.
- Standardisation across the region.

- Straightforward process to award.
- Most of the procurement work is already complete.
- Reduced procurement costs as a full tender exercise would not be required.
- In previous market testing exercises, MIAA have been the successful bidder.
- In the corporate benchmarking exercise undertaken across the country, Internal Audit and Counter Fraud costs are consistently in the lowest quartile for cost per £100m income.

Risks:

- Requires buy in from all Trusts in the region to potentially achieve greater value for money.
- Development of specification that covers all Trusts requirements may take some time.
- Specification agreement and sign off will be required from all Trusts and may take some time.
- Potential of legal challenge for the Trusts not being open to further competition within the framework.
- Potential of large supplier response to required capability assessment required for direct award.

Option 3 – ICS Mini Competition via a Framework

Further competition within a framework via a mini competition on behalf of the L&SC Trusts.

Benefits

- Standardisation and collaboration across the region.
- Leveraging spend as a collaborative may allow for a greater discount, achieving value for money across the system.
- Reduced procurement costs as a full tender exercise would not be required.
- Suppliers have been pre-assessed.
- Most of the procurement work is already complete.
- Allows all suppliers on the framework an opportunity to bid (based on capability assessment).
- Reduced risk of legal challenge as the Trusts have been open to competition.

Risks

- Requires buy in from all Trusts.
- Specification agreement and sign off will be required from all Trusts and may take some time.
- Requires engagement from all Trusts to properly evaluate bids.
- Engagement and time required to moderate the bids and have supplier presentations.
- Limited to only opening competition to suppliers awarded to the framework.
- Potential of large supplier response.

Option 4 – Open Competition

A tender process to be undertaken on behalf of the LSC Trusts.

This would require ‘buy-in’ from all Trusts, and whilst it would be ideal to have agreement from all Trusts prior to going out to tender, provision could be made to include estimated values based on them joining at a later date.

Tender process would be undertaken via the ‘Find a Tender’ service.

Benefits

- Standardisation across the system.
- Leveraging spend as a collaborative may allow for a greater discount, achieving value for money across the region.
- Straightforward and compliant route to market.

- Allows suppliers who are not awarded to frameworks to bid.

Risks

- Requires buy-in from all Trusts.
- Specification agreement and sign off will be required from all Trusts and may take some time.
- A potentially lengthy process to run a full tender.
- Potential of large supplier response.
- Requires engagement from all Trusts to properly evaluate bids.
- Engagement and time required to moderate the bids and have supplier presentations.

4. Financial implications

There will be financial implications associated with contracting with any provider. It is worth noting that any route to market that is undertaken via a framework attracts a 2% additional fee.

5. Legal implications

There are legal requirements in relation to procuring services and this paper focusses on the procurement requirements. Each of the options, except for option 1, is legally compliant.

6. Risks

The Trust will have a short period of time without any appointed IAS. However, discussions with MIAA have confirmed that they would continue to provide the service for the short period of time between the ed of contract term and the decision to appoint at Board on 4 April.

The delay in adopting a collaborative way forward in good time for the end of the current contract has fettered the discretion to do anything other than re-appoint MIAA for a short term whilst an open process is undertaken (whether the decision ultimately is for that process to be solely in respect of services at LTH or as part of a wider collaborative initiative).

Whilst the provision of Internal Audit services may be procured collaboratively, each Trust under professional standards a direct reporting line is maintained from the service provider to each trust separately. However, the strategic implications of engaging in a collaborative Internal Audit Service could be considered by the Audit Committee in order to provide assurance to the Board on the merits of this approach.

7. Impact on stakeholders

None

8. Recommendations

It is recommended that:

i. The Board approves the appointment of MIAA for Internal Audit and Counter Fraud Services as set out in option 2 for a term of 2 years with an option to extend by a further 1x12 months.
ii. the aim to undertake a market engagement exercise in 2025-26, ready for a new contract term from 2026-27 be endorsed.
iii. A report for assurance be submitted to the Audit Committee on proposals for a collaborative provision of IAS

Trust Headquarters

Board of Directors Report

Board Safety and Experience Programme			
Report to:	Board of Directors	**Date:**	4 April 2024
Report of:	Chief Nursing Officer	**Prepared by:**	S Cullen
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of the report is to review the Board Safety and Experience programme for 2023/24.

The aim of the programme is to:

- Demonstrate meaningful attention and visibility within the organisation balancing the value, appreciation and understanding of clinical and non-clinical areas.
- Allow the Board to explore topics presented for information and/or assurance in Committees and at Board and triangulate the written information with seeing this in practice.
- Respond to staff survey feedback, encourage and support the development of a positive safety culture within the organisation with Board members participating in leading conversations through an appreciative enquiry approach.
- Be effortlessly inclusive and hold conversations as senior leaders that provide a demonstrative commitment to inclusivity in all areas of our organisation.
- Observe in practice the impact of improvement methodology across the organisation, recognise this and celebrate with teams promoting cultures of improvement.
- Promote our values driven culture.
- Ensure colleagues know the Board, feel able to contact them should they wish to raise concerns and share good practice.
- Enable the Board to consider feedback, observations in the context of strategic development at Board level.

The safety and experience programme has provided the opportunity for the Board to spend time with teams and meet patients in 27 of our services. This programme is one part of a series of interactions the Board has with teams and services. The review has identified there is recognised value in the programme with opportunities to enhance further outlined within the report.

Recommendation

The Board is asked to endorse the approach to the safety and experience programme.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims	Ambitions

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

1. Introduction

The purpose of the report is to review the Board Safety and Experience programme. A pack with the format for the visits is prepared for members of the Board and Divisional teams prior to the visits providing the opportunity to prepare for the activity. The areas selected are based on feedback from committee agendas, areas of focus and attempt to maintain equal divisional, corporate and site presence.

2. Background

The aim of the Board Safety and Experience programme is to:

- Demonstrate meaningful attention and visibility within the organisation balancing the value, appreciation and understanding of clinical and non-clinical areas.
- Engage and listen to patients and service users experiences.
- Allow the Board to explore topics presented for information and/or assurance in Committees and at Board and triangulate the written information with seeing this in practice.
- Respond to staff survey feedback, encourage and support the development of a positive safety culture within the organisation with Board members participating in leading conversations through an appreciative enquiry approach.
- Be effortlessly inclusive and hold conversations as senior leaders that provide a demonstrative commitment to inclusivity in all areas of our organisation.
- Observe in practice the impact of improvement methodology across the organisation, recognise this and celebrate with teams promoting cultures of improvement.
- Promote our values driven culture.
- Ensure colleagues know the Board, feel able to contact them should they wish to raise concerns and share good practice.
- Enable the Board to consider feedback, observations in the context of strategic development at Board level.

2.1 How this programme fits with our strategic aims and ambitions?

Safety and Experience fundamentally underpins each of the four ambitions. Visibility of the Board is a fundamental part of connecting with front line staff, role modelling the values of the organisation, understanding the services delivered and identifying strategic opportunities that exist. In line with our culture counts, Board members will support the behaviours that underpin creating a culture that enables teams to flourish.

Image 1 – Our culture counts behaviours

Care Comes First Putting patients at the centre of everything we do.	**Provide Excellent Service** Making quality and safety our top priority.	**You Can Count On Me** Having an 'I'm here to help' frame of mind.
Two Ears and One Mouth Actively listening to patients and colleagues to truly understand views, aspirations, priorities, needs, abilities and limits.	**We Not Me** Working as one team providing a seamless service.	**Call It Out** Speaking out if standards are not being met, behaviours or practices are not in line with our values.
Be the Best in Class Never accepting average, taking part in using continuous improvement methods to enhance our team and services.	**Be Yourself Always** Recognising and celebrating diversity and differences by valuing each and every person.	**Do Right** Treating colleagues fairly, with trust, openness and without blame.
Hello My Name Is Being welcoming, friendly and warm to everyone you come in contact with.	**Kindness Rules** Being kind, courteous and polite, taking care of ourselves and each other.	**Ask, Act, Give** Seeking out, acting on and giving constructive feedback.
Look in the Mirror Being self-aware, taking responsibility for own actions, behaviour and impact on others.	**Stay Fresh** Keeping on learning, discovering and developing yourself and others to grow competence and unleash your potential.	**Tread New Ground** Being open to ideas and research by being curious, willing to change and explore new approaches.

2.2 Summary of Board visits 2023-2024

7th March 2023 (Surgery)
- RPH Day of Surgery Assessment Unit
- RPH Theatres
- RPH Sharoe Green Theatres
- RPH surgical wards

2 May 2023 (Maternity and Neonatal)
- RPH Maternity
- RPH Neonatal unit
- RPH Birth centre
- RPH Antenatal clinic
- RPH Maternity Assessment Unit
- RPH Delivery suite

5 September 2023 (DCS & Womens – CDH)
- CDH Ophthalmology
- CDH Rawcliffe ward
- CDH Endoscopy
- CDH Pharmacy
- CDH Birth centre
- CDH Cuerden
- Rookwood A

7 November 2023 (Childrens and surgery RPH)
- RPH Children's area in ED
- RPH Outpatients
- RPH Paediatric assessment unit
- RPH Ward 4

- RPH Ward 8

22 February 2023 (corporate/ virtual)

- All site Workforce
- All site Recruitment
- All site Research
- All site Education
- All site Safeguarding

Two of the planned visits have not taken place due to a CQC inspection and operational pressures.

The number of attendees determine the number of departments/services that are visited.

2.3 Board Feedback

A survey of Board members identified the following for consideration;

- Good opportunity to meet and talk to staff in real time and hear the risks and challenges faced and see the positive work that is being undertaken.
- Helps enable a better understanding of risks/challenges to inform decision making at Board level.
- Provides further insight into how the trust is performing.
- Preference of face-to-face visits, although mix of teams/round table and face to face visits may allow for more visits throughout the year.
- Consider how Board members could be present in more regular forums.
- Each department should have the opportunity to have a conversation with a board representative each year.
- Consider how the Board can have more contact with staff working out of hours and off site.
- The visits have given useful insight into financial management and opportunities as well as understanding the impact of operational pressures on staff.
- Departments should be able to request a Board visit.
- Increased 'in-conversation' with sessions could increase engagement opportunities.
- Attendance should be seen as important as Board meeting itself.

3. Conclusion

The Board Safety and Experience programme has facilitated visits to 27 teams and areas across the organisation during 2023/24. It is recommended the visits continue as per the current format into 2024 with the following enhancements.

- Increase the number of departments visited by reducing the number of board members of each visit.
- Provide an opportunity for teams to invite a Board visit.
- Explore as part of Board development additional engagement opportunities including ‘in conversation with’ and roundtable events that would allow greater reach.
- Confirm attendance ahead of the scheduled visits to maximise reach to a larger number of departments.

4. Recommendation

The Board is asked to endorse the approach to the safety and experience programme.

Board of Directors Report

Data Quality Assurance Report

Report to:	Board	**Date:**	April 24
Report of:	Chief Information Officer	**Prepared by:**	D Hudson, T Caton
Part I	√	**Part II**	

Purpose of Report (tick only one then delete this instruction)

For approval	☐	**For ratification**	☐	**For discussion**	☐	**For information**	☒

Executive Summary:

The paper informs the Board in relation to current data quality assurance activities and provides an update in relation to data quality performance.

The Report details performance in relation to:

- Data Quality Team activities
- Update in relation to Data Quality Risks
- Waiting List Minimum Dataset Data Quality
- National Data Quality Assurance Dashboard and Maturity Index

The Board is asked to note current Data Quality Assurance activities and the on-going developments that support further improvements to data quality assurance processes and data quality clinical engagement.

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

Data Quality Assurance Update Report

Background/Context

The benefits of using routine health care data for planning, policy making, and research, future demand, and quality of service are well established. Using data for these purposes requires that data is high quality, timely, complete and accurately coded. As part of Board Assurance and in response to actions identified in the Trusts Well Led Review this paper sets out the effective processes used to monitor, manage and report on the quality of data.

This report provides an overview of current data quality assurance activities within the Trust to assure the quality of data used for reporting.

Introduction

Data quality is defined as the state of accuracy, completeness, reliability, validity, timeliness and systemic consistency that makes data fit for purpose. Acceptable data quality is crucial to operational processes and to the reliability of Trust performance reporting. The use of high quality information leads to better decision making to improve patient care and safety.

Poor data quality puts organisations at significant risk in terms of damaging stakeholder trust, weakening frontline service delivery, incurring financial loss, poor forward planning and poor value for money.

Data Quality Assurance (DQA) compliments and underpins the principles of Information, Clinical, Research and Corporate Governance, which ensure that personal data is dealt with legally, securely and efficiently, in order to deliver the best possible care. The current climate of scrutiny from audit bodies and the Information Commissioner's Office enforces the requirement, with significant risk of potential fines for non-compliant practice.

This paper sets out actions to date undertaken to maintain data quality standards within the Trust.

Discussion

Internal and External Scrutiny

Information Governance

Information Governance (IG) is the way in which the NHS handles all organisational information - in particular the personal and sensitive information of patients and employees. Information Governance provides a framework that ensures information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care. The DQA team continues to undertake data quality assurance initiatives to support IG compliance and the delivery of quality assured data collection and collation processes.

The data quality assertion of the 'Data Protection and Security Toolkit' (1.7 – effective data quality controls are in place) has been completed for the 2023 baseline submission and evidence supplied.

Data Quality Assurance Activities

Harris Flex (previously Quadramed) Masterfile Maintenance

The Trust is working with Harris Flex CPR to implement a programme of work to update all Commissioner allocation master files to the latest version available. This includes:

- Postcode
- GP and Practice
- Health Authority
- Clinical Commissioning Groups (CCG's)

Work remains ongoing on Harris Flex Test system to finalise robust process to ensure Flex reference tables are consistent with national standards and incorporate the latest available updates. The work is monitored through the Harris Flex Customer Care Board as appropriate. The work of the group will seek to minimise system data quality risks as well as improve SUS activity reporting. It is expected that once the work is complete quarterly updates to masterfiles will move into business as usual process.

This will address the issues raised in Risk 54 GP Masterfile maintenance on Harris Flex.

Secondary Uses - Completeness & Validity Audits

Part of the rolling audit programme is review of patient casenotes and assessment against the HSCIC – NHS Information Governance – Data Output Quality Standards. This details the minimum standards of completeness and validity across a range of key demographic and activity driven data items.

However due to the continued pressures following the COVID pandemic and the increase in volumes of validations and change to documentation processes and priorities the programme continues to be on hold.

Shared Care Record - ShCR (formerly Lancashire Person Record Exchange Service (LPRES)) – update

The ShCR project aims to establish data interoperability across the health and social care system in Lancashire. The process allows the exchange of personal identifiable data, including discharge summaries, PACS images, patient care summaries, medication information and clinical correspondence.

Currently the following documents are being transferred electronically direct to GP systems within the North West Region catchment area: -

- Immediate Hospital Discharge Information produced from FlexCPR
- Trauma & Orthopaedic, Colposcopy and Colorectal clinic letters
- Advice & guidance documents
- GP Patient Death Notifications

The DQA team monitor rejected records, updating patient details where necessary and ensuring timely receipt of clinical information. Rejected records are resent either electronically to the correct practice following review and update on Harris Flex or printed and posted if the practice is not part of ShCR.

The table below shows a summary of records transferred via ShCR for the GP practices April 2023 – February 2024.

Month	Total Records Sent	Total Rejected	% of records	No. EMIS issue	No. True Rejections (inc NOP, dupes etc)	True rejections as a % of all records sent	True rejections as a % of rejected records
April	23130	714	3.09%	103	611	2.64%	85.57%
May	25267	570	2.26%	25	545	2.16%	95.61%
June	26121	672	2.57%	56	616	2.36%	91.67%
July	25443	613	2.41%	30	583	2.29%	95.11%
August	24260	561	2.31%	28	533	2.20%	95.01%
September	25606	585	2.28%	14	571	2.23%	97.61%
October	30480	1205	3.95%	14	1191	3.91%	98.84%
November	26607	710	2.67%	14	696	2.62%	98.03%
December	25856	525	2.03%	12	513	1.98%	97.71%
January	27258	611	2.24%	79	632	1.95%	87.07%
February	~~264467~~26467	617	2.33%	67	550	2.08%	89.14%
Total	**286495**	**7383**	**2.58%**	**442**	**6941**	**2.42%**	**94.01%**

Rejection Reasons:-

- Not registered at GP practice IHDI sent to
- Baby – delay in registering at GP practice
- GP patient registered with practice, not on SCR system
- Duplicate IHDIs being sent to Practices

There are minimal numbers of summaries being posted for GP practices that are not currently part of ShCR. Savings on consumables and posting for discharge summaries and letters achieved to-date in this financial year is £31,266.88

Current developments for incorporation into ShCR include the transfer of all clinical documentation via the digital dictation process. The roll out across specialities has begun the volume of documents being posted has decreased and savings increased. However, this has started to have an impact on the DQA team and the volume of rejections requiring review, update and resending.

Data Completeness and Validity

The Data Quality Team has a key role in identifying missing and incomplete documentation that directly impacts on activity and income levels. This role includes highlighting to divisions outpatient appointments that have not been documented as either patient attended or Did Not Attend and gives divisions the opportunity to action these historical appointments on the system.

The tables below show the volume of activity identified and updated by the DQA team:

Month (2023-24)	Attended	DNA	Cancelled	Pended
April	241	110	11	457
May	355	121	10	748
June	237	150	10	560
July	229	105	14	465
August	261	112	9	554
September	220	85	13	557
October	304	200	12	656
November	304	118	9	691
December	337	93	12	584
January	306	162	10	689
Total Appts	2794	1256	110	5961
Average	254	114	10	542

There has been some improvement in the volume of appointments not fully documented, resulting in a decrease in the number of records requiring review and update on Harris Flex CPR. However, there is still ample scope for further improvement to ensure records are recorded in real time or as near to it as possible.

Data Quality Newsletters

The Data Quality Assurance team also published a newsletter in December 23 giving an update on:

- Hospital Discharge Summaries
- Unrecorded Outpatient activity
- DQ/IG Presentations
- Meet the team
- Updates on the SCR(LPRES) project

DQA Newsletter December 23.pdf

Data Quality Risks

The Data Quality Assurance Team undertake regular audit tasks to identify risk areas, working with services to implement remedial/improvement actions through the corporate quality improvement programme. A full risk assessment has been completed for each item; these are held locally on the Business Intelligence Risk Log.

The Team continue to monitor the key risks and remedial actions identified to sustain improvements and minimise risks. The table below shows the current risks to key data quality items and how they are being mitigated.

RA No	Risk Item	Issue	Action 2023-24	Update
54	Harris Flex GP Masterfile maintenance (current rating 12)	In-active GPs linked to patient records. In-accurate GP records in Masterfile on Harris Flex. Continued misdirected correspondence.(NOPs).	Move to ODS quarterly updates. Increase volume of documents transferred via SCR.	Harris flex team working with BI & DQA to establish process to upload files onto TEST PROD. Standing item on bi- weekly applications call with Harris team. Digital dictate process live – due to transfer letters via SCR
122	Corporate system recording issues. In-accurate recording of patient data/activity (current rating 12)	Variety of in-accurate event documentation. Incomplete linking across activity flows.	Review SUS issues on key data items. Continue to review functionality to improve correction of data on Harris Flex.	Additional Harris flex validation reports implemented. Working on supporting divisions with identifying reasons for issues with activity recording
1207	Inability to meet the monthly clinical coding submission standards (current rating 9)	Non-availability of comprehensive coded data. Timeframe for reviewing / coding data.	Improvement Action plan Draft Bespoke Harris Flex report Review inpatient to outpatient activity reporting Implement onsite / agile working	Action plan implemented, coding compliance 100% at flex Bespoke report finalised. Team agile working.

Data Quality and Compliance Group

The Trust Data Quality & Compliance Group has been established to act on Grant Thornton recommendations, to resolve data quality and documentation compliance issues following enhancements made within systems such as Harris Flex, Opera Theatre system, Sectra Radiology System and Badgernet maternity system and to mitigate the above risks. The system changes fully support recording of activity and clinical pathways from pre-referral advice, out-patients, to diagnostics, and patient admissions, however adherence to workflow can vary. The group will work in line with the 6 dimensions of good data quality:

- Accuracy
- Completeness
- Consistency
- Timeliness
- Validity
- Uniqueness

The group brings together a range of Digital, Business Intelligence, Data Quality, Training, Clinical Business Unit staff to address ongoing data quality issues and risks.

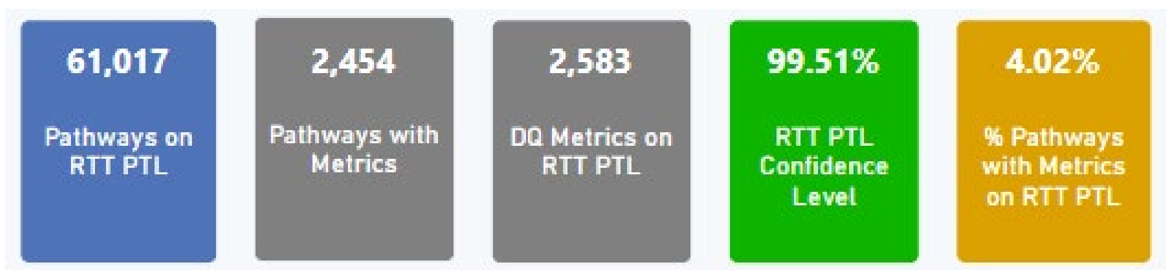
External Data Quality Assurance Monitoring

Elective Recovery - Waiting List National Minimum Dataset

As part of the elective recovery drive all acute trusts were mandated to provide a weekly record level waiting list extract covering referral to treatment, diagnostic and planned/surveillance care. The dataset is a mandated requirement for organisations and has been approved by the NHS Digital Data Standards Board. The data is being used to better understand and manage the waiting list position as part of the National Elective Restoration Programme, as well as being a key component of the elective care recovery fund (ERF) data validation gateway. It is expected that the WLMDS submissions will become the main source of reported waiting time performance data for Trusts with the phasing out of aggregated returns. The information within the WLMDS will also be used to populate waiting time information displayed in the My Planned Care Platform.

Nationally a Data Quality Reporting tool (LUNA) has been developed to support Trusts in making improvements to the quality and consistency of the datasets. Organisations submissions are assessed against 20 key data quality standards and assigned an overall data confidence level. The current week position for the Trust is shown below. The Trust confidence level score of 99.51% is above the national target of 95%, with the weekly trend showing sustained compliance and improvement. Of the total pathways submitted just 4% of records have been identified with a data quality flag that may warrant further review. Actions are ongoing to further improve the completeness and validity of submissions.

Current Week – Confidence Level



Confidence Level Trend

	17/03/2024	10/03/2024	03/03/2024	25/02/2024	18/02/2024	11/02/2024	04/02/2024	28/01/2024	21/01/2024
RTT PTL Confidence Level	99.51%	99.49%	99.48%	99.48%	99.47%	99.47%	99.49%	99.48%	99.49%

Data Quality Maturity Index (DQMI)

The DQMI is a monthly national publication intended to raise the profile of data quality in the NHS by providing data submitters with timely and transparent information in relation to the quality of key data submissions. The DQMI scores are based on the completeness, validity, coverage and use of default values within core data items held within key datasets submitted nationally by the Trust to the Secondary Uses Service. Data items monitored include NHS number, date of birth, gender, postcode, speciality and consultant as well as dataset specific items. Overall and dataset specific scores for the Trust are shown below for the period to end November 2023. Scores for all datasets are extremely positive showing a consistently high performance score during 2023/24. The Trust performs at well above the national average of 89% across all datasets.

	Overall	Emergency Care Dataset	Admitted Patient Care Dataset	Out-Patient Dataset
National Average	88.9	82.6	92.6	93.5
Lancashire Teaching	92.4	86.4	99.5	98.2

Scores by individual data items within each dataset are show in Appendix 1. The summary position shown below indicates a consistent compliance score with 5 fields worse than the national average, an improvement compared to the previous reported position.

Data Set	Key Fields	Compliant Fields	Var	% Compliance
OP	14	14	0	100.00%
APC	22	22	0	100.00%
ECDS	31	26	-5	83.87%
	67	**62**	**-5**	92.54%

Plans in place to implement further improvements to the content of the ECDS data flow now that the nationally mandated requirement to submit daily ECDS has been implemented.

Clinical Coding Completeness

The Clinical Coding Team continues to ensure the availability of comprehensively coded data in line with the national flex and freeze timetable. During 20222/23 the Coding team maintained a coding completeness level at flex above 90% and 100% at freeze. This position has been maintained into 2023/24, with 100% coding completeness achieved at flex for a number of months.

The Coding Team Business Plan sets out the overall strategy for the future development of the Coding Service incorporating:

- A programme of clinical engagement to enhance quality and depth of coding – limited during COVID pandemic
- Wider programme of internal audit to enhance coder skill sets including the appointment of a dedicated Audit & Quality Manager to drive quality improvements within the Clinical Coding team
- Fully implemented an enhanced End Coder system that supports additional quality and consistency checks. The upgrade of 3M Medicode system to Medicode 360 will provide additional audit and consistency capability.
- Engaged with IQVIA to implement their Clinical Coding Analytics tool plus 12 days consultancy over the next 6 months to identify opportunities to enhance the depth of admitted care clinical coding and support the development of outpatient coding completeness. Work has commenced to action monthly opportunity reports provided by IQVIA.

Recommendations

The Board is asked to note current Data Quality Assurance activities, internal and external monitoring processes and the on-going developments that support further improvements to data quality assurance and data quality engagement.

Appendix 1 –DQMI Dataset Compliance

Trust coverage compared to the national average for key data items for the period to Apr-Nov 2023. This is a coverage dashboard not a check of the accuracy of content.

Data Item	Trust Nov 2023	National Average	Variance	Rating	Actions
OUTPATIENT KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	96.00%	94.40%	1.60%		
ADMINISTRATIVE CATEGORY CODE	100.00%	92.00%	8.00%		
CARE PROFESSIONAL MAIN SPECIALTY CODE	96.00%	94.00%	2.00%		
CONSULTANT CODE	96.00%	86.80%	9.20%		
ETHNIC CATEGORY	93.00%	79.10%	13.90%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	100.00%	87.00%	13.00%		
NHS NUMBER	100.00%	81.90%	18.10%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	97.10%	2.90%		
ORGANISATION CODE (CODE OF COMMISSIONER)	100.00%	95.10%	4.90%		
PERSON BIRTH DATE	100.00%	93.70%	6.30%		
PERSON GENDER CODE CURRENT	100.00%	96.30%	3.70%		
POSTCODE OF USUAL ADDRESS	100.00%	91.50%	8.50%		
SITE CODE (OF TREATMENT)	100.00%	84.60%	15.40%		
SOURCE OF REFERRAL FOR OUTPATIENTS	95.00%	89.10%	5.90%		
ADMITTED CARE KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	100.00%	94.40%	5.60%		
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)	100.00%	95.70%	4.30%		
ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	100.00%	96.10%	3.90%		

CARE PROFESSIONAL MAIN SPECIALTY CODE	100.00%	94.00%	6.00%		
CONSULTANT CODE	100.00%	86.80%	13.20%		
DECIDED TO ADMIT DATE	100.00%	53.90%	46.10%		
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	100.00%	97.20%	2.80%		
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	100.00%	94.80%	5.20%		Changed to mandatory field in Flex to improve coverage, now above national average
DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	100.00%	94.40%	5.60%		
ETHNIC CATEGORY	90.00%	79.10%	10.90%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	100.00%	87.00%	13.00%		
NHS NUMBER	100.00%	81.90%	18.10%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	97.10%	2.90%		
ORGANISATION CODE (CODE OF COMMISSIONER)	100.00%	95.10%	4.90%		
ORGANISATION CODE (CODE OF PROVIDER)	100.00%	95.80%	4.20%		
PATIENT CLASSIFICATION CODE	100.00%	96.80%	3.20%		
PERSON BIRTH DATE	100.00%	93.70%	6.30%		
PERSON GENDER CODE CURRENT	100.00%	96.30%	3.70%		
POSTCODE OF USUAL ADDRESS	99.70%	91.50%	8.20%		
PRIMARY DIAGNOSIS (ICD)	99.90%	86.80%	13.10%		
SITE CODE (OF TREATMENT)	100.00%	84.60%	15.40%		
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	100.00%	95.60%	4.40%		
EMERGENCY CARE DATASET KEY DATA ITEMS					
CHIEF COMPLAINT (SNOMED CT)	98.00%	77.20%	20.80%		
ACUITY (SNOMED CT)	100.00%	84.30%	15.70%		
DIAGNOSIS (SNOMED CT) - FIRST	67.00%	63.60%	3.40%		
ARRIVAL DATE	100.00%	98.20%	1.80%		
ARRIVAL TIME	100.00%	97.80%	2.20%		
INITIAL ASSESSMENT DATE	100.00%	89.80%	10.20%		
INITIAL ASSESSMENT TIME	99.00%	87.90%	11.10%		
DATE SEEN FOR TREATMENT	98.00%	84.00%	14.00%		
TIME SEEN FOR TREATMENT	98.00%	84.00%	14.00%		

DEPARTURE DATE	99.00%	97.10%	1.90%		
DEPARTURE TIME	100.00%	95.50%	4.50%		
NHS NUMBER	100.00%	81.90%	18.10%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	97.10%	2.90%		
ATTENDANCE SOURCE (SNOMED CT)	100.00%	90.60%	9.40%		
DISCHARGE STATUS (SNOMED CT)	99.00%	84.90%	14.10%		
DISCHARGE FOLLOW-UP (SNOMED CT)	99.00%	67.20%	31.80%		
DISCHARGE DESTINATION (SNOMED CT)	99.00%	82.20%	16.80%		
DISCHARGE INFO GIVEN (SNOMED CT)	1.00%	5.80%	-4.80%		Slight improvement since incorporation via ECDS V3.0 Implementation plan
ETHNIC CATEGORY	98.00%	79.10%	18.90%		y
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.00%	87.00%	12.00%		y
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	98.00%	83.20%	14.80%		y
PERSON BIRTH DATE	100.00%	93.70%	6.30%		y
PERSON STATED GENDER CODE	100.00%	86.90%	13.10%		y
POSTCODE OF USUAL ADDRESS	100.00%	91.50%	8.50%		y
ARRIVAL MODE (SNOMED CT)	100.00%	91.90%	8.10%		y
ATTENDANCE CATEGORY	100.00%	93.40%	6.60%		y
PROCEDURE (SNOMED CT) - FIRST	99.00%	70.90%	28.10%		y
PROCEDURE DATE - FIRST	47.00%	61.90%	-14.90%		Continued improvement since incorporation via ECDS V3.0 Implementation plan
PROCEDURE TIME - FIRST	43.00%	61.90%	-18.90%		Slight deterioration
CLINICAL INVESTIGATION (SNOMED CT) - FIRST	44.00%	66.80%	-22.80%		Continued improvement since incorporation via ECDS V3.0 Implementation plan
INJURY INTENT (SNOMED CT)	13.00%	37.60%	-24.60%		Continued improvement since incorporation via ECDS V3.0 Implementation plan

Trust Headquarters

Board of Directors Report

Use of Common Seal 2023-24

Report to:	Board of Directors	**Date:**	4 April 2024
Report of:	Company Secretary	**Prepared by:**	J Wiseman
Part I	✓	**Part II**	

Purpose of Report

For approval	☐	**For noting**	☐	**For discussion**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to confirm the application of the Foundation Trust's Common Seal for the period 1 April 2023 and 31 March 2024, as required by the Foundation Trust's Standing Orders. Section 10, sub-section 10.3.1 states a report of all sealings shall be made to the Board of Directors on an annual basis, containing details of the Seal number, description of the document and the date of Sealing.

Although there are a substantial number of individual sealings in year the majority either relate to the decision to acquire East Lancashire Financial Services (ELFS) or to a legacy matter as notified by the Trust Solicitors in respect of the delivery of renal services at Blackburn.

It is recommended that the Board of Directors receive the report and note 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

Not applicable

1. USE OF COMMON SEAL

1.1 The Board is requested to note the Foundation Trust's Common Seal was applied as follows during the period 1 April 2023 and 31 March 2024:

- **Seal reference 220**: As authorised by the Chief Executive Officer and the Interim Chair on 22 June 2023 in respect of the business transfer agreement for East Lancashire Financial Services (ELFS) Shared Services.

- **Seal reference 221**: As authorised by the Chief Executive Officer and the Interim Chair on 22 June 2023 in respect of the deed of settlement (dilapidations) at Preston Business Centre, Second Floor and Basement Rooms B16 and B17.

- **Seal reference 222**: As authorised by the Chief Executive Officer and the Interim Chair on 22 June 2023 in respect of:
  (a) the assignment of a lease contract between (1) Northern Care Alliance NHSFT and (2) LTH NHSFT relating to lease of first and second floors, Viscount House, Arkwright Court, Commercial Road.
  (b) Counterpart Licence to assign between (1) North West Industrial Estates Limited and (2)Northern Care Alliance NHSFT and (3) LTH NHSFT relating to lease of first and second floors, Viscount House, Arkwright Court, Commercial Road.

- **Seal reference 223**: As authorised by the Chief Executive Officer and the Interim Chair on 22 June 2023 in respect of:
  (a) the assignment of a lease contract relating to part of 1st floor, St James House, Pendleton Way, Salford between (1) Northern Care Alliance and (2) Lancashire Teaching Hospitals.
  (b) Licence to assign in respect of the above between: (1) Northern Care Alliance, (2) Lancashire Teaching Hospitals and (3) Edgewear Properties Limited.

- **Seal reference 224**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Barnet Enfield and Haringey Mental Health Trust.

- **Seal reference 225**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for South Tees Hospitals NHS Foundation Trust.

- **Seal reference 226**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Greater Manchester Mental Health NHS Trust.

- **Seal reference 227**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Alder Hey Children's NHS Foundation Trust.

- **Seal reference 228**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Hull University Teaching Hospitals NHS Trust.

- **Seal reference 229**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Imperial College Healthcare NHS Trust.

- **Seal reference 230**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for London Ambulance Service NHS Trust.

- **Seal reference 231**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Barnet Enfield and Haringey Mental Health Trust.

- **Seal reference 232**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Northern Lincolnshire and Goole NHS Foundation Trust.

- **Seal reference 233**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Coventry and Warwickshire Partnership NHS Trust.

- **Seal reference 234**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Milton Keynes University Hospitals NHS Foundation Trust.

- **Seal reference 235**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Stockport NHS Foundation Trust.

- **Seal reference 236**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for University Hospitals Morecambe Bay.

- **Seal reference 237**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for North East London Mental Health Trust.

- **Seal reference 238**: As authorised by the interim Chief Executive Officer and the Vice Chair on 17 October 2023 in respect of the ELFS novation of contract for North West Ambulance Service NHS Trust.

- **Seal reference 239**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Locala Community Partnership CIC.

- **Seal reference 240**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Greater Manchester Integrated Care Board.

- **Seal reference 241** As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Tameside and Glossop IC NHS Foundation Trust.

- **Seal reference 242**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for University Hospitals of North Midlands NHS Trust.

- **Seal reference 243**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for North East London NHS Foundation Trust.

- **Seal reference 244**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Whittington Health NHS Trust.

- **Seal reference 245**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Birmingham Community Healthcare NHS Foundation Trust.

- **Seal reference 246**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Moorfields Eye Hospital NHS Foundation Trust.

- **Seal reference 247**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for University Hospitals Dorset NHS Foundation Trust.

- **Seal reference 248**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Hertfordshire Community NHS Trust.

- **Seal reference 249**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for GSPV Limited.

- **Seal reference 250**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Cosmo Graphis Imaging Limited.

- **Seal reference 251**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Hornbill Service Management Limited.

- **Seal reference 252**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for AOB Financial Solutions.

- **Seal reference 253**: As authorised by the interim Chief Executive Officer and the Chair on 17 October 2023 in respect of the ELFS novation of contract for Audit Partnership Limited.

- **Seal reference 254**: As authorised by the interim Chief Executive Officer and the Chair on 02 November 2023 in respect of the Rosemere Cancer Foundation supplemental Deed of Declaration.

- **Seal reference 255**: As authorised by the Chief Executive Officer and the Chair on 23 January 2024 in respect of the Blackburn Renal Centre Consultants Deed of Warranty with (1) C2C Consulting Engineers Limited, (2) Sandycroft Construction Limited, (3) Diaverum UK Limited and (4) Lancashire Teaching Hospitals NHS Foundation Trust.

- **Seal reference 256**: As authorised by the Chief Executive Officer and the Chair on 23 January 2024 in respect of the Blackburn Renal Centre Building Contractors Deed of Warranty with (1) Sandycroft Construction Limited, (2) Diaverum UK Limited and (3) Lancashire Teaching Hospitals NHS Foundation Trust.

- **Seal reference 257**: As authorised by the Chief Executive Officer and the Chair on 23 January 2024 in respect of the Blackburn Renal Centre Building Contractors Deed of Warranty with (1) Hopkins Coats Associates, (2) Sandycroft Construction Limited, (3) Diaverum UK Limited and (4) Lancashire Teaching Hospitals NHS Foundation Trust.

- **Seal reference 258**: As authorised by the Chief Executive Officer and the Chair on 23 January 2024 in respect of the Blackburn Renal Centre Building Contractors Deed of Warranty with (1) Christopher Taylor Design Limited, (2) Sandycroft Construction Limited, (3) Diaverum UK Limited and (4) Lancashire Teaching Hospitals NHS Foundation Trust.

- **Seal reference 259**: As authorised by the Chief Executive Officer and the Chair on 23 January 2024 in respect of the lease relating to offices 17,18 and 19, Croston House, Lancashire Business Park, Leyland with Lancashire County Development (Property) Limited.

- **Seal reference 260**: As authorised by the Chief Executive Officer and the Chair on 20 February 2024 in respect of the Blackburn Renal Centre Construction Documents with (1) Further Collateral Warranty Consultants, (2) Ellis Hilman Partnership Limited and (3) Diaverum UK Limited.

1.2 The arrangements for the use of the Common Seal are set out in section 10 of the Foundation Trust's Standing Orders. The transactions are set out in the Register of Use of Common Seal which is held by the Office of the Company Secretary.

2. Financial implications

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

3. Legal implications

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

4. Risks

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

5. Impact on stakeholders

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

6. Recommendations

It is recommended that the Board of Directors receive the report and note the contents for information.

Board of Directors Report

Governor Election 2024			
Report to:	Board of Directors	**Date:**	4 April 2024
Report of:	Company Secretary	**Prepared by:**	J Leeming
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to confirm the results of the 2024 election to the Council of Governors. The governor election process is an annual process carried out in line with the Trust's Constitutional requirements and in accordance with Model Election Rules as published by NHS Providers. The election was conducted by Electoral Reform Services who acted as Returning Officer on behalf of the Trust.

For the 2024 governor election, there were eight vacancies in the public constituency and four vacancies in the staff categories of non-clinical, doctors and dentists, unregistered healthcare and support workers, and other healthcare professionals/healthcare scientists. As there was only one candidate for doctors and dentists, this was elected to uncontested and a copy of the report is included. The results of the election, declared on 22 March 2024, are included in the report for information. A copy of the Report of Voting from the Returning Officer is attached which includes the list of candidates elected and a breakdown of voting.

The new governors will be attending their first meeting of the Council of Governors on 16 April 2024 and will be undergoing induction into their new roles over the coming weeks. One governor has also been re-elected for the period 1 April 2024 to 31 March 2027.

It is recommended that the Board of Directors receive the report and note the results of the 2024 Governor election 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

1. Introduction

The governor election process is an annual process carried out in line with the Trust's Constitutional requirements and in accordance with Model Election Rules as published by NHS Providers. The election was conducted by Electoral Reform Services who acted as Returning Officer on behalf of the Trust.

For the 2024 governor election, there were eight vacancies in the public constituency and four vacancies in the staff categories of non-clinical, doctors and dentists, unregistered healthcare and support workers, and other healthcare professionals/healthcare scientists. As there was only one candidate for doctors and dentists, this was elected to uncontested, and a copy of the report is included. The results of the election, declared on 22 March 2024, are included in the report for information. A copy of the Report of Voting from the Returning Officer is attached which includes the list of candidates elected and a breakdown of voting.

The new governors will be attending their first meeting of the Council of Governors on 16 April 2024 and will be undergoing induction into their new roles over the coming weeks. One governor has also been re-elected for the period 1 April 2024 to 31 March 2027.

2. Outcome of the 2024 Election to the Council of Governors

The outcome of the 2024 governor election is confirmed as follows:

CONTEST: PUBLIC

The following candidates were elected:

Liz Bamber
Pav Akhtar
Carole Cochrane
Graham Robinson
Christine Pownall
Louise Tudor
Angela Kos
Philip Curwen

ELECTED: STAFF

Lesley Purcell (Non-Clinical)
Tom Ramsay (Other Health Professionals and Healthcare Scientists)
Christopher Heap (Unregistered Healthcare and Support Workers)
Teik Chooi Oh (Doctors and Dentists)

3. Financial implications

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

4. Legal implications

The election process has been conducted in line with the Trust's Constitution and the Model Election Rules published by NHS Providers.

5. Risks

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

6. Impact on stakeholders

Stakeholders will be advised of the outcomes of the elections.

7. Recommendations

It is recommended that the Board of Directors receive the report and note the results of the 2024 governor election for information.

Excellent care with compassion

Trust Headquarters

Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors

Maternity and Neonatal Services Update			
Report to:	Board of Directors	**Date:**	04th April 2024
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to provide the Board of Directors with an update in relation to safe staffing and the safety and quality programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) within the maternity and neonatal services up until February 2024. This was discussed in detail at Safety and Quality committee in March 2024.

The perinatal quality surveillance outcomes (PQSO) tables have been split by indicator type for the first time to provide clarity of understanding of clinical outcomes and key safety intelligence across the continuum. Safe staffing, clinical indicators, perinatal quality experience, regulation and clinical escalation are detailed to provide both the specified minimum data set requirements and additional local level indicators required by NHS England.

The fill rates for Registered Midwives (RM) is 86% day and 87% night and Maternity Support Workers (MSW) fill rate is75% day and 95% at night in February 2024. Despite this, all intrapartum areas reported 100% compliance to one-to-one care and the coordinator retained supernumerary status 100% of the time. All shifts continue to be sent to bank and agency. The risk related to reduced fill rate is mitigated through the use of divert procedures and by prioritising obstetric work with the movement of teams through services. Positively, when comparing the sickness rates this quarter to the last quarter there has been improved position of 2.6%.

The outstanding Birthrate plus safe staffing uplift continues to present a risk to the service. A solution to funding has not yet been identified, however, a phased approach to this has been proposed by the Chief Nursing Officer and Divisional Midwifery and Nursing Director and will form part of the financial pressure's discussion. This proposal prioritises support staff to address the increased risk of turnover of RM, whilst RM recruitment takes place. This would lead to a required investment of £487,794 for 9.91 WTE of support staff in phase 1. Phase 2 RM staffing would then be addressed in 2025, by which time the existing vacancy for RM would aim to be in an improved position. This will be considered by the Board of Directors in April 2024.

Red flags reported this month include those associated with delay in time critical activity, delay in obstetric review, delay in augmentation of labour and deferred community visits. This reflects the pressure points within the service. The trend in reporting is consistent and is demonstrating the areas of pressure within the service which correlates to reduced staffing levels in midwifery and funding gaps in the obstetric workforce. (Appendix 7)

The perinatal quality surveillance tables indicates antenatal booking performance and the antenatal as an area that requires improvement and places the Trust as an outlier compared to regional peers. An improvement plan has been developed to address this and progress against this will be reported as part of this report. In February 2024, the service reported 2 incidents of moderate harm or above, of these incidents there was one case of therapeutic cooling in a term infant, in line with guidance, has been referred for external investigation by the maternity and neonatal safety investigation branch (MNSI). The second incident of moderate harm was of an unexpected term admission to the neonatal unit for birth trauma and a review of this has commenced.

Recommendation

The Board of Directors are asked to:

i. Receive the contents of the report for information.

All appendices are listed, as follows:

1. Progress Tracker MBRRACE MIS 1
2. PMRT Cases MIS 1
3. ATAIN Dashboard MIS 3
4. Training Compliance MIS 8
5. Safety Champions Action Log MIS 9
6. MNSI Tracker MIS 10
7. Red Flags

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work and present the monthly staffing position within the maternity and neonatal services. The report also triangulates workforce information with safety, patient experience and clinical effectiveness indicators for Board assurance and oversight. The report details positive performance but will mainly focus on areas where action is required.

2. MATERNITY INCENTIVE SCHEME (MIS)

The Year 5 CNST MIS has closed with the Trust declaring compliance against all 10 safety standards. However, there is an expectation that programmes of work will continue to be shared in line with the ongoing reporting requirements of CNST and that the Board will continue to oversee specific reports.

As part of the cycle of business, reports and associated action plans will continue to be brought periodically and the requirements for reporting adjusted once the technical guidance and standards for year six of the CNST MIS have been published. Updates are anticipated April 2024.

A summary of the 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, 3, 8 and 10 are included in appendices for continued oversight.

3. THE PERINATAL QUALITY SURVIELLENCE DASHBOARD

The perinatal quality surveillance model was developed by NHS England to ensure maternity services monitor set parameters overtime in relation to key safety indicators. The perinatal quality surveillance outcomes (PQSO) table has been split by indicator type for the first time. It is intended that presenting the data by category will provide a clearer interrogation and understanding of the position and therefore risk. Although obstetric and neonatal outcome data is reported separately, several parameters are included to provide triangulation of performance metrics.

Table 3: Perinatal Quality Clinical Safety Indicators March 2023 to February 2024. (MIS Standard 9)

Metric	Red flag		Green flag		March 23	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
CNST 10 Key safety actions (Year 5 scheme)					100%	100%	100%	40%	40%	60%	60%	80%	90%	100%	100%	100%
CQC Rating Overall					Good	Good	Good	Good	Good	Good	Good	Good	RI	RI	RI	RI
Clinical Safety Indicators																
Births					376	298	339	371	362	369	352	344	327	315	377	334
Total stillbirths represented as a number. New Dec 23													3	1	0	0
Total stillbirth rate (per 1,000 births)	>	4.9	≤	4.9	5.3	3.4	2.9	0.0	2.8	5.4	2.8	2.9	9.2	3.2	0	0
Stillbirth rate excluding termination for fetal abnormality					5.3	3.4	2.9	0.0	2.8	5.4	2.8	2.9	9.2	3.2	0	0
Examination of the newborn completed within 72 hours	<	95%	≥	95%	94.7%	95.6%	96.2%	95.7%	96.7%	96.5%	92.6%	95.1%	93.5%	95.2%	95.8%	96.4%
Breastfeeding initiation	<	70%	≥	70%	82.9%	79.8%	76.3%	77.6%	79.8%	77.9%	76.1%	78.4%	74.7%	80.3%	76.4%	77.8%
Booked by 9+6	<	50%	≥	50%	47.3%	42.2%	51.5%	51.3%+	47.4%	48%	30.3%	32.5%	35.1%	52%	48.4%	Awaited
Booked by 12+6	<	90%	≥	90%	88.9%	83.3%	92.7%	90.3%	48%	85.5%	81.5%	83.1%	87.3%	92.3%	90.3%	Awaited
Women giving birth in a midwife-led setting	<	25%	≥	30%	15.1%	16.6%	14.2%	15.8%	15.2%	14.2%	12.5%	14.8%	16.3%	11.9%	14.4%	12.8%
Home birth	<	1.7 %	≥	2.0%	2.1%	3.7%	3.2%	2.4%	2.5%	3.3%	2.3%	2.9%	3.7%	1.6%	1.6%	2.1%
Incidence of severe tears grade 3 and above	≥	2.4 %	<	2.4%	2.8%	2.3%	1.5%	2.7%	2.6%	1.8%	2.9%	3.0%	4.6%	1.1%	4.0%	2.1%

3.1 STILLBIRTH

The stillbirth rate continues to be monitored monthly by maternity Safety and Quality Committee. For 2 consecutive months in January and February 2024, the stillbirth rate was 0 per 1000 births.

3.2 BOOKING BY 9+6 WEEKS

NICE recommends first booking by 10+0 weeks of pregnancy to ensure timely and appropriate antenatal sickle cell and thalassaemia screening by the same gestation and first trimester screening by 14+2. Staffing pressures in Quarter 4 continue to have had a detrimental impact on the ability to achieve and sustain performance and has also resulted in reduced choice and patient experience. Additional bank and agency shifts have been generated to support staffing gaps with an aim to improve the position and performance.

An early bird booking (Part A) test of change within 2 midwifery teams has commenced in March 2024. The trial for 3 months aims to streamline the booking process, which will in turn will increase available capacity for (Part B) of the midwifery booking. Early referral for ultrasound during part A will ensure more timely screening can be achieved.

It is anticipated that if agreed, the maternity support uplift recommended by birthrate plus would enable this to be rolled out across the service and would mitigate some of the risks identified. The proposed service annual staffing review and professional judgement has included an uplift the band 2 and 3 Maternity Support Workers (MSW) and specialist portfolio and the outcome of the financial planning round is awaited.

4. PERINATAL QUALITY EXPERIENCE AND REGULATION

Table 4 Perinatal Quality Experience and Regulation March 2023-February 2024 (MIS Standard 9)

Metric	Red flag	Green flag	March 23	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
Perinatal Quality Governance Experience and Regulation														
Incidents of moderate harm and above	--	--	2	0	0	3	0	3	2	3	6	3	1	2
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened.	--	--	1	0	0	0	0	0	2	2	1	0	1	1
Complaints	--	--	2	2	2	2	1	2	2	3	3	1	2	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	2	1	0	0	0
Maternal Death	> 1	<1	0	0	2	0	0	0	0	0	0	0	0	0

Table 4 details above provides the data of harm incidents, external investigation, CQC and regulations issued. The maternity serious incidents continue to be reported to Safety and Quality Committee and a bi monthly report is received by the Board of Directors to provide detailed oversight of all serious incidents and associated learning.

4.1 MODERATE HARM OR ABOVE INCIDENTS

In the Month of February 2024, the service reported 2 incidents of moderate harm or above, of these incidents there was one case of therapeutic cooling in a term infant. Following commencement of therapeutic cooling, the baby's clinical condition deteriorated and after discussion with the parents, a decision was made to reorientate the baby's care to palliative and the baby sadly died. The case has been referred for external investigation by the maternity and neonatal safety investigation branch (MNSI). The second incident of moderate harm was of an unexpected term admission to the neonatal unit for birth trauma following an instrumental birth. Duty of candour has been provided to the family and investigation of the incident is ongoing.

4.2 MATERNITY AND NEONATAL SAFETY INVESTIGATION

Details of all Maternity and Neonatal Safety Investigation (MNSI) referrals are included within appendix 6. In February 2024, there was one case referred to MNSI, this was a case of therapeutic cooling in a term infant as detailed above. There were no ongoing cases concluded.

5. SAFE STAFFING INDICATORS

The service has a vacancy rate of 13.14 WTE (midwives, band 5-7) this includes maternity leave. The service continues to recruit to maternity leave to cover the shortfall. Despite a rolling programme of ongoing recruitment to all vacancies, there continues to be a risk associated with the inability to recruit to all vacancies compounded by a higher sickness absence rate, albeit there has been an improvement noted. Alternative approaches and long-term options are being explored by the services to include apprenticeships and clinical specialist roles to manage and mitigate the ongoing shortfall. The maternity service also has a

workforce plan which details the ongoing actions for recruitment and retention. This has been shared in previous reports and will be updated in future reports.

The outstanding Birthrate plus safe staffing uplift continues to present a risk to the service. A solution to funding has not yet been identified, however, a phased approach to this has been proposed by the Chief Nursing Officer and Divisional Midwifery and Nursing Director and will form part of the financial pressure's discussion. This proposal prioritises support staff to address the increased risk of turnover of Registered Midwives, whilst Registered Midwife recruitment takes place. This would lead to a required investment of £487,794 for 9.91 WTE of support staff in phase 1. Phase 2 Registered Midwife staffing would propose to be addressed in 2025 by which time the existing vacancy for RM would aim to be in an improved position. This will be considered by the Board of Directors in due course.

Table 5 details the midwifery and nurse staffing indicators that are monitored by the service monthly. (MIS standard 5)

Metric	Red flag	Green flag	March 23	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
Safe Staffing Indicators														
One-to-one care in labour in Delivery Suite.	< 100 %	= 100%	99.7%$	99.2%	97.6%	100%	100%	100%	99.5%	100%	100%	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%	100%	100%
Supernumerary status of DS coordinator	< 95%	= 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Births per Funded Clinical Midwife WTE	>28	≤26	25	21	23	24	26	25	24	23	23	21	25	24
Neonatal Nurse Staffing compliance to BAPM (Badger Net report)	<90%	>90%					90%	98%	65%	69%	93%	77%	97%	Awaited
Staff sickness rate	4%	4%	8.6%	7.9%	8.47%	8.6%	8.7%	8.8%	8.6%	9.0%	9.2%	6.9%	6.3%	5.9%
Fill rate RM Day	<85%	>85%	81%	82%	NA	93%	95%	91%	74%	79%	84%	84%	87%	86%
Fill rate MSW Day	<85%	>85%	71%	73%	NA	93%	90%	86%	76%	74%	79%	71%	77%	75%
Fill rate RM Night	<85%	>85%	90%	97%	92%	90%	84%	82%	82%	81%	87%	87%	89%	87%
Fill rate MSW Night	<85%	>85%	95%	100%	94%	89%	91%	100%	94%	98%	100%	98%	98%	95%
Registered Midwife shifts sent to agency per month.	--	--	152	107	110	110	127	127	146	146	151	152	121	142
Registered Midwife Agency hour fill rate percentage.	--	--	51%	51%	46%	45%	39%	49%	42%	42%	52%	51%	64%	42%
Maternity Triage BSOT standard (15min)			86%	94%	90%	91%	93%	89%	91%	92.4%	89.4%	94.6%	89%	93%
Maternity Triage NICE standard (30 min)			94%	99%	98%	98%	98%	98%	97%	97%	97%	100%	95.7%	99%

5.1 SICKNESS ABSENCE MANAGEMENT

Sickness absence rates across the service has been higher than the Trust standard of 4% for over 12 months. In the month of February 2024, the sickness absence rate was 5.9%. This is the 3rd consecutive month where a steady reduction in sickness in the cohort of maternity has been demonstrated. When comparing this quarter to the last quarter there has been improved position of 2.6%. Intensive work continues with the workforce partners with divisional oversight to review long and short-term absence and a work force people plan is in place.

5.2 ONE TO ONE CARE

The ability for midwives to provide one to one care in labour and the supernumerary coordinator status is monitored each month by intrapartum care location and provides a reference point which is then used with other metrics to identify potential pressure points. In February 2024 all intrapartum areas reported 100% compliance to one-to-one care and the coordinator retained supernumerary status 100% of the time. This data is triangulated reviewed and validated each month to ensure accuracy of reporting.

5.3 FILL RATES

Registered Midwifery fill rate is 86% in the day and 87% at night and maternity support worker fill rates are 75% in the day and 95% at night. The fill rates continue to be monitored monthly. As part of responding to the continued reduced staffing establishment within the unit, attendance at the daily huddles and LMNS staffing calls support continued oversight of the ongoing pressures. Divert arrangements are utilised when appropriate to do so and whilst this mitigates the risk to women, when it occurs, it can adversely affect the experience of women who live locally and are required to access care with an alternative provider within Lancashire and south Cumbria.

5.4 MATERNITY TRIAGE

Review within 15 minutes by a midwife (Birmingham Specific Obstetric Triage System (BSOTS standard) and in 30 minutes (NICE Guidance) continue to be audited and monitored by the service monthly. In February 2024 93% of women were seen by a midwife within 15 minutes and 99% were seen within the 30-minute timeframe specified by NICE.

The Royal College of Obstetricians and Gynaecologists (RCOG) has published a new Good Practice Paper providing recommendations for maternity triage operational structure and pathways, to support safe care of pregnant and newly postnatal woman and people outside of scheduled appointments. A benchmarking document is being collated by the service to measure compliance to the new standards. Significant work has already been undertaken to meet the BSOTS recommendations and the service acknowledges the financial investment already undertaken of the Board of Directors. The benchmarking will identify any areas of focus and will inform future deployment of resources and prioritisation of additional requirements. The outcome will be shared as part of the bi-annual staffing paper due in April 2024.

6. OBSTETRIC/NEONATAL MEDICAL INDICATORS

Table 6 Obstetric/neonatal and medical indicators (MIS standard 4)

Metric	Red flag	Green flag	March 23	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
Obstetric Medical Staffing														
Number of Consultant hours on obstetric unit	<70 hrs	=/> 96.5hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs
BAPM Neonatal medical staffing consultant vacancy	n=9													2.0
BAPM Neonatal medical staffing Tier 1 vacancy rate	n=7													1.4
Compliance to BAPM Neonatal medical staffing Tier 2 vacancy rate n=7	n=7													1.0
RCOG obstetric benchmarking compliance	<100%	100%	94%	100%	100%	100%	91%	100%	100%	100%	91%	98.4%	100%	100%
24-hour acute obstetric medical staffing fill rate	<95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Progress to achieve 96.5-hour cover for acute obstetrics is ongoing and 2 further obstetric positions have been recruited to in January 2024. One for complex obstetrics and the second to support maternal medicine. To meet the requirement for 96.5-hour cover, a further 2 consultants are required. Neonatal medical staffing has been added to track vacancies and ongoing progress against the achievement of the standards applied by the British Association of Perinatal Medicine (BAPM) related to the neonatal medical workforce. Recruitment plans are in place and business case proposals are in progress and the outcome awaited.

Ongoing monitoring of compliance related to consultant attendance for the clinical situations listed in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' continues. Local audit confirms that there was 100% compliance against the standard in February 2024. In addition, the service confirms that it was able to cover the acute service 100% of the time. It should be noted that prioritisation of the acute service continues and that other rostered duties, specialist PA time and study sessions may be deferred as required to maintain safe obstetric acute care.

7. CLINICAL ESCALATION SAFETY INDICATORS

Table 7 details the clinical escalation performance over time to include March 2023- February 2024

Metric	Red flag	Green flag	March 23	April 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
Clinical Escalation														
Maternity Diverts	> 1	<1	0	0	0	0	1	0	2	0	0	0	0	0
Women who transfer to an alternative provider during induction of labour (New Jan 24) Internal mutual aid.	--	--												2
In- utero transfers declined to accept from other units (maternity)	--	--	2	0	2	5	4	5	5	5	3	2	2	2
In- utero transfers declined to accept from other units (NICU)	--	--	0	2	1	1	2	0	4	10	4	4	3	2
In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)	--	--	0	0	10	0	0	1	1	0	0	0	0	2
Provision of a Transitional Care Nurse for TC (new Feb 24														5
NICU Closure	> 1	<1	2	5	13	1	1	0	1	2	0	2	1	6

7.1 INTRAUTERINE TRANSFER (IUT) NEONATAL AND MATERNITY

In total the number of Intrauterine Transfers (IUT)'s declined by the maternity and neonatal service was 4 (2 due maternity service pressures and 2 due to neonatal service capacity or staffing). 2 women were also transferred to another provider due to lack of a neonatal cot availability.

Due the high acuity and increased intensive cot requirements associated with birth of triplets and several other cases, there were 5 occasions where there was limited availability of a transitional nurse. During times of high acuity, a risk assessment is undertaken to confirm whether care could be facilitated by the postnatal midwife or neonatal nursery nurse. This was only undertaken within the scope of safe practice.

7.2 CLOSURES OR DIVERTS

In the month of February 2024 there were no maternity diverts however, there were six instances of neonatal unit closure. The service acknowledges the temporary and ongoing reduction in intensive care cot capacity as

result of a requirement to undertake critical electrical upgrades. Capital funding has been prioritised to support this work. It is expected this will be completed within 10 weeks.

7.3 DELAYS IN INDUCTION OF LABOUR

To demonstrate the ongoing impact of established vacancies, the uptake of mutual aid during the induction of labour process is included in table. During times of high acuity, women who require induction or who are being induced but are delayed, are offered transfer to alternative providers for augmentation of labour. Whilst mutual aid is part of the North West clinical escalation policy and is usually facilitated within the Lancashire and South Cumbria region, the impact of transfer should not be underestimated. In February 2024 there were 2 women booked with the service who transferred their care due to reduced midwifery staffing. This action was taken to prevent delay in the induction process and in response to a clinical need to maintain safe care.

7.4 RED FLAGS

The incidence of maternity red flags continues to be monitored by the maternity service. In addition, the red flags are added to the associated risks on the register for additional oversight by the Division. The service reported 170 red flag Datix incidents in the month of February 2024. The breakdown by category is provided in appendix 7. The highest number of red flags reported was a delay in time critical activity, followed by deferred community postnatal visits, delay in obstetric review within 30 minutes in triage and delay in transfer for artificial rupture of membranes (induction). This data is demonstrating the areas of pressure within the service and correlates to reduced staffing levels in midwifery. It also emphasises the requirement to invest in obstetric staffing to meet the standards for a 2-tier rota and 96.5-hour cover.

8. SAFETY CHAMPIONS

The safety champions bi-monthly meetings and monthly safety walk rounds provide valuable, first-hand source of safety intelligence that is used to consider when actions or response is required so that executive members can appraise the Trust Board of the findings. A face-to-face visit was undertaken to the early pregnancy service on the 20 February 2024. Staffing establishment at weekend, environmental improvements and ring fencing a private space for women who require admission following pregnancy loss were discussed and raised by the team. Several actions have been commenced in response to staff feedback and the latest action tracker is included in appendix 5.

9. 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 the position against the workstreams set out by the CNST NHS Resolution for year 5 and confirms that the year 6 standards are awaited.

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 for first trimester ultrasound remain an area of improvement focus. 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 red flag reporting also indicates pressure points in the induction of labour pathway, postnatal care and timely review in triage and this must be acknowledged.

The outstanding Birthrate plus safe staffing recommendation has been adjusted to reflect a phased approach and the proposal is included as part of the safe staffing report scheduled for the April Board.

10. RECOMMENDATION

The Board of Directors are asked to:

i. Receive the contents of the report for information.

APPENDIX 1 MIS Safety Action 1 Updated position May 2023 to March 2024

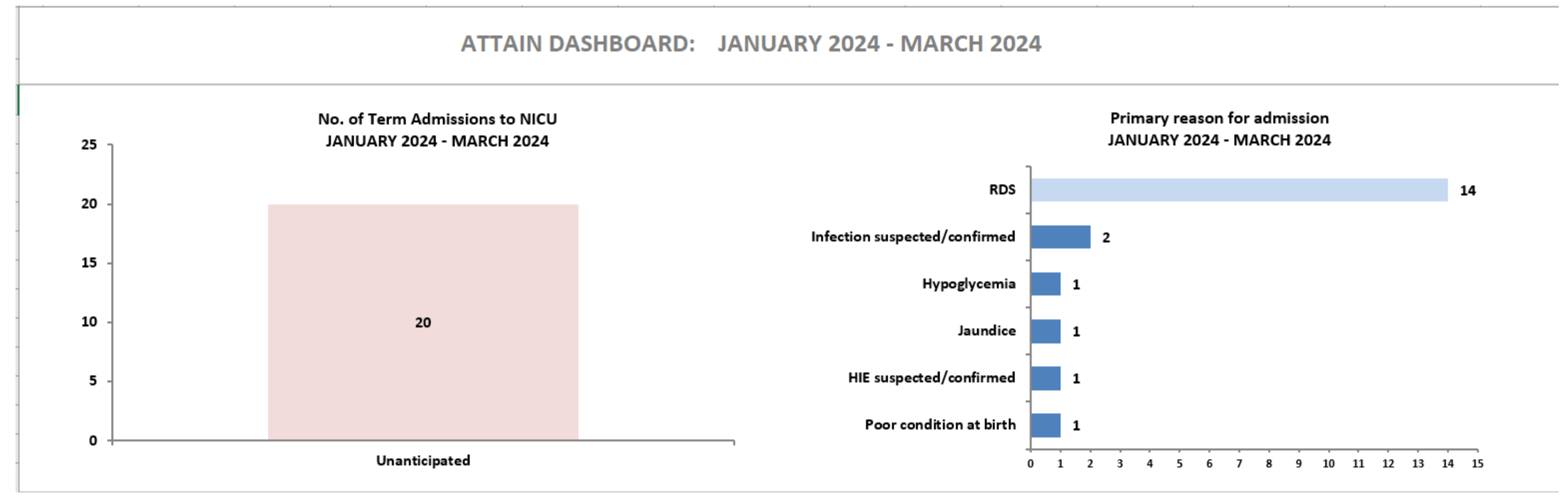
Safety Action 1 (Standard A) *	Compliance score		RAG
i. All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	**Notification**	**19/19**	
	Surveillance	**17/17**	
Safety Action 1 (Standard B) *			
i. For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	**On track**	**17/17**	
Safety Action 1 (Standard C) *			
i. For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months	**On track**	**Commenced with 2 months. 17/17**	
		Completed within 4 months: 17/17	
		Completed within 6 months: 17/17	
Safety Action 1 (Standard D) *			
i. Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023 onwards that include details of all deaths reviewed, thematic learning and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**April 2023**		
	July 2023		
	September 2023		
Neonatal Deaths			
I. The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death	**9/9 on track**		
II. Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information.	**9/9 on track**		

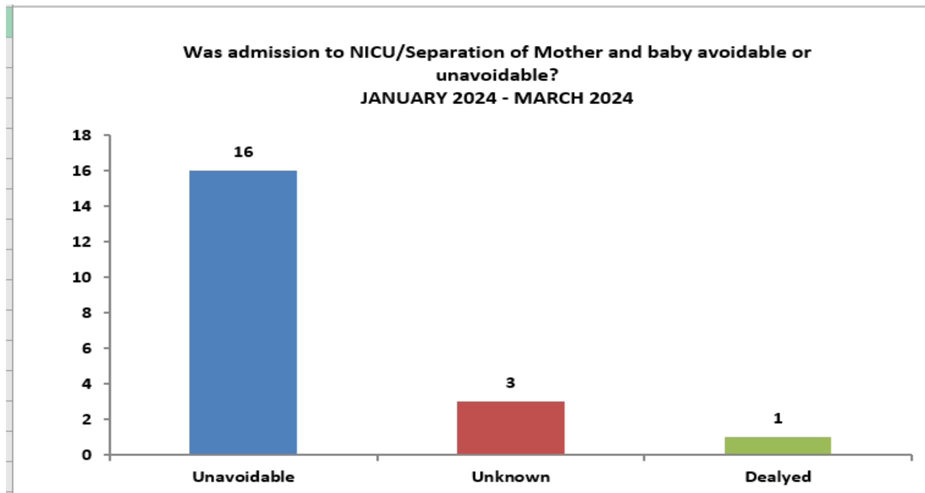
Appendix 2 PMRT MIS 1 Tracker CNST Year 5

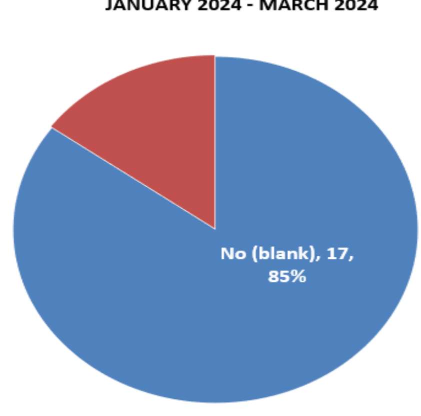
ID (Datix/PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report drafted within 4 months	Actions ongoing
125023	33+1	Neonatal death	IUT from BVH. Antenatally diagnosed fetal anomaly.	Yes	88023	Yes	Yes	PMRT has been completed, care graded as B, B, C. Ongoing 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	Review commenced.
133056	24+1	Antepartum stillbirth	Early onset fetal growth restriction. Antenatally Trisomy 18 suspected.	Yes	89093	Yes	Yes	Review commenced
135345	28+4	Antepartum stillbirth	Early onset fetal growth restriction -declined delivery at earlier gestation.	Yes	89276	Yes	Yes	Review commenced
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 review to convened.
141893	36+3	Antepartum stillbirth	Admitted with vaginal bleeding and pain. No fetal heart could be auscultated on admission. Clinically unstable, transferred to theatre for delivery by caesarean section. Placental abruption confirmed at caesarean section. Total blood loss 5300mls.	Yes	90390	Yes	Yes	Consideration being given for additional investigation with PSII.
142732	36+2	Antepartum stillbirth.	Admitted with vaginal bleeding and pain. No fetal heart could be auscultated on admission. Transferred to theatre for delivery by caesarean section.	Yes	90548	Yes	Yes	Review commenced

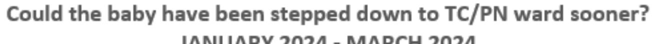
143530	28+6	Antepartum stillbirth	Attended with reduced fetal movements. No fetal heart could be auscultated on admission.	Yes	90662	Yes	Yes	Villous infarction identified on the placental histology report which was reported to be a clinically significant finding.
150075	24+5	Neonatal death	In-utero transfer from BVH for level three neonatal care.	Yes	91767	Yes	Yes	Review commenced
151211	39+3	Neonatal death	Compassionate reorientation of care following the initiation of therapeutic cooling treatment.	Yes	91936	Yes	Review ongoing, deadline not yet met.	Referred to MNSI for external investigation. StEIS reported. Formal DOC provided to the family.
151421	22+6	Neonatal death	Triplet 2. Extreme prematurity.	Yes	91959/2	Yes	Review ongoing, deadline not yet met	Review commenced

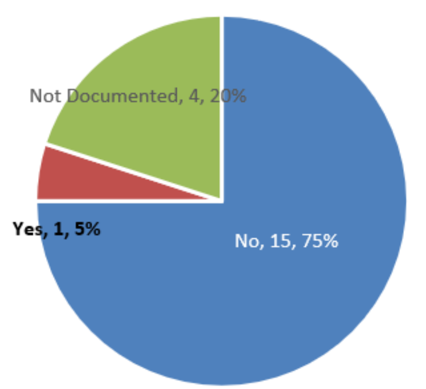
APPENDIX 3 MIS 3 ATAIN DASHBOARD



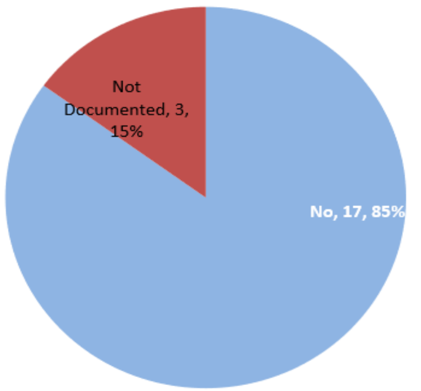




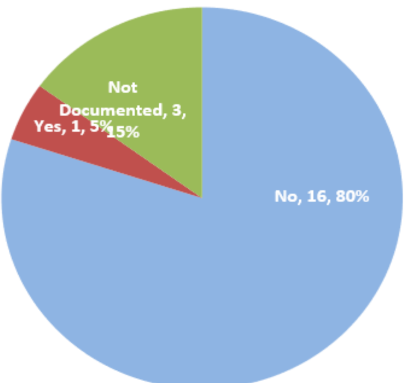


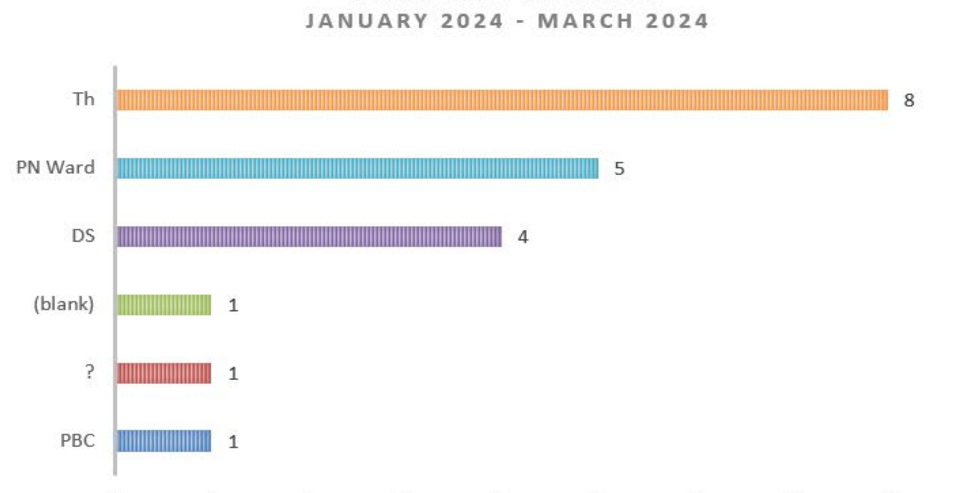


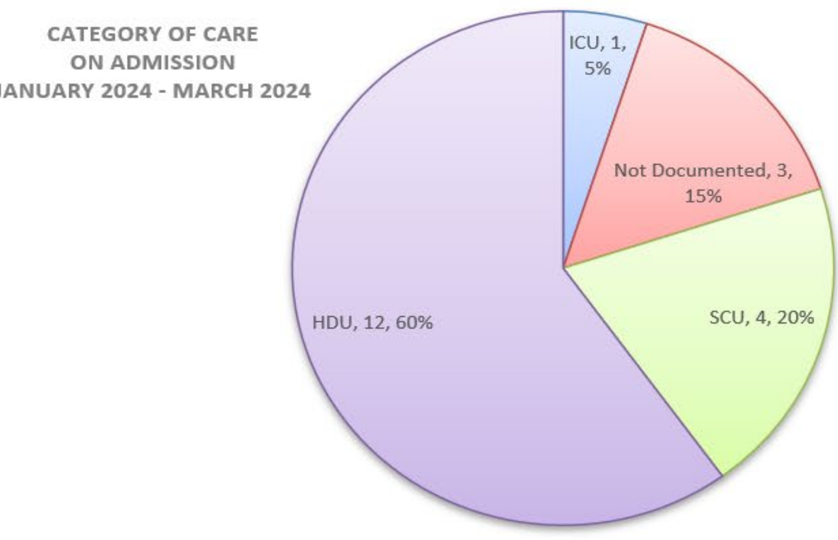
Was baby admitted to NICU for NGT feeding?
JANUARY 2024 - MARCH 2024



Did baby remain on NICU for NGT feeding?
JANUARY 2024 - MARCH 2024




ADMISSION LOCATION
JANUARY 2024 - MARCH 2024
Th
PN Ward
DS
(blank)
?
PBC
8
5
4
1
1
1
0
1
2
3
4
5
6
7
8
9


CATEGORY OF CARE
ON ADMISSION
JANUARY 2024 - MARCH 2024
ICU, 1, 5%
Not Documented, 3, 15%
SCU, 4, 20%
HDU, 12, 60%

APPENDIX 4 TRAINING COMPLIANCE MIS 8

Training Compliance by Staff Group 29/02/2024 (February figures)

	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	**94 %** *166 compliant out of 176*	**100%** *12 compliant out of 12*	**100%** *18 compliant out of 18*	**95%** (Same) *196 compliant out of 206*
Fetal Monitoring training Attendance at full day fetal monitoring training	**100 %** *171 compliant out of 171*	**100%** *12 compliant out of 12*	**100%** *18 compliant out of 18*	**100%** (Increase 1%) *201 compliant out of 201*
CTG Equipment	**100 %** *171 compliant out of 171*	**100%** *12 compliant out of 12*	**100%** *18 compliant out of 18*	***100%*** (Increase 1%) *201 compliant out of 201*
GAP/GROW	**90%** *158 out of 176*	**100%** *12 out of 12*	**89%** *16 out of 18*	**90%** (Same) *186 compliant out of 206*
Human Factors (attended PROMPT or fetal monitoring)	**100%** *176 out of 176*	**100%** *12 out of 12*	**84%** *21 out of 25*	**98%** (Same) *209 compliant out of 213*

	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETISTS	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT)	**94%** 166 out of 176	**100%** 12 out of 12	**84%** 21 out of 25	**96%** 25 out of 26	**98%** 48 out of 49	**94%** (Same) *272 compliant out of 288*
Pool Evacuation	**98%** *172 out of 176*	**83%** *10 out of 12*	**84%** *21 out of 25*	**85%** 22 out of 26	**84%** 41 out of 49	**92%** **(Increase 18%)** 266 out of 288

APPENDIX 5 MIS 9 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. 14.2.24 Action completed. Works agreed for all rest areas.	
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 Northwest 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. 14.2.2024 Outpatient staffing and template review to be considered.	
20/02/24	Face to face visit to EPGAU. Weekend staffing discussed in view of the increasing demand for services at weekend	Executive Safety Champion	1.06.2024	Weekend staffing of the EPGAU to be considered as part of the annual staffing review planned for March 24. Paper being prepared by Chief Nursing Officer	
20/02/24	Finishing touches to EPGAU to be signed off by Charity to ensure environment is reflective of service needs.	Matron for Gynaecology and Baby Beat lead	31.03.2024	20/02/24 Confirmed that Additional baby beat bid had been signed off	
20/02/24	Challenges to ability to ring fence dedicated space for women who require care following baby loss.	Clinical Business Manager	31.03.2024	20.2.24 Paper to be prepared and presented to SOG to request 2 dedicated side room for responsive provision of private care following pregnancy loss.	

APPENDIX 6 MNSI/HSIB CASE MIS 10 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
36750	The mother attended the maternity assessment suite with reduced fetal movements and irregular uterine activity. Fetal heart rate monitoring was commenced which was assessed to be abnormal and a decision was made for category one caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated for 72 hours, the post cooling MRI showed moderate HIE.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes
36837	The mother attended the maternity assessment suite with reduced fetal movements for 24 hours and irregular uterine activity. Fetal heart rate monitoring was commenced which was assessed to be abnormal and the mother was transferred to the delivery suite for intrapartum care. Following transfer to delivery suite the CTG deteriorated, and a decision was made for caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated for 72 hours, the post cooling MRI showed moderate HIE.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes

APPENDIX 7 RED FLAGS

Red flag Reporting Metrics	**Jan 23**	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun 23**	**Jul 23**	**Aug 23**	**Sep 23**	**Oct 23**	**Nov 23**	**Dec 23**	**Jan 24**	**Feb 24**
Delay in time critical activity	2	13	54	22	17	17	50	43	34	38	23	10	28	51
Missed or delayed care> 60 mins in washing or suturing	0	0	1	0	0	1	2	0	0	0	0	1	1	0
Failure for women to receive the medication required.	0	0	1	0	0	0	0	0	0	0	1	0	0	0
>30-minute wait for pain relief.	0	0	1	0	0	0	3	2	3	0	1	0	1	1
Lack of full examination when woman presents in labour.	0	0	1	0	0	0	0	1	1	1	1	0	1	0
>2-hour delay in induction?	1	0	10	1	6	4	30	10	16	10	7	0	23	9
Delay in recognition of and action of abnormal signs.	0	0	2	2	0	0	0	2	0	0	4	0	1	0
Inability to provide one to one care in labour?	0	0	2	0	0	0	7*	0	1	2	1	0	4	1
>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	12	18
>30-minute wait for obstetric triage.	1	1	40	15	15	15	29	29	25	11	10	5	9	15
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	0	0	0	0	0	0	1	0	0	0	1	0	4	1
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)	1	0	7	3	5	3	24	5	15	8	19	0	23	18
Was there a delay in transfer once labour was established? (New parameter Oct 22)	0	0	1	0	0	1	3	1	1	1	1	0	2	1
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)	0	0	0	0	0	0	0	1	0	0	1	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	0	0	0	0	1	0	0	1	0	0	1	0	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	0	0	2	0	1	0	7	1	3	1	1	0	0	1
Has there been any cancelled or delayed community work? (New parameter Oct 22)	0	1	4	1	27	177	31	4	85	14	5	0	28	38
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)												0	19	18
Total numbers of red flags	**5**	**15**	**126**	**44**	**72**	**218**	**187**	**105**	**205**	**103**	**90**	**17**	**156**	**170**