Board of Directors

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

Agenda

At 12.45pm, there will be a **Patient Story** presented by members of the Women and Children's Division

№	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 August 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 (10mins: Q&A)	✓	Information	S Nicholls
8.	Board Assurance Framework	1.20pm (10mins: Disc)	✓	Decision	S Regan
9.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
9.1	Safety and Quality Committee Chair's Report	1.30pm (10mins: Q&A)	✓	Information	P O'Neill
9.2	Maternity Service Annual Staffing Review	1.40pm (5mins: Q&A)	✓	Decision	J Lambert
9.3	Mid-year Safe Staffing Review for Nursing	1.45pm (5mins: Q&A)	✓	Decision	S Cullen
10.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
10.1	Workforce Committee Chair's Report	1.50pm (10mins: Q&A)	✓	Information	U Patel
10.2	Education, Training and Research Committee Chair's Report	2.00pm (10mins: Q&A)	✓	Information	P O'Neill
11.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
11.1	Charitable Funds Committee Chair's Report	2.10pm (10mins: Q&A)	✓	Information	V Crorken
11.2	Finance and Performance Committee Chair's Report	2.20pm (10mins: Q&A)	✓	Information	T Watkinson
11.3	Integrated Performance Report as at 31 August 2024 including Finance update *(considered by appropriate Committees of the Board)*	2.30pm (10mins: Pres) (10mins Q&A)	✓	Assurance	K Foster-Greenwood/ S Cullen/ N Pease/ A Mulholland-Wells

№	Item	Time	Encl.	Purpose	Presenter
12.	**FIT FOR THE FUTURE** (STRATEGY AND PLANNING)				
12.1	Single Improvement Plan	2.50pm (10mins: Pres)	✓	Assurance	A Brotherton
12.2	Trust Strategy	3.00pm (20mins: Pres)	✓	Assurance	G Doherty
13.	**GOVERNANCE AND COMPLIANCE**				
13.1	Audit Committee Chair's Report	3.20pm (10mins: Pres)	✓	Assurance	T Watkinson
13.2	Accountability Framework	3.30pm (10mins: Pres)	✓	Decision	A Brotherton
13.3	Establishment of Trust Management Board	3.40pm (5mins: Pres)	✓	Decision	J Foote
14.	**ITEMS FOR INFORMATION**				
14.1	(a) AHP Safe Staffing Report (b) Data Quality Assurance Report		✓		
14.2	Date, time and venue of next meeting: *5 December 2024, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital*	3.45pm	Verbal	Information	P White

Board of Directors

1 August 2024 | 1.00pm
Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital

Part I

Present:

Mr P White	Chair
Dr T Ballard	Non-Executive Director
Ms V Crorken	Non-Executive Director *(part meeting)*
Ms S Cullen	Chief Nursing Officer
Professor S Nicholls	Chief Executive *(part meeting)*
Professor P O'Neill	Non-Executive Director
Mr U Patel	Non-Executive Director
Dr G Skailes	Chief Medical Officer
Ms K Smyth	Non-Executive Director
Mr T Watkinson	Non-Executive Director
Mrs T Whiteside	Non-Executive Director
Mr J Wood	Chief Finance Officer

In attendance:

Mrs K Brewin	Associate Company Secretary *(minutes)*
Ms L Cook	Specialist Midwife for Maternal Medicine *(minute 124/24)*
Mrs A Brotherton	Director of Research and Continuous Improvement
Mrs N Duggan	Director of Communications and Engagement
Ms K Fielding	Deputy Divisional Nursing Director of Medicine *(minute 124/24)*
Mrs J Foote	Company Secretary
Ms J Lambert	Interim Divisional Nursing and Midwifery Director *(minute 127/24)*
Mr N Pease	Chief People Officer
Mr S Regan	Associate Director Risk and Assurance *(minutes 125/24 and 137/24)*
Ms R Sansbury	Divisional Nursing Director of Medicine *(minute 124/24)*
Mr I Ward	Head of Planning

Governors observing: Margaret France, Janet Miller, Frank Robinson, Graham Robinson,

Observers: Steve Leggett, System C Healthcare
Raj Purewal, C2-Ai

118/24 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.

Board was informed that the Chief Executive would be joining the meeting as soon as possible following attendance at a meeting that needed to take priority. Therefore, the running order of the agenda had changed and the Chief Executive's report would be delivered later in the meeting.

119/24 Chair's report

The report provided a summary of work and activities undertaken during June and July 2024 by the Trust Chair including a resume of the items discussed in the part II and Special Board meetings in June and July.

The Chair referred to the tragic events that had occurred in Southport during the week and offered Board members' condolences to the families following the tragedy. The Board recognised the resulting disorder that followed which added further grief to the families and people within that community. The Trust treated patients from the Southport catchment area therefore people could present at the hospitals for care and treatment. It was also recognised that staff could be affected by the events and should be encouraged to utilise available support services.

120/24 Apologies for absence

Apologies for absence were received from Ms E Ince, and Mr G Doherty.

121/24 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.

122/24 Minutes of the previous meeting

The minutes of the meeting held on 6 June 2024 were approved as a true and accurate record.

An update was requested regarding the Placed-based section to be introduced in the Single Improvement Plan (SIP) as referenced in minute 101/24. It was explained that work had been focused on identifying what specifically was within the Trust's gift to improve and discussions had commenced to identify the key shared priorities with partners as a range of the improvement actions would require system support. An update would be provided within the report to Board once discussions had progressed further. In the meantime, the Chair and Director of Research and Continuous Improvement would discuss and agree outside the meeting how reporting would be structured to provide assurance to the Board and clarity for the public.

123/24 Matters arising and action log

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

124/24 Patient Story

The Board was joined by representatives from the Divisions of Medicine and Women and Children who attended to present the patient story. The story related to a pregnant woman with complex health needs and demonstrated how those needs had been met and how the maternal medicine service would facilitate improved outcomes for complex women closer to home. The story was supplemented by a short video of the patient

describing their journey, the different experiences they had during each of their two pregnancies, and the positive multidisciplinary approach between maternity and the maternal medicine services which had enhanced their experience during the birth of their second child.

During the presentation the Board heard the phrase *'we devised a plan'* and recognising that the person was the expert in their condition, and the importance of keeping them empowered, the Board asked for clarification on how much the person was involved in inputting to the plan. It was explained that the patient had told the team what they wanted and the team worked hard to ensure all their expectations were met, therefore the plan was very much led by the patient who was aware of their limitations and input into the arrangements.

Board members acknowledged the patient-centred nature of the service provided and asked why maternal medicine was so important. The team explained that the demographic was changing with more mature women completing their families, therefore the Trust must be able to offer joined up care to complex women. Maternal medicine co-ordinated what was required and brought together the range of specialists needed to build care around the patient.

The Chair thanked the team for attending to deliver the story and asked that the Board's thanks be passed to the patient and family for allowing their story to be heard.

125/24 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. 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 six strategic risk scores since the June Board meeting and three operational risks remained escalated to the Board relating to exit block (risk ID 25); elective restoration (risk ID 1125); and *C.difficile* infection (risk ID 1157).

The Board was asked to consider and accept escalation of operational risk ID 584 relating to limited provision of the Neurointerventional Service including thrombectomy. It was noted that some progress had been made to work towards a 24/7 service and cover had been provided during commissioned hours (8am to 6pm) however the service remained fragile. A northwest rapid improvement event was planned in September to look at the service across the system. During discussion the Board acknowledged the progress that had been made to manage the risk and agreed that the risk would be monitored by the Safety and Quality Committee.

The Board RESOLVED that:

1. **the updates to the Board Assurance Framework be approved; and**
2. **progress on management of risk ID 584 would be monitored by the Safety and Quality Committee.**

126/24 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee provided an overview of items discussed at the meetings on 31 May and 28 June 2024 based on the 3As methodology

(Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Board was alerted to the continued variation in the ability to deliver a 7-day thrombectomy service as referred to in the previous minute. Two never events had occurred in ophthalmology and were being investigated as part of the Patient Safety Incident Response Framework with early learning identified and acted upon. *C.difficile* infection rates had been discussed including a range of actions to be addressed such as the functionality of the single stack waste system, and the inability to expand beyond 15 areas for full roll-out of the 2021 domestic cleaning standards.

There continued to be higher than expected sickness rates within paediatrics and neonatal services and following referral to the Workforce Committee assurance had been provided that work was ongoing to ensure sickness absence was managed in line with Trust policy. At the time of the Committee meeting the number of boarded patients was reducing and the Board was informed that as of 31 July 2024 there were zero boarded patients.

The Committee received a range of assurance reports providing an overview of areas of strength and areas that required continued focus.

In terms of *C.difficile* infection, Board members acknowledged the impact of the Trust's ageing estate and requested clarification on the barriers to address cleaning standards. It was explained that the barrier was purely financial and was considered at the start of the year as part of financial planning. The team had introduced some mitigations, such as UV light treatment for areas that previously could not be fogged and was exploring the next roll-out in year. The remaining pressure would form part of budget planning for 2025-26. In respect of prioritising resources, discussions had been held with the national lead for infection prevention and control regarding sewage leakage, and the Committee would continue to monitor the position.

127/24 Maternity and Neonatal Services Report

The report provided an update in relation to safe staffing and the safety and quality and assurance and oversight programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) within the maternity and neonatal services up to June 2024. In addition, obstetric medical and neonatal updates had been included in the report for cross triangulation and information, where appropriate. An overview of the contents was provided and it was noted that whilst the service was under pressure it was relatively stable and the position was improving.

It was noted the Board Safety Champion continued to undertake visits to speak to staff and discuss any highlighted concerns and attention was drawn to a couple of matters within the report. Board was informed that the red flags in the report had a direct correlation with staffing levels and the bi-annual safe staffing report would be included in the October Board meeting pack. Reference was made to the thematic Early Notification Review undertaken by NHS Resolution (NHSR) and completed on 29 February 2024 with feedback, outcome and recommendations presented to the Trust on 18 June. A report detailing the actions already taken and the assurance measures that would remain in place was presented to the Safety and Quality Committee on 26 July 2024. It was noteworthy that the team from NHSR was complimentary of staff whom

they met during the review, and the positive comments received regarding the solutions that had been identified including staff 'buy in'.

Clarification was requested regarding the actions being taken in relation to smoking cessation. It was explained that smoking cessation was one of the significant aims for the service and four elements of the safety action remained non-compliant although were on an upward trajectory supported by a range of continuous improvement initiatives. It was noted that some of the actions that had been introduced were new for year 6 and would take time to embed in practice. A smoking cessation service had been introduced and the position would be monitored by the Safety and Quality Committee.

Discussion was held regarding the CQC should do recommendation to improve the culture where staff felt listened to and how that improvement would be evidenced. It was explained that improvements in culture was a continuous process and could not be defined by a national plan. Staff were encouraged to express how they felt and leadership work had been undertaken with key members of the team along with leadership sessions for consultants to help understand different ways of working and encourage time to talk sessions with each other to build stronger working. Clinical escalation workshops had also been embedded. The score survey was about to be explored which would provide an additional snapshot into the mindset of the team and would result in work around the workforce and improvement.

In response to a question regarding Birthrate plus and previous reporting regarding vacancies and the inability to recruit, an update was requested on the current position. It was noted that from a staffing perspective a decision had been taken not to invest in registered midwives and to over offer posts. The Executive Management team had decided to test that approach which had worked well and there would be zero vacancies by September.

The Board RESOLVED that:

1. **the maternity and neonatal services update including the safe staffing position be approved;**
2. **it was satisfied that a comprehensive level of check and challenge had been applied by the Board-level Safety Champion to understand the performance and pressures affecting the maternity and neonatal service; and**
3. **the associated action plans provided the required oversight and assurance.**

The Chief Executive joined the meeting at this point

128/24 Chief Executive's report

The report provided an overview on matters of interest since the previous meeting. In addition, the Chief Executive highlighted the following:

A meeting had been attended earlier in the day with the Chief Finance Officer at NHSE. It was encouraging to hear that the Integrated Care Board (ICB) had provided positive feedback regarding Trust culture when compared to previous years with more grip and granularity in terms of the improvement plan. Appreciation was extended to the Executive Management team and the wider organisation for the work they had undertaken to reach the current position recognising that the organisation needed to make some difficult risk-based decisions in terms of savings, driving out waste and reducing duplication.

Reference was made to the recent announcement from the Chancellor of the Exchequer regarding reviewing public sector spend and how the review related to the New Hospitals Programme (NHP). Informal feedback had been received that the government intended to progress the review quickly and the announcement was not about stopping the programme rather looking at timescales and prioritisation. The issue of land sale had been raised earlier today with the Chief Finance Officer at NHSE who recognised the need to resolve the matter sooner rather than later and the Trust was in touch with local MPs to see if they could bring any influence to bear. In the meantime, the Trust would continue business as usual in respect of the NHP as work still needed to be completed in relation to impact assessments and due diligence.

The report to be presented later in the meeting (agenda item 14.2) included a letter from NHS England outlining a range of enforcement undertakings the Trust had accepted on 4 July 2024 in relation to its Provider Licence. It was explained that the letter was a reflection of the original draft of the undertakings which had been produced some months ago when senior regional leader changes were being introduced. In addition, the undertakings were evidence-driven meaning strong evidence of sustained improvement would be required against the improvement plan. The Trust's Single Improvement Plan (SIP) aligned with the undertakings and whilst recognising it would be challenging and difficult to deliver, the Trust had accepted the undertakings.

The Chief Executive echoed the Chair's comments on the tragedy in Southport. The Trust had been stood up at the time although did not receive any casualties and the Trust was involved in treating 14 police officers following the subsequent riots. It was important to recognise the tensions created in communities following the incident and the security team had been asked for vigilance around members of the public and staff who might be targeted by racial issues. Discussions had also been held with the Trust Imams to provide advice and guidance on the support available and how to signpost people who might need support.

129/24 Workforce Committee Chair's report

The Chair's report from the Workforce Committee provided an overview of items discussed at the meetings on 13 June and 9 July 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

Attention was drawn to the alert regarding the Guardian of Safe Working annual report which had raised continued concerns regarding senior cover at Chorley and clarification was requested on what those matters related to. It was explained that for the first time in recent months the Trust had received financial penalties for doctors' rotas that were non-compliant. The Guardian of Safe Working was actively reporting to the Workforce Committee and would be addressing the issues raised. The key issue was the fragile nature of the rota as the 24/7 acute service was delivered across both hospital sites meaning there was limited resilience and Chorley was a small site in terms of the number of doctors taking part in the rota. When doctors in training rotated the Deanery was unable to fill the required posts and the Trust would need to rely on clinical fellows. A piece of work was being undertaken to look at how to introduce and strengthen appropriate sustainable levels of cover and the Guardian of Safe Working would be attending Workforce Committee meetings to provide regular updates on the position.

The Board RESOLVED that the Appraisal, Revalidation and Medical Governance Annual Report (agenda item 15.1e) be approved to allow the Chair to sign-off the compliance statement prior to submission to NHS England by 31 October 2024.

130/24 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee provided an overview of items discussed at the meeting on 11 June 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

There had been concerns for some time about the number of staff trained in advanced paediatric life support. There had been cross-Committee discussions with the Safety and Quality Committee and assurance had been received that each shift was correctly covered with appropriately trained staff. The Committee also discussed the low scores in the National Education and Training Survey relating to bullying and undermining which had been referred to the Workforce Committee for monitoring.

131/24 Charitable Funds Committee Chair's report

The Chair's report from the Charitable Funds Committee provided an overview of items discussed at the meeting on 18 June 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Committee had decided not to support the video-telemetry funding request from LTH charitable funds although agreed that there may be an opportunity to reapply for funding support in the future. The Committee had a robust discussion on the investment strategy which included significant scrutiny of the methodology, risk, tolerance and future direction of the investment portfolio.

Reference was made to the Rosemere Cancer Foundation charity and the practice of the Rosemere Management Committee on occasion requesting that bids be reviewed to wrap in both the purchase and revenue costs, and clarification was requested regarding whether the Committee could consider that as part of the video-telemetry funding request. It was confirmed that had been explored and the funding bid was above the amount that the Committee felt could be afforded. The team had been asked to look at their fundraising activity and the fund total and if their fundraising efforts achieved the required total then the bid would be reconsidered at a future date.

132/24 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee provided an overview of items discussed at the meetings on 28 May and 25 June 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The SIP and Financial Recovery Plan (FRP) had been scrutinised at both meetings. The FRP targets had been achieved although there was reliance on non-recurrent efficiencies and during the next three months the Committee would be looking for assurance on delivery of recurrent savings. There had been a seismic shift in terms of the quantity and opportunity of schemes with many of the schemes moving into the

lower risk category. Assurance had been provided regarding cash management and it was positive there had not been a reliance on drawing down additional cash. However, there was significant work to be completed in terms of savings and delivery of the SIP/FRP in the latter half of the year.

The Committee also discussed development of the Programme Management Office, the Equality and Inclusion Quality Impact Assessment process, and the longevity of the three-year plan which would be reviewed in September.

133/24 Integrated Performance Report as of 30 June 2024

The integrated performance report as of 30 June 2024 provided an overview of key performance indicators aligned to Our 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*** – a reduction in pressure ulcers and falls continued to be seen during the past six months although levels were not yet at the expected position. Mortality indicators remained stable and within expected range. STAR quality assurance accreditation Gold award events had been held during June and July at both hospital sites with 13 areas receiving Gold recognition. *C.difficile* infection levels remained static or had reduced in six out of seven months and the team continued to work on the issues that needed to be addressed. The NHSE Infection Prevention and Control (IPC) Lead and the IPC Medical Director visited the Trust in July to check and challenge the actions in place and the IPC Board Assurance Framework would be updated to provide additional assurance to the Board. Ward nursing staff fill rates were positive and there had been a reduction in boarded patients to zero as at today, as reported earlier. In terms of CQC must and should do recommendations, all must do actions would be completed by the end of August with a couple of exceptions where the deadline would need to be extended into 2025.

With regards to emergency care, there had been some improvement in the 4-hour emergency care standard and significant work still needed to be completed to further improve. Bed capacity remained an area of concern which impacted on the 12-hour target and an overview was provided on the position in respect of patients not meeting the criteria to reside, the support being provided by the Integrated Care Board (ICB) in relation to the Urgent and Emergency Care Programme, and the position on ambulance handover times. Reference was made to the decision by GPs who had voted to undertake collective industrial action which would start immediately. It was difficult to predict what impact GP industrial action would have on the hospitals but the intention was that a finite number of patients would be seen by a GP practice each day and it was anticipated the Trust would have more patients presenting at the emergency department as a result. The Trust was working with GP colleagues to attempt to mitigate the position as far as possible. With regard to the elective position, the Trust reported zero 78-week waits in July and continued to focus on 65-week waits. Tier 1 meetings had commenced by the regional Chief Operating Officer on the consistency of reducing long waits. In terms of diagnostics the Trust did lose some activity due to the junior doctors' industrial action and those patients would be listed as soon as possible, Cancer and theatre performance were relatively stable.

In response to a question regarding whether theatre utilisation at Chorley was being used to maximum capacity to improve performance, it was noted that it was not always possible to identify appropriate patients to fill the gaps although the position was constantly under review. As part of the SIP and FRP there was a piece of work included around theatre utilisation.

(b) ***Great Place to Work*** – there was a gap in the musculoskeletal and psychology sickness absence target to reduce instances by 10% and the metric had recently changed to the full-time equivalent rate which would be reported from the next Board report. A good response had been evidenced on sickness absence during the first part of the year although an increase had been seen during the reporting period where respiratory illness had spiked short-term illness. It was recognised that there was work to be completed on the metrics reported in the Integrated Performance Report and work would be completed to align the data to the ambitions within the SIP. There was focus on violence and aggression and a need to understand whether the incidences related to complex medical patients or whether people were being consciously violent/aggressive. A deep dive had been undertaken and seven out of 10 incidences related to people with medical conditions so it was possible to differentiate the cause from data analysis. Work was also being completed around patients with a mental health condition with dysregulated behaviour and the Trust was working with Lancashire and South Cumbria NHS Foundation Trust in respect of training for staff. There was also focus on the usage of the Team Engagement and Development (TED) tool across the organisation.

Ms V Crorken joined the meeting at this point

A question was asked regarding health services for people with complex mental health conditions and dysregulated behaviour and whether the Trust had the right set of control standards to protect staff. It was confirmed that the nursing and people teams were working together and some changes had been introduced, such as moving patients to Finney House when they were ready for discharge which included patients with complex conditions: this practice was included in the SIP under safeguarding. Reference was made to the excellent security team at the Trust and some of the practical actions they took such as providing training for non-security staff relating to aggressive patients. The security team had gone through a comprehensive training programme and CCTV across the Trust had facial recognition built in to strengthen onsite security.

(c) ***Deliver Value for Money*** – the Trust had achieved an underspend at the end of the reporting period. Industrial action costs amounted to around £500k in June which had offset some of the cost improvement achievements. The capital plan was overspending as a system and as Trusts had been expected to fund an additional £10m efficiency saving the Trust's capital plan had been reduced by around £3.5m. A piece of work had been commissioned internally to ensure that medical equipment within the capital plan was safe.

In response to a question regarding how metrics on health inequalities were being reported, it was confirmed that performance data was currently being reported to the Safety and Quality Committee. The proposal to report performance twice per year as part of the Health Inequalities Plan update was supported by the Board.

The Board CONFIRMED it was assured in respect of the actions being taken to improve performance.

134/24 Single Improvement Plan

The report provided an update on the implementation of the Single Improvement Plan (SIP) and an overview of the current position was provided for information.

Good progress was being made with the SIP and the risks were being actively managed. Positive feedback on the plan had been received from both ICB and regional team colleagues. There had been detailed discussions by the Finance and Performance Committee regarding the SIP and focus was directed to delivering what was required during 2024/25. The current programme of work was around the Accountability Framework which it was expected would be introduced at the end of August and work would be commencing on the redesign of the Integrated Performance Report based on the work that had been completed on the SIP performance report. The Finance and Performance Committee would also be discussing the plan of work for the next six months. In respect of the Place-based work, there was a community programme and there was close working with colleagues to develop an integrated team to deliver those developments. In terms of the SIP and what it meant, a communications plan would be developed to ensure the information was reader-friendly and easily understood by all, across every profession.

The Board CONFIRMED it was assured of the progress being made on the Single Improvement Plan.

135/24 New Hospital Programme

The report provided a brief update on the status of and progress with acquisition of land for the new hospital build.

The NHP Assurance Committee had met just prior to the announcement by the Chancellor of the Exchequer as mentioned earlier in the meeting. Work would continue in respect of the land acquisition to ensure there were no delays introduced and in readiness for the outcome of the review. The NHP team remained in place and would continue with business as usual.

Clarification was requested on planning for transformation of clinical services to ensure they were fit for the future. It was confirmed that those discussions had been signposted with the Provider Collaboration Board (PCB) and an agenda item had been included for the Senior Leadership Group to ensure all Trusts were involved in conversations regarding clinical reconfiguration.

136/24 Audit Committee Chair's report

The Chair's report from the Audit Committee provided an overview of items discussed at the meeting on 21 June 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Committee received the outcome of the Data Quality Review audit to evaluate the systems and processes in place to accurately report performance against the Trust's Patient Initiated Follow-up (PIFU) target key performance indicators. Assurance that

progress was being made with the recommendations would be monitored by the Finance and Performance Committee.

The key focus for the June meeting was scrutiny of the 2023/24 Annual Report and Financial Accounts which were recommended for approval at the Special Board meeting on 25 June 2024. A copy of the report was included in the meeting pack for information (item 15.1a) and had been published on the Trust website.

137/24 NHS England Enforcement Undertakings

The report provided details of the Replacement Enforcement Undertakings issued to the Trust by NHSE along with the Trust's response. It was noted that a range of documents required agreement with NHSE in line with the undertakings which would be presented to the System Improvement Board including the Enforcement Undertakings Delivery Plan; Trust Financial Recovery Plan; Single Improvement Plan; and Quality Improvement Plan. The undertakings action plan would be monitored and reported to Board through the Single Improvement Plan which would provide a direct response to the specific NHSE Undertakings. An overview of the contents and the structure of the action plan was provided.

Attention was drawn to reference 3.9 in the action plan relating to the licensee (Trust) working in partnership with the Provider Collaborative and ICB to support the timely delivery of the System Clinical Strategy. Clarification was requested on what the expected outcome would be from the actions to be delivered in respect of collaboration on fragile services . It was explained that the Trust was contributing towards shaping the clinical strategy of the ICS. Currently the action plan reflected the ongoing Straysys work and once that had been completed there would be an understanding to inform what the Trust needed to do to exit the undertaking and the plan would provide measures on Trust engagement and its involvement in helping to find solutions on fragile services.

The Board acknowledged that the action plan was an early iteration developed following receipt of the enforcement undertakings and recognised the importance and gravity of the situation and the work that would be required to exit from the undertakings. Improvements had started to be seen on performance over the previous 10 months including the good financial position at the end of 2023/24. However, the enforcement undertakings should be seen as a further reminder that the organisation was not where it needed to be and the Board was grateful for the continued focus being applied to improvement.

The Board ENDORSED the plans for monitoring and reporting progress as a response to the NHSE Enforcement Undertakings.

138/24 Delegated Authority: EPRR Core Standards Annual Return

The report outlined a proposal for the Board to delegate authority to the Finance and Performance Committee for submission of the Emergency Preparedness Resilience and Response (EPRR) annual core standards assurance return to the ICB prior to formal Board approval. The approval pathway was complex and delegating authority would ensure a timely submission and alignment with the NHSE check and challenge process; allow for a smoother and more efficient submission process; and align Trust practices with those of other organisations that had already adopted the approach. It was noted

that prior to the September Finance and Performance Committee meeting the report would be shared with all Board members to allow input to the report. The Executive Management team would also be reviewing the report before formal presentation to the Board for approval.

It was noted that some Board members had expressed concerns regarding the submission pathway. However, as the report would be shared with all Board members prior to the September Finance and Performance Committee meeting for comment then the Board was satisfied to approve the proposal.

The Board RESOLVED that authority be delegated to the Finance and Performance Committee to submit this and future years' EPRR annual core standards assurance returns prior to formal Board approval on the basis that the report was shared with all Board members prior to submission to the Finance and Performance Committee annually in September.

139/24 Items for information

The following reports were received and noted for information:

(a) Annual Report and Accounts 2023-24
(b) Quality Account 2023-24
(c) Safeguarding Annual Report
(d) Mortality Annual Report
(e) Appraisal, Revalidation and Medical Governance Annual Report
(f) Freedom to Speak Up and Raising Concerns at Work (including Whistleblowing) Annual Report
(g) Fit and Proper Person Annual Review: Confirmation of Completion

In terms of the Safeguarding and the Freedom to Speak Up and Raising Concerns at Work annual reports it as agreed that in future these would be included as part of the main agenda rather than for information only.

140/24 Date, time and venue of next meeting

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

Signed: _____
Chair

Date: _____

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

There were no outstanding actions from previous Board meetings and no actions identified during the meeting on 1 August 2024.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chair's Report					
Report to:	Board of Directors		**Date:**	3rd October 2024	
Report of:	Chair of the Trust		**Prepared by:**	Rebecca Black System Collaborative Business Manager to CEO	
Part I	✓		**Part II**		
Purpose of Report					
For assurance	☐	**For decision**	☐	**For information**	☒

Executive Summary:

The purpose of this report is to provide a summary of work and activities undertaken during August and September by the Trust Chair.

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

Chair's Report

1. Introduction

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

Part II Board of Directors' meetings – August and September 2024 (Karen Brewin to provide)

The items discussed at the 1st August part II Board meeting are outlined below along with a brief resume of the discussions.

1. **One LSC: Strategic Collaboration Agreement** – the Board approved the Strategic Collaboration Agreement and received an update on the progress being made to establish One LSC.
2. **Diagnostics Business Case** – the Board approved commencement and mobilisation of a business case to support improvements in performance and reduce the waiting list for diagnostic tests.
3. **Psycho-oncology Business Case** – the Board approved a business case for a fully funded three-year pathway of care pilot.
4. **Governance Review Task and Finish Group** – the Board received a brief update on progress with the work of the Task and Finish Group and supported the extension of the Group to the end of October to ensure actions had been embedded.
5. **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.
6. **Maternity Serious Untoward Incidents** – the Board received the report in line with Ockenden recommendations.
7. **Minutes of meetings** – the Board received copies of relevant approved minutes from meetings of Committees of the Board.

2. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during August and September 2024.

Date	Activity
August 2024	
1st August	Non-Executive Directors meeting
1st August	Board of Directors – Part 1 and 2
6th August	Chief Executive, LTHTR
6th August	Healthwatch Lancashire – Introductory Meeting

6th August	Nominations Committee
13th August	L Tudor, Governor Introductory Meeting
13th August	NW System Leaders Call
13th August	Interim Chair, ICB
13th August	Induction – K Foster-Greenwood, COO
15th August	Managing Director – 1LSC
15th August	Cllr A Bradley
16th August	Chief Executive, LTHTR
20th August	P Curwen, Governor Introductory Meeting
20th August	Company Secretary
20th August	Board Agenda Setting
20th August	Board Workshop
22nd August	University Hospital Status
September 2024	
3rd September	Non Executive Director Meeting
3rd September	Board Workshop
6th September	Council Training session
26th September	Chief Executive, ICB
26th September	Annual Members Meeting

3. Financial implications

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

4. Legal implications

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

5. Risks

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

6. Impact on stakeholders

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

7. Recommendations

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

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	3 October 2024
Report of:	Chief Executive	**Prepared by:**	N Duggan
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

The Darzi Report

In early September, Lord Darzi published his report following an investigation of the National Health Service in England. This came following a Government ask to provide a rapid investigation of the state of the NHS, assessing patient access, quality of care and the overall performance of the health system.

Lord Ara Darzi is an independent peer and practising surgeon with 30 years' experience in the NHS. He examined over 600 pieces of analysis from the Department for Health and Social Care (DHSC), NHS England and external organisations during his investigation.

The 10-week investigation has found the NHS is in a 'critical condition' amid surging waiting lists and a deterioration in the nation's health. It points to four heavily interrelated drivers of current performance: austerity and constrained funding; the impact of the pandemic; a lack of patient voice and staff engagement; and management structures and systems.

Lord Darzi concluded that "despite the challenges, the NHS's vital signs remain strong" but acknowledges that it will "take years rather than months to get the health service back to peak performance." The report also highlighted a number of important themes that have emerged for how to repair the NHS, which will need to be considered alongside strategies to improve the nation's health and reforms to social care.

The Government will now use the reports findings and recommendations to help form its 10-year NHS plan which is expected to be released in spring 2025. The plan was framed around three big shifts - moving from an analogue to a digital NHS; shifting more care from hospitals to communities; and being much bolder in moving from sickness to prevention.

Following the report's release, Prime Minister (PM) Keir Starmer pledged to oversee the 'biggest reimagining of our NHS since its birth'. The PM also set out his belief in the 'profound responsibility' of government to do the hard work necessary to tackle them.

Getting our finances back on track

Throughout September we have written to colleagues to provide an update on our current financial position and what further measures we are introducing to help deliver our financial recovery plan.

Delivering our Single Improvement Plan and our Financial Recovery Plan (FRP) are amongst our highest priorities in 2024/25. Our Always Safety-First commitment is also non-negotiable as we are clear that patient safety must not be compromised as we recover financially. We must therefore achieve the right balance and have developed a suite of safety and operational performance balancing measures that will act as an early alert of any unintended consequences of the decisions being taken to reduce our spend.

We have already made significant steps to deliver against our financial challenges and commenced a temporary pause to recruitment (except for critical posts) and put in place controls for discretionary non-pay spending to ensure we are getting best value for money. All these actions are already having a positive impact, though there is still much more to do.

At the time of writing, we have a number of vacancy control process in place including a "firebreak" meaning that where appropriate posts will be held for 13 weeks before being advertised and recruited to which should allow us to make significant savings in a controlled and appropriate way. This will also give us the space to consider whether we can do things differently with the intention of working smarter, not harder.

We have also been carrying out a Sustainable Staffing Review to make sure we have the right colleagues working in the right places so we can provide the best care, and ensure every area has a much clearer budget going forward which will make it easier to plan our services and staffing arrangements accordingly.

New Hospitals Programme update

On 29 July, the Chancellor made a statement in the House of Commons announcing a review of the New Hospital Programme (NHP), to ensure it had a 'thorough, realistic and costed timetable for delivery'. We have welcomed the review and the opportunity it provides us in ensuring the programme is on the soundest possible footing for delivery.

On 20 September, we received the review's Terms of Reference (ToR) and acknowledge that the review is being undertaken at pace for a swift conclusion on the changes to be made ensuring an affordable and realistic delivery schedule.

Whilst the review is taking place, and in the period between the review ending and the outcome being confirmed and communicated, all schemes within the NHP will be supported appropriately to continue to make progress. As soon as we are in a position to communicate anything further, we will do so.

Sharing our improvement work at the first NHS IMPACT national conference

We welcomed the opportunity to share our innovative approach to system level improvement testing the Engineering Better Care Framework to co-design and deliver frailty services at the first national NHS IMPACT conference. Professor Ailsa Brotherton, our Director of Improvement, Research and Innovation presented with Dr John Dean, Deputy Medical Director at East Lancashire Hospitals NHS Trust and Vice Clinical President of the Royal College of Physicians and Professor John Clarkson, Cambridge University. They shared how our Improvement Directors have worked collaboratively to facilitate this work across our ICS, sharing the key lessons learned. This work forms part of our Central Lancashire UEC plan as we aim to provide care closer to home in our local communities, reducing the demand for hospital care. Colleagues will recall that this work was recognised as an example of outstanding practice by the Care Quality Commission in our last inspection. Thank you to all colleagues involved.

Peter White to retire as Chair of Lancashire Teaching Hospitals

After joining the Trust in August 2023 and bringing extensive experience and a period of stability to the Board between the changeover between Kevin McGee, Faith Button, and myself as Chief Executives, Peter White has confirmed his intention to retire as Chair of Lancashire Teaching Hospitals by March 2025.

The timing of Peter's departure has been thought through to enable a new Chair to be involved in a number of Non-Executive Director appointments next year as some of our current NEDs come to the end of their tenures. It is anticipated that the appointment of Peter's successor will be ratified at the Council of Governors meeting on 7 November 2024. If the successful candidate were able to join the Trust earlier than March 2025 then Peter would step aside to enable them to take up their new role earlier.

I know that many colleagues will be sorry to see Peter move on and on a personal note, I have very much valued Peter's knowledge, support, sense of humour and common-sense approach. I am very much looking forward to continuing to work with him in the months ahead of a new appointment being made.

Interim Chief Finance Officer appointed

David Stonehouse joined us as our Interim Chief Finance Officer for six months from 9 September 2024.

David has over 20 years' experience as a Finance Director, most recently in the role of Interim Finance Director at Manchester University NHS Foundation Trust. He has also worked at a variety of other NHS Trusts, including Dartford and Gravesham NHS Trust, The Hillingdon Hospitals Foundation Trust, Barnet, Enfield and Haringey Mental Health NHS Trust and The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

David brings with him a wealth of experience and will support the organisation across the next six months as we work on our Financial Recovery Programme which is crucial to the longer-term health of our Trust.

I'd like to put on record my thanks to Jonathan Wood, who took up the role of Managing Director for the Lancashire and South Cumbria Provider Collaborative on the same date. Jonathan played a huge role in the start of our financial transformation journey, and I wish him all the best for his future role.

Annual Members' Meeting 2024

On Thursday 26 September we held our Annual Members' Meeting at Lancashire Conservation Studios in Preston between 2pm – 4pm.

We were pleased to welcome colleagues, governors and public members to the session along with Health Watch and the Royal National Institute of Blind People (RNIB). I was pleased to provide a review of our 2023/24 Accounts and Financial Overview and our Chief Nursing Officer, Sarah Cullen, provided a keynote presentation on Health Inequalities.

If you weren't able to attend the session, it is available to watch back on our website.

One LSC information and consultation period now underway

An information and consultation period has commenced for colleagues who will be transferring into One LSC on 1 November.

Following many months of detailed planning, the consultation and informing period started on Monday 9 September and will run until Monday 7 October.

One LSC is the formal partnership agreement between all five trusts across the Lancashire and South Cumbria Provider Collaborative, including ELHT (who will be the host employer), that will bring together many of our central services.

It will deliver a more resilient and sustainable group of professional services, fit for the future, bringing them together into one team, and serving Lancashire and South Cumbria in a joined-up way.

The purpose of the consulting and informing period is to provide colleagues who are transferring with the opportunity to ask questions and understand what this transfer means for them.

Staff side colleagues have also been fully engaged in the planning for the consultation and informing period, and are another source of support for colleagues affected by the transfer.

National, Regional and Local recognition

While it is important to highlight our key challenges, we must not lose sight of the incredible work and achievements of our colleagues which are being recognised on both a local and national level.

- **Golden boy Gregg celebrates epic Paralympics rowing victory**

The Olympic and Paralympic Games were inspirational, and it was particularly satisfying to see a former colleague, Gregg Stevenson, come away with a gold medal.

Gregg is a former Lead Physical Instructor and Mental Health Practitioner with the Trust's Specialist Mobility Rehabilitation Centre (SMRC), having been referred for treatment following the loss of both his legs to an IED blast while on patrol in Helmand Province in 2009.

The former Royal Engineer Commando from Foulridge in East Lancashire joined rowing partner Lauren Rowles to win the mixed double sculls, staging a remarkable comeback, having been adrift of China's Liu Shuang and Jiang Jijian with only 100m to go in the 2,000m race.

Paralympic, World and European champions, Gregg and Lauren had won all their previous 11 international races together, setting four new world records along the way, including in the heat in Paris!

I was delighted that Gregg joined us at our monthly All Colleague Team brief to share his experiences both in and outside work in what was a truly memorable and inspiring session.

- **Tony's special treat for Royal Preston Hospital patients, families and staff**

It's not often you have radio royalty pay a visit, but it was a memorable day when Tony Blackburn dropped in to Royal Preston Hospital to perform a two-hour slot on Preston Hospital Radio in September!

The legendary DJ played requests and read out dedications, as well as recalling stories from his time on the airwaves, including the times he met Frank Sinatra and Gene Pitney!

Stefanie Johnson, Head of Recruitment and Volunteers, had appealed for guest presenters on Scott Mills' breakfast show on BBC Radio 2, as part of the promotion around the Radio 2 in the Park festival at nearby Moor Park.

Richie Anderson covered for an hour in the morning, before Blackburn was also asked to fill in later that afternoon. The Hospital Radio volunteers provide a fantastic service, lifting the spirits of patients, families and staff, and it was a great to be able to host Radio 2 for two surprise shows.

- **Paediatric Surgical Hub recognised for enhancing children's surgical car**e

I was delighted to see that the Trust's Paediatric Elective Surgical Hub has been accredited as part of a Getting It Right First Time (GIRFT) quality improvement scheme, recognising clinical and operational enhancements to children's surgical care.

The accreditation of the hub, which is based at the Trust's Chorley and South Ribble District Hospital, comes after the Trust's Elective Surgical Hub was one of the first eight sites to be recognised when the scheme was piloted in early 2023.

The Paediatric Hub used the established Elective Surgical Hub to create a pop-up children's day case pathway, moving activity from an acute site at Royal Preston Hospital to be able to treat more children in the same number of theatre sessions, as well as transforming the existing adult day case ward to a children's day case ward that is staffed by children's nurses and play specialists with games, toys and posters.

The service - specific to certain specialties including dental and facial surgery, ophthalmology, plastic surgery and ear, nose and throat procedures - has had a huge impact, with waiting list numbers decreasing and an increase in elective procedures taking place.

The Hub was also a runner-up for the Improving Care for Children and Young People Initiative of the Year at this year's HSJ Patient Safety Awards.

- **Trust recognised for providing highest quality anaesthesia care**

Congratulations to the Trust's Department of Anaesthesia, who have been recognised for providing the highest quality care to patients, after formally being reaccredited with the Anaesthesia Clinical Services Accreditation (ACSA) by the Royal College of Anaesthetists.

A benchmark in quality, the Trust received the prestigious award as a result of a painstaking process, in excess of 18 months, undertaken by the Department of Anaesthesia and Theatres, and the Trust's ACSA lead for this cycle of reaccreditation, Dr Phillippa Shorrock, Consultant Anaesthetist with Special Interest in Obstetric and Paediatric Anaesthesia.

Dr Shorrock, with the support of her clinical director Dr Alison Waite, and alongside her fellow Associate clinical directors, spent that time driving the changes required to maintain accreditation, with the ACSA standards also aligning with the Care Quality Commission (CQC) mandate, sought as a seal of approval when accrediting Elective Surgical Hubs by the Getting It Right First Time (GIRFT) programme.

- **New service to help women with hypertension and pre-eclampsia**

I was delighted to see that a dedicated clinic for the management of pregnant and newly birthed women and birthing people with hypertension, pre-eclampsia and eclampsia opened in August, as part of Lancashire Teaching Hospitals' maternal medicine centre.

The Lancashire Antenatal Pre-eclampsia and Hypertension Clinic, or LeAPH for short, was developed by Dr Emma Ingram, lead Obstetric Consultant for hypertension, and Sr Lisa Cook, Specialist Midwife for Maternal Medicine, and runs on Wednesday mornings in the Trust's Antenatal clinic.

As part of the service, pregnant women and birthing people are provided with a home blood pressure monitor, where they can upload their results onto their electronic maternity record, and clinical staff can then view their recordings. The app uses a red-amber-green system, meaning that if a user's blood pressure is too low or high, advice is available on what to do. Previously, if hypertension was identified at an early antenatal appointment, there was no clear management pathway in place, which meant women and birthing people were passed between different primary and secondary care areas, with little continuity.

- **Paediatric Neuromuscular Centre receives Centre of Excellence award from MDUK**

I was honoured to be present as the Trust's Paediatric Neuromuscular Service received a prestigious Centre of Excellence award from Muscular Dystrophy UK – recognition for outstanding care.

The awarded was for promoting best practice locally and nationally and demonstrating commitment to improving health and care for patients.

Rob Burley, MDUK Director of Care, Campaigns and Support, travelled to Royal Preston Hospital to present the 'Centre Pursuing Clinical Excellence with Research' award to Dr Christian De Goede Consultant Paediatric Neurologist and his team.

Dr DeGoede spoke about the history of paediatrics and neurology at the Trust, from Gordon Hesling to Neil Gordon, and Pam Tomlin, who was Dr De Goede's predecessor and helped set up a neurology centre in Preston. All of us are stood on the shoulders of giants, in terms of how we develop services over many years, and it is great to see how the service has come on over a long period, and how the treatments we are able to offer have developed as well.

- **Sharoe Green Unit celebrates 20th anniversary**

At the beginning of September, the Sharoe Green Maternity Unit celebrated a special milestone, marking 20 years of providing care for women and their families at Royal Preston Hospital.

Named in honour of the maternity hospital it replaced, the £17m maternity and gynaecology unit was built with new maternity delivery suites and wards, an ultrasound department, antenatal clinic, neo-natal unit, a special early pregnancy assessment unit, gynaecology outpatient department and 28-bed ward with three operating theatres.

Over the last 20 years the Trust has seen numerous upgrades and advancements to the maternity unit, most recently with the new LeAPH clinic for women with pre-eclampsia or hypertension.

Back in 2004, there was a Neonatal Unit with one ANNP (Advanced Neonatal Nurse Practitioner), and now there is a NICU with complex care, and the Trust is the Maternal Medicine Lead for Lancashire and South Cumbria and Foetal Management teams.

Bringing everything on to one site has enabled cross-speciality collaboration, especially for expectant mothers - the Trust is now the only provider in the North West to have co-located NICU and Adult Critical Care/Oncology/Neurosurgery and Interventional Radiology all on one site.

- **New Acute Medical Assessment Unit opens at RPH**

The new Acute Medical Assessment Unit (AMU) officially opened at Royal Preston Hospital on 23 September. The AMU comprises of 24 beds spaces, 2 assessment bays and 10 side rooms. Having the additional space within the assessment bays will allow the acute team to pull patients directly from the Emergency Department, with an aim to improve patient experience, length of stay, admission avoidance and performance within the Emergency Department. A full write up is available on the Trust website.

1. RECOMMENDATIONS

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

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Board Assurance Framework (BAF) Risk Report			
Report to:	Board of Directors	**Date:**	3rd October 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 the 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 may 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.

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 of exit block on patient safety, which has been escalated to Board since December 2020 due to the 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 1157 (scoring 20), Increased cases of clostridioides difficile (C.*difficile*) Infection, which has been escalated to Board since April 2024.

Review of the Board Assurance Framework

The Board Assurance Framework is currently under review to enable alignment to the new Trust strategy. It is planned that the new Trust strategy will be presented for approval at the Board of Directors meeting in October 2024.

Upon approval of the new strategy, the new approach to the Board Assurance Framework will be finalised with Executive and Non-Executive Directors and will be presented to the Board of Directors in December 2024 for approval, along with plans for the transition from the current version of the Board Assurance Framework.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.

Appendix 1 – Board Assurance Framework
Appendix 2 – Strategic Risks

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Committees of the Board in line with cycles of business

1. Background

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

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

2. Discussion

2.1 Board Assurance Framework (BAF)

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

2.2 Strategic Risk Register

2.2.1 There has been no change in score for:

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

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

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

2.3 Operational Risk Register

2.3.1 There are three operational high risks that continue to 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 1157 (scoring 20), Increased cases of clostridioides difficile (C.difficile) Infection, which has been escalated to Board since April 2024.

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

2.4 Review of the Board Assurance Framework

2.4.1 The Board Assurance Framework is currently under review to enable alignment to the new Trust strategy. It is planned that the new Trust strategy will be presented for approval at the Board of Directors meeting in October 2024.

2.4.2 Upon approval of the new strategy, the new approach to the Board Assurance Framework will be finalised with Executive and Non-Executive Directors and will be presented to the Board of Directors in December 2024 for approval, along with plans for the transition from the current version of the Board Assurance Framework.

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 risks can 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 2024/2025 – Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Trust Aims and Ambitions

Current principal risks on the Strategic Risk Register –October 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	Aug 2023 Score	Oct 2023 Score	Dec 2023 Score	Feb 2024 Score	Apr 2024 Score	June 2024 Score	Aug 2024 Score	Oct 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	CONTROLLED		
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		860	6	Seek	9-12	20	20	16	16	16	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	16	16	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 2024/2025 – Risks to achievement of Trust Aims & Ambitions

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Strategic Risk Summary

Risk		Risk ID	Risk Summary
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research.		860	There is a risk that we are unable to deliver world class education, training and research due to challenges in effectively implementing high quality, appropriately funded and well-marketed education, training and research opportunities due to a range of internal and external constraints. This impacts on our ability to develop our reputation as a provider of choice sustaining our position in the market, supporting business growth and retaining our status as a teaching hospital.
Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Services		859	There is a risk to the Trust's ability to continue delivering its strategic aim of providing high quality specialist services due to integration and reconfiguration of specialist services across the ICS. This may impact on our reputation as a specialist services provider and commissioning decisions leading to a loss of services from the Trust portfolio and further unintended consequences affecting staff and patients. **Risk Controlled in June 2024.**
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities	**Risk to delivery of Strategic Ambitions.. Consistently Delivering Excellent Care**	855	There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to: a) Availability of staff b) High Occupancy levels c) Fluctuating ability to consistently meet the constitutional and specialty standards d) Constrained financial resources impacting on the wider system, the deficit position facing the Trust and the significant costs of operating the current configuration of services. e) Health inequalities across the system.
	Risk to delivery of Strategic Ambitions.. Great Place to Work	856	There is a risk to the delivery of the Trust's Strategic ambition to be a great place to work due to the inability to offer a good working environment; inability to treat staff fairly and equitably; poor leadership; inability to support staff development. This could lead to staff losing confidence in the Trust as an employer and result in poor staff satisfaction levels, impacting on the organisations reputation and culture subsequently affecting the ability to attract and retain staff, causing key workforce shortages, increasing the use of temporary staffing and poor patient care.
	Risk to delivery of Strategic Ambitions.. Deliver Value for Money	857	There is a risk that we are unable to deliver the Trust's strategic objective 'deliver value for money' due to the inability of the Trust to transform given the range of internal and external constraints (relating to complex models of care, workforce transformation, planning processes, capital resources and dealing with high levels of backlog maintenance) which could result in a failure to move toward segment 2 of SOF and less than a 'good' rating from the use of resources of inspection.
	Risk to delivery of Strategic Ambitions.. Fit For the Future	858	There is a risk to the delivery of the Trust's Strategic Objective to be fit for the future due to the challenges of effectively implementing and developing Place and System (i.e. Integrated Care System and Provider Collaborative) level working we fail to deliver integrated, pathways and services which may result in Lancashire Teaching Hospitals no longer being fit for purpose and our healthcare system becoming unsustainable.

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

Board Assurance Framework 2024/2025 – Risks to achievement of Trust Aims & Ambitions

Key Operational Risk Summary for Escalation to the Board

Lancashire Teaching Hospitals NHS Foundation Trust

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

Escalated Risks

- **Impact of Emergency Department (ED) Exit Block on Patient Safety (Risk ID 25 – Initial Score 20, Current Score 20)** – The Emergency Department (ED) Dashboard has demonstrated an improvement in a number of key metrics in the last quarter. This is in part due to seasonal variations and in part due to a number of flow interventions underway as part of the UEC plan. Patients continue to wait extended periods of time in the ED and ED boarding continues leading to suboptimal patient and staff experience.

  - The approach to UEC continues to be a priority focus through the Single Improvement plan. The Lancashire place UEC plan was approved at the September Urgent Care Delivery Board, progressing the collaborative approach to UEC at place. The next phase of this will see the presentation of the newly developed community physical health plan in October. This has evolved following the development of the integrated leadership function between LTHTR and LSCFT and whilst early in function, it is demonstrating potential in working more collaboratively in future.
  - The new Acute Medical Unit opened in line with plan on 23 September increasing the number of assessment beds by 10 with the aim of improving length of stay at the start of patient pathways.
  - Finney house has converted from pathway 1 to a pathway 2 and 3 facility, resulting in increased focus on those patients delayed leaving hospital due to therapy or social needs. Social Care have now revised the model with a dedicated social worker within Finney House enabling improved MDT working, it is hoped this will reduce length of stay in pathway 2 and 3 patients. The funding model for this is not yet finalised and discussions with the ICB continue.
  - The demand and capacity analysis is currently being reassessed by the new Chief Operating Officer to understand the gap now a number of internal and system schemes have been implemented, acknowledging there will continue to be a gap given the starting bed gap position of 123. This affects the ability to run at occupancy levels that prevent the need to board in ED and on the wards, however, recent improvements have enabled boarding on the wards to reduce, albeit it is expected the increase in winter activity will increase the risk of this.
  - The winter plan – system level funding has been aligned to increasing capacity schemes to support the winter surge. Clarity on the benefits of the schemes outcome benefits has been requested to allow month on month monitoring and assurance.

- **Elective restoration (Risk ID 1125 – Initial Score 20, Current Score 20**) – Operational focus on achieving the agreed trajectories continues. Plans set and include:

  - Elimination of 65 week waits by end of September 2024. There is a risk that a small number of patients may exceed the target.
  - DMO1 at 95% of patient waiting at under 6 weeks for routine diagnostics by March 2025. Currently there are a number of risks associated with this that are being managed through weekly monitoring and diagnostic improvement groups in addition to the fortnightly Tier 1 NHS England oversight.
  - Cancer 28 day faster diagnostic standard at 77% by March 2025. This was achieved in July and is on track for delivery.
  - Cancer 62 day treatment at 70% by March 2025. The trajectory has been achieved in the first 4 months of the year. This is on track for delivery.

  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 oversight.

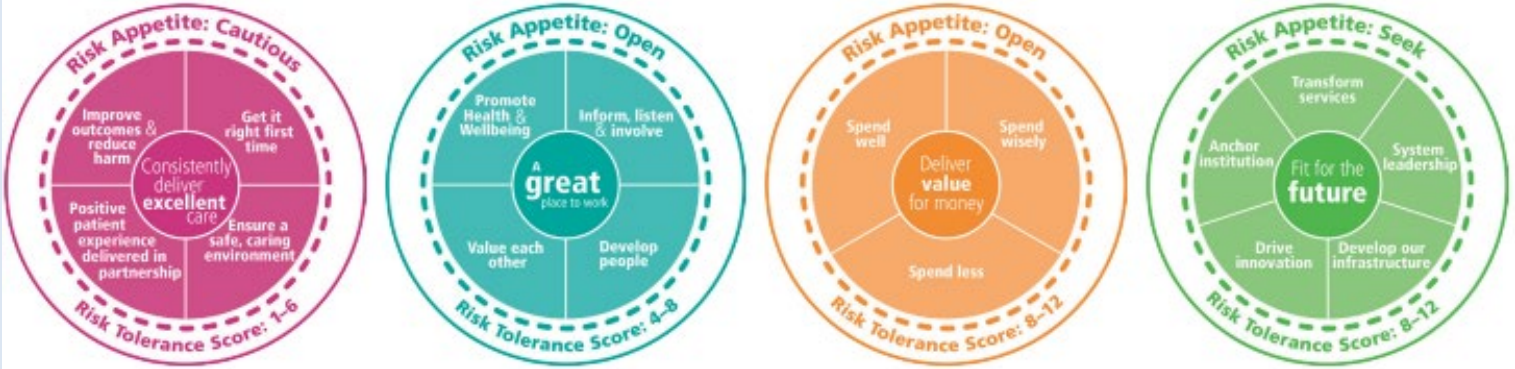
- **Increased cases of clostridioides difficile (C.*difficile*) Infection (Risk ID 1157 – Initial score 16, Current score 20)** - The Trust continues to see higher than planned rates of C.difficile infection. The new national trajectory has been reset for 2024/25 and has increased the allocation to 199 cases per year reflective of the national increase in C.difficile post pandemic. This has resulted in the trajectory being breached by 2 cases this month. In the last reporting period advances have been made in relation to 1. Commencing the UV light treatment programme 2. Relaunch of the estates and facilities partnership board chaired by the Chief Nursing Officer enabling closer working relationships between clinical and estates teams to address challenges. 3. The continued focus on the 'bin the wipes' campaign aims at reducing the number of blockages leading to contamination. 4. NHS England have completed a review of the actions contained within the C.difficile improvement plan and the outcome of this will be fed back in the next reporting period. 5. The compliance with antimicrobial guidance quarterly audits demonstrated 92% in Quarter 2. The national cleaning standards remain the primary outstanding action that will be considered as part of the 25/26 planning round.

Appendix 1 - Board Assurance Framework 2024/2025 – Details of Risk Appetite and Risk Tolerance alignment with Strategic Risks

Lancashire Teaching Hospitals NHS Foundation Trust

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

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



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

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

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

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

Appendix 1 - Board Assurance Framework 2024/2025 – Risk Appetite Statement

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Trust Risk Appetite Statement

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

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

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

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

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

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

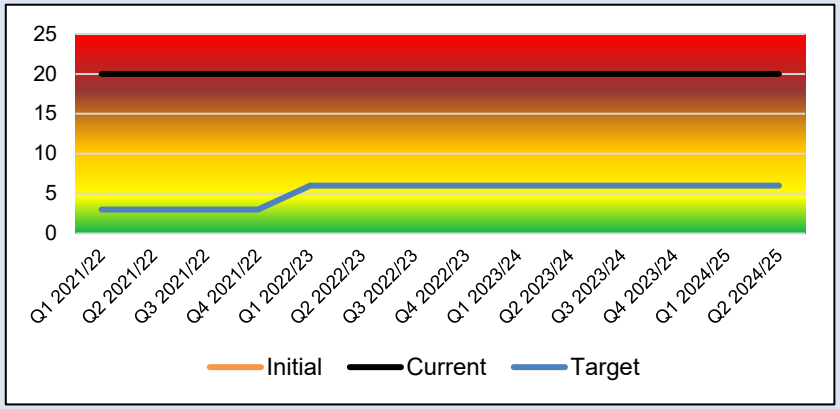
1-6

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 7% of addressable spend and overall Financial Recovery Plan in excess 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 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	• 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 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)*** • The environment and facilities within the children's ward require improvement. (***CDEC 021)*** • The increasing finance and operational pressures present potential risk to patient and staff safety and experience. ***(CDEC 023)*** • The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient. (**CDEC 024)** • There is currently a lack of timely discharge options for patients who are no longer meeting the criteria to reside in hospital leading to extended lengths of stay once medically optimised. **(CDEC 025)**	**<u>Internal</u>** • STAR Assurance Framework in place with mandated fundamental standards to achieve green detailed and reported through Safety & Quality Committee. • Always Safety First Learning and Improvement Group • PSIRF Oversight 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. • Bi annual safe nurse staffing assessment completed with inclusion of covering safe staffing recommendations for 2023 Birthrate plus assessment. **<u>External</u>** • National Surveys • Clinical Negligence Schemes for Trust • Validation of year 5 CNST 10 maternity safety actions • External regulators and benchmarking	[None detailed]

• Planned programme of work commenced focused on fragile services across the ICS.		• Medical Examiner's Office, Perinatal Mortality Tool • Internal Audit • External system assurances, PLACE based arrangements, ICB and PCB • NHS England performance monitoring	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 014	Completion of planned expansion of MAU and SAU	Chief Nursing Officer	30 November 2024		Ongoing	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 016	Determine mechanism to fund safe staffing recommendations for 2023 Birthrate plus assessment.	Chief Financial Officer	30 April 2024	6 April 2024	Completed	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 April 2024	6 April 2024	Completed	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	~~31 August 2024~~ Unable to determine delivery date		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.
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	~~31 August 2024~~ 31 October 2024		Ongoing	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.
CDEC 021	To develop a plan to improve environment within the children's ward.	Chief Nursing Officer	~~31 August 2024~~ 30 April 2025		Ongoing	Control	• The environment and facilities within the children's ward require improvement.
CDEC 022	To review STAR and mandated fundamental standard delivery to achieve green and disaggregate inpatient	Chief Nursing Officer	31 August 2024	31 August 2024	Completed	Assurances	• The approach to quality assurance within inpatient areas and specific focus on fundamentals requires strengthening.

	outcomes from outpatients to strengthen assurance.						
CDEC 023	Further review of the Equality Quality Impact Assessment process.	Chief Nursing Officer	30 June 2024	30 June 2024	Completed	Assurances	• The increasing finance and operational pressures present potential risks to patient and staff safety and experience.
CDEC 024	Undertake analysis of demand and capacity across the UEC pathway to determine capacity required.	Chief Operating Officer	30 November 2024		Ongoing	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 025	Agree in partnership with LSCFT the approach to transforming physical health community services to improve length of stay in ED and as inpatients.	Chief Nursing Officer	30 September 2024		Ongoing	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 026	Develop a central Lancashire PLACE Urgent and Emergency care plan.	Chief Operating Officer	31 July 2024	~~31 July 2024~~ 11 September 24	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 027	Revisit the LTHTR Urgent and Emergency Care plan to reflect system and organisational priorities.	Chief Operating Officer	31 July 2024	31 July 2024	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 028	Agree funding approach to Finney House intermediate care service to secure immediate to medium term plan.	Chief Nursing Officer	30 September 2024		Ongoing	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.

Summary of review – August and September 2024

- Risk reviewed by Chief Nursing Officer in August and September 2024
- Action CDEC 020 - The delivery date for the health inequalities plan has been extended due to stakeholder feedback and is expected to be complete by 31 October 2024.
- Action CDEC 021 – The scheme will be added to the capital planning forum and be will included for 2025 capital planning considerations, thus the due date extended to 30 April 2025.
- Action CDEC 022 – This is now completed and mandated standards are now live, with reporting being evidence through safety & quality. This in turn removes the gap in assurance on this risk and enhances the assurances around the STAR framework.
- Action CDEC 026 - The draft place plan was reviewed on July and required further detailed work including a measurement strategy. This has now been completed and was approved at the Urgent care delivery Board (Place) on 11 September 2024.
- The UEC plan is being reviewed in light of the new Chief Operating Officer appointment.

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

Risk ID: 857

Risk owner: Chief Finance Officer (updates contributed to by Assistant Director of Financial Services)

Date last reviewed: 17th September 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

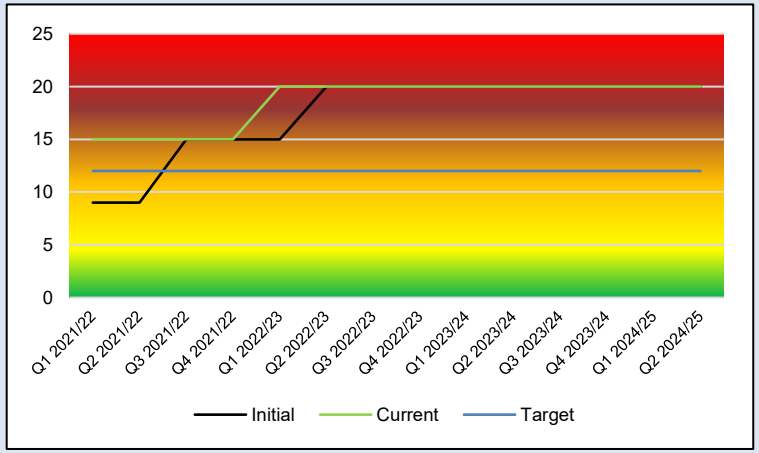
8-12

Rationale for Current Score

- **Undertakings** The Trust is in segment three for the NHS Oversight Framework (NOF). 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 close a gap of £58m in 2024-25. 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 continues to place pressure on the UEC pathway. Despite additional capacity, the Trust's performance standards are not being met.
- **Industrial relations** – Continuing industrial tension is giving rise to additional financial and performance pressures which will further hamper the delivery of VFM. The Trust's 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 2024-25 and will aim to rebalance its finances over a three-year period. The Trust has set a challenging financial improvement target for future years, and it needs to ensure that the associated change is managed through an effective equality and quality impact assessment process.
- **Financial Recovery (system)** – In outlining their financial plans all NHS organisations in Lancashire and South Cumbria will be challenged to deliver their financial trajectories. To do so will likely 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. In addition, an external Improvement Director has been assigned to the ICS to support speedier financial recovery.
- **Productivity** – Despite significant transformation programmes, Trust productivity when compared to 2019-20 has decreased. Input costs have essentially risen faster than the measured outputs. This has directly impacted upon value for money.
- **Dependencies** – Whilst there are many improvements to be driven internally, to further improve value for money there are many dependencies on partners, e.g. to develop a clear out of hospital strategy, to help tackle not-meeting criteria to reside, to support the reorganisation of services or to fund the alternatives to hospitalised care.

Risk Rating Tracker (Likelihood x Consequence)

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



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

	Future and Escalating Risks • **Investment** – The Trust in the meantime has an underlying overspend which will need to be addressed. The failure to improve financial performance is likely to impact on future major investment decisions facing the Trust, along with potential future risk of failing to deliver the Trust's challenging FRP. • **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. • **National financial framework –** The national framework has now been issued this clarifies that overspending systems will have capital allocations curtailed and will result in top sliced allocations in future periods.	**Future Opportunities** • Benchmarking indicates opportunities remain to reduce waste and the underlying overspend. • There is an opportunity to reduce financial risk through reorganisation, adoption of technologies, automation and the removal of unnecessary duplication and waste. • There is opportunity to participate in the national support offer for NHS IMPACT, which will focus on increasing productivity in priority areas • 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. • There is opportunity to commission end to end pathways to maximise out of hospital care, closer to home.

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, ○ Annual Business Plan Planning framework established to track delivery of schemes. ○ Always safety first ○ Urgent and Emergency Care Board ○ ICS Transforming Community Services Programme	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • Service disruption due to ongoing industrial tensions (Managed through operational risk ID 1182 (probability of strike action)) • 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	**Internal** • Specialty Performance meetings • Divisional Improvement Forums • Performance Review Group • Outpatient Improvement Group • 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 NHS Oversight Framework (NOF)). • 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	• Inability to demonstrate delivery of key financial and operational metrics ***(DVFM 033)*** • The Urgent and Emergency Delivery Boards are being reset. The ICB is leading a programme of change which should result in better value for money. The benefits require reporting as part of the financial Recovery Plan. ***(DVFM 038)*** • Update on the developing Clinical Strategy from the ICS

• Scheme of delegation/Standing Financial Instruction • Accountability Framework • Long term case for change the New Hospitals Programme • Contract management and activity under regular monitoring • National Planning Framework and Capital now given to ICS areas. • 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.	decision making at system and PLACE such as priority setting in development and deployment of system and PLACE Urgent and Emergency Care Strategy) • The financial run rate may improve at a slower rate than that which is required. Recovery plans need to ensure that there is sufficient pace or alternative mitigation to drive change quickly and de-risk the financial position appropriately, whilst maintaining a focus on safety ***(DVFM 039)***. • Delays in planning cycle ***(DVFM036)*** • Embody changes such as EVO into the improvement work to better capture benefits ***(DVFM 037)***	• 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. • A monthly update is provided to the Finance and Performance Committee on the Financial Recovery Programme • Temporary Workforce Controls have been reviewed by internal audit and gained substantial assurance. • A Single Improvement Board has been established, chaired by the CEO which will report into Finance and Performance Committee • Workforce and Digital transformation programmes now designed, and the board has been established, to oversee the implementation. This work will transition as the new single improvement plan is established • Updates on the drivers of financial and operational performance shared with Finance & Performance Committee **External** • Head of Internal Audit Opinion/Going concern review • Benchmarking model hospital/GIRFT • External Auditor review • External system assurances, PLACE, ICB and PCB including a new system improvement board, chaired by the NHS England regional team. • The contract monitoring report is shared with FPC to provide stronger assurances on the underlying trading position and associated activity now reintroduced.	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 010	Develop Financial Sustainability Plan as part of the single improvement plan. The Trust's Turnaround Director is focussing on maturing the recovery plan for 2024-25. This should be completed by the end of June.	Chief Financial Officer and Director of Strategy and Planning	30.06.24	30.06.24	Complete	~~Assurance~~ Control	Agreed organisational plan to ensure improvements in finance & operational performance.
DVFM 033	Review performance and accountability framework **Note:** NHS England have updated their oversight framework. This will delay the delivery of the revised PAF.	Director of Improvement, Research and Innovation	30.09.24		Ongoing	Assurance	Inability to demonstrate delivery of key financial and operational metrics
DVFM 034	Develop the People and Culture Plan as part of the Single Improvement Plan and the associated Financial Recovery Plan.	Chief People Officer	30.06.24	06.06.24	Complete	Control	Agreed organisational plan to ensure improvements in finance & operational performance
DVFM 035	Develop an Operational Performance plan as part of the Single Improvement Plan and the associated Financial Recovery Plan.	Chief Operating Officer	30.06.24	06.06.24	Complete	Control	Agreed organisational plan to ensure improvements in finance & operational performance
DVFM 036	To review planning cycle ahead of 2025/2026.	Director of Strategy and Planning	30.09.24		Ongoing	Control	Delays in planning cycle
DVFM 037	Review approach to benefits realisation for programme management and continuous improvement	Director of Improvement, Research and Innovation	30.08.24	30.08.24	Complete	Control	Embody changes such as EVO into the improvement work to better capture benefits
DVFM 038	Report of the UEC Delivery Board Improvement Programme through the Single Improvement Plan and the Financial Recovery Plan.	Chief Operating Officer	31.07.24	31.07.24	Complete	Assurance	Provide assurance on externalities and impact on internal programme.
DVFM 039	Robust delivery of the financial recovery plan and other financial risks which may arise during the course of 2024/25	Chief Financial Officer and Turnaround Director	31.03.25		NEW		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

Summary of updates to risk – August and September 2024

- Update to "Rationale for Current Score" to include detail of an external Improvement Director has been assigned to the ICS to support speedier financial recovery
- New gap in assurance identified regarding updates on the wider Clinical Strategy from the ICS.
- Action DVFM 037 – Noted as being completed, with update that this will be incorporated into SIP and will be picked up with work as it advances for PMO.
- Action DVFM 038 is noted to be completed, as UEC Operational Performance Portfolio reports are included within the Operational Performance Single Improvement Plan.
- New action (DVFM 039) identified in recognition that the financial recovery plan that has been developed needs robust delivery over the financial year. The Phase 1 work relating to the Investigation & Intervention work has now concluded and the system is planning to enter the second phase of work. It is anticipated that there will be support for this work.
- Updates on Capital - The capital available to the Trust in 24/25 was significantly reduced and this required a reduction to sums available to backlog maintenance, medical equipment renewals and ICT renewals. A small contingency of £0.6m was set aside to deal with emerging issues. As at the end of August 2024 the value of remaining contingency is down to £0.3m. There is a serious risk that the Trust will be unable to respond to issues that arise in the remainder of the year and this may impact upon patient safety/care if equipment is not available or parts of the hospital estate are out of service. The Finance Department is in the process of developing a risk and mitigating action plan regarding Capital, taking into consideration other risks across the Trust referencing capital restraints and also the Lancashire Procurement Cluster's risk register position in regard to Capital.
- Updates on Cash - The Trust should be supported by DHSC with cash support up to the level of the agreed control total (£21m). If the plan deficit is not achieved there will be a corresponding cash requirement which will not be supported by DHSC. Furthermore, if the FRP target of £52m is achieved through non-cash releasing measures there will be a further unsupported cash shortfall. Slowing and limiting payments to suppliers to manage the cash position will result in supplier accounts being restricted, increased instances of late payment charges, and prices being increased by suppliers. Compliance against BPPC performance targets will drop and remain well below the 95% target.

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: 21st August 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

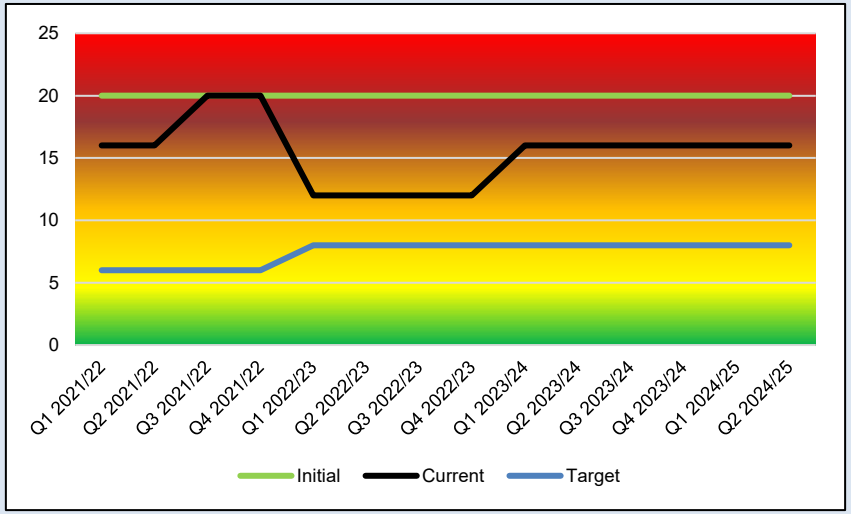
4-8

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.
- Trustwide Financial Recovery agenda requires resource and is impacting on colleague morale, making it harder for staff to focus on working practices, morale, culture.

Risk Rating Tracker (Likelihood x Consequence)

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



	Future Risks • Ageing workforce profile in some services, leading to significant gaps post retirements. • Development of new roles may be hindered by inability to fund training posts and service posts simultaneously. • Impact of 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.	**Future Opportunities** • 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**

• Our People Plan - Workforce and OD strategy related strategies and plans in place
  ○ Single Improvement Plan
  ○ Trust Values
  ○ Workforce Plan
  ○ Attendance Management Reduction 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
	• 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)
		• Single Improvement Plan impact measures
		• 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.
		• External regulatory oversight e.g., Re-accreditation of Workplace wellbeing charter (5 out of 8 domains sitting as excellent)
			[None identified]

• Equality, Diversity, and Inclusion strategy • Freedom to Speak Up and Guardian of Safe working arrangements • Education & Training strategy • Risk Management Strategy • Health and Safety Plan • Always Safety Strategy • Safe staffing reviews • Our Big Plan • Communications strategy • Accountability Framework • Safety Forums • New Hospitals Programme • 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
GPTW002	Identify, develop and deliver transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	Chief Operating Officer	Identify & develop: 31st December 2024 Deliver: TBC as schemes developed		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.
GPTW003	Strengthen the planning guidance/requirements in relation to transformational workforce schemes and incorporate the identified schemes within the planning cycle/submissions	Director of Strategy and Planning	30th September 2024		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.

Risk updates – August 2024

The risk was reviewed by the Deputy Director of Workforce & OD on behalf of the Chief People Officer. There was update made to the rational for current score narrative to include “Trustwide Financial Recovery agenda requires resource and is impacting on colleague morale, making it harder for staff to focus on working practices, morale, culture”.

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: 16th September 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.

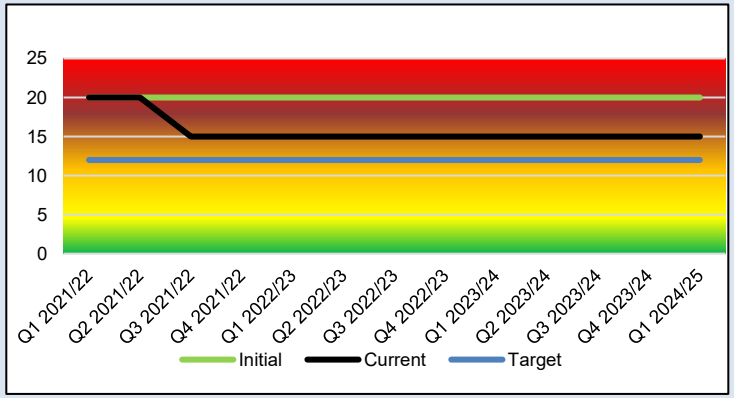
Risk Appetite: Seek – Eager to be innovative and to choose options offering higher rewards, despite inherent business risk.

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.
- Delivering the above will be a major challenge which will require the highest levels of staff engagement and communication, areas where the Trust scores relatively well compared to our peers but we will need significant improvement in future to deliver our ambitions
- Delivering the above will require the Trust to develop its capacity, capability and governance to robustly deliver major change programmes

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



Future Risks

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

Future Opportunities

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

Controls	Gaps in Control	Assurances	Gaps in Assurances

• LTH establishing a Single Improvement Plan approach, taking best practice from other Trusts/systems drive transformation at pace
• Workstream related strategies in place
  o Clinical Strategy
  o Digital Strategy,
  o Estates Strategy, including New Hospital Programme
  o 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	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	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	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	30th September 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
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		Ongoing	Control	• Integration of services and pathways
FFTF 007	Redesign our Social Value Strategy	Chief People Officer	~~30th September 2024~~ 31st December 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	~~1st August 2024~~ 30th September 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working. • Single Improvement Plan approach still under development

Updates – August and September 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:** The PCB "ONE Team" has been retitled as the Collaboration & Delivery Group and is focusing on driving progress for Stroke and Gastroenterology – LTH are represented by the CNO, COO and DoS. The ICB have finalised the Urgent Care Strategy, following feedback from all Trusts including LTH. Good engagement has taken place with Place Leaders and Health and Wellbeing Boards in Chorley & Preston regarding the draft LTH Long Term Strategy. L&SC Strategy Directors have shared their current/draft strategies and a session is with planned with CEOs and other key leaders to consider alignment. The 4th Strasys Workshop took place – please see the External Dependency update paper for more details. The Place level Urgent Care plan is under development, supported by the LTH Continuous Improvement team. LTH Directors continue to invest significant time and energy into place/system working to maximise our influence e.g. the DoS is the SRO for Elective Recovery and EPR Convergence, the CMO is the lead for the Cancer network, the COO is the SRO for the Gastro fragile services work, the Director of CI is one of the SROs for the system Frailty work etc.
- **FFTF 004 – Develop and deliver Digital Northern Star strategy** OneLSC technical readiness has progressed with a plan for Digital to Tupe in November. The single ICS wide EPR strategy is progressing and development of an ICS wide strategic digital plan framework is underway. This includes mapping over 300 clinical and operational systems that need harmonising across the ICS.
- **FFTF 005 - Deliver staff engagement/comms strategy (including reputation monitoring/management)** - Stakeholders continue to be informed of key successes and challenges via proactive media activity; series 3 of the Channel 5 documentary Cause of Death; briefings on specific issues; social media activity; Trust Matters Magazine; updates at Board; management of reactive media enquiries and VIP visits. Within internal communications key activity has been around the Trust's Financial Recovery Plan and the implementation of the new Single Improvement Plan; publicising the One LSC engagement workshops and reassurance and practical messaging following the terrible Southport stabbings and subsequent civil disorder and racist and Islamophobic activity. Our bimonthly All Colleague Team briefs and Senior Leaders Forms continued to provide the opportunity to brief staff on key issues as well as hearing and celebrating their success stories and continue to attract several hundred participants either on the day or watching back online. Our website presence has continued to increase over the last two months, with an upwards trend of engaging with more of our local population. Our social media channels are also continuing to gain increased interaction. The team continue to lead on shaping supporting and promoting collaborative work cross the system including One LSC and Pathology. Preparation is underway for an increase in communications and engagement for the clinical model as part of the New Hospitals Programme.
- **FFTF 006 - Establish new governance arrangements to support the development of the PCBC in conjunction with the programme office and the ICB –** the new Provider Collaborative Managing Director has now commenced in post and will be driving the agreed PCB plan to strengthen the existing governance arrangements and to establish new governance arrangements.
- **FFTF 007 - Redesign our Social Value Strategy** – Action amended from "Deliver" to "Redesign" of the Social Value Strategy to more accurately reflect the action being taken, with an extended due date to 31st December 2024 as the strategy is currently being re-written and will be presented at Board in December 2024.
- **FFTF 008 - strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change** –An update on the Trust Long Term Strategy was given to the Board on the 25th July and 3rd September, which reported that the Trust engagement events were well attended and well received. The Trust PMO is now established and The Business Case to review/finalise the recurring resources needed for our PMO will be produced in the next 4 weeks. The Single Improvement Plan was agreed at the August Board meeting.

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: 17th July 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

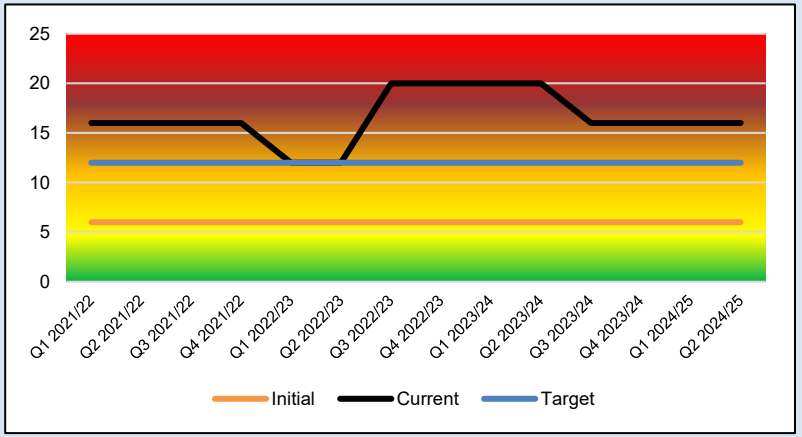
9-12

Rationale for Current Score

- Continuing inability to meet Trust mandatory training targets across all disciplines, which has resulted in continued breaches of CQC regulations.
- A number of areas of Postgraduate Medical Education are being monitored within the NHSE Intensive Support Framework.
- Audit requirements for management of research and educational income limit flexibility to deliver educational activity which is based on academic years or to support innovative developments funded through income generation.
- Inability to invest research and educational income in capital development programmes to expand our education infrastructure.
- 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 and difficulties regarding access to diagnostics across the board to support R&I, notably 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
- Service pressures impacting availability of staff to be released from clinical environments to attend essential and mandatory education and training.

Risk Rating Tracker (Likelihood x Consequence)

Initial: 2x3= 6 Current: 4x4 = 16 Target: 9-12



Future Risks

- NHSE Long Term Workforce Plan will impact education and training pathways for new and emerging roles.
- Potential impact of OneLSC on Education and Training provision at LTH.
- Capacity for effective marketing and communications.
- Potential impact of the New Hospitals Programme on Education and Research 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 NHSE

Future Opportunities

- Continued participation and development of funded, commercial Vaccine Innovation Pathway 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.
- Potential to become Centre of Excellence for Technology Enhanced Learning in partnership with NHSE.

	• 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 Workforce Development funding and/or potential bid income.	• O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist commercial and financial growth • Aspiration to become a University Hospital • Outcomes from Financial Recovery Plan for R&I

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 • Divisional education contracts. • NHS Education Contract. • 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. • Strategy progress for Research and Education reviewed each year at ETR Committee. • 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** • NHSE Monitoring the Learning Environment review meetings. • Full OFSTED inspection completed August 2022 with 'Good' rating achieved. • ESFA audits • NHSE self-assessment return. • Matrix accreditation. • Annual and interim 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	• Inability to meet Trust Mandatory Training targets across all disciplines across all divisions ***(ETR 008)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
ETR 007	Have Research roles in place within 2 Divisions – Suggested Medicine and Women's and Children's Divisions	Head of Research & Innovation	31.03.25		Ongoing	Control	• Lack of research leads embedded in divisions.
ETR 008	Review and consider options to support all disciplines to meet the Trust mandatory training target and ensure reporting provides the necessary assurances, to support regulatory compliance	Deputy Director of Education	31.08.24		Ongoing	Assurance	• Inability to meet Trust Mandatory Training targets across all disciplines across all divisions

Summary of Updates – July 2024

- Regarding Action ETR 008: Following a full review of the training requirements and delivery methods that was presented within the Core Skills report in June, actions are underway in to improve Moving and Handling and Resuscitation training. Improvements and impact to mandatory training compliance will be reported in August Core Skills Report. Work is ongoing to align the reporting format and this will be available for July 2024 training data. This will require further testing and updates will be presented at ETR in October 2024.

Chair's Report to Board		
Chair: Non-Executive Director Ms Kate Smyth	Safety and Quality Committee	
Date: 26 July 2024 & 30 August 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	• Maternity and Neonatal Services Report • Mid-year Safe Staffing Review for Nursing

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	**The continued non-compliance of national cleaning standards. The next phase areas were being costed. The Committee received the cleaning audit data as mitigation for the lack of compliance.** **The continued gap in compliance with cleaning standards. The committee received data that demonstrated the gap in compliance with the frequency of cleaning and this reinforced the requirement to identify a solution to this in the 2025/26 financial plan.** **Mandatory Training compliance is not yet at the required standard.** **Sepsis Training – target audience has been extended and compliance is not yet at the required standard.**
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**Registered midwife staffing remained pressured with newly recruited midwives to help close the staffing gap from September 2024.** **The Trust had been selected in phase 1 of Martha's Rule.** **International visits had been hosted for Hong Kong, Sweden and New Zealand at the Birth Centre due to its national beacon status.** **The Thrombectomy service had agreed a model for delivering a 7 day service with the start date still to be confirmed.** **The external audit of the radio pharmacy service received into the Trust on 26th June 2024 gave an overall risk rating of 'High'. The key issue identified was an acute shortage of suitably trained pharmacists. This had now been addressed and resolved by the service. The report also identified the requirement for a capital development plan for the future; planning for this had commenced. The service had been placed in 'Stage 1 Compliance Management: Enhanced Oversight'.** **The PSIRF quarterly report was received and the Committee was assured of the increased focus on learning and noted the management of incidents was progressing in line with PSIRF expectations.** **AHP Paper – The Committee noted the positive progress in AHP workforce management and the outcomes of the admissions avoidance programme of work.** **Patient Survey (inpatients) – The Committee discussed the outcomes of the national Picker patient experience survey and the improvement required in this area.**

ASSURE **Assurance received; Matters of positive note.**	**The committee received assurance reports relating to** - **Infection prevention and control** - **Clinical audit** - **Patient Experience and Involvement** - **Coroner response for the Thrombectomy 7 day service** - **Safeguarding practices and outcomes** - **Medicines governance** - **Health Inequalities** - **Mid-year Adult and Children Safe Staffing Review** - **Quarterly PSIRF thematic review and learning report** - **Quality Improvement Plan (CQC)** - **Annual AHP Staffing Report** - **Bi-annual Sepsis Report** - **Civil Claims Report** **The reports provided an overview of areas of strength and areas that required continued focus.** **The Committee received annual assurance reports relating to Pathology and the Safety Triangulation Accreditation System (STAR). The Committee scrutinised the NHS Resolution for maternity findings and response, and the maternity and neonatal report. In relation to CNST, where trusts were not compliant with a funded establishment based on Birth Rate Plus or equivalent calculations, the Trust Board and Committee minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.** **The Committee noted the improved boarding situation. The reduction in boarding had continued compared to the peak, however, the boarding of patients was still part of the escalation procedures to maintain safety within the ED.**

Safety and Quality Committee

26 July 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 28 June 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 Report	1.10pm	✓	Assurance	S Cullen
7.4	NHS Resolution - Maternity	1.20pm	✓	Assurance	J Lambert
7.5	Annual STAR report	1.30pm	✓	Assurance	C Gregory
7.6	Annual Pathology Report	1.40pm	✓	Assurance	R Dineley
7.7	Coroner Response for Thrombectomy 7 Day Service	1.50pm	✓	Assurance	R Dineley
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	2.00pm	Verbal	Decision	K Smyth
8.2	Items for referral to the Board or to/from other Committees	2.05pm	Verbal	Information	K Smyth
8.3	Reflections on the meeting and adherence to the Board Compact	2.10pm	✓	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) PSIRF Oversight Group d) Always Safety First Learning and Improvement Group e) Medicines Governance Committee f) Patient Experience and Involvement g) Health Inequalities Group		✓		
9.3	Date, time and venue of next meeting: *30 August 2024, 12.30pm, Microsoft Teams*	2.15pm	Verbal	Information	K Smyth

Safety and Quality Committee

30 August 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 July 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	H Ugradar
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Bi-annual Adult and Children Safe Staffing Review	1.00pm	✓	Assurance	C Gregory
7.3	Children and Young People Report	1.10pm	✓	Assurance	S Cullen
7.4	Quarterly PSIRF thematic review and learning report	1.20pm	✓	Assurance	H Ugradar
7.5	Quality Improvement Plan (CQC)	1.30pm	✓	Assurance	H Ugradar
7.6	Annual AHP Staffing Report	1.40pm	✓	Assurance	C Granato
7.7	Bi-annual Sepsis Report	1.50pm	✓	Assurance	C Roberts
7.8	Picker Inpatient Survey	2.00pm	✓	Assurance	S Cullen
7.9	Radio Pharmacy Inspection Report	2.10pm	✓	Information	G Price
8.	GOVERNANCE AND COMPLIANCE				
8.1	Annual Civil Claims Report	2.20pm	✓	Assurance	H Ugradar
8.2	Strategic risk register review	2.30pm	Verbal	Decision	K Smyth
8.3	Items to alert, advise or assure the Board.	2.35pm	Verbal	Information	K Smyth

№	Item	Time	Encl.	Purpose	Presenter
8.4	Reflections on the meeting and adherence to the Board Compact	2.40pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Terms of Reference: a) IPC b) Safeguarding Board c) PSIRF Oversight Group		✓		
9.2	Exception report from Divisional Improvement Forums		✓		
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Always Safety First Learning and Improvement Group e) Medicines Governance Committee f) Patient Experience and Involvement g) Health Inequalities Group h) Mortality and End of Life Care i) Health and Safety Governance		✓		
9.4	Date, time and venue of next meeting: *27 September 2024, 12.30pm, Microsoft Teams*	2.45pm	Verbal	Information	K Smyth

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity Service Annual Staffing Review					
Report to:	Board of Directors	**Date:**	3 October 2024		
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert		
Purpose of Report					
For Assurance		**For decision**	x	**For information**	☐

Executive Summary:

The purpose of this report is to present the Board of Directors with the findings of the annual maternity staffing review. The report details the workforce strategies taken and the scrutiny and monitoring that has been applied to ensure all aspects of safe staffing have been duly considered. The perinatal quality surveillance dashboard (PQSD) triangulates workforce information, patient experience and clinical effectiveness indicators to provide assurance of safe staffing levels.

In determining staffing requirements for maternity services: the BirthRate plus (BR+) midwifery acuity tool continues to be utilised alongside professional judgment to define the appropriate and required staffing levels. A summary of obstetric, neonatal nursing and neonatal medical staffing levels and quality indicators is also included in the report because of the direct correlation between appropriate staffing levels and maternal and neonatal outcomes.

The findings of the BR+ assessment undertaken at the end of 2022 confirmed that an uplift to the funded establishment of 29.7 WTE (Midwives and Postnatal Support Workers) was required to meet safe staffing requirements. In accordance with the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) year 6, a plan to achieve the appropriate uplift in funded establishment must include a timescale for completion. Given the financial investment required, and the level of midwifery vacancy at the time of the review, a decision was taken to implement the recommendations using a in a phased approach and this was approved by the Board of Directors in 2024. Phase 1 was transacted into the midwifery budget in April 2024 and focused on key leadership and support roles whilst registered midwifery recruitment took place. Phase two is included within this recommendation and equates to 6.86WTE Registered Midwives and an investment of £441,708.

The service confirms that the current level of midwifery continuity of carer (MCoC) can continue to be delivered safely without impacting on one-to-one care in labour. However, until the projected staffing establishment gaps are filled there will be no further expansion of CoC at this time.

The obstetric consultant rota presence has improved from 76.5 hours per week cover to 88 hours per week because of recruitment to substantive posts. A further internal review is underway to scope the potential to reach 96.5-hour obstetric cover required.

The Neonatal Consultant workforce review has led to the realignment of job plans and inclusion of the ORDER programme resulting in a plan to deliver a 1:8 rota for all grades from February 2025. This will enable the neonatal service to declare BAPM compliance.

Overall compliance rates for Practical Obstetric Multi-Professional (PROMPT) and fetal monitoring training remain over 90% overall.

Within this reporting period, there have been no whistleblowing CQC enquiries relating to staffing levels, however, there have been 3 freedom to speak up cases, these related to generic issues and not culture or safety. A culture improvement plan continues using the results of the SCORE survey to inform the focus.

The highest red flags reported includes those associated with delay in time critical activity, obstetric review, augmentation of labour and review in triage out of hours. This reflects the known pressure points within the service.

Analysis of the PQSD has not demonstrated significant safety concerns or causal harm; however, specific areas of the service continue to report red flags which are associated with pressures in midwifery obstetrics and neonatal staffing. This is evident within key performance indicators relating to deflection and delay of inductions, delay in review in triage and rescheduled community visits. This triangulates with the areas of the service that require workforce investment. Despite this, the service continues to demonstrate stability. Positive evidence of improvement from the PQSD has been demonstrated in booking by 9+6 weeks, PPH incidence in Black, Asian women and stillbirth rates year to date.

Finally, the service has been shortlisted for 2 Royal College of Midwives national awards. These are in recognition of 1. Outstanding Contribution to Midwifery Services: Pregnancy Loss & Bereavement Care and 2. Outstanding Contribution to Midwifery Services: Improving Safety & Quality of Care. The results of the judging are awaited at this time.

Overall, the establishments recommended by the Divisional Midwifery and Nursing Director and 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 the Board of Directors

i. Note the Safety and Quality committee has scrutinised the safe staffing review and endorses the report is approved by Board.
ii. Approve the maternity safe staffing review phase 2 investment, noting this should form part of the 2025/26 financial plan.
iii. Note the Perinatal Quality Surveillance Dashboard and CNST supplementation information as part of the Maternity Incentive Scheme (MIS) requirements for year 6.

Appendices

Appendix 1 BirthRate Plus summary 2022
Appendix 2 Breakdown of Specialist Midwife Portfolio
Appendix 3 Clinical Negligence Scheme for Trusts (CNST) MIS Year 6 Supplementary Information
Appendix 4 Perinatal Quality Surveillance Dashboard
Appendix 5 Red flag reporting

Trust Strategic Aims and Ambitions supported by this Paper:

Aims	Ambitions

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

Previous consideration

None

1.0 INTRODUCTION

The report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust, September 2024 annual midwifery staffing review. The review triangulates workforce information with safety, patient experience, and clinical effectiveness indicators to provide an overview and assurance of safe staffing levels within the maternity service.

The report fulfils the requirement outlined in the National Quality Board (NQB) staffing guidance for maternity services (NQB 2018) and the CNST Maternity Incentive Scheme MIS. The Incentive Scheme guidance recommends maternity services should undertake a bi-annual safe staffing review to demonstrate that there is an effective system of midwifery workforce planning.

The bi-annual review continues to be collated using the three National Quality Board expectations for safe, sustainable, and productive staffing levels adapted for maternity services namely right staff, right skills and right place and time. Additional local measures are included in Table 1 (8.0) to include people planning and well led elements aligned to the Trust Single Delivery Plan.

Table 1: National Quality Board's expectations for safe, sustainable, and productive staffing (2016) adapted for maternity settings.

Right Staff (5.0)	**Right Skills (6.0)**	**Right place and time (7.0)**	**Monitor and Learn (8.0)**
Evidence-based workforce planning every 6 months Appropriate skill mix Review staffing using the BR+ workforce planning tool annually and with a midpoint review.	Multiprofessional mandatory training development and education Working as a multi-professional team Recruitment and retention	Productive working Efficient deployment and flexibility including robust escalation. Workplace national drivers.	Leadership oversight and assurance Safety Culture: Optimising collaborative working across the much wider multi-professional team. Actively seeking the views of women and working in partnership with them to develop and improve services.

2.0 SCOPE

This report details includes the arrangements for midwifery staffing provision across all inpatients, community, and specialist midwifery services and is the 2024 annual report.

It is acknowledged that a safe and effective workforce planning for maternity services must include core medical services. Reference to obstetric, neonatal medical and nursing workforce aligned to national priorities is therefore included. This ensures triangulation of the perinatal workforce and facilitates forward planning and sustainability of the midwifery, obstetric and neonatal workforce as an interdependent continuum.

3.0 METHODOLOGY

A planned safe staffing review is undertaken by the Chief Nursing Officer, Divisional Midwifery and Nursing Director, Finance Business Partner and Midwifery Matrons every 6 months. Findings of each review continue to be driven by the requirements of Birth Rate Plus (BR+) and are cross checked using professional judgement, clinical indicators, and ongoing perinatal safety intelligence.

4.0 MATERNITY SPECIFIC SAFETY AND QUALITY METRICS PERINATAL DASHBOARD

Maternity staffing metrics are presented as part of the PQSD each month which are report submitted to Safety and Quality Committee and presented to the Board of Directors. The PQSD also tracks performance over time in relation to key safety indicators to include perinatal quality governance, experience and regulation, clinical escalation and MIS year 6.

In determining safe staffing requirements, services must continue to hold a helicopter view of safety data, using intelligence as an early warning system or a call to action for safety critical staffing decision making. Determining appropriate staffing levels must also use internal and external sources. This includes but is not limited to Maternity and Newborn Safety Investigations (NMSI), CQC enquiry, thematic learning from Patient Safety Incident Response Framework (PSIRF), Perinatal Mortality Review Tool (PMRT), incidents, safe staffing fill rates for midwifery and obstetric acute cover, coronal regulation 28 cases and safety champion's oversight.

In addition, the service continues to utilise the dashboard to track positive improvement and performance which is used as an indicator of stability and evidence of good clinical practice.

4.1 BOOKING BY 9+6

Evidence of improvement is indicated by the sustained improvement in booking by 9+6 and 12 +6 weeks gestation since February 2024. The is attributed to a redistribution of midwifery resources and the maternity support investment as part of the BR+ phase 1. The service has reported between 50 and 62%, which is a significant improvement against a target of 50%.

4.2 STILLBIRTH RATES

Improvements are also demonstrated in the mean rate of stillbirth year to date. The MBRRACE Report 2022 confirms that the stillbirth rate is nationally 3.35 per 1000 births. Between September 2023 to August 2024 the service rate of stillbirth overall was 2.8 per 1000. When compared with the same period from 2022- August 2023 when the rate was 3.9 per 1000. This demonstrates that rates are lower than the national average and are on a reducing trajectory.

4.3 POSTPARTUM HAEMORRAGE FOR BLACK ASIAN AND ETHNIC MINORITY WOMEN (NHS RACE OBSERVATORY)

The ongoing continuous improvement project in collaboration with the NHS Race Observatory related to PPH within black Asian and ethnic groups has resulted in a reduction in the incidence of PPH. The rates have reduced from 12% to 9% in this cohort. Although this is an early finding from the test of change work, the Statistical Process Control charts have indicated that this is a statistical reduction. This will be continued to be monitored.

5.0 RIGHT STAFF

Maternity teams must have sufficient and appropriate staffing capacity and capability to ensure safe, high quality and cost-effective care for women and their babies always. Staffing decisions must be aligned to operational and strategic planning and must be able to demonstrate sufficient flexibility, capacity and workforce planning to meet demand safety. This includes having effective leadership from floor to board, a clear governance framework, a positive safety culture of learning and transparency with a model of care that promotes choice of place of birth, and which continues to, when possible, to prioritise continuity of carer.

5.1 BIRTH RATE PLUS - EVIDENCE BASED WORKFORCE PLANNING

The Three-Year Delivery Plan for Maternity and Neonatal services (March 2023) states that services should undertake regular workforce planning reviews and where they do not meet the staffing establishment levels set by BR+ do so as soon as possible no later than by 2027/2028.

BR+ looks at both the midwife-to-birth ratio and the considers acuity and complexity, making it maternity-unit specific. The first bi-annual report referred to an increase in complexity of case mix. Although the birth rate has remained stable (4,200), a significant change in the complex care requirements has been demonstrated since 2022. This is expected to increase further with the implementation of the maternal medicine centre and fetal medicines services.

The latest BR+ assessment undertaken in 2022, recommended an uplift to 190.10 WTE. To align the workforce to a 90/10 skill mix split for postnatal and community work, 171.09 WTE Registered Midwives and 19.01WTE Midwifery Support Workers (MSW) are required.

Specifically, 16.67 WTE registered midwives, 5.93 WTE Midwifery Support Workers and 5.53 WTE Health Care Assistants (HCA) would be needed. The findings and uplift have been reviewed and accepted as correct and were approved by the Board of Directors and endorsed by the Integrated Care Board (ICB) Chief Nurse in August 2023.

Although the recommendations to meet BR+ are understood, due to the financial investment required and an existing midwife vacancy, a phased approach to funding was agreed by the Trust and Integrated Care Board. Phase one was approved in April 2024 which funded the specialist midwifery portfolio and the maternity support staff. Phase two requirements are presented within this report to be considered in the 2025/26 financial planning round.

Table 2 Phase 2 approach to comply with BR+

Phase 2 October 2024	WTE required	Costs
Band 6 Registered Midwives (RM)	6.86	£441,708

5.2 APPROPRIATE SKILL MIX

BR + advises that any additional specialist workforce should equate to 10% of the funded clinical midwifery establishment to support for the provision of a safe service. This is anticipated to increase to 12% to reflect the additional specialist workforce aligned to the Ockenden and Three-year plan deliverables. The service confirms that outstanding 2.95 WTE specialist portfolio has been recruited to following the staffing review in April 2024.

5.3 SERVICE DEVELOPMENT FUNDING WORK STREAMS (OCKENDEN)

NHS England provides targeted service development funding (SDF) based on key national priorities and operational planning guidance to support specific work streams within midwifery and obstetrics. The priority focus continues to be on recruitment and retention, bereavement, maternity support and leadership PAs for Clinical Directors (CD). Table 3 details the current allocation of SDF funding for financial year 2024/25 and includes other non-recurrent posts for oversight. It is anticipated that these specific workstreams will be continued as part of the 2025/26 agreement.

Table 3 details the external funding breakdown.

External Funding Workstreams 2024/25	WTE
Preceptorship Lead Midwife B7	0.8
Pelvic Health Midwife B7	0.5
Bereavement midwife B6	0.8
Clinical Director Leadership	2 PA's
Maternal Medicine B7	1.0
RSV Vaccination Lead (2-year funding from NHSE) B5/6	1.0
Total WTE externally funded posts	**4.1**

5.4 FILL RATES

Fill rates for registered midwives (RM) are around 86-90% which is an improving picture overall. The current registered midwifery vacancy rate is 5.25 WTE (vacancy and maternity leave). The midwifery establishment trajectory tracker monitors and tracks staff in post, adjusting for maternity leave to ensure that the establishment meets safe staffing requirements.

All shifts are sent to bank following budget holder approval. If the shift is unfilled then they are converted to agency once a further review of fill rates and safe staffing levels has been undertaken by the Deputy Divisional Midwifery and Nursing Director or Divisional Midwifery and Nursing Director. Consistently the service fills between 50-60% of shifts that are converted to agency. To provide continuity of staffing all agency colleagues have also been offered a bank contract. If this initiative is successful, it will provide a more consistent and sustainable solution to temporary staffing.

Targeted action and innovative recruitment continue, including the registered midwifery apprenticeship, workforce profiling, the over offer during key times in the academic calendar and professional recruitment adverts. Demonstrating a commitment to student midwife education, bespoke teaching sessions are also being delivered by the midwifery and education teams from October 2024 as an example of investing in our future workforce.

5.5 CONTINUITY OF CARER

In accordance with the three-year single delivery plan for maternity and neonatal care, the service continues to monitor their ability to offer Midwifery Continuity of Carer (MCoC). Considering the principles of safe staffing, the Divisional Midwifery and Nursing Director and leadership team regularly reviews the service provision and workforce requirements. They confirm that three established continuity models can be continued without impacting on the safety of the service. This is because the impact of suspension of specialist diabetes care and

home birth services would have a detrimental effect on service delivery with negligible impact on fill rates. Removal of the diabetes continuity team would also put MIS standard 6 related to Saving Babies Lives care bundle at risk. The Core20plus5 ambition of providing continuity of carer to women from Minority Ethnic groups and the most deprived groups has led to analysis of the provision of care and to date has established that 29.3% of minority ethnic groups are receiving continuity of carer compared to 30.3% of white British women. The next development will be to understand the access to continuity based on the Indices of Multiple Deprivation (IMD) and seek to understand the barriers to access and aim to increase this.

5.6 NEONATAL NURSE STAFFING (The British Association of Perinatal Medicine BAPM) FILL RATES

The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard is presented within the Activity Capacity Demand (ACD) report. The most recently published 2023/24 report confirms that the service has enough nurses within the establishment to be compliant to BAPM standards based on the average activity for the previous 3 years.

Neonatal nurse staffing ratios continue to be tracked via the PQSD and neonatal dashboard monthly to ensure that staffing levels are sufficient to meet the BAPM requirements. Performance is also monitored via the Operational Delivery Network (ODN) and a neonatal workforce action plan to detail the wider overarching BAPM best practice standards is submitted for ongoing monitoring.

5.7 OBSTETRIC WORKFORCE

Although the birth rate is falling nationally, there continues to be increased requirements in other areas due to demographic shifts, an aging childbearing population and health inequalities. Rising levels of clinical complexity, medical co-morbidities including diabetes, epilepsy and venous thrombosis continue to place additional pressures on the service. The service confirms that it is fully recruited to consultant posts and that work is ongoing to review the job plans to maximise efficiency. Currently, the consultant rota presence is up to 88 hours per week. This is an improvement on previous months where 76.5-hour cover was provided. The aim of the internal review is to scope the potential to reach 96.5-hour cover. Wider trainee scoping work is also ongoing.

5.8 NEONATAL MEDICAL WORKFORCE

A local workforce review of the neonatal medical staffing requirement to achieve British Association of BAPM standards was undertaken in 2023. Following this, further gap analysis of the workforce has been completed. Realignment of job plans, and use of the ORDER programme means that from February 2025 a 1:8 rota for all grades will be achieved. This will enable the neonatal service to declare BAPM compliance.

6.0 RIGHT SKILLS

Organisations must have robust mandatory training, development, and education programmes for multidisciplinary teams. Boards must assure themselves that sufficient staff have attended such training and are competent to deliver safe maternity care. Staffing establishments must allow for staff to be released to undertake the required training and development. The core national, regional and local priorities for training were included in the April 2024 report and the position remains the same.

The current compliance rates for the MIS year 6 standard 8 in relation to PROMPT, fetal monitoring and neonatal resusitation is included in table 6. Reduced compliance below 90% for trainees is demonstrated. This was anticipated following the new rotation of doctors and a detailed action plan and trajectory for completion is in progress.

Amendments to MIS standard 8 were published on the 27 August 2024 in response to concerns from Trusts that new trainees starting in post would affect the ability to achieve 90% compliance for training by the end of the reporting period. Therefore, for rotational staff that commenced in post after the 1 July 2024, a lower compliance will be accepted, providing there is a commitment to recover this position by 6 months.

This should be demonstrated with an action plan. Although the local trajectory plan anticipates recovery by the end of the reporting period an action plan has been included in Appendix 3 E for assurance and to meet reporting requirements.

Basic neonatal life support and Newborn Life Support (NLS) continue to be monitored. Gap in current assurance relate to 2 nursery nurses who are booked on training in September 2024 and 1 trainee is booked for October 2024.

6.1 SICKNESS ABSENCE

The sickness levels within the service have been variable over the last 12 months. Several interventions by the division and workforce partners, as well as a review of long-term sickness management strategies within the division, has been effective in reducing absence overall. In August 2024 the rate of sickness was 5.54%. This compared favourably to 7.49% in July 2024.

7.0 RIGHT PLACE AND TIME

7.1 RED FLAGS

Midwifery red flags highlight potential areas of staffing concern within the service. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing levels.

The service continues to report and monitor red flag incidents monthly via the PQSD. The breakdown by category is provided in appendix 5. The highest reporting categories relate to delayed induction of labour, delay in obstetric review in triage of more than 30 minutes and delay in time critical activity.

These reporting categories illustrate that the areas of pressure in the service have not changed over time and are consistently reported. Reporting therefore triangulates to known pressure points within the service and consideration of the high reporting red flag indicators should be used as a lever for phase two of BR+ and obstetric middle grade funding as required.

7.2 SUPERNUMERARY STATUS

The requirement for MIS standard 5 is that: **Standard 5 Element C** *The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.*

The service reports 100% compliance to the standard which is consistently achieved. The staffing model with a second band 7 as unit coordinator, is an effective safety netting model to ensure this standard is met. This also provides wider flexibility for the service to safely manage unplanned gaps in the roster. Performance will continue to be monitored monthly via the PQSD.

7.3 ONE TO ONE CARE

The ability to provide one to one care in labour is monitored each month and provides a reference point from which safe staffing levels can be confirmed. Since October 2023, the service has been able to report 100% compliance with one-to-one care for all women across 4 places of birth. At times staff report a red flag associated with one-to-one care. Staff can misunderstand the term one to one care and may declare non-compliance when more than one midwife has provided care throughout labour. When this happens the case notes are reviewed, and findings validated or amended.

7.4 ROYAL COLLEGE OBSTETRICS AND GYNAECOLOGISTS ATTENDENCE

Ongoing monitoring of compliance related to consultant attendance for the clinical situations listed in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' continues. Monthly audits demonstrate 100% compliance with the standards.

Acute obstetric unit medical staffing and consultant availability (daytime labour ward cover and out of hours/on call) is also monitored via the PQSD. The data submission reflects 100% cover month on month. These are important metrics to sense check the system pressures and track the clinical impact of gaps within the obstetric workforce.

The service also monitoring/effectiveness tool contained within the 'RCOG guidance on the engagement of short and long-term locums in maternity' to audit their compliance with the recommendations for locum doctors and have a plan to address any shortfalls in compliance. A monitoring process is in place to ensure that the standards are met. The audit is undertaken bi-annually and 100% compliance has been achieved on both occasions.

7.5 CLINICAL ESCALATION UNIT DIVERT

Both the maternity and neonatal service data indicates that the service continues to be under intermittent times of pressure associated with obstetric, midwifery and neonatal staffing and acuity which is closely monitored. The service confirms that appropriate escalation processes and responses are embedded into practice in line with the North West Maternity Escalation Policy. In addition, the daily GOLD call provides prompt system response and mutual aid in the event of high activity, or a requirement for deflection of work or emergency divert.

Maternity diverts are not currently classified as a national red flag event; however, the service continues to monitor capacity issues that have resulted in a request to divert. There has been one maternity divert in September 2024. This is the first time that the service has been required to divert activity in 12 months. The service was diverted for 10 hours, and this affected two women. The first service user required a triage appointment and returned to Lancashire Teaching Hospital for care in labour and the second required a pre-term emergency caesarean at a neighbouring Trust. This woman was repatriated to the postnatal ward for care when her baby was transferred back to the Neonatal Unit. A letter of apology has been issued to both service users.

The service also collates data related to inability to accept intrauterine transfers. The decision to decline Northwest Connect requests for a level 3 neonatal cot is undertaken using a multi-disciplinary approach, recognising the financial and family impact of a declined admission.

The PQSD so includes a separate breakdown of all categories of transfer associated with capacity. Early signs of improvement have been noted with fewer declined IUT's across both maternity and neonatal services.

7.6 STAFFING RELATED RISKS

Detailed below in table 5 are the open risks on the women's health risk register that are associated with the ability to maintain safe staffing levels.

Table 4 Staffing related risks. (Maternity)

Risk ID	Title	Current risk rating
581	Maternity staffing deficit	15 (Active risk)
1592	Delays in induction of labour process	15 (Active risk)
1292	Inability to accept intra-uterine transfers from other organisations	15 (Active risk)
569	Elective caesarean sections list over running	15 (Active risk)
1708	Deferring and rearranging planned consultations in midwifery led services	15 (Active risk)
1688	Maternity Assessment Suite (MAS) – partial implementation of the Birmingham symptom specific obstetric triage (BSOTS) system.	12 (Active risk)
1535	Delay in implementing a maternal medicine centre for Lancashire and South Cumbria	10 (Active Risk)
1762	Inability of the maternity service to achieve BFI full level 3 accreditation by 2024	10 (Active Risk)

All high risks associated with staffing are reviewed by owners and handlers and monitored by the maternity safety and quality committee. Each risk is considered for status, current rating and assurances and gaps in controls, and this is overseen by the risk management group. This ensures that risks are prioritised and managed effectively.

7.7 MATERNITY TRIAGE RISK 1688

Compliance to the Birmingham Specific Obstetric Triage System (BSOTS standard) and (NICE Guidance for triage review within 30 minutes) continue to be audited and monitored by the service monthly. Over the last 12 months, over 90% of women were reviewed by a midwife within the NICE 30-minute target range. The 15-minute standard set by BSOTS for women seen by a midwife is between 86% and 94%.

Improved performance over time, is consistent with the 9am-5pm weekday obstetric cover in triage that was put in place to improve waiting times and mitigate risk in 2023. Longer waits are typically seen out of hours when the on-call team is responsible for reviewing women in triage. The service is currently exploring how to approach covering the service 24/7 on a substantive basis.

Call handling and dropped calls was identified during the Care Quality Commission maternity inspection as a must do action. The local audit of dropped calls continues to be undertaken daily by the maternity support workers, however the service notes the limitations of this solution and awaits the introduction the contact centre call handling system to queue calls and divert non triage calls via an automated system to other departments. This will ensure a sustainable solution and provide assurance to the CQC when the SAFE domain is reassessed.

7.8 DELAYS IN INDUCTION OF LABOUR PROCESS RISK 1592.

Delays in induction of labour continue to be monitored as part of daily safety huddles and consultant board rounds, these are also captured as part of red flag reporting and linked to the risk register. Timing for admission

for induction is overseen by the capacity and flow manager and when delays occur the on-call team are asked to review risk and plan care in partnership with the woman. The service is developing a monthly audit including clinical outcomes delay data to ensure that delays can be monitored and tracked over time. A focused Maternity and Neonatal Voice Partnership quarterly meeting is planned around experience of induction of labour. Several online engagement sessions are publicised on social media to obtain feedback from service users. The feedback will be shared in due course.

8.0 LEADERSHIP AND BOARD SAFETY CHAMPIONS

The executive safety champions visit the service monthly to provide an opportunity for staff to see and speak with members of the Board and for them to explore whether safety intelligence presented to the Board of Directors triangulates with the 'work as done' in practice. The Maternity and Neonatal Board Safety Champions also continue to support the perinatal quadrumvirate in their work focusing on positive cultures within the services. In addition to the Safety Champions meetings, the Board Safety Champion(s) Perinatal 'Quad' leadership team meetings have now been established bi-monthly.

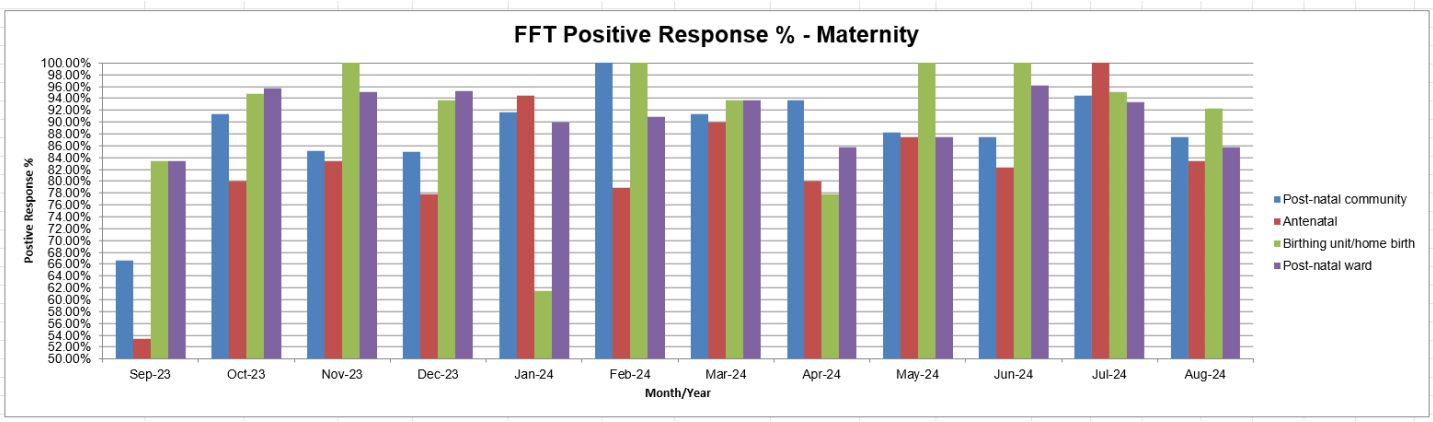
8.1 SYSTEM OVERSIGHT AND ASSURANCE

Local Maternity and Neonatal system and Integrated Care Board level continue to be jointly responsible with providers for implementation, monitoring and oversight of progress against national agenda, independent reviews, safety initiatives and care bundles to ensure that maternity and neonatal care is safer, more personalised, and more equitable for women, babies, and families.
Quarterly assurance and improvement visits with the Local Maternity and Neonatal System have taken place in June, September and November 2024. The service is on track with MIS year 6, 50/89 requirements are validated with the remaining 39/89 on track for completion by the end of the reporting period on the 30 November 2024.

9.0 PATIENT EXPERIENCE

The maternity service continues to actively seek feedback from service users to continuously improve the experience of women and families. The maternity CQC survey, complaints triangulation, lived experience feedback, maternity and neonatal voices partnership and the friends and family response rates provide a wide platform of intelligence in relation to how the service is performing. Graph 1 details the maternity friends and family survey finding from September 2023 to August 2024.

Graph 1: Maternity friends and family survey responses September 2023 to August 2024.



The Friends and Family Test (FFT) is an important feedback tool that provides a temperature check of patient experiences. Table indicates that FFT results for maternity has been variable over the last 12 months, Reduced performance has been linked with midwifery and obstetric workforce establishment variation and this is expected to improve as vacancies are filled. An improvement has been demonstrated across all touch points in July 2024 with all areas improving the average scores. The service will continue to monitor response rates.

9.1 MATERNITY SURVEY

The last CQC maternity survey and the service was published in 2023. The findings of the last survey have been discussed in detail in the April bi-annual report and the 2024 survey is awaited. Once the updated recommendations are available a further update will be provided.

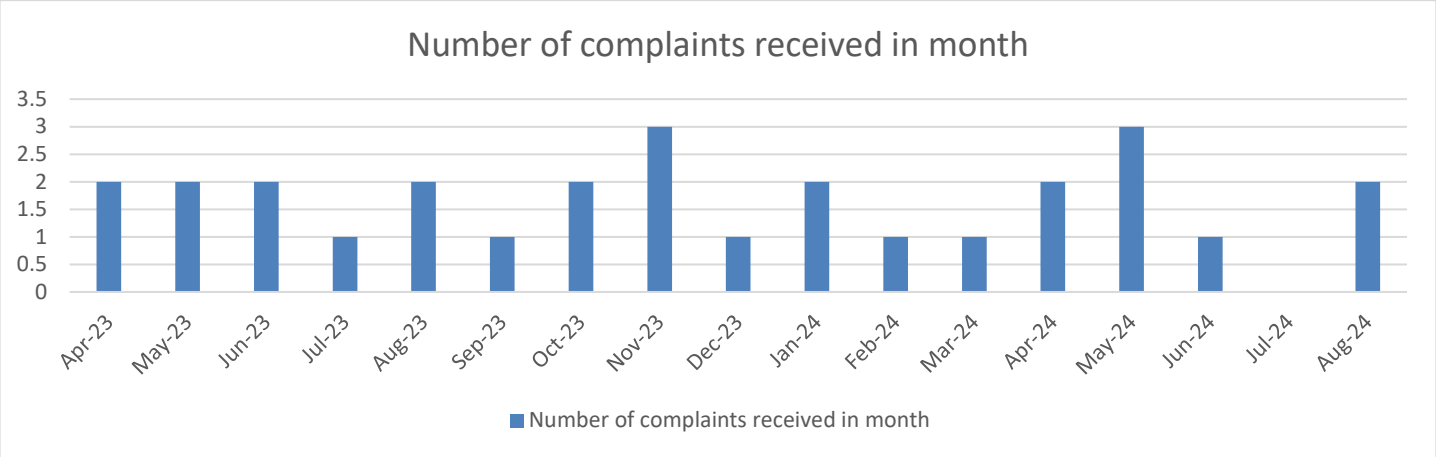
9.2 COMPLAINTS

Learning from patient experience is a divisional priority and the maternity service, along with the rest of the division, meets with the corporate patient experience team on a weekly basis to ensure that there is early identification of learning from complaints, and that a timely response is provided to families. When wider learning is identified from patient experience, the maternity service shares this not only within the organisation but also at system level.

Triangulation of claims, the claims score card, complaints and patient safety incidents is key to learn and improve clinical practice and systems. The maternity service continues to monitor claims, StEIS investigation findings and complaints, and reports into the maternity safety and quality committee and safety champions on a quarterly basis.

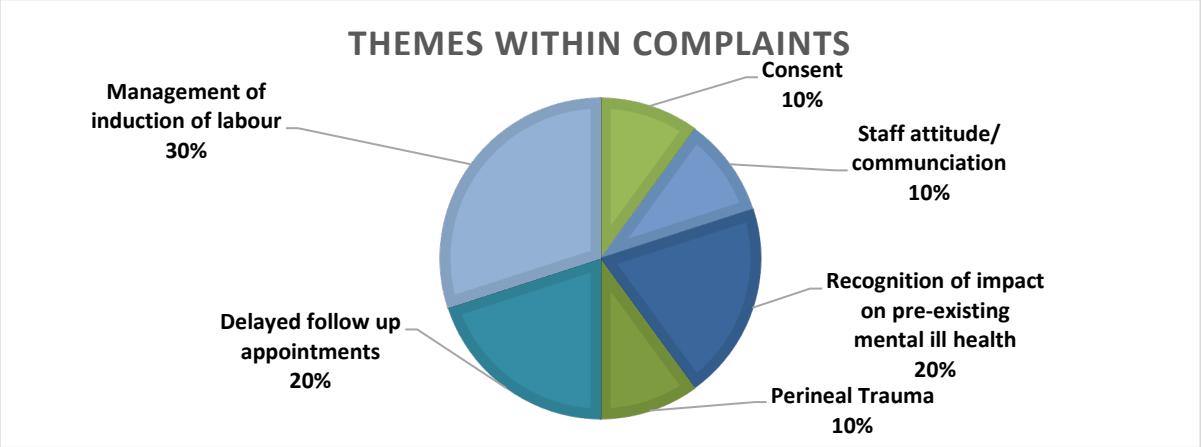
Quarterly thematic analysis of all complaints is undertaken by the Matron for Safety and Quality to identify trends and actions to be undertaken. The number of complaints as well as clinical themes are reviewed to aid further triangulation of experience against clinical outcome measures. Graph 2 details the number of complaints received from April 2023 to August 2024.

Graph 2: Number of complaints received from April 2023- August 2024



The latest thematic analysis undertaken in quarter 1 of 2024 provides a snapshot of the trend analysis.

Chart 1 Themes from complaints received from complaints



Within the new letters of claims being considered/ letters of claim received within quarter one, 66% of the claims were associated with management of the second stage of labour with birth being expedited either with Neville Barnes forceps or episiotomy. Of the new complaints received within the quarter, 17% of the complaints were associated with concerns regarding perineal repair and postnatal complications associated with the repair.

Research shows that one in three women experience urinary incontinence in the first year after having a baby and up to three quarters of these women continue to experience this in the following 12 months after giving birth. The three-year delivery plan for maternity and neonatal services includes a requirement for integrated care boards to commission and implement perinatal pelvic health services by March 2024, in line with national specifications.

In December 2023 the Trust appointed a specialist pelvic health midwife. Since coming into post the pelvic health specialist midwife has been delivering OASI (obstetric anal sphincter injury) and APPEAL (antenatal preventative pelvic floor exercises and localisation) training to the multidisciplinary team. In addition to the perineal clinic, a specialist pelvic health clinic is also being established which will offer women a way of seeking help and support quickly and easily when they have pelvic health complications following childbirth. The maternity service continues to closely monitor all instances of third- and fourth-degree perineal tear using statistical process control charts. All incidents are also Datix reported to allow for an assessment of duty of candour to be made and to action learning timely where identified.

9.3 MATERNITY AND NEONATAL VOICE PARTNERSHIP

The maternity service remains committed to listening and learning from service user feedback to continuously improve services for women and families utilising various platforms to engage and co-produce provision of care. The service has an independent MNVP lead and a joint work plan for 2024/25 is ongoing which has been completed and will be ratified at the Local Maternity and Neonatal Programme Board in October 2024. The plan continues to align to the priorities of the Three-Year Delivery Plan for maternity and neonatal services.

A maternity 15 steps visit has also been undertaken and the final report shared with the service in September 2024. The overall findings were positive with areas for improvement identified and associated actions have been developed.

The MNVP lead continues to attend both maternity and neonatal safety and quality committees. They are also a quorate member of the safety champions bi-monthly meeting which enables co-production and contribution to service delivery.

10.0 STAFF ENGAGEMENT

There has been 3 freedom to speak up escalations in the last 6 months. All 3 cases did not relate to concerns with the culture or safety of the service itself but to other more generic issues. These are detailed in table 7, concerns were reviewed and resolved with actions.

Table 5 details the whistle blowing concerns since between April and September 2024

Concern related to staff car parking
Concern related to business use for car insurance
Concerns with smoking outside of the maternity unit.

The monthly maternity and neonatal engagement forums are held by the Divisional Midwifery and Nursing Director, the Chief Nursing Officer and the Non-Executive Director who all hold a responsibility as named Safety Champions. The forums are held both virtually and face to face and provide a valuable opportunity for staff to speak with and escalate any concerns to the maternity and neonatal safety champions. The latest you said we did is included in appendix 3 D. Listening events have also been undertaken in 2024 across all staff groups and actions have been taken in response to feedback received.

11.0 SCORE SURVEY

The SCORE survey measures important dimensions of organisational culture such as local leadership, learning systems, resilience / burnout and work-life balance. The insights and findings from the report are critical for improvement and the ability to drive habitual excellence. The SCORE survey has been funded and undertaken as part of the national perinatal safety programme.

In April 2024 153 colleagues participated in the survey and answered questions specifically around culture and engagement. Local leadership (42% positive result) and safety climate (40% positive rate) are two of the key parameters that are considered as significant temperature checks when understanding culture. Table 6 details a snap shot of the Trust benchmark percentile scores for these parameters from 2024. It also includes other notable positives.

Table 6 Comparator summary SCORE 2024.

Culture Score Domains	SCORE 2024	Ranking	Breakdown of questions (Percentile)
Local leadership (Regularly makes time to provide positive feedback)	52% (Agree or strongly agree	64th Percentile	65th in this work setting, local leadership provides frequent feedback about my performance. 64th in this work setting, local leadership is available at predicted times. 62nd The values of the leadership are the same values that people in this work setting think are important.
Safety Climate (I would be safe being treated as a patient here)	66% (Agree or strongly agree	49th Percentile	28th Errors are handled appropriately. 44th My suggestions about quality would be acted upon.
Growth Opportunities (I have a feeling that I can achieve something)	67% (Agree or strongly agree	51st Percentile	44th, I have enough variety in my work. 54th I have opportunity for personal growth.

Table 7 Headline feedback and includes areas of strengths and opportunities from the SCORE survey

Strengths	Opportunities
Safety Climate Work life balance Improvement Readiness	Burnout Climate Teamwork Intention to leave

Creating supportive and learning cultures for staff as well as having opportunities for personal and professional development will be key focus areas for the culture plan. The existing Divisional People Plan includes ongoing leadership and safety culture actions which are progressing well. The plan will also include actions arising from the SCORE culture survey in due course, once the staff feedback sessions are completed. The Safety and Quality Committee will be updated in due course.

11.1 CULTURE OF SAFETY

In 2022 The Royal College of Obstetricians (RCOG) and the Each Baby Counts project launched the escalation toolkit. The campaign is to help maternity units to build the right culture, behaviours and conditions that enables effective clinical escalation. The project acknowledges that at times of immense pressure, a rise in incivility is often seen which in turn has the potential to impact adversely on patient safety. The campaign interventions are designed to promote excellence in communication, teamwork, and escalation by providing standardised frameworks for all staff to use.

Since July 2024 and in response to feedback from listening events, the maternity service has implemented workshops targeted at key staff groups across the multidisciplinary team. To date 48 members of the multidisciplinary team have attended the workshops and sessions will continue until October 2024. In addition, the service has developed training videos to standardise the use of safety critical language. The teach or treat communication strategy has also been implemented. Team of the shift boards have been introduced in all clinical areas to support flattening of the hierarchy and create a supportive environment, which empowers staff of all levels to speak up when they identify deterioration or a potential mistake.

12.0 CELEBRATING SUCCESS AND MILE STONE ACTIONS

The principle of continuous improvement is a key enabler to safer maternity care. The team is encouraged to contribute and celebrate when things go well.

Each year the Royal Collage of Midwives hold an awards ceremony to commend and highlight exemplar evidence-based projects showcasing world-class midwifery standards. This year the service has been shortlisted for two awards across 2 categories. These are detailed in table 8.

Table 8 Royal College of Midwives nominations 2024

Category	Team
Outstanding Contribution to Midwifery Services: Pregnancy Loss & Bereavement Care	Claire Braithwaite Bereavement Lead Midwife
Outstanding Contribution to Midwifery Services: Improving Safety & Quality of Care	Tulip Continuity Team (Diabetes care)

The service has recently implemented a new public health vaccination service for Respiratory Syncytial Virus (RSV) in response to a call to action from NHS England. This initiative has been introduced at pace to enable all pregnant women to be offered a vaccination to protect their baby against RSV. There is a significant burden of RSV illness in the UK population, which has a considerable impact on NHS services during the winter months.

13.0 CONCLUSION

This report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust annual maternity staffing review 2024. The review identifies a service that is stable but is demonstrating the need for additional midwives to reduce the delays associated with delays in induction. The maternity service continues to experience intermittent pressure resulting from higher acuity and staffing vacancies and this is reflected in the red flag Datix reporting. Colleagues work flexibly across several areas as required to ensure safety is maintained. Deflection and divert procedures are utilised to maintain safety in line with the Regional Escalation Policy, however the impact on families continues to be acknowledged and prioritised.

There is a robust set of oversight arrangements in place ensuring maternity services retains a high profile within the organisation and dedicated Board level leadership. The outstanding phase 2 of the Birthrate plus investment is required as part of the 2025/26 financial planning enabling evidence of compliance with BR+.

In line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Divisional Midwifery and Nursing Director and the Chief Nursing Officer confirms that they are satisfied with the outcome of the bi-annual safe staffing assessment.

15.0 RECOMMENDATIONS

It is recommended the Board of Directors

i. Note the Safety and Quality committee has scrutinised the safe staffing review and endorses the report is approved by Board.
ii. Approve the maternity safe staffing review phase 2 investment, noting this should form part of the 2025/26 financial plan.
iii. Note the Perinatal Quality Surveillance Dashboard and CNST supplementation information as part of the Maternity Incentive Scheme (MIS) requirements for year 6.

APPENDIX 1 BIRTH RATE PLUS

Birthrate Plus® Staffing: inclusive of 23% uplift

Clinical WTE required	
Delivery Suite: • Births • A/N cases • Postnatal Readmissions • Non-viable pregnancies • Induction of labour	45.90wte RMs
Triage - BSOTS Model	14.69wte RMs
Preston Birth Centre • Births & postnatal care • Births only • Transfers to Delivery Suite	21.36wte RMs
Antenatal Ward • A/N Admissions • Inductions of Labour Postnatal Ward • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions • Postnatal ward attenders	11.02wte RMs *min staffing 2 RMs per shift)* *38.38wte* *(Includes B3 MSWs for postnatal care)*
Outpatients Services • midwife led clinics • Obstetric/Specialist clinics • Fetal medicine • CDH clinics • Maternity Day Care Unit	11.43wte RMs 1.84wte MWs
Community Services: • Home births • Community cases • Attrition • Additional safeguarding	37.44wte RMs and B3 MSWs *(Includes 6.00wte for Homebirth Team, and MSWs -postnatal care)*
Chorley Birth Centre • Births/Triage cases	8.04wte RMs
Total Clinical WTE	**190.10wte RMs & PN MSWs**

APPENDIX 2 – SPECIALIST ROLES BREAKDOWN

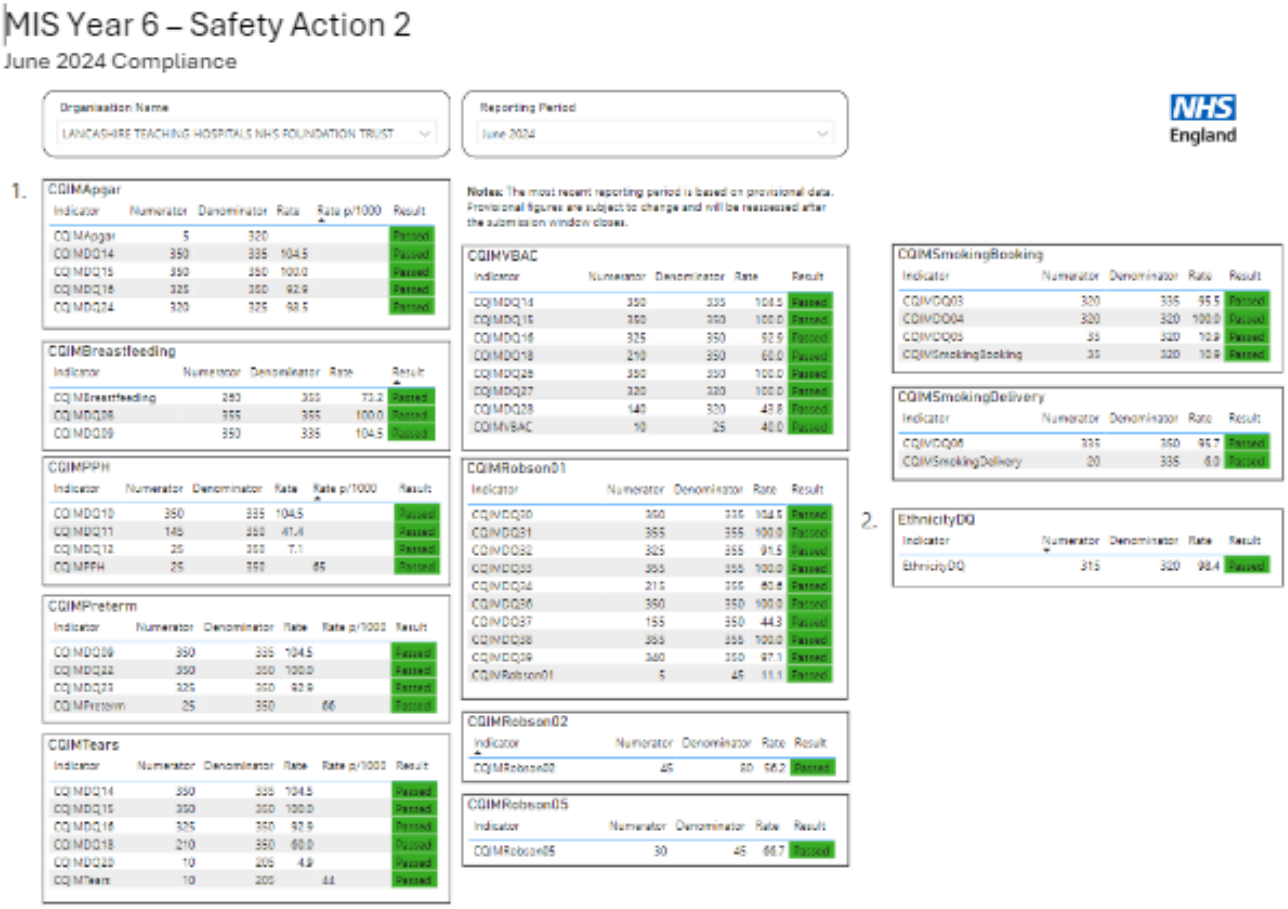
Specialist Midwifery Roles.	WTE	Clinical WTE	Non Clinical
Consultant Midwife	1.0	0.0	1.0
Antenatal & Newborn Screening Lead Band 7	1.0	0.5	0.5
Newborn Screening/Fetal Medicine Lead Band 7	1.0	0.5	0.5
Digital Midwife Band 7	1.0	0.0	1.0
Preterm Birth and midwife sonographer Lead Band 7	0.4	0.4	0.0
Capacity and Flow Coordinator	1.0	0.0	1.0
Named Midwife for Safeguarding Band 8a	1.0	0.0	1.0
Safeguarding Lead Band 7	1.0	0.0	1.0
Specialist Perinatal Mental Health – Band 7	1.0	0.5	0.5
Infant Feeding Coordinator Band 7	0.8	0.0	0.8
Specialist Diabetes Band 7	1.0	0.2	0.8
Public Health Midwife Band 7	1.0	0.0	1.0
Practice Education and Development Midwife Band 7	0.8	0.0	0.8
Bereavement Specialist Midwife Band 7 (Corporate)	1.1	0.2	0.9
Bereavement Midwife Band 6 (Corporate)	0.4	0.4	0.0
Service Improvement Midwife Band 7 corporate team (Corporate)	1.0	0.0	1.0
Information Technology Midwife Band 6	1.0	0.0	1.0
Clinical Audit Midwife Band 6	1.0	0.0	1.0
Governance and Risk Midwife – Band 7	1.0	0.0	1.0
Fetal Monitoring Lead Midwife Band 7	0.6	0.0	0.6
Multiple Birth Lead	1.0	0.4	0.6
Total WTE Funded Posts	19.01	3.1	16.0

CLINICAL NEGLIGENCE FOR TRUSTS MATERNITY INCENTIVE SCHEME INFORMATION PACK (A-H)

STANDARD 1 PMRT A

ID (Datix/PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report drafted within 6 months	Actions ongoing
150075	24+5	Neonatal death	In-utero transfer from BVH for level three neonatal care.	Yes	91767	Yes	Yes	
151211	39+3	Neonatal death	Compassionate reorientation of care following the initiation of therapeutic cooling treatment.	Yes	91936	Yes	Yes	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	Yes	
154632	41+5	Neonatal death	Admitted to MAS with reduced fetal movements, terminal bradycardia identified on admission. Category one caesarean section, baby born in poor condition. Cooling commenced but decision made to compassionately reorientate care to palliative.	Yes	92488	Yes	Yes	Referred to MNSI and StEIS reported. Formal DOC provided to the family.
154842	24+3	Antepartum stillbirth	Admitted with reduced fetal movements and FDIU diagnosed.	Yes	92519	Yes	Yes	AAR performed; to proceed with PMRT investigation.
154826	27+5	Neonatal death	Admitted with spontaneous onset of labour, placental abruption identified on admission. Vaginal breech birth with entrapment of the aftercoming head.	Yes	92532	Yes	Yes	AAR performed; to proceed with PMRT investigation.
158232	33	Antepartum stillbirth	Multiple pregnancy, twin one feticide for complex congenital anomaly at St.Mary's hospital. Admitted unwell one week after the feticide and FDIU diagnosed.	Yes	92922	Yes	Yes	AAR performed, to proceed with PMRT investigation. St Mary's hospital Manchester sharing PMRT review.
158565	26+3	Antepartum stillbirth	Baby known to have an antenatally diagnosed exomphalos. Admitted via the emergency department with abdominal pain, FDIU diagnosed on admission to maternity.	Yes	93059	Yes	Yes	AAR performed, to proceed with PMRT investigation.
161087	23+5	Antepartum stillbirth	In-utero transfer from Bolton for regional neurology bed. Diagnosis of central pontine myelinolysis. Seizures. FDIU diagnosed on day 3 of admission to LTHTR.	Yes	93462	Yes	Review ongoing and shared with Bolton	Bolton reviewing the antenatal care provided – significant safeguarding concerns identified following transfer to LTHTR. LTHTR made section 47 referral made for the mother in her own right and police strategy meeting convened.
168379	24+0	Neonatal death	Vaginal breech birth. Extreme prematurity.	Yes	94527	Yes	Review ongoing deadline, within deadline	AAR to be performed
PMRT 94790	23+3	Neonatal death	Extreme prematurity. Active resuscitation declined by the parents following counselling.	Yes	94790	Yes	Review ongoing deadline, within deadline	AAR to be performed
PMRT 94965	37+2 at birth 27 at diagnosis	Antepartum stillbirth	Antenatally diagnosed FDIU at 27 weeks gestation in a multiple pregnancy. Pregnancy continued to 37+2 weeks gestation	Yes	94965	Yes	Review ongoing deadline, within deadline	AAR to be performed.

STANDARD 2 Maternity Incentive Scheme - Maternity Service Data Set



SAFETY ACTION 6 SAVING BABIES LIVES COMPLIANCE C

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	96%	Partially implemented	96%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	90%	Partially implemented	90%	CNST Met

SAFETY ACTION 7 MATERNITY VOICE PARTNERSHIP UPDATE D

Preston, Chorley and South Ribble Maternity Voices Partnership
L/SC LMNS Board Report

September 2024 / Reporting month July 2024

Current Key Priorities:
1. Completing MNVP 24/25 workplan. Workplan now agree by trust and provisionally at MNVP quarterly meeting - now ready for next ICE Meeting ratification in October.
2. Engaging service users and collating a service user database to ensure we have a consistent and effective feedback stream – New page summary report dashboard still on hold until possible support can be given from an ICB or Trust level to programme, so the dashboard automatically pulls the data from the spreadsheet. In the meantime, use of excel sheet now in place.
3. Continuing to raise profile of MNVP
4. Work on engaging minority groups including recent connections to LGBTQ groups, religious groups and ethnic minority groups. Work ongoing to outreach – build connections and working relationships to ensure collaborations and long-term engagement and feedback results.
5. Recruiting volunteers – previous volunteers dropped out of process.

Activity highlights
Attendance at Preston Mela with NCT – however limited engagement but flyers shared
Engagement session with NCT Breastfeeding and Infant feeding groups
MNVP Quarterly Meeting – face to face and networking event
Supporting feedback for Antenatal and Postnatal service user surveys
Attendance at Chorley Birth centre Summer Event
Attendance at Empowering Women Event
Supporting feedback for new PPH leaflet

Coproduction opportunities / requests for support for coproduction activities
Ongoing Leyland Hotel work inclusive with work with Infant feeding team
Diabetes in pregnancy project with Maternal medicine network

Additional key messages or documents for sharing (attach any docs on email)	From
LGBTQ+ Feedback	

SAFETY ACTION 8 TRAINING COMPLIANCE BY MONTH AUGUST E

	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	**99%** *185 compliant out of 187*	**92%** *11 compliant out of 12*	**100%** *21 compliant out of 21*	**99%** (Same) *217 compliant out of 220*
Fetal Monitoring training Attendance at full day fetal monitoring training	**99%** *181 compliant out of 183*	**92%** *11 compliant out of 12*	**62%** *13 compliant out of 21*	**95%** (Decrease 4%) *205 compliant out of 216*
GAP/GROW	**96%** *179 out of 187*	**92%** *11 out of 12*	**67%** *14 out of 21*	**93%** (Same) *204 compliant out of 220*
Human Factors (attended PROMPT or fetal monitoring)	**99%** *185 out of 187*	**92%** *11 out of 12*	**50%** *14 out of 28*	**93%** (Decrease 6%) *210 compliant out of 227*

	MIDWIVES	CONSULTANT	DR's	ANAESTHETISTS CONSULTANTS	ANAESTHETISTS ROTATIONAL	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT) Including Basic Neonatal Resusitation	**99%** 185 out of 187	**83%** 10 out of 12	**50%** 14 out of 28	**90%** 12 out of 13	**50%** 7 out of 14	**94%** 49 out of 52	**91%** (Decrease 7%) *277 compliant out of 306*
Pool Evacuation	**99%** *185 out of 187*	**92%** *11 out of 12*	**52%** *14 out of 28*	**100%** 13 out of 13	**43%** 6 out of 14	**94%** 49 out of 52	**91%** (Decrease 6%) 278 out of 306

	NICU Nurses	NICU nursery nurses	CONSULTANTS	ANNP's	JUNIOR DOCTORS ST4 and below	JUNIOR DOCTORS ST5 and above	COMPLIANCE PERCENTAGE OVERALL
Neonatal Basic life support	**91 %** **73 compliant out of 80*	**60 %** *4 compliant out of 6*	**100%** *9 compliant out of 9*	**100 %** *6 compliant out of 6*	**100 %** *6 compliant out of 6*	**100%** *5 compliant out of 5*	**92 %** *103 compliant out of 112*
NLS certification medical staff.	**98.8 %**		**100 %** *9 compliant out of 9*	**100 %**	*Not required*	**80%** *4 compliant out of 5*	**95%** *19 compliant out of 20*

	79 compliant out of 80			*6 compliant out of 6*			

SAFETY ACTION 8 TRAINING TRAJECTORY ACTION PLAN F

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
Obstetric compliance with attendance at maternity emergencies and multi-professional training.						
1	**Maternity emergencies and multi-professional training - Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards:** • **Obstetric consultants and SAS doctors.** • **All other obstetric doctors including obstetric trainees (ST1-7), sub speciality trainees, Locally Employed Doctors (LED), foundation year doctors and GP trainees contributing to the obstetric rota.**	Identify obstetric consultants that require PROMPT training that do not yet have a date booked to attend and escalate to the clinical director for obstetrics and gynaecology.	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – action completed, and escalation performed. All obstetrics consultants now have PROMPT dates booked.	
		Identify all obstetric trainees that do not yet have a date booked to attend PROMPT and escalate to the rota master and the clinical director for obstetrics and gynaecology	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – action completed, and escalation performed. All trainees now have PROMPT dates booked.	
		Facilitate two PROMPT study days in September, October and November to provide additional capacity to book learners onto study days to achieve compliance.	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – 2 PROMPT study days have been organised for September, October and November to provide additional capacity for staff to be booked onto PROMPT study days.	
		Closely monitor the training trajectory monthly and provide a monthly training report, broken down by staff group, to the maternity safety and quality committee.	Midwifery education and practice development midwife	30.11.2024	09.09.2024 EH – monthly training report and trajectory provided to the maternity safety and quality committee. For the committee to continue to closely observe compliance improvement. Chair to escalate accordingly if required.	

		Report all instances of non-attendance to the clinical director for obstetrics and gynaecology and the divisional midwifery and nursing director.	Midwifery education and practice development midwife	30.11.2024	09.09.2024 EH – monthly monitoring ongoing.	
2	**Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards:** • **Obstetric consultants and SAS doctors.** • **All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor).**	Identify obstetric consultants that require fetal surveillance training that do not yet have a date booked to attend and escalate to the clinical director for obstetrics and gynaecology.	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – action completed, and escalation performed. All obstetrics consultants now have dates booked.	
		Identify all obstetric trainees that do not yet have a date booked to attend fetal surveillance training and escalate to the rota master and the clinical director for obstetrics and gynaecology	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – action completed, and escalation performed. All trainees now have dates booked.	
		Facilitate two fetal surveillance training study days in September, October and November to provide additional capacity to book learners onto study days to achieve compliance.	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – 2 study days have been organised for September, October and November to provide additional capacity for staff to be booked onto study days.	
		Closely monitor the training trajectory monthly and provide a monthly training report, broken down by staff group, to the maternity safety and quality committee.	Midwifery education and practice development midwife	30.11.2024	09.09.2024 EH – monthly training report and trajectory provided to the maternity safety and quality committee. For the committee to continue to closely observe compliance improvement. Chair to escalate accordingly if required.	
		Report all instances of non-attendance to the clinical director for obstetrics and gynaecology and the	Midwifery education and practice	30.11.2024	09.09.2024 EH – monthly monitoring ongoing.	

		divisional midwifery and nursing director.	development midwife			
Anaesthetic compliance with attendance at maternity emergencies and multi-professional training.						
3	**Maternity emergencies and multi-professional training - 90% of each of the following groups should attend training to meet the minimum standards:** • **Obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors.** • **All other anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota**	Identify obstetric anaesthetic consultants that require PROMPT training that do not yet have a date booked to attend and escalate to the college tutor and the obstetric lead consultant for anaesthetics.	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – consultants have been identified and email of escalation has been sent action is awaited from the anaesthetic consultant team.	
		Identify all anaesthetic trainees that do not yet have a date booked to attend PROMPT and escalate to the rota master and the clinical director for obstetrics and gynaecology	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – trainees have been identified and email of escalation has been sent action is awaited from the anaesthetic consultant team.	
		Facilitate two PROMPT study days in September, October and November to provide additional capacity to book learners onto study days to achieve compliance.	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – 2 PROMPT study days have been organised for September, October and November to provide additional capacity for staff to be booked onto PROMPT study days.	
		Investigate the potential of organising an additional PROMPT study day for anaesthetic trainees that have been identified as being unable to attend the dates already planned in September, October and November 2024.	Midwifery education and practice development midwife	30.09.2024	09.09.2024 EH – communication between the midwifery practice educator and the anaesthetic college tutor is ongoing.	
		Closely monitor the training trajectory monthly and provide a monthly training report, broken down by staff	Midwifery education and practice	30.11.2024	09.09.2024 EH – monthly training report and trajectory provided to the maternity safety and quality committee. For the committee to continue	

		group, to the maternity safety and quality committee.	development midwife		to closely observe compliance improvement. Chair to escalate accordingly if required.	
		Sub split the anaesthetic training compliance report to show compliance for those trainees joining the organisation prior to 01.07.2024 and those joining after.	Midwifery education and practice development midwife	30.10.2024	09.09.2024 EH – to be actioned in the training report presented to the October 2024 maternity safety and quality committee.	
		Report all instances of non-attendance to the obstetric lead consultant for anaesthetics, clinical director for obstetrics and gynaecology and the divisional midwifery and nursing director.	Midwifery education and practice development midwife	30.11.2024	09.09.2024 EH – monthly monitoring ongoing.	
		Anaesthetic college tutor to provide the midwifery practice educator with the names of those anaesthetic trainees rotating into the obstetric rota every 3 months to allow planning of attendance at PROMPT.	Anaesthetic college tutor	30.11.2024	09.09.2024 EH – communication between the midwifery practice educator and the anaesthetic college tutor is ongoing.	
Neonatal Basic Life Support training – Neonatal team						
4	**90% of the following staff groups should attend annual neonatal basic life support training:** • **Neonatal Consultants/SAS doctors or Paediatric consultants/SAS**	Identify consultants requiring NLS basic life support annual update training that do not yet have a date booked and escalate to the clinical director.	Neonatal practice educator.	30.09.2024	09.09.2024 EH – consultants have been identified and escalation has been performed.	
		Identify all neonatal trainees and ANNP's requiring NLS basic life support annual update training that	Neonatal practice educator.	30.09.2024	09.09.2024 EH – trainees have been identified and clarification requested by the neonatal practice educator.	

	Doctors covering neonatal units. • **Neonatal junior doctors (who attend any births) Neonatal nurses (Band 5 and above)** • **Advanced Neonatal Nurse Practitioner (ANNP)**	do not yet have a date booked and escalate to the clinical director.				
		Identify all neonatal nurses requiring NLS basic life support annual update training that do not yet have a date booked and escalate to the matron.	Neonatal practice educator.	30.09.2024	09.09.2024 EH – nursing staff have been identified and booked onto training dates accordingly.	
		Closely monitor the training trajectory and provide a monthly training report, broken down by staff group, to the neonatal and maternity safety and quality committees.	Neonatal practice educator.	30.11.2024	09.09.2024 EH – monthly training report and trajectory provided to the maternity safety and quality committee. For the committees to continue to closely observe compliance improvement. Chairs to escalate accordingly if required.	
		Assess from the training trajectory if additional training sessions will be required to achieve compliance by November.	Neonatal practice educator.	30.09.2024	09.09.2024 EH – assessment being undertaken by the neonatal practice education team.	
		Report all instances of non-attendance to the clinical director for neonatal services, the divisional nursing director for paediatric and neonatology and the divisional midwifery and nursing director.	Neonatal practice educator.	30.11.2024	09.09.2024 EH – monthly monitoring ongoing.	

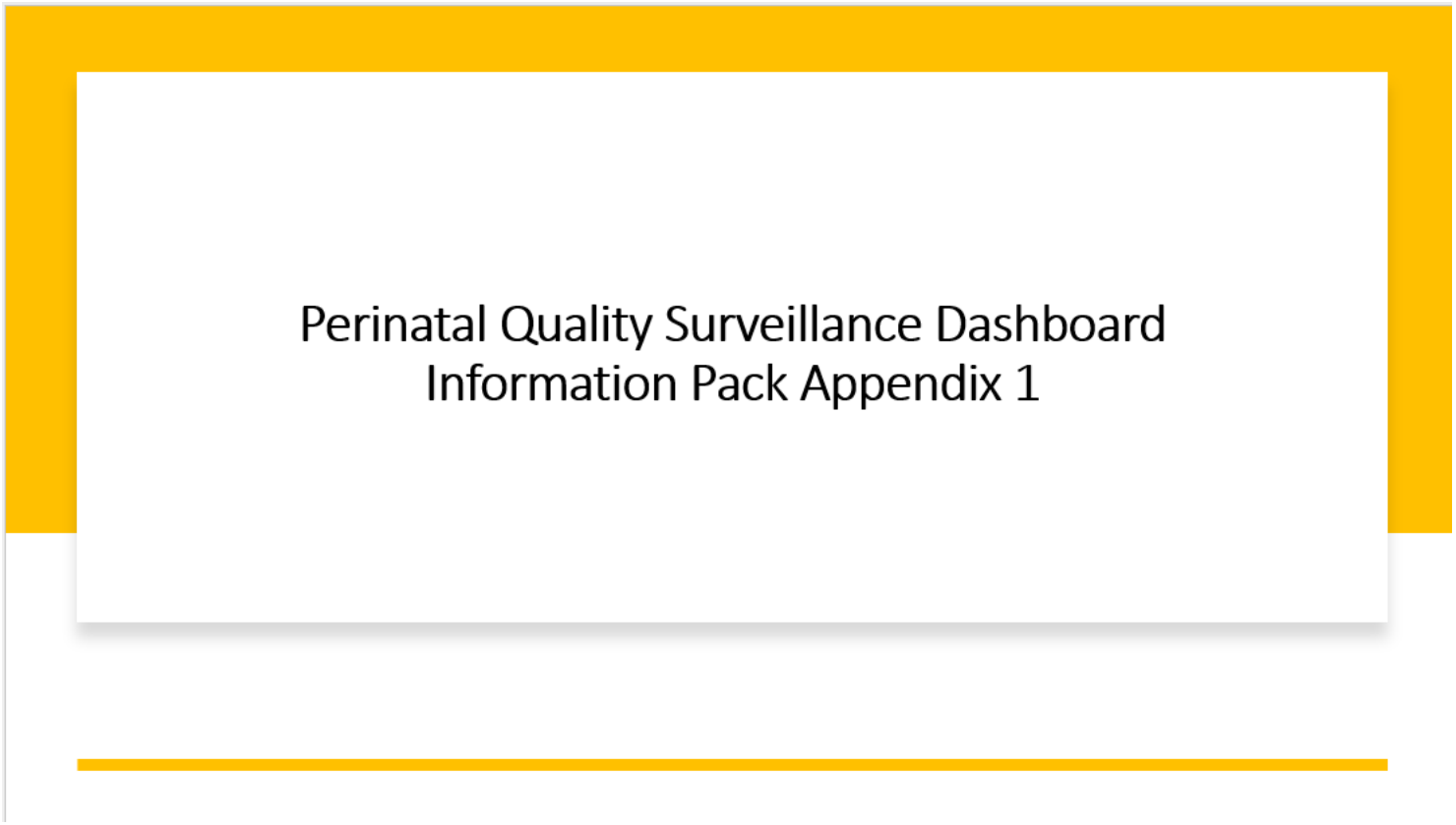
SAFETY ACTION 9 SAFETY CHAMPIONS FEEDBACK LOG G

You said…..	We did….
The IT for electronic CTG monitoring is not reliable and means that paper CTG are being used. This has been a problem for 9 months and leads to concerns regarding accuracy of documentation and evidence of monitoring should case notes be reviewed or problems in care being identified.	Digital midwife to provide update in relation to reliability of CTG recording within Badger Net.
The timeliness and scanning of records is often delayed and the team worry that they may not get into the patient record.	Plan in place to purchase scanners to allow for real time scanning of documents into Badger Net
The drug room was much better located nearer to the delivery rooms.	Positive feedback. No further action required.
The core staff approach has been well received and builds confidence in the skills available within the units.	To continue to ensure all core positions are recruited to in each department.
The increase in MSW has been welcomed and staff felt they would make a difference.	Positive feedback. No further action required.
The ability to understand agency midwife and locum doctor competency and experience is limited and leads to additional pressure on coordinators. Is there a way to enable this.	Competency requirements managed by Medacs for both midwives and doctors. Any concerns identified to be escalated via email to enable review and any required action. This message has been reiterated during the one to ones with the Delivery suite coordinators.
Caesarean section lists over run in the week and lead to additional pressures in theatre access in the afternoon. They do not run over at the weekend, can this be made more productive, so this doesn't happen?	Joint project work with theatre team to be convened to ensure all theatre lists are efficient to ensure best productivity. Meetings also planned progress to discuss the plan for the new theatre 4.
Delivery suite coordinators feel it is important to have 2 senior Midwives, one for fresh eyes and one as supernumerary to be able to co-ordinate. Additional core midwife requested.	To continue to roster 2 co-ordinators per shift as per roster template. Once BR+ requirements met to reconsider this as an option for increasing numbers of core staff.
The delivery suite requires additional midwives per shift to reduce the time women spend waiting for induction. (Up to 7). The future birthrate plus investment is positive to hear as is the new midwifery apprentices and new recruits.	12 new midwives commencing in post Sept/Oct. Bi-annual staffing paper to be submitted to Trust Board in October to request phase 2 of Birthrate Plus (increase in midwifery staffing establishment).

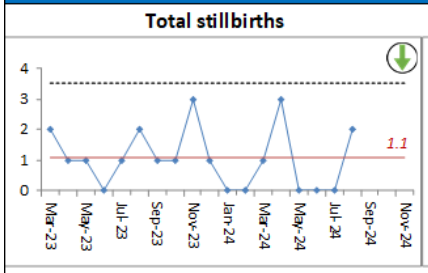
SAFETY ACTION 10 MATERNITY AND NEONATAL SAFETY INVESTIGATION SUMMARY

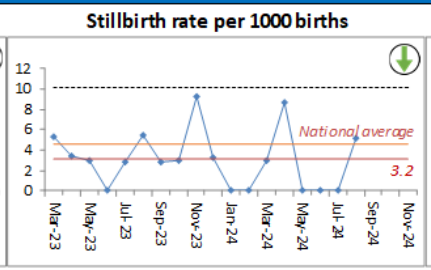
MI number	Case Summary	Early Notification applicable	Early notification completed	Status of HSIB investigation	Final HSIB report sent to legal team.	Duty of Candour
36750	The mother attended the maternity assessment suite with reduced fetal movements and irregular uterine activity. Fetal heart rate monitoring 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
36948	The mother attended the with reduced fetal movements and irregular uterine activity, the mother was due for induction of labour that day. An abnormal fetal heart rate pattern was detected on admission and the mother was transferred urgently for a category one caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated but after 24 hours a decision was made to compassionately reorientate care to palliative and the baby died shortly after.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes

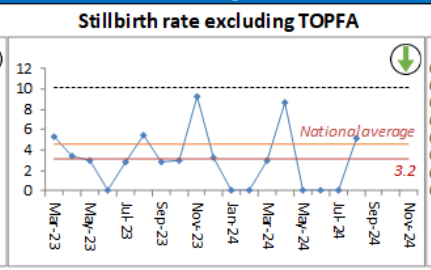
APPENDIX 4 PERINATAL QUALITY SURVIELENCE DASHBOARDS

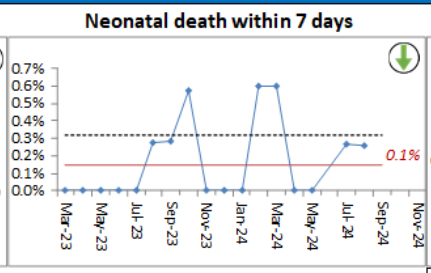


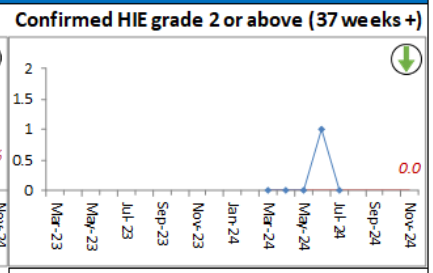
Clinical Safety Indicators

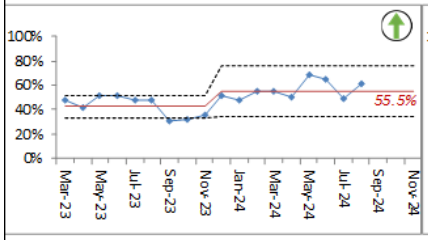


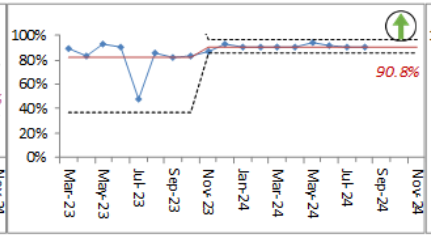


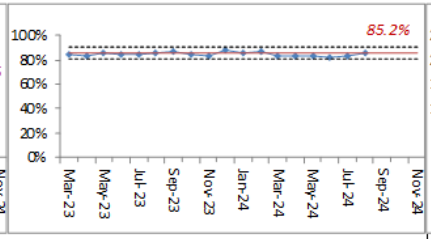


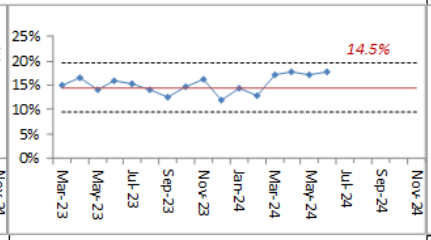


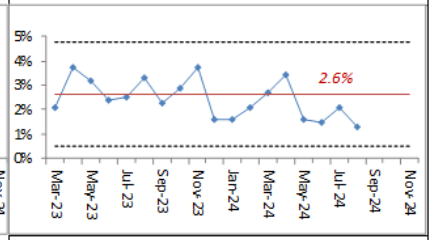


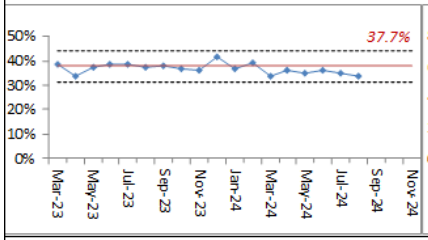


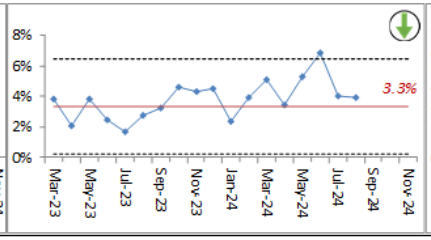


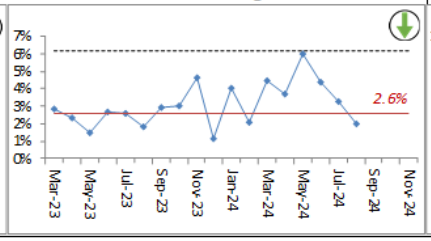


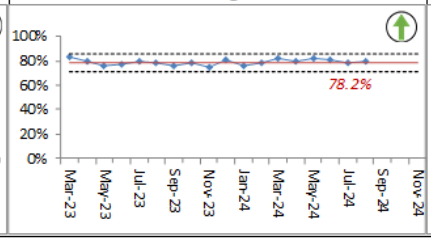


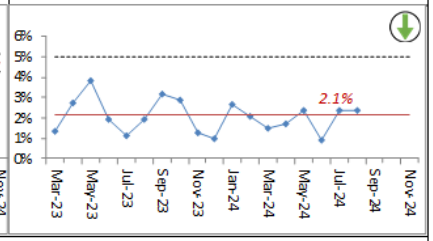


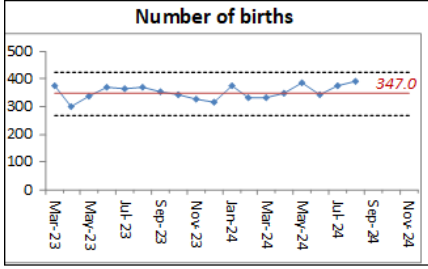












Stillbirth Rates There have been no stillbirths in May and June and July 2024. There were 2 cases in August.

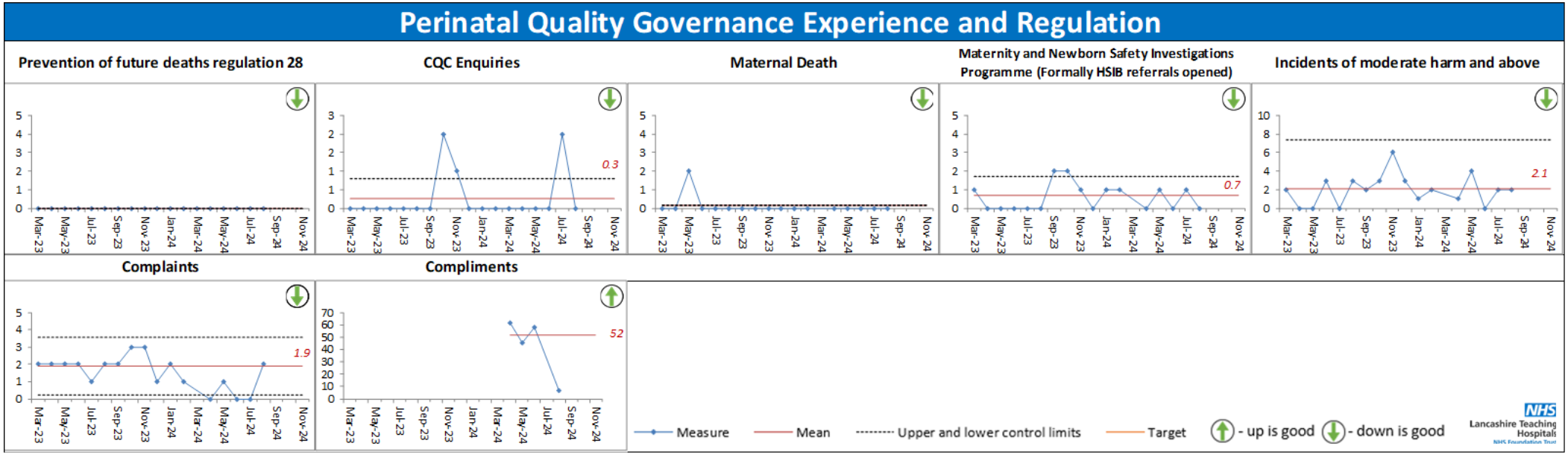
Confirmed HIE The service has added confirmed HIE as a performance indicator as a measure of understanding and tracking safety and quality of care.

Booked by Booking compliance is on an upward trajectory since February 24 . This is the 6th consecutive month where compliance is over the target of 50%

Severe tears The incidence of 3rd and 4th degree tears are being closely monitored. A led obstetrician and midwife are now in post and learning is ongoing with a target date for 90% by September 2024. A positive downward trajectory for 3 touch points is evident.

Measure Mean Upper and lower control limits Target - up is good - down is good

Lancashire Teaching Hospitals NHS Foundation Trust


Perinatal Quality Governance Experience and Regulation
Prevention of future deaths regulation 28
CQC Enquiries
0.3
Maternal Death
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened)
0.7
Incidents of moderate harm and above
2.1
Complaints
1.9
Compliments
52
Mar-23
May-23
Jul-23
Sep-23
Nov-23
Jan-24
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Measure
Mean
Upper and lower control limits
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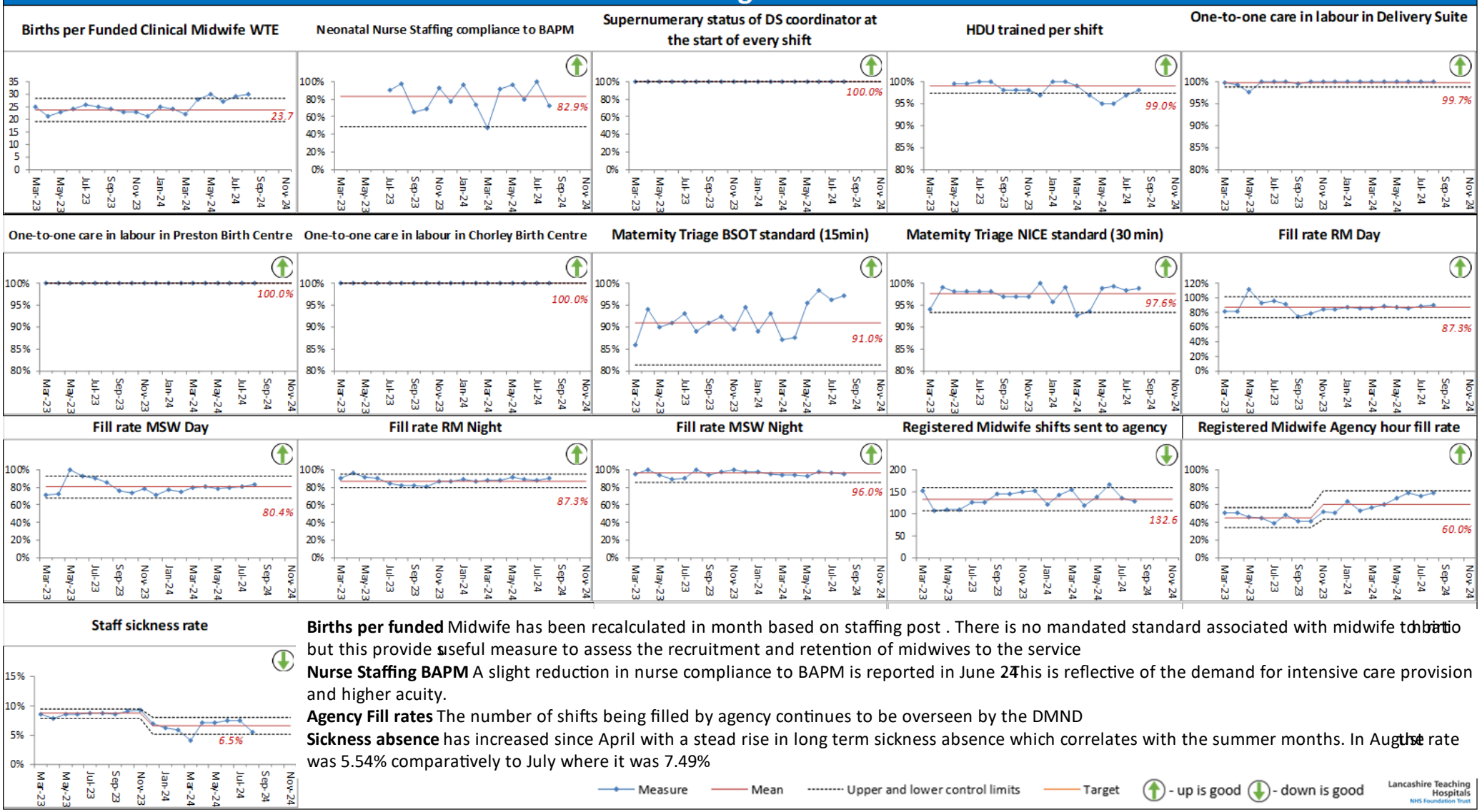
- up is good
- down is good
Lancashire Teaching Hospitals

Safe staffing indicators



Births per funded Midwife has been recalculated in month based on staffing post . There is no mandated standard associated with midwife to birth ratio but this provide a useful measure to assess the recruitment and retention of midwives to the service

Nurse Staffing BAPM A slight reduction in nurse compliance to BAPM is reported in June 24. This is reflective of the demand for intensive care provision and higher acuity.

Agency Fill rates The number of shifts being filled by agency continues to be overseen by the DMND

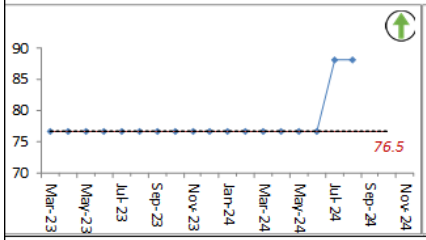
Sickness absence has increased since April with a stead rise in long term sickness absence which correlates with the summer months. In August the rate was 5.54% comparatively to July where it was 7.49%

Measure — Mean ····· Upper and lower control limits — Target ↑ - up is good ↓ - down is good

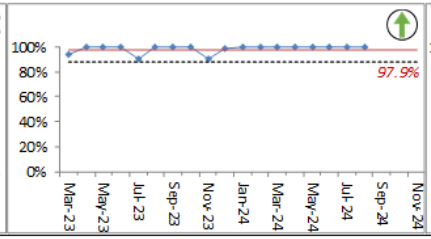
Lancashire Teaching Hospitals NHS Foundation Trust

Obstetric Medical Staffing

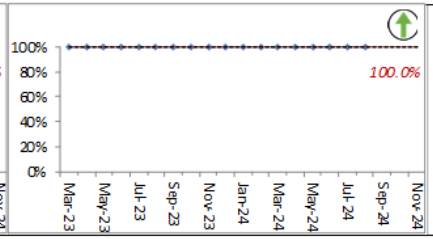
Number of Consultant hours on obstetric unit



RCOG obstetric benchmarking compliance



24-hour acute obstetric medical staffing fill rate



Consultant hours in the obstetric unit. The service continues to invest in consultant funding and the service confirms an increase in hours from 76.5 to 88 hours consultant cover.

RCOG attendance remains at 100%

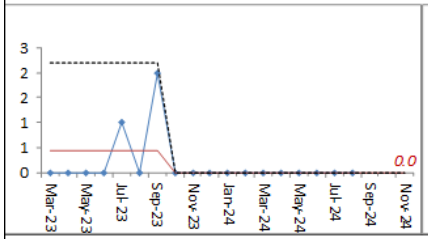
Consultant fill rates Consultant fill rates for acute care continues to be 100%

Measure Mean Upper and lower control limits Target - up is good - down is good

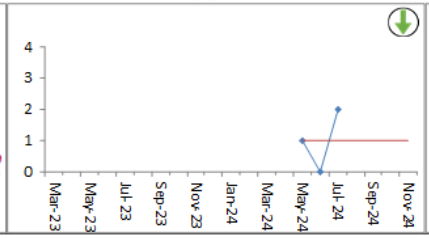
Lancashire Teaching Hospitals NHS Foundation Trust

Clinical Escalation

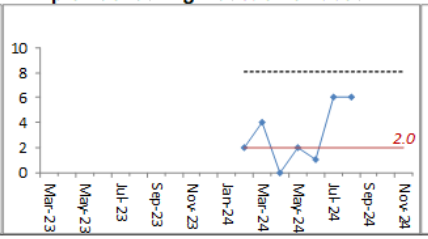
Maternity Diverts



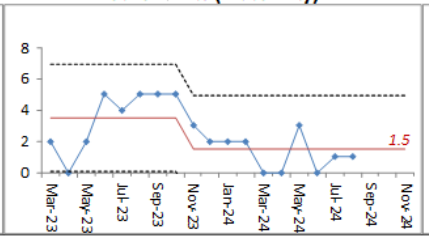
Number of times home birth service stood down



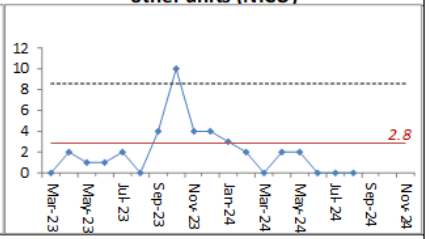
Women who transfer to an alternative provider during induction of labour



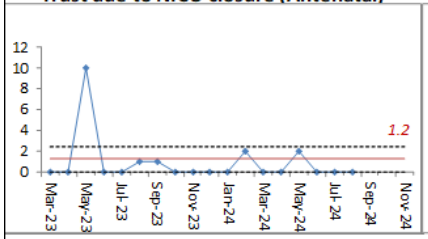
In- utero transfers declined to accept from other units (maternity)



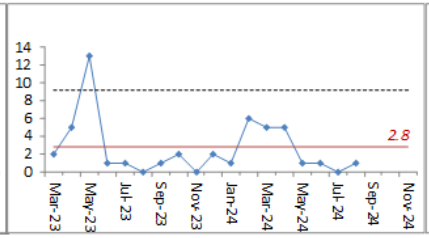
In- utero transfers declined to accept from other units (NICU)



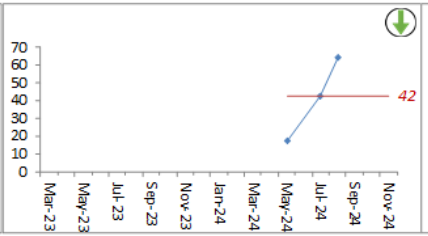
In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)



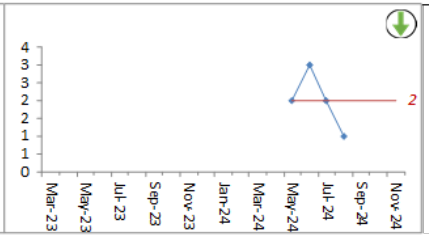
NICU Closure



Delay in inductions (New)



Elective sections stood down (New)



The service has included new monitoring parameters to indicate pressure points in the service. This includes reporting when elective activity and mutual aid is accepted during delays in induction.

In- Utero Transfers (IUT) IUT decline rates have reduced for maternity. NICU did not decline any IUT's in July

NICU Closure There has been an increase in closures associated with intensive care cot capacity since February 24 linked to higher sickness absence. The down ward trajectory is related to the reduced sickness absence rates from over 10% to below 4% in August 2024.

Measure — Mean ------ Upper and lower control limits — Target ↑ - up is good ↓ - down is good

NHS Lancashire Teaching Hospitals NHS Foundation Trust

APPENDIX 5 RED FLAGS

Red flag Reporting Metrics	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	April 24	May 24	Jun 24	July 24	Aug 24
Delay in time critical activity	43	34	38	23	10	28	51	38	16	24	36	18	41
Missed or delayed care> 60 mins in washing or suturing	0	0	0	0	1	1	0	1	0	2	1	2	0
Failure for women to receive the medication required.	0	0	0	1	0	0	0	0	0	0	3	1	0
>30-minute wait for pain relief.	2	3	0	1	0	1	1	0	0	4	3	3	0
Lack of full examination when woman presents in labour.	1	1	1	1	0	1	0	1	0	0	2	1	0
>2-hour delay in induction?	10	16	10	7	0	23	9	18	9	16	20	22	42
Delay in recognition of and action of abnormal signs.	2	0	0	4	0	1	0	1	0	2	0	1	0
Inability to provide one to one care in labour?	0	1	0	0	0	0	0	0	0	3	4	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	29	43	38	20	46	24
>30-minute wait for obstetric triage.	29	25	11	10	5	9	15	12	30	31	43	47	20
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	0	0	0	1	0	4	1	0	0	1	2	0	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)	5	15	8	19	0	23	18	12	5	0	30	30	28
Was there a delay in transfer once labour was established? (New parameter Oct 22)	1	1	1	1	0	2	1	2	0	3	3	1	1
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)	1	0	0	1	0	0	0	0	0	1	2	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	1	0	0	1	0	0	0	0	0	0	0	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	1	3	1	1	0	0	1	1	0	1	1	1	0
Has there been any cancelled or delayed community work? (New parameter Oct 22)	4	85	14	5	0	28	38	28	95	12	13	25	5
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)					0	19	18	2	9	7	12	17	9
Total numbers of red flags	**105**	**205**	**103**	**90**	**17**	**156**	**170**	**146**	**207**	**145**	**195**	**219**	**171**

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Adult and Children Safe Staffing Bi-annual Review							
Report to:	Board of Directors			**Date:**	3 October 2024		
Report of:	Chief Nursing Officer			**Prepared by:**	C. Gregory, N. Ross		
Purpose of Report							
For decision		x	**For assurance**		**For information**		

Executive Summary

The purpose of this report is to detail the findings of the Lancashire Teaching Hospitals NHS Foundation Trust 2024 bi-annual nurse safe staffing review to provide assurance to the Board of Directors that safe staffing levels have been set within the services. The report triangulates workforce information with safety metrics, patient experience and clinical effectiveness indicators (Appendix 1). The report has been scrutinised by the Safety and Quality committee in August 2024.

The report fulfils the requirement outlined in the Developing Workforce Safeguards (NHS Improvement), 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.

The review triangulates staffing and outcome data across 4 clinical divisions: Surgery, Medicine, Women's and Children's and Diagnostic Clinical Support (DCS) and includes all admission/assessment areas; adult, neonates and children and young people inpatient areas and community inpatient wards.

Surgery
The bi-annual nurse safe staffing review has concluded that clinical areas have safe staffing establishments in place and that the use of daily safe staffing processes for deployment and documentation of mitigations are being utilised effectively within the division of surgery.

Medicine
The bi-annual nurse safe staffing review has concluded that clinical areas have safe staffing establishments in place and that the use of daily safe staffing processes for deployment and documentation of mitigations are being utilised within the division of medicine with the exception of ward 17 that requires temporary additional staff at times to respond to enhanced care patients, this will be reviewed further as part of the annual review once the transformation work in medicine has been completed.

Emergency Department and Urgent and Emergency Care Pathway
The bi-annual nurse safe staffing review has concluded that the emergency department is enacting safe staffing establishments, albeit, these continue to exceed the allocated budget in response to continued escalation within the ED. The department proactively engages in daily safe staffing processes for the deployment of staff in

response to increased occupancy. The new Acute Medical Unit (AMU) pathway is being developed to take effect during Quarter 3. Once agreed, this will require a review of nurse staffing levels which is anticipated to fall between the allocated 6 monthly mandated reviews. Until the impact of the new pathway has been assessed, the professional judgement for ED is that the staffing levels remain unchanged and are considered safe and appropriate, with the caveat that there is an ability for the department to flexibility respond to peaks in activity and respond with additional staff to an increasing number of patients waiting for an inpatient bed. The report outlines a defined approach to this, with staged escalation and staffing increases that will allow a greater understanding of the overspend relating to staffing when the department is escalated. Appendix 2 outlines the approach to this.

Women and Children's

The bi-annual nurse safe staffing review has concluded that clinical areas have safe staffing establishments in place and that the use of daily safe staffing processes for deployment and documentation of mitigations are being utilised within the division of women's and children's. Maternity services are scheduled to undertake their focused bi annual review in September 24 which will focus on the next steps of implementing Birthrate plus.

DCS including Community Services

The bi-annual nurse safe staffing review has concluded that clinical areas have safe staffing establishments in place and that the use of daily safe staffing processes for deployment and documentation of mitigations are being utilised within the division of DCS. The safety and quality metrics for Critical Care indicate a safe, stable service whilst the service has introduced a new level1 area allowing a reduction of 1 Registered Nurse per shift leading to a cost improvement contribution.

NHS England Nursing and Midwifery workforce review 5 July 2024

A scheduled review with the NHS England workforce team took place on 5 July 2024. The review identified a number of areas of positive practice, including; strong engagement from recruitment lead with NHS E recruitment community of practice, low number of RN vacancies, high bank fill rates, adherence with agency cap rates, no agency HCA use, progress with Professional Nurse Advocate (PNA) implementation, safe staffing arrangements, international recruitment progress and the health and wellbeing offer from the Trust. Areas that require improvement were identified as, retention and vacancy rate of HCAs, Registered Midwife recruitment, sickness rates (although noted to have improved in the last quarter).

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 the Safety and Quality committee has scrutinised and endorse its approval.
ii. Approve the bi-annual staffing review, the approach to managing safety in the ED and confirm it is satisfied of the assurances within the report.

Appendix 1 – Triangulated patient and workforce outcomes
Appendix 2 – ED escalation safe staffing

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To offer excellent health care and treatment to our local communities	☒	Consistently Deliver Excellent Care	☒
To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☒	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒
Previous consideration			
None			

1.0 INTRODUCTION

The report details the findings of the Lancashire Teaching Hospitals NHS Foundation Trust 2024 bi-annual nurse safe staffing review. The bi-annual review triangulates workforce information with patient safety, patient experience and clinical effectiveness indicators to provide assurance of safe nurse and midwifery staffing levels within the services.

The report fulfils the requirement outlined in the Developing Workforce Safeguards (NHS Improvement), 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)

2.0 SCOPE

The review triangulates nurse staffing and outcome data across 4 clinical divisions, Surgery, Medicine, Women's and Children's and Diagnostic Clinical Support (DCS) which include admission assessment areas, adult, neonates and children and young people inpatient areas and community inpatient wards.

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		
Cardiac Unit CDH			
Rookwood A			
Rookwood B			
Hazelwood			
Cuerden			

3.0 CONTEXT

3.1 Safe staffing establishments are annually approved by the Chief Nursing Officer and agreed with the ward manager, matron, and divisional nurse/midwifery leader. Establishments are set using evidence-based methodology and validated audit data following the requirements of the Safer Nursing Care Tool (SNCT). This mid-year 6 monthly review follows the annual review 2023/2024 which was approved by Trust Board in April 2024. Implementation has used a phased approach and the changes agreed have only recently been enacted and so will not be evident in the data analysis at this point but will be scrutinised in the annual review due to be presented in Quarter 4 2024/2025.

Outside of the annual safe staffing cycle of business the ward managers have approval to:

- Recruit substantively to maternity leave for registered (RN) and Health Care Assistants (HCA).
- Request immediate bank in response to changes in patient acuity or dependency (with approval controls via DNDs in place).
- Request an establishment review at any time if the assessment by the ward manager, matron and divisional nurse director (DND) show that the clinical area is not meeting the needs of the patients.

3.2. Areas that require improvement – identified in Annual Safe Staffing Review 2023/2024 - update

3.2.1. Healthcare Assistants (HCA)

The HCA vacancy rate continues to run at 16%. This continues to be an area of focus in the Trust as 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. A new apprentice pathway has been created and is currently out to advert and alongside this the development of a band 2 to 3 career pathway is the next area of development. This is critical to ensure the recruitment and retention of high quality support workers, some of which will progress to become the registered nurses of the future.

3.2.2 Sickness

Sickness rates in all inpatient units exceed the 4% target with an average sickness rate of 7.84% (January – June 2024). This is multifactorial with influencing factors in the clinical environment including: enhanced levels of care, violence and aggression, stress, increased occupancy levels, complex health and home circumstances. Staff frequently report the adverse experiences that lead to prolonged periods of sickness, this should be considered a fundamental link to safe staffing. 2024-2025 will see a renewed focus in this

area to reduce sickness rates aligned to the Trust objective of 4%, this will include a focus on the management and support interventions enacted at team level alongside wider cultural interventions.

3.3 Roster Key Performance Indicators

The effective management of rosters is key to delivering safe care. A report for core rostering metrics is shared with the senior nursing teams on a weekly basis to enable greater oversight and scrutiny of the rosters within each division. In addition, key rostering metrics will be fed into the divisional workforce and OD dashboards from September 2024, for wider visibility and monitoring. Monthly rostering efficiency meetings are now embedded which review key metrics before approval and publication of rosters. The fundamental purpose of these meetings is to ensure that the rosters are produced and published 6 weeks ahead and are as safe and effective as possible with the resources available, and thereby support the Trust to deliver the best, most efficient care possible.

4.0 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 sickness and maternity leave levels are also included in the analysis. This analysis is then converted to Care Hours per patient day (CHPPD).

5.0 METHODOLOGY

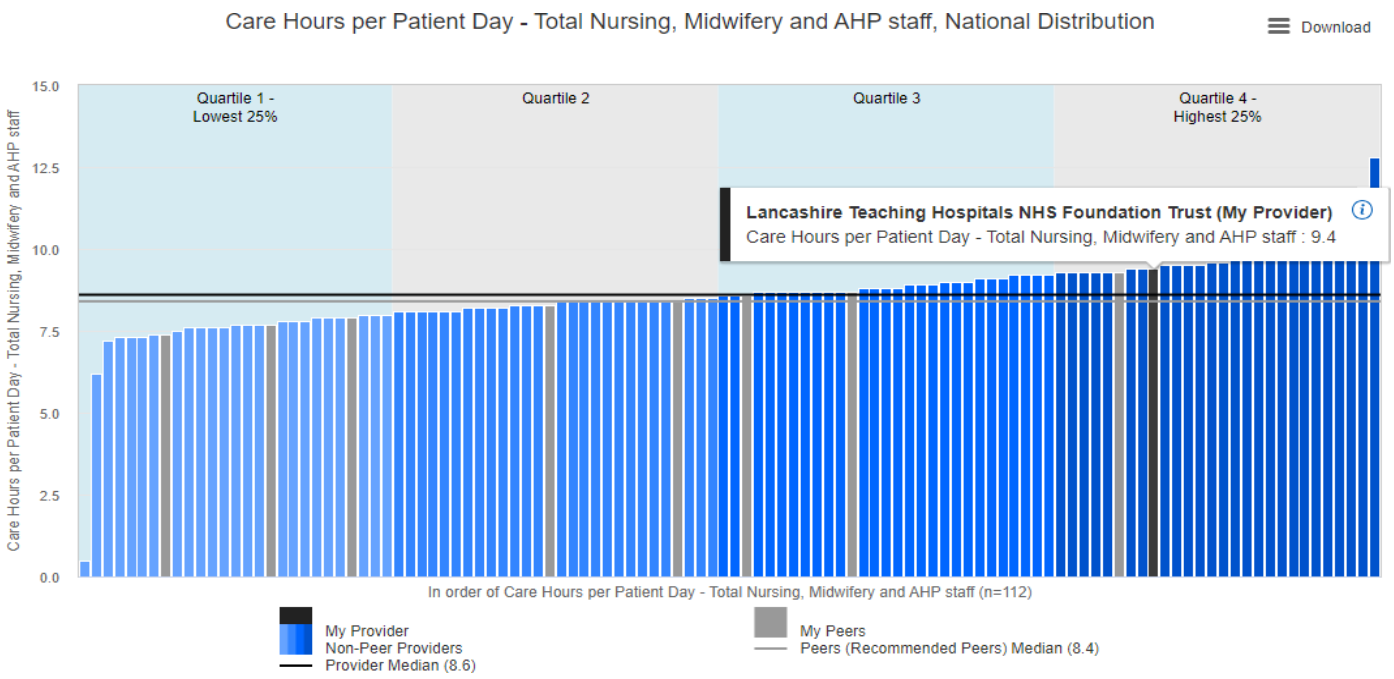
This review has followed the desk top review approach and has reviewed all areas using a triangulated approach to compare and analyse, outcomes metrics for patients and staff from the last 6 months (January 2024 – June 2024) and professional judgment as recommended by the NHS Improvement in Developing workforce safeguards (2018).

Findings within the review have been confirmed as being appropriate using professional judgement by the Divisional Nurse and Midwifery Director for each division.

6.0 PEER COMPARISON

The data graph 1 reflects Model hospital data from (May 2024) and places Lancashire Teaching Hospitals in the 4th quartile for CHPPD. This is alongside other tertiary providers in the Northwest including Northern Care Alliance, Manchester Foundation Trust and Liverpool University Hospitals Trust.

Graph 1 – Model Hospital Lancashire Teaching using CHPPD – May 2024



CHPPD 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. 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.

Table 1 – CHPPD compared to Northwest Region. (May2024)

Organisation Name	Organisation Value	Quartile
Countess of Chester Hospital NHS Foundation Trust	6.2	Quartile 1
Warrington and Halton Hospitals NHS Foundation Trust	7.7	Quartile 1
Mid Cheshire Hospitals NHS Foundation Trust	7.8	Quartile 1
East Lancashire Hospitals NHS Trust	8	Quartile 1
East Cheshire NHS Trust	8.1	Quartile 2
Mersey and West Lancashire Teaching Hospitals NHS Trust	8.1	Quartile 2
Wirral University Teaching Hospital NHS Foundation Trust	8.3	Quartile 2
Blackpool Teaching Hospitals NHS Foundation Trust	8.4	Quartile 2
Tameside and Glossop Integrated Care NHS Foundation Trust	8.5	Quartile 2
Wrightington, Wigan and Leigh NHS Foundation Trust	8.9	Quartile 3
Bolton NHS Foundation Trust	9.2	Quartile 3

University Hospitals of Morecambe Bay NHS Foundation Trust	9.3	Quartile 4
Manchester University NHS Foundation Trust	9.3	Quartile 4
Liverpool University Hospitals NHS Foundation Trust	9.3	Quartile 4
Lancashire Teaching Hospitals NHS Foundation Trust	9.4	Quartile 4
Northern Care Alliance NHS Foundation Trust	9.5	Quartile 4

7.0. 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.

8.0 SURGERY

Analysis of the triangulated outcomes metrics for patients and staff and professional judgment for the division of surgery has identified that orthopaedic wards as having a high number of red flag reporting under the category of delay/omission of regular checks as per care plan. Review of the safety metrics does not highlight any concerns for patient safety and it has been confirmed that the escalation processes within the Trust has been used when red flags have been raised and appropriate mitigation is documented as per safe staffing processes which will continue to be enacted to support patient acuity and dependency.

The bi-annual review has concluded that clinical areas are safe, and the use of daily safe staffing processes are being utilised effectively.

9.0 MEDICINE

Analysis of the triangulated outcomes metrics for patients and staff alongside professional judgment for the division of medicine has identified evidence of safe staffing establishments with the exception of ward 17.

Ward 17 is a 32 bedded elderly care ward and hence treats and cares for very dependent frail and elderly patients who require enhanced care to keep them safe and also for some of the more complex elderly care presentations such as Parkinson's Disease. The data shows that over the past 6 months safe staffing has been managed through creation of additional shifts amounting to circa 2 HCAs per shift. The frailty pathway is currently under review and options for future models of care are being developed. IN addition to this a change in the number of pathway 2 and 3 patients moving into Finney presents an opportunity to review the approach to dependency within some wards. Whilst this review is underway, safe staffing on Ward 17 will be maintained by redeploying HCAs from wards where dependency is less

and if this is not possible additional shifts will continue to be created to ensure safety is maintained. A further Safer Nursing Care Tool (SNCT) dependency audit will be collected and further safe staffing analysis will be undertaken in the annual cycle in Quarter 3.

There has been an in-year test of change on ward 23 with the aim of reducing occupancy on the respiratory high care unit, the outcome of this test of change has resulted in a reduced length of stay and occupancy on the respiratory high care unit. The staff involved on both units have provided positive feedback and both ward managers are supportive of implementing the change in approach substantively. There is no financial impact to this change. This will enable a reduction in enhanced care occupancy secondary to the presence of a tracheostomy without an underlying organ support requirement being identified and these patients will be cared for within ward 23. Training is underway to facilitate this.

Except for the above proposed changes, the bi-annual review has concluded that clinical areas are safe, and the use of daily safe staffing processes being utilised effectively.

9.1. Emergency Department and the Urgent and Emergency Care pathway

The Emergency Department (ED) dashboard is presented to the Safety and Quality Committee monthly basis; 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. There is evidence of improvements in July and August at RPH pertaining to triage, time to see a clinician, and the number of patients spending longer than 12 hours in the department, however, it is possible this is in part due to seasonal variation, therefore, it is important to continually asses the staffing needs of the department in response to fluctuations in demand.

The development of the new Acute Medical Unit (AMU) pathway is underway and will be presented in due course. Until the impact of the new pathway has been assessed the professional judgement for ED remains that the staffing levels are considered appropriate when the department is operating under baseline circumstances plus escalation into the waiting room.

There is a current risk (ID25) of exit block, which has been escalated to Trust Board since December 2020 due to the operational pressures. The operational environment is directly linked with the ability to provide safe staffing. There is a requirement to increase staffing to respond to peaks in activity and expansion/escalation of the department to maintain patient safety. The guidance for this is included in Appendix 2 which stipulates the increased occupancy levels of ED in correlation with the staffing requirements.

The safe staffing policy will be updated to include an addendum for ED staffing and how this should be safely staffed at each escalation level:

- ED baseline plus waiting room escalation
- Internal surge step 1
- Internal surge step 2
- Internal surge step 3
- Extreme escalation

Currently the establishment is set for ED baseline plus waiting room escalation and the guidance detailed in Appendix 2 demonstrates the staffing required, and the rationale for this, at each level of escalation.

There will be daily oversight of staffing by the ED Matron and coordinators feeding into weekly oversight of staffing within ED by the Divisional Nurse Director (DND) with a retrospective review of the week past and a forecast position of the week ahead.

Additional measures are commencing for the DND or their deputy to have 2nd tier approval for all bank and agency shifts to be cascaded to the temporary staffing office so that every shift is scrutinised.
There is a plan underdevelopment that will provide a trajectory for recruiting into vacant posts and subsequent reduction in agency and bank shifts required. The ED roster and performance against the safe rostering policy is currently undergoing an in-depth review. There are areas that require strengthening in relation to roster management within the ED and these are being managed through the workforce review processes in place.

10.0 WOMEN AND CHILDREN'S

Children and Young People

Analysis of the triangulated outcome metrics for patients and staff and professional judgment for women's services identified evidence of safe staffing establishments, however, consistently high sickness rates within the gynaecology ward alongside high levels of maternity leave in the band 6 staffing group have led to staffing challenges during the last 6 months including the induction of a junior, senior workforce. This is being overseen through the matron and divisional midwifery and nurse director.

Gynaecology

Analysis of the triangulated outcome metrics for patients and staff and professional judgment for the children's ward identified evidence of safe staffing establishments, however, high sickness level within ward 8 and a junior, senior leadership team have presented challenges to driving improvements in patient outcomes over the last 6 months. Paediatric nurse establishments reflect the guidance from within the RCN and NHS Improvement guidance. The outcome measures are reported to the Safety and Quality committee on a monthly basis and improvements have been noted in audit results during July and August 2024 after a sustained focused improvement programme of work.

Children's day case surgery is now in place at Royal Preston Hospital and Chorley District Hospital. This activity is being support with staff from the paediatric day case and surgical day case unit and meets the required safe staffing standard. The CDH unit has recently been accredited as a GIRFT paediatric surgical hub.

The professional judgement for woman's and children is that the staffing levels set are sufficient to meet the needs of the service.

11.0 DIAGNOSTICS AND CLINICAL SUPPORT

Finney House

Analysis of the outcome metrics for patients and staff and professional judgment for Finney House identified evidence of safe staffing establishments. The review identified that registered nurse fill rates continue to be raised due to an over establishment within the registered staffing within community services due to international nurse recruitment focus. on recruiting and re-deploying staff to ensure the units can effectively staff the units to the agreed staffing levels agreed in October 2023 is needed before the annual safe staffing reviews in November 2024. The review acknowledged the difficulties the services have experience in recruiting to the band 4 requirement that the staffing establishment is based

upon. Sickness and turnover rates are noted to be raised within the Orchard unit. Falls incidents and friends and family feedback have been identified as areas that require increased focus within Meadow unit.

Critical Care

Analysis of the outcome metrics for patients and staff and professional judgment for the critical care unit identified evidence of safe staffing establishments. The safety and quality metrics for Critical Care indicate a safe, stable service. Progress has been made during the last 6 month in introducing a level 1 area within critical care enabling the reduction of 1RN per shift. The review of the outcome data for the unit has not demonstrated an adverse impact as a consequence of these changes, therefore the change will now be made substantively enabling a cost improvement to be delivered.

Overall, the bi-annual review has concluded that clinical areas are safely staffed with fill rates of greater than 95% albeit this fluctuates, the daily safe staffing arrangements result in staff being moved throughout the hospitals in response to changing patient demands.

12.0 FINANCE

- **Run rate**

There are no new financial pressures as a result of the bi-annual review.

- **Cost Improvement Programme**

The cost improvement project associated with the creation of the level 1 area within critical care unit has been delivered and the Equality Quality Impact Assessment has been undertaken in line with policy. This is reflected within the Financial Recovery Programme.

- **Sickness**

The ongoing financial pressures associated with covering sickness leave are the focus of improvement work as part of the single improvement plan.

- **UEC plan**

The Urgent and Emergency Care plan is critical in enabling the reduction of addition spend in areas of escalation, primarily ED, but also other areas across the organisation. Whilst assurance can be provided that appropriate safe staffing is deployed in response to periods of escalation, it is important to note that this often results in a lower nurse to patient ratio and is not within the agreed budget, therefore continues to present as a budget pressure. Daily staffing arrangements are in place to ensurestaff are deployed in the most efficient way possible whilst maintaining safety.

Appendix 2 sets out the arrangements associated with ED escalation to ensure clarity and oversight is applied to this area whilst ensuring safety is maintained.

Enhanced levels of care continue to require a responsive staffing approach. The staffing establishments are not configured to respond to patients with very high level of enhanced care needs, as such, when patient need determines this, to reduce the risk of harm to self or others, additional duties are created. This continues to create a budget pressure that is reflected within the run rate. A programme of work to understand how enhanced care can be minimised whilst maintaining safety is due to commence and aims to minimise spend in this area.

- **Agency**

Agency use for registered nurses is now limited to ED, intensive care and high care units only. Agency use has reduced significantly over the previous year and has more than halved from 1490 shifts in June 2023 to 699 shifts in June 2024. Off Framework shifts have been sustained at Zero since Month 5 and NHS England, in the recent Nurse and Midwifery workforce review noted the Trust have made this a priority action to maintain this. Trust have met the NHSE deadline of July 2024 for Zero Off Framework agency use for this staff group.

13.0 SAFE STAFFING GOVERNANCE

The 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.

14.0 NHS ENGLAND NURSING AND MIDWIFERY WORKFROCE REVIEW – 5 July 2024

A scheduled review with the NHS England workforce team took place on 5 July 2024. The review identified a number of areas of positive practice, including strong engagement from recruitment lead with NHS E recruitment community of practice, low number of RN vacancies, high bank fill rates, adherence with agency cap rates, no agency HCA use, progress with Professional Nurse Advocate (PNA) implementation, safe staffing arrangements, international recruitment progress and the health and wellbeing offer from the Trust. Areas that require improvement were identified as, retention and vacancy rate of HCAs, Registered Midwife recruitment, sickness rates (although noted to haveimproved in the last quarter). The detail of the review will be shared with the workforce committee oncenotes are finalised.

15.0 CONCLUSION

In line with the recommendation from NHS Improvement Workforce Safeguards guidance, the Chief Nursing Officer confirms they are satisfied with the outcome of the bi-annual safe staffing assessment and that staffing is safe, effective and sustainable. (Workforce Safeguards 2018).

The focus moving into the second part of 2024/25 will be on reducing sickness, strengthening leadership, and attracting and retaining healthcare assistants to close the persistent 16% vacancy gap.

16.0 RECOMMENDATIONS

It is recommended that the Board of Directors:

i. Note the Safety and Quality committee has scrutinised and endorse its approval.
ii. Approve the bi-annual staffing review, the approach to managing safety in the ED and confirm it is satisfied of the assurances within the report.

Appendix 1 – Triangulated patient and workforce outcomes
Appendix 2 – ED escalation safe staffing

Appendix 1 – Triangulation of workforce, safety, quality and experience data (The red areas are those that are subject to additional scrutiny and focus)

Ward/Dept	No of Beds 2024	% Fill Rate RN Days (6months - January - June)	% Fill Rate UnReg Days (6months - January - June)	% Fill Rate RN Nights (6months - January - June)	% Fill Rate UnReg Nights (6months - January - June)	Incident reports relating to Staffing (6months - January - June)	Red Flags raised (6months - January - June)	Falls (6months - January - June)	Pressure Ulcers (6months - January - June)	Clostridium difficile (6months - January - June)	Medication Errors with Harm (6months - January - June)	Sickness % FTE (6months - January - June)	Turnover % FTE (6months - January - June)	STAR rating (last accreditation audit)	Friends and family Good % (6months - January - June)	Friends and family Poor % (6months - January - June)	Friends and family Responces (6months - January - June)	Formal complaints (6months - January - June)	Compliments (6months - January - June)
ED (RPH) (adult)	46	121%	96%	121%	100%	3	0	62	32	2	6	3.94 %	1.37 %	81%	57%	32%	1392	19	72
ED (RPH) (children)	4	96%	93%	95%	95%			0	0	0	0	13.51 %	-	93%	77%	17%	212		
AAU	18	105%	101%	107%	105%	0	7	10	4	0	0	8.35 %	-	89%	93%	5%	118	1	35
Acute Frailty	10	99%	96%	99%	100%	0	13	8	2	0	0	8.19 %	-	99%	88%	10%	40	0	9
Bleasdale Ward	21	88%	115%	107%	122%	17	65	31	9	1	1	6.01 %	6.30 %	91%	74%	18%	39	0	1
NRU (Barton)	16	191%	107%	100%	186%	0	1	7	2	0	1	3.53 %	1.63 %	96%	80%	11%	35	0	6
MAU (RPH)	29	100%	85%	91%	101%	4	38	20	9	4	3	5.62 %	6.41 %	88%	88%	9%	33	6	17
CCU RPH	6	86%	62%	100%	N/A	0	1	0	0	0	0	4.00 %	-	93%	98%	2%	49	0	23
Ward 5	28	104%	89%	104%	105%	1	30	34	23	1	1	7.99 %	1.88 %	89%	46%	23%	13	0	1
Ward 17	32	103%	113%	103%	126%	2	63	40	22	4	0	5.40 %	11.23 %	91%	61%	28%	18	6	5
Ward 18	28	99%	93%	102%	99%	2	10	15	5	0	2	7.96 %	1.08 %	95%	85%	9%	54	2	7
Ward 21	24	105%	86%	99%	102%	1	6	19	3	1	0	9.19 %	0.46 %	95%	84%	10%	62	0	3
Ward 23	34	100%	96%	97%	115%	4	28	22	11	2	1	5.78 %	3.07 %	91%	71%	14%	63	3	7
Ward 24	32	100%	90%	99%	104%	1	12	40	12	2	0	7.43 %	1.36 %	91%	65%	26%	34	5	24
Ward 25	23	125%	86%	93%	110%	1	24	23	4	3	1	10.62 %	5.21 %	91%	77%	15%	39	4	6
Enhanced High Care (Ward 20)	22	96%	97%	103%	106%	0	19	8	23	0	0	4.14 %	3.49 %	94%	100%	0%	3	2	9
ED (CDH)	17	101%	126%	N/A	N/A	2	0	10	7	0	0	9.16 %	5.65 %	90%	87%	9%	1558	4	18
MAU (CDH)	29	118%	139%	115%	157%	0	9	33	7	1	4	10.35 %	1.58 %	93%	70%	19%	81	7	6
Brindle	30	101%	102%	102%	123%	0	10	23	11	2	3	9.91 %	8.22 %	91%	83%	10%	69	1	21
Cardiac Unit CDH	10	99%	103%	117%	103%	4	50	13	4	0	0	5.36 %	4.20 %	95%	0%	0%	0	0	70
Rookwood A	24	135%	94%	127%	109%	5	69	27	6	1	3	6.65 %	4.61 %	92%	80%	10%	107	1	27
Rookwood B	24	139%	110%	136%	134%	2	63	18	15	1	1	7.18 %	-	90%	72%	12%	81	1	7
Hazelwood	19	110%	90%	109%	105%	0	9	22	5	1	1	11.16 %	4.16 %	92%	85%	6%	103	4	60
Cuerden	24	99%	88%	111%	100%	0	33	27	1	0	1	13.71 %	9.95 %	92%	95%	3%	110	0	19
Neuro High Care	10	114%	99%	113%	252%	0	11	1	5	0	2	8.23 %	-	93%	0%	0%	0	0	33
Ward 2a	17	97%	109%	100%	137%	0	9	15	3	0	0	8.60 %	1.67 %	97%	85%	11%	55	0	49
Ward 2b	17	100%	106%	100%	135%	2	1	14	8	1	0	3.79 %	-	94%	89%	5%	38	0	55
Ward 2c	17	93%	104%	100%	127%	0	3	6	3	0	1	5.26 %	7.40 %	92%	98%	0%	55	1	6
Ward 3	14	107%	96%	121%	116%	1	2	2	6	2	0	7.74 %	-	94%	92%	3%	76	0	3
Ward 4	26	134%	75%	118%	101%	0	10	11	5	1	0	5.19 %	-	97%	85%	11%	101	3	22
Ward 10	29	99%	117%	98%	136%	0	3	18	6	3	0	3.88 %	4.39 %	93%	89%	7%	105	1	50
Ward 11	22	96%	93%	104%	95%	0	4	0	3	0	0	8.71 %	3.90 %	92%	92%	6%	103	0	0
Ward 12	33	110%	97%	101%	135%	0	10	8	7	7	3	4.67 %	3.33 %	96%	74%	18%	65	1	2
Ward 14	24	105%	115%	100%	128%	0	31	9	22	0	0	3.23 %	3.91 %	94%	85%	8%	62	1	50
Ward 15	33	102%	85%	99%	103%	0	6	38	26	5	4	4.91 %	1.80 %	84%	83%	15%	46	2	19
Ward 16	24	112%	103%	105%	125%	0	32	10	16	2	0	7.25 %	-	93%	86%	11%	28	1	17
Major Trauma Ward	10	97%	96%	100%	109%	0	3	0	5	0	0	7.46 %	10.81 %	94%	98%	2%	55	0	46
Ribblesdale Unit	24	106%	103%	122%	101%	0	42	29	21	4	1	10.59 %	4.01 %	91%	92%	8%	26	1	30
Surgical Assessment Unit RPH	17	91%	87%	97%	94%	0	5	5	4	0	2	10.91 %	-	93%	68%	22%	294	5	6
SECU	4	97%	N/A	95%	N/A	0	0	1	0	0	0	5.31 %	-	96%	100%	0%	61	1	8
Surgical Unit (CDH)	16	81%	72%	90%	72%	0	2	4	0	0	0	7.45 %	11.17 %	95%	100%	0%	13	0	0
Leyland Ward	15	116%	69%	97%	93%	1	1	6	1	0	0	6.33 %	7.29 %	96%	98%	1%	228	1	11
Ward 8	30	90%	88%	91%	94%	3	3	1	0	2	0	11.20 %	5.56 %	71%	89%	6%	430	3	148
PAU	10	93%	97%	98%	100%	5	0	0	0	0	1	7.58 %	4.39 %	95%	97%	1%	87	2	16
Pead Day case	7	75%	69%	N/A	N/A	0	0	0	0	0	0	3.47 %	12.12 %	95%	95%	4%	251	0	7
NNU	28	85%	65%	90%	42%	28	29	0	1	0	1	10.67 %	2.79 %	97%	100%	0%	58	0	31
Gynae Ward RPH	18	98%	91%	100%	100%	5	19	9	2	0	0	10.83 %	3.93 %	96%	92%	4%	397	0	19
GAU		92%	97%	N/A	N/A	0		1	0	0	0	-	-	93%	65%	24%	17	2	3
Maternity A	28	97%	89%	91%	88%	173	50	0	0	0	0	10.30 %	-	92%				1	21
Maternity B	28	93%	93%	95%	98%	19	5	1	0	0	0	8.20 %	4.98 %	91%				0	83
Delivery suit		93%	103%	90%	96%	24	14	0	0	0	0	8.87 %	5.43 %	95%				2	18
Critical Care	32	86%	87%	95%	94%	39	0	1	57	7	1	7.63 %	2.18 %	93%	97%	1%	76	1	263
Buttercup (CHH)	32	112%	94%	83%	106%	2	6	26	9	0	1	5.75 %	1.74 %	94%	93%	2%	44	0	19
Meadow (CHH)	32	86%	87%	95%	94%	0	0	41	8	0	2	5.62 %	2.15 %	95%	81%	4%	70	0	22
Orchard	32	297%	86%	201%	68%	0	0	17	2	0	0	8.79 %	7.93 %	86%	0%	0%	0	0	13

Appendix 2

ED staffing levels in response to fluctuating capacity and operational scenarios

The ED has a full capacity protocol that is enacted when occupancy levels reach certain limits, this results in actions that are taken in ED and across the organisation leading to the temporary placement of placements against planned discharges into non designated bed spaces. These patients become boarded patients in ward areas and allow the ED to share the risk of the over occupied department across the organisation.

The Board has accepted the operational risk - ID 25 Exit Block as escalated to Board since Dec 2020.
The Royal College of Physicians (RCEM) and Royal College of Nursing (RCN) Nursing workforce standards for type 1 EDs provides clear guidance on the required staffing for ED's. Coordinators, Streaming triage nurses and resus coordinators must be band 6 or above.

The guidance provided states that patients requiring resuscitation or attending with major trauma require 2 nurses to 1 patient for the initial phase. The guidance advises a band 7 educator and for areas above 75 staff a further band 6/7 educator is required.

The ED size fluctuates significantly in response to increase in demand. This presents risks often referred to as exit block risks, there is an accepted evidence base that high occupancy ED's adversely impacts mortality rates, therefore the approach to mitigating risk should be taken seriously.

The purpose of this set of standards is to provide a clear outline of the steps taken in response to increase occupancy to mitigate risks and to ensure leaders and staff are clear on the steps that should be taken in response to fluctuations in occupancy levels.

RPH ED Baseline
Baseline operating conditions are defined as:

- Normal levels of ED patient attendances (circa 151 patients per 24 hours)
- 1-2 patients with a LoS of 12 hours or more (Mental heath or unwell in resus)
- 12-15 patients with a decision to admit waiting for admission (all under 12 hours)

Baseline Nurse Staffing		
Band 7 co-ordinator	1 band 7	
Majors coordinator	1 band 6	
Triage	1 RN band 6 (or senior band 5)	1HCA
Majors 1 (8 cubicles including 1 designated mentalhealth cubicle)	2 RN band 5	2 HCA (1 HCA mental health 1:1)
Majors 2 (8 cubicles + 4 Chairs)	2 RN band 5	2 HCA
Majors 3 (5 cubicles)	1 RN band 5	1 HCA
Majors 4 (9 isolation cubicles + 5 trolleys)	4 RN band 5	2 HCA
Resus (6 Cubicles)	1 RN band 7 2 RN band 5	1 HCA
RATS (7 Cubicles)	1 RN band 6 ambulance triage - 2 RN	1 HCA

Total **43 cubicle spaces** **5 trolleys** **4 chairs**	**Total 18 RNs**	**Total 10 HCAs**

RPH ED – Waiting room escalation (Current funded template August 2024)

Waiting Room escalation is defined as:

- Normal levels of ED patient attendances (circa 151 patients per 24 hours)
- >5 ED patients with a LoS of 12 hours or more (delayed assessments, mental health or unwell in resus)
- =/>20 patients with a decision to admit waiting for admission some over 12 hours
- Patient care being provided in the waiting room due to increased cubicle occupancy
    - Ambulance arrival patients assessed as “fit to sit” as no space in RATS
    - Patient delayed waiting ED medical assessment having vital signs monitoring and pain relief
    - Patients with decisions to admit receiving treatments (eg IV antibiotics)

Waiting Room Escalation		
Waiting Room Nurse	1 RN	
Total **43 cubicle spaces** **5 trolleys** **4 chairs** **5 patients in waiting room receiving assessments and treatment**	**Total 19 RNs**	**Total 10 HCAs**

RPH ED – Waiting room escalation plus Internal Surge activated
Internal Surge is defined as waiting room escalation plus the following**:**

- Increased ambulance/helicopter arrivals > 8 per hour
- > 15 ED patients with a LoS of 12 hours or more (delayed assessments, mental health or unwell in resus)
- 30 patients with a decision to admit waiting for admission most over 12 hours
- > 70 patients in the department

Internal Surge Step 1		
Majors 4 – convert 1 cubicle into fit to sit for 8 patients	1 RN	1 HCA
Majors 2 – 4 extra patients on the corridor on trolleys	1 RN	
Total **43 Cubicles** **5 trolleys** **12 chairs** **Patients in waiting room being treated**	**21 RNs**	**11 HCA**

4 patients on the corridor		
Internal Surge Step 2		
Majors 1- 2 extra patients on trolleys on corridor		

Majors 4- 4 extra patients on trolleys on corridor	1 RN	1 HCA
Total **43 Cubicles** **5 trolleys** **12 chairs** **Patients in waiting room being treated10 patients on the corridor**	**22 RN**	**12 HCA**
Internal Surge Step 3		
RATS- extra 3 patients on corridor on trolleys	1 RN	
Waiting room escalation and Majors sub wait escalation chairs > 5 patients with DTA waiting room > 10 patients with DTA Majors sub wait	1 RN	2 HCA
Total **43 Cubicles** **5 trolleys** **12 chairs** **15 Patients in waiting rooms being treated13 patients on the corridor**	**24 RN**	**14 HCA**

RPH ED – Extreme Escalation

Extreme Escalation is defined as internal surge plus the following**:**

- Increased ambulance/helicopter arrivals > 8 per hour
- > 20 ED patients with a LoS of 12 hours or more (delayed assessments, mental health or unwell in resus)
- > 40 patients with a decision to admit waiting for admission most over 12 hours
- > 100 patients in the department
- NWAS cohorting 4 or more patients on the corridor or NWAS enact escalation procedure and so ED reverse que 4 or more patients on the main ED corridor

Extreme Escalation		
2nd Majors Co-ordinator - allocated to oversee safety of patients on corridors and waiting rooms NWAS support for ambulance cohorting/ED additional corridor care ** plus additional support requested Critical Care Outreach Tissue Viability Nurse Additional House Keeper	1 band 6 RN 1 band 5 RN (if ED providing care on main corridor)	1 HCA
Total **43 Cubicles**	**Total 26 RNs**	**Total 15 HCAs**

5 trolleys **12 chairs** **>15 Patients in waiting rooms being treated** **>17 patients on the corridor**		

CDH ED internal surge and additional nurse staffing Requirements

CDH Internal Surge Step 1		
Majors 1 – convert cubicle 11 into fit to sit for8 patients	1 RN	1 HCA
Majors 1- 3 extra patients on trolleys on the corridor	1 RN	
Total	10 RNs	5 HCA
CDH Internal Surge Step 2		
Ambulance corridor – 3 extra patients on trolleys on the corridor	0 RN	
Resus to be used as overflow if required- upto 2 cubicles	1 RN	
Isolation resus 2 - convert into fit to sit for 5 patients	1 RN	1 HCA
Total	12	6 HCA

Reference List

- National Quality Board (2018)Safe, sustainable and productive staffing – adult inpatient wards in acute hospitals https://www.nice.org.uk/guidance/sg1/resources/safe-staffing-for-nursing-in-adult-inpatient-wards-in-acute-hospitals-61918998469

- National Quality Board (2016) Improvement and Assessment Framework for Children's and Young People's health services https://cdn.ps.emap.com/wp-content/uploads/sites/3/2018/02/Improvement_and_assessment_framework_for_children_and_young_people_FEB_2018_version_3.pdf

- National Quality Board (2017) Safe, Sustainable and productive staffing: An improvement resource for neonatal, children and young people services https://www.england.nhs.uk/wp-content/uploads/2021/04/safe-staffing-cyp-june-2018.pdf

- National Quality Board (2017) Safe, sustainable and productive staffing An improvement resource for urgent and emergency care https://www.england.nhs.uk/wp-content/uploads/2021/04/safe-staffing-uec-june-2018.pdf

- Care hours per patient day (CHPPD): guidance for all inpatient trusts https://www.england.nhs.uk/long-read/care-hours-per-patient-day-chppd-guidance-for-all-inpatient-trusts/

- BAPM guidance https://www.bapm.org/resources/157-calculating-unit-cot-numbers-and-nurse-staffing-establishment-and-determining-cot-capacity

- RCN CYP staffing guidance https://www.rcn.org.uk/clinical-topics/children-and-young-people/neonatal-nursing

- Guidelines for the provision of intensive care services https://www.ficm.ac.uk/sites/ficm/files/documents/2022-07/GPICS%20V2.1%20%282%29.pdf

Chair's Report to Board		
Chair: Uzair Patel	Workforce Committee	
Date(s): 10 September 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
Being a Great Place to Work – current score 16	→	

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

None

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Business continuity risks around One LSC.
- Healthcare support worker vacancies remained high at 16% and limited capacity for care certificate placements further impacted recruitment. Turnover had placed the Trust under amber oversight by NHSE.
- Risks were identified regarding inadequate medical staffing, including lack of senior cover for FY1 doctors in Chorley Medicine, insufficient junior doctor cover in vascular surgery and concerns about less competent doctors filling SHO roles at RPH. Understaffed areas and Deanery gaps impacting staffing plans required urgent attention and further workforce planning solutions.

ASSURE

Assurance received; Matters of positive note.

- A new healthcare support worker apprenticeship had been launched, with 25 candidates starting in September.
- The Trust's recruitment efforts, particularly regarding healthcare support workers, had been recognised as best practice by NHS England.
- A new recruitment flipbook, designed for entry-level roles, had been developed and nominated for an award, being the first of its kind in the NHS.

Workforce Committee

10 September 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	U Patel
2.	Apologies for absence	1.01pm	Verbal	Information	U Patel
3.	Declaration of interests	1.02pm	Verbal	Information	U Patel
4.	Minutes of the previous meeting held on 9 July 2024.	1.03pm	✓	Decision	U Patel
5.	Matters arising and action log: • Referral from ETR (actions for targets to be met around mandatory training and appraisals).	1.05pm	✓	Decision	U Patel
6.	Strategic risk register review	1.10pm	Verbal	Assurance	U Patel
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	1.15pm	✓	Assurance	K Downey
8. STRATEGY DELIVERY					
8.1	Recruitment strategy report	1.25pm	✓	Assurance	K Downey
8.2	One LSC update (TBC)	1.35pm	Verbal	Information	N Pease
9. TO BE INCLUSIVE AND SUPPORTIVE					
9.1	Annual violence and aggression report	1.45pm	✓	Assurance	R O'Brien
10. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
10.1	Annual onboarding and retention strategy report	1.55pm	✓	Assurance	L Graham
11. GOVERNANCE AND COMPLIANCE					
11.1	Guardian of Safe Working quarterly report	2.05pm	✓	Assurance	D Kendall

№	Item	Time	Encl.	Purpose	Presenter
11.2	Strategic risk report	2.20pm	✓	Decision	S Regan
11.3	Reflections on the meeting and adherence to the Board construct	2.30pm	✓	Information	U Patel
11.4	Items for escalation to the Board or items to/from other committees	2.40pm	Verbal	Information	U Patel
12.	ITEMS FOR INFORMATION				
12.1	Exception report from the DIFs		✓	Information	
12.2	Feeder group Chair's reports: Raising Concerns Group		✓	Information	
12.3	Date, time, and venue of next meeting: *12 November 2024 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	U Patel

Chair's Report to Board		
Chair: Professor Paul O'Neill	Education Training and Research Committee	
Date(s): 13 August 2024 5 Sept 2024	Agendas attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
Include current score – in trend column show an arrow going up / down or static	→ 16	None.

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

The Committee expressed concerns over the GMC survey results presented in the quality surveillance report, which had identified 19 specialities that needed internal monitoring.

A meeting was held on the 5th September for the annual review of the education contracts for clinical divisions. Limited assurance was received in terms of post-graduate medical training & partial assurance was received in some areas due to delayed reports caused by work pressures. The Committee did receive assurance that the good analysis had taken place, the divisions knew their business and had plans in place.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

The Committee noted the number of super red appraisals in the core skills training report, and it was agreed a discussion would be undertaken with the divisional directors to ensure this was integrated into the people section of the DIFs and that the appropriate actions were in place for the targets to be met around mandatory training and appraisals.

ASSURE

Assurance received; Matters of positive note.

The Committee received the education annual report strategy update and acknowledged the of achievements in education and training aligned to information in the Trust Annual Report.

The Committee was assured by the Research and Innovation update including financial plan, and the progress within the R&I department year to date 2024/25.

Education, Training and Research Committee

13 August 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 11 June 2024	1.03pm	✓	Decision	P O'Neill
5.	Matters arising and action log	1.04pm	✓	Decision	P O'Neill
6	Strategic risk register review	1.05pm	Verbal	Assurance	P O'Neill
7.	PERFORMANCE				
7.1	(a) Core skills training report (b) APLS report	1.15pm	✓	Assurance	L O'Brien
7.2	Quality surveillance report	1.30pm	✓	Assurance	L O'Brien
8.	STRATEGY AND PLANNING				
8.1	Education annual report strategy update	1.45pm	✓	Assurance	L O'Brien
8.2	Edovation update	2.00pm	✓	Information	P Brown
8.3	Research and Innovation update including financial plan	2.15pm	✓	Information	P Brown
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic Risk Register Review	2.30pm	✓	Decision	P O'Neill
9.2	Items for referral to the board or items to/from other committees	2.35pm	Verbal	Information	P O'Neill
9.3	Reflections on the meeting and adherence to the Board Compact	2.40pm	✓	Assurance	P O'Neill
10.	ITEMS FOR INFORMATION				
10.1	Feeder groups Chair's reports negative/positive escalations:		✓	Information	L O'Brien/ P Brown

№	Item	Time	Encl.	Purpose	Presenter
	a) Apprenticeships Strategy & Assurance Committee b) Training Compliance and Assurance Sub-committee c) Education Quality & Performance Sub-Committee d) Research and Innovation Sub-Committee				
10.2	Date, time, and venue of next meeting: 5 September 2024, 1pm via MS Teams (annual review of Divisional Education Contracts)	2.45pm	Verbal	Information	P O'Neill

Education, Training and Research Committee

5 September 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 13 August 2024	1.03pm	✓	Decision	P O'Neill
5.	Matters arising and action log	1.05pm	✓	Decision	P O'Neill
6.	PERFORMANCE				
6.1	Education contracts review: Medicine	1.15pm	Pres	Decision	Mark Brady, Michael Brown, Rachel Sansbury
6.2	Education contracts review: DCS	1.40pm	Pres	Decision	Russell Dineley Deborah O'Mahoney
6.3	Education contracts review: Surgery	2.05pm	Pres	Decision	Lisa Elliott Steve Canty Kate Hudson
6.4	Education contracts review: Women's & Children's Services	2.30pm	Pres	Decision	Jo Connolly Jo Lambert Nick Wood
7.	ITEMS FOR INFORMATION				
7.1	Items for referral to the board or items to/from other committees	2.55pm	Verbal	Information	P O'Neill
7.2	Reflections on the meeting and adherence to the Board Construct	2.57pm	✓	Assurance	P O'Neill
7.3	Date, time, and venue of next meeting: 8 October 2024, 1pm via MS Teams	3.00pm	Verbal	Information	P O'Neill

Chair's Report to Board		
Chair: K Smyth	Committee: Charitable Funds Committee	
Date(s): 17 Sept 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
N/A – CFC is not an assurance committee	⇨	N/A

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- The unintended consequences of the current financial controls on the charities' operations were highlighted. It was important to emphasise the need for an expedited solution to mitigate these effects, especially as the funding situation was expected to worsen.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Approval of funding requests:
    1. Two years' worth of funding for complimentary therapies for cancer patients under the LTH umbrella
    2. Upgrade to the robotic software for the Hillrom motion table, which accompanied the Da Vinci Surgical Robot system located in Preston and Chorley, was expected to enhance patient outcomes by reducing operation times and risks associated with surgeries performed on standard operating tables.
    3. The request for RCF to cover the full financial year of 2024/25 for cancer related stays in Bowland House was approved.

ASSURE

Assurance received; Matters of positive note.

- Assurance was provided regarding the continued use of Bowland House for cancer patients, which demonstrated that the Committee had listened to concerns and taken appropriate action to support patients.
- The Committee resolved that the adoption of the Annual Report and Accounts be approved.
- The strong financial performance of both LTH Hospitals Charity and Rosemere Cancer Foundation over a five-month period was highlighted. The total income across both charities amounted to £1.074 million, surpassing the planned budget of £780,000 by nearly £300,000.

Charitable Funds Committee

17 September 2024 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chairman and quorum	1.00pm	Verbal	Information	K Smyth
2.	Apologies for absence	1.01pm	Verbal	Information	K Smyth
3.	Declaration of interests	1.02pm	Verbal	Information	K Smyth
4.	Minutes of the previous meetings held on 18 June 2024	1.03pm	✓	Decision	K Smyth
5.	Matters arising and action log	1.04pm	✓	Decision	K Smyth
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Baby Beat	1.05pm	✓	Assurance	D Hill
6.2	Rosemere Charity update including funding requests: a) Complementary therapies for LTH patients b) Operating table – Hillrom Motion Table and upgrade of robotic software at LTH c) Patients know best (PKB) at LTH d) Bowland House Accommodation for Cancer Patients at LTH	1.20pm	✓	Decision	D Hill
7.	FINANCE AND PERFORMANCE				
7.1	Finance update including review of spending plan and balances	1.40pm	✓	Assurance	B Patel
7.2	Investment & Reserves Policy	1.50pm	✓	Assurance	B Patel
8.	GOVERNANCE AND COMPLIANCE				
8.1	Annual Report and Accounts	2.00pm	✓	Assurance	B Patel/D Hill
8.2	Items to alert/advise/assure the Board	2.10pm	Verbal	Information	K Smyth
8.3	Reflections on the meeting	2.15pm	Verbal	Information	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Rosemere Management Committee Chair's report		✓		
	Date, time and venue of next meeting: *10th December 2024, 10.30am, MS Teams*	2.20pm	Verbal	Information	K Smyth

Chair's Report to Board		
Chair: T Whiteside	Committee: Finance and Performance	
Date(s): 23 July 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20	⇨	None

ALERT
Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- **Service Line Reporting: -** Lack of assurance on the progress made against the Value Based Improvement outcomes for Service's in their path to breakeven and improved performance targets. A further report to be brought to the August meeting.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Financial Position**: The month 3 financial position was delivered without the need for additional cash support. However, there was a need for continued scrutiny on cash and capital provisions.
- **Capital Provision**: The Trust was challenged to take £3 million out of the plan despite the plan already been oversubscribed reflecting broader national scrutiny. Focus has been applied to further prioritisation options.
- **Operational Performance**: The importance of improving pace of delivery was emphasised, including across collaborative programmes whilst continuing to balance their risk and reward. Particularly important for strengthening Fragile Services, improving UEC performance, and establishing One LSC,
- **Financial Recovery Plan**: Positive progress seen in moving from high-risk ideas to more substantiated, qualified and qualified improvement programmes. The focus is now on delivery and execution, with a prudent approach to maintain a buffer of ideas to respond to future risk of slippage.
- **Risk Position Reset**: The risk articulation lacked full assurance due to the need for further detailed work. The representation of risk exposures was considered fair, but more work was required on controls, mitigations, and transitioning Specialist Commissioning and Fit for the Future Risks onto the Committee agenda.

ASSURE

Assurance received; Matters of positive note.

- **Operational Performance**: Improving trajectories in boarding and ambulance handovers.
- **Returning to breakeven or better**: Positive improvements seen in trading account performance (Catering, Accommodation and Car-Parking).
- **Staff Experience: thanks to Facilities teams**, acknowledging the positive impact that has been reported by colleagues from improved catering options.

Chair's Report to Board		
Chair: T Whiteside	Committee: Finance and Performance	
Date(s): 27 August 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20	⇨	None

ALERT
Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- **M4 Finance Report:** Some slippage on planned M4 outturn position seen, with the need to increase the pace of grip and control measures in overspending areas.
- Focus to be applied on right sizing organisational staffing – especially medical staffing and following further planned work on demand and capacity modelling.
- **Cash Management:** Continued pressure on cash reserves mitigated at M4, but expected cash support will likely be sought at M5 (September).
- **Financial sustainability:** Deficit risk assessed – against know threats and anticipated headwinds, to support the drive for further planned interventions to protect committed position. Scale of risk remains significant.
- **Risk Trade-offs:** Continued vigilance required by all on maintaining balance across risks areas (financial sustainability, improving operational performance – patient outcome and experience, and colleague experience) as we approach an intense period of change.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Community Integration:** A new shared governance arrangement for transforming together with LSCFT has been established, with the formation of a shared leadership group including the inclusion of a local GP which is being sought from Voice of Central Lancashire (VoCL).
- **Accountability Framework**: Further assurance is being sought (via Audit Committee) on adequate actions been in place to address a recurring theme of weaknesses in operational rigour and compliance to policy and practice in colleague behaviours
- **Service Line Breakeven**: Continued concern on the pace of progress towards Service Line breakeven or better position across 2023/24, with areas of largest lost making subject to further scrutiny and work as part of the Value Based Improvement Plan.
- **SIP:** The Committee agreed that by necessity focus had thus far been on the financial recovery, but a shift in focus was now required onto the operational performance improvements so they have the same level of consideration and rigour applied.

ASSURE

Assurance received; Matters of positive note.

- **Risk Update:** Assurance was provided around the VFM risk however the Committee noted that further actions were required to reflect the findings of the Turnaround Director on identified weakness in financial controls. Further work is in progress to reset the Fit for the Future risk for September.
- **Financial Recovery Plan**: Increased certainty of plans, with a notable shift from hopper/high risk to lower risk schemes, and growing confidence of delivery provided positive assurance to the Committee on the plans ambition and intentions
- **Performance Assurance Progress Report**: Significant operational pressure continues, with assurance provided on the executive oversight in place, and the planned actions being driven forward as part of the Single Improvement Plan. The scale and time needed to fully develop the capacity and demand model to help right size the organisation in addressing its flow and workforce capacity issues, was acknowledged by the Committee.
- **Planning Framework**: A positive update was provided on the steps being taken to improve planning controls, strengthen levels of partner, stakeholder and colleague engagements, in the formulation of the 10-year Strategic Plan and 2025/26 Operating Plans.

Finance and Performance Committee

23 July 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 25 June 2024	09.03am	✓	Decision	T Whiteside
5.	Matters arising and action log:	09.05am	✓	Decision	T Whiteside
6.	Strategic Risk Register a) VFM – JW b) Tertiary Services – GS c) FFTF – GD	09.10am	✓ ✓ ✓ Verbal	Decision	S Regan/ G Doherty/ G Skailes
7.	STRATEGY AND PLANNING				
7.1	Planning Controls Update	09.25am	✓	Assurance	G Doherty
7.2	Single Improvement Plan	09.35am	✓	Information	A Brotherton
7.3	Financial Recovery Plan	09.55am	✓	Assurance	J Roberts
7.4	External Dependency Update	10.10am	✓	Information	G Doherty
	COMFORT BREAK 10.20am-10.30am				
8.	FINANCIAL PERFORMANCE				
8.1	M3 Finance Report	10.30am	✓	Assurance	J Wood
8.2	Service Line Reporting Update Q4 2023-24	10.45am	✓	Assurance	J Wood
8.3	Trading Accounts Q1 2024-25	11.00am	✓	Assurance	J Wood

8.4	Lancashire Procurement Collaborative Update	11.15am	Verbal	Assurance	J Collins
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report	11.30am	✓	Assurance	E Ince
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items to alert, advise or assure the Board.	11.50am	Verbal	Information	T Whiteside
10.2	Reflections on the meeting & adherence to the Board Compact	11.55pm	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Chairs' reports**: (a) ICS, ICP, PCB System update (b) Capital Planning Forum (stood down) (c) EPRR Committee (stood down) (d) ELFS Management Board Minutes (e) SIB Minutes (f) CSESC Update		✓ ✓ ✓ ✓		
11.4	Deficit Protocol Controls Overview		✓		
11.5	Date, time and venue of next meeting: *27 August 2024 09.00am – 12.00pm* *Microsoft Teams*	12.00pm	Verbal	Information	T Whiteside

Finance and Performance Committee

27 August 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 23 July 2024	09.03am	✓	Decision	T Whiteside
5.	Matters arising and action log: (a) Finney House Update on Timescales (b) Action Log	09.05am	✓	Decision	T Whiteside
6.	Strategic Risk Register	09.15am	✓	Decision	H Ugrader/J Wood
7.	STRATEGY AND PLANNING				
7.1	Planning Controls Update	09.25am	✓	Assurance	G Doherty
7.2	Single Improvement Plan	09.40am	✓	Assurance	A Brotherton
7.3	Financial Recovery Plan	09.55am	✓	Assurance	J Roberts
7.4	External Dependency Update	10.10am	✓	Information	G Doherty
7.5	LSC Pathology Business Case – Presenting the Options	10.20am	✓	Information	G Doherty
7.6	Data Quality including update on Grant Thornton	10.35am	✓	Assurance	I Ward
COMFORT BREAK 10.45am-10.50am					

8.	FINANCIAL PERFORMANCE				
8.1	M4 Finance Report including National Cost Collection Post Submission Report	10.50am	✓	Assurance	J Wood
8.2	Financial Risk Paper	11.00am	✓	Discussion	J Wood
8.3	Service Line Reporting Update	11.05am	✓	Assurance	J Wood/S Stow
8.4	Use of Resources	11.10am	✓	Information	I Ward
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report	11.20am	✓	Assurance	K Foster-Greenwood
9.2	Community Service Integration Update	11.40am	✓	Information	S Cullen
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items to alert, advise or assure the Board.	11.50am	Verbal	Information	T Whiteside
10.2	Reflections on the meeting & adherence to the Board Compact	11.55pm	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Feeder Group Terms of Reference:** (a) Capital Planning Forum (inc. expensive medical equipment)		deferred		
11.4	**Chairs' reports**: (a) ICS, ICP, PCB System update (b) Capital Planning Forum (c) SIRO/AIO Working Group (d) Digital & Health Informatics Divisional Board (e) SIB Minutes (f) CSESC Update		✓ deferred ✓ deferred ✓ deferred		
11.5	Deficit Protocol Controls Overview		✓		

	Date, time and venue of next meeting: *24 September 2024 09.00am – 12.00pm* *Microsoft Teams*	12.00pm	Verbal	Information	T Whiteside

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Integrated Performance Report							
Report to:	Board of Directors			**Date:**	3rd October 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 August 2024, unless otherwise stated. The report content and format has been updated to reflect the metrics agreed as part of the Trusts Single Improvement Plan (SIP) and the SIP Board format.

Operational Performance

Operational Performance Summary

UEC: Performance against the national 4 hour access standard has shown an improvement in month and for the third consecutive month, however remains marginally below the improvement trajectory set. Similarly, improvements have been seen against the 15-30 min and over 60 minute ambulance handover standards, reductions in boarding on wards and overcrowding within the Emergency Department. However, pressures persist with patients experiencing long lengths of stay (12 hours+) within the Emergency Department and this is a key area of focus within the UEC Improvement Plan and links closely to hospital bed occupancy and the number of patients who are classified as 'No criteria to reside' (NCTR). Whilst the number of patients within this NCTR cohort have reduced in August, further analysis is underway to better understand the time/days each person is spending away from their home, to allow a better understanding of the associated bed pressure.

Elective Recovery: August has seen a continued reduction in long waits for elective treatment with further reductions seen in the over 52 week waits 2090 (Aug 24) versus 2308 (July 24) this is the fifth month of reduction. Similar trends have been delivered in patients waiting 65 weeks and above (136 (Aug 24) versus 189 (July 24). LTH is currently the second best performing Trust in L&SC for long waiting elective restoration.

Cancer: 62 day compliance for July 24 has again exceeded trajectory for the fourth month. Similarly, the Faster Diagnosis Standard (FDS) trajectory was achieved for July 24 for the first time this financial year. There are a small number of tumour group areas with fragilities however improvement plans have been developed for each tumour group and are monitored closely.

Diagnostics: Performance against the Diagnostic access standard (DM01) has exceeded the trajectory for the second month however remains significantly below the national standard and LTH is the second worst performing Trust in this area in the NW region. A Diagnostic Improvement group has been established with ICB partners to drive through productivity, demand and transformation opportunities.

Operational Performance commentary

Access Standards - Emergency Care Performance Summary:

- 4 Hour ED performance continues to show an improved position, with August 24 at 72.0%, compared to July 24 at 71.2% however remains below the performance trajectory. The Trust is below the national average position of 76.3%.

- In August, 331 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, decrease of 43 from last month. 83 patients waited over 60 minutes to be handed over from NWAS to the Trust in July 24, a decrease from 122 in July. Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways.

- The number of patients waiting over 12 hours (admitted and non-admitted) in ED increased in August to 9.14% from 8.65% in July 2024. The UEC improvement programme is focusing actions to reduce such extended ED LOS via the roll out of ward and board round standards, adherence to internal professional standards, review of models of care within the emergency village, increased SDEC activity and work with LSCFT re mental health pathways.

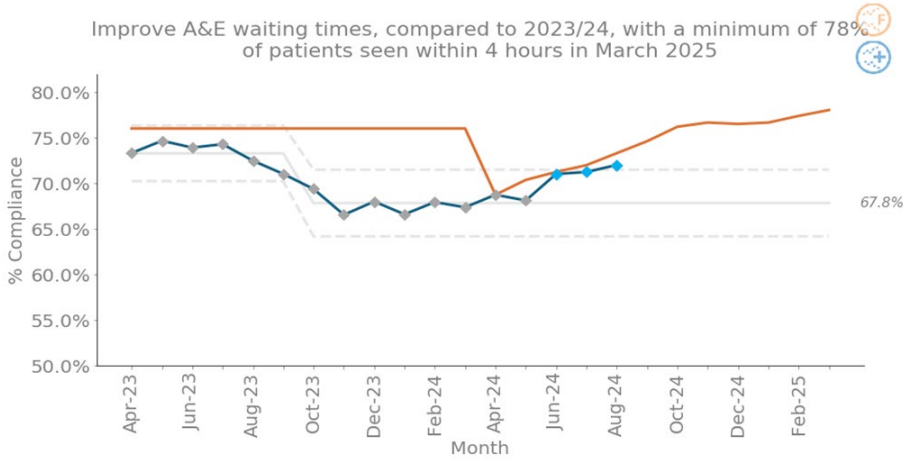
- The occupancy metric has been updated to reflect the new requirement to *reduce adult general and acute (G&A) bed occupancy to 92% or below*, with Trust occupancy for August of 92.75%, a decrease compared to last month's position of 96%.

- On average 4 patients were boarded each day across both sites during August with 124 associated bed days. This is a further reduction compared to the July position of 7 patients. These are predominantly medical patients requiring admission to an acute medical ward. The Urgent and Emergency Care Improvement Plan has identified the reduction in boarding as the first priority aligned to the delivery of improvement.

- The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NCTR) has decreased from last month's position of 12% to 9.7% in August 24. There has been good utilisation of available capacity in the Home First service, but changes to the commissioning model for the Community Healthcare Hub (CHH) at Finney House have caused some delay to decision making as part of the discharge pathway. The Trust is working with system partners to resolve. Further data analysis is required relating to the number of bed days occupied whilst NCTR.

4 Hour Trajectory: 2024/25

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trajectory - 4 Hour Performance	68.7%	70.4%	71.2%	72.0%	73.3%	74.6%	76.2%	76.7%	76.5%	76.6%	77.4%	78.0%
Actual - 4 Hour Performance	68.7%	68.1%	71.0%	71.2%	72.0%							

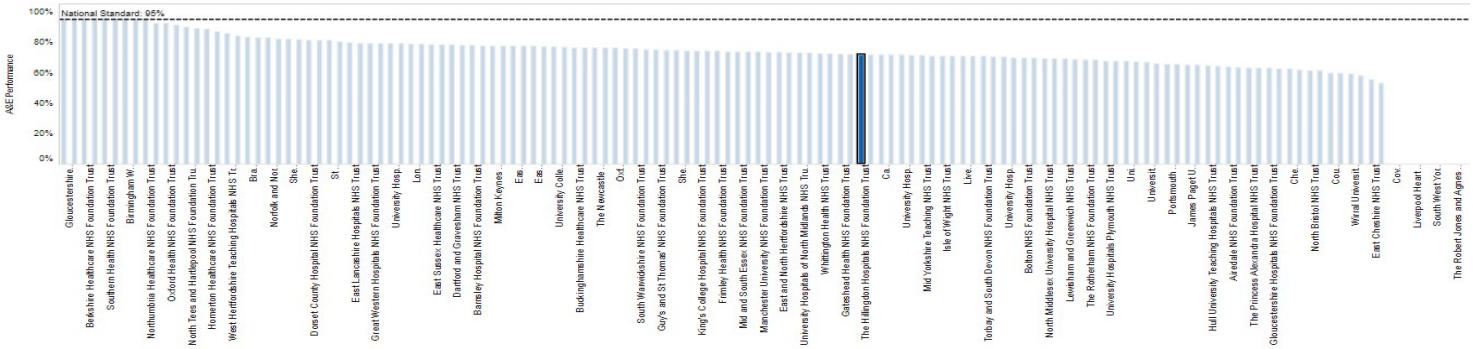


- A monthly improvement trajectory in relation to the 4-hour standard has been agreed for 2024/25, with an expected improvement to 78% during March 2025.

- A key delivery dependency of the trajectory is a reduction of patients not meeting the criteria to reside (NCTR) to 5% (42 patients) against the against the actual 9.7% (73 patients). The Trust continues to experience pressure from an urgent and emergency care pathway perspective, which is understandably impacting on performance.

National context of UEC Performance:

National Position August 2024 – Overall 4 Hour Performance



August 2024 – All Dept Types

Category	Performance
National	76.3%
NW Region	73.8%
L&SC	77.5%
LTH	72.0%

Risks & Mitigations to delivery

Key risks, with plans to mitigate within the UEC internal and system plans, include:

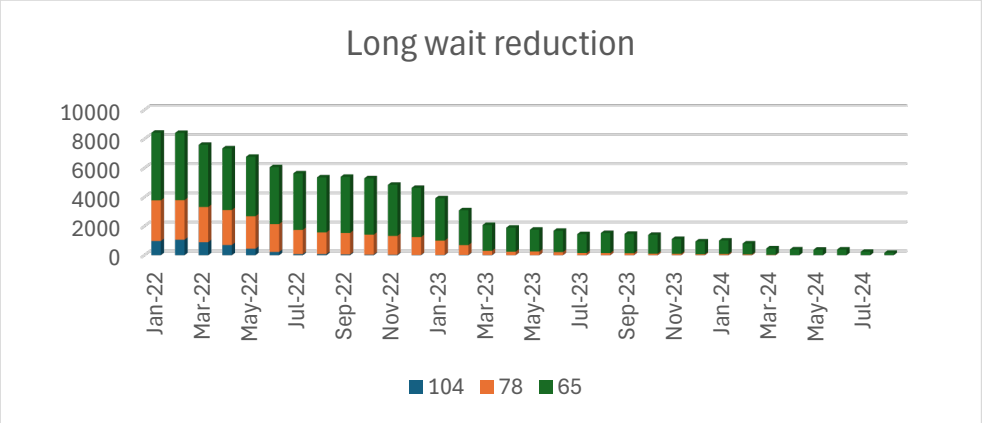
- **Risk:** Risk of negative performance and patient harm caused by delays in timely access to care due to overcrowding within the Emergency department and assessment units.
  Mitigations: Comprehensive system wide UEC Improvement plan focused areas including Flow into and within ED (includes alternatives to ED), Flow across the hospital, mental health and escalation and co-ordination.
- **Risk:** Risk of poor hospital flow preventing timely access to care and hospital discharge due to in hospital and out of hospital delays and shortfalls in community capacity.
- **Mitigations:** Comprehensive system wide UEC Improvement plan focused areas including Flow out of hospital and into communities and escalation and co-ordination.
- **Risk:** Risk of increased demand resulting from GP collective action, the impact of this on the Trust is currently being monitored in terms of advice and guidance activity, referral volumes and presentations to ED and UTC.
- **Mitigations:** Close monitoring of impact and system wide engagement re possible mitigations.

Access Standards - Elective restoration

65 and 78 Week Access Standards – Performance Summary

Maintaining 78 week clearance and clearing 65-week waits is a priority for the divisional teams with performance under daily review.
The Trust achieved 0 over 78 weeks at the end of August 24 and has shown a continued reduction in over 65 week waiters with the aim of eliminating 65 week waiters by the end of September 2024.
There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits.

- The end of August over 78 week position was 0.
- Presently there remains a risk of 4 patients (Opthalmology) breaching 78 week waits at the end of September, however ongoing attempts to resolve treatment barriers continue.



There are a number of risks to delivery of the required reduction in the number of patients waiting a long time for treatment, the below risks pertain to elective, cancer and diagnostic care and include:

- **Risk:** Risk of increased demand resulting from GP collective action, the impact of this on the Trust is currently being monitored in terms of advice and guidance activity, referral volumes and presentations to ED and UTC.
- **Mitigations:** Close monitoring of impact and system wide engagement re possible mitigations.

- **Risk:** Risk of unforeseen workforce absence resulting in capacity shortfalls resulting in a failure to achieve the agreed target
- **Mitigations:** Close monitoring of patient pathways
- **Risk:** Risk of unforeseen workforce absence or new vacancies resulting in capacity shortfalls resulting in a failure to achieve and maintain the agreed target
- **Mitigations:** Close monitoring of patient pathways. Refresh of capacity and demand modelling and productivity benchmarking to support opportunities to bridge capacity gaps.
- **Risk:** Risk of insufficient in-patient bed capacity resulting from poor discharge flow leading to elective activity being cancelled.
- **Mitigations:** Comprehensive system wide UEC Improvement plan focused areas including Flow out of hospital and into communities and escalation and co-ordination.
- **Risk:** Risk of insufficient in-patient bed capacity resulting from poor discharge flow leading to elective activity being cancelled.
- **Mitigations:** Comprehensive system wide UEC Improvement plan focused areas including Flow out of hospital and into communities and escalation and co-ordination.
- **Risk:** Risk to the delivery of performance trajectories due to capacity demand gaps
- **Mitigations:** Close monitoring of patient pathways. Refresh of capacity and demand modelling and productivity benchmarking to support opportunities to bridge capacity gaps.

Access Standards – Diagnostic Waits

- Diagnostics performance in relation to the under 6 weeks standard was 47.7% in August compared to the July position of 48%, a slight deterioration of 0.3%. The deterioration has predominantly been in Echocardiography and Endoscopy procedures (see surveillance impact below). Urgent and cancer patients are prioritised and seen within 2 weeks. The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. In order to support NOUS capacity in the short term, outsourcing arrangements are in place. A business case for capacity to clear the backlog is being progressed, together with longer term plans as part of the single improvement plan, to ensure capacity meets demand at modality level going forwards.

- 2 ultrasound machines are now out of service due to age and poor image quality. There is a plan to fund via capital with recoup of funds from the ICB.

- Relevant patients have now been moved to the active DM01 waiting list and have been reflected in the month end June 2024 position, leading to a slight deterioration of 1-2% in the compliance percentage for June 2024 and to a less extent into July 2024.

- Endoscopy remains pressured with a further delay to increased service capacity relating to pipes and water supply within the modular, this has been factored into the trajectory with interim plans to utilise Medinet Endoscopy capacity whilst the longer-term capacity identified in the business case moves to mobilisation in September 2024

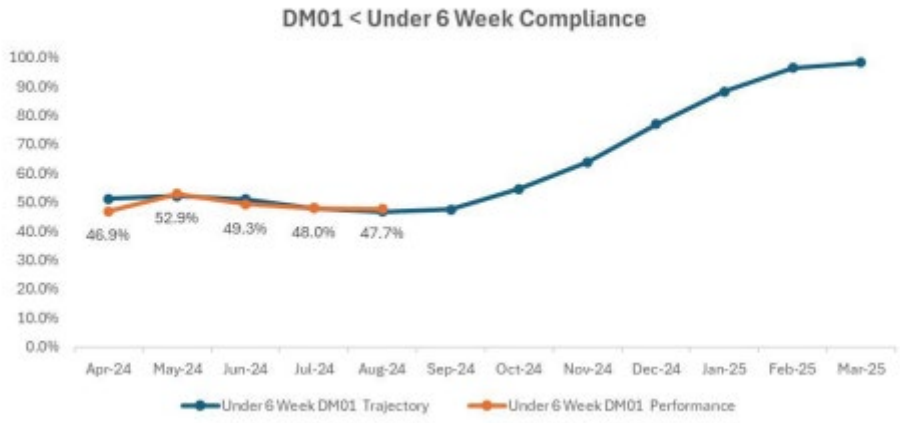
- The Trust has been placed on Tier 1 for diagnostics and has developed an improvement trajectory to deliver the national objective of 95% of DM01 patients waiting under 6 weeks by end March 2025. The trajectory is predicated on the agreement to deliver through additional capacity and productivity improvement, including plans to improve capacity and demand modelling across the Trust.

- Diagnostics Improvement Group (DIG) commenced in August. The group has been established to focus on a programme for diagnostic improvement that will reduce the reliance on outsourcing. The areas of focus are shown below

Capacity Optimisation To improve how we best use capacity	Productivity Focus areas	Transformation and System Focus areas
1. Capacity and Demand 2. Optimising use of community diagnostic centres 3. Repatriation of outsourced activity 4. Booking and scheduling through 6/4/2	1. Demand Management 2. Utilisation and reporting TAT 3. Reducing DNAs and cancellations 4. Modality efficiency standards 5. Internally generated demand	1. Direct access 2. Tertiary referral pathway 3. Workforce models 4. Repatriation of outsourced activity 5. Digital transformation

2024/25 DM01 Compliance Trajectory: Under 6 Weeks Compliance

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Under 6 Week DM01 Trajectory	51.2%	52.1%	51.1%	48.0%	46.7%	47.5%	54.6%	63.9%	77.1%	88.3%	96.5%	98.3%
Under 6 Week DM01 Performance	46.9%	52.9%	49.3%	48.0%	47.7%							



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 were 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 and add these patients to the PTL at the end of Q1 and Q2.

- The Endoscopy Polyp task and finish group is working alongside this to identify patients on the surveillance pathway with the highest clinical risk so their procedure can be expedited. The surveillance patients are treated in date order with other long waiting patients but are now expedited above if clinically required.

Access Standards 2024/25 - Cancer Recovery:

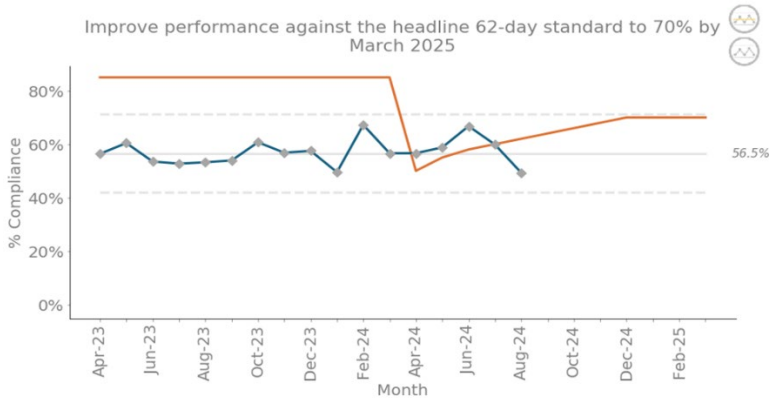
In 2024/25 the Trust will be monitored against 2 key cancer standards:

- 62 Day Treatment % Standard
- 28 Day Faster Diagnosis Standard

62 Treatment Compliance

The Trust has set a performance trajectory to achieve 70% compliance by end December 2024. Performance in August 2024 was 52.8%, below the monthly trajectory. There is continued validation of the position until the deadline for submission for August performance. Cancer tumour site plans form part of the cancer workstream within the Single Improvement Plan reporting into the Operational Performance portfolio.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
62 Day Trajectory	50.0%	55.0%	58.0%	60.0%	62.0%	64.0%	66.0%	68.0%	70.0%	70.0%	70.0%	70.0%
62 Day Compliance	56.8%	58.6%	66.7%	62.5%	52.8%							

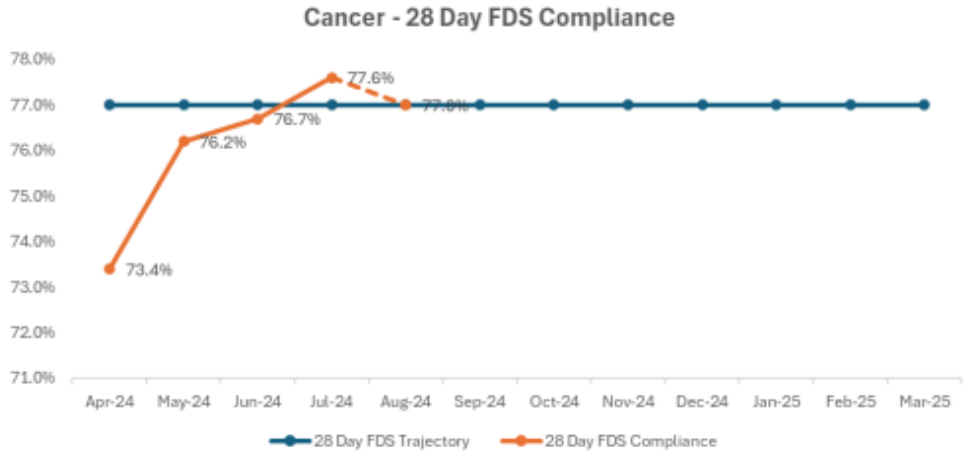


28 Day Faster Diagnosis Standard

Performance compared to the Cancer FDS trajectory to March 2025 is shown below. Performance to the end August was 76.1% compared to the expected performance of 77%, slightly below trajectory for the month. There is continued validation of the position until the deadline for submission for August performance.

The trajectory has been reprofiled to a flat 77% as this is achievable now and there is an ambition to sustain performance at this level, supporting the removal of the Trust from Tier 1 for Cancer.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
28 Day FDS Trajectory	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%
28 Day FDS Compliance	73.4%	76.2%	76.7%	77.6%	77.0%							



Performance by individual tumour site is shown below for the current financial year:

Tumour Site	Apr-24	May-24	Jun-24	Jul-24
Brain	72.8%	94.6%	78.9%	85.4%
Breast	96.8%	92.4%	91.4%	96.8%
Breast Symptomatic	96.7%	90.9%	92.2%	93.4%
Colorectal	43.5%	52.3%	45.8%	45.9%
Gynaecology	69.3%	65.9%	72.3%	78.9%
Haematology	-	100.0%	28.6%	-
Head and Neck	76.2%	72.2%	71.7%	76.9%
Lung	76.7%	68.2%	81.5%	60.7%
NSS	75.0%	88.9%	100.0%	71.4%
Other	-	-	50.0%	100.0%
Paediatric	85.7%	83.3%	100.0%	81.8%
Sarcoma	61.1%	69.0%	60.0%	65.6%
Skin	90.8%	89.6%	91.7%	89.1%
Upper GI	71.3%	78.2%	84.5%	78.6%
Urology	28.9%	42.3%	43.1%	47.9%
Total	**73.4%**	**76.2%**	**76.7%**	**77.6%**

- **Colorectal**
  Colorectal pathway has been redesigned. The front end of the pathway is showing improvements following introduction of an ACP provision with a Rapid Diagnostic Clinical triage occurring for each patient by day 6 of the referral being received. However, FDS performance remains below the 77% trajectory with August compliance being reported as 44.8%. Key drivers for performance being below trajectory relates to access times for endoscopy. A business case has been approved and will provide increased capacity however the mobilisation has been delayed until Q3. The tumour group is projected to support achievement of trust wide FDS trajectory by the end of March 25.

- **Urology**
  The Urology pathway has been redesigned, by training ACPs to undertake the front end of the pathway. This has improved the front end of the pathway however Urology is below FDS trajectory of 77% achieving 58.2% in August, but showing steady improvement compared to previous months. The factors in not meeting compliance is mainly due to reporting time of prostate biopsy and time to first appointment. A successful bid was made to the National Cancer team which has provided £200k funding to support outsourced biopsy reporting a reduce turnaround time. Time to first appointment is impacted by not receiving bloods and up to date PSA at the time of the referral. Cancer Alliance are supporting with GP education, whilst our lead cancer nurse is targeting practices with the highest amount of incomplete referrals for targeted education. Additionally, a gap analysis is being undertaken in histopathology, specifically relating to prostate biopsies, commissioned by the cancer alliance the results of this and any actions arising will be worked on jointly between LTH and Cancer Alliance.

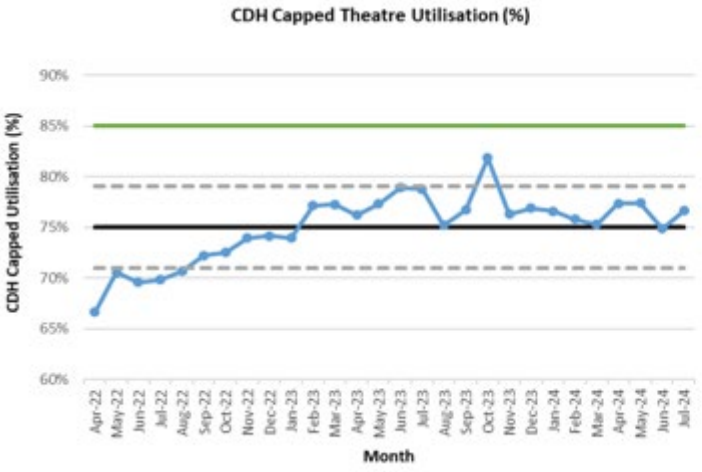
- **Lung**
  The lung pathway is undergoing redesign to ensure capacity is in place for current GA EBUS requirement and plans for any additional requirement following Targeted Lung Health Checks, that are due to be implemented in Q1 2025. All GA EBUS's for the region are undertaken at LTHTR as the specialist interventional pulmonology centre. The service has been successful in implementing Lung Vision, which enables clinicians to reach deeper into the lungs and therefore diagnose at an earlier stage and thereby better survival outcomes. Performance against FDS is under trajectory of 77% at 69.6%. Key drivers for this are due to consultant maternity leave and under resourced CNS staff to support the service, however the Clinical Director has taken over as cancer lead for lung, and targeted transformation support has been aligned to the tumour group. Theatre capacity for EBUS has been achieved, with an AM and PM session aligned to EBUS, however staffing from endoscopy is yet to be achieved. This will increase capacity for GA procedures and thereby reduce waiting times for local and alliance patients. It is more important for current complex procedure workload and increased demand in future.

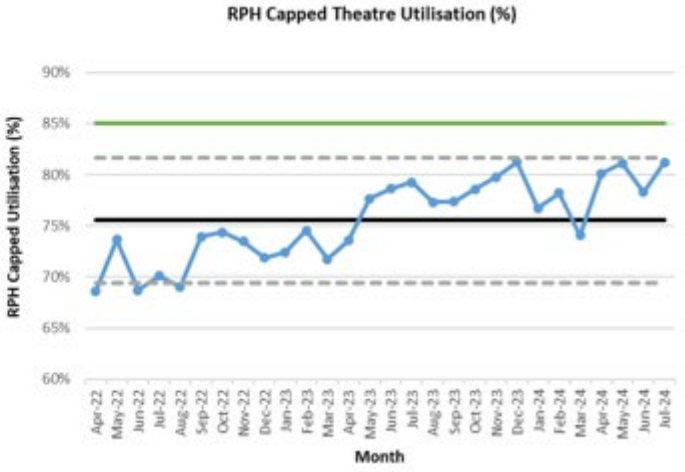
- **Sarcoma**
  Sarcoma performance is based on a small number of patients. On average, less than 30 patients are referred with suspected sarcoma per month and of those patients 3.47% are found to have cancer. The average day to tell patients whether they have cancer (FDS) is 31 days and in August 1 patient had cancer confirmed and treated, but unfortunately this was over 62 days. The sarcoma pathway is complex, both to diagnose and treat patients. However, in order to reduce any unnecessary process delays, the sarcoma tumour group site is now discussed in PTL meetings twice per week with representation from the Sarcoma Lead Nurse. The outcome of this will be measured and any learning or actions added to the Tumour site action plan.

Theatre Efficiency Programme

A Theatre Efficiency Programme reports progress through the Elective Care Improvement Group under the operational performance portfolio within the single improvement plan.

- The current capped theatre utilisation rates are shown below indicating an improving and consistent capped performance at CDH until Dec 2023, but has shown recovery from April 2024. Performance on the RPH site further deteriorated in March 2024 but has shown consistent recovery from that point into July 2024. Further consistency checks is in progress against the Model Hospital data which places the Trust in the top quartile. Paediatric Surgery has successfully moved to CDH and the national team has commended this achievement.

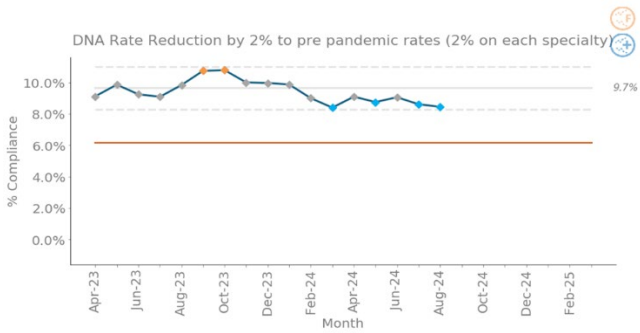


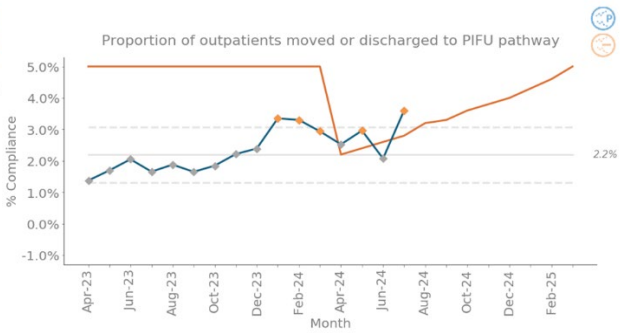


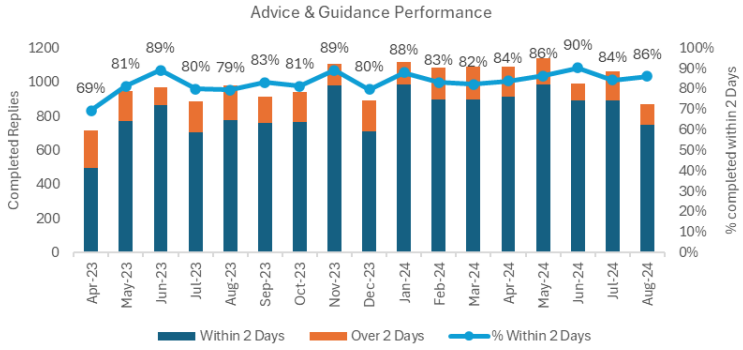
Outpatient transformation

The Outpatient Improvement Programme is led by the Chief Medical Officer and is a key part of the productivity workstream within the Financial Recovery Plan. The plan is focussed on reducing follow ups/DNA's, reforming triage before appointment bookings including Advice & Guidance, digital opportunities.
Performance in relation to key elements of the programme are detailed below:

- Referral optimisation – delay with ICB work focusing on commissioning framework; quality improvement and digital delivery. Awaiting update on when the Task & Finish Group will commence
- PIFU – Maternity PIFU patients now captured and increase in PIFU rates has been delivered. Focus for next month is to apply a similar process for Orthopaedic fracture clinic patients to capture more PIFU activity.
- DNA – work continuing to deliver FRP schemes relating to DNA reduction in M6. DNA rate in August is similar to July position. Further focus required on targeting patients for courtesy call where there is evidence that they are more likely to DNA.
- Further Faster GIRFT programme – initiatives have commenced where funding had been allocated. Improvements seen in validated PTL positions across a number of specialties.
- OP increase OPFA and OPROC to 46% - performance being tracked with check and challenge commencing







Safety and Quality

Safe Staffing requirements
The adult, children, community, AHP and maternity annual and biannual safe staffing reviews have been completed in August and September in line with the agreed annual schedule. Monthly detailed oversight of adult, children and maternity safe staffing continues through the safety and quality committee.

The adult inpatient areas remain in a positive position with RN staff fill rates achieving >95% fill rates, despite the current HCA vacancy rate being circa 16%, bank HCA's enable the fill rates to meet the required standard.
The maternity fill rate position for registered midwives (RM) ranges between 86-90% which is an improving picture overall. Overall, when combined with Maternity Support Workers the fill rate is 97%.

Patient Experience and Involvement
The number of complaints per 1000 beds days continues to demonstrate a reduced rate which is positive and is as a result of increased focus on local resolution for patients and families. The focus on patient experience continues with specific focus on the Urgent and Emergency improvement plans and inpatient pathways and the safety and quality committee receives 6 monthly updates on the actions being taken to improve the experience of patients in this area.

The Friends and Family feedback responses demonstrate for August, 100% positive feedback for neonatal services, >95% adult day case, CYP inpatients, >90% adult inpatients, adult outpatients. Children's and adults Emergency Department positive experience data is achieving 76% and reflects the challenges within the urgent and emergency care pathways. The department remains focused on improving this for patients and it should be recognised adverse experiences often correlates with the time patients spend in the department and is not entirely a reflection of the care provided. Recognising this, the UEC part of the single improvement plan is expected to positively affect this for patients and colleagues and each division will have a UEC section with the accountability framework ensuring appropriate focus on this area.

The overall number of compliments recorded in August was 480 which is increasing month on month currently. This provides an excellent opportunity to motivate teams recognising positive practice that impacts on patient experience.

STAR accreditation
The Star accreditation process has been refreshed to introduce the mandatory standards that mirror areas that are consistently not achieving. This is expected to initially negatively impact the outcomes within STAR with the aim to leading to an improvement. The disaggregation of the whole Trust position from that of the higher risk ward, ED and theatre areas is now scrutinised by the Safety and Quality committee.

Clostridium *difficile*
In August the 2024/2025 NHS England objective was received which has seen an increase in cases from 122 in 2023/2024 to 199 cases in year in recognition of the national increases in C.*difficile* following the pandemic. This increases the monthly trajectory to 17. In August, there were 7 Hospital onset Hospital Associated (HOHA) cases and 5 Community Onset hospital associated (COHA) cases which is below trajectory but overall, by the end of August the cumulative position shows 2 cases above trajectory. Whilst the objective has been increased, the focus on reducing C. *difficile* prevention remains and actions are ongoing.

In the last reporting period advances have been made in relation to 1. Commencing the UV light treatment programme 2. Relaunch of the estates and facilities partnership board chaired by the Chief Nursing Officer enabling closer working relationships between clinical and estates teams to address challenges. 3. The continued focus on the 'bin the wipes' campaign aims at reducing the number of blockages leading to contamination. 4. NHS England have completed a review of the actions contained within the C.*difficile* improvement plan and the outcome of this will be feedback in the next reporting period. 5. The compliance with antimicrobial guidance quarterly audits demonstrated 92% in Quarter 2.

Pressure Ulcers
The pressure ulcer data is now presented against the average number of pressure ulcers reported in the last 3 years. The change is aimed at understanding the organisations performance against previous months. When making this comparison there is evidence of lower than previous levels of pressure ulcers. Pressure ulcers are considered as a proxy for the standard of care delivered and an underpinning improvement plan is aimed at minimising both the overall numbers and the category severity of pressure ulcers recognising the poor experience that occurs for patients when a pressure ulcer is acquired in hospital. This work will continue.

HSMR
Mortality metrics remain stable and within expected parameters.

Care Quality Commission
In total, the Trust has 54 recommendations in the form of Must Do's* or Should Do's** (18 Must Do's and 36 Should Do's). Some recommendations are duplicated across the different core services and upon streamlining, there are 44 recommendations in total (13 Must Do's and 31 Should Do's).

The Quality Improvement Plan is the response to these must and should dos and forms part of the single improvement plan. Progress in relation to the progression of CQC must and should do's is now being reported through the Single Improvement Plan Board chaired by the Chief Executive.

Of the 75 actions identified within the action plan, 50 actions have been delivered, (a further 8 since the last report to Board) and 11 actions have been assessed as on track for delivery demonstrating a significant amount of progress to date. Two actions have been stood down as no longer applicable.

From the 18 'Must Do' recommendations, 11 have been assessed as delivered and the themes of the 7 outstanding 'Must Do' recommendations are related to training and appraisal compliance by professional group and CQC core service, medical staff training compliance in urgent and emergency care and medicine, evidence of a timely assessment by a senior decision making in surgery, medical staffing in medicine and documentation specifically in relation to fluid balance and vital signs. A delivery date has been set for each of the outstanding must do's.

From the 36 'Should Do' recommendations, 29 have been assessed as delivered and the themes of the outstanding 7 'Should Do' recommendations are related to medical staffing in ED, timely medical review when not being provided care and treatment on the correct medical speciality ward, compliance with infection, prevention and control standards in medicine, evidence of NEWS2 recording in medicine, STAR audit outcomes in ED, equipment and environment maintenance and midwifery staffing. A delivery date has been set for each of the outstanding should do's.

People and Culture

The sickness absence rate increased to over 6%, which is a concern given the significant work underway to upskill managers in absence management and create improved rigour around the management of cases. MIAA have now completed their audit around organisational sickness absence management, and the results will be shared with Audit Committee.

A comprehensive sickness absence reduction plan is in place, including workstreams around Data, Policies & Processes, Education and Wellbeing. Key areas of focus include the upskilling of managers in absence management (209 attendances of re-training to date) and plans to pilot a digital absence management system (Empactis). Known barriers to reducing sickness absence include delays in access to treatment (this affects our long-term absence rate) and insufficient capacity to meet increased demand for psychological wellbeing support. Mental health is overwhelmingly the highest reason for FTE days lost.

Vacancy rates have continued to increase, which is reflective of vacancies being held to contribute to the financial recovery plan. Further changes have been made to vacancy control processes, with a 'firebreak' being integrated into our existing vacancy control process to support financial recovery.

Agency usage remains favourable to plan. Bank usage increased during M05 with reported reasons equating to vacancy cover (65%), enhanced care (45%) and high acuity (15%) (% of net increase to M05). Nursing & Midwifery agency and Medical & Dental bank resourcing services will be brought back in-house on 01 October 2024.

Financial Sustainability

Income and Expenditure

The Trust has submitted the final plan in line with the NHSE control total. At month 5 the Trust has an adverse position against a plan of £25.8m, a deficit of £23.4m. The Trust continues to have considerable underlying financial pressures to manage and a financial recovery plan target of £58m to deliver.

Capital Position

Capital expenditure in the year to date at £18.2m is c£5.5m less than plan.

The delegated capital limit for the system has been reduced by £10m as a consequence of the system revenue plans being in deficit. The Trust has reduced the capital plan by £3.2m to contribute to the system reduction of £10m. This reduction is being worked through the Capital Planning Forum, however it should be noted that this £3.2m reduction requires the Trust to defer expenditure on backlog maintenance and equipment replacement, and as a consequence this significantly increases the risks to operational areas.

Cash Position

The Trust has not required cash support in the year to date but forecasts a requirement for support in September. A cash support application for September was submitted to NHSE/DHSE and an outcome is pending. Should the request be rejected or reduced in value the Trust will have to restrict supplier payments and utilise capital cash for revenue which is contrary to DHSC guidance.

Operational pressures associated with the revenue deficit are adding to the cash burden in the plan.

Financial Recovery Plan Target

'The Trust's objective to reach financial balance on a recurrent basis by th end of the three year period (2026-27) will require delivery of an ambitious and very challenging financial recovery plan. In 2024-25 a gap of £58m will need to be mitigated. Of this £8.3m will be closed through income/productivity contribution, £8.3m through system optimisation/risk and a balance of £41.4m (5%) will be delivered through core cost improvement.

In month 5 the Trust has delivered £7.1m year to date, which is on plan of £8.3m however 57% of this was non-recurrent. Annually £13.3m; (£9.6m recurrently) has been delivered towards the £58m target which is 23%.

Use of Resources

The Trust is in Segment 3.

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 regional teams with input from the national intensive support team where requested.

The Agency spend to month 5 was £5.2m, 2.3% of pay expenditure. This compares favourably to the agency cap of 3.2% of pay expenditure which has reduced from the cap of 3.7% in 2023/24.

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

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Single Improvement Plan

Trust Board
Performance Pack
August 2024

SIP PROGRAMME STRUCTURE

Well Led	People & Culture	Safety, Quality and effectiveness	Financial Sustainability	Operational Performance
Clear Vision and Strategy	Attract, Recruit and Resource	Deliver Annual Safe Staffing Requirements	3 Year FRP – Identify and Develop	UEC In Flow
Information Improvement	Engage, Retain, Reward & Recognise	Patient Experience & Involvement	Budget Planning	UEC Flow
Learning, Continuous Improvement & Innovation	Create a Positive Organisational Culture	Safeguarding	Budget Holder Allocation	UEC Outflow/Community Collaborative
Corporate Communications Approach	Be Well Led	C Difficile Improvement Programme	Procurement (LPC) & Contracts Hub	Strengthening Weekend Discharge
CQC Quality Improvement	Supporting the Health & Wellbeing of Colleagues	Deliver Always Safety First Strategy		Strengthen UEC Workforce
Governance and Risk Maturity	Being Consciously Inclusive	Maternity & Neonatal		Elective: General
Community Services Place (incl. Primary Care)	Education, Training & Research	Childrens Improvement		Elective: Cancer
Digital	Junior Doctors	Health Inequalities		Outpatient Transformation
Estates	Medical Staffing Improvement	Critical Care and Enhanced Care Areas		Major Trauma
Strategy & Planning – Trust Planning Process		Medication Safety		

SPC Metric Summary

Safety & Quality
Operational Performance
People and Culture
Finance

Variation \ Assurance	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	- Reduce not meeting criteria to reside to 5% - Staff Survey: Recommend Trust as place to work	- Vacancies (% FTE) - Number of violence and agression incidents toward staff	- Overall Fill Rate Registered Midwife (RM) and Maternity Support Worker (MSW) - Turnover %
Normal variation - no recent change	- Maximum wait of 12 hours as Total Time in Department Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% - 85% theatre utilisation - aggregate - Capped - Sickness Absence (% FTE)	- Complaints per 1000 bed days - Performance against national trajectory - no more than 122 Hospital Acquired cases - Pressure Ulcers per 1000 beds days (Stage 2 and above) - Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions - Perinatal - Number of Stillbirths - Compliance with 60 minute ambulance turnaround time target - Bed occupancy to 92% - Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026 - Improve performance against the headline 62-day standard to 70% by March 2025	- STAR Accreditation all trust
Recent positive pattern in the data	- Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025 - Number of boarded patients - 52 week waits - Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties) - Eliminate >78 week waits	- Overall Fill rate Registered Nurse (RN) and Health Care Assistant (HCA)	

Non SPC Metrics flagged as a concern

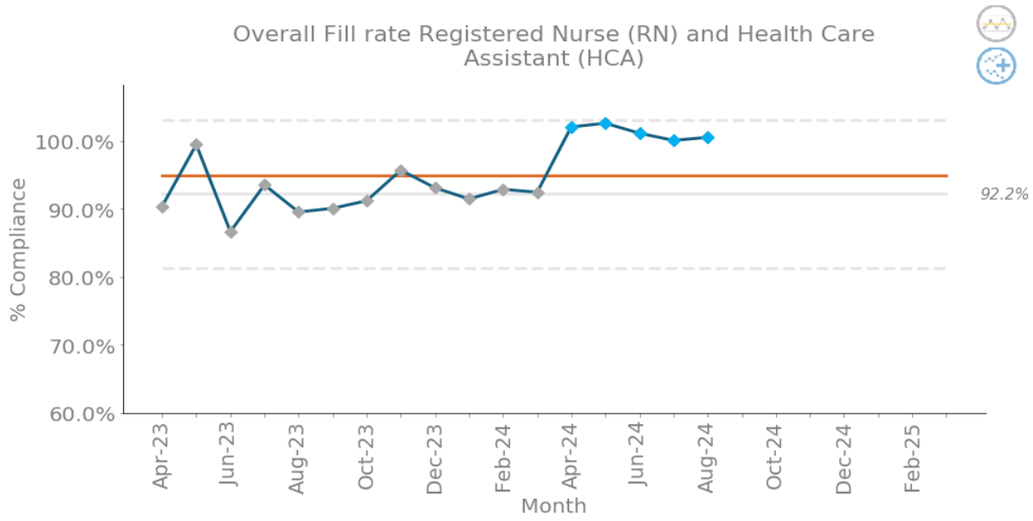
Appraisal Compliance (% HC)
FRP schemes delivery

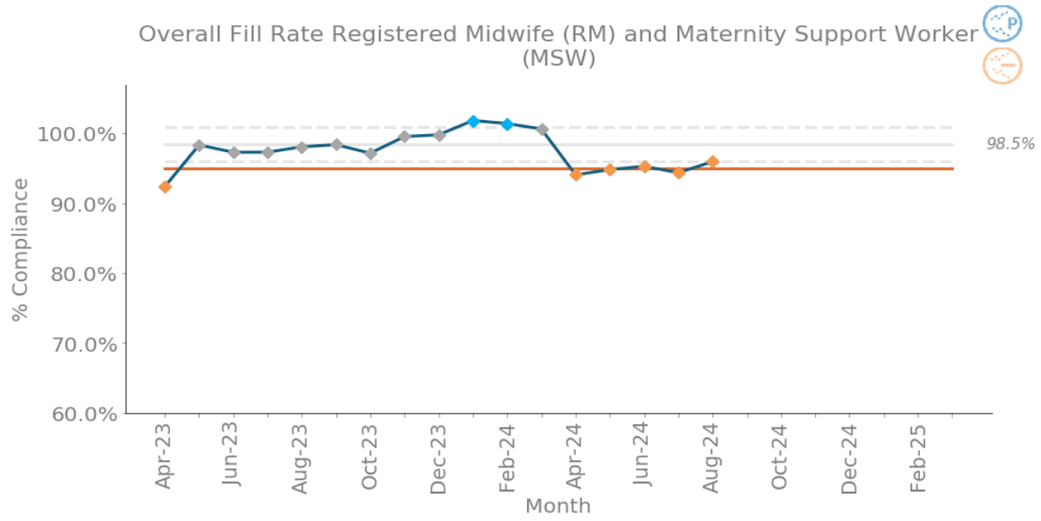
Non SPC Metrics

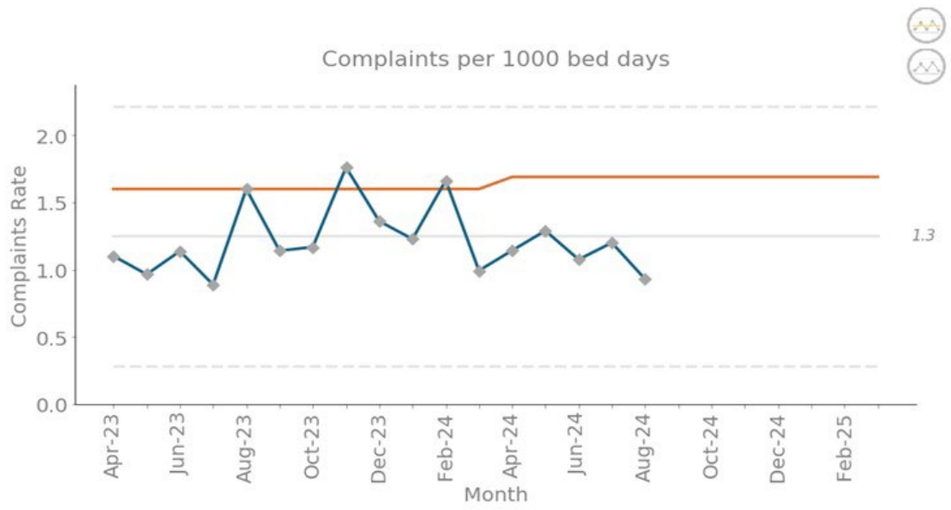
Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected
Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected

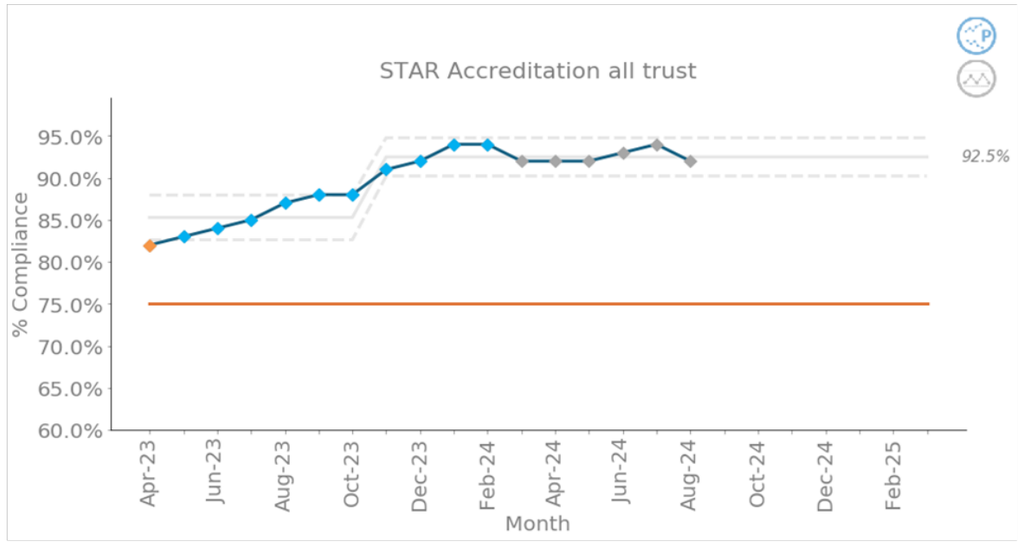
Single Improvement Plan - Safety & Quality

Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-25	Latest Month Target		
Deliver Annual Safe Staffing Requirements	Overall Fill rate Registered Nurse (RN) and Health Care Assistant (HCA)				95.0%	95.0%	100.5%	Aug-24
	Overall Fill Rate Registered Midwife (RM) and Maternity Support Worker (MSW)	P			95.0%	95.0%	95.9%	Aug-24
Patient Experience and Involvement	Complaints per 1000 bed days				1.69	1.69	0.93	Aug-24
	STAR Accreditation all trust	P			75.0%	75.0%	92.0%	Aug-24
C Difficile Improvement	Performance against national trajectory - no more than 122 Hospital Acquired cases				16	17	12	Aug-24
Always Safety First	Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected					63.2	Apr-24
	Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected					66.2	Apr-24
	Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected					182.2	Apr-24
	Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected					106.0	Apr-24
	Pressure Ulcers per 1000 beds days (Stage 2 and above)				3.48	3.40	2.83	Aug-24
Maternity	Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions				100%	100%	80%	Aug-24
	Perinatal - Number of Stillbirths				0	0	2	Aug-24

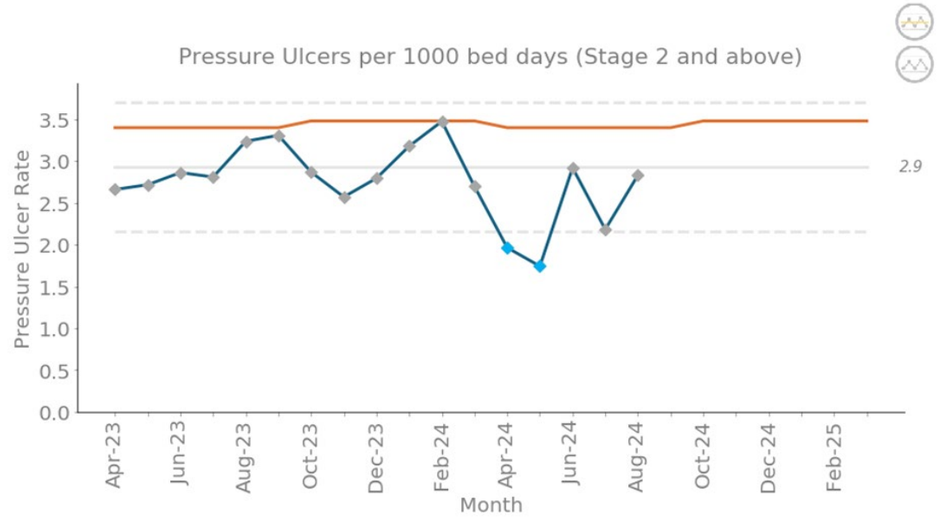

Overall Fill rate Registered Nurse (RN) and Health Care Assistant (HCA)
% Compliance
100.0%
90.0%
80.0%
70.0%
60.0%
92.2%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

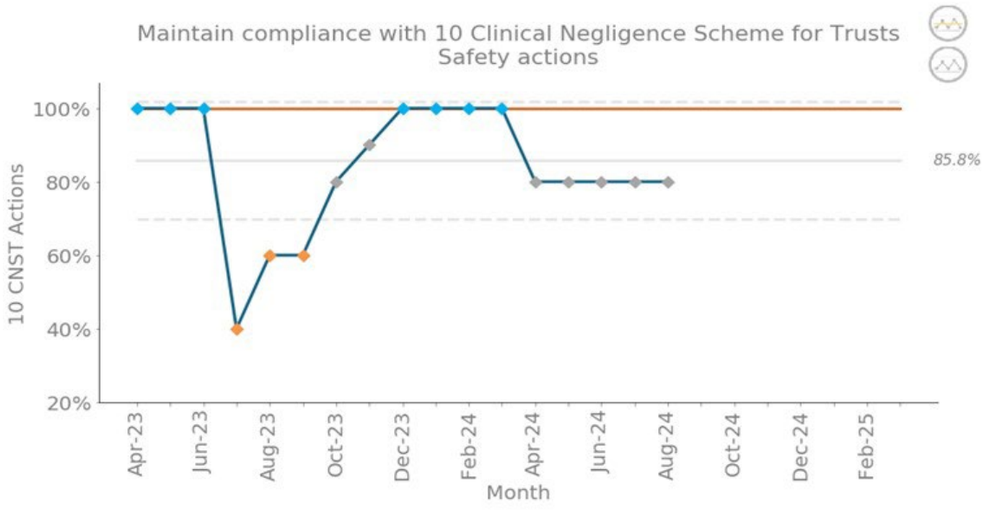

Overall Fill Rate Registered Midwife (RM) and Maternity Support Worker (MSW)
% Compliance
100.0%
90.0%
80.0%
70.0%
60.0%
98.5%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

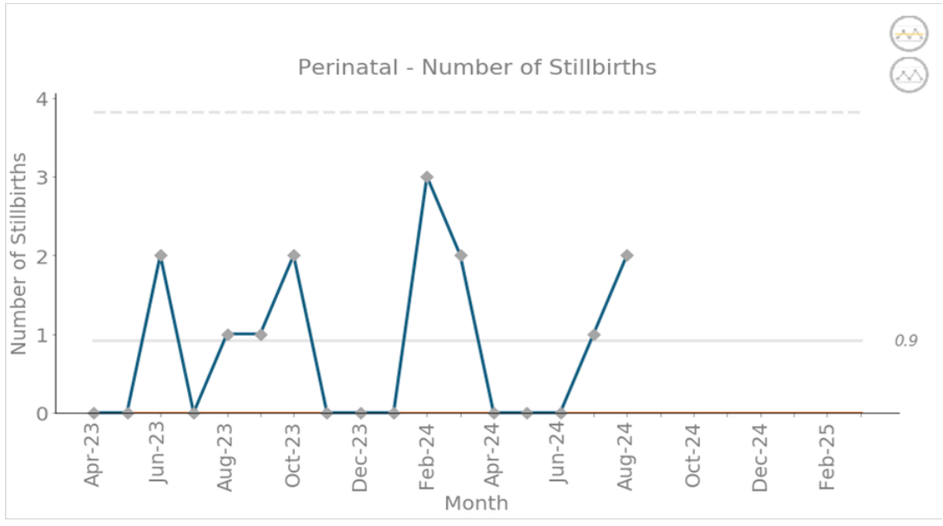

Complaints per 1000 bed days
Complaints Rate
2.0
1.5
1.0
0.5
0.0
1.3
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month


STAR Accreditation all trust
% Compliance
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
92.5%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month


Performance against national trajectory - no more than 199 Hospital Acquired cases
Number of Patients
30
25
20
15
10
5
0
16.9
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

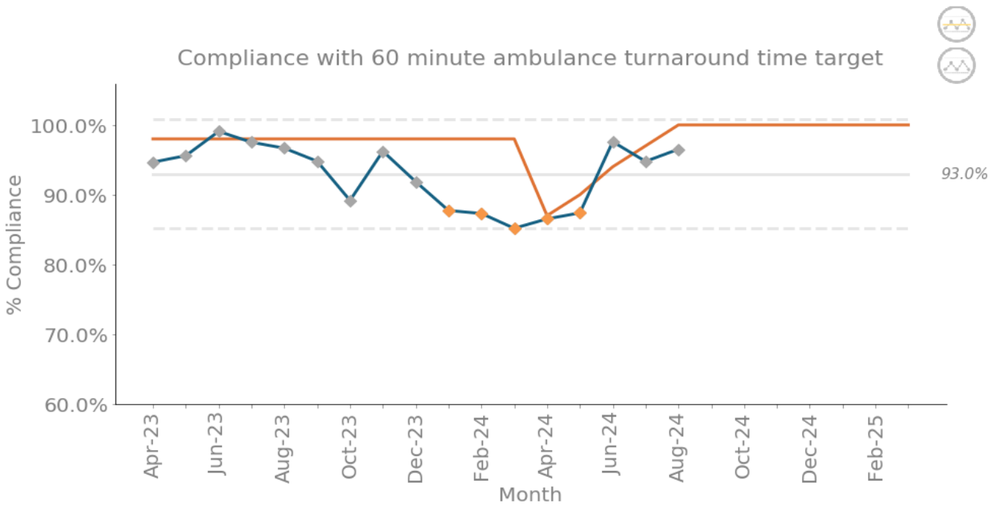

Pressure Ulcers per 1000 bed days (Stage 2 and above)
Pressure Ulcer Rate
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
2.9
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

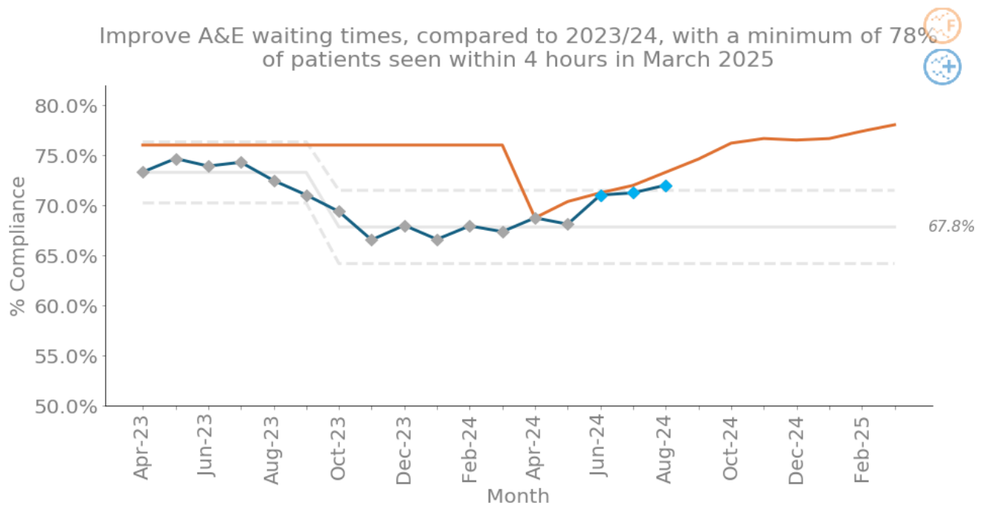

Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions
10 CNST Actions
100%
80%
60%
40%
20%
85.8%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

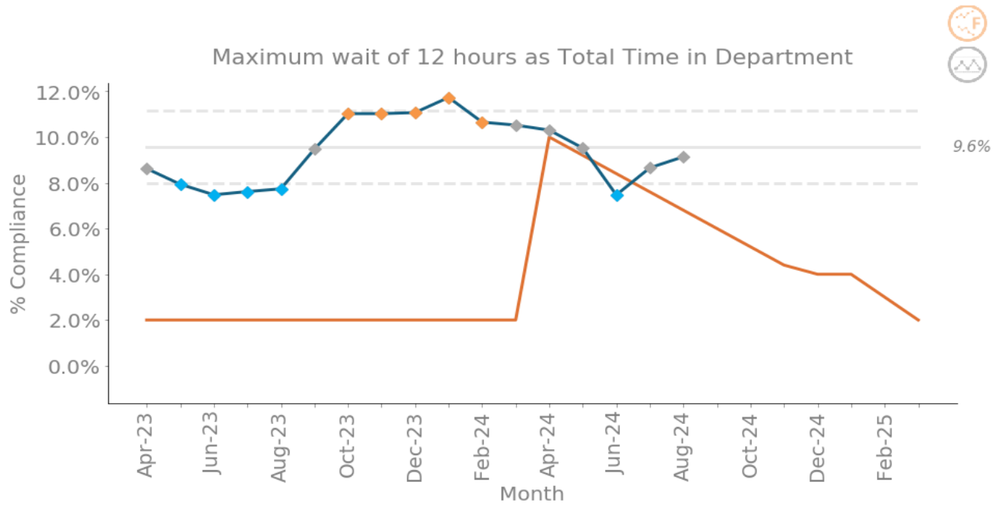

Perinatal - Number of Stillbirths
Number of Stillbirths
4
3
2
1
0
0.9
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

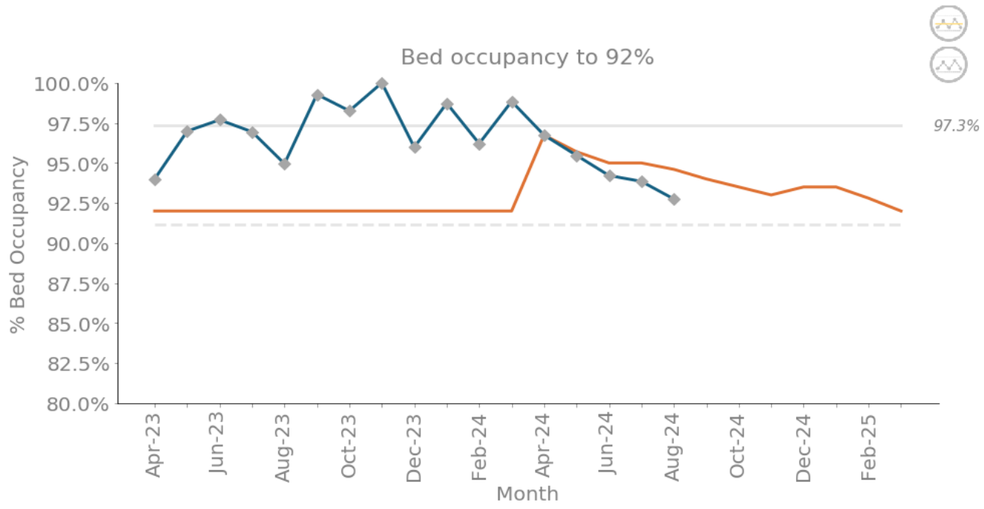
Single Improvement Plan - Operational

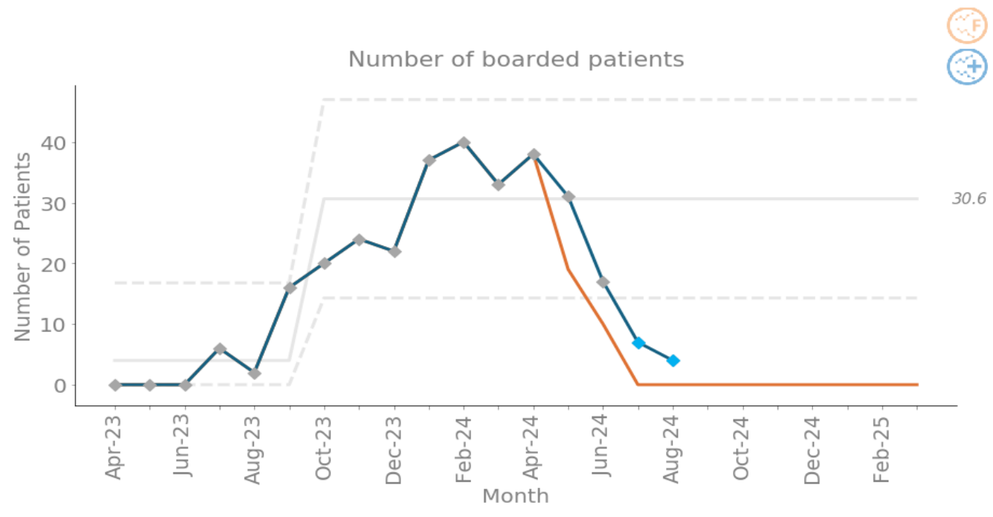
Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target				
				Concern	Mar-25	Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100%	100%	96.52%	Aug-24
	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025				78%	73.29%	72.00%	Aug-24
	Maximum wait of 12 hours as Total Time in Department				2%	6.8%	9.0%	Aug-24
UEC Flow	Bed occupancy to 92%				92%	94.60%	92.75%	Aug-24
	Number of boarded patients				0	0	4	Aug-24
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside to 5%				5%	8.00%	9.77%	Aug-24
Elective (diagnostics)	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%				98%	46.70%	47.70%	Aug-24
Elective (long waits)	52 week waits				0	1543	2090	Aug-24
	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)				0	73	136	Aug-24
	Eliminate >78 week waits				0	0	0	Aug-24
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				85.00%	79.47%	79.40%	Aug-24
Elective (Cancer)	Improve performance against the headline 62-day standard to 70% by March 2025				70%	62.00%	62.00%	Aug 24 expected
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026				77%	77.00%	77.00%	Aug 24 expected

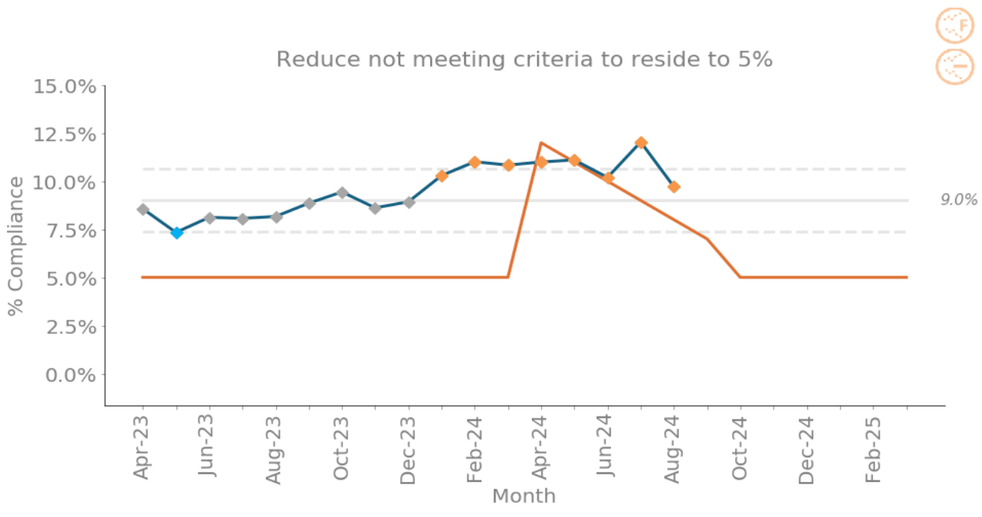

Compliance with 60 minute ambulance turnaround time target
% Compliance
100.0%
90.0%
80.0%
70.0%
60.0%
93.0%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

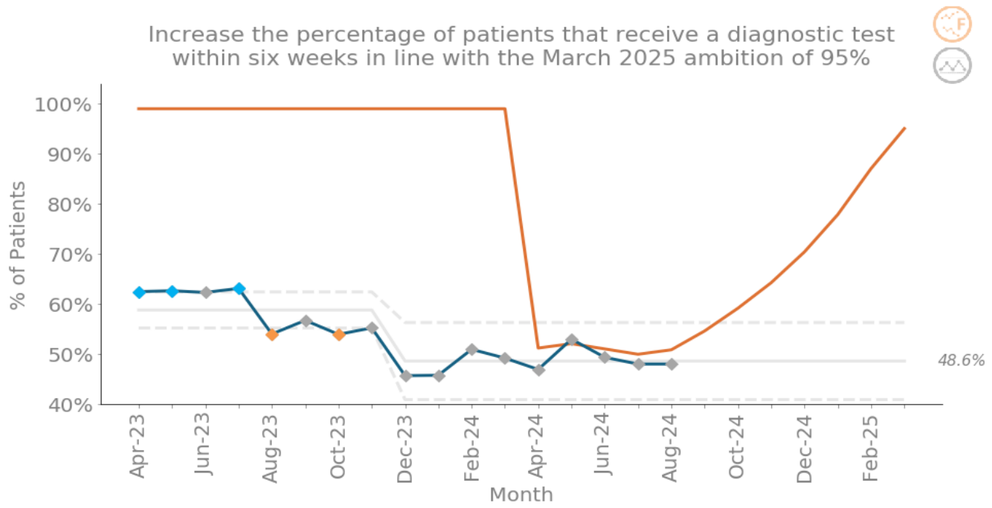

Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
% Compliance
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
67.8%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

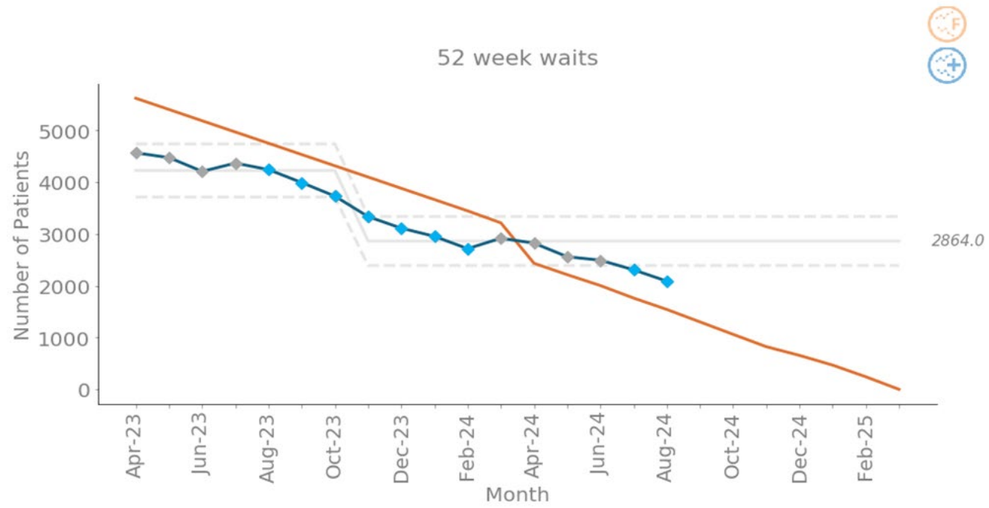

Maximum wait of 12 hours as Total Time in Department
% Compliance
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
9.6%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

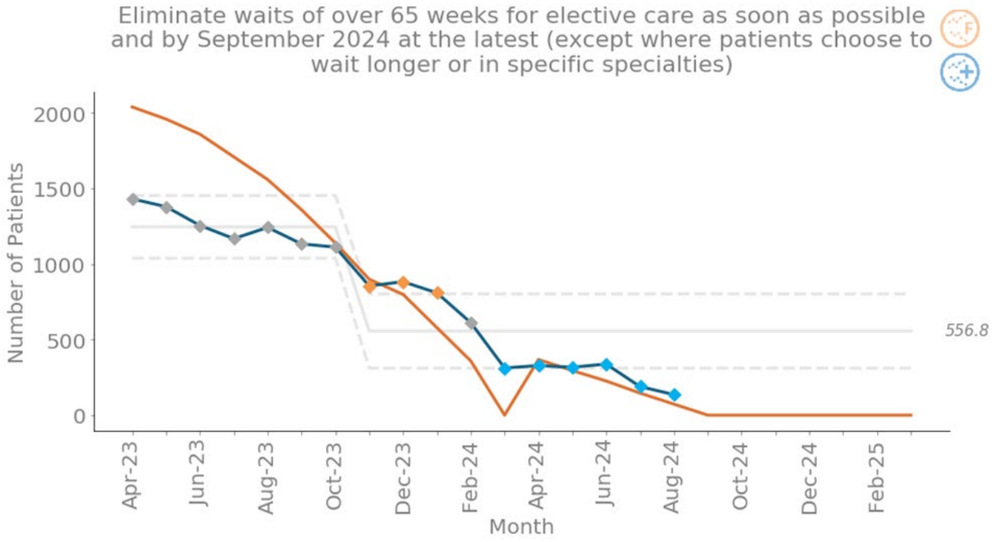

Bed occupancy to 92%
% Bed Occupancy
100.0%
97.5%
95.0%
92.5%
90.0%
87.5%
85.0%
82.5%
80.0%
97.3%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

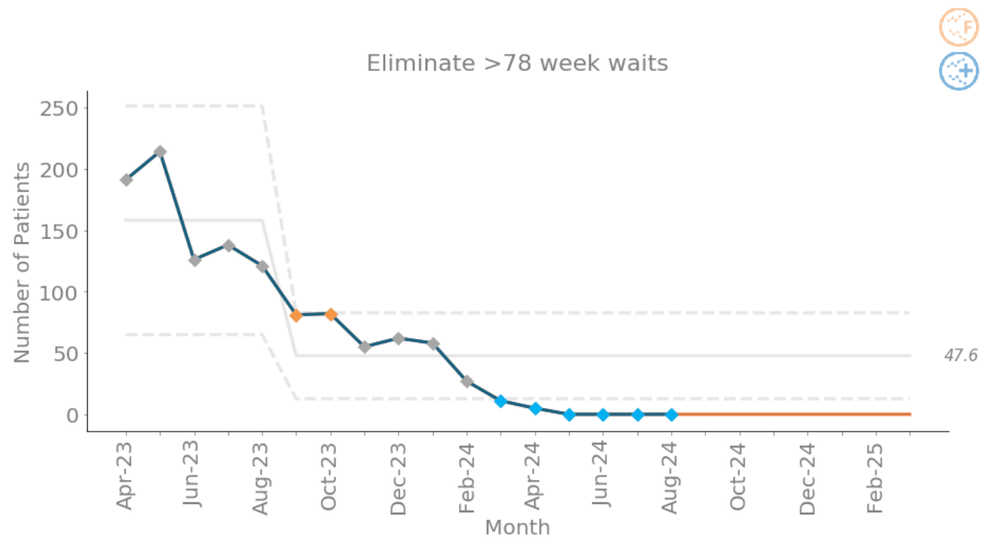

Number of boarded patients
Number of Patients
40
30
20
10
0
30.6
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

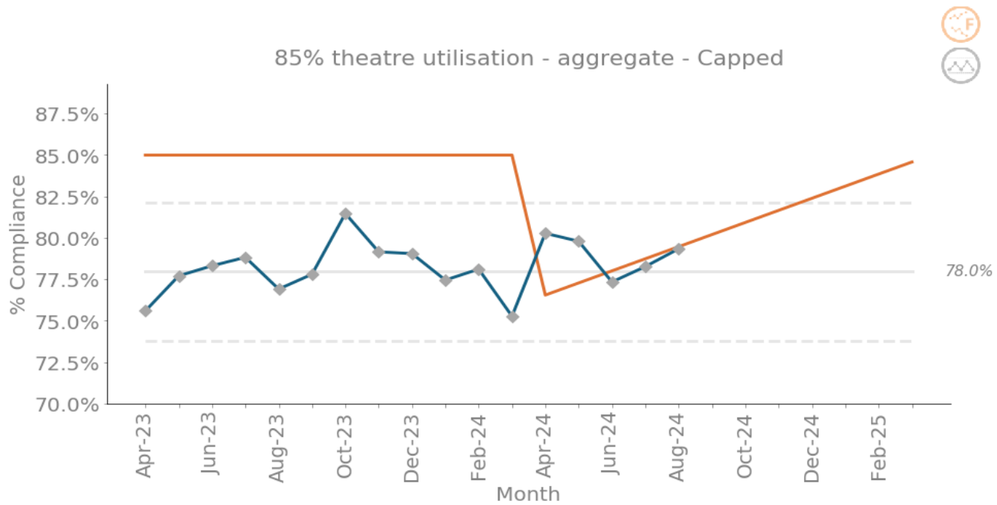

Reduce not meeting criteria to reside to 5%
% Compliance
15.0%
12.5%
10.0%
7.5%
5.0%
2.5%
0.0%
9.0%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

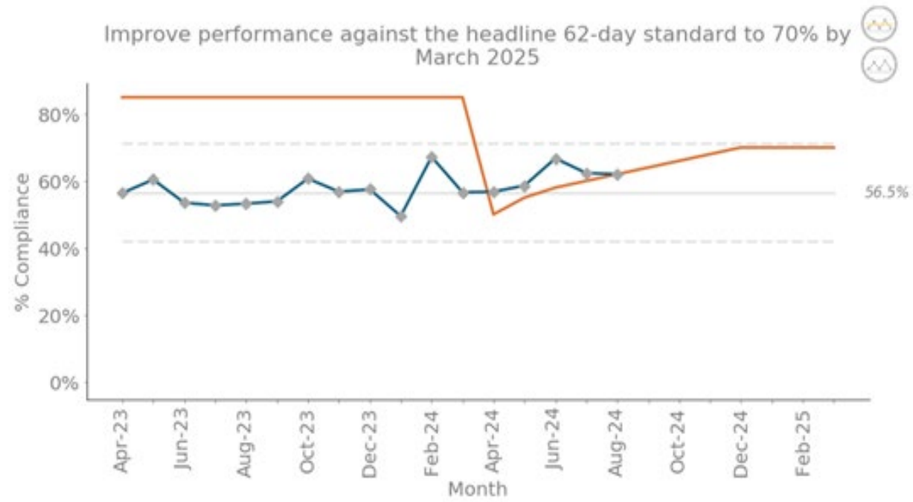

Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
100%
90%
80%
70%
60%
50%
40%
% of Patients
48.6%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

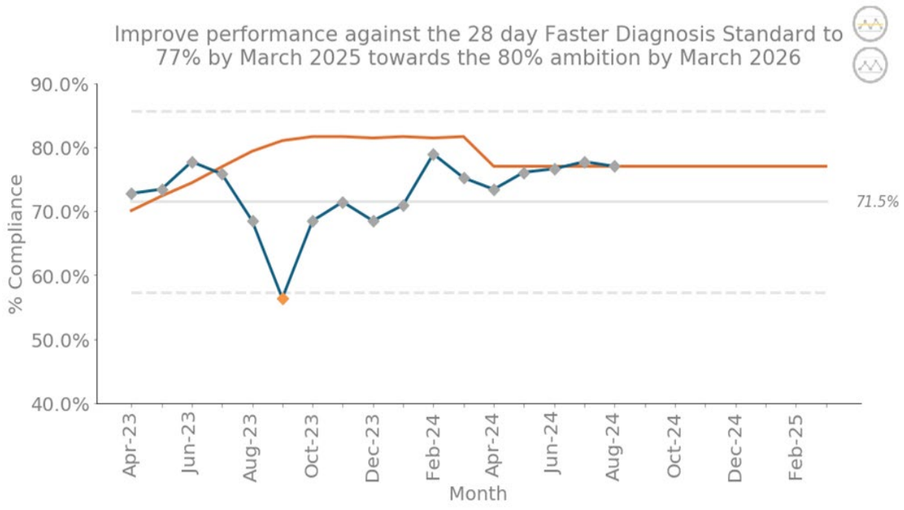

52 week waits
5000
4000
3000
2000
1000
0
Number of Patients
2864.0
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month


Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
2000
1500
1000
500
0
Number of Patients
556.8
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month


Eliminate >78 week waits
250
200
150
100
50
0
Number of Patients
47.6
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

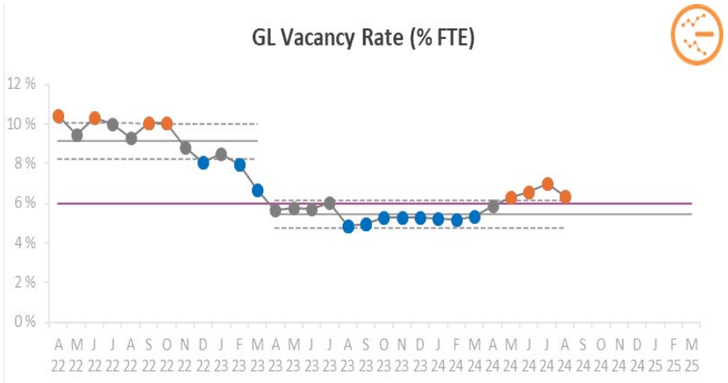

85% theatre utilisation - aggregate - Capped
87.5%
85.0%
82.5%
80.0%
77.5%
75.0%
72.5%
70.0%
% Compliance
78.0%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

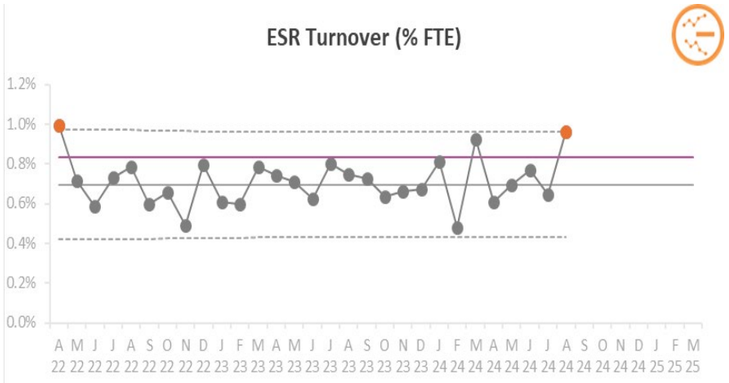

Improve performance against the headline 62-day standard to 70% by March 2025
80%
60%
40%
20%
0%
% Compliance
56.5%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

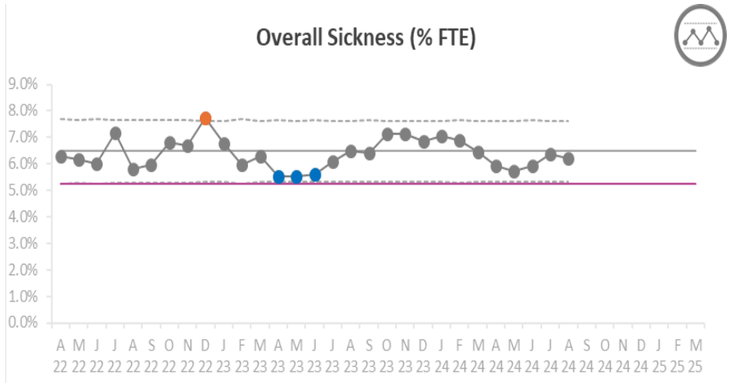

Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
% Compliance
71.5%
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Month

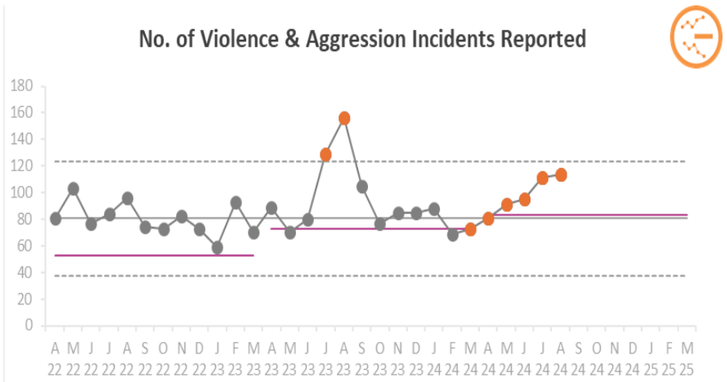
Single Improvement Plan - Workforce

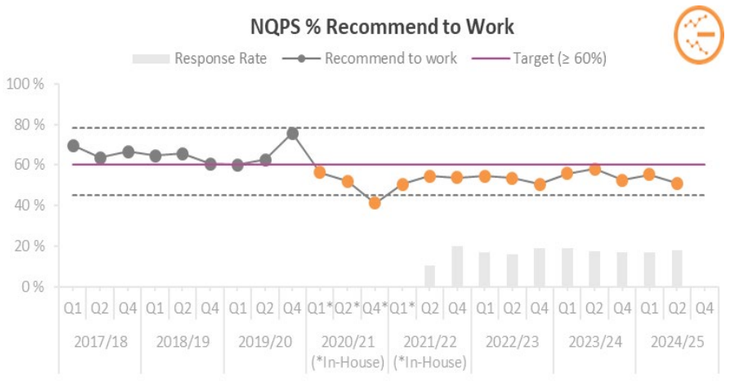
	Metric Description	FY2425 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2425	Latest Month Target		
People and Culture	Vacancies (% FTE) (source: General Ledger)				≤ 6%		6.33%	Aug-24
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.96%	Aug-24
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.24%		6.19%	Aug-24
	Number of violence and agression incidents toward staff (annual assessment; in-month reported)				996		114	Aug-24
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				≥ 90%		93.80%	Aug-24
	Appraisal compliance (% HC)				≥ 90%		87.93%	Aug-24
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		50.99%	Q2





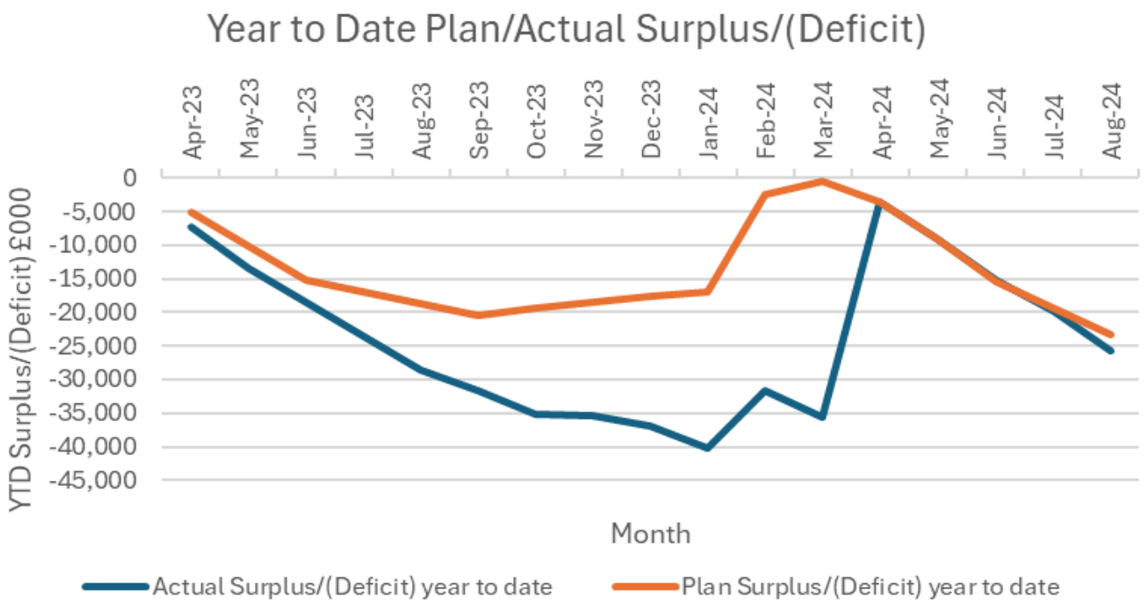


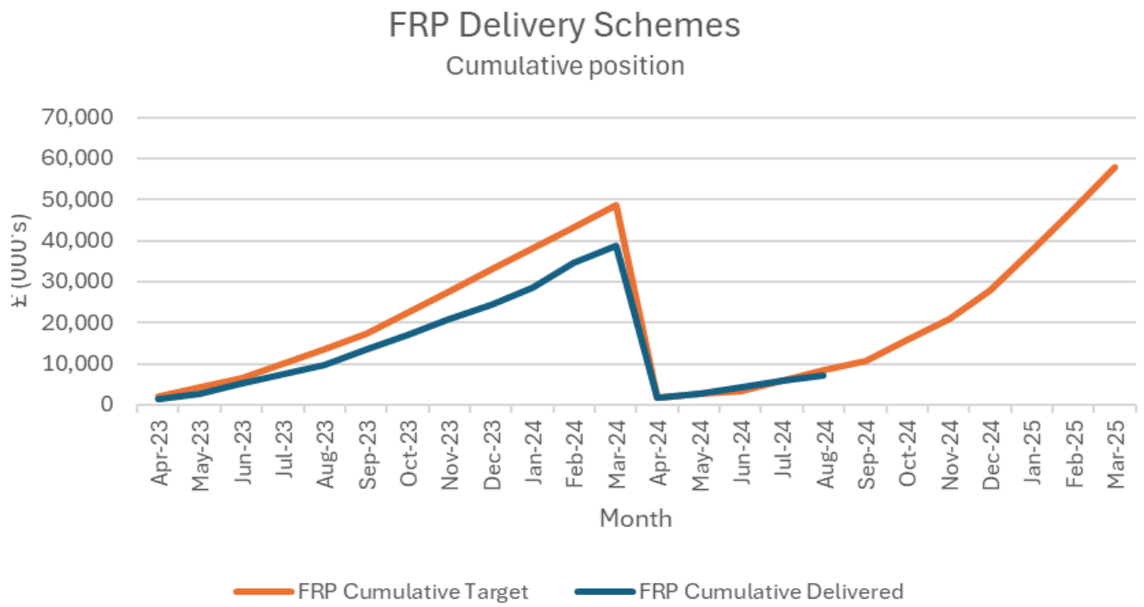




Single Improvement Plan - Finance

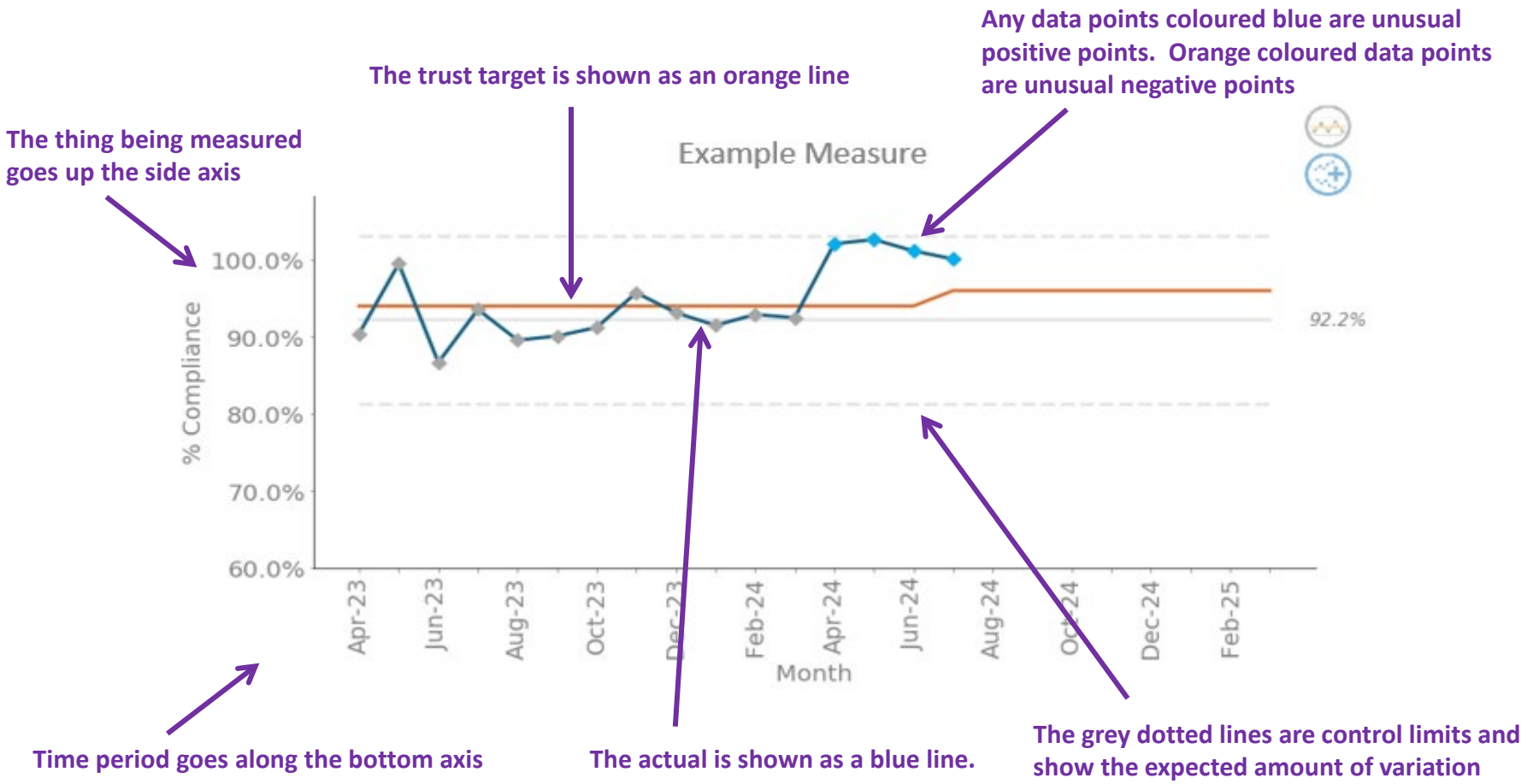
Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target (£ 000's)			Latest Month Actual (£ 000's)	Latest Month
				Concern	Mar-25	Latest Month Target		
Finance	I&E Normalised run rate					-23374	-25838	Aug-24
	FRP schemes delivery (Refer to the FRP pack for further detail)				58040	8278	7116	Aug-24





How to Read SPC Charts

Statistical process control (SPC) charts are a tool used to understand change over time and variation of a process or system. They are used commonly within healthcare to understand if improvement actions are impacting the data and to give assurance around set targets.



Lancashire Teaching Hospitals
NHS Foundation Trust

Key to Metric Variance and Assurance Icons

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
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

Key to Metric SPC Chart and Variance and Assurance Icons

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*

Report heading explanation

The Assurance Icon indicates whether the metric is failing or passing the target, or is inconsitently passing and

A flag is generated for metrics that are calculated as requring

The latest month target or threshold.

Data to the end of.

Metric Description	Assurance @ Mar-25	Variation to Latest Actual	Target: Concern	Target: Mar-25	Target: Latest Month Target	Latest Month Actual	Latest Month
Example Measure				100.00%	98.00%	95.00%	Jul-24

The name of the Metric

This shows whether there is a special or common cause variation of the metrics.

This March 2025 target

The current month actual performance.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Single Improvement Plan			
Report to:	Board	**Date:**	3rd October 2024
Report of:	Chief Executive	**Prepared by:**	A Brotherton
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this paper is to provide an update to the Board on the delivery of the Trust's Single Improvement Plan.

The main focus in month has been developing additional recovery interventions in response to the ICB Investigate and Intervene financial recovery programme. Our response was developed in collaboration with the senior leadership team. This has resulted in several additional financial 'grip and control' measures being designed and implemented in month, including daily executive led approval meetings for variable pay spend and non-pay spend with additional weekly reporting to the ICB.

As previously discussed and agreed with the Board, a new integrated performance report has been developed which reports progress on the key SIP metrics that it was agreed will have board oversight. Key actions required to recover performance where performance is off trajectory are outlined in the Integrated Performance Report.

Work has progressed to develop the more detailed measures that will be reported to the sub-board committees and the Safety and Quality Committee was the first committee to receive their SIP measures at the September meeting and the remaining committees will receive the SIP measures at the meetings held this month (October).

Work has also commenced to improve the reporting of the progress of the SIP programmes/projects following feedback from the Board that more detail was required to report the progress of the projects in terms of completed actions, key milestones and managing risks than the RAG rating table previously reported. Engagement with board members is underway to seek views on reporting options which will ideally be automated using Power BI and a project management tool such as Microsoft Project, given the capacity challenges of the small PMO team.

A review of what has worked well and what could be improved from the first six months of delivery of the Single Improvement Plan is underway to inform the delivery of the programme in the second half of the year.

It is recommended that the Board:

I. Review and discuss the progress made on the development and delivery of the Single Improvement Plan

II. Note the work underway to develop improved reporting for the second half of the year.

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 work outlined in this paper has been considered at the Single Improvement Plan Portfolio Board in August and September 2024.

1. **Context**

The Trust has committed to the prioritisation of the delivery of the Single Improvement Plan with the aim of year one being to stabilise the organisation. The purpose of this paper is to provide an update on the work undertaken in month to deliver the Single Improvement Plan, the work to develop a new integrated performance report containing the Board level SIP metrics and actions to recover performance where this is not on trajectory and to identify any areas of concern to the Board.

2. **Discussion**

The financial recovery programme is a key element of the Single Improvement Plan. The Financial recovery programme summary position is outlined below:

- As part of the Single Improvement Plan the Trust committed to having a credible £58.0m saving plan for 24/25 to sure up its mid-term financial plan by 25/26.
- The Trust has presented its 24/25 FRP at the System Improvement Board on 30th July 2024 and the FRP and its phasing has been approved and signed off by NHSE and ICB. Accordingly, going forward, the Trust will continue to measure its performance against this plan.
- 62% of the programme is now either in delivery or is fully signed off and therefore should be available for delivery. However, limited work has been done on progression of hopper or high-risk schemes and given the non-delivery in Month 5, the overall value of FRP has reduced to £57.6m. We are working with the Divisions and the High Impact Programmes SROs on how to recover this shortfall and progress the already identified schemes to delivery stage.
- The Trust has implemented a wide-range of immediate cost reduction actions (as per the ICB Investigate and Intervene programme) and it monitors its pay and non-pay spend and commitments on daily basis. These actions should have an immediate impact on run rate and should help to make up the Month 5 FRP shortfall as well as contribute towards the delivery of the Month 6 cost reductions.
- As anticipated, mainly due to the non-delivery of the UEC cost reductions, the Trust has not delivered its Month 5 FRP plan. The actual in-month delivery was £1.3m against a plan of £3m, leaving a shortfall of £1.7m.
- This represents a significant risk as the Trust needs to deliver £5.1m of cost reductions in Month 6 to meet its FRP Month 6 target.
- There are several programmes and opportunities which the teams are focused on to bring forward delivery (e.g. immediate implementation of procurement opportunities planned for Q3) which should help us to mitigate some of the losses suffered to date and improve the Trust run rate.
- The team is also looking at the largest areas of overspend which again, if mitigated will improve the run rate and mitigate losses.
- More detailed analysis of each workstream and actions and mitigations will be provided in Month 6.

Update since last Report

Work has progressed/ is progressing in the following key areas:

1. **In-month delivery –** there has been a further focus on the delivery of Month 5 and ensuring delivery on M6 to M9.
2. **SOP for the programme finalised –**the SOP for the programme is now complete
3. **Sign-off of the schemes –** The PMO and Turnaround Director have continued working with all divisions and high impact workstreams to progress each scheme to sign off through the governance gateways.

4. **Limited Liability Partnerships (LLPs) –** the work is progressing and the Trust now has a started implementing the individual strategies with have been agreed in previous weeks. The team is now developing SOPs, processes and procedures to ensure that the Trust has a grip and control over its insourcing going forward.
5. **Business case -** Revised SOP for business cases will be presented to Trust Management Board in October and subject to timelines to the FRP either in October or November and we will provide an update on the business case reviews in October (Turnaround Director).
6. **Procurement –** the newly appointed interim CFO agreed to allow the Turnaround Director to implement procurement opportunities as identified by PA Consulting. As a result, a process of agreeing a plan of action for 24/25 with LPC is in development; the programme will include significant changes to governance, processes and procedures as well as several large recurrent opportunities such as moving significant number of products from procurement to catalogue; product and supplier rationalisation. A detailed update will be provided in the next report
7. **Focus on UEC –** the Chief Operating Officer has held several meetings with the Division of Medicine to agree mitigating actions to reduce the under-delivery of the UEC programmes. As a result, and subject to EQIA, the Division of Medicine agreed to take several immediate recovery actions. The financial benefits should be delivered within 4 to 8 weeks.
8. **Immediate vacancy firebreak and other I&I related cost reducing actions (further details below) –** following the implementation of the NHSE I&I programme, the Trust agreed to immediately implement numerous cost reducing actions such as vacancy firebreak, daily workforce and non-pay review meetings. The impact will be measurable in several weeks, however, it is anticipated that it will help to further reduce costs and support the delivery of the FRP.

Work progressed in month

The following work has been undertaken since the August Board meeting:

- ***Prioritisation of the workstreams in the FRP –*** SROs have continued to progress their actions; prioritising those related to the FRP with enhanced oversight of the programmes that are behind delivery and additional support being provided for the medicine division.
- ***Recovery plan development in response to the system financial intervention*** - the team has focused in month on the development of a recovery plan for the financial recovery programme as a result of non-delivery of key areas of the programme. This includes the establishment of an Executive led daily approvals non-pay group, a vacancy firebreak (except for clinically critical and business critical posts), and a further ten recommendations being explored to recover the financial position, including improved oversight of the overspending cost centres, establishing a daily pay approvals group (over cap agency, extra duty payments, waiting list initiatives, overtime). A programme of work to reduce medical premium rate spend is also in development.
- ***Continued programme delivery*** – for impact and key actions in each domain see integrated performance report.
- ***Strengthening of key plans*** – following the discussion at Board in August plans have been updated to strengthen the key actions and milestones aligned to the trajectories for improvement, including the UEC plan, with key benefits identified (quadruple aim).
- ***Completion of the Place UEC improvement plan*** – This plan has been developed in collaboration with system partners and presented to the UEC board. The plan fully aligns to the SIP and includes a focus on admission avoidance and mental health (Appendix 1).
- ***Development of the PMO Business Case and increasing the PMO capacity***– the capacity in the PMO team is limiting the ability to progress and track the programmes at the pace and scale required. The Turnaround Director has finalised the Business Case for the new PMO which is now

under consideration by the Executive team. Given the scale of work for the Investigation and Intervene programme two further colleagues have been identified to move to the PMO in the short term to support programme delivery and tracking of progress.

- ***New integrated performance report*** - As previously discussed and agreed with the Board, a new integrated performance report has been developed which reports progress on the key SIP metrics that it was agreed will have board oversight. Key actions required to recover performance where performance is off trajectory are outlined in the Integrated Performance Report.
- ***Metrics reported to sub-board committees*** - Work has progressed to develop the more detailed measures that will be reported to the sub-board committees and the Safety and Quality Committee was the first committee to receive their SIP measures at the September meeting and the remaining committees will receive the SIP measures at the meetings held this month (October).
- ***Improved reporting of the SIP plan-*** work has also commenced to improve the reporting of the progress of the SIP programmes/projects following feedback from the Board that more detail was required to report the progress of the projects in terms of completed actions, key milestones and managing risks than the RAG rating table previously reported. Engagement with board members is underway to seek views on reporting options which will ideally be automated using Power BI and a project management tool such as Microsoft Project, given the capacity challenges of the small PMO team.
- ***A review of the first six months of the SIP*** - key learning from the first six months of the year (what has worked well and what has worked less well) is being collated and themed which will inform the development of improved reporting for the second half of the year.

Planned work for next month

- ***Standardising project management and monitoring –*** work will continue to develop robust tracking and reporting of each programme of work
- ***Adoption of a high-level Single Improvement Plan programme overview tracker (developed in month)*** – this adopts the same format as the Undertakings plan to ensure consistency of our plans
- ***Refinement of the new IPR for board*** following feedback

Priorities for the second half of the year

These have been discussed by the Executive team and it has been agreed that the current programmes of work are the ones that need to continue into the second of the year to maximise delivery as we deliver the ‘stabilise’ phase of the SIP. Priorities for year two are in development as part of our planning process for 2025/26.

Issues and concerns to raise to the Board members

- BI capacity remains a concern given the volume of work required to redesign the integrated performance report
- Lack of an adequately resourced PMO is impacting on the level of support that can be provided to the divisional teams to progress the CIPs and to the delivery and tracking of the Single Improvement Plan. This has been further compounded in month with one member of the team leaving and other priority workstreams limiting capacity.

3. Financial implications

Achieving financial sustainability is a key element of the plan and the capacity to deliver this scale of financial recovery is limited. A Business Case has been developed to secure continued support from PA consulting to support delivery.

4. Legal implications

None

5. Risks

Risks derived from individual projects and plans are recorded within each programme and reported to the regularly to the weekly financial recovery programme meetings, chaired by the interim Chief Finance Officer.

6. Impact on stakeholders

The Executive team is working in partnership with stakeholders to ensure whole system working to deliver these priorities. This has included an Executive-to-Executive team meeting with colleagues from Lancashire and South Cumbria Foundation Trust to agree shared priorities.

Recommendations

The Board is asked to:

i) Review and discuss the progress made on the development and delivery of the Single Improvement Plan
ii) Note the work underway to develop improved reporting for the second half of the year.

Meeting:	**Urgent and Emergency Care Delivery Board**		
Title of Report:	**Central Lancashire UEC Improvement Plan**		
Agenda Item: **6**	Date: **11th September 2024**	Purpose of Report: **For approval**	FOIA Exemption: N/A
Report of: **UEC Improvement Plan**		Author: Ailsa Brotherton and Kurt Bramfitt	

Our Vision	
Our ambition is to help the citizens of Lancashire to have longer healthier lives, whilst staying as independent as possible.	
The items in this paper contribute to the Lancashire Place Partnership Delivery and Ambitions:	
1. To have Connected Colleagues	☒
2. To have Seamless Services	☒
3. An Integrated Infrastructure	☒
4. A Healthier and Happier Lancashire	☒

Executive Summary/Context:

Partners have been working collaboratively to develop our UEC Place based plan for delivery during 2024/25 with a strong focus on ensuring we adopt a robust improvement approach where appropriate and that there is clarity of the work that requires transformation and the work that needs to be led by our operational teams.

Discussion:

- The plan developed is comprehensive, covering all elements of the UEC patient pathway with a strong focus on supporting individuals to stay well in the community, signposting individuals to the right local service (minimising attendance at the Emergency Departments), improving streaming within ED, reducing length of stay within the acute trust (by removing avoidable delays) and improving our discharge processes.
- The plan has a robust measurement strategy with both process and outcome measures which will enable the board to track progress.
- A new highlight report has been co-designed to ensure that the board is updated on progress and barriers.

Approval of the Central Lancashire Urgent and Emergency Care Place plan.

- Although the Board reviewed the UEC plan in August 2024, board members requested some changes, especially to the measurement plan. This further work has now been undertaken and the board is therefore asked to review and approve this plan for delivery
- To reflect learning from other systems, two further secondary drivers have been added to the admission avoidance primary driver;
  (i) ***Engineering Better Care Frailty training*** – Colleagues in East Lancashire have reduced their attendances of patients over 65 years in their ED through the implementation of a training package developed as part of the Engineering Better Care programme which was codesigned and delivered across the ICS. Mirroring this would significantly improve our UEC flow this Winter, reducing demand for ED. Work is just commencing on this programme in Central Lancashire but it is recommended that this work is reported to the UEC delivery board so its progress and impact can be tracked.
  (ii) ***Pilot to reduce the number of patients with Caudia Equina syndrome attending ED***. One current test of change at Blackpool Victoria Hospital is demonstrating significant positive impact. In brief GIRFT guidance categorises patients suspected of CES as those with symptoms <2 weeks and >2weeks. The test of change undertaken in Blackpool is a community CES pathway for patients with suspected CES systems for >2weeks. This pathway involves assessment by a competent clinician within MSK Tier 2, utilisation of the CES assessment tool developed by the Big Room, appropriate direct access to diagnostic support for imaging, utilisation of SDEC for patient awaiting urgent scan results, Orthopaedic on-call cover for any positive scan result management including referral onto patient pass to neurosurgery. This test of change to date has required no financial investment to deliver but has resulted in a number of positive impacts including but not exclusively:
    - Approximately 80 patients per month not requiring to visit BVH ED *this is currently being costed by the finance team at BVH along with a review of impact upon reducing mortality given the reduced ED attendance
    - Streamlined process for patients with suspected CES symptoms lasting >2weeks with more timely diagnosis and management planning

    The proposal is that we test this in Central Lancashire; initial work has begun engaging with key stakeholders within and outside of the CES Big Room including Ascenti and our Diagnostics Team. It is proposed that progress is reported to the UEC Delivery Board.

Potential further addition to the UEC Place based plan

Initial improvement testing was undertaken by our teams to test a streamlined discharge process for patients who require support on discharge. Initial small scale testing demonstrated that a two day length of stay reduction could be made per patient when testing was undertaken of the new process designed by our teams. This work has not, to date, been scaled and it is proposed that our teams are asked to develop a proposal for the Board to consider next month to assess if this should be added as an additional secondary driver to the plan.

Recommendations:
Recommendations to the UEC Delivery Board The Board is asked to note the further work undertaken, especially in the development of the measures and approve the UEC Place based delivery plan and the request for our teams to develop the proposal for improving the discharge processes to remove complexity and delay.

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Trust 2030 Strategy			
Report to:	Board of Directors	**Date:**	3 October 2024
Report of:	Director of Strategy and Planning	**Prepared by:**	G Doherty
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 the first draft of the Trust 2030 Strategy. The paper covers the following key areas:

1. A summary of the context including Board discussions/decisions and wider processes for discussion and engagement
2. A summary of the key sections/contents of the Strategy
3. Proposed next steps

It is recommended that the Board receives this first draft of the 2030 Strategy and provides feedback to inform the final draft, which will come to the December Board meeting.

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

Previous discussions/decisions are summarised in the first section of this paper.

1. Context

To date the Trust has combined its overall Strategy with a three year plan to create the Big Plan. Given the strategy component within the Big Plan has been relatively high level, the Trust has over twenty five individual strategies to support and give more strategic context for the Big Plan.

Significant work was undertaken with a range of key clinical staff during 2022 to develop and agree a Clinical Services Strategy. The Strategy 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, at which point the decision was made that an overall Trust Strategy should be developed, which would run until 2030 to coincide with the New Hospitals Programme.

At the April 2024 Board meeting a paper was received summarising the key strategic issues we faced as well as providing updates with regards to relevant work streams/activities in Lancashire & South Cumbria and a summary of those key areas needing to be addressed to develop our strategy. At the Board workshop on the 14th May we considered an initial version of the key components of our strategy. Discussions were held with the Council of Governors in June and a series of engagement events took place including:

- Patient/carer forums
- Partner forums including Health & Wellbeing Boards
- Senior leader meetings/sessions
- All staff Team briefings
- Director of Strategy VLOGs
- Four AM/PM Staff workshops
- Other engagement opportunities e.g. Preston Rotary Club

The staff workshops were well attended and well received:

- 254 staff attended
- 68% found the events highly engaging
- 97% agreed they had the opportunity to share views and contribute

The agenda for the staff events is shown below:

- Welcome & Introduction
- Setting the scene
- Where are we now – key health challenges facing our population, key challenges facing the Trust
- Our current strategy - groupwork, poll and feedback
- Proposed Strategic priorities - groupwork, poll and feedback
- Break
- Proposed Strategic priorities continued - Groupwork, poll and feedback
- What have we missed ? Groupwork, poll and feedback
- Summary & Close

Staff who were unable to attend the engagement sessions were offered the opportunity to contribute through an online survey.

The feedback on the events and online suggested strong support for the proposed strategic priorities.

The Board discussed the developing strategy at its development/workshop sessions in July and September.

2. Contents of the Draft Strategy

The key contents of the draft Strategy are shown below:

Vison:	Working together to improve the health and wealth of the population we serve.
Our purpose:	To provide the best specialist and local health and care services
Strategic Priorities:	5 strategic priorities which taken together allow us to be ready for our prime priority, the New Hospitals Programme
Strategic Framework:	5 areas to frame our annual Corporate Objectives
Values:	5 core values that define our culture and behaviour
Key Enabling Strategies:	5 key strategies that will underpin and drive our overall strategy

3. Next Steps

Following discussion today the Strategy will come back to the Board for final approval in December. This will allow us to undertake further engagement with the Trust and with key partners and stakeholders as well as allowing us to reflect our developing Estates Strategy refresh. In addition, we will be able to elect any feedback we have received from the national review of the New Hospitals Programme.

4. Financial implications

No direct implications.

5. Legal implications

No direct implications.

6. Risks

There are no direct risks arising from receiving the draft Strategy. Following discussion today the draft Strategy will feed into the work which has already commenced to review and revise our Board Assurance Framework.

7. Impact on stakeholders

No direct impact.

8. Recommendations

It is recommended that the Board receives this first draft of the 2030 Strategy and provides feedback to inform the final draft, which will come to the December Board meeting

Our Strategy
2025 – 2030

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Working together to improve the health and wealth of the population we serve

Our Strategy for 2025-2030

Published by Lancashire Teaching Hospitals NHS Foundation Trust, XXX 2025

Contents

Foreword - Welcome from our Chairman and Chief Executive

Welcome to our Lancashire Teaching Hospitals strategy, which we will be using to guide our priorities and decisions over the next five years, in preparation for our new hospital.

As we look ahead to the next five years, it is with great enthusiasm that we present the Lancashire Teaching Hospitals NHS Foundation Trust Strategy for 2025-2030. This document outlines our ambitious plans to enhance healthcare delivery, align with the NHS Long Term Plan, and continue our journey towards building a new hospital that meets the evolving needs of our communities that we serve both locally and across Lancashire and South Cumbria. The recent findings from the Darzi report demonstrate the scale of the challenge we face but our priorities align well with the recommendations arising from the Independent Review, including the development of integrated care models and a focus on population health, a drive to adopt new technology, and engaging with and empowering our colleagues and patients[1].

Our Changing Context

In alignment with the current NHS Long Term Plan[2], acknowledging a new plan is in development and due to be completed around Spring 2025, we are reimagining how we deliver services. This forms our strategic priorities:

New models of care and Population Health: Working closely with primary care, social care, and other partners to redesign services, integrate pathways to provide seamless, coordinated care closer to home for patients, with a focus on reducing health inequalities

Our role as an Anchor Institute: By working closely with local partners, we aim to strengthen our joint working and make a greater contribution to their key priorities whilst gaining commitment of our partners to our strategies and plans. Lancashire and South Cumbria will be wealthier and healthier, with more support to local suppliers, more opportunities for good local jobs, busier high streets and a cleaner, better environment

Pioneering Specialist Services: As the provider for Specialist services in Lancashire we will use the opportunity of our New Hospital to deliver comprehensive, pioneering services that will give better outcomes for patients, more opportunities for staff and will make these services more effective and sustainable

Advanced Diagnostics: We will work with partners across L&SC to agree and deliver our “Clinical Blueprint” and identify and invest in cutting edge diagnostic technology

Stronger links with Academic Partners: Our links with our academic partners will be reviewed and strengthened and we will expand our research and development and innovation to gain University Teaching Hospital status

[1] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england
[2] https://www.longtermplan.nhs.uk/

Our new strategic framework is centred around five Ps: Patients, People, Partnerships, Productivity and Performance. Theses pillars will guide us in delivering exceptional healthcare services and achieving our vision of working together to improve the health and wealth of the population we serve. We will enhance patient care by adopting innovative approaches and integrating advanced technologies, ensuring that our services are accessible, efficient, and patient-centred. Our strategy is underpinned by our core values which help to guide everything that we do.

Our New Hospital

One of the most exciting aspects of our strategy is the once in a lifetime opportunity to build our new hospital. This state-of-the-art facility will be designed to provide a modern, efficient, and patient-friendly environment. It will incorporate the latest advancements in medical technology and sustainable building practices, ensuring we are well-equipped to meet future healthcare demands to deliver specialist services across Lancashire and South Cumbria, while also providing essential local services to our immediate community.

Taking this forward

We will now work together across our teams, services and the system to embed this strategy, to improve the health and wellbeing of the population we serve - together we can achieve our exciting vision of the future.

Peter White

Chair

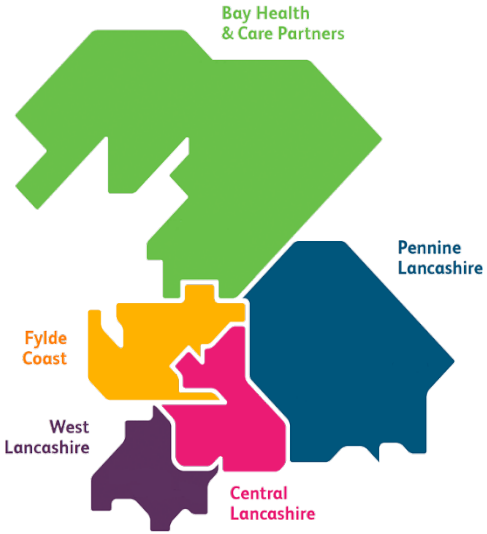
Professor Silas Nicholls

Chief Executive

About Lancashire Teaching Hospitals

Lancashire Teaching Hospitals NHS Foundation Trust is a leading healthcare provider in the Northwest of England, renowned for its commitment to delivering high-quality, patient-centered care. Our Trust was established on 1 April 2005, encompassing two major hospitals: Royal Preston Hospital and Chorley and South Ribble Hospital, serving a diverse population across Lancashire and South Cumbria.

Being one of the larger acute Trusts in the county, employing over 9000 staff, we provide general hospital services to 390,000 people in Preston, South Ribble and Chorley and specialist care to 1.8 million people across Lancashire and South Cumbria. Therefore, the Trust has a pivotal role to play in enhancing people's lives beyond the confines of the traditional hospital.



The specialist services we provide across Lancashire and South Cumbria include:

- Allergy & Clinical Immunology
- Cancer (including radiotherapy, drug therapies and cancer surgery)
- Disablement Services such as artificial limbs and wheelchairs
- Major Trauma
- Neurosciences including neurosurgery and neurology (brain surgery and nervous system)
- Plastics
- Renal (kidney disease)
- Specialist vascular surgery
- Maternal Medicine

Our Partnerships

Lancashire and South Cumbria Integrated Care Partnership

Lancashire and South Cumbria Provider Collaborative

One LSC Together

NHS Lancashire Procurement Cluster

We recognise that Our Strategy and vision cannot be achieved in isolation. We need to work together with our partner organisations for the best patient outcomes, delivering care that better meets the needs of our people. We are working closely with health, social care and the voluntary sector partners across the Lancashire and South Cumbria Integrated Care System (ICS) to develop joined up care and integrated care for our populations. We also work in partnership with Lancashire and South Cumbria Provider Collaborative, working with colleagues and clinical networks to improve the co-ordination and delivery of care. Our members, who currently total 18,889, include both the general public and staff contribution to Trust matters to ensure the interests of both are represented.

Lancashire Teaching Hospitals was the first Trust in the Lancashire and South Cumbria region to be awarded Teaching Hospital status. With a rich history of excellence in clinical care, education, and research we are dedicated to advancing healthcare through innovation and collaboration. Our

strategic vision focuses on enhancing patient outcomes, fostering a culture of continuous improvement, and ensuring the well-being of our staff. We are proud to be at the forefront of medical education and research, partnering with esteemed institutions to drive forward the boundaries of medical science and aim to enable as many of our patients as possible to take part in and benefit from cutting-edge clinical research.

As we look to the future, our strategy is underpinned by our core values: being caring and compassionate, recognising individuality, seeking to involve, building team spirit and taking personal responsibility. Through our strategic framework, we aim to build on our successes and address the challenges ahead, delivering value for money through productivity and efficiency gains, ensuring that we remain a trusted and respected healthcare provider for generations to come. We are committed to creating a sustainable healthcare system that meets the evolving needs of our community, while maintaining the highest standards of safety and quality.


Being Caring & Compassionate


Recognising Individuality


Seeking To Involve


Building Team Spirit


Taking Personal Responsibility

Why we need a new Strategy

As demonstrated in the 2024 Independent Investigation of the National Health Service in England, the NHS is in critical condition, but its vital signs are strong. Across all our services and our wider health and care system we need to respond to the challenges and opportunities we face. We need a strategy to take us up to 2030 so we are ready for our new hospital.

We serve a **growing and ageing population**, with local housing growth, alongside increasing numbers of people aged 80 and over, requiring us to better co-ordinate joined up care

The **COVID-19 pandemic** has significantly changed the way we work and we need to continue to work together with our staff, patients and partners to deliver care safely

There are **significant differences in healthy life expectancy** and quality of life across Preston, Chorley and South Ribble, with the data suggesting the gap is widening

Attracting, training, supporting and retaining the right workforce is one of our biggest challenges and a key challenge across the NHS

Digital technology, innovation and Artificial Intelligence (AI) are creating opportunities to radically transform how we deliver our services and make them more effective and efficient

We have growing opportunities to collaborate beyond LTH and across our local health system and networks to join up care, share learning and improve outcomes for patients

Our strategy will help us develop the detailed plans we will need to reach our destination – laying out what needs to be done by when, to meet the ambitions of the NHS Long Term Plan, NHS People Plan and the Lancashire and South Cumbria ICS plan across all of our teams and services and by working with our partners.

Our Operating Environment

As we have developed our new five-year strategy, we are clear about our leadership role both in the local health and care system but also as one of the major anchor institutions in the wider NHS and community. Our challenge is not only to maintain and develop our own organisation, to improve the health and wellbeing of people in Preston, Chorley and South Ribble, but also that of the wider population, continuing to deliver specialist services across the Lancashire and South Cumbria system.

Our strategy needs to show how we will work with partners to help the population we serve be healthy and happy and will help us to develop the detailed plans we will need to reach our destination.

The changing landscape of how hospital services are now delivered since the COVID-19 pandemic, moving to more of a collaborative way of working has provided us with a spring board forward towards achieving what was set out in the NHS long term plan. We want to continue with this transformation of delivery of care, maintaining the momentum by accelerating our use of technology and nurturing the extraordinary talent of our people which has shone through the last couple of years.

Our strategy sets out how we will build on our strong foundations of excellent care, effective joint working and strategic partnerships across Lancashire and South Cumbria, through our effective joint working with the Provider Collaborative Board (PCB), using our values and key enabling strategies to underpin this.

However, we are conscious that the NHS and the Trust faces unprecedented challenges including:

- A growing and ageing population with a longer life expectancy than ever before but living with multiple health conditions and social care needs
- Significant financial challenges to achieve recurrent savings identified to balance our books, alongside increased levels of demand
- Restoration and Recovery of our elective waiting lists with particular focus on diagnostics and cancer performance
- Improvement of our urgent and emergency care waiting times
- Alignment with the NHS long term plan
- Significant support needs against the NHS Oversight Framework to improve our CQC rating, with particular focus on Finances, Performance and Quality
- Improving our Trust accountability framework to ensure we have appropriate oversight

The above challenges facing Lancashire Teaching Hospitals are from present across the NHS, as powerfully evidenced in the recent Lord Darzi review.[3] Our strategy positions us in the best place to tackle these challenges, working with our partners and within the Lancashire and South Cumbria system to agree, develop and improve the services we provide to the region.

[3] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

Our world in data 2023–2024

We saw

48,970 day cases

12,971 elective procedures

570,680 outpatient appointments

192,612 A&E and urgent care attendances

Our performance

71% performance against the faster diagnosis standard for patients referred for a suspected cancer are diagnosed or ruled out within 28 days (target is **75%**)

46% performance against 6-week diagnostic standard (target is **95%**)

70% performance against A&E 4 hour wait standard (target is no less than **76%**)

312 the number of patients waiting over 65 weeks for elective care (target eliminate waits over **65** weeks)

We have

855 beds

47 wards

7 MRI scanners

5 CT scanners

7 linear accelerators

33 operating theatres

Each day

162 patients admitted to hospital

487 referrals received

82 urgent referrals

1559 outpatient appointments

Our people

The Trust has **18,889** members

LTH has **9,893** members of staff

There are **299** volunteers working across the Trust

Our community

LTH is **1 of 5** Trusts in Lancashire and South Cumbria Provider Collaborative Board

LTH provides local community and secondary care working alongside **80** GP practices

3 main sites serving a population of **390,000**

We have reduced carbon emissions by **32%**

We spend

£845,000,000 a year

£16,250,000 a week

£2,321,428 a day

£97,726 per hour

£1,628 a minute

£27 a second

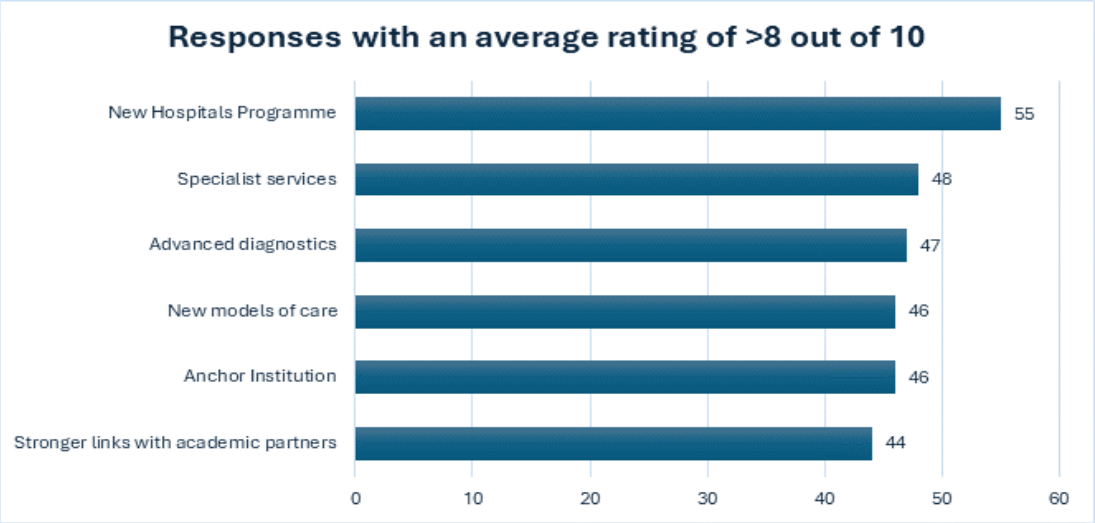
Developing our new Strategy

The Trust has taken an approach in designing our strategy by engaging patients, colleagues, and partners about what matters to them. This approach aims to ensure everyone has their voice heard and contribute to shaping a strategy that reflects how our patients, staff and partners view our future and contribution to the health and wellbeing of our local residents. During 2024, engagement events were held with a broad range of stakeholders as below:

- Colleagues from across the organisation - representing Trust sites, professions, divisions and teams
- LTH Board workshops
- Patients and carer forums
- Council of Governors
- Preston Health and Wellbeing Partnership, Chorley and South Ribble Partnership

The engagement discussions were a mixture of internal workshops, public meetings, stakeholder forums and smaller groups so that a broad range of ideas could be suggested, challenged, refined and agreed. We worked within the local, regional and national contexts, to ensure the strategy aligned with relevant developments and the NHS longer term plan. We asked our staff to score the priorities between one and ten to help shape and inform how the strategy should be developed. Staff who were unable to attend the engagement sessions were offered the opportunity to contribute through an online survey, selecting their top ten focus of what matters to them. Respondents were very positive about the proposed priorities and rated each of them as being of high importance.

Our engagement activities have helped us ensure that our refreshed vision, new strategic framework, and priorities provide the platform for the Trust to transform our services and deliver outstanding care to patients. We will continue to engage with staff, partners and patients to lead the implementation of strategy through the development of our annual corporate objectives and our three-year single improvement plan.



Our Strategy on a Page

Our vision

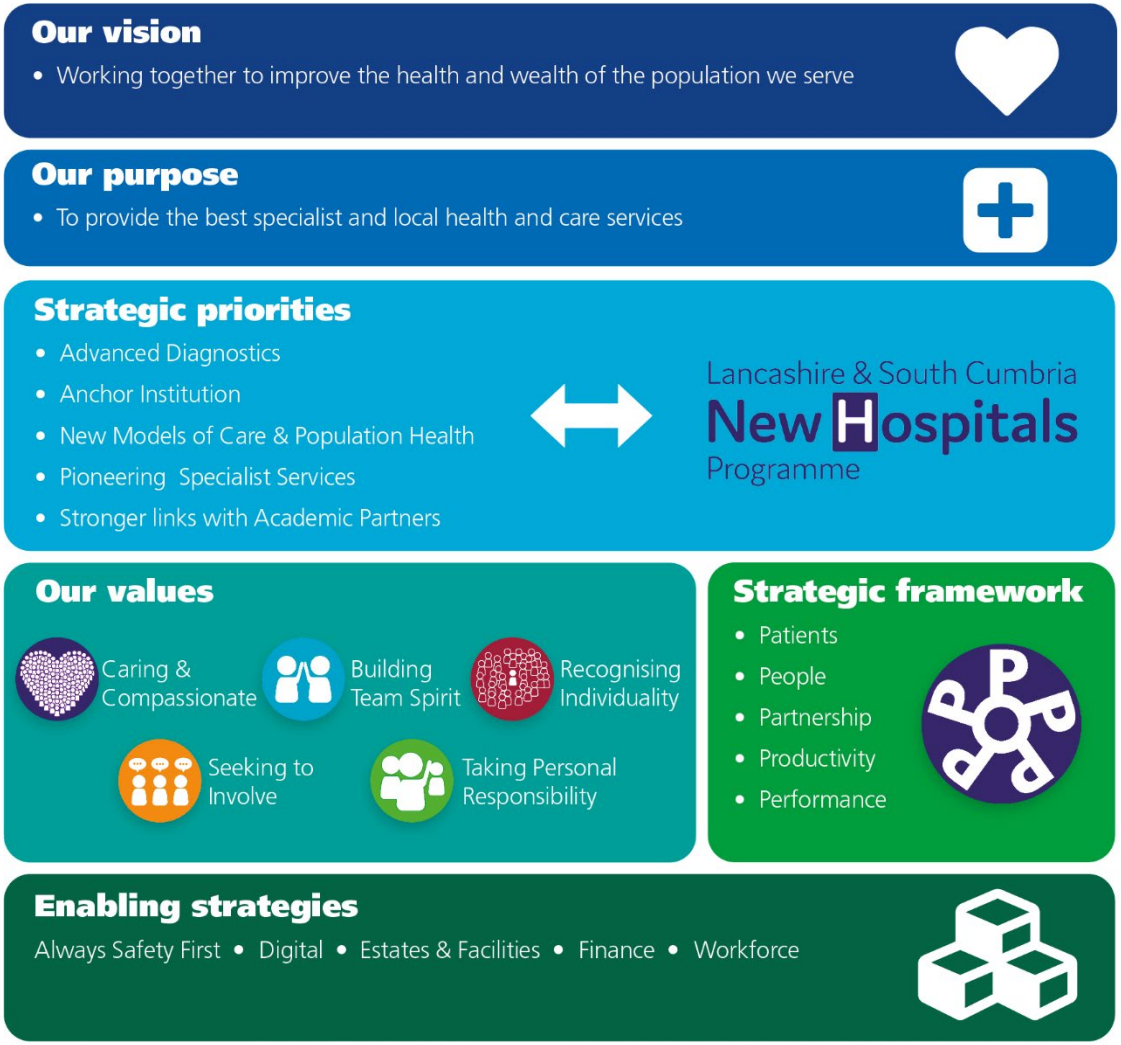
Working together to improve the health and wealth of the population we serve.

Our purpose

To provide the best specialist and local health and care services.

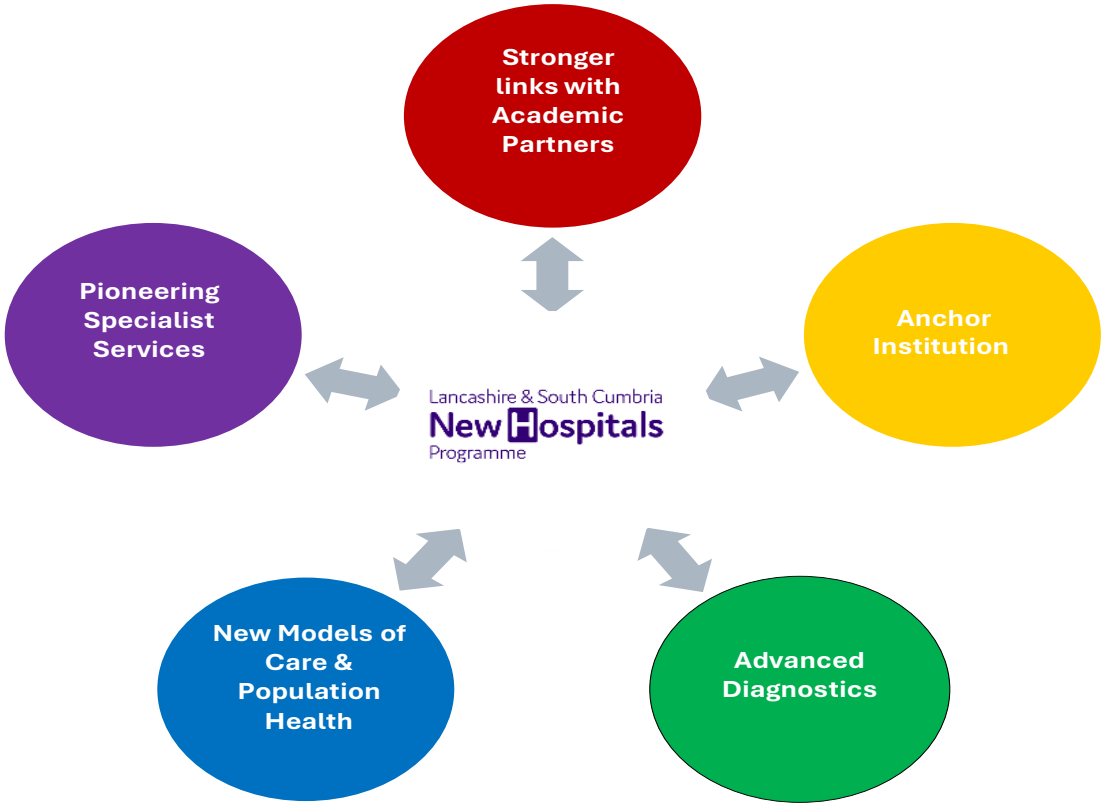
Our vision, purpose, priorities and strategic framework were developed by our Board of Directors following engagement events and feedback from stakeholders.

Our vision and purpose summarises our desire to achieve the highest standards in service delivery, improve health for the population we serve and provide the best possible care through pioneering services that will give better outcomes.



Our Values

Our values were created by our staff over ten years ago, and while we have reviewed and developed them they have remainedg the bedrock of our organisation and guide everything that we do as we
grow to achieve our vision.



Our Strategic Priorities

To support us in achieving our vision we are focusing on five strategic priorities, all feeding into our new hospitals programme. These reflect the ambition of the NHS long term plan, which sets out the journey of our national health services to ensure the NHS is fit for the future, with a strong focus on care being delivered closer to home through greater integration of primary, community and hospital service. These also align to the recent findings of the Darzi[1] report suggesting, innovative care delivery closer to home, embracing new technology, engaging staff and patients to take as much control of their care as possible.

New Hospital Programme

We have a once in a generation opportunity, with a state-of-the-art new build to replace Royal Preston Hospital on a new site, providing major trauma and specialist services to the population of Lancashire and South Cumbria and acute hospital services to central Lancashire. Our hospital will have 100% single patient rooms, will be net zero carbon and will be fully digitally-enabled. In addition, the development and construction of our new Hospital will bring benefits and opportunities across the whole economy. As shown above, our new Hospital is our prime strategic priority – ensuring we seize this opportunity, and that we and our partners undertake the necessary transformational change to be fit for the future is an essential driver for the development of this strategy.

New models of care/Population Health and Anchor institute

We need new models of care to allow us to achieve a “left shift” so we focus on earlier stage treatment in ambulatory and community settings and on maintaining the health, wealth and happiness of our population. We recognise we also need more joined up, proactive, integrated services across acute, community and primary care with new service models in urgent care, frailty, mental health and other areas.

Our role as an Anchor Institute, provides long-term sustainability linked to the wellbeing of the population we serve. 80% of health outcomes are determined by non-health related matters such as education, employment, income and housing – therefore it has to be a priority for us. By helping to be a good employer, creating opportunities for local communities to develop skills and access jobs, buying from local suppliers, reducing our environmental impact and supporting the local economy, we can improve the wellbeing of our communities.

What this means for you:

- We will collaborate with system partners to help plan /commission services to:
    - Focus our services and resources on reducing health inequalities.
    - Invest more in prevention & personalised proactive care
    - Ensure services work with people as equal partners in their care
    - Tackle gaps, duplication & barriers across health and social care
    - Locate services closer to patients, where they give the widest possible benefits
- L&SC will be wealthier and healthier, with more support to local suppliers, more opportunities for good local jobs, busier high streets and a cleaner, better environment
- Lancashire Teaching Hospital will be a better system partner

What this means for us:

- By working in partnership and relocating/redesigning services we will reduce the growth in emergency demand and the costs of meeting that demand, and improve our waiting times for those patients that need hospital car
- We will work to better integrate pathways and services, which may result in us providing a greater range of service
- We will have strengthened our joint working and will be making a greater contribution to our partners key priorities - our influence will grow, as will the commitment of our partners to our strategies and plans.
- We will maximize local training and trading opportunities
- We will move some of our services to be closer to patients and/or to help our high streets
- We will drive improvements in our environmental impact through our short term actions and through our New Hospital Programme

The difference we aim to make:

- More people being supported to live healthy lives in the community with fewer people needing to use healthcare services in an unplanned way
- A wealthier, cleaner, healthier Lancashire and South Cumbria

Pioneering Specialist Services, Advanced Diagnostics and Links with Academic partners

What this means for you:

- As the provider for Specialist services in Lancashire we will further develop and transform, whilst preparing for our New Hospital to deliver comprehensive, pioneering services that will give better outcomes for patients, more opportunities for staff and will make these services more effective and sustainable
- Our patients will have access to the latest technologies and treatments. Using advanced diagnostics we will be able to detect illnesses and diseases much earlier, meaning patients can have the quickest treatments and those treatments should be less invasive and have less impact on peoples everyday lives – ideally we will be able to avoid or at least delay the onset of serious illness and lengthen the time people live a healthy and happy life

What this means for us:

- In strategy terms a “Big Bet” is the attempt to try to identify future “game changers”– they are hard to predict other than after the event when they are obvious. Healthcare systems are increasingly adopting medical technologies that allow diseases to be detected earlier, risk factors identified and addressed and treatments to be more targeted. Advanced diagnostics are being developed across the world - heart sensors in the handles of shopping trollies, smart watches that detect Parkinson's, genome sequencing, nanotechnology, the use of artificial intelligence – these all suggest to us that focusing on this area is key part of our future strategy
- We will work with partners across L&SC to agree and deliver our shared “Clinical Blueprint”, which will ensure that patients receive the right care in the right place, and that we have a high quality, financially sustainable health and care system
- National policy is to establish pathology networks to make better use of our highly skilled workforce and equipment to deliver improved, earlier diagnosis supporting better patient outcomes
- Our links with our academic partners will be reviewed and strengthened and we will develop our research and development and innovation to gain University Teaching Hospital status

The difference we aim to make:

- By providing a wide range of high quality, high tech, integrated, efficient, services LTH will better meet the health needs of our population and benefit our local economy

Our Strategic Framework

Our new strategic framework is founded on our vision and values and organised around five strategic objectives – our 5 'P's, these will be the focus of the next five years in order to achieve our strategy.

The five Ps – Patients, People, Partnerships, Productivity and Performance summarise the areas on which we want to focus our development and improvement. These five Ps will form the basis of our annual corporate objectives which will be reviewed annually to help us measure our progress and success in the delivery of our priorities and to guide decision making.

These objectives are supported by key themes, which set out how we will achieve these shifts through our key enabling strategies: digital technology, safety first, estates and facilities, continuous improvement, finance, and workforce. It also provides a framework for individual services to consider their priorities and plans in order to help achieve our Trust objectives and strategy.

Patients at the core of everything we do.
Treating patients with respect and dignity to deliver personalised care and a patient experience of the highest quality.

Performance which meets expectations.
Delivering on key workstreams to achieve standards.

People in the right number, in the right place, with the right skills.
Creating an inclusive environment where people can reach their potential.

Productivity which makes the most of what we have.
Delivering on key workstreams to maximise resources.

Partnerships which deliver high-quality healthcare.
Transforming services and making a positive contribution to our local communities.

Patients at the core of everything we do

Treating patients with respect and dignity to deliver personalised care and a patient experience of the highest quality




As a major employer and provider of healthcare, our strategic priorities include working with patients, families and carers to better manage their health and wellbeing. We want to reduce health inequalities within Lancashire and the North West through prevention strategies, earlier diagnosis and be delivering outstanding care and treatment. Delivering services closer to home with seamless integrated services with our primary, social care, mental health and voluntary sector partners.

We will do this by:

Improving outcomes and preventing harm

- Implement Patient Safety Incident Response Framework
- Use of antimicrobials in line with national guidelines
- Complete the ten Clinical Negligence Scheme for Trusts safety actions
- Complete work to reduce C. difficile rates

Patient Experience

- Care for patients in appropriate areas
- Review complaint response timeframes
- Improve the way we listen to and communicate with patients and their families and friends
- Review and update digital systems to improve ease of access to patient history
- Increase mental health assessments in Urgent and Emergency Care
- Provide safe spaces for patients

How we know we have been successful

- Improve average time to see a clinician in the Emergency Department
- Reduction in C Diff rates
- Reduction in the number of boarded patients
- Deliver agreed patient complaints response timescales
- Implement Martha’s rule
- Improve our National Oversight Framework rating and CQC rating

People in the right number, in the right place, with the right skills

Creating an inclusive environment where people can reach their potential

Our staff and volunteers are integral to the success of our organisation and are advocates of and ambassadors for our services. Workforce has been highlighted as the biggest challenge facing departments and divisions, with staff working in increasingly complex and challenging environments with many clinical and support areas facing shortages. We therefore need to secure and develop high calibre staff to deliver services now and in the future.

We will do this by:

Deliver a workforce model that meets the needs of the community

- Increased availability of staff in pressured services
- Introduce new workforce models

Training and education

- Safeguard time to ensure training, supervision and appraisal professional standards are maintained

Staff Wellbeing

- Increase the availability of suitable rest facilities for staff
- Ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care

Equality, diversity and inclusion

- Implement the sexual safety at work charter
- Health inequalities

How we know we have been successful

- Reduction in the number of vacancies
- Reduction in agency spend
- Compliance with professional standards
- Improved staff advocacy scores & Improved staff survey results

Partnerships which deliver high-quality healthcare

Transforming services and making a positive contribution to our local communities

We will develop and strengthen effective strategic partnerships across health and social care as well as academia and industry. To be truly successful we need to be part of a successful surrounding ecosystem which will translate into integrated and multi-agency pathways of care for our patients.

We will do this by:

Estates and facilities

- Complete purchase of land and commence the delivery of new hospital programme
- Lead the clinical model of care for the new hospital programme
- We will work with partners across L&SC to agree and deliver our shared “Clinical Blueprint”

Collaboration

- Develop partnerships across Lancashire and South Cumbria
- Develop and strengthen our Pathology network
- Implement our One Lancashire and South Cumbria collaborative for those corporate services which are included
- As an anchor institute, work with partners to improve population health, supporting development of a thriving local economy and reduce health inequalities

Social Value

- Refresh our Social Value Strategy and work with partners to deliver

Research, development and innovation

- Deliver the requirements for University Hospital status to enable further research and development opportunities

How we know we have been successful

- New hospital operational
- Sustainable, high quality health and care services are in place across Lancashire and South Cumbria Clinical
- Achieve University Hospital status

Productivity which makes the most of what we have

Delivering on key workstreams to maximise resources

We want to adopt healthcare technologies and digital tools to help streamline our processes, allowing us to focus more on patient care. Encouraging a culture of open communication and collaboration among departments can lead to more efficient workflows and problem solving.

We will do this by:

Providing value for money services by spending less, spending well and spending wisely

- To evidence improved value for money and delivery of the financial recovery programme

Continuous improvement

- Deliver our Single Improvement Plan
- Deliver our continuous improvement strategy in line with NHS IMPACT, the NHS framework for improvement

Performance

- Achieve the 85% capped theatre utilisation
- Achieve average cases per list as recommended by GIRFT
- Reduce new to follow up rates across all clinical units
- Reduce length of stay across all wards and clinical areas
- Reduce cost per patient/case

How we know we have been successful

- Achieve financial recovery targets
- Deliver a cash balance to fund ongoing revenue commitments and planned capital investments
- Deliver agreed capital programme
- Improve our National Oversight Framework rating and CQC rating

Performance which meets expectations

Delivering on key workstreams to achieve standards

We want to grow and develop to consistently provide healthcare of the highest standard in terms of quality and safety while improving operational, clinical and financial sustainability.

We will do this by:

Delivery of the Cancer recovery plan

- Achieve the 70% 62-day standard by March 2025
- Achieve the 77% 28-day Faster Diagnosis Standard (FDS) by March 2025

Diagnostics

- Improving performance of the diagnostic DM01 target, achieving 95% within 6 weeks or less

Minimising risk to patients through delivery of the elective recovery plan

- Reduce waiting times for elective procedures
- Work in partnership with providers across L&SC to maximise our collective assets
- Achieve elective recovery targets

Urgent and emergency care

- Improve our Emergency Department (ED) national waiting times for 4 hours
- Reduce the number of patients waiting longer than 12 hours

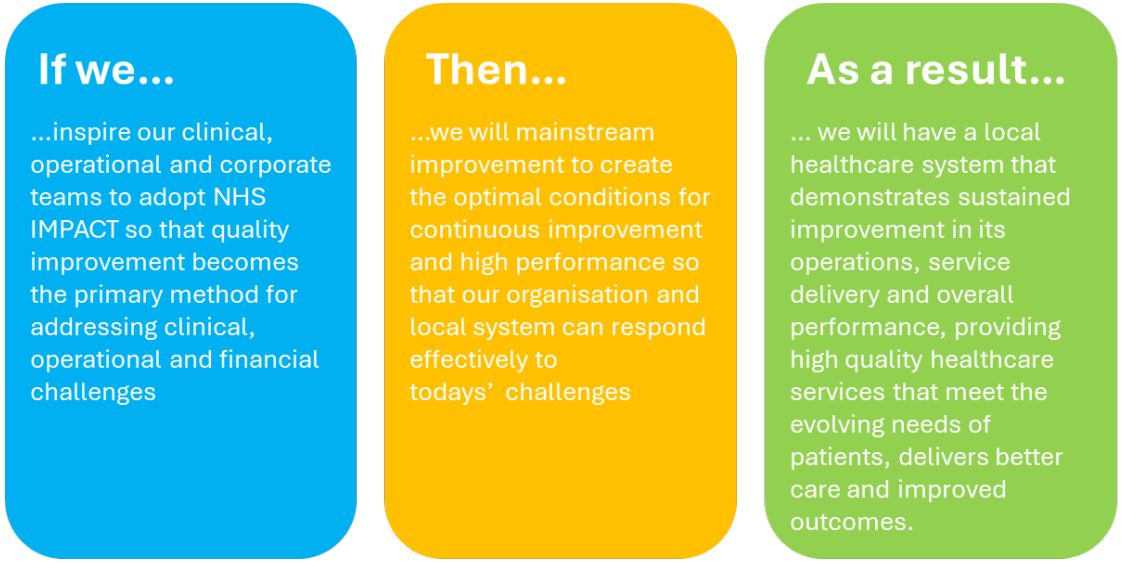
How we know we have been successful

- Improve the cancer and FDS performance against targets
- Achieve DM01 target
- Eliminate waits of over 52 and 65 weeks
- Deliver the system specific elective activity targets
- Improved ED waiting times

Mainstreaming Improvement using the NHS IMPACT framework

The NHS in England, through the work of the National Improvement Board, has set an ambition for the NHS to become the fastest improving healthcare system globally over the next five years as it delivers the NHS IMPACT strategy.

Over five years ago our Board committed to investing in continuous improvement and we design and deliver improvement at macro (system), meso (pathway) and micro (local) levels. We have trained 87 colleagues to the level of internal quality expert as defined in the report 'Building capacity and capability for improvement: embedding quality improvement skills in NHS providers[4]. We have also trained over 1700 colleagues in introductory continuous improvement methods, with over 130 able to coach improvement in their own clinical areas through our Microsystem Coaching Academy programme. We are now making our e-learning module for improvement part of our core essential training which will mean that all of our workforce understand the importance of 'doing their job' and 'improving their job. Our approach to continuous improvement was recognised as good practice in our recent Care Quality Commission report, with some of our improvement programmes also being recognised as examples of outstanding practice and these have been shared across the NHS. Whilst we are building on strong foundations, there is still much to do and through this strategy we commit to making our contribution to achieving the NHS IMPACT goal of becoming the fastest improving healthcare system in the world. We understand that to achieve this we need to 'think global' and 'act local', taking the best learning from healthcare providers nationally and globally but remaining grounded in delivering improvements locally. For this to be successful, we must mainstream improvement, adopting an improvement approach to our greatest challenges, truly embedding improvement across every level of our organisation and system.



To achieve this, we will adopt the NHS IMPACT framework and theory of change, aligning our improvement team to the organisational priorities through our Single Improvement Plan and developing a learning system.

[4] https://www.england.nhs.uk/nhsimpact/assessment-and-improvement/how-to-build-capacity-and-capability-for-improvement/

How we will mainstream improvement

Our Single Improvement Plan is a three year plan which brings together our priorities in five domains: **Well-led; People and Culture; Safety, Quality and Clinical Effectiveness; Financial Sustainability and Operational Performance.**

We will adopt the five guiding principles for implementing the NHS improvement approach, outlined by the Health Foundation[5], and will:

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1. ***Set the right pace for sustained improvement*** – our Single Improvement Plan will be the organisation's established roadmap to guide our pace of improvement, aligning all colleagues behind our shared purpose and vision

2. ***Set expectations in ways that build commitment –*** our Board has committed to adopt and embed the NHS Impact approach to improvement to achieve organisation-wide improvement. As leaders at Lancashire Teaching Hospitals, we will push improvement to the front of our strategic agendas.

3. ***Enable learning across systems -*** our commitment to learning underpins successful efforts to drive organisation and system-wide improvement. We will create opportunities to develop, share and analyse learning, and prioritise learning and reflection, as we understand that these are hallmarks of high-performing organisations and systems. This requires an outward-facing mindset at individual, team, organisation and system level that includes a desire to pull in ideas and insights from elsewhere, and a willingness to share experiences in an honest and thoughtful way.

4. ***Build capability at provider and ICS level to navigate and reconcile competing priorities –*** we understand that a characteristic of effective leadership is the ability to navigate between competing strategic and operational priorities and goals. We have adopted a systems engineering approach to our system level improvement and will continue to work in partnership to further build improvement capability and capacity across our organisation and system

5. ***Align our policies and strategies around the NHS Impact approach to improvement –*** we understand that The NHS Impact approach to improvement has the potential to make a real and lasting difference to the way every part of our health care system operates and, most importantly, to how care is co-designed and delivered. To achieve this impact at scale we will see this as the defining way of doing things as we mainstream improvement and will develop a barometer for improvement across our organisation.

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[5] https://www.health.org.uk/publications/long-reads/five-principles-for-implementing-the-nhs-impact-approach

Our Key Enabling Strategies

To deliver our overall Strategy we will build on our existing enabling strategies, which have been developed with our staff and our partners. We have five key enabling strategies, which are listed below along with their key work programmes/priorities:

Always safety first

Insight – improve our understanding of safety by drawing insight from multiple sources of patient safety information. **Involvement** – Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system. **Improvement** – Design and support programmes that deliver effective and sustainable change in the most important areas including delivery of a safety culture.

Digital

Key workstream focus – digitally empowered patients, digitally enabled staff, hospitals without walls, smart buildings, interoperable and intelligent systems.

Estates and facilities

We are currently refreshing our Estates and Facilities Strategy, with a key focus being to deliver high quality, functionally suitable facilities for healthcare creating a safe, pleasant environment internally and externally.

Finance

Governance and communication - creating conditions for success. **Operational capacity planning** - restoring back to business as usual, integrated approach to planning and establishing strategic collaboration with the independent sector. **Knowing the business** - understanding population health dynamics, service reviews and patient level information. **System engagement** - commissioning approaches and provider collaboration. **Workforce** – developing workforce information and reducing the cost of premium rate. **Enabling waste reduction and efficiency** – continuous improvement, developing commercial approach to trading and R&D, technology led productivity and waste reduction, effective use of medicines and effective management of non-pay expenditure. **Capital investment** – agreed, long term investment strategy.

Workforce

To Engage, retain, reward and recognise - To create a positive organisational culture - To deliver a responsive, future focussed and enabling service - To attract, recruit and resource - To be inclusive and supportive - To be well led.

How we will move Forward

We have set a timeframe of five years for this strategy as we head closer to our new hospital build, with a commitment to review progress annually, through developing annual corporate objectives alongside the three-year single improvement plan. Our strategy is supported by our key enabling strategies which set out in more detail our approach to developing our digital capability, developing and supporting our staff, maintaining our estate whilst planning for the new hospital, improving our financial position and safety first. Our single improvement plan details all the improvement work underway to ensure we remain focused on delivery and progress and is reported to Board.

Each year we will set annual corporate objectives which focus on delivering the strategy, whilst remaining agile to changes in policy and the operating environment. These will inform our service and divisional plans which set out the detailed aims and objectives for each year, to ensure we measure our progress and prepare for the delivery of our new hospital.

Working with our partners within the Lancashire and South Cumbria Integrated Care Partnership (ICP), Lancashire and South Cumbria Provider Collaborative (PCB), place and social care we will develop integrated pathways bringing care closer to home for our patients, with more people being supported to live healthy lives in the community with fewer people needing to use healthcare services in an unplanned way.

By providing a wide range of high quality, high tech, integrated, efficient services Lancashire Teaching Hospitals will better meet the health needs of our population and benefit our local community.

Thank you

Keep In Touch:

If you would like to know more about our strategy, please contact communications@
www.Lancsteachinghospitals.nhs.uk
Follow us on: (Facebook, Instagram, YouTube, X)

Working together to improve the health and wealth of the population we serve

Our Strategy for 2025-2030

Published by Lancashire Teaching Hospitals NHS Foundation Trust, XXX 2025

Chair's Report to Board		
Chair: T Watkinson	Committee: Audit	
Date(s): 19 Sept 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
N/A		None

ALERT

Areas of concern; Matters requiring urgent attention; Insufficient assurance received.

- Continuing high volume of waivers on procurement, meaning tenders for new contracts have not consistently been sought as might be expected. Greater rigour and oversight is needed.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- There have been delays in receiving final versions of internal audit reports in some critical areas. Improvements are being made to the sign off processes within the Trust.
- Whilst there is a good record of implementing internal audit recommendations, the Committee has asked for greater oversight when deadlines for implementation are extended.

ASSURE

Assurance received; Matters of positive note.

- Good assurance received on cyber security arrangements.

Audit Committee

19 September 2024 | 10.30am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.30am	Verbal	Information	T Watkinson
2.	Apologies for absence	10.31am	Verbal	Information	T Watkinson
3.	Declaration of interests	10.32am	Verbal	Information	T Watkinson
4.	Minutes of the previous meeting held on 21 June 2024	10.33am	✓	Decision	T Watkinson
5.	Matters arising and action log	10.34am	✓	Decision	T Watkinson
6.	LSC Audit Chairs' Meeting	10.35am	Verbal	Information	T Watkinson
7. INTERNAL AUDIT					
7.1	Internal Audit Progress Report	10.40am	✓	Assurance	MIAA
7.2	Combined Internal Audit and Anti-Fraud Follow-Up Summary Report	10.50am	✓	Assurance	MIAA
7.3	Counter-Fraud Progress Update (including previous investigations)	11.00am	✓	Assurance	MIAA
8. GOVERNANCE AND RISK					
8.1	Risk Management Strategy Update	11.10am	✓	Decision	S Regan
8.2	Clinical Audit Programme Update	11.20am	✓	Assurance	H Ugradar
8.3	Process for the Appointment of External Auditors	11.30am	✓	Assurance	B Patel
8.4	Single Tender Waiver Report	11.40am	✓	Assurance	B Patel/K Fletcher
8.5	Losses and Special Payments Report	11.50am	✓	Decision	B Patel
8.6	Cyber Security	12.00pm	✓	Assurance	S Dobson
8.7	Addendum to the Fit & Proper Person Policy (response to recommendation following Internal Audit)	12.10pm	✓	Decision	J Foote
8.8	Items to alert, advise and assure the Board	12.15pm	Verbal	Information	T Watkinson

№	Item	Time	Encl.	Purpose	Presenter
8.9	Reflections on the meeting	12.25pm	Verbal	Information	T Watkinson
9. ITEMS FOR INFORMATION					
9.1	Strategic Risk Report		✓		
9.2	KPMG Technical Update		✓		
9.3	Civil Claims Annual Report		✓		
9.4	Policy Management Assurance		✓		
9.5	MIAA Final Audit Reports a) Fit and Proper Persons Test b) Data Security & Protection Toolkit		✓ ✓		
	Date, time and venue of next meeting: *16 January 2025, 10.30am, Microsoft Teams*	12.30pm	Verbal	Information	T Watkinson

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Oversight and Accountability Framework			
Report to:	Board of Directors	**Date:**	3 October 2024
Report of:	Director of Improvement, Research and Innovation	**Prepared by:**	A Brotherton
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this paper is to provide an update to the Board on the work undertaken to develop a new Oversight and Accountability Framework for the Trust and to seek approval to (i) progress the policy for ratification of the Oversight and Accountability Framework and (ii) to test the new processes for the Divisional and Corporate Improvement Forums (DIFs).

The paper also outlines the next steps needed to support implementation including: populating the assessments and allocating ratings (levels 1-4), testing the new framework and plan for the DIF's, assessing improvement maturity across the organisation in line with the NHS IMPACT framework and undertaking a review of the final version of the NHS England Oversight and Assessment Framework when published to ensure that the Trust is able to undertake and submit the anticipated quarterly self-assessments in line with anticipated national requirements.

It is recommended that the Board approve the new Oversight and Accountability Framework and policy so that it can be progressed through to the ratification committee and/or advise of any further changes needed.

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 paper has been considered by the Trust Management Board on 4 September. The Trust Management Board endorsed the Oversight and Accountability Framework and the recommendation is that the new framework is approved for implementation from October 2024.

1.0 Context

Development of the Trust's new Oversight and Accountability Framework

NHS England has published a new draft Oversight and Assessment Framework which sets out the roles and responsibilities of Integrated Care Boards and Providers in the NHS. The Trust's Oversight and Accountability Framework has therefore been updated to ensure alignment to the new framework. In developing this new framework account has been taken of the proposed new self-assessment submission that the Trust will have to make to NHS England if the draft framework is implemented and the aim has therefore been to align oversight and accountability of the divisions and corporate teams to the new NHS England approach.

The NHS England Oversight and Assessment Framework sets out the arrangements for oversight of providers, monitoring arrangements, how NHS England will identify the scale and nature of support or intervention needs and how they will implement support or intervention activity. The Framework also provides details of how organisations are determined to be high performing and this has been incorporated into Lancashire Teaching Hospitals Trust Oversight and Accountability Framework as we work together to deliver the new Single Improvement Plan.

The Single Improvement Plan is focused on improving patient safety and quality of care, patient and colleague experience, operational performance and financial sustainability, as well as building on the excellent work undertaken to improve the right culture and create the conditions for improvement to flourish. The specific domains that divisions and teams will be assessed on are the domains in the Single Improvement Plan; well-led (including strategy, continuous improvement and learning), safety, quality and clinical effectiveness (including patient experience), operational excellence, people and culture and financial sustainability).

The intention for providers to be required to submit a regular self-assessment is also outlined in the NHS England draft Oversight and Assessment Framework and therefore an assessment process has been adopted in the new Trust Framework. Further details of this are expected in the final version of the national framework and it is therefore proposed that a further review is undertaken when the national framework is published and any amendment required to the Trust framework and policy be made and reported back to the Trust Management Board and the Trust Board if amendments are material.

2.0 Discussion

The following work has been undertaken in the development of the Trust's new Oversight and Accountability Framework:

- ***Review of the new draft NHS England Oversight and Assessment Framework*** – the Director of Improvement, Research and Innovation reviewed the new NHS England Oversight and Assessment Framework to identify the key elements which should be included in the new Trust framework to ensure alignment with the draft national framework.

- ***Drafting of the new Trust Oversight and Accountability Framework*** **–** this was written by the Director of Improvement, Research and Innovation and the Chief Nursing Officer.

- ***Consultation***– the first draft of the framework was shared with the senior leadership colleagues who attend the joint executive and senior leadership development workshops. Initial comments were incorporated and further feedback sought at the development workshop held on 14th August 2024. The policy was updated to reflect comments received and a summary of the feedback received and how it had been incorporated into the policy circulated.

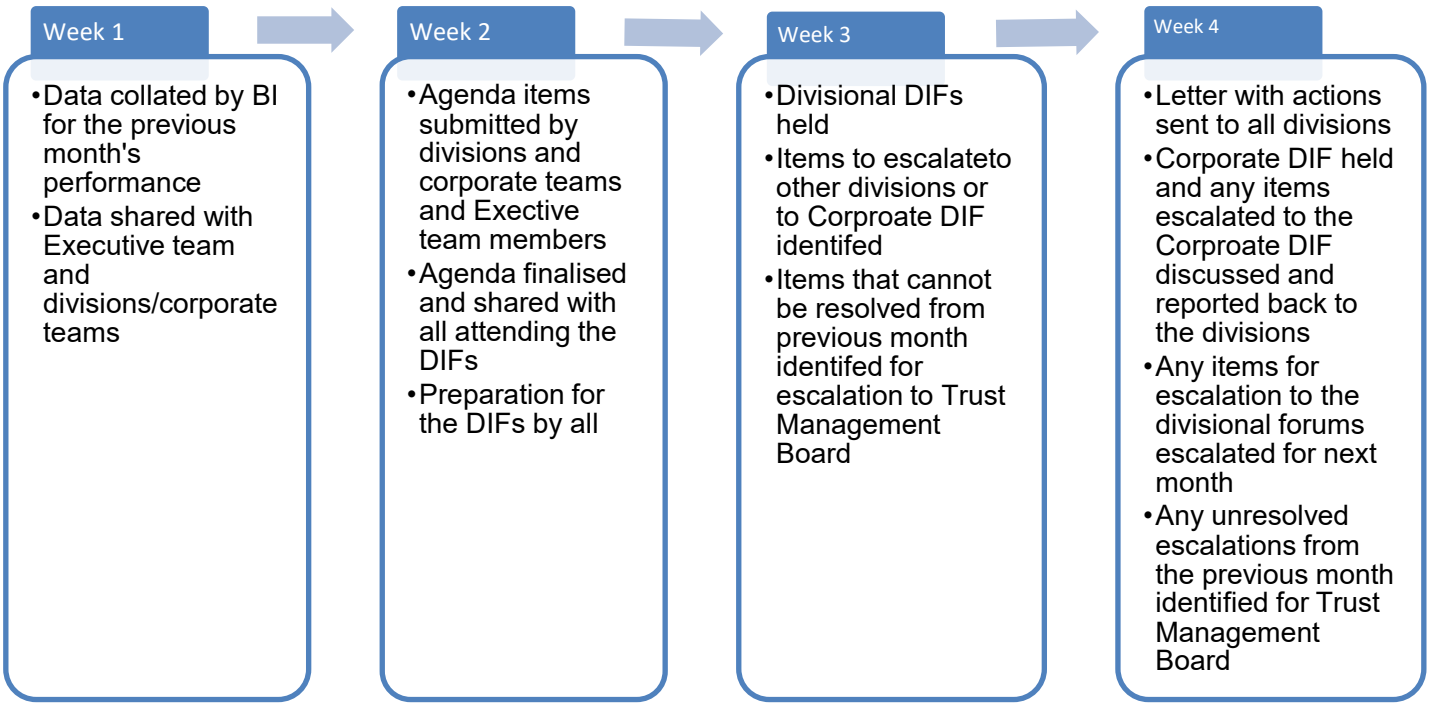
- ***Development of a Recovery Support Programme Offer for divisions and corporate teams in Level 4 (Insufficient Progress)*** – following feedback at the leadership development workshop that more frequent oversight meetings alone would not be helpful in supporting teams to improve, a recovery support programme has been developed in line with the national approach to support Trusts in National Oversight Framework (NOF) level 4. This will be bespoke to each division/corporate team in level 4 but outlines the process that will be followed to optimise improvement when divisions/corporate teams enter level 4. This includes establishing a recovery support programme board with clear exit criteria to transition to level 3 and an improvement plan with specialist input to support the work.

- ***Assessment Process and allocation of ratings*** – a small group of colleagues with divisional representation has considered the proposal for scoring and allocation of ratings and developed an early draft for review. Some of the measures within the framework will not be part of the calculations that determine the outcome, either because they are balancing measures or that they are outside of the divisions control in totality, however are required as evidence of contributing toward the overall aims and ambitions of the organisation or evidence of healthy reporting cultures. Additionally, some of the areas requiring oversight cannot be measured with a single score so within the attached draft scoring excel, there is a column which indicates if there is a score to be allocated. Further work is now required to populate this template for each division and undertake the testing. It is proposed that BI populate the templates and the scores are used to calculate the ratings to inform a discussion. It is anticipated that adjustments will be required and therefore it is proposed that an update is reported back to the Trust Management Board in 3 months, following initial testing and amendment.

- ***Review by NHS England and ICB colleagues*** – the new Oversight and Accountability Framework policy was reviewed by an Improvement Director at NHS England and no suggestions were made for improvements, other than to develop a concise update for colleagues so that the changes are clear. A powerpoint presentation has been developed which outlines the purpose of the new framework and plans for implementation. The framework was also reviewed by the ICB and no suggestions for amendments were suggested.

- **Endorsement of the new framework policy** – the new Trust framework was presented to the Trust Management Board on 4th September 2024 who endorsed this policy, the implementation of the new framework, the testing of the scoring and allocation of ratings and the establishment of a local recovery support programme if any divisions or corporate teams are rated level 4 (insufficient progress) prior to approval from Board.

3.0 Proposed cycle for the implementation of the new Oversight and Accountability Framework



4.0 Next Steps

1) **Populating the assessment –** the BI team are now populating the assessment template to enable the scores and ratings to be calculated
2) **Testing the implementation of the new framework and development of a monthly timeline –** it is proposed that the new framework and assessments are implemented from October 2024 and that a weekly cycle of business is developed to ensure the data packs and agendas are disseminated in line with the timetable developed. Feedback will be sought and improvements made as the new process is tested.
3) **Developing an NHS IMPACT barometer as an indicator of the maturity of improvement in each division –** in line with recognised best practice from other Trusts who are progressing the adoption of NHS IMPACT, this will be co-designed with teams within the next 90 days
4) **Developing the data at specialty level –** this is required to enable the divisional management teams to have oversight and accountability within their divisions and for the specialty teams to be able to manage their business effectively.
5) ***Review and update of the Trust Oversight and Accountability Framework when the final version of the national NHS England Oversight and Assessment Framework is published -*** this is required to ensure that our internal assessments align fully with the self-assessments that NHS England have proposed for Trusts to undertake and submit quarterly.

5.0 Financial implications

The implementation of the Trust's new Oversight and Accountability Framework is anticipated to contribute to the successful delivery of the financial recovery plan as oversight and accountability is improved across the organisation.

4.0 Legal implications

None identified.

5.0 Risks

Lack of BI resource remains a risk to successful implementation of this Oversight and Accountability Framework, especially in collating the data and production of the balanced score cards at specialty level. To mitigate this risk the initial development of the scoring templates have been designed with input from the Continuous Improvement team and if necessary the CI team will support this work to mitigate the risk.

Impact on stakeholders

The Trust's new Oversight and Accountability Framework should have a positive impact for key stakeholders on the System Improvement Board as the development and implementation is a key deliverable for the Trust from the Board.

7.0 Recommendations

It is recommended that the Board endorse the new Oversight and Accountability Framework and policy so that it can be progressed through to the ratification committee and/or advise of any further changes needed.

DOCUMENT TYPE: Policy		**UNIQUE IDENTIFIER:** TP- XX	
DOCUMENT TITLE: Policy for delivering the Oversight and Accountability Framework		**VERSION NUMBER:** 2 **STATUS:** Draft to be ratified	
SCOPE: Trust wide		**CLASSIFICATION:** Organisational	
AUTHOR: Ailsa Brotherton	**JOB TITLE:** Director of Improvement, Research and Innovation	**DIVISION:** Corporate	**DEPARTMENT:** Chief Executive
REPLACES: Previous Oversight and Accountability Framework		**HEAD OF DEPARTMENT:** Ailsa Brotherton	
VALIDATED BY: Trust Management Board		**DATE:**	
RATIFIED BY: Procedural Documentation ratification Group		**DATE:**	
(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:** September 2025 in line with the annual planning and the ongoing updating of this policy becomes the responsibility of the planning team	

AMENDMENT HISTORY

Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
1.0	TBC		New Oversight and Accountability Framework draft written	

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
Document for Public Display: No
Evidence reviewed by Library Services Not applicable

CONTENTS –

1. SUMMARY

National Context

NHS England has published a new draft ***Oversight and Assessment Framework*** which sets out the roles and responsibilities of ICBs and Providers in the NHS. The Trust's Oversight and Accountability Framework has therefore been updated to ensure alignment to the new framework. In developing this new framework account has been taken of the proposed new self-assessment submission that the Trust will have to make to NHS England and the aim has been to align oversight and accountability of the divisions and corporate teams to the new NHS England approach. The NHS England ***Oversight and Assessment Framework*** sets out the arrangements for oversight of providers, monitoring arrangements, how NHS England will identify the scale and nature of support or intervention needs and how they will implement support or intervention activity. The Framework also provides details of how organisations are determined to be high performing and this has been incorporated into Lancashire Teaching Hospitals Trust ***Oversight and Accountability Framework*** as we work together to deliver the new Single Improvement Plan. This is focused on improving patient safety and quality of care, patient and colleague experience, operational performance and financial sustainability as well as building on the excellent work undertaken to improve the right culture and create the conditions for improvement to flourish. The specific domains that divisions and teams will be assessed on are the domains in the Single Improvement Plan; well-led (including strategy, continuous improvement and learning), safety, quality and clinical effectiveness (including patient experience), operational excellence, people and culture and financial sustainability). Details are also provided in the NHS England ***Oversight and Assessment Framework*** for an annual assessment of the Integrated Care Boards performance, and assessment of the ICBs capability and an assessment of providers capability. The detail of the assessment of the providers capability has therefore been incorporated into the updated ***Oversight and Accountability Framework***[1]

Local Context

The Trust is in the process of developing a new ten-year strategy which will set out Lancashire Teaching Hospital's strategic intentions, including the development of the new hospital programme. The Trust has also this year, replaced its 'Big Plan' with the Single Improvement Plan, which clearly sets out the Trust's objectives for the next three years and brings together organisational priorities into one single plan. The progress against the delivery of the plan is overseen in the Single Improvement Plan portfolio board, chaired by the Chief Executive and progress is reported to the sub-board committees and the Board of Directors.

The Trust's strategic planning and monitoring framework sets out the Trust's current strategies. It is designed to ensure that there is a clear link between the objectives of the Trust, how these are planned to be delivered through the business planning process, how achievement of the objectives will be monitored and most importantly, how our colleagues will understand what the organisational strategy means for them in their day-to-day work. Each section of the framework provides clear guidance on the journey from strategy to delivery.

The aim of this ***Oversight and Accountability Framework*** is to ensure that a coherent set of business-critical performance indicators which includes those aligned to the trusts Single Improvement Plan are systematically monitored and managed to ensure delivery of the strategic objectives and associated performance metrics. The Oversight and Accountability Framework is underpinned by a range of governance, assurance and planning mechanisms including the Trust's risk management policy, organisational plans and strategies and the Board Assurance Framework (BAF). The Trust has established a Risk Management Group chaired by the Chief Executive to ensure oversight and proactive management of our risks and has established a Trust Management Board which will bring together the senior leadership team to work collectively on the Trust's priorities. This Oversight and

[1] This Policy will be reviewed and updated when the final version of the new NHS England Oversight and Accountability Framework is published. This document will fully reference the national policy document when available.

Accountability Framework also ensures alignment of our oversight and accountability arrangements with the new NHS England ***Oversight and Assessment Framework*** and is especially focused on establishing the arrangements that will support the Trust to improve as move towards becoming a high performing organisation.

1. Detailing the approach to oversight and accountability is critical to the implementation of the Operating Framework, driving a culture of continuous improvement, and building on a commitment to support divisions and corporate teams to achieve high performance.

2. In the new NHS England ***Oversight and Assessment Framework***, it has been recognised that to better serve patients, system partners have expressed a desire for greater clarity of roles and responsibilities, use of a broader range of short- and medium-term outcome measures, less subjectivity in measuring success, and adoption of mature relationships in supporting organisations to improve. The aim is to mirror this clarity of roles and responsibilities and collaborative working across Lancashire Teaching Hospitals. There are therefore some new sections in the framework that provide clarity of the roles and responsibilities as well as details of expectations of each other.

3. The approach aims to ensure that colleagues:

    - have a robust process of oversight, transparency, assessment and accountability that recognises and rewards improvement and brings all parts of the organisation together around common goals, realising benefits for patients, colleagues and the wider population and partners.

    - have a clear approach to developing leadership capability in line with the findings of the Messenger Review, giving leaders in the organisation the tools they need and the competency to drive change

    - can explain how improvement will be delivered through the principles established as part of NHS IMPACT, the national improvement framework.

This framework applies to all divisions and corporate teams. It supports the development of an approach to oversight across the Trust that provides a shared understanding of the accountabilities and roles between each division and team, provides clarity on how performance is monitored, and how support or intervention needs are identified and addressed. It also focuses on the importance of delivery against the objectives of teams so that the organisational objectives are achieved and colleagues work together to become a high performing organisation. Improvement will be recognised through positive feedback and escalation, teams being invited to share their work, increased freedom to innovate, less frequent oversight and increased autonomy.

2. SCOPE

The Oversight and accountability framework applies to all Divisions (clinical, non-clinical and corporate teams who deliver essential support functions, several of which are patient facing). There is an expectation that support functions work in partnership with divisional and corporate teams whilst also being part of the oversight and accountability framework to ensure support is maximised. The Trust has a clear set of objectives and expected outcomes which are outlined in the Single Improvement plan and measured through the Single Improvement Plan performance report, the delivery of these is integral to this framework, there will also be additional areas of focus that become emerging risks throughout the year that will require appropriate responses in line with the oversight and accountability framework.

Oversight of the Executive team is outside the scope of this document as this is clearly outlined in the Trust's constitution alongside the accountability arrangements for the Board. Details can be found at
https://www.lancsteachinghospitals.nhs.uk/media/.resources/638a31733d7e97.85640938.pdf

3. PURPOSE

Oversight and assessment

The principles of this ***Oversight and Accountability Framework*** reflect those of the NHS England ***Oversight and Assessment Framework*** and are underpinned by the NHS values and behaviors including transparency, accountability, responsiveness, recovery, integration and proportionality as well as the Trust's values.

The Trust's ***Oversight and Accountability Framework*** has 5 core purposes:

- to align priorities across divisions and corporate teams to drive shared ownership of positive performance and improvement
- to enable the sharing of good practices to support mutual improvement
- to identify where divisions and corporate teams may benefit from or require support or intervention
- to make explicit the leadership behaviours expected by those involved in the oversight and accountability framework
- to provide an objective basis for decisions about when and how the Executive team intervenes given the level of concern regarding performance.

The approach to oversight is characterised by the following key principles:

- as set out in the Operating Framework, effective leadership behaviours underpin all interactions
- balancing the contributions of individual divisions and corporate teams with shared organisational performance and outcomes
- working in partnership with the Senior Leadership Team (including the Executive team) to discharge the leadership teams responsibilities
- understanding variation and, where appropriate, holding divisions and corporate teams to account for addressing this
- promoting improvement and mutual accountability
- devolved decision making will be maximised to enable divisions and corporate teams to function as effectively and efficiently as possible. This will include devolved decision making to the Trust Management Board.

For this document, oversight and accountability are defined as:

Oversight is the ongoing monitoring of performance and quality of services being delivered by the divisions and corporate teams, to manage the delivery of the priorities set out in organisational plans and strategies including, the Single Improvement Plan. Its purpose is to provide assurance of performance and delivery as well as identify areas of challenge, identifying barriers that require support and identifying the divisions and corporate teams and/or individuals requiring support or intervention. This oversight and accountability framework specifically sets out how divisions and corporate teams are overseen (fully aligned to how the Trust is overseen by the ICB and NHS England).

Accountability is the process by which a division and/or corporate team is assessed and includes the team's leadership capability, improvement capability and capacity (as aligned to the NHS IMPACT framework), the contribution to strategic priorities, performance, safety and quality, workforce, financial recovery, reducing health inequalities and governance structures and processes. The assessments of performance are detailed in this framework and the

accompanying technical document. The assessments are aligned to the assessments undertaken by the Care Quality Commission (CQC) to ensure the organisation is providing safe and effective care and delivering services in line with the conditions of the provider licence. The Trust's Integrated Performance Report is the method in which ward to Executive reporting takes place. The Divisional Improvement Forums (DIFs) are the forums where Executive Oversight of performance takes place and divisional and corporate leaders are held to account for the delivery of the organisational plans. The outcomes of the Divisional Improvement Forums are reported into the committees of the Board.

A critical element of oversight is the early identification of emerging issues and concerns so that they can be addressed before they have a material impact or performance deteriorates further. Divisions and corporate teams are expected to manage the risks associated with issues as they arise and escalate issues where there are significant actual or prospective changes in performance or quality risks in line with the Operating Framework. The ICB and NHS England has the same expectation of the Trust and it is therefore critical that there isa culture of open and transparent early escalation in place.

3. ROLES AND RESPONSIBILITIES

The ICB is responsible for arranging for the provision of healthcare services to meet the health needs of our local population, alongside other statutory duties. The ICB is the leader of the NHS system within the Lancashire and South Cumbria ICS and oversees the delivery of joint system plans and strategies requiring mutual accountability.

A key element of discharging its responsibilities is to ensure that the service-delivery models in the NHS system are working effectively via place-based partnerships, provider collaboratives, the primary-secondary care interface and integrated neighbourhood teams. The ICB leads the oversight of the organisation in line with the principles outlined in the NHS England Oversight and Assessment Framework, and co-ordinates support or interventions, as appropriate, working in partnership with NHS England.

The Lancashire Teaching Hospitals Oversight and Accountability Framework defines the roles of those responsible for overseeing and functioning with the framework.

The Board of Directors

The Board of Directors is responsible for overseeing the performance of the organisation and is accountable to the ICB and NHS England for its performance.

The Board is responsible for demonstrating adherence to NHS England provider licence standards and compliance with the Health and Social Care Act 2012. It does this by ensuring the provision of safe, effective, efficient, and quality services. This includes working effectively with NHS system partners to deliver shared objectives, plans and priorities, including financial, safety, quality and operational performance.

The Chief Executive

The Chief Executive provides strategic leadership of the organisation ensuring effective governance and alignment with NHS principles. The CEO will balance the long-term strategy with day-to-day responsibilities ensuring the executive leaders of the organisation enact their responsibilities whilst fostering a culture of high performance, quality, safety, and patient experience.

The Executive Team

The Executive team are part of the Board of Directors and are held to account for the delivery of the organisational plans through the Non-Executive Directors of the Board and accountable to the Chief Executive Officer. The Chief Operating Officer will chair the DIF process. The Executive role is to actively participate in the Divisional Improvement Forums monthly, ensuring cross portfolio challenge and partnership working takes place to deliver outcomes outlined in the Trusts strategy, aims and objectives.

The Executive team will

- Work in support of the divisions, alongside other partners in the system as required, to find local resolutions to risks, concerns and challenges, and co-ordinate and tailor necessary support or intervention, proportionate to performance.
- Respond to changes in performance in line with the oversight and accountability framework.
- Test the robust governance arrangements in place within divisions and corporate areas and where necessary request additional assurances are provided.
- Determine the level of confidence in a division and corporate team's capability through an assessment process with an aspiration that all divisions and corporate teams achieve a rating of 'Excelling' or 'Achieving'.
- Encourage the sharing of good practice between divisions and facilitate the adoption of good practice throughout the organisation, this includes learning from other organisations who are high performing.

The Business Intelligence team

The BI team is responsible for

- Redesigning our *DIF* metrics and scorecards in line with agreed metrics
- Development of a new BI DIF metrics poral/dashboard in line with this policy
- Production of the data, dashboards and reports in line with the timetable to enable circulate of the DIF packs 7 days prior to the DIF meetings
- Making timely changes to the DIF scorecards in line with agreed changes
- Production of SPC charts where appropriate to allow tracking over time and to highlight the metrics that require discussion in the DIF meetings where there is special cause variation or where the metrics are outside the agreed KPI parameters.

The divisional* and corporate management teams

(*This includes the Divisional Director, the Divisional Nurse/Midwifery/Allied Health Professional Director, the Divisional Medical Director and the professional and/or Chief roles at the head of the divisional/corporate departments.

The divisional and corporate management teams are responsible for

- Operational delivery of the single improvement plan and supporting plans.
- Overall coordination of the division and corporate area ensuring alignment with other divisions and corporate areas takes place when necessary to ensure outcomes are maximised for the organisation as a whole.
- Ensuring data provided to scrutinised and is challenged to ensure accurate performance data is reported to the Executive team.

- Operational leadership of the Trusts aims and objectives within the division and across the organisation.
- Enact good systems of governance and oversight within the division and corporate areas.
- Support to specialities to deliver their plans, including the financial recovery plan
- Ensure additional support for specialties that are not delivering against plan with increased oversight

The Chief Operating Officer Executive Assistant

The COO Executive Assistant is responsible for providing the administration of the DIFs and will:

- Ensure an agenda is prepared in liaison with the Executive team and the divisional leadership team/corporate leads
- Produce timely minutes of the meetings including a record of any decisions taken and an action log which will be circulated within 5 working days of the DIF being held
- Ensure letters are produced and circulated which summarise the agreed actions and outline any support being put into place

4. The key features of the oversight of divisions and corporate teams are detailed in Table 1.

Table 1: Oversight of divisions and corporate teams

Oversight of divisions and corporate teams rated as 'Excelling' or 'Achieving'	Oversight of divisions and corporate teams rated as 'Progressing' or 'Insufficient progress'
• The Executive team oversee performance, safety and quality, finance and delivery against the Single Improvement Plan and divisional/corporate team plans through robust governance arrangements and DIF meetings • The Executive team and divisional management teams/corporate team leaders have open and mature discussions on issues and challenges, including any early warning signs, and agree on the way forward • The Executive team acts as a liaison for the divisions with the ICB and NHS England regional colleagues and escalates issues in a timely and transparently way • The Executive team proactively oversees and ensures the management of organisational and divisional and corporate team risks, seeking support from the ICB and NHS England regional colleagues as and when required • The Executive team finds local resolutions to issues and challenges in a division and corporate team through leadership, peer support, facilitating mutual aid, etc.	• The Executive team oversees the divisions and corporate teams and support/ interventions will be provided to the divisions and corporate teams as required; the support needed will be discussed and agreed with the divisions and corporate teams and may include (but not be limited to) support from other teams across the organisation (for example support from the organisational development team to improve culture, support from the continuous improvement team or PMO). • Reviews of progress on the priority areas of concern are undertaken regularly in the DIF meeting to discuss safety and quality, performance, finance, and progress against improvement plans. • Support may be sought directly from the ICB, NHS England regional colleagues or an external consultancy depending on the challenge, resources available and the level of oversight from the ICB and NHS England in place.

• The Executive team and divisional management team/corporate leadership teams will work together to ensure greater freedom and independence for the division, increased autonomy and decision making (for example, no need to attend vacancy control panel for approvals for positions when in level 1 (Excelling), formal acknowledgement of achievement with the division being held up as an exemplar, greater permissions to innovate.	• The Executive team actively support the Division and corporate teams in managing risks and find resolutions to issues and challenges. • Where necessary, the Executive team decide the structure of support or intervention for the division or corporate teams. For divisions and corporate teams in level 4 (Insufficient progress) a recovery support programme board will be established, chaired by the Director of Improvement which will mirror at a local Trust level the national recovery support programme in its approach. See Appendix 1 for details. • The Executive teamwork with the divisions and corporate teams to agree an improvement plan for challenged divisions and corporate teams, setting the 'exit /transition criteria' and planned timelines for any support or intervention and take an active role in monitoring progress and supporting divisions and corporate teams to meet those criteria.

4.0 OVERSIGHT MODEL

The Lancashire Teaching Hospitals oversight model is built around the four national objectives that are outlined in the NHS England Oversight and Assessment Framework. These have been adapted for use at organisational, divisional and corporate team level. These reflect the contribution of each division and corporate team to deliver the Trust's Single Improvement Plan.

These are transparent and balanced to reflect both current operating priorities and longer-term strategic ambitions of the organisation and expectations (see Table 2). These are underpinned by a set of principles of how the Executive team work with divisional and corporate teams to identify support needs, deploy support or intervention and drive improvement to address the most complex and challenging problems that the organisation faces.

Table 2: Metrics to assess divisions contribution to the Trust objectives and priorities as outlined in the Single Improvement plan. The Single Improvement plan is a three-year plan and the priority programmes are agreed and shared. The priorities are reviewed through the annual planning process.

Table 2 – DIF metrics

The national objectives outlined in the NHS England Framework	Alignment of our Trust Priorities to the national objectives as outlined in the Single Improvement Plan
Improve population health and health care	Urgent and emergency care
	Elective care
	Cancer care
	Diagnostics
	Mental health care
	Learning disabilities and autism care
	Primary and community care
	Children and young people
	Frailty
Tackle inequalities in outcomes, experience and access	Inequalities in access and outcomes
	Outcomes and prevention
Enhancing productivity and value for money	Finance
	People
Support social and economic development	Social value Anchor Institution
A governance dashboard will be used alongside the national metrics to ensure oversight of governance within the divisional and corporate functions.	

5.0 MONITORING

Executive Team

The divisional and corporate improvement forums are the place where the detailed oversight of plan delivery and outcomes takes place. The divisional and corporate leadership teams will prepare to report on progress through the forums.

- The divisional improvement forums will be chaired by the Chief Operating Officer or nominated deputy and attended by a defined group of the Executive team.
- The corporate DIF will be chaired by the Director of Improvement and attended by a defined group of the executive team.
- DIF packs will be circulated 7 days ahead of the meeting with the agenda outlining the areas of focus for the meeting.
- The Executive team will discuss and agree with the divisional / corporate team the work required and appropriate timescales for improvement. Trajectories and any support required will be agreed as part of the discussion.
- Feedback regarding corporate team support will be acted upon with the aim of strengthening outcomes across the organisation.
- As part of the oversight process, the executive team will monitor and gather insights across the oversight domains. The information collected and reviewed includes both quantitative data using the defined delivery metrics as well as qualitative information. Qualitative information may include issues and concerns raised through freedom to speak up, visits to wards and departments and discussions with divisions around confidential risks.
- The use of benchmarking data will be strengthened in the oversight process so there is clarity and a shared understanding of where high performance exists across the organisation and where the Trust requires improvement.
- The oversight framework will include feedback from external partners including the feedback received from ICB assessments, Tier One meetings, any emerging safety and clinical quality risks, as well as other relevant information provided by third parties such as through 360-degree feedback, peer reviews, or formal publications/assessments.
- Alongside this, the Executive team will take account of the insights available from key regulators including the CQC, the Health and Care Professions Council (HCPC), the General Medical Council (GMC), General Pharmaceutical Council (GPC) and the Nursing & Midwifery Council (NMC) and will use the reports and surveys available to identify areas of best practice and areas for improvement.
- Where challenges and issues are emerging for divisions and corporate areas there is an expectation that teams will work together utilising the Divisional/Corporate Improvement Forums to discuss issues and actions in place to manage any risks.
- Trust Management Board and Risk Management Group are forums where risks and issues that cut across the wider organisation can be scheduled for discussion, both forums have executive and senior leadership team attendance.

Divisional and corporate teams

The divisional improvement forums will be attended by all members of the divisional management team and the finance and workforce business partners. Deputies will attend to cover leave.

- Divisions will report by exception identifying positive and negative areas of performance.
- Division and corporate teams will be encouraged to share examples of outstanding practice including examples of where learning has taken place and adopted across divisions.
- The divisional and corporate teams will prepare for an action focused discussion of the topics requiring improvement on the agenda.
- The divisional and corporate teams will identify the support required if the division is unable to address the issues within the division using the business partner structures.

Frequency

- The divisional/corporate improvement forum frequency will vary according to the performance of the division/corporate team.
- It may be necessary to enact intensive monitoring and oversight where a specific risk becomes evident, and a judgement is made that increased scrutiny and oversight is required.
- An annual longer meeting linked to an annual performance assessment will be undertaken with an annual effectiveness review of the DIF/CIFs and actions agreed to strengthen the process.

Essential support functions from the corporate teams

- A key function of the corporate teams is to provide the essential support functions for the divisions to deliver their annual plans and priorities, including the CQC action plans, especially where the divisions are the ‘owners’ of the delivery but success is dependent on the provisions of services from corporate teams.
- To enable effective oversight of the functions and progress on actions, each division will have an opportunity to escalate to the executive team in their corporate DIF any support from corporate teams that is essential to progress the action plans and improve outcomes that is behind trajectory for delivery. These will be collated from the clinical division and estates and facilities DIFs and discussed in the corporate DIF which will be held one week after the clinical DIFs to enable these escalations to be collated and circulated to the corporate teams so they are able to provide an update in the corporate DIF.
- The essential work of the corporate teams is also dependent upon engagement and ownership of issues at divisional and speciality levels. The corporate teams will also have an opportunity to escalate any issues that they have been unable to resolve with divisions so that these can be discussed in the divisional DIFs.
- Escalations that cannot be resolved within the DIFs will be reported to and discussed at Trust Management Board as part of the DIF reporting to Trust Management Board so the whole senior leadership team has oversight of the issues that remain unresolved.

6.0 IDENTIFIYING THE SCALE AND NATURE OF SUPPORT INTERVENTIONS REQUIRED

Each division and corporate team is assigned a segment between 1 and 4 (see section below) indicating their respective level of delivery and support or intervention needs. Decisions on segments will be made considering the following elements:

a. a set of objectives, measurable criteria based on metrics associated with the six domains of the oversight framework

b. the capability of the division or corporate team to improve without additional support or intervention.

c. The direction of travel is the position improving or deteriorating.

d. the division or corporate team's contribution to the organisation's improvement trajectories. Consideration will also be given whether the challenges are long-standing and how the division or corporate team is working to address them and whether the challenge is within the division's/corporate team's ability to influence or if the solutions lie elsewhere in the organisation or system.

- Delivery scores are determined through a metric-driven process based on a range of measures linked to the unique contribution of the division or corporate team to the specified oversight domains detailed in Table 2, plus the local metrics that are deemed critical to success such as mortality. The metrics that are used to determine this initial score are reviewed on an annual basis and reflect a balance between the major operating priorities of the organisation and the longer-term strategic and cultural improvement measures. The list of metrics being used to guide segmentation is outlined in a separate technical document.

- Each metric is individually scored and contributes to a specific 'domain' score. Domain scores are then brought together to form the indicative delivery score. Metric and domain scores may also be used in their own right to support the diagnosis of issues that could benefit from targeted support or interventions. The scoring model for each individual metric is detailed in a separate technical document.

Table 3: Segment definitions and expectations

Segment	Description	How the Executive team will support	How the Divisions and Corporate teams will drive improvement with support from the Executive team	How the Executive team will intervene
1	Consistently high-performing across domains, delivering against plans and operating in a high-functioning NHS system. Has a track record of successful delivery or effective recovery.	No specific support or intervention needs are identified. Expected to offer peer support to others or support the development of best practice tools.	Will work alongside the Executive team to develop best practices and improvement initiatives in areas in which the organisation excels. May be asked to work with other divisions to provide expertise to support them to improve.	It is anticipated that no intervention is required in this segment, but if intervention is needed this will be discussed with the division and agreed together.
2	Developing with confidence in the ability to improve further and operate as a high-functioning division. Specific issues exist with plans in place that have the support of the Executive team and where required, system partners	The division can diagnose and clearly explain its support needs which will be predominantly supplied from within the organisation. Support on specific issues is provided where appropriate.	Will work with the Executive team to support the development of best practices in areas of high performance. Targeted support aimed at improving specific challenges where issues have been identified	Due to the relatively high-performing nature of the division or corporate team and its level of maturity, any support required will be discussed and agreed
3	Division or corporate team are significantly off-track in a range of areas. We lack confidence in the capability to respond to challenges without support.	Support needs are diagnosed together and delivered through local support offers which may include support from the ICB and NHS England regional interventions.	Receives enhanced scrutiny targeted at delivering improvement in the most challenged performance areas. Recovery KPIs and trajectories are agreed upon and proactively monitored.	Additional interventions and/or direct actions may be required. This will be discussed with the division or team and a plan agreed
4	There have been multiple serious failures of patient safety, quality, finance, leadership, or governance within the division or corporate team	An intensive support team will be created with colleagues from across the organisation (and if necessary across the system) to provide support, undertaking a full diagnostic to identify support needs and develop a full recovery plan in collaboration with system partners as required.	A member of the executive team will join, and if necessary chair, the divisional management board to directly oversee progress and additional improvement support will be put in place to support the division or corporate team to improve at pace.	Executives of their deputies will work directly alongside the division to support improvements.

7.0 OVERSIGHT FRAMEWORK LEVELS

Table 4 outlines how this will be operationalised

1	**Excelling** [Outstanding]	**No Concerns and leadership team focused on any emerging risks**	**6 monthly**	• **No additional escalation required.** • Full autonomy and decision rights
2	**Achieving** [Good]	Consistent delivery against operational plan and Single Improvement plan but some domains requiring focused action	Quarterly	• Review led by relevant Executives associated with individual domains at risk. • Area of risk within domain requires action plan/trajectory
3	**Progressing** [Requires Improvement]	Not delivering all of the operational plan or Single Improvement plan, significant continuing risks, recovery trajectories agreed	Monthly	• Review by the Executive team (except CEO) • Areas of risk with domains have agreed action plan and trajectories • Targeted support agreed to improve
4	**Insufficient Progress** [Inadequate]	Not delivering operational plan or Single Improvement Plan, significant continuing risks, not meeting recovery trajectory, or recovery trajectories not in place	Monthly DIF and Monthly Recovery Support Programme Board (therefore formal meeting fortnightly)	• Review with the executive team including the CEO • Intensive oversight put in place (frequency to be determined), including where needed from the ICB, NHS England regional colleagues or consultancy • Decision-making rights suspended for any spend >£1000 • Where required full turnaround support covering all domains of delivery risk

8.0 IMPLEMENTING SUPPORT OR INTERVENTION

The Executive team will ensure direct support or intervention in circumstances such as the following:

i. A division or corporate team has been assigned a delivery segment of 3 or 4, or there is significant underperformance of a key national priority

ii. A division or corporate team does not have the necessary capability to lead the requisite improvement

iii. improvement is not being seen at the pace or scale required

iv. there has been a serious failure of governance, leadership, finance, quality, or patient safety, or there are long-standing challenges

All divisions may benefit from the universal support offered under NHS England's NHS IMPACT Programme. NHS IMPACT will support the delivery of clinical and operational excellence, both by helping to develop the leadership and organisational capacity, capability and infrastructure to create the conditions for improvement and delivering a small number of programmes to drive adoption and local adaptation of operational processes and clinical pathways that are proven to improve quality and productivity.

Divisions assigned a segment of 2 may receive targeted support aimed at improving specific pathways where issues have been diagnosed, such as our offers of support on elective, cancer, and urgent and emergency care recovery, in line with the national programmes of work.

Where a division or corporate team is assigned a segment of 3, there will be discussion and agreement focused on the support or intervention needed to transition to segment 2. The agreed support or interventions are recorded in the DIF and form part of the regular review discussions.

Our most intensive support intervention will be assigned to divisions and corporate teams in segment 4. For these divisions, the transition criteria to move to segment 3 will be agreed in DIF meetings.

Where regulation notices are in place, there is an expectation that progress is demonstrated on a monthly basis through the Divisional and Corporate Improvement Forums.

9.0 HIGH PERFORMING DIVISIONS AND CORPORATE TEAMS

For divisions and corporate teams that are allocated to segment 1 for at least 1 year, the Executive team will consider undertaking the formal oversight meetings on a bi-annual basis, with quarterly informal touchpoints to discuss any emerging issues, opportunities, and hot topics.

The Executive team will also support the division to share best practice with the remainder of the NHS, for example, in the NHS IMPACT learning and improvement networks and improvement collaboratives.

10.0 ASSESSMENT

Divisional and corporate team quarterly performance assessment

- Taking the learning from the NHS England Oversight and Assessment Framework on assessment, within the Lancashire Teaching Hospitals Oversight and Assessment framework, the Trust's senior leadership team will test a new approach to assessment.
- The assessment will consider how well the divisions and corporate teams have discharged their functions and include;
- An assessment of performance using the segmentation and delivery of the division's contribution to the Single Improvement Plan (including the financial recovery plan) and delivery of the divisional/corporate team plans
- Adopting and embedding improvement (the NHS IMPACT framework in line with national planning guidance) to improve the quality of services. This includes an improvement barometer of the five domains of NHS IMPACT; building a shared purpose and vision, investing in people and culture, developing leadership behaviours; building improvement capability and capacity, embedding improvement into management systems and processes

- Progress on reducing health inequalities, inequality of access and outcome
- Engagement in research and innovation activity and outcomes
- Patient Experience and involvement activity and outcomes

The annual performance assessment in respect of the preceding year will include consideration of the following:

- An annualised delivery score resulting in a segment of 1-4 (see section 4.2)
- A capability self-assessment, which includes looking at how the divisions have performed their functions during the year, by reference to 6 core functional areas over the year (see section 5.2), the outcome of which will include a capability rating
- In Quarter 1 of each financial year, one of the DIFs will include a dedicated discussion of the annual performance assessment for the preceding year. As part of this meeting, we will discuss the outcome of the capability self-assessment in respect of the previous year, reflect on existing and emerging issues and plan divisional management team development as part of the discussion.
- Alongside the capability self-assessment, the Executive team will also summarise their feedback for the divisions on their overall delivery taking into consideration the segment for quarter 1 and performance over the previous year, as well as reflecting on overall delivery against local and national objectives. This is an opportunity to celebrate successes as well as focus on areas of challenge.
- All of the divisions and corporate team's capability rating and delivery segment for the previous year will then be agreed and shared in one of our development sessions to ensure there is a focused discussion on sharing best practice and planning for our current challenges. This will form part of our well-led domain in the Single Improvement plan. Where appropriate these will also inform the development of our corporate objectives.

11.0 CAPABILITY AND SELF ASSESMENT

The divisions and corporate team's capability assessment forms part of our annual performance assessment. Our capability assessment is based on 6 functional areas listed in Table 6

Table 5: Functional areas for divisions and corporate teams' capability assessment

Area	Criteria for Divisions	Criteria for Corporate teams
Strategy and planning	Developing strategies with the Executive team and corresponding delivery is essential for our success as an organisation. Each specialty within the division will ○ have an activity plan and have undertaken capacity and demand planning in line with the new approach ○ have undertaken agreed service reviews in year (following the 8	Developing strategies with the Executive team and corresponding delivery is essential for our success as an organisation. Each corporate team will ○ contribute to the trust strategy development and implementation and where appropriate have their own strategy and be accountable for delivery

	week service review process) and have delivered/be delivering their improvements in line with the service reviews.	○ Undertake a service review in year and ensure the appropriate team structure is in place ○ Develop and deliver against an agreed set of KPIs which are set in collaboration with the divisional teams
Leadership	Well-led rating in the CQC report Build strong partnerships and effective governance and decision-making arrangements in the division. Engage in the senior leadership development and work as one senior leadership team, in line with the agreed expectations. Provide strong leadership across the division and support the development of the leadership skills at specialty level. Develop your leadership behaviours in line with Trust values and the NHS IMPACT framework and engage in training in NHS IMPACT and improvement methodology	Build strong partnerships and effective governance and decision-making arrangements in the division. Provide strong leadership to the corporate team and ensure leadership development within the team Develop your leadership behaviours in line with Trust values and the NHS IMPACT framework and engage in training in NHS IMPACT and improvement methodology
Assuring performance, safety and quality and delivery	There are clear arrangements for assuring quality, performance, delivery, and financial accountability against agreed ambitions and spending limits. Ensuring that an appropriate response is in place to address risks to delivery and drive improvement.	There are clear arrangements for assuring quality, performance, delivery, and financial accountability against agreed KPIs and spending limits. Ensuring that an appropriate response is in place to address risks to delivery and drive improvement.
Transformation of services through the development of new clinical models	Contributing to the system-wide transformation of services, workforce, data, digital and estates and an embedded approach to learning, which supports innovation and research, enabling service quality improvement.	Contributing to the system-wide transformation of services, workforce, data, digital and estates and an embedded approach to learning, which supports innovation and research, enabling service quality improvement.
Effective governance and people	Ensuring that the division is effective and well-run with a high-performing divisional management board, robust governance and a healthy workforce and culture.	Ensuring that the corporate team is effective and well-run with robust governance and a healthy workforce and culture which is overseen by the lead executive for each team and the corporate DIF.

Table 6: Capability ratings

Rating	Rating description	Potential support or interventions
Excelling (Outstanding)	The division/corporate team can demonstrate it fully delivers/excels against the criteria outlined.	No Specific support or intervention needs are expected to be identified. Expected to offer peer support to others or support the development of best practice tools and actively learn from other high performing organisations.
Achieving (Good)	The Division/corporate team can demonstrate it fully delivers against most of the criteria.	Limited support or intervention is required. Support on specific issues may be provided where appropriate.
Progressing (Requires Improvement)	The Division/corporate team can demonstrate partial delivery against the criteria or full delivery of a small number.	We will work in partnership to support the division or corporate team. Specific support is likely to be put in place to support improvement.
Insufficient progress (Inadequate)	The Division/corporate team has not demonstrated, or cannot currently demonstrate, delivery against the criteria.	We will work in partnership to develop an intensive support offer.

12.0 THE TRUSTS CAPABILITY ASSESSMENT

The NHS provider licence sets specific requirements on trust governance, including the ability to deliver national priorities, maintain standards of organisational and quality governance, and collaborate effectively with system partners.

The Trust board represents the first line of oversight and assurance. It is anticipated that NHS England will require the board to undertake a quarterly self-assessment against specific operational areas on behalf of their organisation as outlined in the draft National Oversight and Assessment Framework. The areas are likely to include strategy, quality, people, access, productivity and finance, though the final framework is still to be published. Until the details of the self-assessment are published the Trust Oversight and Accountability Framework has been fully aligned to the Trust's Single Improvement Plan, annual plan and the System Improvement Board exit criteria. When the full list of the proposed criteria is published by NHS England the Trust policy and self-assessment metrics will be reviewed and updated.

13.0 AUDIT AND MONITORING

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group/ committee which will receive the findings / monitoring report and act on findings.	Group / committee/ individual responsible for ensuring that the actions are completed
Oversight and Accountability Framework delivery	Monitored though Divisional Improvement Forums (DIFS)	Trust Management Board	As outlined in the policy depending on rating	DIFs	DIFs

14.0 TRAINING

TRAINING Is training required to be given due to the introduction of this policy? N/a Please delete as required		
Action by	**Action required**	**Implementation Date**
Not applicable		

15.0 DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
1	Recovery Support Programme
2	Equality, Diversity & Inclusion Impact Assessment Form
3	

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS References in full	
Number	References
	Not applicable
Bibliography	
Not applicable	

DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition
Board Assurance Framework (BAF).	Document that brings together in one place all of the relevant information on the risks relating to the Board's Strategic Objectives.

DISTRIBUTION PLAN	
Dissemination lead:	Ailsa Brotherton
Previous document already being used?	Yes
If yes, in what format and where?	Policy
Proposed action to retrieve out-of- date copies of the document:	Remove from Heritage
To be disseminated to:	Trust wide
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the LTHTR weekly Procedural documents communication– New documents uploaded to the Document Library

Appendix 1 – Recovery Support Programme for divisions and corporate teams in Level 4 (Insufficient Progress)

What is our LTH Recovery Support Programme?

The LTH Recovery Support Programme (RSP) supports the divisions/corporate teams with the toughest challenges, and complex issues within the organisations including **Governance, Leadership, Culture, Operational Performance, Workforce, Patient Safety and Financial Sustainability**.

NHS England launched the NHS IMPACT framework in 2023 with the National Improvement Board setting an ambition for the NHS in England to become the fastest improving healthcare system globally. To achieve this ambition, all parts of the NHS are being asked to adopt an improvement approach to improve their performance. The Trust will therefore adopt a rigorous improvement approach to the design and implementation of its recovery support programme for divisions and corporate teams in Level 4 to maximise improvements in critical safety, quality and performance metrics and financial recovery and sustainability. There will be clarity at the point of entry to Level 4 why the division or corporate team is entering level 4 with clear exit criteria set for transition to level 3.

The RSP is:

- Available to support divisions/corporate teams with increasing, complex challenges, helping to embed improvement upstream to prevent further deterioration and enable stabilisation. The programme will be designed to address the key challenges, adopting the five domains in the Single Improvement Plan so the division or corporate team will have a comprehensive improvement plan to address the specific areas that placed them in Level 4
- Focused on whole organisation (and where necessary system), recognising that many challenges faced by the divisions/corporate teams are system or organisation wide issues while still providing tailored, intensive and specialist input to the individual division.
- Collaborative with the trust, Place based partners and where necessary the ICS to diagnose problems and agree solutions focused on the underlying drivers of the problems that need to be addressed and those parts of the organisation that hold the key to improvement.
- Able to draw in support from an expert multidisciplinary team coordinated by the Director of Improvement, Research and Innovation
- Time limited with clear exit criteria and focus on resilience with knowledge and skills transfer, providing sustainable capability within the division following exit from the programme.
- A streamlined improvement offer to support the division to improve which will be co-designed with the division.

Elements of the RSP

Stage	Element	Detail
Entering	**1. Assessment**	Following assessment as part of the new Accountability Framework a division/corporate team will formally enter Level 4 and a formal meeting will be arranged, chaired by the Director of Improvement to review the metrics and rationale for the allocation of Level 4 for the division
	2. Diagnostic and set exit criteria	Led by the Executive team, working with the division the exit criteria will be set
	3. Improvement Director (ID)	The Trust's Improvement Director will chair a divisional recovery support programme board
	4. Formal entry	The decision will be made by the Executive team that the Division/corporate team is formally entering the recovery support programme. Formal letter to the division will be sent from the Chief Executive to confirm RSP status for the division/corporate team.
Delivering	**5. Improvement plan developed**	Facilitated by the Improvement Director and aligned to the Trust's Single Improvement plan to ensure one coherent plan that meets both the exit requirements for RSP and Trust delivery. Signed off by the Executive team
	6. Multi-disciplinary Team	Led by the Improvement Director and deployed from within the Trust's improvement team and with specialist input from other corporate teams (and externally where the expertise/skills are not available in the Trust). Quarterly review of support against exit criteria will be undertaken.
	7. Review of progress	Ongoing oversight of progress facilitated by the Improvement Director and including key executives. RSP review will be undertaken as part of the DIF meeting.
Reporting	**8. Reporting to Trust Management Board**	A quarterly assessment will be undertaken and an update on progress and whether on track to meet exit criteria and risks will be reported.
Transition	**9. Recommendation to exit RSP and transition to Segment 3**	The RSP Board makes judgement that exit criteria have been sustainably met and makes a recommendation for RSP exit and transition to segment 3 with transitional support package agreed at that time as appropriate.
	10. Formal exit from RSP and transition to segment 3	Formal decision made by the Executive team that the exit criteria have been met on a sustainable basis. If approved, formal letter to the divisional management team to confirm they now in segment 3. If the Executive team is not satisfied exit criteria have been met, on a sustainable basis, the division remains in RSP for a limited period to allow for further improvements.

What specialist input can the Division/corporate team expect from the RSP?

The LTH Recovery Support Programme provides tailored, comprehensive interventions coordinated by the Trust Director of Improvement, Research and Innovation. Examples of recovery support offered as part of the RSP, subject to resources and availability, include but are not limited to:

- Access to subject matter experts (for example tissue viability specialists, microbiologists, data analysts, OD specialists, project managers), focusing on areas such as governance, finance, project management, quality, patient safety, risk management, organisational development, information reporting (Making Data Count) and performance management. Coordinated organisation wide support and response focusing on developing sustainable improvements will be developed.
- Support from the OD team to undertake cultural diagnostics and intervention such as TED.
- Specialist support to identify capacity and/or capability issues across the team. Access to support to develop leadership capacity, capability, and resilience. This will include bespoke support to address skills shortages as needed.
- Support drawn from other areas external to the Trust (where the Trust is able to secure this) for example, interventions from the national improvement teams such as Emergency Care Intensive Support Team (ECIST), Getting It Right First Time (GIRFT), links to the Maternity Safety Support Programme (MSSP), Mental Health Support, Workforce, Training and Education, etc.
- External bespoke support from a range of specialists for specific elements of work that are identified during the diagnostic phase.
- Financial turnaround support from a range of teams who can support with the financial recovery programme.

It is important to note that the Division or corporate team remain responsible for delivery and the recovery support programme will focus on ensuring the division or corporate team is leading the work that is required which mirrors the national and regional approach to recovery support. However, where capacity is an issue (rather than capability) the Recovery Support Board will do everything possible to secure the additional resources and capacity needed from across the organisation, system or from national teams to deliver improvement. Where capability is the issue, training will be put into place to build the required skills and expertise. Where necessary performance management will be instigated to address issues of poor performance in line with Trust policy.

Planning for sustainability and continued improvement: Alignment of the RSP to NHS IMPACT as the team prepare to transition to level 3 following the initial work

Improvement principle	Alignment
Building a shared purpose and vision	• As part of the recovery support programme the division will create a shared purpose and vision which will drive the improvement work and plan needed as they enter level 3 to progress towards level 2. • As part of this we will work collaboratively with our expert patients to ensure improvements are patient focused • The shared purpose and vision will be aligned to our Trust governance, resources, priorities, operating model and Single Improvement Plan
Investing in people and culture	The improvement plan will focus on: • Ensuring the division has a workforce strategy and plan to continue to drive improvements • Improving culture and colleague experience • Workforce productivity
Developing leadership behaviours	• Leaders across the division or corporate team in Level 4 will undergo the Trust's Improvement training to build the skillset required for adopting an improvement approach to the greatest challenges in line with national guidance. • Through the RSP we will ensure leaders across the organisation are focused on developing solutions for the most complex issues that will prevent transition to level 2
Building improvement capability and capacity	• Achieving sustainable improvement is key to progressing out of RSP to level 3 and continuing the improvement work to achieve level 2. The RSP will include a review of the improvement capacity and capability in the division/corporate team and a plan developed to build the skillset and expertise in the division/corporate team
Embedding improvement into management systems and processes	• Embedding improvement within Board governance, reporting, PMO functions and management processes is key for achieving RSP exit with sustainable improvement and this will form part of the improvement plan.

Appendix 2 Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Strategy and Planning			
Lead Assessor	Ailsa Brotherton			
What is being assessed?	Impact of document on equality.			
Date of assessment	29 July 2024			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☒
	Please give details: Senior Leadership Team			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact (Positive / Negative / Neutral)**	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non- belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		

Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights, social)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	Not applicable

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	**Lead**	**Timescale**
Not applicable		

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	☐
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	☐	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	☐
4. The patient will be at the heart of everything the NHS does.	☐	4. Provide support and opportunities for staff to maintain their health, wellbeing and safety.	☐
5. The NHS works across organisational boundaries.	☐	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	☐
6. The NHS is committed to providing best value for taxpayers' money.	√	6. To have a process for staff to raise an internal grievance.	☐
7. The NHS is accountable to the public, communities and patients that it serves.	√	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	☐
WHICH AIMS OF THE TRUST APPLY? Click here for Aims	**Tick those which apply**	**WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions**	**Tick those which apply**
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching and research.	√	3. Deliver value for money.	√
		4. Fit for the future.	√

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Establishment of Trust Management Board			
Report to:	Board of Directors	**Date:**	3 October 2024
Report of:	Company Secretary	**Prepared by:**	J Foote
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of the report is to set out the proposals for a new Trust Management Board. Such a board to comprise members of the executive and senior leaders and to act as the highest decision-making authority at a management level within the Trust.

It is recommended that the Board:

1. **Approves the establishment of a formal Trust Management Board together with the terms of reference as set out in this report.**
2. **Recognises that the authority granted in the terms of reference as an amendment to the Scheme of Reservation and Delegation (pending the inclusion of these requirements in a later planned revision).**
3. **Note the associated terms of reference of the Executive Management Team.**

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

Development sessions of Executive Management Team/Senior Leadership Team

1. Introduction

The corporate governance of the Trust comprises the Board of Directors, a number of assurance committees and several other committees that carry delegated authority. Below this corporate/strategic level a wide variety of management and operational groups exist. There has been a shift in NHSE corporate governance guidance to give some form and alignment and recognition of these high-level management committees through the establishment of a 'management board' or similar. This high-level operational group should act as the conduit between the strategic Board of Directors and the day-to-day management of the organisation, rather than a multiplicity of smaller management groups reporting directly into the assurance committees of the Board.

2. Background

Executive Management Team

To date the highest collective authority within the Trust below Trust Board and Committee level has been the Executive Management Team. The membership of the team includes all executive directors but has operated historically with no terms of reference and with any actual decisions resting with the CEO under both Standing Orders and the Scheme of Delegation.

Risk Management Group

This was established in March 2024, with a membership comprising senior leaders within the Trust and with a formal reporting route through to Audit Committee.

Divisional Forums

These were established in 2020/21 with a view to allowing a greater degree of autonomy and ownership of issues at management level. However, these can operate in silos and therefore not benefit from the fertilization of ideas or collective ownership that comes with a cross functional group.

Trust Management Board

In keeping with many trusts a proposal has been considered by both the EMT and senior leaders for the establishment of a formal meeting structure at management level that was both cross functional and that comprised of both executive members and senior leaders. The intent would be for the meeting to have some formal, delegated authority from the Board of Directors and a degree of accountability recognised in the Accountability Framework. Therefore, the naming convention of 'board' with the inherent assumption that this is a meeting of the highest level and with actual authority is proposed.

Proposal

An organogram of the corporate governance structure at the Trust, showing the Board of Directors, assurance committees and then how the established Risk Management Group, Executive Management Team and the newly formed Trust Management Board would fit into this is attached as appendix 1.

In order not to duplicate function, a formal set of terms of reference for EMT has been drafted to reflect the advisory nature of this group. These are set out at appendix 2.

It is proposed that the TMB will:

- be recognised as the formal decision-making authority at the highest management level.
- have a role in either approving business cases or testing business cases prior to referring them to the Board of Directors.
- have strategic oversight of trust plans.
- act as the oversight body for divisional forums.
- have a nimble, clearly defined membership.

The terms of reference of the TMB are set out as appendix 3.

Other Trust documents such as Scheme of Delegation and Reservation, SFIs and Business Case Approval Process will need to be amended to reflect that the TMB carries the authority to approve the award of contracts and business cases up to £1m (i.e. the authority level that currently rests with the CEO).

This is the first step in a wider review of the Trust's Scheme of Reservation and Delegation and SFIs that need to take place both to incorporate these amendments and to reflect any other imminent changes (for instance new procurement regulations due to be in place shortly). These revised documents will be brought back to the Board in February.

3. Financial implications

No additional resource required but there will be a number of amendments required to financial control documentation.

4. Legal implications

The establishment of the TMB is within the powers of the Trust.

5. Risks

There is a risk that the TMB may act outside its powers or seek to increase its authority. TMB is serviced from the Corporate Affairs Team to ensure a high level of corporate governance oversight. The Terms of Reference cannot be amended other than by the Board of Directors to ensure that the authority of the TMB remains appropriate.

6. Impact on stakeholders

The establishment of the TMB evidences a maturity of corporate governance processes and demonstrates an inclusivity of leadership that should deliver a positive benefit for the Trust.

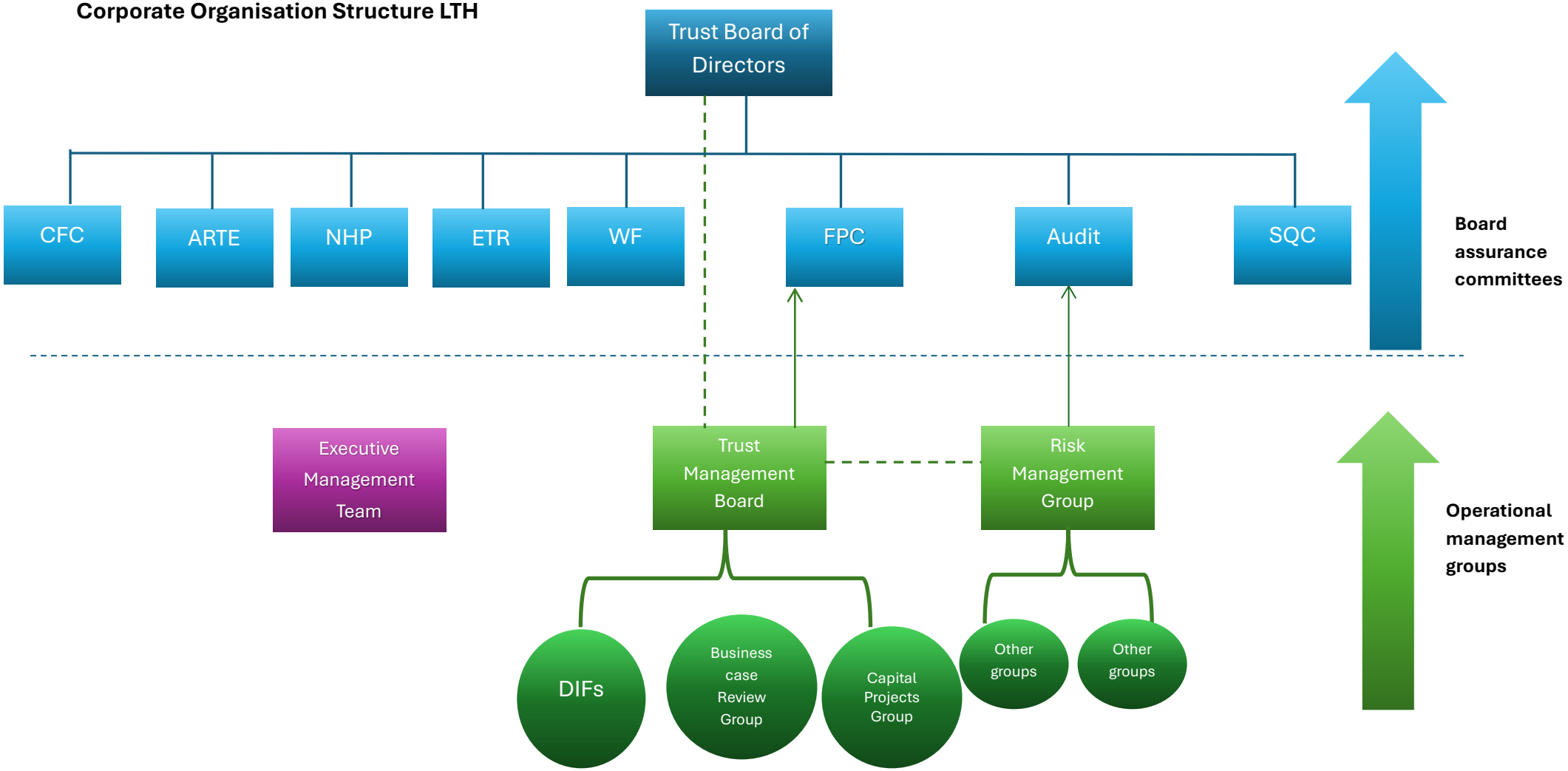
7. Recommendations

It is recommended that the Board:

1. Approves the establishment of a formal Trust Management Board together with the terms of reference as set out in this report.
2. Recognises that the authority granted in the terms of reference as an amendment to the Scheme of Reservation and Delegation (pending the inclusion of these requirements in a later planned revision).
3. Note the associated terms of reference of the Executive Management Team.

Appendix 1

Corporate Organisation Structure LTH



Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust
Executive Management Team
Terms of Reference

The Trust Management Executive is established by the Chief Executive as a forum for strategic debate, advice and counsel within the Lancashire Teaching Hospitals NHS Foundation Trust.

1. Purpose

The Trust Management Executive is accountable to the Board of Directors through the Chief Executive for the operational management of the Trust. It is the formal mechanism for supporting the Chief Executive in effectively discharging his/her responsibilities as Accounting Officer

2. Membership

2.1 Membership of the EMT shall be decided by the CEO and shall ordinarily correspond to those VSM posts with oversight exercised by the ARTE committee of the Board.

2.2 The CEO shall act as Chair of the EMT (and in his absence another member of the EMT shall be nominated by the CEO to take the chair). In the absence of a nomination the EMT shall agree one of those present to chair.

3. Quorum

3.1 Four, including either the CEO or DCEO or CNO/CMO. Nominated deputies will count toward the quorum.

4. Attendance

4.1 Staff and others may attend by the invitation of the chair as required. The Executive Administration Team will service meetings.

5. Frequency of Meetings

5.1 Meetings shall be convened ordinarily on Mondays and Wednesdays.

5.2 Additional meetings may be scheduled as necessary to effectively manage the business of the Trust as determined by the chair.

6. Decision Making

6.1 The EMT may from time to time have delegated authority as set out in the Trust Standing Financial Instructions and Scheme of Reservation and Delegation.

6.2 Other than authority as set out above the EMT shall act in an advisory capacity, with any decision resting with the CEO as Accounting Officer.

7. Remit

The EMT shall

7.1 Be responsible for the delivery of the Single Improvement Plan and Financial Recovery Plan (or similar as may be required from time to time).

7.2 Consider and advise the CEO on Trust strategy or the position of the Trust in respect to partnership, collaborative and system working or on any associated matter as may be put forward for consideration by the CEO.

7.3 Receive the report of the Risk Management Group and consider any matters referred to it by that group.

7.4 Inform the reports to Trust Board and its assurance Committees.

8. Variation, Revocation and Review

8.1 These terms of reference may be varied or revoked at any time at the discretion of the CEO and shall be reviewed annually.

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust
Trust Management Board
Terms of Reference

The Trust Management Board is established by the Trust as the senior cross functional operational group within the Lancashire Teaching Hospitals NHS Foundation Trust.

1. Purpose

The Trust Management Board is accountable to the Board of Directors through the Chief Executive for the coordination and operational management of the system of internal control and for the delivery of the objectives set by the Board of Directors.

This is undertaken through:

- providing leadership in decision making
- creating a team approach in responding to opportunities and challenge
- supporting effective continuous improvement and transformation
- developing and delivering the cultures, values and behaviours of the organisation

2. Membership

2.1 Membership of the TMB shall comprise the following posts (or their equivalent) and shall be decided by the CEO:

Chief Executive Officer
Chief Finance Officer
Chief Medical Officer
Chief Nursing Officer
Chief Operating Officer
Chief People Officer
Director of Continuous Improvement
Director of Strategy and Planning
Director of Communications and Public Relations
Company Secretary
Divisional Directorates
Chief Pharmacist
Chief AHP
Director of Estates

2.2 The CEO shall act as Chair of the TMB (and in his absence a member of the Trust Executive shall take the chair).

2.3 Clause 2.1 may be amended at the discretion of the CEO from time to time to reflect the change in role title or remit of role, but an increase in membership shall be taken as a material revision requiring the approval of the Board of Directors.

3. Quorum

3.1 Eight, including at least two representatives from the Trust Executive, and at least one from each of the divisional directorates.

3.2 Nominated deputies may not ordinarily attend. However. Each of the following may send an alternate member in their absence, providing that the alternate member represents the portfolio of the original member:

Chief Finance Officer

Chief Medical Officer

Chief Nursing Officer

Chief Operating Officer

Chief People Officer

3.3 If quoracy is not in place at the start of the meeting, or if the meeting falls below quoracy during proceedings then the meeting will not be deemed to be properly constituted and no record will be kept. Business from an inquorate meeting will be either deferred for consideration at the next ordinary meeting, or a further meeting will be arranged as soon as possible to effect the business of the non-quorate meeting.

4. Attendance

4.1 Staff and others may attend by the invitation of the chair as required. The Corporate Affairs Team will service meetings.

5. Frequency and Format of Meetings

5.1 Meetings shall be convened ordinarily every month.

5.2 Additional meetings may be scheduled as necessary to effectively manage the business of the Trust as determined by the chair.

5.3 The meetings may be held in person or virtually at the discretion of the Chair.

6. Decision Making

6.1 The TMB has delegated authority as set out in the Trust Standing Financial Instructions and Scheme of Reservation and Delegation.

6.2 If a decision is required as a matter of urgency that cannot reasonably wait until the next meeting, the CEO (or in his/her absence the DCEO) shall have authority to decide the matter. This decision must be reported to the next meeting of the TMB.

6.3 A decision of the TMB may be given effect by written resolution on the advice of the Company Secretary. For a written resolution to be valid it must be issued to all standing members of the TMB in writing with a notified longstop date for decision no later than 5 working days after the notification of the written resolution. The resolution shall be valid upon receipt of a majority of responses as if given at a quorate meeting.

7. Business

The TMB shall:

7.1 Contribute towards the development of the Trust Strategic Plan.

7.2 Monitor the delivery of the Trust strategic goals and plans.

7.3 Monitor of Trust performance across all key metrics (including the SIP and any regulatory action plans).

7.4 Approve, via the Business Case Review Group business cases to deliver key Trust strategic objectives and business plan which are below £1m and recommend to the Board of Directors via the Finance and Resources Committee, any above £1m.

7.5 Approve any policies for which the Board is recognised as the designated approval authority.

7.6 Consider any matters referred to it by either the Risk Management Group or Executive Management Team.

7.7 Receive regular updates from Executive Directors to ensure effective operational integration with the following:

− Trust policy & strategy

− National & local strategies, policies and developments

− Legal issues

7.8 Undertake scrutiny and oversight of the Divisional Improvement Forums, including receiving any minutes, chairs, and other reports therefrom.

7.9 Receive 3A reports from operational management led groups as may be decided from time to time.

8. Reporting

8.1 The TMB shall report through to the Finance and Performance Committee for information using the 3A format.

9. Variation, Revocation and Review

9.1 These terms of reference may be varied or revoked at any time solely at the discretion of the Trust Board of Directors and shall be reviewed on alternate years.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Allied Health Professionals Bi-annual Safety & Quality Review

Report to:	Board of Directors	**Date:**	3 October 2024
Report of:	Chief Nursing Officer	**Prepared by:**	C. Granato

Purpose of Report

For assurance		**For decision**	☐	**For information**	x

Executive Summary:

The purpose of this report is to detail the findings of the Lancashire Teaching Hospitals (LTH) bi-annual Allied Health Professionals (AHPs) workforce safeguards review for the reporting period of December 2023 to May 2024.

The report includes several workforce developments and celebrations, despite the current financial challenges. These include:

- A successful first 5 months for the therapy admission avoidance service at Preston, the team have avoided 248 admissions which could translate to 12 less beds being open if demand was not exceeding capacity, in the current circumstances this will have led to less boarded patients and less patients waiting in the ED for a bed. Financially the bed saving equates to £1.2m, with the cost of the team already removed. A full data summary can be found in appendix 1.
- 2 of the internationally recruited Occupational Therapists have progressed from band 5 to band 6 positions within 12 months of commencing at LTH and in turn are filling the intended supply gap.
- Apprenticeship standards are now in place for 9 out of the 10 AHPs and from September 2024 we will have apprentices in all 9 of these areas, supporting the future supply chain.

Vacancy rates and trends continue to be captured using statistical process control (SPC) charts. Over the past 6 months 6 professions have maintained low vacancy rates and have no immediate supply concerns, their charts are in appendix 2. In section 4.4 further narrative is provided on 4 professions, the first is a positive narrative, Dietetics have successfully recovered from a 15% vacancy rate and are almost fully established (0.34WTE vacancy). This is due to their successful re-structure within budget making positions more attractive and a new local supply of graduates from UCLAN, resulting in all band 5 positions being filled for the first time in 2 years.

Physiotherapy has become a new area of concern with a slowly rising vacancy rate, they had maintained a rate of 2-3% between September 2022 and November 2023, since then is has increased and in May was 9%. A low rate was maintained last year due to permissions to over offer to new graduates who then went onto fill gaps as they arose through the year, permission was not granted to do this in summer 2023, but has now been agreed for 2024 and this should ensure an improved vacancy position by the end of the year. Occupational Therapy and Speech and Language Therapy remain a concern but are both heading in the right direction after experiencing supply issues last year and both report recent successful recruitment which will close the gaps further.

Maternity leave rates are minimal and no specific professions reporting pressures as a result. Absence rates with the exception of 2 areas are within the Trust target, ODP absence remains high but is 50% less than the last reporting period and remains an area of focus the Theatres SBU. It is unusually high is Prosthetics and Orthotics due to 2 long term absences relating to sudden illness, both are being managed as per policy.

The annual benchmark of specific AHP teams to national staffing guidelines is located in section 4.6. There are no significant changes compared to 12 months ago. In summary, the Trust is compliant with the Royal College of Physician AHP guidelines in Stroke and the teams are delivering a 6 day service with excellent outcomes. In Critical Care there is a gap of 7.91WTE across the 4 professions included and therefore unmet need which is evident in the Datix summary in section 6.3. In Neonatal there is a gap of 2.45WTE across the 4 professions and the banding of all but one of the positions are not at the recommended 8a level.

Key areas of improvement linked to safety and quality include STAR outcomes, with 1 further gold STAR achieved in Main X-ray CDH, resulting in all 13 AHP departments in the accreditation process now having a gold STAR. In addition to this all Theatre areas have also achieved their gold STARs, ODPs largely contribute to the performance of these areas. Although important to note that this is likely to be short lived due to imminent changes to the accreditation process, where some areas may be downgraded. Datix reporting remains consistent, with the majority attributed to Occupational Therapy and Physiotherapy (Core Therapies collectively). Critical Care, Burns and Plastics, Neurosurgery and Acute Medicine are the clinical areas with the highest number of incidents reported as a result of workforce shortages and this correlates with the risk register.

Essential training compliance is improved compared to previous reporting periods and many red rated metrics are within 5% of achieving compliance, further focus is required on the practical elements for basic life support and moving and handling. The action plan in appendix 4 details mitigation and plans to address all areas of concern and appendix 3 details the profession specific positive and negative escalations to the committee.

Recommendation

The Board of Directors is asked to receive the AHP bi- annual report for information noting the Safety and Quality Committee has confirmed it is assured of the workforce safeguards in place for AHPs and will receive a further report in line with the Workforce safeguards in 6 months' time.

Appendix 1 –Therapy Admission Avoidance Team Data Summary
Appendix 2 – AHP Vacancy SPC Charts
Appendix 3 –Profession specific positive and negative escalations
Appendix 4 – Action plan

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

1.0 INTRODUCTION

This report details the findings of the Lancashire Teaching Hospitals (LTH) Allied Health Professionals (AHPs) staffing review, for the reporting period December 2023 to May 2024. This report is in response to the 2018 'Developing Workforce Safeguards' recommendations and also meets the recommendations in relation the AHP governance arrangements from the 2019 NHSE/I 'Guide to Reviewing AHP Leadership for Trust Boards and Clinicians'.

The review triangulates workforce information with safety and quality indicators in order to provide assurance of safe staffing levels within the AHP services.

There are currently no specific guidelines or frameworks for AHP workforce safeguards, therefore professional judgement and national/local benchmarking are heavily relied on. Four clinical specialities do have workforce guidelines covering Physiotherapy, Occupational Therapy, Dietetics and Speech and Language Therapy. These include Critical Care, Stroke, Neurology Rehabilitation and Neonatal Intensive care.

2.0 SCOPE

All 10 Allied Health Professional groups at Lancashire Teaching Hospitals, across both inpatient and outpatient pathways. The 10 professions are; Dietitians, Occupational Therapists, Operating Department Practitioners (ODP's), Orthoptists, Physiotherapists, Prosthetists & Orthotists, Diagnostic Radiographers (including Sonographers), Therapeutic Radiographers and Speech & Language Therapists.

3.0 METHODOLOGY

A triangulated approach to the review of staffing has been undertaken by the Chief AHP supported by the Chief Nursing Officer. In the absence of national guidance findings within the review have been cross checked using professional judgement and benchmarking data where appropriate.

4.0 WORKFORCE

4.1 Leadership

The Chief AHP is the most senior AHP in the trust and provides clinical, professional and strategic leadership to the AHP services. This includes the 9 AHP Professional Leads/Heads of Service and 1 Matron (ODP).

The Chief AHP is currently in a secondment 2 days per week as the joint NMAHP lead for the New Hospitals Programme. A Deputy Chief AHP commenced in post September 2021 and is currently contracted until April 2025. The Chief AHP reports to the Chief Nursing Officer.

4.2 Current Workforce Development and Planning

<u>Therapy Admission Avoidance Service</u>

The therapy admission avoidance service commenced in January 2024 and in the last report to the committee promising early data was shared for the first month. It was requested that a further summary is included in this report. The service commenced 5 days per week from January and since February has provided a 7 day service to the ED and all assessment units (except the acute frailty unit (AFU) as the LIFT service cover this). The team have prioritised admission avoidance and in addition provided therapy to other high risk patients on the medical assessment unit (MAU) who were not yet medically optimised. Appendix 1 contains slides summarising the first 6 months of the service. Highlights include:

- 248 admissions avoided and 403 additional patients receiving therapy.
- A reduction in missed opportunities over time through collaborative working with community partners.

- Increased 0 day and 1<2 day lengths of stay on the MAU.
- Average annualised bed saving of 11.8 (excluding January data as this was only a 5 day service) using the average LoS in specified Medicine wards during 2023 and if all other factors remained equal.
- This could translate into an estimated financial recurrent saving of £1.5m, minus the current team cost of £330k.

Further expansion of the service is planned at no extra cost, due to a merger of the therapy admission avoidance team and the LIFT therapy team. These 2 teams will integrate from July 1st and become known as the admission avoidance and frailty therapy team (AAFTT). By merging both workforces, efficiencies can be created and the service expanded to Chorley ED and MAU (over 5 days) and a 7 day service will be provide to the AFU (along with RPH ED and all other assessment areas).

International Recruitment Promotions

In the last report to the committee the successful international recruitment of 3 Occupational Therapists was detailed, all commenced in band 5 positions to allow them to induct and adjust to the NHS and local ways of working. All 3 have settled in well and have been great assets to the Occupational Therapy department, recently 2 of the 3 have applied for and been successful in band 6 promotions. International recruitment was initially explored to support the band 6 supply issues we were experiencing, therefore it is positive to see that after a short time 2 have progressed from band 5 to 6 and it is likely the 3rd candidate will later this year.

Apprenticeship Development

Apprenticeship standards for AHPs continue to be developed and approved at pace and the number of AHP apprentices at LTH is slowly rising. More apprentices would be recruited if there was an alternative salary funding source for the training period, currently band 5 vacancies are being held to allow these opportunities to be offered.

From September 2024 there will be AHP apprentices in the following areas; ODP, Physiotherapy, Occupational Therapy, Diagnostic Radiography, Therapeutic Radiography, Dietetics, Prosthetics/Orthotics and Speech and Language Therapy. Orthoptics is currently the only area without approved apprenticeship standards but these are in development.

4.3 Specialist AHP Roles

Table 2 – AHP Specialist Roles

Role	Number						Comments
	Sept 21	Mar 22	Nov 22	May 23	Nov 23	May 24	
Consultant AHP	7	7	8	8	8	8	2 Speech & Language Therapist 3 Therapeutic Radiographer 1 Sonographer 2 Physiotherapist
ACP/ASP (Trainee and qualified)	12	12	12	15	17	18	11 Physiotherapist 1 Occupational Therapist 4 Therapeutic Radiographer 2 Speech & Language Therapist
Research	2	2	3	2	3	2	2 Physiotherapist

Other roles (where being an AHP is not part of the essential criteria)	6	7	7	8	9	9	1 Matron (ODP) 2 SBM's (Therapeutic Radiographer & Orthoptist) 1 CI Fellow (Physiotherapist) 1 CD (Therapeutic Radiographer) 1 DD (previously a Diagnostic Radiographer) 1 Board Member (previously a Dietitian) 2 Education (Therapeutic Radiographer & Physio)
Total	25	28	30	33	37	37	

Table 2 positively evidences AHPs are taking on advanced and Consultant practice roles in the organisation and also crossing professional boundaries. In the last 6 months 1 Physiotherapist has taken up a new role in Advanced Practice (Frailty) and 1 seconded Physiotherapist in Research has returned to their substantive position.

These metrics are a core component of developing services of the future whilst maximising the offer of AHPs in shaping services delivered through an evolving and multi-professional team. These will be monitored and a continued upward trend is predicted based upon many roles in the organisation being open to registered professionals with the correct skills and experience.

4.4 Workforce Metrics

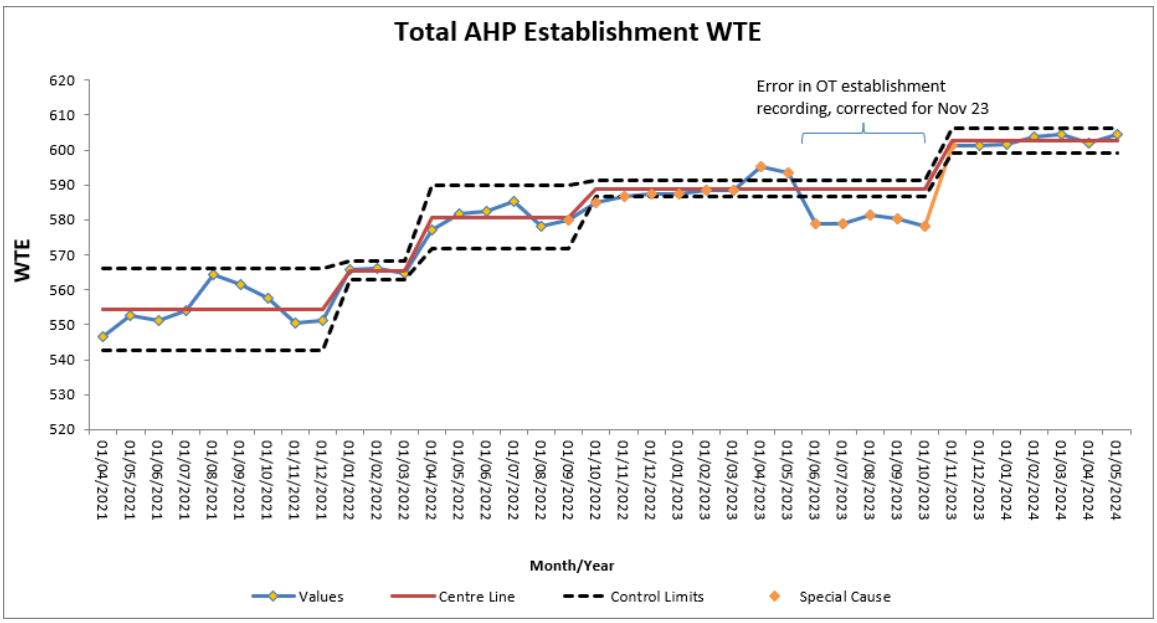
Registered AHP Establishment

The following workforce metrics are taken from ESR. Owing to a previous ESR cleanse, we are assured that our AHPs are aligned to the correct occupational codes.

There are 2 main limitations of the ESR data set for AHPs, firstly the Prosthetist and Orthotists cannot be split out as they have the same occupational code. Secondly, the ODP data does not accurately describe establishment/vacancy as any vacant posts are advertised to Nurses and ODP's and budget lines then moved around dependent on the outcome.

Recording and displaying of AHP establishment and vacancy data is displayed over time using statistical process control (SPC) charts.

Graph 1 – AHP Establishment April 2021 Onwards



Over the 6 month reporting period the total AHP establishment has remained static, with an overall +3wte position across 10 staff groups, which is attributed to an increase of ODPs into theatre practitioner roles (and a reduction of Nurses).

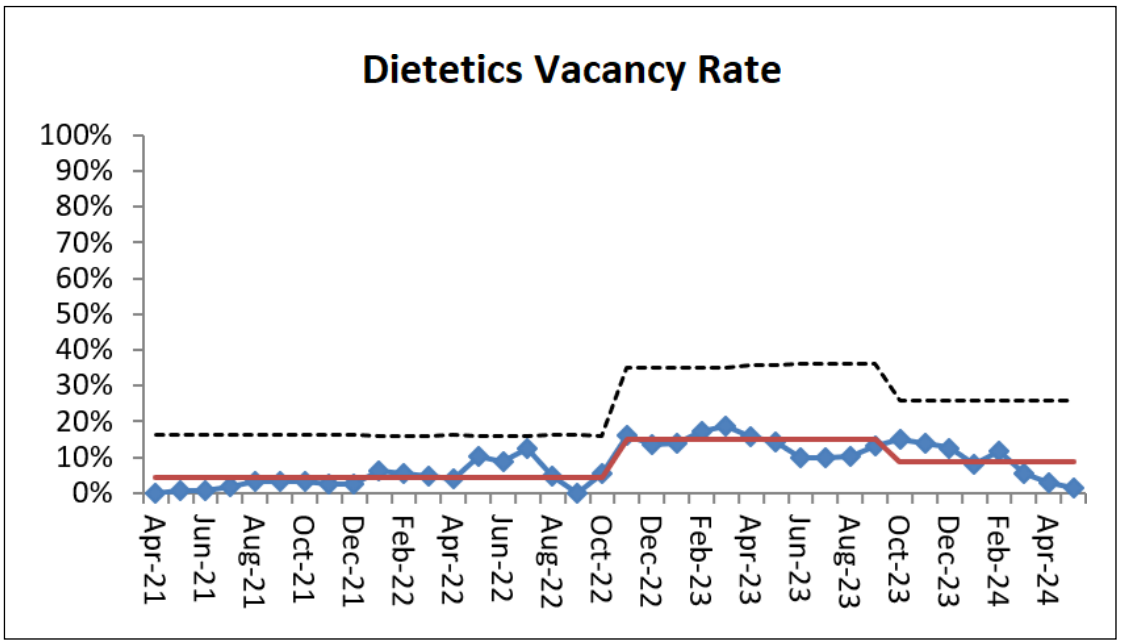
Reporting from June 2023 – October 2023 is inaccurate due to movement of Occupational Therapy establishment to fund the new admission avoidance service, in turn this removed the profession specific code from ESR and prevented it being included in reporting. This has been corrected from November 2023 to ensure Occupational Therapy establishment can be reported correctly.

Vacancy Rate

The majority of AHP areas are maintaining low vacancy rates and meeting the Trust's target, their vacancy SPC charts can be found in appendix 1.

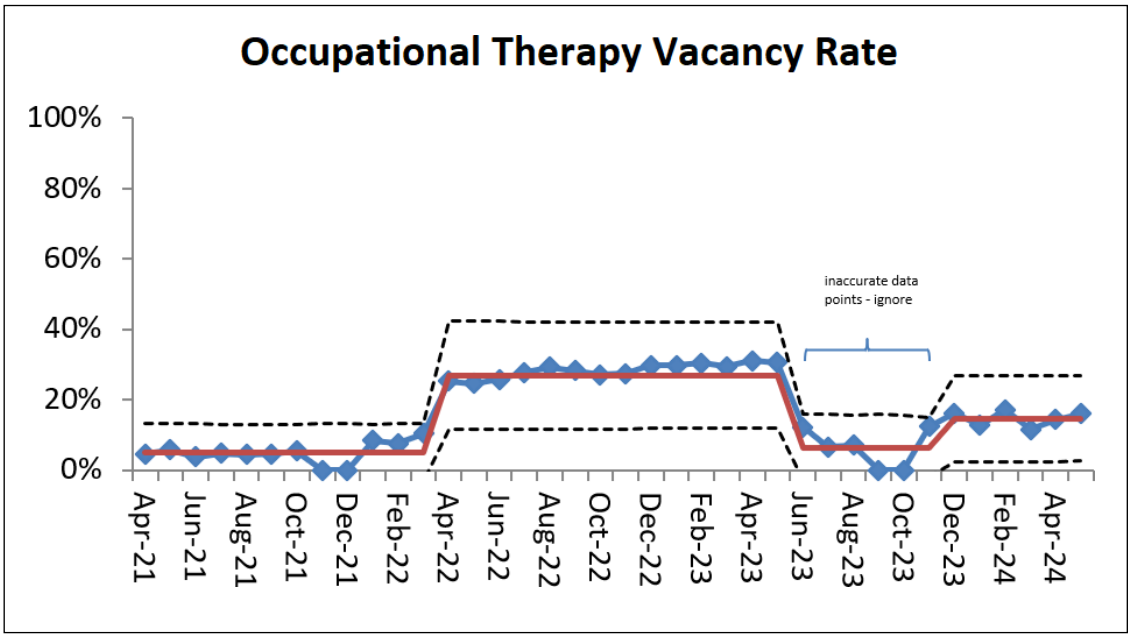
There are 4 specific areas to provide more detail on, 1 due to the much improved vacancy position and 3 as areas of concern.

Graph 2 – Dietetics Vacancy Rate April 2021 to May 2024



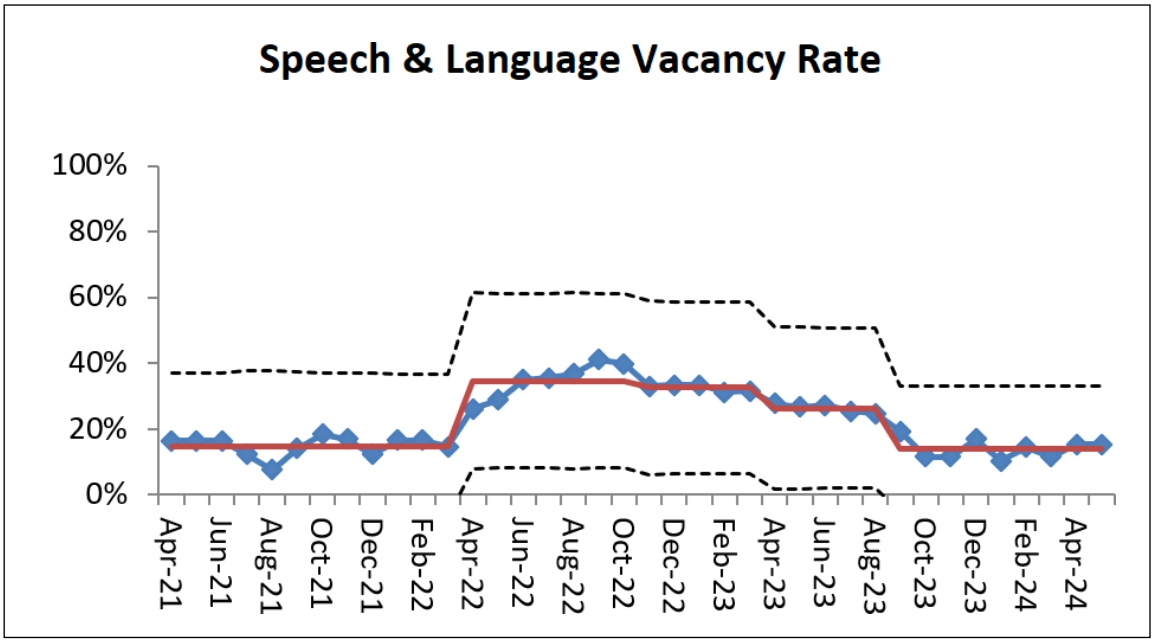
Dietetics is now in a much more positive position; over the past 8 months the vacancy has gradually reduced from 15% down to 1% (0.34wte). This is the first time in 2 years that Dietetics have been fully established and there are currently no planned leavers. This is partly owing to new local graduates and all of the band 5 positions fully recruited to.

Graph 3 – Occupational Therapy Vacancy Rate April 2021 to May 2024



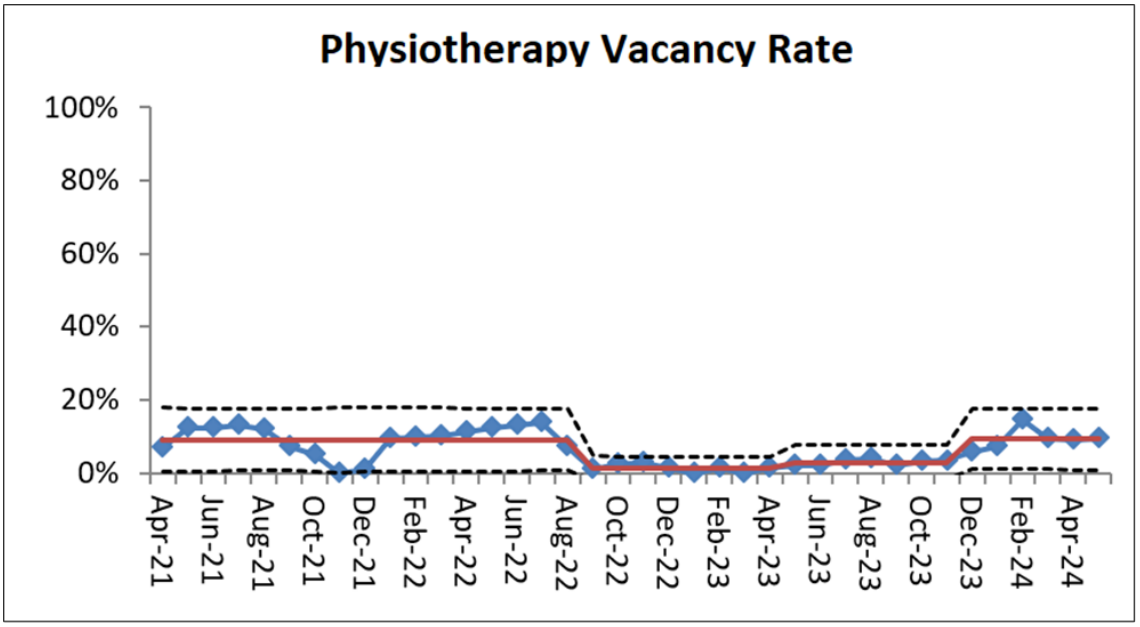
There are now 7 months of correct data points for Occupational Therapy, following the ESR error. The vacancy rate is approximately 50% lower than this time last year, it was 14% in May compared to a high of 31% in April 2023. A further reduction is expected based on recent recruitment and permission to over offer, however, it still requires continued focus as it remains above the Trust target.

Graph 4 – Speech and Language Therapy Vacancy Rate April 2021 to May 2024



Overall, Speech and Language Therapy are showing an improved position from a high or 41% 2 years ago to between 11-15% the past few months, which is 3-4WTE. It does remain above the Trust target and still requires focus and careful planning. There has been recent successful recruitment to 3 band 7 posts which will further improve the position.

Graph 5 – Physiotherapy Vacancy Rate April 2021 to May 2024



Between September 2022 and November 2023 Physiotherapy had maintained a vacancy rate of between 2-3%, in the main this was due to successful over recruitment of new graduates who commenced in post September 2022. Unfortunately, the same agreement was not reached in 2023 and therefore only established posts for band 5's were offered, this has resulted in a rising vacancy rate since December 2023 and it is currently 9.3%. An improved position is predicted for late 2024 onwards as an 'over offer agreement' has been supported by the Board and recruitment is underway. The vacancy trend in Physiotherapy supports the annual approval of over offer requests for AHPs, as it is the most effective and efficient way of maintaining low vacancy rates without overspending.

Maternity Leave Rate

Table 2 – Maternity Leave by Profession December 2023 – May 2024

Profession	Dec 23 (wte)	Jan 24 (wte)	Feb 24 (wte)	Mar 24 (wte)	Apr 24 (wte)	May 24 (wte & %)	Trend/ RAG Rating
Dietetics	0.80	0.80	0.80	0.80	0.80	0.80 3.2%	Static
Occupational Therapy	2.35	3.20	3.20	3.20	3.20	3.2 5%	Static
ODP's	0.76	0.76	0.76	0.76	0.76	0.17 0.3%	Static
Orthoptics	0	0	0	0	0	0 0%	Static
Physiotherapy	4.38	3.96	3.96	3.55	1.90	1.54 1.6%	Reducing
Prosthetics & Orthotics	0.53	0.53	0.53	0.53	0.53	0.53 3%	Static
Diagnostic Radiography	5.00	5.00	4.10	3.00	3.00	3.00 2%	Reducing
Therapeutic Radiography	1.09	1.00	1.00	1.00	1.47	1.61	Static

						1.8%	
Speech & Language Therapy	2.32	3.00	3.00	3.00	3.00	3.00 12%	Static

During this reporting period, the impact of maternity leave is minimal. Speech and Language Therapy is the only red rated area, however, 2 of the 3 current maternity leaves are set to return by September.

All AHP leads are proactively covering their maternity leaves where possible. Authority to recruit substantively to maternity leave (when indicated) aims to improve impact and recruitment within these specialties.

Absence

Table 3 – Absence by Profession December 2023 – May 2024 (combined long term and short term)

Profession	Dec 23 (wte)	Jan 24 (wte)	Feb 24 (wte)	Mar 24 (wte)	Apr 24 (wte)	May 24 (wte)	May RAG Rating
Dietetics	1.18	2.08	2.11	2.05	1.24	1.13	4.6%
Occupational Therapy	2.32	3.24	2.66	3.21	2.15	2.56	3.9%
ODP's	6.40	7.39	4.06	5.05	5.56	5.17	8.9%
Orthoptics	1.03	0.83	1.39	0.68	0.67	0.35	2.7%
Physiotherapy	3.58	4.71	4.37	5.14	3.13	2.84	2.9%
Prosthetics & Orthotics	0.06	1.16	0.78	0	1.68	2.25	12.8%
Diagnostic Radiography	4.44	3.55	4.67	5.76	4.83	5.70	3.9%
Therapeutic Radiography	1.83	3.73	4.43	4.30	2.59	2.73	3.1%
Speech & Language Therapy	1.56	1.47	1.11	2.18	1.50	1.06	4.2%

Absence rates in May for 6 AHP groups are meeting the Trust target. Dietetics are slightly outside of the target, however, this is due to just 1 long-term absence and their small establishment.

Unusually, Prosthetics and Orthotics are seeing a higher than normal absence rate, this is due to 2 long-term absences linked to unexpected ill health and both are being managed accordingly. Being a small department (17wte) this results in a high percentage.

ODP absence rates continue to be a concern, although gradually reducing and 50% lower than November 2023. This continues to be an area of focus for the Theatres SBU.

4.5 Overtime, Bank and Agency Usage

Overtime is the main source of additional resource for the AHPs, there is an identified gap in AHP bank services.

Overtime in Diagnostic Radiography and ODPs is high and correlates with their role in the elective recovery programme and for ODPs at times high absence rates.

The current AHP agency market is poor, even with approval to use, often no candidates cannot be sourced. In May 2 of the 10 AHPs utilised agency, with ODPs being the main user.

Table 4 – May WTE of overtime

Profession	May 24 Overtime (wte)	May 24 Bank (wte)	May 24 Agency (wte)
Dietetics	0.21	0	0.28
Occupational Therapists	0.56	0.14	0
ODP's	2.63	0.84	4.17
Orthoptists	1.35	0.65	0
Physiotherapy	0.56	0.62	0
Diagnostic Radiographers	3.93	0.43	0
Therapeutic Radiographers	0.78	0.28	0
Speech & Language Therapy	0.09	0.28	0

4.6 Safe Staffing for Specialties with Guidelines

As described in section 1, there are 3 specialty areas for 4 AHP groups that have specific staffing ratio guidelines. In the August 2023 report to the committee the Trust's position against these guidelines was included, along with the history of funding. In this report the benchmark is included along with narrative on any changes over the past 12 months.

Critical Care

Guidelines for the Provision of Intensive Care Services (GPICS 2022) provide AHP recommended staffing levels for Intensive Care Units. The guidelines provide whole time equivalent (WTE) for level 2 and 3 beds, there are no recommendations for level 1 beds, therefore professional judgment is sought.

Over the past 12 months the 34 beds have remained in use, therefore table 6 is the current benchmark. There has been no increase in AHP establishment over the past 12 months and there is currently no plan to gain compliance against GPICS (7.91wte gap). There is a risk register item to reflect this gap and its impact (risk ID 1701 detailed in section 6.2)

The teams continue to work as efficiently as they can within the available resource however this does lead to patients being unable to receive therapy on some days within critical care when resource needs to be prioritised. (see table 11 in section 6.3).

Table 5 – AHP Critical Care Staffing 28 Beds

AHP Group	GPICS Recommended Ratios	Requirement for 28 beds	Total Requirement	Current Establishment	Current Gap
Physiotherapy	0.25wte per bed	16 x L3 = 4 12 x L2 = 3	7wte	6wte	1wte
Occupational Therapy	0.22wte per bed	16 x L3 = 3.52 12 x L2 = 2.64	6.16wte	2.77wte	3.39wte
Dietetics	0.1wte per bed	16 x L3 = 1.6 12 x L2 = 1.2	2.8wte	2.4wte	0.4wte

Speech & Language Therapy	0.1wte per bed	16 x L3 = 1.6 12 x L2 = 1.2	2.8wte	1.92wte	0.88wte

Table 6 – AHP Critical Care Staffing 34 Beds

AHP Group	GPICS Recommended Ratios	Requirement for 34 beds	Total Requirement	Current Establishment	Current Gap
Physiotherapy	0.25wte per bed	18 x L3 = 4.5wte 12 x L2 = 3wte 4 x L1 = 0.5wte	8wte	6wte	2wte
Occupational Therapy	0.22wte per bed	18 x L3 = 3.96wte 12 x L2 = 2.64wte 4 x L1 = 0.4wte	7wte	2.77wte	4.23wte
Dietetics	0.1wte per bed	18 x L3 = 1.8wte 12 x L2 = 1.2wte 4 x L1 = 0.2wte	3.2wte	2.4wte	0.8wte
Speech & Language Therapy	0.1wte per bed	18 x L3 = 1.8wte 12 x L2 = 1.2wte 4 x L1 =0.2wte	2.8wte	1.92wte	0.88wte

Stroke

The Royal College of Physicians (RCP) national clinical guideline for stroke (2016) provides AHP recommended staffing levels for stroke units, the recommended ratios are based on a 5-day provision and require uplifting for 6 or 7-day services.

Table 7 evidences compliance against RCP guidelines for 5 day services, with extra WTE in some groups to enable 6 day working and to compensate for duel site cover (acute at RPH and rehab at CDH). This is a positive benchmark and has resulted in the Sentinel Stroke National Audit Programme (SSNAP) scores relating to AHPs reaching an 'A'.

Table 7 – AHP Stroke Staffing Mapped to RCP Guidelines

AHP Group	RCP Recommended Ratios	Beds	Total Requirement	Current Establishment	Current Gap
Physiotherapy	0.84wte per 5 beds	25 Acute 24 Rehab	8.2wte	8.2wte	0 >Currently working 6 days.
Occupational Therapy	0.82wte per 5 beds	25 Acute 24 Rehab	8.0wte	9.3wte	0 >Currently working 6 days.
Dietetics	0.15wte per 5 beds	25 Acute 24 Rehab	1.47wte	1.5wte	0
Speech & Language Therapy	0.40wte per 5 beds	25 Acute 24 Rehab	3.92	5wte	0 >funded for 6 day working to allow for a 1 in 5 rota
AHP Trainee Assistant Practitioners	No guidance	-	-	4wte	0

Neonatal

The professional bodies for the AHPs each provide guidance on the recommended staffing ratios per neonatal cot. These are summarised in the North West Neonatal Operational Delivery Network (NWNODN) Toolkit: Building a sustainable neonatal team.

Table 8 is reflective of the current workforce benchmark, this remains unchanged over the past 12 months, with a gap of 2.45wte. In early 2024 the Speech & Language Therapy position for Neonatal was re-banded (within budget) from 7 to 8a, to match professional recommendations and retain a highly skilled member of staff. There are still aspirations in the other professions to do the same should funding become available.

Table 8 – AHP Neonatal Staffing Mapped to Professional Guidelines

AHP Group	Recommended Cot Ratios	WTE Requirement for Cots	Total Requirement	Current Establishment	Current Gap
Physiotherapy	0.03-0.05 wte per IC/HD/SC	IC x 6 = 0.18-0.3 HD x 9 = 0.27-0.45 SC x13 = 0.39-0.65	0.84 – 1.4	0.6wte	0.24-0.8wte
Occupational Therapy	0.05-0.1wte per IC 0.025-0.05wte per HD 0.025-0.05wte per 2 SC	IC x 6 = 0.3-0.6 HD x 9 = 0.23-0.45 SC x13 =0.16-0.0.33	0.69 – 1.38	0.7wte	0-0.68wte
Dietetics	0.05-0.1wte per IC 0.025-0.05wte per 2 HD 0.017-0.033 per 3 SC	IC x 6 = 0.3-0.6 HD x 9 = 0.11-0.23 SC x13 =0.07-0.14	0.48 – 0.97	0.7wte	0-0.27wte
Speech & Language Therapy	0.04wte per IC/HS/SC 0.02wte per TC	IC x 6 = 0.24 HD x 9 = 0.36 SC x13 =0.52 TC x 4 = 0.08	1.2	0.5wte	0.7wte

5.0 TRAINING

5.1 Training Compliance

Mandatory staff training compliance as of May 2024 (table 9) provides assurance of compliance in most training requirements for all AHP areas. There are 18 red rated metrics in the table, however 13 of these are within 5% of the target compliance. There are actions plan in place in red rated areas for recovery of compliance.

Physiotherapy, Occupational Therapy and Orhtoptics are currently the only areas that can separate the registered AHPs out and report accurate compliance. There are some limitations to the report for the other AHPs:

- Diagnostic Radiographers and ODP's are reported on below using SBU Radiology and SBU Theatres, this is due to how the department's budget codes are organised and splitting them out would be a large task.
- The Prosthetists and Orthotists, Dietitians, Speech and Language Therapists and Therapeutic Radiographers are a mixture of registered AHPs, non-AHPs, non-registered support staff and admin staff.

Table 9 – Training metrics by Profession May 2024

Metric	Information governance	Conflict resolution	IPC	H&S	Fire	Adult BLS	Appraisal	SG Adult 2	SG Adult 3	SG Children 2	SG Children 3	M&H	Prevent
Profession	%	%	%	%	%	%	%	%	%	%	%	%	%
Dietitians	100	97	90	95	90	86	79	97	90	91	100	80	97
Occupational Therapists	96	98	94	92	96	90	90	97	100	92		90	97
ODP's (Theatres)	96	99	96	98	97	96	94	98	98	99		94	97
Orthoptists	100	100	100	94	94	88	89	100		100		77	94
Physiotherapists	94	100	91	97	94	93	87	100	96	97	100	88	98
Prosthetists & Orthotists (SMRC)	100	100	100	99	100	98	87	100	100	98		96	100
Diagnostic Radiographers & Sonographers (Radiology)	96	100	96	97	97	81	91	99	89	98	100	88	98
Therapeutic Radiographers	89	100	89	95	93	78	90	99	100	99		90	96
Speech & Language Therapists	96	100	91	96	96	86	88	100	100	100	100	91	95

6.0 GOVERNANCE

6.1 Star accreditation

Findings from the recent STAR Quality Assurance accreditation visits are highlighted in the table 10. 9 of the 10 AHPs are part of the accreditation process, with 13 AHP departments accredited. AHPs contribute towards achieving STAR standards in each department they are present.

For the first time since STAR accreditation commenced all 13 AHP departments have been awarded their gold status. There are planned changes to the accreditation process, to ensure ratings are fully reflective of the departments performance, this may result in some areas losing their gold STAR status whilst higher standards are attained.

Changes since the last reporting period are:

- First gold stars awarded to Main X-ray CDH and Main Theatres RPH.
- Orthoptics, Radiotherapy, SMRC, IRDU, Core Therapies CDH and Main X-ray RPH have maintained their gold star statuses.

Table 10 – STAR accreditation outcomes as of May 2024

Area	Star rating	1st Visit	2nd Visit	3rd Visit	4th Visit	5th Visit	6th Visit	7th Visit	8th Visit	9th Visit	15 Step Challenge (last visit)
Orthoptics Optometry		92%	99%	94%	95%	91%	91%	95%			A
Radiotherapy outpatients		90%	97%	97%	92%	94%	98%	95%			A
Specialist Mobility Rehabilitation Centre (SMRC)		93%	96%	95%	98%	98%	90%	97%			A
Speech and Language Therapy		85%	99%	98%	98%	96%	92%	95%			A
Interventional Radiology (IRDU)		95%	99%	99%	98%	98%	96%	97%			B
MRI Scan RPH		95%	91%	94%	95%	96%					A
Core Therapies RPH		72%	69%	89%	98%	96%	96%	94%	94%	97%	B
Core Therapies CDH		79%	60%	89%	96%	89%	94%	96%	93%		A
CT Unit RPH		86%	92%	85%	90%	91%	91%	94%			A
Nuclear Medicine		95%	91%	95%	96%	90%	93%				A
Sharoe Green Ultrasound		85%	95%	87%	93%	90%	91%	90%			B
Main X-Ray RPH		91%	90%	89%	92%	93%	97%	92%	92%		B
Main X-ray CDH		87%	73%	86%	89%	89%	97%	92%	93%		A

The ODP's do not have a specific accredited department like the above areas but are integral to the STAR inspections in all Theatre areas. The following 4 areas have ODP's contributing to their performance and again for the first time have all been awarded gold stars.

During this reporting period Main Theatres RPH have gained their first gold status and Charles Beard Theatre and Sharoe Green Theatres have maintained their gold statuses.

Table 11 – STAR accreditation outcomes (ODP) departments as of May 2024

Area	Star rating	1st Visit	2nd Visit	3rd Visit	4th Visit	5th Visit	6th Visit	7th Visit	8th Visit	15 Step Challenge
Charles Beard Theatre		97%	89%	97%	94%	94%	94%	97%		A
Main Theatres RPH		72%	80%	85%	89%	96%	95%	94%		A
Main Theatres CDH		98%	98%	94%	96%	95%				A
Sharoe Green Theatres		79%	95%	97%	97%	95%	93%	96%		A

6.2 Risk

There are currently 13 active AHP workforce related risks on the trusts risk register. Since the last reporting period 8 have been controlled and closed and 4 new risks have been added. This evidences good risk management within the AHP departments, with a large number closed this past 6 months and risks revised to ensure reflective of the current situation.

9 out of 13 have been reviewed in the last 3 months and all have associated action plans. At the last review no open risks had reduced in score and 2 have increased in score:

- 584 - Risk of patient harm due to limited provision of the Neurointerventional service has increased from 15 to 20.
- 1351 - Reduced SLT service to workforce pressures has increased from 8 to 12.

The following 4 new risks have been added:

- 1818 – Inability to meet inpatient service need in Core Therapies due to staffing constraints, scoring 10.
- 1819 – Patients at risk of poor outcomes post-surgery due to lack of therapy provision in outpatient services, scoring 6.
- 1824 – Insufficient substantive anaesthetic practitioners across all theatres, scoring 10.
- 1701 – Insufficient AHP, pharmacy and psychology staff to consistently meet GPICS standards on CrCU, scoring 9.

Table 12 – AHP Workforce Risk Overview

ID	Title	CBU	Current Score	Date of last review	Direction of score since last report	Action Plan
584	Risk of patient harm due to limited provision of the Neurointerventional service	Diagnostics Clinical Business Unit - RPH	20	17/07/24	↑	• Job planning for weekend INR cover • Benchmark other organisations for rotas/payment • Recruit 2 INR's

614	Impact on staff well-being, recruitment and retention due to theatre over-runs	Theatres & Day Case Surgery - RPH	16	30/06/24	→	• Monitor objectives agreed in Staff survey leadership workshop • Send response form and close • Overruns to be tracked through speciality S&Q • DMC to provide quarterly update from theatre scheduling and efficiencies group
1007	Orthotic Clinical Management. Excessive Waiting Times	Trauma – PBC	12	29/04/24	→	• Increase staffing • Clinical spaces • Measure the impact
1117	SMRC Clinical Risk - Physiotherapy Referrals for Amputees	Trauma Clinical Business Unit - PBC	12	29/04/24	→	• Recruitment to additional band 6 physiotherapist.
1351	Reduced SLT Service to Workforce Pressures	Acute & Specialist Surgery - Trustwide	12	02/07/24	↑	• Outcome of recruitment to B6 split post • List of Datix incidents relating to lack of SLT review • Update on SLT staff dysphagia training • Confirmation that B5 post(s) is funded • Review of referral form and process • Implementation of RAG rating system • Update on ongoing recruitment • Upload monitoring waiting times • Update on MCA project • Escalation SOP in place for SLT • 3 x B5s undergoing dysphagia training •
1818	Inability to meet inpatient service need in Core Therapies due to staffing constraints	Psychology & Therapies – RPH	10	19/03/24	NEW	• Big Room Deconditioning project ongoing • Discuss risk at DCS workforce committee • Outcome of Core Therapies over-recruit paper • Report for Single Improvement Plan • Burns and Plastics Business Case
1824	Insufficient substantive anaesthetic practitioners across all theatres	Theatres & Day Case Surgery - Trustwide	10	20/06/24	NEW	• Active recruitment • explore if the reduction of agency hourly rate can be prevented • Providing recovery staff with anaesthetic course • All clinical Managers identifying shortfalls and following escalation pathway. • Gaining financial approval for staffing new floorplan & existing services not funded.
1701	Insufficient AHP, pharmacy and psychology staff to consistently meet GPICS standards on CrCU	Critical Care, Pain & Outpatient Services Clinical Business Unit - RPH	9	07/06/24	NEW	• Look back exercise to identify and link all incidents • Identify current staffing levels across specialities in relation to GPICS
1822	Inability to provide a medical skin camouflage service	Psychology & Therapies – RPH	9	14/08/24	→	• Review of service to transfer to Max Fax
1122	Lack of Core Therapy on the Wards at the Weekend (Acute and specialist surgery)	Acute & Specialist Surgery – RPH	8	30/04/24	→	• Outcome of Therapy Paper to Execs • Exploration of Funding for Sellars/SECU Physio Cover
1803	Bank Holiday working in Radiotherapy (limited number of AIMs trained staff)	Oncology, Head & Neck Clinical Business Unit - RPH	6	30/06/24	→	• Increase number of AIMs trained staff – due date Oct 2024
1819	Patients at risk of poor outcomes post surgery due to lack of therapy provision in out patient services	Psychology & Therapies – Trustwide	6	25/03/24	NEW	• Review patient pathways, look for efficiencies to create more capacity
1443	Delayed listing of orthoptic appointments	Oncology, Head & Neck Clinical Business Unit - CDH	6	10/07/24	→	• Meeting with the waiting list team to streamline booking appointments • Orthoptics Team to review and prioritise patients on the waiting list

Table 13 – Rejected and Controlled Risks

ID	Title	Updated position
595	Risk of loss of Interventional Radiology service due to insufficient Trained Interventional radiology radiographers	• Controlled 15/05/24
361	Risk of patient harm due to inability to meet current demand within OT orthotics (MTS)	• Controlled 15/05/24
879	Risk of patient harm initially due to no service then due to limited neuro outpatient physiotherapy & significant waiting list	• Controlled 19/03/24
1126	Delays to patient services due to inability to fully staff CDH Imaging department for all shifts	• Controlled 20/12/23
1254	Patient harm due to significant unmet need in therapy services	• Risk closed and replaced with two that better described the issue (1818 and 1819).
1272	Impact on staff wellbeing as a result of insufficient staff to provide required therapy services	• Risk closed and replaced with two that better described the issue (1818 and 1819).
1386	Insufficient Core Therapy/Physio cover for RPH ortho wards at the weekend	• Controlled
1500	Child Health Dietetic Waiting Lists -Vacancies now only remain in paediatric dietetics	• Controlled

6.3 Datix Themes

Overview

A total of 200 Datix relating to the AHP workforce were raised between December 2023 and May 2024. 199 incidents were level 1 (green) and there was 1 incident with no level assigned. The majority of incidents, 192 were 'no harm', 8 were 'low harm', 0 were 'moderate harm' or 'severe harm'. Of the 'no harms' 12 were a 'near miss'. 198 incidents are now closed, 2 incidents are still open and are being managed locally.

In comparison to the last report to committee the theme of staff shortages continues to run throughout the narrative of all incidents raised within all categories of incidents, largely due to staff absence and resource issues. This is then noted as being compounded by additional vacancies causing further stress to colleagues creating more sickness absence in some areas.

2 staff groups account for 85% of all Datix raised. They were Physiotherapy and Occupational therapy (referred to collectively as Core Therapies), which were also in the top reporting groups in last report to committee. Lack of staff cover was particularly highlighted for the acute medical therapy team at all locations but particularly at Chorley Hospital (CDH) and for therapists supporting Burns and Plastics, Critical Care and Neurosurgery departments.

The number of incidents in Diagnostic Radiography are similar in number to last reporting period but are spread across more clinical areas, indicating wider disruption linked to resource gaps and sickness absence.

Data Summary and Analysis

Table 10 – AHP Workforce Datix Summary

Total no. Datix	Incident Level		Level of Harm				Near miss	Datix status		
	Level 1	Level 2	Severe Harm	Moderate Harm	Low Harm	No Harm	Yes	Under Review	Closed	Monitoring RIR/ SI Action
200	199	0	0	0	8	192	12	2	198	0

Severe Harm

No incidents recorded as severe harm for this reporting period.

Moderate Harm

No incidents recorded as moderate harm for this reporting period.

Near Misses

The 12 identified as 'near miss' incidents were categorised as:

- Insufficient number of healthcare professionals (8)
- Failure/incomplete/insufficient monitoring of the patient (2)
- Treatment/surgery delayed (1)
- Treatment/surgery no available (1)

AHP Staff Type by Location

5 specialty areas accounted for 78% of all Datix raised. This was within:

1. Core Therapies RPH
2. Core Therapies CDH
3. Critical Care RPH
4. Occupational Therapy RPH
5. Plastics RPH

Physiotherapy and Occupational Therapy (jointly Core Therapies) locations accounted for 85% of all Datix raised.

5 AHP staff groups accounted for all workforce Datix raised. These are:

1. Physiotherapists
2. Radiographers
3. Speech and Language Therapists
4. Occupational Therapists
5. ODPs

Summary and numbers of Datix are shown in table 11.

Table 11: AHP staff type by location (top 5 services accounting for 78% of Datix)

AHP staff type by location	Physiotherapy	Burns & Plastic Therapy	Occupational Therapy	Core Therapies
Core Therapies CDH	3	0	0	22
Core Therapies RPH	50	0	38	1
Critical Care Unit RPH	17	0	0	0
Occupational Therapy Department RPH	6	8	0	0
Ward 4 (Plastics)	11	0	0	0

Core Therapies (Physiotherapy and Occupational Therapy) remain the highest reporting location. At Preston the majority of incidents are related to Critical Care, Neurosurgery and Acute Medicine and at Chorley they are all attributed to Acute Medicine.

The 11 incidents reported by Ward 4 (Plastics) are linked to resourcing within Physiotherapy and ability to respond to patients nearing discharge, this in turn impacts patient length of stay and flow.

Although not featuring in the top 5 locations, there were 13 incidents related to Diagnostic Radiography/Sonography attributed to Gynaecology, Interventional Radiology, Main X-ray Chorley and Theatres. This is a similar number to last reporting period but across more clinical. From the narrative in the incidents reported this is due to sickness absence and availability of Radiographers.

Table 12 – AHP Workforce Datix Category

Datix Category	Datix Category Total
Clinical Care	**133**
Failure/incomplete/insufficient monitoring of patient	124
Failure/insufficient response to a significant change in patient status	4
Nutrition related incident	3
Deconditioned patient	2
Systems & Equipment	**40**
Insufficient number of healthcare professionals	36
Insufficient number of support staff	4
Treatment/Surgery	**14**
Treatment/surgery delayed	8
Treatment/surgery not available	5
Treatment/surgery not completed	1
Admission/Transfer/Discharge	**5**
Appointment not available in appropriate time frame	1
Discharge delayed	4
Diagnostic	**6**
Imaging Investigation – delayed	6
Environment	**2**
Workplace stress/demands	2

Although the Datix reports are split into the categories as shown in table 12, on further interrogation of the reporting narrative given almost all show root cause was staff shortages due to under resourced teams, sickness absence and vacancy rates with a few exceptions related to operational pressures. On analysis of the supporting narrative 48 incidents all referenced risk of increased length of stay as well as directly impact on delaying a discharge.

7.0 CONCLUSION

This report details the findings of the LTH bi-annual AHP workforce review to provide an overview of the developing mechanisms in place to assess the impact of the AHP workforce on safety and quality. The report is currently heavily focused on attendance and standards within the service and is based on the best available data. The report has evolved this time to display AHP establishment and vacancy rates as SPC charts, resulting in visible and clear trends over time.

A number of successes and improvements have been delivered between December 2023 and May 2024 these include:

- A successful first 5 months of the therapy admission avoidance service, equating to a £1.2m recurrent saving (when the cost of the team has been removed).

- 2 of the 3 internationally recruited Occupational Therapists gaining promotions from band 5 to 6 and in turn filling the intended gaps of the project.
- Degree apprenticeships now available and recruited to in 9 of the 10 AHP areas, supporting the future supply chain.
- Improved vacancy position for the areas of concern last reporting period (Occupational Therapy, Speech and Language Therapy and Dietetics)
- Improved overall training compliance metrics compared to previous reports.
- 2 further gold stars awarded, resulting in all AHP areas and all Theatre areas achieving gold status.

Areas for continued development are:

- Compliance against national workforce guidelines in Critical Care and Neonatal for Physiotherapy, Occupational Therapy, Dietetics and Speech and Language Therapy.
- ODP sickness absence rate, as part of the focused work in Theatres
- Basic life support practical compliance in 6 areas, however, 4 of these are within 5% of compliance.
- Physiotherapy and Occupational Therapy establishments to support, length of stay, patient flow and deconditioning as evidenced in section 7.3, where 85% of all workforce related Datix are attributed to these 2 professions.
- Compliance with all training metrics.

8.0 RECOMMENDATIONS

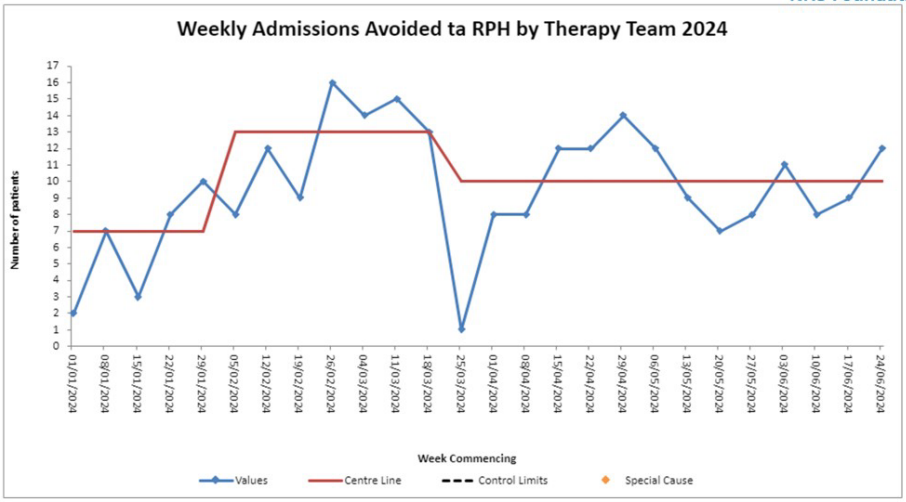
The Board of Directors is asked to receive the AHP bi- annual report for information noting the Safety and Quality Committee has confirmed it is assured of the workforce safeguards in place for AHPs and will receive a further report in line with the Workforce safeguards in 6 months' time.

Appendix 1 –Therapy Admission Avoidance Team Data Summary
Appendix 2 – AHP Vacancy SPC Charts
Appendix 3 –Profession specific positive and negative escalations
Appendix 4 – Action plan

Appendix 1 – Therapy Admission Avoidance Team Data Summary

Admissions Avoided

Lancashire Teaching Hospitals
NHS Foundation Trust



- A total of 248 admissions avoided since the team commenced in assessment areas at RPH
- During the final week of March and the first 2 weeks of April this number reduced, with only 2 missed opportunities the week of 25/03/2024. A reduction in referrals to therapy in these weeks is attributed to higher acuity of patients and a resulting reduced therapy demand.

KPI

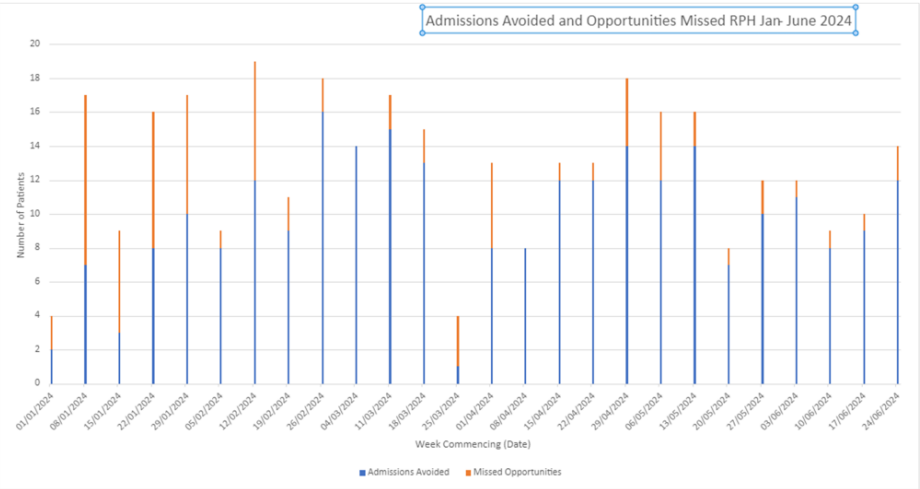
NHS Lancashire Teaching Hospitals NHS Foundation Trust

KPI = Avoid 14 admissions per week

Admissions Avoided per week	Weeks achieved since 1st Jan 2024
14+	5 (19%)
8-13	16 (62%)
1-7	5 (19%)
0	0

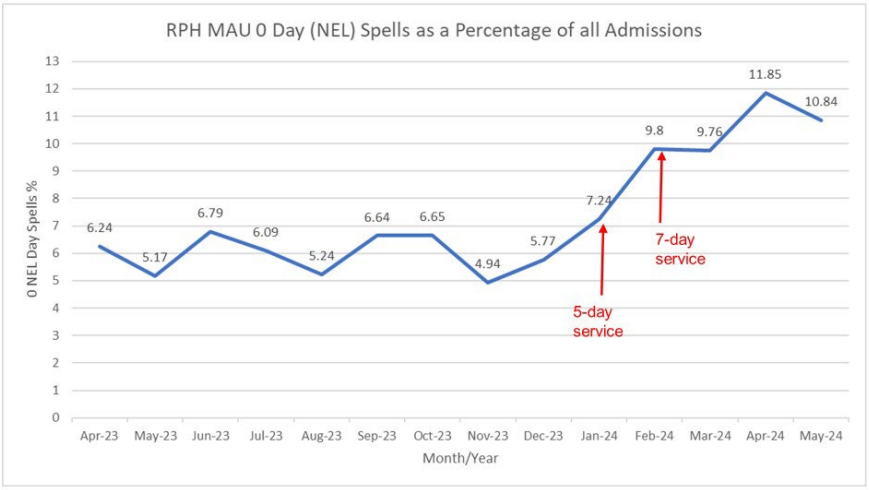
Missed Opportunities

NHS Lancashire Teaching Hospitals NHS Foundation Trust



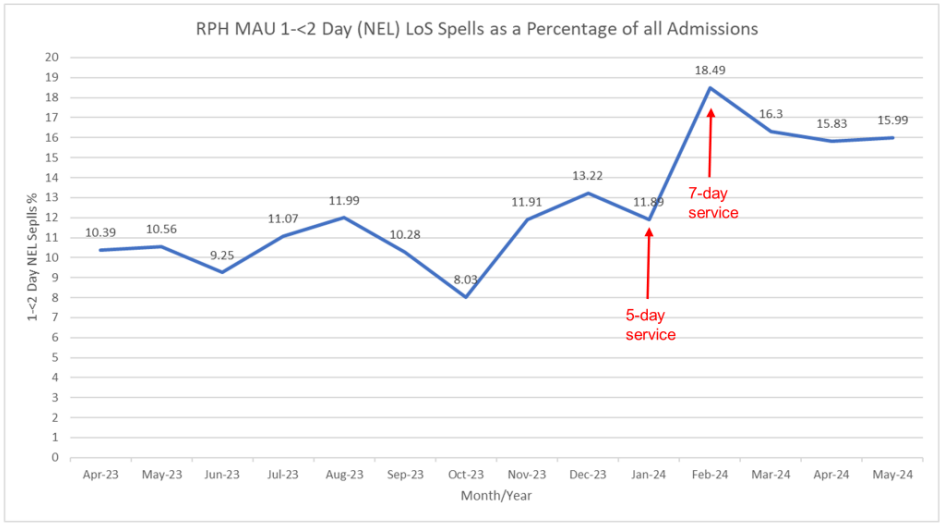
- Total opportunities= 332 Achieved=255 (77%) Missed=77 (23%)
- Missed opportunities for admission avoidance linked to capacity in community partners, including the lack of crisis hours and urgent response availability.
- Sustained reduction in missed opportunities is evident through collaborative working.

MAU RPH 0 day (NEL) LoS



- From February onwards the percentage of patients with a 0-day LoS increased.
- This coincides with the 7 day admission avoidance service

MAU RPH 1-<2 day (NEL) LoS



- From February the percentage of patients with a 1-<2 day LoS increased.
- This coincides with the 7 day admission avoidance service

Performance Comparison

NHS Lancashire Teaching Hospitals NHS Foundation Trust

	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024
Admissions Avoided	24	44	50	44	51	42
KPI Met (2 or more per day)	32% (7days)	45% (13 days)	48% (15 days)	40% (14 days)	45% (14 days)	47% (14 days)
KPI Partially Met (1 per day)	27% (6 days)	38% (11 days)	16% (5 days)	29% (10 days)	35% (11 days)	20% (6 days)
Missed Opportunities	40	12	7	9	14	8
Additional Patient Contacts	54	74	59	75	68	73
Annualised Beds Saved	6.1 beds	11.3 beds	12.8 beds	11.3 beds	13.1 beds	10.7 beds

Bed Days/Beds Saved

NHS Lancashire Teaching Hospitals NHS Foundation Trust

January data excluded as a 5-day service and not comparable to months with a 7-day service

Assumptions

1 bed = 365 days per annum. Ward = Av. 28 beds = 28 * 365 = **10,220 bed days per annum.**

Medicine 2022/23 combined av. LoS for Wards 17/5/24/18/25/Bleasedale = **7.8 days**

Calculated benefit for Feb-Jun 2024 (5 months)

231 patients * av. LoS 7.8 = 1,801.8 bed days in 5 months

Annualised impact of avoided admissions = 1,801.8/5 *12 = **4324.3 bed days saved per annum.**

Beds saved (annually)

4324.3 bed days / 365 bed days = **11.8 beds per annum could be removed if all factors remain equal**

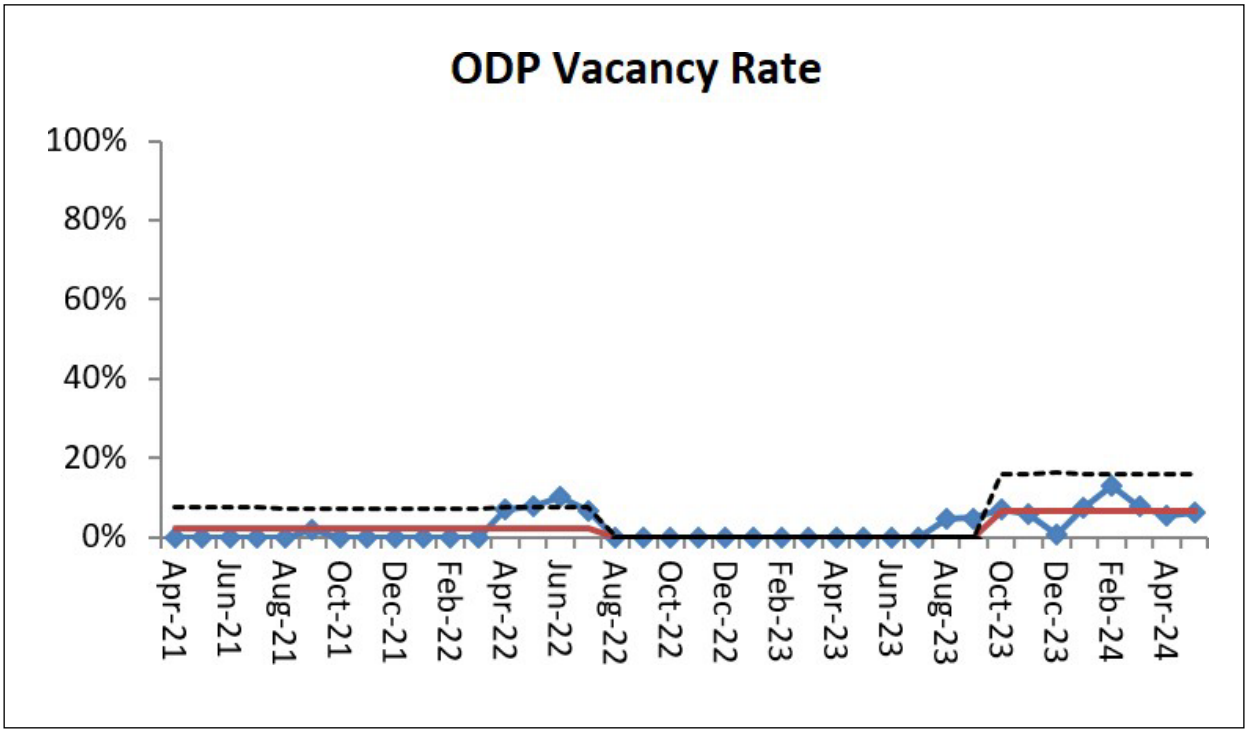
Estimated Financial Impact (annually)

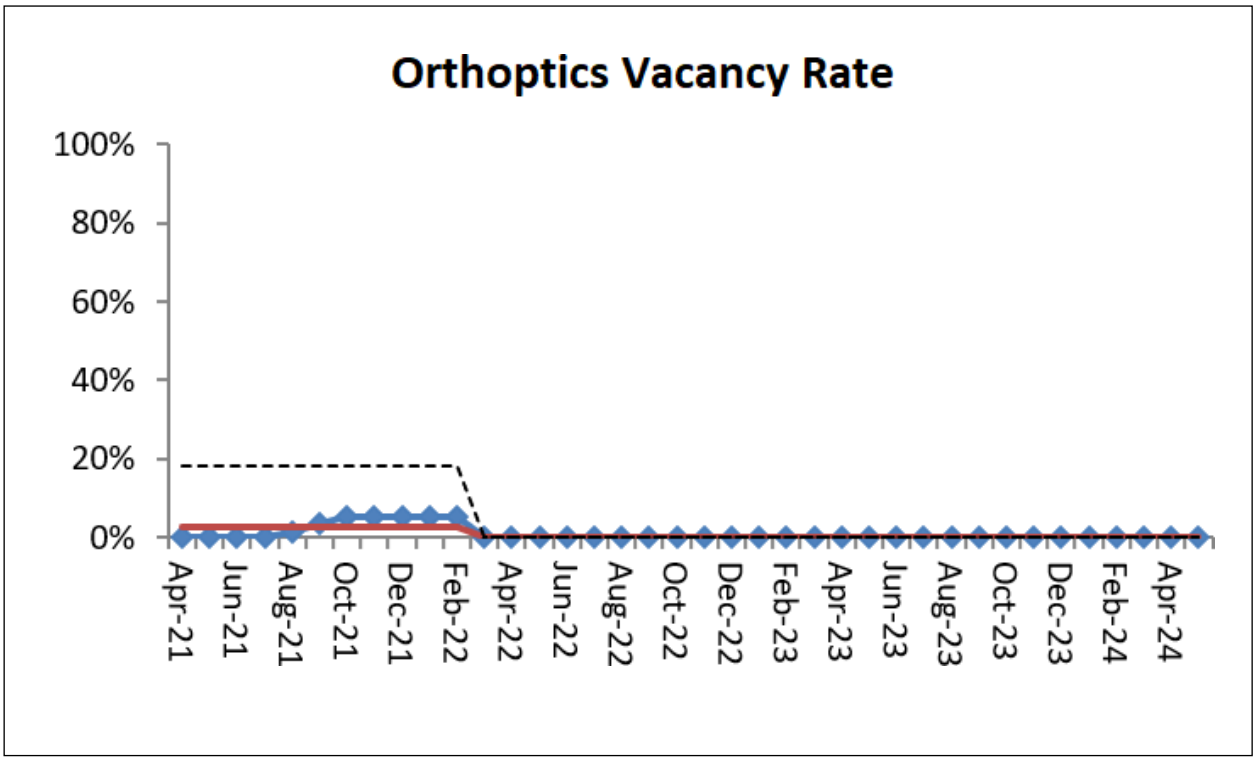
Conservative estimation of 1 bed day in a medical bed = £350

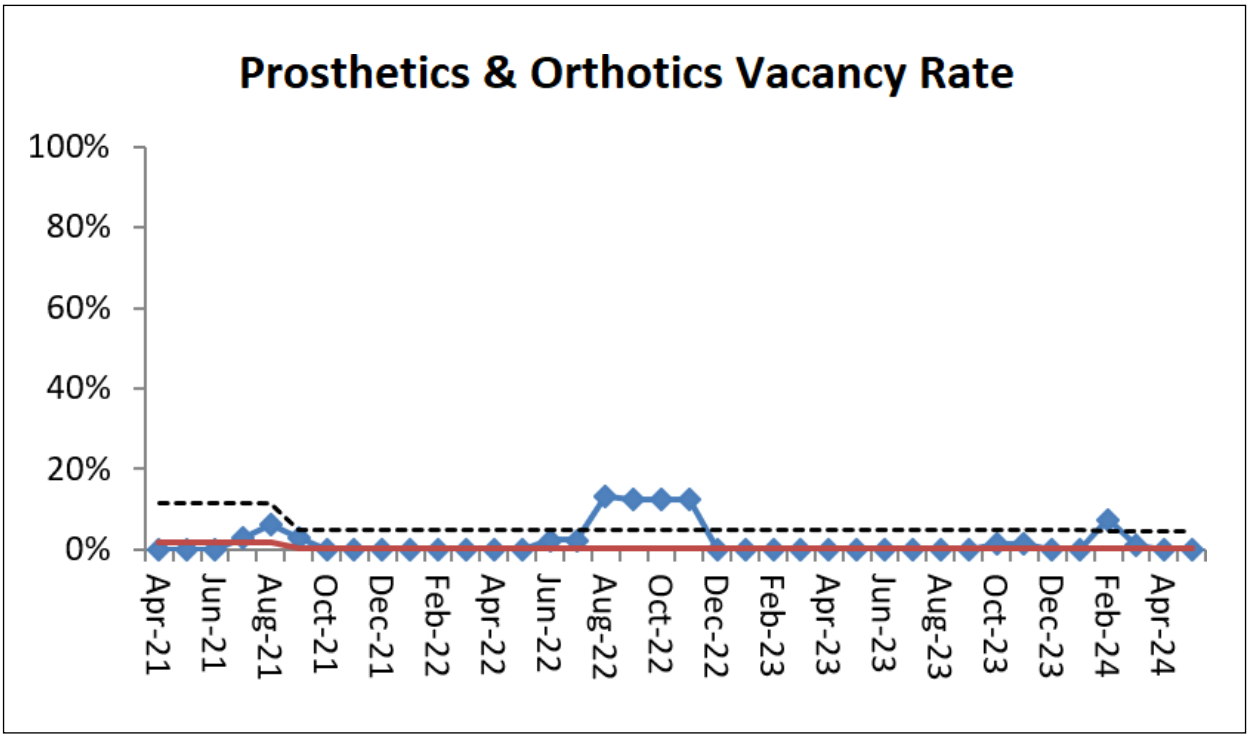
£350 * 4324.3 bed days saved = **£1,513,505 saved per annum**

Current additional staffing cost of Admission Avoidance Team per annum £330K

Appendix 2 – AHP Vacancy SPC Charts (areas of no concern)






Prosthetics & Orthotics Vacancy Rate
100%
80%
60%
40%
20%
0%
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22
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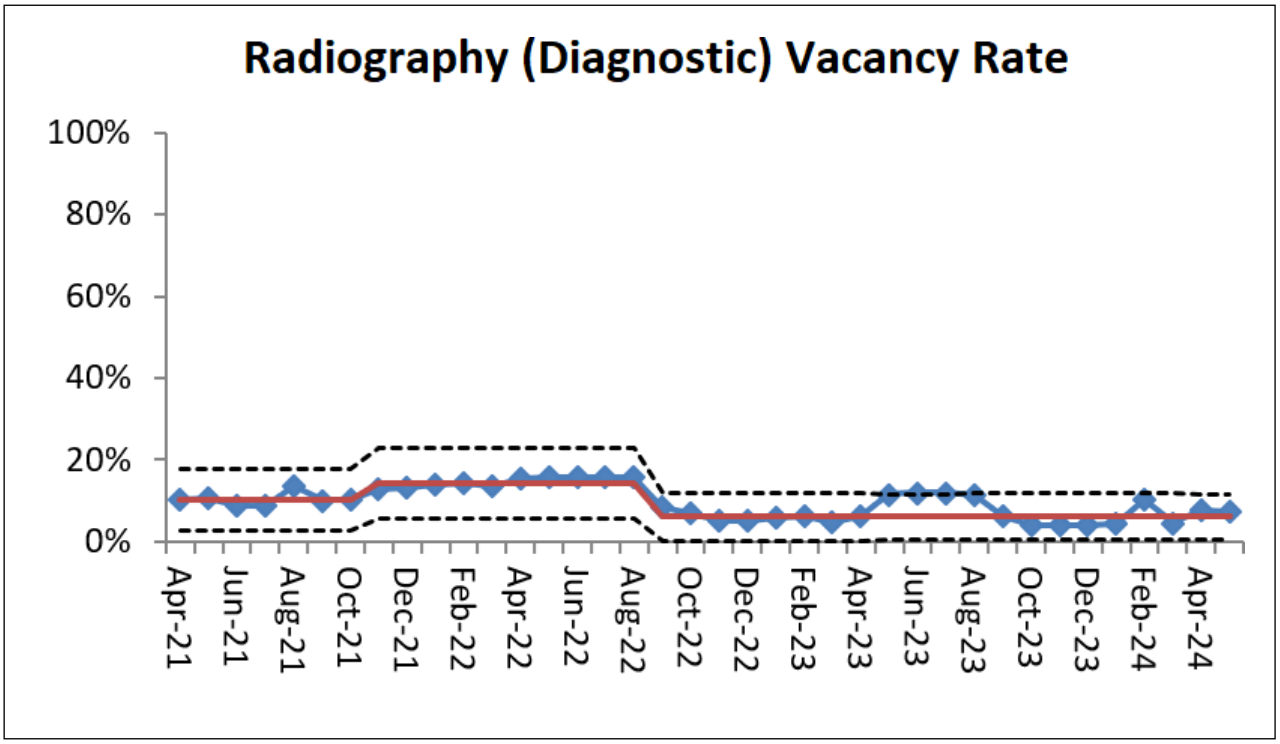
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24


Radiography (Diagnostic) Vacancy Rate
100%
80%
60%
40%
20%
0%
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22
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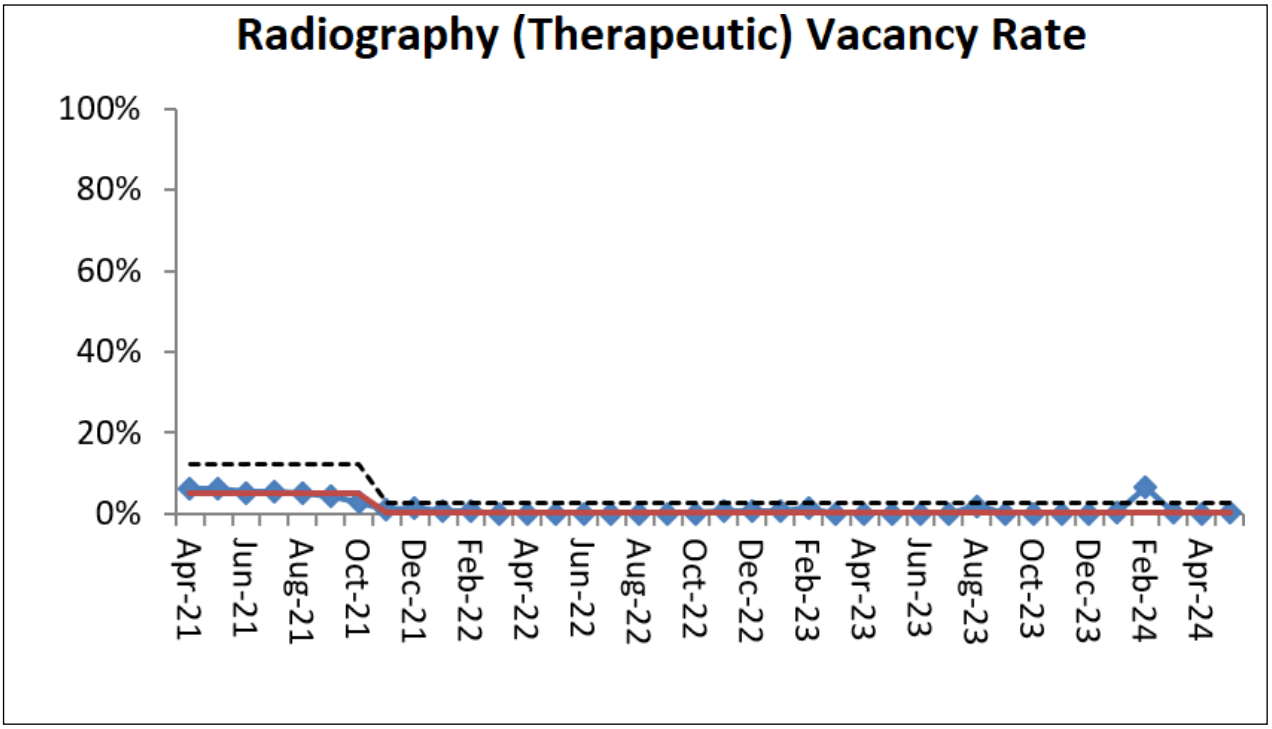
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24


Radiography (Therapeutic) Vacancy Rate
100%
80%
60%
40%
20%
0%
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24

Appendix 3 – Profession Specific Safety and Quality Escalations

Dietetics

	Positive Escalations		Negative Escalations
1	Successful recruitment into the band 5 Dietetic posts, first time in 2 years all have been filled.	1	Ongoing vacancy and long term sickness impacting the paediatric service. ACTION: Locum in place, whilst banding of vacnact post reviewed to aid attractiveness.
2	The Nutrition BI dashboard has gone live, all information/risks in one place which should reduce patient harm and improve outcomes.	2	Higher than average cancellation and DNA rates for outpatient appointments. ACTION: Implement PIFU.
3	Funding secured (Cancer Alliance) for 1WTE band 6 Dietitian in Prehab.	3	

Occupational Therapy

	Positive Escalations		Negative Escalations
1	Workforce: • Introduction of a band 6 rotation across 7 specialist areas. • Successful recruitment to a newly developed Major Trauma Outreach post. • Progression of 2 international recruits from band 5 to 6. • Over offer agreement approved and 3 band 5's recruited. • 4th apprentice recruited and starting September 2024.	1	Inappropriate cognitive assessments taking place in acute settings leading to incorrect patients on waiting lists for the Neuro Rehab Unit (impacts LoS and patient expectations). ACTION: Working alongside Dr Shakespeare to increase training opportunities. New Major Trauma OT post will support this pathway and assessment.
2	Research and Education: • 1 OT accepted onto the NHIR INSIGHT programme commencing September 2024. • Hand Therapy actively involved in 2 national research trials. • 2 OTs completed PG certs in Healthcare Leadership and 1 in Medical Leadership.	2	The MHRA safety alert for bed rails/leavers has impacted equipment prescription practice for OTs. ACTION: Local agreement to no longer prescribe bed leavers as no follow up in available in the community. Risk assessment completed and issue escalated through the Chief AHP to the ICB.
3	Recognition: • 2 international Ots received awards at the Trusts celebration event. • TTAP shortlisted for an NHS Health and Social Care Award.	3	Medical skin camouflage service (managed by OT lead) has not been open for 2 years due to retirement and delayed decision making on its future. This has resulted in a long waiting list and associated complaints. ACTION: Service placed on the risk register with actions in place. Awaiting approval to continue with the service.
5			

ODP's

	Positive Escalations		Negative Escalations
1	The first group of ODP apprentices (9) have graduated and move into registered positions this summer .	1	Unable to offer any ODP apprentices (cohort 4) for September 2024 due to financial constraints. ACTION: Explore having an April 2025 cohort.
2	The pre-op practitioner job descriptions have been updated and are not inclusive of ODP applicants.	2	
3	ODP establishment has increased across all theatre areas.	3	

Orthoptists

	Positive Escalations		Negative Escalations
1	Governance: • 100% compliance monthly STAR • All current PGDs reviewed and signed off by pharmacy • Orhtoptic audit plan up to date and many ready for presenting	1	Continued challenges for stroke clinical space on or near to Ward 21, negatively impacting new SSNAP requirements. ACTION: The team are working as efficiently as possible and use a mobile trolley or the RPH department, however this does impact daily activity.
2	Sub-Specialty Focus: • SEN school visits continue to be successful, enabling assessments in a familiar setting. • Paediatric MDT clinics running well on both sites, reducing wait times and access to the service. • Positive patient feedback regularly received for the stroke team.	2	Increased wait times for the visual processing disorder (VPD) service due to limited staff skilled in this area. ACTION: 1 band 6 is in training and will commence autonomous clinic in September 2024.
3	Education & Development: • 2 Orthoptists are now undertaking the Surgery 1st Assist role for adult/paediatric squint cases. • HoloLens live streaming continues with Liverpool University.	3	No current route to progress business planning for paediatric ophthalmology which could release medical time through Orthoptists triaging. ACTION: Escalated to SBU.

Orthotics

	Positive Escalations		Negative Escalations
1	Orthotics ICS stroke pilot now operational across the whole of L&SC. This provides an Orthotics service to all stroke patients alongside staff training. Various in-service training dates are planned in addition to a system wide conference in November	1	Waiting list times for Orthotics remain high and outside of KPIs. ACTION: PIFU implemented to reduce wasted appointments and reduce waiting list.
2	A digital system has been launched which transfers digital X-rays between LTHTR and Orthotics suppliers, this will reduce waiting times for spinal bracing in adolescents with time dependent conditions.	2	SMRC accommodation remains a challenge and limits clinical capacity. ACTION: Off-site clinic locations are being utilised along with hybrid working for non-patient contact time.
3	Vacancy rate for the profession remains at 0%		

Physiotherapy

	Positive Escalations		Negative Escalations
1	Executive approval for over offer paper enabling recruitment of new graduate Physiotherapists in one large cohort to efficiently manage the vacancy rate for 6-12months and associated risks.	1	Outpatient waiting lists • Spinal rehab (post-surgery) currently at 8 months. • Pain physiotherapy currently at 17 months (over 100 patients). In both cases the services do not have a recovery plan and waiting lists will continue to grow. ACTION: Position paper to detail the risk/impact within division. Aim to address a fixed term contract in trauma (band 7 line) which is preventing recruitment to an over established budget line.
2	Successful first 5 months of the Therapy Admission Avoidance Team covering all assessment areas at RPH and future plans to Integrate with Frailty therapists.	2	Under-resourced inpatient therapy teams resulting in unmet need and associated harm. Risk number 1818 with incidents of low and moderate harm reported. ACTION: • Mitigation of current and future vacancy with over-offer agreement. • Deconditioning Big Room focussing on all members of the MDT preventing deconditioning. • Improvements made to the referral process to therapies (reducing inappropriate referrals and improving efficiency)
3	SSNAP score of B achieved in Physiotherapy specific domain, linked to 6 day working and a fully established team.	3	Vacancy rate slowly climbing in physiotherapy owing to challenges progressing posts through vacancy control panel, and inability to over-offer to new graduates earlier this year. ACTION: Over offer now approved and vacancy control held posts resolved.

Prosthetics

	Positive Escalations		Negative Escalations
1	A Prosthetists has been accepted onto the NHIR INSIGHT programme commencing September 2024.	1	Experiencing issues ordering high cost prosthesis items due to the new hierarchy approval and process of reimbursement by NHSE. This is impacting patient and creating internal financial pressures as fines are incurred due to breaches of loan components. ACTION: Escalated to finance and Division.
2	0% vacancy rate maintained.	2	Potential challenge in covering the Prosthetist that has been successful on the NIHR programme, as this will be a fixed term contract. ACTION: Submit TRAC, gain internal approval and then advertise/promote.
3	Gold star retained in most recent inspection.		

Diagnostic Radiographers

	Positive Escalations		Negative Escalations
1	The first 2 Apprentice Radiographers qualified and are now working as band 5 radiographers for the Trust. Both started with the Trust as Imaging assistants before becoming assistant practitioners and now radiographers. A further apprentice is currently training	1	Inability to recruit to key roles including: • Clinical Lead for Nuclear Medicine • Sonographers. Further compounded by changes to finance and agency processes leading to delays in recruiting suitable agency sonographers. ACTION: Agency approved for Sonography but process ongoing with temporary staffing. Recruitment retention premium being explored for Nuclear Medicine.
2	NWIA funding was obtained mainly to develop practice education within the different modalities and better support our learners at all levels.	2	Aging equipment not supported by service contracts and delays in replacements have led to reduced service and clinical incidents in fluoroscopy/intervention. ACTION: Some staff have adjusted their working hours to facilitate greater capacity. Risk assessments in place for equipment. Cases are being clinically prioritised.
3	Bi planar room installed and 7 day service recommenced for neuro intervention, second room currently being installed and staff being recruited to allow service provision for extended days.	3	Changes to theatre schedules and clinic activity have impacted Radiographer workloads. This is negatively impacting staff morale and patient care through delays to other services e.g. direct referrals from GPs. ACTION: Service line agreement being written for theatre provision and activity being reviewed and escalated. Agency staff requested to support activity increase.

Therapeutic Radiographers

	Positive Escalations		Negative Escalations
1	Surface-guided radiotherapy roll out has continued to progress successfully. The Rosemere Cancer Foundation has supported the installation of systems on the final linac and CT scanner.	1	Radiotherapy referrals increased by 20% on 2019/20 activity and Radiographic establishment and machine capacity does not meet demand. ACTION: Business case being developed which will be an invest to save (due to income generation).
2	The new Harmony Linac is demonstrating an effective reduction in treatment times by 4 minutes per patient. Second machine to be installed later this year.	2	
3	Vacancy rate continues to be sustained at 0%		

Speech & Language Therapists (SLT)

	Positive Escalations		Negative Escalations
1	First degree apprentice has been recruited and has gained a placed at Sheffield for September 2024 (4 year apprenticeship). The successful candidate is an existing assistant practitioner in the department.	1	Outpatient waiting lists are currently 52+ weeks due to: 1. Unsuccessful recruitment to a B7 Clinical Lead ENT post which has been advertised twice. 2. Limited number of clinics available per week for routine and non-complex patients only. 3. Outpatient sessions having to be pulled to meet inpatient pressures in Medicine and Neurology. ACTION: Explore integration of ENT post with current airways SLT to increase attractiveness of post and improve SLT working across ENT and respiratory. Newly recruited band 7 in Medicine/Surgery to commence 1 session in outpatients from July.
2	A difficult to recruit to position has been filled, a highly specialist (band 7) SLT for Medicine and Surgery. The candidate will start in July and positively impact response times across both sites and provide clinical leadership at Chorley.	2	Videofluoroscopy clinic (VFS) capacity has been reduced due to replacement scheme of radiology equipment . 2 clinics per week (RPH) with a total of 9 appointments has been reduced to 1 clinic per week with 3- 4 appointments, a 60% reduction. (links to Diagnostic Radiography escalation) ACTION: VFS waiting list put in place. Limited LSCFT patients to 1 appointment per month and out of area patients to 1 per month to allow timely access for LTH inpatients and urgent LTH outpatients.
3	The Neonatal/0-2 years complex feeding SLT post has been re-banded from 7 to 8a. This is in-line with national and royal college guidance and benchmarks to peers. It has also ensured retention of a highly skilled member of staff who had been offered the same position elsewhere in the Northwest.		Delayed commencement of a fibreoptic endoscopic evaluation of swallowing (FEES) service to CDH. New equipment faulty and returned to manufacturer. This has delayed associated staff training too. ACTION: Medical engineering liaising with the manufacturer. CDH service to commence once equipment is available and staff training completed.

Appendix 4

AHP Safety and Quality Action Plan – May 2024

Key	
Delivered	
On Track	
Overdue/Risk to delivery	

Number	Report Section	Area of Concern	Required Action	Date to be Completed	Lead(s) Responsible	Update	RAG
1	4.4	Occupational Therapy vacancy rate remains above Trust target (16% May 2024).	• Implement over offer agreement. • Continue to exhaust all supply routes. • Innovative recruitment to ensure roles are as attractive as possible. • Focus equally on retention.	Dec 24	AT	• Further successful recruitment over the summer months. • Supply appears healthy. • July vacancy rate 10%.	
2	4.4	Speech and Language Therapy vacancy rate remains above Trust target (13.8% May 2024 which is 3wte).	• Continued promotion of the service/team. • Innovative recruitment to ensure roles are as attractive as possible. • Focus equally on retention.	Dec 24	HA-N	• Further successful recruitment over the summer months. • Leaver rate appears to be slowing. • No change to vacancy % in July as no new starters yet.	

3	4.4	Physiotherapy vacancy rate remains above Trust target (9.2% May 2024).	• Implement over offer agreement. • Continue to exhaust all supply routes. • Innovative recruitment to ensure roles are as attractive as possible. • Focus equally on retention.	Dec 24	JP	• Continues to rise, 11.3% in July. • Impact of over offer agreement will change the position by late 2024.	
4	4.4	ODP sickness rate 8.9% in May. (Improvement position but remains high)	• Ongoing culture and improvement work in Theatres.	Dec 24	AB ABU Theatres	• Improving picture, 5.3% in May.	
4	6.1	BLS practical training compliance in 6 AHP areas	• Linked to limited access to face-face practical element. • Education team are prioritising this and seeking solutions. • Departments to ensure staff can be released to attend when booked on. • Mitigate BLS risk with E-learning content whilst awaiting practical.	Sept 24	AHP Leads	• July data shows an improving picture, 4 of the 6 areas now compliant. • 2 areas remaining none compliant (Dietetics and SLT) are 2-3% off 90%. • Continued focus required.	
5	6.1	Moving and handling compliance in Dietetics and Orthoptics	• Ensure red rated staff are booked onto the practical session.	Sept 24	PC CC	• Both now compliant. • Dietetics at 94% in July • Orthoptics at 94% in July	

6	4.6 & 7.3	Physiotherapy and Occupational Therapy resource and associated Datix and Model Health benchmarking. Occupational Therapy further impacted by vacancy, but minimal vacancy (2%) in Physiotherapy.	• Maximise efficiency. • Engage with all relevant improvement projects. • Datix accordingly. • Ensure risk register is reflective of current provision.	Apr 25	CG JP AT	• Due to current financial pressures, there is no route to increase resource into these areas. • Teams continue to maximise efficiency and engage with improvement work to benefit demand and capacity e.g. Pride & Joy	

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Data Quality Assurance Report

Report to:	Board of Directors	**Date:**	3 October 2024
Report of:	Chief Information Officer	**Prepared by:**	D Hudson, T Caton
Part I	✓	**Part II**	

Purpose of Report

For assurance	☐	**For decision**	☐	**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
- External Data Quality Assurance
- 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 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

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 final submission and evidence supplied. The MIAA overall assurance level across all standards was rated as **substantial assurance**.

Data Quality Assurance Activities

Harris Flex Masterfile Maintenance

The Trust is working with Harris Flex 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 – 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 Harris Flex
- Trauma & Orthopaedic, Colposcopy and Colorectal clinic letters
- Advice & guidance documents
- GP Patient Death Notifications
- Discharge summaries from Maternity
- Clinic letters for majority of specialities utilising digital dictate system (TPro)

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 2024 – August 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	35665	929	2.60%	116	813	2.28%	87.51%
May	46628	1006	2.16%	79	927	1.99%	92.15%
June	47754	1966	4.12%	721	1245	2.61%	63.33%
July	51257	1196	2.33%	60	1136	2.22%	94.98%
August	49471	1103	2.23%	76	1027	2.08%	93.11%
Total	**230775**	**6200**	**2.69%**	**1052**	**5148**	**2.23%**	**86.22%**

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 £23,893.30.

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 in Q1 2024-25 identified and updated by the DQA team:

Month (2024-25)	Attended	DNA	Cancelled	Pended
April	168	132	17	488
May	197	175	28	365
June	125	106	17	355
Total Appts	490	413	62	1208
Average	163	138	21	402

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. 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 August 24 giving an update on:

- Activity Reporting
- T-Pro Digital Dictation Electronic Letters
- Audit Programme
- DQ/IG Presentations
- Meet the team
- Updates on the ShCR project

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 2024-25	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 – rolling out transfer of letters via ShCR
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. Investigate amendment of incorrect discharge dates on patient records on Flex Establish data quality forum	Further additional Harris flex validation reports implemented. Working on supporting divisions with identifying reasons for issues with activity recording. Working with BI on SUS errors highlighted. Data Quality & Compliance group established but requires divisional representation
1207	Inability to meet the monthly clinical coding submission standards (current rating 9)	Non-availability of comprehensive coded data. Timeframe for reviewing / coding data.	Ebooks – time risk assessment Review ICD11 classifications Implement coding ebook Recruit to coder position	Ongoing review / risk assessment. Ongoing review / risk assessment. New trainees using ebooks, ongoing monitoring New member of staff due to commence 30th September

1554	Inability to fully run the Trusts Data Quality programme (current rating 15)	Volume of in-accurate patient records on core patient system Harris Flex. Increase in number of rejections from sending clinical documentation via ShCR. Move from SLAM to SUS reporting (requiring additional validations) External issues with ShCR process (increasing volumes of rejections) Volume of pended outpatient appoints requiring review / documenting Audit programme on hold due to pressures.	ShCR resource paper – additional documentation transfer Establish data quality forum Recruit vacant DQA Assistant role	Approved additional resource in principle – awaiting funding Data Quality & Compliance group established but requires divisional representation Vacancy freeze

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

Grant Thronton Data Quality Review

Grant Thornton were commissioned to undertake an audit following ongoing data quality issues in relation to the implementation of the Trusts theatres system and wider system documentation risks identified.

The review around data quality and pathways was to provide independent external assurance in relation to data recording and capture. Key activities focussed on:

- Desk based longitudinal analysis and review of activity over the last 4 years
- On site review of hypothesis identified through analysis and desk-based review
- Targeted review of urgent care

- Consolidated findings – identifying areas of risk to activity baselines and recommendations for improvement

Summary Recommendations from the initial findings are below. Trust actions and timescales for implementation were reported to the August Finance and Performance Committee with trust actions detailed in Appendix 1.

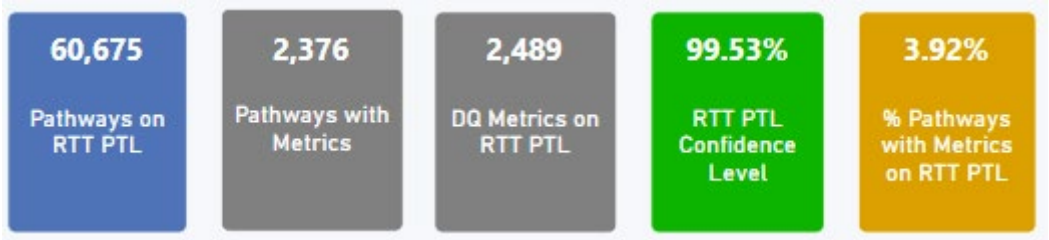
- The categorisation of Chorley's emergency department as type 3 (due to not being a 24-hour department) impacts on the value of the Healthcare Resource Groups (HRGs) being assigned to the activity being treated as there is a flat rate tariff for type 3 emergency care.
- The review also identified areas of omission and errors in ED treatment and investigation code recording which means that the complexity of cases (and subsequent HRG assignment) is under-reported.
- There are high levels of errors and omissions for outpatient procedures across different specialties, reflecting both over and undercharging. Analysis and testing found that accuracy of outpatient coding is poor, with procedures undertaken omitted, or not coded correctly in line with national coding standards to reflect the care being given in this setting or ensure accurate HRG assignment. However, it was unlikely that this has led to income loss.
- Coding in admitted patient care (APC) is low risk and supported by good processes enacted by the central coding team. There are opportunities to digitalise some high volume, low complexity work, such as haemodialysis and endoscopy, which would enable coders to focus their time on more complex areas.

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 99.53% is above the national target of 95%, with the weekly trend showing sustained compliance and improvement. Of the total pathways submitted just 3.9% 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

	15/09/2024	08/09/2024	01/09/2024	25/08/2024	18/08/2024	11/08/2024	04/08/2024	28/07/2024	21/07/2024
RTT PTL Confidence Level	99.53%	99.52%	99.54%	99.54%	99.49%	99.49%	99.46%	99.49%	99.48%

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 May 2024. Scores for all datasets are extremely positive showing a consistently high-performance score during 2024/25. The Trust performs at well above the national average of 80.1% across all datasets.

	Overall	Emergency Care Dataset	Admitted Patient Care Dataset	Out-Patient Dataset
National Average	80.1	80.2	89.4	87.2
Lancashire Teaching	92.6	86.7	99.5	98.7

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, a reduction of 1 compared to the previously 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 2023/24, the Trust maintained a coding completeness level at flex above 90% and 100% at freeze. This has been maintained into 2024/25, however with a slight reduction in the level of coding at flex due to an increase in the number of episodes to code. 100% of records are coded by freeze.

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 has provided 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 with an expected extension to the contract for a further 12 months.

Recommendation

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 May 2024. This is a coverage dashboard not a check of the accuracy of content.

Data Item	Trust May 2024	National Average	Variance	Rating	Actions
OUTPATIENT KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	99.00%	93.90%	5.10%		
ADMINISTRATIVE CATEGORY CODE	100.00%	93.10%	6.90%		
CARE PROFESSIONAL MAIN SPECIALTY CODE	99.00%	93.60%	5.40%		
CONSULTANT CODE	99.00%	85.50%	13.50%		
ETHNIC CATEGORY	92.00%	78.30%	13.70%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	100.00%	85.70%	14.30%		
NHS NUMBER	100.00%	80.70%	19.30%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	97.10%	2.90%		
ORGANISATION CODE (CODE OF COMMISSIONER)	99.70%	94.60%	5.10%		
PERSON BIRTH DATE	100.00%	92.60%	7.40%		
PERSON GENDER CODE CURRENT	100.00%	94.70%	5.30%		
POSTCODE OF USUAL ADDRESS	99.80%	90.60%	9.20%		
SITE CODE (OF TREATMENT)	100.00%	82.70%	17.30%		
SOURCE OF REFERRAL FOR OUTPATIENTS	93.00%	88.30%	4.70%		
ADMITTED CARE KEY DATA ITEMS					
ACTIVITY TREATMENT FUNCTION CODE	100.00%	93.90%	6.10%		
ADMINISTRATIVE CATEGORY CODE (ON ADMISSION)	100.00%	94.70%	5.30%		
ADMISSION METHOD (HOSPITAL PROVIDER SPELL)	100.00%	95.40%	4.60%		
CARE PROFESSIONAL MAIN SPECIALTY CODE	100.00%	93.60%	6.40%		
CONSULTANT CODE	100.00%	85.50%	14.50%		
DECIDED TO ADMIT DATE	99.90%	52.40%	47.50%		
DISCHARGE DATE (HOSPITAL PROVIDER SPELL)	100.00%	96.70%	3.30%		
DISCHARGE DESTINATION CODE (HOSPITAL PROVIDER SPELL)	100.00%	94.50%	5.50%		Improved to 100% from 94.9% in Nov 2023

DISCHARGE METHOD CODE (HOSPITAL PROVIDER SPELL)	100.00%	95.10%	4.90%		
ETHNIC CATEGORY	90.00%	78.30%	11.70%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	100.00%	85.70%	14.30%		
NHS NUMBER	100.00%	80.70%	19.30%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	97.10%	2.90%		
ORGANISATION CODE (CODE OF COMMISSIONER)	100.00%	94.60%	5.40%		
ORGANISATION CODE (CODE OF PROVIDER)	100.00%	95.50%	4.50%		
PATIENT CLASSIFICATION CODE	100.00%	96.00%	4.00%		
PERSON BIRTH DATE	100.00%	92.60%	7.40%		
PERSON GENDER CODE CURRENT	100.00%	94.70%	5.30%		
POSTCODE OF USUAL ADDRESS	100.00%	90.60%	9.40%		
PRIMARY DIAGNOSIS (ICD)	100.00%	84.20%	15.80%		
SITE CODE (OF TREATMENT)	100.00%	82.70%	17.30%		
SOURCE OF ADMISSION CODE (HOSPITAL PROVIDER SPELL)	100.00%	94.60%	5.40%		
EMERGENCY CARE DATASET KEY DATA ITEMS					
CHIEF COMPLAINT (SNOMED CT)	98.00%	75.80%	22.20%		
ACUITY (SNOMED CT)	100.00%	84.30%	15.70%		
DIAGNOSIS (SNOMED CT) - FIRST	73.00%	66.00%	7.00%		Improved to above the national average
ARRIVAL DATE	100.00%	98.90%	1.10%		
ARRIVAL TIME	100.00%	97.20%	2.80%		
INITIAL ASSESSMENT DATE	100.00%	89.00%	11.00%		
INITIAL ASSESSMENT TIME	99.00%	86.70%	12.30%		
DATE SEEN FOR TREATMENT	99.00%	87.50%	11.50%		
TIME SEEN FOR TREATMENT	98.00%	83.80%	14.20%		
DEPARTURE DATE	100.00%	95.50%	4.50%		
DEPARTURE TIME	100.00%	94.60%	5.40%		
NHS NUMBER	99.00%	80.70%	18.30%		
NHS NUMBER STATUS INDICATOR CODE	100.00%	97.10%	2.90%		
ATTENDANCE SOURCE (SNOMED CT)	100.00%	90.80%	9.20%		
DISCHARGE STATUS (SNOMED CT)	99.00%	86.80%	12.20%		
DISCHARGE FOLLOW-UP (SNOMED CT)	98.70%	69.10%	29.60%		

DISCHARGE DESTINATION (SNOMED CT)	99.00%	84.00%	15.00%		
DISCHARGE INFO GIVEN (SNOMED CT)	1.00%	5.20%	-4.20%		Slight improvement since incorporation via ECDS V3.0 Implementation plan
ETHNIC CATEGORY	98.00%	78.30%	19.70%		
GENERAL MEDICAL PRACTICE CODE (PATIENT REGISTRATION)	99.00%	85.70%	13.30%		
ORGANISATION IDENTIFIER (CODE OF COMMISSIONER)	98.00%	85.10%	12.90%		
PERSON BIRTH DATE	100.00%	92.60%	7.40%		
PERSON STATED GENDER CODE	100.00%	85.40%	14.60%		
POSTCODE OF USUAL ADDRESS	99.00%	90.60%	8.40%		
ARRIVAL MODE (SNOMED CT)	100.00%	92.20%	7.80%		
ATTENDANCE CATEGORY	100.00%	92.40%	7.60%		
PROCEDURE (SNOMED CT) - FIRST	99.00%	73.00%	26.00%		
PROCEDURE DATE - FIRST	45.00%	64.70%	-19.70%		Slight deterioration
PROCEDURE TIME - FIRST	42.00%	48.50%	-6.50%		Slight deterioration
CLINICAL INVESTIGATION (SNOMED CT) - FIRST	47.00%	69.00%	-22.00%		Continued improvement since incorporation via ECDS V3.0 Implementation plan
INJURY INTENT (SNOMED CT)	10.00%	38.40%	-28.40%		Slight deterioration