Board of Directors

2 February 2023 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Noting	P O'Neill
2.	Apologies for absence	1.01pm	Verbal	Noting	P O'Neill
3.	Declaration of interests	1.02pm	Verbal	Noting	P O'Neill
4.	Minutes of the previous meeting held on 1 December 2022	1.03pm	✓	Noting	P O'Neill
5.	Matters arising and action log update	1.05pm	✓	Noting	P O'Neill
6.	Chairman's opening remarks and report	1.10pm (5mins: Pres)	✓	Noting	P O'Neill
7.	Chief Executive's report	1.15pm (15mins: Pres)	✓	Noting	K McGee
8.	Board Assurance Framework	1.30pm (10mins: Disc)	✓	Approval	S Regan
9.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
9.1	Safety and Quality Committee Chair's Report	1.40pm (10mins: Pres)	✓	Noting	A Pennell
9.2	Maternity and Neonatal Services update including CNST and Ockenden	1.50pm (5mins: Pres) (5mins: Q&A)	✓	Approval	E Ashton
9.3	Patient Story	2.00pm (20mins: Video) (10mins: Q&A)	Pres	Discussion	Patient/ Major Trauma Team
10.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
10.1	Education, Training and Research Committee Chair's Report	2.30pm (10mins: Pres)	✓	Noting	P O'Neill
10.2	Workforce Committee Chair's Report	2.40pm (10mins: Pres)	Verbal	Noting	J Whitaker
10.3	Recommendation for approval: (a) Gender Pay Gap Report	2.50pm (10mins: Q&A)	✓	Approval	K Swindley
11.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
11.1	Finance and Performance Committee Chair's Report	3.00pm (10mins: Pres)	✓	Noting	T Whiteside
11.2	Charitable Funds Committee Chair's Report	3.10pm (10mins: Pres)	✓	Noting	K Smyth
11.3	Integrated Performance Report as at 31 December 2022 including Finance update *(considered by appropriate Committees of the Board)*	3.20pm (10mins: Pres) (15mins Q&A)	✓	Discussion	F Button
12.	**FIT FOR THE FUTURE** (STRATEGY AND PLANNING)				

№	Item	Time	Encl.	Purpose	Presenter
12.1	Big Plan Metrics Annual Review	3.45pm (10mins: Q&A)	✓	Approval	G Doherty
12.2	New Hospitals Programme Update	3.55pm (5mins: Pres)	Verbal	Noting	K McGee
13. GOVERNANCE AND COMPLIANCE					
13.1	Audit Committee Chair's Report	4.00pm (10mins: Pres)	✓	Noting	T Watkinson
13.2	Well Led Plan including Good Governance Institute Recommendations	4.10pm (10mins: Q&A)	✓	Adoption	S Regan
13.3	(a) Standing Orders for Board (b) Terms of Reference for Committees of the Board	4.20pm (5mins: Pres)	✓	Approval	J Foote
13.4	Board Visibility: Safety and Experience Programme	4.25pm (5mins: Pres)	✓	Noting	S Cullen
14. ITEMS FOR INFORMATION					
14.1	Register of Interests		✓		
14.2	Date, time and venue of next meeting: *6 April 2023, 1.00pm, Microsoft Teams*	4.30pm	Verbal	Noting	P O'Neill

Board of Directors

1 December 2022 | 1.00pm | Microsoft Teams

Part I

PRESENT	07/04/22	09/06/22	04/08/22	06/10/22	01/12/22	02/02/23
NON-EXECUTIVE DIRECTORS						
Professor P O'Neill (Interim Chair)	P	A	P	P	P	
Professor E Adia (Chair)	P	A	P			
Ms V Crorken	P	P	P	A	P	
Ms A Pennell	P	P	A	A	P	
Ms K Smyth	P	P	P	P	P	
Mr T Watkinson	P	Chair	P	P	P	
Mr J Whitaker	A	P	P	P	P	
Mrs T Whiteside	P	P	P	P	P	
EXECUTIVE DIRECTORS						
Ms F Button Chief Operating Officer	P	P	P	P	P	
Ms S Cullen Chief Nursing, Midwifery and AHP Officer	P	P	P	P	P	
Mr K McGee Chief Executive Officer	P	P	P	P	P	
Dr G Skailes Chief Medical Officer	P	P	P	P	P	
Mrs K Swindley Chief People Officer	P	P	P	P	P	
Mr J Wood Chief Finance Officer/Deputy Chief Executive	P	P	P	P	P	
IN ATTENDANCE						
Mrs K Brewin (minutes) Associate Company Secretary	P	P	P	P	P	
Mrs A Brotherton Director of Continuous Improvement	P	P	P	P	P	
Mr S Dobson Chief Information Officer	P	A	A	P	P	
Mr G Doherty Director of Strategy and Planning	P	P	P	P	P	
Mrs N Duggan Director of Communications and Engagement	P	P	P	P	P	
Mrs J Foote MBE Company Secretary			P	P	P	
ASSOCIATE NON-EXECUTIVE DIRECTORS						
Mr M Wearden			A	A	P	
Mr P Wilson			A	P	P	

P – present | **A** – apologies | **D** – deputy

***Quorum**: 4 Directors and must have at least 2 Executive Directors (one to be the Chief Executive or nominee) and 2 Non-Executive Directors (one to be Chair or Vice-Chair)*

***Chair** – Professor P O'Neill took over as Interim Chair with effect from 1 September 2022 following the departure of Professor E Adia*

Governors in attendance: Dr K Ackers, Dr M France, Mrs L Lynch, Mrs J Miller, Mr E Pope, Mr F Robinson and Mr P Spadlo

Observers: Christopher Boden, PR and Communications Specialist
Paul Faulkner, Local Democracy Reporter, Lancashire Post
Jo Leeming, Corporate Affairs Officer
Josephine Neil, PR and Communications Specialist
Sam Parker, Democratic Services Office, Lancashire County Council
Jo Wiseman, Corporate Affairs Officer

IN ATTENDANCE TO PRESENT THE PATIENT STORY (Minute ref 217/22)	
Claire Granato	Chief Allied Health Professional
Paul Leishman	Prosthetist, Specialist Mobility Rehabilitation Centre
Gregg Stevenson	Patient

IN ATTENDANCE TO PRESENT BOARD ASSURANCE FRAMEWORK (Minute ref 218//22)	
Simon Regan	Associate Director of Risk and Assurance

IN ATTENDANCE TO PRESENT MATERNITY AND NEONATAL SERVICES REPORT (Minute ref 222/22)	
Emma Ashton	Interim Divisional Midwifery and Nursing Director

210/22 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.

211/22 Apologies for absence

Apologies for absence were received and recorded in the attendance matrix at the front of the minutes.

212/22 Declaration of interests

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

213/22 Minutes of the previous meeting

The minutes of the meeting held on 6 October 2022 were approved as a true and accurate record.

214/22 Matters arising and action log

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

215/22 Chair's opening remarks and report

The report provided a summary of work and activities undertaken by the Interim Chair during October and November 2022.

The Chair highlighted Disability History Month, which was supplemented by a verbal overview by Non-Executive Director K Smyth outlining the work she was undertaking to improve inclusivity and access to health. The Chair had agreed to act as Chair of the Board for a series of shadow Board meetings in the Lancashire and South Cumbria Inclusive Non-Executive Director Development Programme.

The report marked the recent presentation to the Chief Executive of his OBE recognising his work for the NHS and system collaboration. The Chief Executive noted he was fortunate to be awarded the OBE earlier in the week and had received the honour on behalf of colleagues in the NHS.

Other key highlights included the significant changes in the NHS and the Trust's approach to working in partnership; the strategic vision moving forward to ensure the community received the best possible care; and recognition of the work undertaken within research and education by great leaders and teams. The Chair also recognised the ongoing dedication and resilience of staff evident during recent visits to wards and departments.

216/22 Chief Executive's report

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

- The appointment of a new Prime Minister and Secretary of State for Health and Social Care along with a revised autumn statement recognising the different context within which the NHS was working. There was some positive news in the autumn statement regarding additional funding for social care and the expectation that health and social care would work in an integrated way moving forward.
- The Build up to winter, which officially commenced on 1 December 2022 in that each Integrated Care System (ICS) had to have in place a strategic command centre (Gold overview) reporting to NHS England and Improvement. There would be an impact on the Trust in terms of reporting, service provision and how the Trust integrated with other providers.
- Recognition of clinical and operational teams and the work being undertaken to manage waiting list backlogs.
- The pressurised operational period currently being faced within the Trust and the increased numbers of ambulance conveyances and walk-ins.
- A recent visit to Ward 21 to see how data and visual boards were driving activity which was a positive example of the improvement work going on within the Trust.
- Appendices were attached to the report providing an overview from the Provider Collaborative Board (PBC) and the Integrated Care Board (ICB) Chief Executive's Board report outlining common themes around performance, finance and winter pressures.
- Preparations were being made in readiness for strike action over the coming weeks and months. Whilst Trust nurses were not involved in the December strike days that may change moving forward. The Board was assured that emergency flow would not be compromised, and any planned care activity stood down would be rescheduled as soon as possible. The North West Ambulance Service would be taking part in strike action in December and other professional groups were considering their position on whether they would enter into industrial action in the future.
- Finney House Community Healthcare Hub – the Trust had now taken over two floors of the facility to help support discharges and step-down arrangements for patients no longer meeting the criteria to reside in a hospital bed. The Chief Executive commended the hard work of the Chief People Officer, Chief Operating Officer, Chief Nurse and Chief Medical Officer who ensured the facility was opened as planned. It was noted the NHS had a keen interest in the success of the initiative to determine whether the model could be replicated across other areas.

A request was made for further clarification regarding the statement in the PCB update (appendix 1) regarding reprioritising the recovery of cancer treatment in a more equitable way. It was explained that there had been close working with national and regional colleagues on elective and cancer recovery. Dermatology 2-week waits was provided as an example where the Trust's waiting list was longer than three other providers therefore those patients should be redistributed across the system to spread the load, and this was being explored further. The Elective Care Recovery Group gathered all Trust data and could see where there was capacity to re-route patient referrals. In essence, it was about ensuring equitable access for patients, the ability to offer earlier appointments at another local hospital, and also allow the Trust to concentrate on patients with complex needs requiring specialist services only provided by this Trust. Discussion was held regarding forecasting future demand and there would be a need to be more sophisticated on this at a system level looking at demography, growth, changes in clinical technology, and processes and procedures to ensure better efficiency and effectiveness as a system rather than individual organisation level.

The Board recognised the work undertaken to introduce the Community Healthcare Hub and asked how assurance was being obtained that gaps around capacity did not lead to the facility being seen as a final solution to the overall problem. It was explained that the Trust could not step in and sort all capacity gaps in terms of social care. An agreement was in place with partners including the local authorities to introduce the facility, and the Trust would undertake a detailed evaluation of the initiative which would assist with informing next steps. The Trust was very aware that this was only one solution to capacity pressures and did not have the resources or finance to step into the gap and working differently with local authority colleagues was a move in the right direction.

217/22 Patient Story

Gregg Stevenson joined the meeting to describe his experience as a patient, ongoing treatment, and the work he continued to undertake with the Trust in his professional capacity. A double amputee war veteran, Gregg was the first patient in the UK to be issued with the world's most advanced prosthetic robotic knee (Genium X3) which was fitted in the Specialist Rehabilitation Mobility Centre (SMRC) at Preston Business Centre. Gregg had also previously been employed by the Trust working as the physical instructor in the SMRC gym where he inspired and motivated many other service users. Gregg was currently an NHS mental health practitioner of Veterans High-Intensity Service North, an NHS mental health service provider designed to help serving personnel due to leave the military, reservists, armed forces veterans, and their families. The Trust has continued to work with Gregg in his professional capacity when referring across services and Gregg was presently completing an MSc in Psychology and a member of the GB paralympic rowing squad.

The Board received the inspirational story noting the clear focus on enabling people and maximising independence thereby reducing clinical demand and improving daily living, concentrating on what could be achieved rather than disabling people.

The Board expressed interest in the 'C-Cards' (mental health crisis cards) which had been designed by Gregg in collaboration with NHS Op Courage Veterans High-Intensity Service and Portfolio, a Bolton-based creative agency, to help distract and stabilise veterans in times of extreme anxiety. The product had been created to help prevent hospital admissions and/or self-harm and had been incredibly well received by both the

veteran community and the NHS. It was noted the Trust had an increasing number of patients with a mental health condition presenting at the emergency department who needed support until the correct setting was available and recognised that educating nurses and wider staff groups would be a positive step forward. Gregg confirmed that he would be happy to work with the Trust and a video had been developed to supplement the C-Cards which highlighted how people could manage their mental health.

Discussion was held regarding the extent to which Gregg felt he needed mental health support during his physical treatment and whether that service was offered internally. It was noted that psychological support was available in the SMRC and was part of the initial discussions with patients although he felt that being around peers and that small community along with the physical activities helped with his mental health.

The Chief Medical Officer took the opportunity to commend Professor Fergus Jepson, Consultant in Rehabilitation and lead clinician for the SMRC over a significant number of years who was awarded the MBE in The Queen's Honours List in 2021. Professor Jepson had recently climbed Mount Kilimanjaro with an amputee and was inspirational in the work he and the team undertook for veterans and amputees.

The Director of Communications and Engagement also invited Gregg to work with her to promote his work more widely and inspire others.

218/22 Board Assurance Framework

The Board Assurance Framework provided details of the risks that compromised the achievement of the Trust's high level strategic objectives, and an overview was provided. There had been no changes since the last report on the overall strategic risk scores and operational high risks (risk IDs 25, 1125 and 1182) had been escalated to the Board.

It was noted that the Board was assured of the work being undertaken on risk. However, the risks appeared static, and actions identified were not improving the position therefore risk owners would continue to challenge the actions to ensure enough was being done to mitigate each risk, acknowledging the pressures within the Trust.

The Board RESOLVED that:

1. **the updates to the Board Assurance Framework be noted and approved.**
2. **it was assured that there continued to be an effective and comprehensive process in place to identify, understand, monitor and address current and future risks in line with statutory requirements.**

219/22 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee meetings on 30 September and 4 November 2022 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Assurance of focus on safety and quality in relation to patient flow and discharge improvement programmes of work.

- Governance arrangements and oversight of areas being monitored by the Care Quality Commission.
- Approval of the Patient Experience and Involvement Strategy 2022-25.
- Processes in place to ensure patient safety remained a priority for patients managed by the virtual ward service.
- Assurance that risks were being regularly reviewed, monitored and mitigated.
- Assurance on the safe staffing levels within maternity services.
- The quarter 1 mortality report 2022-23 provided assurance that the Trust had robust governance arrangements in place to review, report and learn from patient deaths.

In response to a request for assurance that the Trust was doing everything possible in terms of *C.difficile* infection (CDI) which was a recurring issue, it was noted that the Safety and Quality Committee had received an overview of the work being undertaken to improve the metric. CDI rates had increased regionally and nationally owing to the increase in antibiotic prescribing and the Trust was currently reviewing feedback it had received on such prescribing. However, it was recognised that occupancy levels, flow and the ageing estate were significant contributory factors to increased infection rates. The Board was also reminded of the recent infection prevention and control review and early feedback had not highlighted any particular concerns in addition to those identified above. The Safety and Quality Committee would continue to review the position and a twice-annual review specifically in relation to CDI was included on the cycle of business.

220/22 Bi-annual midwifery staffing report

The report presented the findings of the bi-annual maternity staffing review in order to provide assurance to the Board of safe staffing levels within the maternity service. The report triangulated workforce information with safety, patient experience and clinical effectiveness indicators, and had been scrutinised by the Safety and Quality Committee with a recommendation for approval by the Board.

In response to a question regarding international nurse recruitment, it was confirmed the business case had been approved which would see 16 new midwives join the Trust in-year. Sickness levels remained at around 10% and the Workforce Committee would receive a detailed overview of the position at its next meeting to understand the underlying causes.

Reference was made to whether complaints identified within the report were analysed by protected characteristics. It was noted that detailed analysis was not undertaken at the present time although work was being undertaken to explore how such data could be extracted and reported in the future.

The Board RESOLVED that:

1. **the maternity safe staffing review be approved.**
2. **confirmation that no further investment was being requested until the 2022 Birthrate+ assessment report had been reviewed be noted.**

221/22 Quality and safety of mental health, learning disability and autism inpatient services

The report presented a summary account regarding the quality and safety of care provided to patients with mental health, learning disability and autism, following a letter from the National Director for Mental Health in response to the BBC Panorama

programme which showed patients being abused while in the care of an NHS Trust. A full report along with assurance evidence had been presented to the Safety and Quality Committee containing details of the policies and processes in place across the Trust. It was noted that overall, the Trust approach demonstrated a strong safeguarding position regarding the quality and safety of care provided to patients with mental health, learning disability and autism with the relevant policies and procedures in place to ensure appropriate safeguarding of vulnerable patients.

Discussion was held regarding mental health services and the challenges in the emergency department for this cohort of patients. It was confirmed that the Trust ensured full oversight of patients requiring care in a mental health setting and had excellent relationships with partners. There were a range of strategic discussions taking place on how to improve current services in the mental health arena and how organisations could work together around mental and physical wellbeing.

Clarification was requested on the Trust's violence reduction strategy and the techniques to be adopted to diffuse situations to avoid the need to apply restraint. Work had commenced to look at violence and aggression risks as a starting point recognising there was more work to do. It was noted staff genuinely felt vulnerable at times and it was hoped that their anxieties could be reduced through better education and training. In respect of children's services, UCLan had been invited to provide sessions to focus on dysregulated behaviour so clinicians could regulate themselves and also step back and look at different approaches. The Trust had already undertaken a lot of work around the restraint pathway but there were increasing numbers of patients with more complex needs than seen in previous times therefore the position was evolving and there was recognition of other work to be completed. It was also suggested looking to the police service to help and support with restraint interventions.

Discussion was also held regarding independent peer-led support and it was noted the Trust had a good relationship with the local mental health Trust who provided input and peer support. This Trust also had special educational needs groups in place with arrangements for peer review of some of the quality delivery components of the services. In addition, the Trust participated in multidisciplinary forums and was aware this was an area to build on in the annual safeguarding plan.

The Board was informed that a programme of work had been developed and a violence reduction strategy existed, co-designed across a network group of organisations inside and outside health and social care, which had been presented to the Workforce Committee in November.

The Board RESOLVED that it was assured of the actions taken in response to the NHS England letter.

222/22 Maternity and Neonatal Services update including CNST and Ockenden

The report provided an overview of the safety and quality programmes of work within the maternity and neonatal services. The service was on track to deliver all 10 CNST standard recommendations within identified timescales with the caveat that two compliance standards must be sustained in December 2022 to support a full compliance submission in February 2023. The Board noted that the Safety and Quality Committee had received a presentation on the East Kent Report *'Reading the Signals'* and continued to monitor stillbirth rates.

The Board RESOLVED that:

1. **the CNST submission, update report and recommendations be approved.**
2. **the commitment to remain focused on delivering personalised safe maternity and neonatal care in response to the East Kent Report be confirmed.**

223/22 Workforce Committee Chair's report

The Chair's report from the Workforce Committee meeting on 8 November 2022 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided. Key highlights included:

- Risk of industrial action by nurses and the work being completed to assess the potential impact on patients particularly in elective care.
- The Committee received the violence and aggression standard update and acknowledged that good progress was being made in meeting those standards.
- The National Champions on Disability (Chris Rivers and Stuart Moore) attended the meeting to deliver a presentation on the Workforce Disability Equality Standards (WDES) and the Trust's performance against those standards, with the Committee noting that in terms of key metrics the Trust was either in line or better than national standard. Encouraging people to declare their disability status was an area where improvements could be made. The Committee also touched on the equality, diversity and inclusion plan and actions for the future and noted that some funding may be available to support that work.
- The Committee also received a presentation on the Trust initiative 'Best Version of Us' which was a piece of work around the culture of the organisation.
- The risk score on the Trust's ambition to be a Great Place to Work had been increased from 16 to 20.

224/22 Our People Plan 2023-26 (Workforce and Organisational Development Strategy)

The report presented the 2023-26 Workforce and Organisational Development Strategy 'Our People Plan' which set out the strategic aim for the Trust to be a Great Place to Work and the six strategic drivers to support delivery. The Plan was designed to be an enabling strategy to underpin other strategic priorities through ensuring the right conditions were created to enable colleagues to deliver high quality care and services. The plan had been scrutinised by the Workforce Committee with a recommendation for approval by the Board prior to publication.

It was observed that the strategy did not appear to include the evolving system or visibility of the work of ICS colleagues. It was explained that the plan involved work across the system, such as the new undergraduate nursing programme with UCLan, with outcomes being delivered at system level.

Comments were made regarding culture and empowering people to deliver local improvements which would be important. It was also recognised the sections regarding attracting and retaining people needed to be strengthened including opportunities for local growth and support as part of the Trust's anchor institute status. It was noted that those points were highlighted in the social value strategy although it was acknowledged that there was a need to ensure both strategies were aligned, and the Chief People Officer would consider how to take that work forward.

The Board RESOLVED that the 2023-26 Our People Plan be approved for external publication.

225/22 Allied Health Professionals (AHP) Workforce Strategy

The report presented the first Allied Health Professional (AHP) Workforce Strategy for 2022-25 which aimed to address the current and future supply chain issues impacting many of the AHP groups. It was noted that a project team had been established, supported by funding from Health Education England, to lead the development of the strategy and together a widespread scoping and engagement exercise was conducted with all registered AHPs and AHP support workers at the Trust. Engagement on the strategy had resulted in six co-designed key commitments that all AHP leaders had signed up to along with themed objectives across 10 professions. The strategy had been scrutinised by the Workforce Committee with a recommendation for approval by the Board prior to publication.

The Board recognised that the AHP workforce was a shortage specialty and there was a need to invest to retain and attract people otherwise the Trust would not be able to deliver some of its improvement ambitions. It was noted there were a range of recruitment approaches within the strategy including international recruitment, and an ambition to move away from profession-specific roles. A lead healthcare scientist had been employed within the PCB to help with the diagnostics agenda. Alternative models had been tested and the AHP leadership structure and accountability would be important in attracting people to the organisation. Learning was also being taken on board from the stroke model which had been carried across to the strategy. It was felt the AHP workforce held the key for modernising the workforce, however, there was a need to substitute different staff which were not available without changing the workforce elsewhere within the organisation so there was a need to be imaginative when considering changing or swapping roles as there was not a tranche of additional resources, rather a reliance on substitution of roles.

The Board would be holding strategy discussions at their next Workshop and would pick up the discussion on system working and the critical nature of the AHP workforce. There was also a need to consider where the Trust sat in relation to community services, what the supply looked like and how to move forward.

The Board RESOLVED that the AHP Workforce Strategy 2023-26 be approved for external publication.

226/22 Equality, Diversity and Inclusion Strategy

The report provided an annual update against the principles and aims of the Equality, Diversity and Inclusion (EDI) Strategy 2021-24 and formed part of public sector duties as set out in the Public Sector Equality Duty and the Equality Act 2010. The report detailed actions that had been completed during the last 12 months against the five principles within the strategy and highlighted achievements during the year. The report contained the actions that had been taken along with the intent moving forward and divisions were fully engaged and producing individual plans for delivery at local level which would be discussed at the Divisional Improvement Forums (DIFs).

Discussion was held regarding whether Our Big Plan aligned to the strategy to ensure all appropriate EDI metrics had been included. It was noted a connection had been drawn between WDES and the Workforce Racial Equality Standards (WRES) which were picked up through the Workforce Committee and Workforce and Organisational Development Strategy. The EDI strategy did not have the same focus therefore the metrics would not be fully replicated in both strategies. However, the Chief People Officer would consider outside the meeting how this could be enacted.

Prior to publication the Chief People Officer would amend the Board Membership sections on pages 36 and 37 to remove some duplicate wording and include the number of Board members where that information had been missed.

The Board RESOLVED that the report be approved for external publication subject to minor amendments.

227/22 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee meeting on 11 October 2022 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- The research and education teams were commended for the positive work they were completing in their respective portfolios.
- Compliance with core skills training targets in a range of areas with set trajectories for recovery in other areas.
- Health Education England had changed the tariff funding for different learners which had implications for the Trust in terms of the education budget. The way in which education had been managed successfully meant a carry forward of funding for future developments and there was a need to be aware of that in terms of external scrutiny.
- Significant concerns around hygiene factors for staff and students, particularly the availability of hot food out-of-hours for foundation doctors which was a common theme raised within the GMC surveys. It was noted a paper was due to be presented to the Executive Team in the coming weeks regarding the food offer and a potential solution should be agreed for reporting to the December Committee meeting.

228/22 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee meetings on 18 October and 22 November 2022 provided an overview of the items discussed and issues to be brought to the Board's attention, including items for escalation and where assurance had been provided to the Committee. Key highlights included:

- Discussion and scrutiny around winter planning, elective activity, and finances.
- The cost improvement programme trajectory remained steady and continued to be reliant on non-recurrent efficiencies.
- In respect of performance, there were complex issues around demand, capacity, productivity, and the ability to realise efficiencies and reduce wastage.
- The system had introduced protocols around increased scrutiny on finances.

The Committee recognised the Trust was not where it wanted to be in terms of its finance and performance position although it was assured that all necessary internal steps were being taken and work continued with partners across the system to try to improve. The Chief Finance Officer emphasised the key pressures faced as an organisation this year related to nearly 100 additional beds that had been opened although the Trust remained under significant pressure. Work was being undertaken to look at how that could be offset during the year.

229/22 Integrated Performance Report as of 31 October 2022

The integrated performance report as of 31 October 2022 provided an overview of key performance indicators aligned to the Big Plan. Detailed scrutiny of the metrics aligned to the four ambitions was undertaken by respective Committees of the Board. It was noted the report included in the bundle was more detailed to reflect the challenges of the operating clinical environment in which the Trust was working. Key messages identified from the report included:

(a) ***Consistently Deliver Excellent Care*** – the emergency care pathway continued to be under pressure with long waits in the emergency department, the Trust was above the national average on the 4-hour emergency care target, and a high number of ambulances had been unable to offload patients in a timely manner during October. Following a national improvement collaborative event in November, work was being undertaken with system partners on staffing and a location model for patients waiting in the emergency department for mental health beds and a more appropriate setting. Work was continuing on the frailty pathway in collaboration with community partners and the 2-hour rapid response team. Additional cohorting areas had been introduced in the emergency department to support offloading and releasing ambulances and this was part of the 'Be A Bed Ahead' initiative. The Community Healthcare Hub (Finney House) had now opened which was taking immediate pressure out of the emergency department and wards; virtual wards were also operating which was having a small positive impact; and all divisions had winter resilience plans in place.

It was important to closely monitor the position in relation to 78-week waits and cancer backlogs. Patients waiting over 78-weeks were being tracked and the numbers were reducing for patients that needed to be treated. Colorectal surgery, neurology and oral and maxillofacial surgery were noted as the specialties with significant challenges and an overview of the actions being taken was provided. The position for colorectal surgery was particularly challenging as all organisations were experiencing high demand and the system continued to support organisations through mutual aid. Theatre productivity had increased over the last few weeks and the team was focused on maximising activity. In relation to cancer, significant inroads had been made although the specialty remained an outlier across the country. Colorectal and skin were the cancer tumour sites with the highest backlog and the Trust was on a recovery trajectory overall for 62-day wait activity but the position remained challenging.

Discussion was held regarding the clinical pathways currently deployed through virtual wards and any future additional plans. It was noted three main pathways existed linked to respiratory, frailty, and the same day emergency care pathway which encompassed a number of other pathways. The starting point was a step-down protocol for patients in a hospital bed nearing their end of stay but who needed a couple of days prior to full discharge. There was close working with partners at Lancashire and South Cumbria NHS Foundation Trust to enact a step-up pathway which would allow people who would

ordinarily be admitted to be monitored through the virtual route. It was noted the ICB and PCB would be extending the model widely and the Trust introducing this new way of working would help in the future to ensure it was safe, successful, and appropriate governance was in place around virtual wards. The Chief Executive added that a more cautious approach had been taken in Lancashire and South Cumbria to roll-out of virtual wards although take up of virtual wards was the highest in the country when compared to notional beds and was being used nationally as good practice.

In response to a question regarding whether chatbot was inclusive for all patients, it was explained that a number of patients were excluded, and direct contact was made with the patient in such cases. The digital team worked with the operational team to ensure contact was not established with someone where it was know they could not respond digitally. It was noted that where patients did not respond they were not automatically removed from the waiting list and contact would be established in a different format.

Reference was made to the press reports regarding young children suffering from flu and respiratory disease and clarification was requested on the extent to which this was being seen within the Trust. It was confirmed that there was a definite increase in RSV on the children's ward although nothing exceptionally different from the levels being seen by other organisations. With regard to flu, there had been an increase across both adults and children much more so when compared to last year.

In respect of the performance position, the Director of Strategy and Planning mentioned part of his role was to lead on the elective position across Lancashire and South Cumbria. Weekly meetings focused on the 78-week waits and cancer backlogs and feedback from the regional and national team had been positive in terms of the breadth and depth of action plans and progress being made by the Trust, which provided assurance in terms of the external view. It was noted that at the last meeting the Director of Strategy and Planning was asked to pass on the positive comments on the hard work being completed on the performance agenda.

With regard to safety and quality metrics, focus remained on pressure ulcers and the commitment to reduce the numbers. *C.difficile* infection was reported at 122 cases to date which meant the Trust would exceed its annual trajectory. There was ongoing renovation work on the wards to help with infection prevention and control and weekly fogging had commenced. It was noted the output from the recent infection prevention and control review would be received by the Safety and Quality Committee in January.

(b) ***Great Place to Work*** – staff sickness was above target although it was pleasing to note the reduction in mental health related absences which was as a result of the mental health support for staff offered by the Trust. In terms of resilience during winter, Covid and flu vaccination rates were low and communications were being developed to remind people of the importance of getting vaccinated, along with promoting uptake through divisional teams. Incidences of violence and aggression had risen during the year due to some challenging patients admitted to wards. Vacancies were slightly over target at 10% with health support workers running at 16% and discussions at DIFs were focusing on increasing retention and how health support workers could be recruited to those roles.

The Chair mentioned that in previous years the Safety and Quality Committee received comparator data on uptake levels for flu vaccination rates and the Chief People Officer confirmed the data would be going to that Committee and the Workforce Committee. It

was noted the vaccination uptake level had been low (circa 36% compared to circa 75% at the same time in previous years).

(c) ***Deliver Value for Money*** – the Trust reported a £11.8m deficit position year-to-date (month 7) against a £2.7m year-to-date deficit plan. A summary was provided of the capital and cash positions, the status of the cost improvement programme, and the Trust's position in relation to its use of resources. The Chief Finance Officer referred to earlier comments regarding beds, noting it was fair to say the Trust was off track and as a Board needed to recover the position during the remainder of the year. It was noted this would be the challenge over the next few months, but teams would try what was reasonable and possible to deliver against that ambition.

The Chief Executive acknowledged the report presented a complex operational picture. With regard to Covid and flu, Board members were encouraged to spread the message about the importance of being vaccinated as there were large cohorts of the population who had not had either vaccine which was concerning going into winter.

The Board RESOLVED that the contents and actions being taken to improve performance be noted.

230/22 Big Plan metrics annual review

The report provided a revised set of Big Plan metrics which had been discussed during the year by Board members and governors and were reviewed following an Executive Director workshop on 9 November 2022. The metrics would be reviewed in the light of the National Planning Guidance for 2023/24 which was expected at the end of December 2022, and a local review of productivity metrics, and should any additions or revisions be required then they would be highlighted at the February 2023 Board meeting.

A lengthy discussion was held regarding the style and structure of the report, such as clarification on the years by which target actions would be delivered (years 1 to 3); the retrograde position in terms of sickness and staff perceptions; and the need to strengthen some of the wording, such as removing 'reducing' and 'increasing' and express the ambition using specific targets. In addition, it was suggested that where it was known that the target would not be achieved (e.g. 90% 4-hour wait in the emergency department) there was a need to look at appropriate wording. The challenges were acknowledged and it was explained there was always a balance with having realistic and ambitious targets and a national steer would be required on whether some of the targets could be amended. Planning guidance for 2023/24 was expected towards the end of 2022 and as part of the review there would be the opportunity to sharpen some of the language. In respect of those metrics which had gone backwards, such as sickness, it was noted there would be an ongoing sickness rate related to Covid which was a realism within some of the targets. The Workforce Committee had looked at and debated specific workforce metrics, what would be realistic targets whilst still ensuring stretch but not setting up the Trust to fail from the outset by introducing something that could not be achieved. As a general comment the Board also felt that as it was about to embark on its 5-year plan then expressing Our Big Plan metrics across the same period would be more appropriate. Reference was also made to system level metrics and whether the Trust was aligned as both a system and a Trust therefore it would be helpful to undertake a sense check in that regard.

In summarising the conversation, the Chair noted the Board approved the Big Plan metrics as presented, subject to changes articulated during the discussion for re-presenting the revised version at the next Board meeting.

The Board RESOLVED that:

1. **the Big Plan metrics presented in the report be approved subject to the refinements discussed.**
2. **the potential for additions and/or revisions and the intention to highlight those at the February 2023 Board meeting be noted.**

231/22 Trust Constitution 2022

A detailed review of the Trust Constitution had been undertaken during the year with the dual aim of ensuring the revised Constitution would be agile and fit for purpose for new ways of working under an ICS and was compliant with the requirements of the Health and Care Act 2022. A working group of governors was established to ensure input, scrutiny and oversight of the proposed changes. The Constitution was presented to and approved by the Council of Governors on 3 November 2022 and was presented to the Board for approval, following which the 2022 Constitution would take effect.

The Board RESOLVED that the 2022 Constitution as presented by approved.

232/22 Items for information

The following reports were noted for information:

(a) New Hospitals Programme quarterly update

(b) Corporate and Governor Calendar 2023-24

(c) Health and Safety Annual Report 2021/22 – following comments from Board members regarding placement of the report on future Board agendas, it was agreed that a short summary document would be produced for discussion and comment by the Board on an annual basis, following scrutiny of the full annual report by the Safety and Quality Committee.

The Board RESOLVED to:

1. **receive and note the contents of the reports for information.**
2. **to receive a short synopsis of the Health and Safety Annual Report in future for discussion and comment.**

233/22 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 2 February 2023 at 1.00pm using Microsoft Teams.

Signed: _____

Chair

Date: _____

Action log: Board of Directors (part I) – 1 December 2022

There are no outstanding actions from previous meetings

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

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	217/22	1 Dec 2022	*Patient Story* – work to be undertaken with the patient (Gregg Stevenson) on the mental health 'C-Cards' and promotion of the work he undertakes around mental health.	F Button/ N Duggan	2 Feb 2023	**Completed** **Update for 2 February 2023** – the Chief Operating Officer is discussing with the patient the use of 'C-Cards' within the Trust. The Communications team met with the patient for an interview regarding his recovery at SMRC and this has been sent out as a press release, and will appear on the Trust website, intranet and social media channels in January.
2.	226/22	1 Dec 2022	*Equality, Diversity and Inclusion Strategy* – prior to publication, pages 36 and 37 to be amended to remove some duplicate wording and include the number of Board members where that information had been missed.	K Swindley	2 Feb 2023	**Completed** **Update for 2 February 2023** – report amended.
3.	230/22	1 Dec 2022	*Big Plan Metrics Annual Review* – refinements to be made to the report as discussed, including changes following receipt of planning guidance at the end of December, prior to resubmission at the February Board meeting.	G Doherty	2 Feb 2023	**Completed** **Update for 2 February 2023** – update report included on the agenda and final metrics to be presented to April Board meeting (included on the forward plan for that meeting).
4.	232/22(c)	1 Dec 2022	*Health and Safety Annual Report* – a short summary document to be produced for discussion and comment by the Board on an annual basis, following scrutiny of the full annual report by the Safety and Quality Committee.	S Cullen	2 Feb 2023	**Completed** **Update for 2 February 2023** – summary report added to the Board cycle of business.

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:**	2 February 2023
Report of:	Interim Chair of the Trust	**Prepared by:**	Professor Paul O'Neill
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To 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

Chair's Report

I want to start my report by thanking personally our executive directors, managers, administrative and clinical staff for all their work and commitment to our patients and communities over the holidays and winter at a time of unprecedented demands on the NHS including LTHTr. I have worked in the NHS since 1979 and I cannot remember such sustained pressure. We have worked together as a Board to support the Trust and system and I remain certain that the commitment of our staff to provide safe care to our patients will continue.

As I mentioned in my last report, I continue to attend and engage with the work of the Provider Collaborative Board. It is very important that the PCB (and ICB) develops to ensure the success of our system, which is under enormous financial pressures. The PCB is now established as a Joint Committee, which means that it can make decisions for the system and that our Board will have a strong input in shaping those decisions. If we are to move forward strategically, there will probably have to be significant changes to clinical pathways as well as other key elements in our system. More locally, the development of 'Place', meaning local services and local partnerships, will be essential to providing better, seamless, care to the people in our communities.

Given this strong emphasis on strategic direction, I have been reviewing the Board workshops and development sessions. In consultation with my Board colleagues, we are redesigning these to ensure that we will continue to have a coherent approach, which will allow us to develop our strategy and integrate this with the ICS.

Similarly, I am reviewing the development and training programme for governors to ensure that it meets their needs as the new NHS operating framework matures. My one to one discussions with governors have been very helpful to me and reinforce my view of their wide experience and commitment to the Council, Trust and wider NHS.

As I mentioned in my last report, I am acting as the 'Chair of the Board' for participants in the Lancashire and South Cumbria NED Development Programme aiming at promoting inclusivity and widening diversity in our Boards. I have met the participants and will have chaired a shadow Board by the time we meet as the LTHTr Board and I will probably describe my experience in more detail, but the participants are very committed to the programme, come from a wide range of lived experiences and I think will be great assets to NHS Boards going forward. It is very rewarding to be involved and help.

Finally, I need to mention that my term as interim chair will cease at the end of May. This means that I will be your chair at the next Board in April, but, importantly, a process has started to make a permanent appointment, which is very important for the success of the Trust.

1. Introduction

The purpose of this report is to provide an overview of the work and activities undertaken from 1 December 2022 to date.

2. Chair's attendance at meetings

2.1 Details below are the meetings attended and activities undertaken during December 2022 and January 2023.

Date	Activity
December 2022	
1 December	1:1 – Non-Executive Director

	1:1 – Non-Executive Director
	1:1 – Chief Executive
	Board of Directors Public Meeting
	Board of Director Part 2 Meeting
5 December	1:1 – Company Secretary
	Meeting with LTHTR and Cllr Bradley
6 December	1:1 – Non-Executive Director
	Board Visibility Session: GEOFF
	Board Development Session
	Undergraduate Teaching Awards
	Council Development Session
8 December	AAC Panel – Consultant Recruitment
	1:1 – ICB Chair
9 December	AAC Panel – Consultant Recruitment
12 December	1:1 – Non-Executive Director
13 December	Pre Meet – LSCFT NED Shadow Board
	Education, Training and Research Committee
14 December	1:1 – Chief Executive
	1:1 – Company Secretary
	Chair Visit – Finney House
15 December	Provider Collaboration Board Meeting
	Provider Collaboration Board Annual Event
19 December	Operating Model for LSC ICB Workshop
21 December	1:1 – Chief Executive
	1:1 – Governor
3 January	1:1 - Governor
	1:1 – Non-Executive Director
	Introductory Meeting - LTHTR
	Introductory Meeting – East Lancashire Director
4 January	NED Development Programme - LSCFT

	1:1 – Governor
	1:1 – Chief Executive
	1:1 – ICB Chair
5 January	1:1 – Non-Executive Director
	Chairs, Deputy Chairs and Lead Governor Meeting
6 January	Intro Meeting – Chair, ELHT
16 January	Meeting regarding Strategic Planning
	1:1 – Company Secretary
17 January	Governor Election Awareness Workshop
	Non-Executive Monthly Catch Up
	Board Workshop
	1:1 Chief Executive
18 January	Board Pre-Meet
	Governor Election Awareness Workshop
19 January	Provider Chair Meeting
	Provider Collaboration Board Meeting
	1:1 – Company Secretary
	LSCFT NED Development Meeting
23 January	1:1 – Chief Executive
	Meeting with Chair and Deputy Chair of Membership Subgroup
25 January	Pre-Meet ahead of COG
26 January	L&SC NED Development Programme – Shadow Board 1
	Council of Governors Public Meeting
	Council of Governors Part 2 Meeting
31 January	Education, Training and Research agenda setting meeting

3. Non-Executive Director Update

3.1 The chair is meeting regularly with the Non-Executive Directors on site to discuss a wide range of issues and challenges for the Trust and ICS. We are instituting structured on-site visits to a range of departments.

4. Financial implications

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

5. Legal implications

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

6. Risks

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

7. Impact on stakeholders

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

8. Recommendations

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

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	2nd February 2023
Report of:	Chief Executive	**Prepared by:**	Naomi Duggan, Director of Communications and Engagement
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable

CHIEF EXECUTIVE'S REPORT

1. INTRODUCTION

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

2. UNDERSTANDING THE NATIONAL CONTEXT AND EXTERNAL ENVIRONMENT

a. National Headlines

i. NHS Operational Planning Guidance 2023/24 published

On Friday 23 December, NHS England (NHSE) published the 2023/24 priorities and operational planning guidance which sets out its priorities for the year ahead.

The planning guidance sets a range of "national NHS objectives" for 2023/24, with expected performance against key operational standards.

Integrated Care Boards (ICBs) are asked to work with system partners to develop plans to meet the objectives set out in this guidance before the end of March 2023.

The 2023/24 planning guidance sets out three core priorities:

- Recovering our core services and improving productivity
- Make progress in delivering the key NHS Long Term Plan ambitions
- Continue transforming the NHS for the future

Headline ambitions for recovering core services and improving productivity include:

- Improving ambulance response and A&E waiting times.
- Reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard.
- Making it easier for people to access primary care services, particularly general practice.

At national level, total ICB funding allocations are flat in real terms with additional funding available to expand capacity. Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners.

Our Trust leadership has been reviewing this guidance and is working with teams and system partners to understand and implement its delivery.

Full planning guidance documents and supporting guidance can be read here: NHS England » NHS operational planning and contracting guidance.

ii. Strike action

For the first time in the history of the Royal College of Nursing (RCN), tens of thousands of their members took part in industrial action in December 2022. Further strike action took place on 18th and 19th January 2023, including colleagues at Lancashire Teaching Hospitals. Two further dates in February (6th and 7th) have also been announced, which again includes Lancashire Teaching Hospitals' staff.

The Trust has worked very closely with the RCN Strike Committee to ensure that recent industrial action was as safe as possible for patients, and we would like to thank them for the positive dialogue that has taken place. This dialogue and planning helped the Trust to continue with the majority of planned procedures - especially for patients in greatest clinical need and any postponed treatments have been rescheduled at the earliest date available.

Thank you also to those colleagues who let us know that they were choosing to (or not to) strike, as this helped with our planning. In addition to those striking, some chose not to strike on principle, others were simply unable to afford to and some were working in derogated areas. A derogation is an exemption, either of an individual or a whole service, from taking part in strike action. Both people and services can be derogated and these are what the RCN uses to deliver safe strikes.

Whilst NHS pay is a matter for the Government and trade unions, Lancashire Teaching Hospitals respects the right of colleagues to strike and not to strike and highly values all those who work for us.

iii. NHS urges women to book a cervical screening as a third don't take up vital offer

The NHS has issued a call for anyone eligible for cervical screening to come forward for a potentially life-saving appointment, with nearly a third, around 4.6 million, not taking up their latest test.

The plea from senior NHS medics comes on the back of the health service sending a record number of invites for cervical screening in the last year, as part of its ambition to eradicate the cancer through a combination of vaccination and early identification.

More than five million invites were sent in the last full year (2021/22) – up by over a tenth (10.5%) on pre-pandemic levels.

Screening helps prevent cervical cancer by using a highly effective test to check for high-risk human papillomavirus (HPV), which is found in over 99% of all cervical cancers and which may cause abnormal cells to develop in the cervix. These abnormal cells can, over time, turn into cancer if left untreated.

Around 2,700 women are diagnosed with cervical cancer in England each year, but the NHS screening programme helps save around 5,000 lives each year.

iv. Grant Shapps unveils new powers in strike laws

Business Secretary Grant Shapps has set out plans to enforce minimum service levels during strike action, including for ambulance staff, firefighters and railway workers.

Under the bill, some employees would be required to work during a strike and could be sacked if they refuse. Mr Shapps said the aim was to protect lives and livelihoods.

But unions said the proposed bill was "undemocratic, unworkable, and almost certainly illegal." And Labour said it would repeal the legislation if it wins the next general election.

The new bill comes amid a wave of industrial action across public services, with unions calling for pay increases to keep up with the rising cost of living.

It is not set to become law until later this year. Ministers will get the power to set minimum safety levels for fire, ambulance and rail services under the bill, which will apply to England, Wales and Scotland. They would also have the power to set minimum levels of service for health, education, nuclear decommissioning and border security but hope to reach voluntary agreements in these areas.

v. COVID: Leftover swabs to be tested for other viruses in the UK

Millions of UK Covid test samples will be analysed for other serious respiratory viruses, including flu, in a new disease-tracking project.

The Wellcome Sanger Institute team will run detailed genetic reads on the anonymised nose and throat swabs leftover from the pandemic. The initiative could be an early warning system, quickly spotting future disease threats, say scientists. It could also help identify new treatments and ways to stop outbreaks.

If the programme can be scaled up, in a few years the NHS could do these type of checks routinely on patients for large-scale surveillance. In the future, it could scan for certain bacteria and fungal infections too.

The scientists will work with government and public health teams, and all the data will be made freely and publicly available.

vi. Diabetes artificial pancreas tech recommended for thousands on the NHS

More than 100,000 people in England and Wales with type 1 diabetes could soon be offered new technology to manage their condition on the NHS.

The system uses a glucose sensor under the skin to automatically calculate how much insulin is delivered via a pump.

Health assessors said it was the best way of controlling diabetes, barring a cure. A charity said it would transform lives and was the "closest thing to a working pancreas".

The National Institute of Health and Care Excellence (NICE), the health body recommending the technology, said a more cost-effective price still had to be agreed with manufacturers.

In trials, it improved quality of life and reduced the risk of long-term health complications.

Approximately 400,000 people are currently living with type 1 diabetes in the UK, including around 29,000 children.

vii. NHS to buy care beds to make space in hospitals

Thousands of NHS patients in England will be moved into care homes as part of the government's plan to ease unprecedented pressure on hospitals.

The NHS is being given £250m to buy thousands of beds in care homes and upgrade hospitals amid a winter crisis. It is hoped the move will free up 2,500 hospital beds so patients can be admitted more quickly from A&E. There are currently about 13,000 medically fit patients occupying beds in England.

In the coming weeks, some of those patients will be discharged from hospitals into the community, where they will receive care as they recover. The package will include trials of other ideas to free up hospital beds in six areas of England.

The government said these ideas, which include dedicated dementia hubs and new options for rehabilitative care, could be rolled out across the NHS if successful.

viii. UK plan for national mRNA cancer vaccine advice

The UK is embarking on an ambitious plan to accelerate research into mRNA cancer vaccines, with German pharmaceutical company BioNTech.

Following the success of Covid vaccines using the same messenger-ribonucleic-acid technology, scientists now want to conduct more trials in cancer patients.

And they are hoping to provide this personalised type of treatment to about 10,000 patients by 2030.
Britain is the first nation to sign up to such a partnership.

BioNTech has several international cancer vaccine trials in progress but says the UK is ideally placed as it has a great track record and infrastructure for medical research.

Some of the patients in the trials will have cancer that has already been treated and the vaccine will hopefully prevent it returning. Others will have advanced, spreading cancers the vaccine might help shrink and control.

Unlike chemotherapy, which attacks lots of different cells as well as the cancer, the mRNA treatment is tailor-made for the individual and presents the immune system with bits of genetic code from the specific cancer so it can attack only the tumour.

ix. Breast cancer patients take part in proton beam trial

A pioneering NHS trial has begun to assess whether proton beam therapy can help certain breast cancer patients.

The study, which is a world-first, will compare the hi-tech treatment with standard radiotherapy for those deemed at higher risk of long-term heart problems.

The treatment uses charged particles instead of X-rays to target tumours more precisely. The trial will include 192 people across 22 UK sites.

Every year some 30,000 breast cancer patients in the UK are offered radiotherapy following surgery. Typically, the treatment is effective but for some it can lead to heart problems later down the line. This is because the breast tissue and lymph nodes being targeted are close to the heart, or because the patient already has an underlying increased risk of heart problems.

It is hoped that using the proton beam treatment will minimise the amount of radiation delivered to the heart during traditional treatment, while still targeting the cancerous cells. Only those who are estimated to have at least 2% or more potential lifetime risk of heart issues caused by radiotherapy will take part in the trial. Scientists will measure the dose of radiation delivered to the heart and patients will record their experience.

x. Flu nasal spray vaccine for children may reduce Strep A risk

A nasal spray vaccine that protects children against flu may also help protect against strep A infections, the UK Health Security Agency (UKHSA) says.

It found that rates of strep A were lower in areas where the vaccine was offered to all primary-age children when it was first being used.

Everyone eligible for a flu vaccine is urged to get one after the large rise in hospital admission.
Children under five and the over-85s are the most vulnerable age groups.

There are unusually high rates of Group A strep infections in the UK at present, including scarlet fever and strep throat. Most are mild and easily treated, often with antibiotics, but occasionally the infection causes serious problems when it becomes invasive.

The UKHSA study of data from 2013-17, which is not yet peer-reviewed, found that rates of strep infections were lower in areas where the flu vaccine was piloted - 73.5 per 100,000 children aged two to four years old - compared to areas where it was not offered as widely - 93 per 100,000 children.

There was no difference in the number of children reported to have scarlet fever or invasive group A strep (iGAS), however, the analysis said.

xi. Record alcohol deaths from pandemic drinking

A record number of people died from alcohol last year, which is likely to be the result of increased drinking during the pandemic, according to the Office for National Statistics.

There were 9,641 deaths in the UK in 2021, compared to 7,565 in 2019 - a 27% increase.

The ONS says people who were already big drinkers before the pandemic drank more during the Covid years.
The 2021 figures are alcohol-specific deaths, which are defined as a direct consequence of alcohol. Most are from alcoholic liver disease. They account for around a third of all deaths linked to alcohol.

In 2021, UK rates of alcohol-specific deaths per 100,000 people were highest in Scotland and lowest in England:

- 22.4 in Scotland
- 19.3 in Northern Ireland
- 15 in Wales
- 13.9 in England

3. INFLUENCING THE LOCAL HEALTH AND SOCIAL CARE ECONOMY

a. Lancashire and South Cumbria Headlines

i. Chief Executive, Kevin McGee, is the lead for the Hospital Cell and Chief Executive for the Provider Collaborative. The list below highlight's Kevin's meetings in December 2022 and January 2023.

Date / Frequency	Meeting
Weekly – Monday	North West Hospital Cell Gold Command Escalation
Weekly – Tuesday	David Flory, Independent Chair, (LSC) Integrated Care System
Weekly – Wednesday	Executive Team Meeting
Fortnightly – Monday	Lancashire & South Cumbria Joint Cell
Fortnightly – Wednesday	Optimising Urgent and Long Term Pathways Workshop
Monthly – Monday	Central Lancashire Senior Leadership Team
Monthly – Wednesday	Formal LSC Chief Executives Briefing
Monthly – Wednesday	North West Regional Leadership Group
Monthly – Wednesday	Formal Chairs and Chief Executive's Meeting
December 2022	
1 December	LSCFT Meeting
	Pathology Network Partnership Group
	1:1 – Non Executive Director
	1:1 – Interim Chairman
	Board of Directors Public Meeting
	Board of Directors Part 2 Meeting
2 December	PCB Coordination Group
5 December	Executive Finance Meeting
	Annual Staff Loss Memorial
	Reverse Mentoring Meeting
	Provider CEO's and DOF's Meeting
	Chair Recruitment Call
	Meeting with Cllr Bradley
6 December	Consultant Candidate Call
	PLACE Development Session
	Undergraduate Teaching Awards
	Council Development Session
7 December	L&SC ICB Board Meeting
	HFMA Conference
8 December	HFMA Conference
9 December	HFMA Conference
12 December	1:1 – Non-Executive
13 December	Recovery Plan Meeting
	GGI-LTHTR Proposal Meeting
14 December	1:1 – Interim Chairman
	L&SC ICB Delivery Board
	Senior Leadership Team
15 December	Provider Collaboration Board Meeting
	PCB Annual Event
19 December	Operating Model for LSC ICB Workshop
20 December	CEO Visit
21 December	BBC Radio Lancashire Interview
	1:1 – Interim Chairman
	CEO Ward Visits
22 December	Pre Meet – Pathology Board
	Regional Roadshow
	Global Radio Interview
23 December	L&SC Pathology Service Board
	Filming – Christmas Message
	Meeting with Lancashire County Council
	CEO Visit – Closure of Mass Vaccination Centre (St Johns)
January 2023	
4 January	1:1 – Interim Chairman
5 January	Chairs, Deputy Chairs and Lead Governor Meeting
6 January	PCB Coordination Group Meeting

	ED Safety Forum
	Daily Joint Cell
9 January	Extraordinary CRN NWC Partnership Group Meeting
10 January	Intro Meeting – Lancashire County Council
	Daily Joint Cell
	Global Radio Interview
11 January	CEO Ward Visits
	Senior Leadership Team
12 January	ISD Informatics Accreditation – Pre Meet
13 January	Daily Joint Cell
16 January	Strategic Planning Discussion
	1:1 – Non Executive
17 January	ISD Informatics Accreditation Meeting
	Board Workshop
	Daily Joint Cell
	1:1 – Interim Chairman
18 January	Radio Lancashire Interview
	ITV Interview
	L&SC ICB Delivery Board
	Tier 1 LTHTR Meeting
19 January	Provider Collaboration Board Meeting
	Workshop for Finney House
20 January	Meeting regarding Chorley ED
	PCB Coordination Group
	Daily Joint Cell
	PCB/Elective Recovery Proposal Meeting
23 January	1:1 – Interim Chairman
	Meeting with Paediatric Department
24 January	Combined NW System Leaders and Chairs Call
	MSAC Meeting
	Meeting to discuss Maggie's Centre
25 January	LTHTR/Beamtree Steering Group
	PALS Meeting
	Tier 1 LTHTR Meeting
26 January	CEO Visit
	Provider Collaborative Board Follow Up Session
	Surgery DIF
	Council Of Governors Part 1 Meeting
	Council of Governors Part 2 Meeting
	NHP Strategic Oversight Group

ii. Provider Collaborative Board

The Provider Collaborative Board meets monthly using performance updates to inform strategic discussions affecting all local Providers, and works closely with the Integrated Care Board to ensure strategies are aligned for the benefit of the population of Lancashire and South Cumbria, staff and stakeholders. An overview of the January PCB meeting can be found in Appendix A.

iii. ICB Board report update

On 1st February 2023, the Lancashire and South Cumbria Integrated Care Board held their monthly Board meeting with Kevin Lavery presenting his Chief Executive update which is two-fold. The report addresses both the ongoing winter pressures, and system-wide work to mitigate risk to patients; and the work the systema are doing to develop its longer-term strategies seeking to align the different parts of the system and build something

different. Kevin highlighted that the challenge is to deal well with the here and now crises, yet not lose sight of the future and strategic mission that the ICB was set up to address. Please see the full report in Appendix B.

iv. Virtual Wards

Thousands of people across England, including the North West, are benefitting from being treated at home on a virtual ward. This innovative approach is delivering high quality care, safely and conveniently for people at home – where they would rather be.

Virtual wards provide hospital-level care and remote monitoring for patients who would otherwise be in hospital, either by preventing admissions or allowing them to return home sooner to continue their treatment at home.

The roll out and expansion of virtual wards is supported by a growing and developing evidence base that demonstrates benefits for patients, staff and systems. There is good evidence that patients on frailty virtual wards (also known as Hospital at Home) have better outcomes than those treated in hospital.

Multidisciplinary teams are ensuring people receive high quality care. This includes daily senior clinical reviews, using cutting-edge monitoring devices, clinical advice, smartphones and other technology. Healthcare professionals may also visit a patient's home to provide face-to-face care - these types of virtual ward are sometimes known as hospital at home.

v. Vaccinations

Health chiefs in the Northwest have urged people to grab a vaccine boost to protect themselves from Covid-19 and flu amid continuing high infection rates and hospital admissions.

Hundreds of sites across the region, including general practices, pharmacies and hospital hubs, are continuing to offer first, second and autumn booster doses of the Covid vaccine throughout January.

Free NHS flu vaccines are also still available at general practices and pharmacies and school vaccination teams are visiting secondary schools this month to give the vaccine – which is generally given as a nasal spray to children - to students in years 7 to 9.

While more than 2 million people in the North West have had their Covid booster and 2.5 million people have had a flu jab, there are still a number of eligible people who have not taken up their winter vaccinations, placing themselves at an increased risk of serious illness.

General practices and pharmacies are continuing to offer the flu vaccine to eligible people. It's possible to book a flu vaccine at some pharmacies online at https://www.nhs.uk/conditions/vaccinations/book-flu-vaccination/. To find a wider list of pharmacies offering flu vaccination that you can contact directly book, visit https://www.nhs.uk/nhs-services/prescriptions-and-pharmacies/pharmacy-nhs-flu-vaccine-service/

In addition, the free flu vaccine is offered to all two and three-year-olds, all primary school aged children and secondary school-aged children in years 7-9.

4. 

Consistently deliver excellent care

a) Surface Guided Radiotherapy success

Rosemere Cancer Foundation held an open evening in late November to help celebrate their 25th anniversary, with the introduction of Surface Guided Radiotherapy.

SGRT is the application of a near-infrared light, projected onto the patient's skin during radiation delivery to help ensure the patient is treated accurately and safely, by making sure they are in the correct position.

The charity has raised over £800,000 towards their £1.3m appeal target, with much support, generosity and some significant gifts in donors' wills, and the SGRT system – the largest such install to date in the UK - will make a big difference moving forward.

SGRT enables treatment without the need for any permanent tattoos or marks, is completely non-invasive, and proven to be more accurate for treatment setup.

In January, Blackpool school support worker Anita Brown (68) was the very first patient to start and complete a course of radiotherapy treatment using the new kit, having been diagnosed with breast cancer last August after a routine mammogram. Read the full story on the Trust website.

b) Bereavement Team Book Donation

The Bereavement Team based in the maternity unit at Royal Preston Hospital were delighted to accept a generous donation of books aimed at supporting families who are faced with the loss of a pregnancy, baby loss or sadly the loss of a baby shortly after birth. The team received a generous donation of £468.60 from the Governor Patient Experience Fund allowing them to purchase a range of books for parents who unfortunately experience the pain and grief of losing their baby through pregnancy, miscarriage, stillbirth or within the neonatal period.

c) First cohort begin UK first Practice Based Pathway

A 25-strong cohort recently started on a unique and innovative entry route into nursing, delivered by Lancashire Teaching Hospitals Foundation Trust, in partnership with the University of Central Lancashire (UCLan).

The workplace-based programme, leading to a BSc (Hons) Nursing with Registered Nurse (Adult) degree, has been developed over the past couple of years, designed for those aspiring to be registered nurses, learning within their local healthcare provider.

Student nurses will spend their placement time learning alongside practitioners and academics at one of four NHS Trusts within Lancashire and South Cumbria, with an average week consisting of a mix of theory and practice.

In an effort to make university study accessible to all, UCLan has developed a suite of Return to Study entry programmes, designed for those who do not currently have the required entry criteria for a full university programme (formal Level 3 qualifications, such as A Levels or BTECs, or maths or English qualifications). This 6-week free programme is available for entry into a variety of different courses, including to those wanting to undertake this Practice-Based Pathway into Nursing.

This helps to make the Practice-Based Pathway more accessible for students who have the capability to demonstrate the qualities and skills required. No healthcare experience or prior qualifications are needed to access the Return to Study programme.

5. A great place to work

a) Gordon Hesling entrance updated

The Gordon Hesling block entrance at Royal Preston Hospital has reopened after undergoing major improvements.

The completed project includes new flooring, lighting and ceiling, the addition of seating areas and the installation of a reception desk.

Historic items, such as the stained-glass window from the original Royal Preston Infirmary, and the plaque unveiled by Princess Diana to mark the opening of the current hospital, have been incorporated into the design of the new entrance area.

6. 

Deliver value for money

a) Lancashire Teaching Hospitals NHS Trust joins EHDEN consortium

A Lancashire Teaching Hospitals NHS Foundation Trust's application to join the European Health Data & Evidence Network Data Partners, and Observational Health Data Sciences and Informatics, has been successful.

The Trust has been selected to work with the EHDEN consortium in partnership with Health Data Research UK and the UK Health Data Research Alliance.

Based on a data complexity assessment and the proposed work, the Trust have been awarded £60,000.

HDR UK awarded grants to successful UK data partners, and will now collaborate with the Trust and contribute to future research studies.

This, alongside the Trust's role as lead organisation for the NWSDE program, now puts us in an international network of partners using health data to improve care for their populations.

b) UKCRF Network awarded £2.4million in public funding to support the delivery of early phase research studies

The UK Clinical Research Facility Network (UKCRF Network), hosted by Manchester University NHS Foundation Trust (MFT), has been awarded £2.4 million funding by the National Institute for Health and Care Research (NIHR) to support research studies over the next five years.

The UKCRF Network works in collaboration with 54 Clinical Research Facilities (CRFs) based within NHS Trusts across the UK and Ireland, including the NIHR Lancashire CRF based at Lancashire Teaching Hospitals. It also links with other key early phase and experimental medicine infrastructure including for cancer and vaccine trials.

The aim of the network is to benefit the UK early-stage clinical research and life sciences industry by developing, sharing and implementing excellence in operational practice for efficient and effective trial delivery, excellent patient experience and safety.

Interim Director of UKCRF Network, Paul Brown – Lancashire Teaching Hospitals' Head of Research and Innovation, led on the successful proposal to the NIHR alongside MFT, CRF Directors and colleagues within the Network.

The 28 NIHR CRFs belong to the UKCRF Network and are a key part of the UK's leading early-stage clinical research infrastructure and play an important role in making the country a global hub for life sciences.

7. *Fit for the future*

a) New Patient Experience Strategy launched

Patients and their families are at the heart of everything we do as a Trust and this week, we are proud to launch our new Patient Experience and Involvement Strategy for 2022-25, which sets out how we intend to build on the fantastic work we already do to deliver high quality and compassionate care.

Our new Patient Experience and Involvement Strategy sets out tangible and measurable actions which will help transform the experience of patients and ensure that they are fully involved in the decision making around their care.

Our patients, families, carers, colleagues, and governors are our strongest partners. They have played a key role in helping us to co-produce our vision, strategy and implementation plan and they will be key in ensuring that we deliver our vision.

Listening to the lived experience of our patients presents us with a brilliant opportunity to improve existing services and find new and better ways to meet the needs of our patients and their families.

Thank you to everyone who has been involved with the development of this strategy. Patient Experience is everybody's business - and we can't deliver this strategy without you. We look forward to working with you to embed great patient experience in everything we do.

8. AWARDS, ACHIEVEMENTS AND OTHER NEWS

a) Governor elections

Governors have a key role in representing the interests and views of our members, both colleagues and the public, as well as the wider general public. They are essential in making sure that their views and opinions are considered in providing and developing our hospital services, making a huge difference to the lives of those we help.

The Trust are currently looking for Foundation Trust members to join the Council of Governors with nomination still open (at the time of writing). There are eight Governor vacancies available within the public constituency and four within the staff constituency.

The Elections to the Council of Governors will be held in March this year, with the deadline for nominations closing on Monday 6 February 2023.

It is expected that Governors commit to attending the following each year:

- Four formal Council of Governors meetings

- Informal Council workshops and joint development sessions
- Governor subgroup meetings
- Annual Members' meetings
- Ongoing training and development

Key dates are summarised below:

- Deadline for nominations – Monday 6 February, 2023
- Voting packs despatched – Tuesday 28 February, 2023
- Close of Election – Thursday 23 March, 2023
- Declaration of Results – Friday 24 March, 2023

For more details on standing for election, please visit www.cesvotes.com/LTH2023 or email ftnominations@cesvotes.com.

b) MBE for Consultant neurosurgeon for charitable services

Lancashire Teaching Hospitals NHS Foundation Trust's Consultant Neurosurgeon Professor Nihal Trevor Gurusinghe was one of Lancashire's six recipients of an MBE in the New Year Honours List, recognised for his charitable services.

He said: "I'm overwhelmed and very proud to have been honoured, particularly being in the first award list by the King, who I admire very much. I'm a neurosurgeon, but I am involved in some charitable work, mainly in relation to the Buddhist community in the UK. The other project is more local, I founded a neuroscience foundation, and we do a lot of work in relation to education and research in the neurosciences locally in Preston, and the benefit of that work is to the community. When we educate our doctors and nurses, they give it back to the community in the work they do."

c) First batch of medical interns attain PG Diploma in Clinical Practice with University of Manchester

The Trust's Medical Intern Project - shortlisted for Workforce Initiative of the Year at the Health Services Journal awards – has seen its first graduates.

The first batch of Medical Interns who commenced with the Trust in August 2020, shortly after the first lockdown for COVID-19, have now completed their full cycle of the programme.

All 9 have attained their PG Diploma in Clinical Practice with the University of Manchester, and all remain in the NHS system, with five still with the Trust in training in their specialties.

Congratulations to: Dr Ahmed Elmowafy, Dr Menna Elhadidy, Dr Aya Ali, Dr Omar Abdelrazek, Dr Omar Elboraey, Dr Mohamed Komber, Dr Omar Eldeeb, Dr Mohamed Hamdy and Dr Lina Shehabeldin.

d) St John's mass vaccination site closes

The mass COVID-19 vaccination site at St John's Shopping Centre in Preston closed its doors for the final time on Friday 23 December having administered over 200,000 vaccines. The closure was possible because the vaccine programme has reached a point where it can be delivered within primary care, either in GP surgeries or pharmacies, or in settings managed by them.

The Trust would like to thank all colleagues involved in the initiative since its opening in January 2021.

e) The Lilywhites bring some Festive cheer to children's ward

Preston North End – days after a big 4-1 win at local rivals Blackburn Rovers – helped lift the spirits of young patients on the children's ward at Royal Preston Hospital ahead of Christmas.

Manager Ryan Lowe, club captain Alan Browne, Greg Cunningham and Ryan Ledson visited the ward, along with members of staff from the club's Community and Education Trust, to hand deliver a wide range of presents and meet the children. Due to COVID-19, the visit had not been able to go ahead for the previous two years.

Picture courtesy of PNE FC / Ian Robinson.

f) Gregg dreaming of Paris Paralympics place

Veteran Gregg Stevenson is hoping to make the plane for the 2024 Paralympics in Paris, having been helped along the way by Lancashire Teaching Hospitals' Specialist Mobility and Rehabilitation Centre.

Gregg, from Foulridge, near Burnley, was seriously wounded in Kajaki, Helmand Province, Afghanistan in 2009, losing both legs, his left above the knee.

He was referred to the Trust's Specialist Rehabilitation Centre (SMRC) at Preston Business Centre for support, and was fitted with the world's most advanced bionic high-tech Genium X3 knee, which works with Wii gaming technology - worth £70,000.

Following his referral, Gregg ended up working in the gym at SMRC - which provides specialist wheelchair, prosthetic limb and orthotic rehabilitation services throughout Lancashire and South Lakeland – earning some qualifications, before becoming gym assistant manager, and then lead physical training instructor, and progressing to be a Mental Health practitioner.

Now, with NHS Op Courage Veterans High Intensity Service North – and fresh from celebrating success at the National Positive Practice in Mental Health Awards for his pioneering crisis cards mental health aid for veterans – he has his sights set on gold next summer, as he trains with the Paralympic rowing programme in Caversham near Reading, preparing for the 2,000m with double gold winner Lauren Rowles.

g) Publishing success for dental therapist

Dental Therapist Sarah Hartigan, who works in Special Care Dentistry and Restorative Dentistry with Lancashire Teaching Hospitals, has co-written a chapter in a new book on the Care of Head and Neck Cancer Patients for Dental Hygienists and Dental Therapists.

Editor Jocelyn J. Harding has compiled the advisory guide – released earlier this month – from 52 contributors and all proceeds from the book go to the Head and Neck Cancer Foundation.

Read Sarah's thoughts on the full write up on the Trust's website.

h) Festive Lights Switch-on

On Thursday 8 December, Chaplain Simon Gilbertson gave a Christmas reading and led a brief carol service, before those present braved the sub-zero conditions to watch the official switch on by public governor, Janet Miller.

Four days later on Monday 12, the annual Christmas carol service and lights switch on for Royal Preston Hospital was held in the chapel. Trust Lead Chaplain Martin McDonald gave a service of great joy and warmth, helped by the Fulwood Methodists choir, and the service broke off briefly to allow Trust fundraiser Lucy Clark to switch the lights on the tree opposite the chapel, one of a number of trees which have been donated by the Lancashire Teaching Hospitals Charity.

i) Undergraduate Teaching Awards

On 6th December 2022, the Trust held the annual Undergraduate medical education Teaching Awards for academic year 2021/22. These are student led awards and are always well received by the personnel who support the students daily on their clinical placements, as well as those who support them in their group or individual teaching sessions.

This event was led by our own Hospital Dean, Prof Madhavi Paladugu who is also a Consultant Paediatrician within the Trust.

Also in attendance was Prof Margaret Kingston, Director of Undergraduate Medical Studies within the Division of Medical Education in the School of Medical Sciences at Manchester University.

For the full story, including award winners, please visit The Health Academy website.

j) Media round-up

As well as some of the positive coverage reported above, the Trust has also been in the news for other stories, both local and nationally, over the last couple of months.

In December, the Lancashire Post featured the long-established tradition for Children's Services at Lancashire Teaching Hospitals, as members of Scooter Clubs from across Greater Preston came together to take part in the annual scooter selection box run.

And the local newspaper was back on site in January to capture some of the babies born at Royal Preston Hospital in the first month of the year, while also reporting on the new £2m Skylark facility opening at Royal Preston Hospital (an LSCFT facility) for older women living with mental health conditions.

The Post also reported on the decision on whether to build brand new hospitals for both Preston and Lancaster being delayed, and the story of the Preston couple raising £4,000 for Rosemere at their Ruby wedding celebration, having both been diagnosed with cancer.

Meanwhile, Blog Preston featured an NHS Blood and Transplant Service donor drop-in event at RPH, as well as a CuddleCot donated to the Children's Ward at Royal Preston Hospital jointly by Midlands-based Remember Rufus and Freddie's Wish.

The national news covered the two-day strike in January by members of the Royal College of Nursing (RCN) with Trust Chief Executive Kevin McGee interviewed by Granada and Sky News also focused on winter pressures.

Early in December we also welcomed Rock FM, BBC Radio Lancashire and ITV Granada for the two-year anniversary of the COVID-19 vaccine with the Trust's first recipient, Doreen McKeown returning to speak about the importance of our communities receiving their jab.

More recently, The One Show's Angela Rippon was also welcomed to both Royal Preston Hospital and Finney House (pictured) to explore how the Trust is working hard to improve patient flow with the introduction of the Lancashire Community Healthcare Hub.

9. RECOMMENDATIONS

It is recommended that:

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

Lancashire and South Cumbria Provider Collaborative

NHS

Appendix 1:

Provider Collaborative Board – 19 January 2023

The PCB met on 19 January 2023. It received updates on pressures within the acute and mental health trusts; finances; research and innovation; corporate services collaboration; the clinical programme board; workforce resilience and sustainability; Cancer services and pathology.

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

The Joint Committee had been established to give the PCB a mechanism via which to make decisions on a number of areas as agreed with Trust Boards.

System pressures – acute

Urgent and acute care services remain extremely busy, with a collective position of 71.5% on the A&E four hour waiting time target. This is above the regional average and during January the position had risen to 76%. There had been some extremely positive examples of mutual aid over the last four weeks, particularly in relation to ambulance diverts from Blackpool Teaching Hospitals to Lancashire Teaching Hospitals and Morecambe Bay.

The Royal College of Nursing (RCN) industrial action had been well handled with positive working with staff side to ensure that patients remained as safe as possible during the strike. Some elective activity had been stood down with a varied picture across Trusts and there was some best practice learning to be had.

Planning was already underway for the industrial action set to take place in February and March. This was likely to be more challenging than the January strikes as some of the North West Ambulance Service (NWAS) and RCN action was due on the same date. The mooted Junior Doctors strike would also have a significant impact if it proceeded.

With the exception of a number of agreed exemptions, there are no patients waiting 104 weeks within the system. Collectively trusts are on track to meet the 78 week waiting time target by the end of March although challenges remain around this including the as yet unknown impact of ongoing industrial action.

The biggest risk sits with Lancashire Teaching Hospitals due to the volume of patients on their lists, however all Trusts are committed to working together to achieve the target. This meant that some Trusts would experience a worsening of their individual position on 78 weeks, however individual Boards were sighted and supportive of this. LTH also had some specific issues in relation to the waiting list initiatives which were under discussion and may need to be escalated to the ICB and regional teams as this presented a further risk to the 78 week target.

Colorectal cancer remained a challenge across most Trusts so proactive mutual aid would remain very important in ensuring that the target was met by the end of March 2023.

In summary, the system was exceptionally challenged due to the combination of winter, covid, flu. Urgent and Emergency pressures, industrial action, and the work on restoration. However, staff were rising to the challenge and L&SC were delivering well compared with other systems with great examples of mutual aid across all areas of work. This provides a strong platform to move into the next phase of restoration.

Trusts were also committed to working towards having a joint Patient Treatment List (PTL) and a paper providing more detail on the specifics of this would come to a future meeting as part of a wider strategy for scheduled care.

System pressures- mental health

The flow of people with Mental Health (MH) needs from Emergency Departments into the Mental Health Urgent Assessment Centres (MHUACs) had worked well over the Christmas period despite the pressures within the system. Acute Trusts had really noticed the difference that the MUACs had made within the last month or so. A report on the MHUACs was due to come back to the PBC in two months.

The phrase mutual aid within an acute setting applies to other providers within a local geographical area, however within MH this means other MH providers. It was important that the ICS and PCB were as sighted on issues relating to the wider MH system as they were on acute pressures. Secure and rehabilitation services nationally were under considerable pressure, with a number of closures of facilities providing these services both within the NHS and the independent sector.

Skylark, an eleven bedded MH facility was due to open on the Royal Preston site which would help reduce the numbers of out of area patients.

LCSFT were committed to tracking the outcomes of the activity they were undertaking and had now joined a group looking at excess mortality rates as part of that process.

Financial pressures

The system's financial position continues to be very challenged with ongoing conversations taking place with the regional and national teams about the likely year end position.

The current operational challenges including the industrial action would inevitably have a detrimental effect on finances. Unfunded beds remained an issue for some trusts due to a lack of out of hospital capacity – some short-term solutions had been found but these were high cost and unsustainable particularly in relation to temporary staffing premiums.

Changes to discount rates were contributing to technical gains and progress continues to be made across all trusts in terms of grip and control – it would be vital to sustain this throughout the remainder of the year.

Any deficit this year would be carried into the following year and was likely to impact on the ability to attract future capital. The next financial year 2023/20024 was set to be even more challenging with much scrutiny around efficiency and restoration of elective activity.

Research and Innovation (R&I)

An update was given on the current state of the National Institute for Health and Care Research (NIHR) Studies in the PCB Trusts, the interactions with local academia and industry, and innovation and the workforce in Research and Innovation (R&I).

A discussion took place on successes to date, opportunities and limitations and recommended ways to move this agenda forward.

Whilst much progress had been made, colleagues across Lancashire and South Cumbria were keen to ensure that they fulfilled their potential in both R&I and Education. In addition to the ongoing work of the networks it was important to develop a unique proposition for L&SC and fully integrated ways of working between different organisations and to focus on some specific areas of research (e.g., deprivation). The ICS were keen to work with the PCB to develop these areas of expertise particularly given the positive effect that involvement in R&I as part of people's job roles had on both recruitment and retention of staff.

Corporate Services Collaboration

Work around the Workforce Resilience and the Sustainability project had been extensive during December. Three workshops had taken place with HR, Finance and Communications with a further workshop to take place in February/March to finalise proposals for the Target Operating Model.

A clear procurement path has been put forward for Bank and Agency and the ELFs Shared Services proposal, and there was good progress on development of a single payroll and other initiatives such as the ledger for finance.

Clarity of leadership, governance and assurance would be essential to the success of the programme and learning had been taken on board from previous programmes to ensure that this was robust.

Work was taking place to align HR policies such as management of change and infrastructure for redeployment, and relevant processes were being put in place in advance of the development of the target operating model.

A forward plan with a clear decision-making timetable would be developed after the next workshop.

Clinical Programme Board

A positive meeting had taken place between the Clinical Services Programme Board and the ICS Medical Director to begin to agree priorities and milestones, particularly for the next year in relation to both the Clinical and Cancer Strategies.

The programme team had done a lot of work with Senior Responsible Officers on the programme plan milestones, decisions, benefit realisation, and the risk register and the forward look for 2023/24 would be firmed up further with the help of the ICS.

Engagement of staff, and interaction with the ICS team would be critical to the success of the clinical programmes– the ICS would be arranging a workshop in March to set out how and when engagement and consultation needed to take place in connection with any proposed service changes. A tool kit had been developed by the ICB and PCB communications and engagement colleagues to make the process as easy as possible and to ensure a consistent methodology.

There was a consensus that delivery of services needed to take place within the existing infrastructure of the ICS and PCB rather than waiting for the New Hospitals Programme (NHP) to come to fruition and that configuration of existing trusts would be a limiting factor that needed to be taken into account. Interdependencies between services would need to be considered when deciding where services should be located. A commissioning view would also be important for many of the projects, for example with regard to the location of regional centres.

Work is progressing in Pennine to review current community services, and this would inform the PCB considerations about the development and delivery of integrated care models. This would need to be closely integrated with the ICS work, as this was a commissioning responsibility.

Workforce Resilience and Sustainability Project

The Bank and Agency programme had been reset and renamed the Workforce Resilience and Sustainability Programme to reflect the scope of the work required.

A workshop in January including staff side and temporary staffing had been very positive and removed some of the potential barriers to the tender process proceeding at the end of March.

A general communications plan has been prepared and will be disseminated shortly. The Business Case would be coming back to the PCB in March.

Cancer Services

The system has experienced challenges in the delivery of some cancer services and some of them were noticeably fragile.

The findings of a deep dive have been reported to the ICS Board. These encompassed a range of issues and a Cancer Plan addressing these will return to IC Board in Q4.

The PCB and ICS now need to work closely with the specialist commissioning to address these challenges. Difficult decisions may need to be made by providers, informed by the PCB in the interest of the public and the best possible outcomes.

The ICS Board would initially be concentrating on a number of key changes within agreed priority specialties – Vascular, Head and Neck and specialist Urology cancer surgery - and NICUs and non-surgical oncology workforce.

Other clinical programmes need to develop robust networks and focus on delivering best practice pathways informed by Get It Right First Time (GIRFT) principles.

Pathology

Presentations have or will shortly be given to individual Trust Boards about the intention for the pathology collaborative to report into the Joint Committee. Meetings had taken place with Divisional Directors within Trusts.

Further discussions had taken place with Browne Jacobson to understand what might be in the Joint Committee Terms of Reference regarding this and the overall direction of travel, with the focus likely to be on ten key areas.

Appendix 2

Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	**1 February 2023**
Title of paper	Chief Executive's Board Report
Presented by	Kevin Lavery, Chief Executive Officer, Integrated Care Board
Author	Lisa Roberts, Business Manager and Executive Team lead contributors
Agenda item	Item 7
Confidential	No

Purpose of the paper

This paper provides the CEO with the forum to update Board members on actions since the last board and highlight emerging issues and key areas of focus, to ensure Board members are sighted on the business of the ICB and its wider operating environment.

Executive summary

My CEO report last month focused on shining a light on some examples of high performance and innovation.

This month's update to Board is two-fold, covering both the ongoing winter pressures, and system-wide work to mitigate risk to patients; and the work we are doing to develop our longer-term strategies seeking to align the different parts of our system and build something different. Indeed, this is our challenge – to deal well with the here and now crises, yet not lose sight of the future and strategic mission that the ICB was set up to address.

Recommendations

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

Governance and reporting (list other forums that have discussed this paper)

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

Conflicts of interest identified

Not applicable

Implications

If yes, please provide a brief risk description and reference number	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	

Equality impact assessment completed			x	
Privacy impact assessment completed			x	
Financial impact assessment completed			x	
Associated risks			x	
Are associated risks detailed on the ICS Risk Register?			x	

Report authorised by:	Kevin Lavery Chief Executive

Integrated Care Board – 1 February 2023

Chief Executive's Board Report

1. Introduction

1.1 As an organisation, we were born only seven months ago – and yet we have achieved a lot in that time. There have certainly been some challenges, which is to be expected in our first year, but I am proud of the progress we have made so far, and I am excited for the journey ahead as we make progress towards clarity of structures and priorities and really begin to settle into business as usual as an ICB as 2023 goes on.

1.2 This month's update to Board is two-fold, covering both the ongoing winter pressures, and system-wide work to mitigate risk to patients; and the work we are doing to develop our longer-term strategies seeking to align the different parts of our system and build something different. Indeed, this is our challenge – to deal well with the here and now crises, yet not lose sight of the future and strategic mission that the ICB was set up to address.

2. Winter Pressures

2.1 We continue to be profoundly grateful for the efforts of NHS and care staff who have already gone above and beyond the call of duty to ensure our patients receive the highest standards of care throughout this difficult time.

2.2 The LSC executive team will continue to provide timely updates and assurance to Board members in relation to system pressures and industrial action, as this is an ever-changing landscape and as part of this, we will provide a real-time update to Board members during the 01 February meeting, and have included below some observations from the last six weeks:

- We are holding a strong performance position within the region.
- We have coped relatively well as a system, under real pressure and have been commended for our approach as an ICB.
- During the periods of industrial action, we performed well against ambulance handover targets and coped well with the industrial action in December and January.
- There has been positive feedback from NWAS colleagues regarding the changes our Trusts are making and their ongoing commitment to collaborative working.
- As a system, we held our position at Operational Pressures Escalation Level (OPEL) 3 over the Christmas and New Year period, when our neighbouring systems, at times, were in OPEL 4.
- We experienced an increase in the numbers of patients coming through emergency pathways
- Despite NHS and local authority colleagues working closely to support with discharges, we experienced high numbers of patients in all four of our acute trusts who were not meeting medical criteria to reside.
- We have been undertaking regular briefing calls with our Local Authority Chief Executives and Directors of Adult Social Care to both update them

and thank them for the way their teams have responded to winter pressures

2.3 I know, you will have also heard some stark messages in January, with colleagues from all parts of the health and care system saying they have never seen it so challenging. I remain confident that colleagues are doing everything they can, but our trusts and wider system, remains extremely stretched across the board. We know there will be further challenges to come, but it is important to again acknowledge and thank those who have been involved so far.

2.4 I firmly believe that throughout these pressures it is essential that we continue to develop our longer-term plans around workforce, transformation, and organisational development, to help us to cope with pressures in a more proactive way in the future. Our job as a Board is to work with all of the different parts of our system to align and inform our strategic plans going forward, to get 'up-stream' of the problem and break the current cycle.

3. Industrial Action

3.1 I would like to again thank to our staff for their involvement in planning and managing the strikes in December and January. I am not going to comment on whether I think the action is right or wrong. I fully respect the rights of staff to take part in industrial action and appreciate the efforts of union representatives at this time and the cooperation of all involved.

3.2 Alongside the below industrial action dates for January, the GMB union are currently considering up to six further strike dates, affecting ambulance services. We have few GMB members amongst LSC ambulance staff. However, there are significant numbers in Merseyside and Cheshire. Therefore, our service levels will be affected to provide mutual aid to our neighbours. Teachers, Junior Doctors, and Firefighters are being balloted on potential strike action over pay and University staff have industrial action planned for February and March.

January 2023

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3 Highways & Rail staff	4 Highways staff	5	6 Rail staff	7
8	9 Ambulance staff	10 Environment Agency staff	11 Ambulance staff	12	13	14
15	16	17	18 Nurses (RCN)	19 Nurses (RCN)	20	21
22	23 Ambulance staff	24	25	26 Physiotherapists	27	28
29	30	31				

4. Falls Lifting Service

4.1 I am pleased to inform you that we have now implemented a falls lifting service for South Cumbria. The Going Further for Winter document outlined the requirement for all ICBs to have a Falls Response and Pickup service operating as a minimum 8am to 8pm, seven days a week across its geography. Whilst a ground breaking service had been implemented across Lancashire in recent years, the South Cumbria area had proved difficult to commission due to the sparse population, huge geography, and supply challenges. Following joint work with colleagues in the ICB, UHMB and NWAS a solution was developed in conjunction with the North East and North Cumbria ICB and a six-month pilot was agreed, which started on 31 December 2022.

4.2 Referrals are starting to flow from the ambulance service. So now, as in the rest of the ICB, people who have fallen in South Cumbria and phoned 999 are rerouted to this service, receiving improved response and assistance times. Monitoring and evaluation are on-going and there are plans to develop the South Cumbria service to include referrals from Care Homes and Telecare clients over the coming weeks.

5. Operating model for LSC Provider Collaborative Board (PCB) and Integrated Care Board (ICB)

5.1 I wanted to share some observations from the workshop, provided by Dame Ruth Carnall, and Paul Gray which are fully supported by both Kevin McGee and I, to set the context for the report and recommendations which will be discussed in more detail as part of the February agenda.

5.2 The workshop took place on 19 December, amidst a peak in operational pressures. Despite this, colleagues were focussed and contributing throughout which was extremely encouraging and a really good sign of commitment to making the PCB and ICB work. It would have been very easy to be "elsewhere".

5.3 There was a real openness to doing things differently, no one was defending the status quo and nor was there any sense of ‘if only other people would do something’. Tensions between PCBs and ICBs are also evident in other systems, we are not unique, but we do need a continued focus on trust and relationships to move past this, underpinned by a robust operating model that we and the wider system understand.

5.4 Partners demonstrated both commitment and capability but there remains a significant challenge around capacity. The changes discussed on the day will be very demanding on leadership time and especially on clinical leadership, but this will be key to our success. The feedback that Kevin McGee and I have received from the day has been universally positive with all colleagues immensely grateful to Ruth and Paul for their facilitation and leadership.

5.5 The Board will be receiving the report as part of the February agenda. The critical issue is what we do differently going forward. I have agreed with Kevin that we

will do a joint response and action plan for the ICB and PCB. This is a powerful statement about how we will move forward together.

6. LSC Integrated Care Board (ICB) and Integrated Care Partnership (ICP) Meeting with Lord Markham

6.1 On 22 December 2022, David Flory, ICB Chair, Cllr Michael Green, Chair of the LSC Integrated Care Partnership and myself, met (virtually) with Lord Markham, Parliamentary Under Secretary of State, House of Lords. It was a positive meeting, centred around our performance and specifically elective recovery, actions linked to the Adult Social Care Discharge Fund, winter resilience plans and relationships with our local government colleagues.

6.2 I took the opportunity to provide an overview of our ambitions for the LSC system, the productivity improvements we have identified and the associated reinvestment of improvement savings into our hospital and community services. Financial and process freedoms that would help us as an ICB to move faster, better, and smarter, were also discussed. These included the slimming down of targets, 'single-pot' funding allocations to replace separate allocations received throughout the year, and more flexibilities around how we deploy this funding. I am hoping we will get opportunity to explore this further with the Minister and will keep you updated on any developments.

7. Integrated Planning Approach

7.1 This month, the Board is considering our draft **Integrated Care Strategy**, the first of a number of reports that, over the next few formal and informal meetings, will set out how we intend to deliver the four key aims of the ICB over the next 10 years, and detail what we need to do in 2023/24 to start us off on that journey.

7.2 I am preparing my first '**State of the System report'** which I will share with you in March, with key themes presented at the February Board development session. This personal report will set out what good integrated care looks like and how we match up; what we should do differently, and the immediate priorities that we will action within our whole system plan. This report will become an annual fixture to coincide with the sign off of the reviewed/updated Joint Forward Plans, before the start of each financial year.

7.3 All ICBs are required to work with their NHS partners to set out a **five-year joint forward plan**, guidance for these plans was published in December 2022 (see Appendix A). ICBs are required to publish these plans by 30 June 2023. Locally, we have consolidated and aligned the development of a five-year joint forward plan with a number of other national and local planning requirements, into our **whole system plan** which will include:

- a ten-year plan and vision for the ICB
- the five-year joint forward plan with local provider Trusts
- the NHS response to the Integrated Care Strategy with local authority and other partners (as presented on today's agenda)
- the three-year financial framework

7.4 We will bring a summary of the developing 'whole plan' to the February Board development session and to the March Board, prior to formal sign off at the June Board. Just before Christmas, we also received national guidance on the development of our system **Operational Plans for 2023/24** (see Appendix A). These plans need to include detailed activity, performance, workforce, and financial plans across all of our providers; with particular focus on three priority areas, covering recovery, restoration, and increased productivity for the NHS in 2023/24.

7.5 Our plans will need to set out how, within our published allocations, we will achieve a set of 31 objectives that sit within these three priority areas. Objectives are also set for use of financial resources and workforce. Current operational pressures and the financial constraints within which our plans will be developed, will make this a particularly difficult planning round. Nonetheless, I am committed to working closely with our partners to ensure that we deliver maximum benefit to our population from within the £4.5bn we spend on their behalf.

7.6 Draft operational plans are required by the 23 February, with final versions at the end of March. We will bring an update on draft plans to the March Board development session, prior to the approval and submission of final plans.

8. Quarter 2 NHS England Regional Assurance Meeting

8.1 Our next Assurance meeting with NHSE will take place on 10 February and will focus on the development of our ICB with a focus on our people, leadership, and finances; quality of care, access, and outcomes with particular focus on Elective Care recovery, Urgent and Emergency Care, Cancer, Diagnostics and Mental Health, plus areas of escalation regarding improving ill-health and reducing inequalities; and reviewing the SOF ratings of provider trusts within the ICB.

8.2 I will again, use this as an opportunity to have strategic-level discussions with our regional colleagues, identifying the three or four biggest issues/priorities for our system and what we are doing to address them.

9. Financial Update

9.1 The Finance report later in the agenda, provides the detail on the latest financial position which highlights that the financial risk has started to stabilise. There has been continued activity since the last Board meeting in developing and progressing delivery against the ICB and Provider recovery plans, in order to mitigate the collective system risk and achieve the year-end financial targets. We have taken further action as an executive team in January to ensure the plans for recovery of the ICB financial position can be delivered in the remaining part of the year. In addition, there has been good collective working across the providers to mitigate the risk to the year-end position.

9.2 The initial risk identified at planning stage was £177m for the system. This is currently assessed at £40m and through joint working it is anticipated that this can now be reduced further. The system had a historic surplus of £27m and we are

exploring the potential for utilising this against any residual risk at year end. This position will be confirmed as part of the month 10 (end of January) reported position.

10. Mutually Agreed Resignation Scheme (MARS) and Staff Consultation

10.1 The MAR scheme has now concluded with 44 applications being approved which will take effect from 31 March 2023. We will commence the staff consultation process in relation to our final ICB structures from 30 January 2023 which will run for circa four weeks. During this time, there will be a number of opportunities to engage and consult with our staff; including all staff and team briefings, as well as managers having one to one meetings with staff directly impacted by the changes proposed. We continue to work closely with staff side colleagues to ensure that they are able to advise their members effectively during the consultation period. A 20% savings target (providing £6m of recurrent savings) has been agreed within the new structures, which will be delivered through the use of MARS as well as through natural attrition and tight vacancy management.

11. Emergency Preparedness Resilience and Response (EPRR)

11.1 As a Category 1 provider the ICB are subject to the full set of civil protection duties. We are required to assess the risk of emergencies occurring and use this to inform contingency planning and put in place emergency plans. We have fulfilled this responsibility throughout December and January, in relation to numerous challenging situations; Level 3 Met Office weather alerts, water outages, potential energy outages, and industrial action, and the next few months look likely to continue in the same vein. We have described the EPRR resource requirements for our ICB and are recruiting to these posts to ensure we have the relevant expertise and capacity to meet future demands, whilst recognising that suitably qualified and trained EPRR staff are hard to come by.

12. ICB/NHS Core Standards Submission

12.1 As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical, and business continuity incidents whilst maintaining services to patients. The NHS Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR.

12.2 The ICB as a category one responder has to complete a self-assessment based upon a series of questions, indicating the organisation's compliance against the standards – defined as fully (100%), partially (88-77%) or non-compliant (76% or less). The ICB has declared itself as non-compliant against the core standards as it has declared 74% compliance against the relevant core standards (i.e., out of 47 relevant standards, the ICB is declaring fully complaint against 35 standards and partially compliant against 12). This reflects the fact that the ICB is a new organisation who has only had Category One responder duties under the Civil Contingencies Act 2004 since 1st July 2022. The Head of EPRR has developed a comprehensive action plan to enable the ICB to improve its compliance against the

core standards over 2023 - 2024, but this will be subject to improved resources and investment in the EPRR function going forwards.

12.3 A monthly PRR Committee will be established in February to facilitate the monitoring of all provider action plans, as well as the ICB action plan, to ensure improved compliance heading into 2023 – 2024. Th ICB EPRR Core Standards Report has been presented at the Local Health Resilience Partnership meeting as part of the EPRR Core Standards assurance process.

13. Recommendations

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

Kevin Lavery
24 January 2023

Appendix A - GUIDANCE OVERVIEW

JOINT FORWARD PLAN GUIDANCE

NHS England has published guidance on developing the Joint Forward Plan (JFP) designed to support Integrated Care Boards (ICBs) to develop their first 5-year joint forward plans (JFPs) in conjunction with system partners. From 2023/24 onwards, JFPs must be reviewed and where appropriate updated before the start of each financial year.

For this first year, however, NHS England has requested ICBs to publish and share the final plan with NHS England, their Integrated Care Partnerships (ICPs) and Health and Wellbeing Boards (HWBs) by 30 June 2023.

The guidance sets out a flexible framework for JFPs, building on existing system and place strategies and plans, in line with the principle of subsidiarity. It also states specific statutory requirements that plans must meet.

As a minimum, the JFP should describe how the ICB, and its partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements.

Systems are encouraged to use the JFP to develop a shared delivery plan for the integrated care strategy that is supported by the whole system, including local authorities and voluntary, community and social enterprise partners. Previous local patient and public engagement exercises and subsequent action should inform the JFP.

NHS OPERATIONAL PLANNING GUIDANCE 2023/24

This NHS Priorities and Operational Planning Guidance for 2023/24 was published alongside the Joint Forward Plan guidance and outlines three key tasks for 2023/24: to recover core services and productivity; progress the aspirations in the Long Term plan; and continue transforming the health and care system for the future.

The guidance outlines the most critical, evidence-based actions that will support delivery, based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

Our plans will need to set out how –we will achieve a set of 31 objectives that sit within the three priority areas of recovery, restoration, and increased productivity across:

- Urgent and Emergency care
- Community care
- Primary care
- Elective care
- Cancer care
- Diagnostics

- Maternity care
- Mental Health care
- Care of people with Learning disabilities and autism
- Prevention and health inequalities

The guidance is notably shorter with fewer targets and promotes genuine partnership, supporting local decision making and empowering local leaders to make the best decisions for their local populations.

The associated system plans need to be triangulated across activity, workforce, and finance, and signed off by ICB and NHS partner trust boards before the end of March 2023.

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:**	2nd February 2023		
Report of:	Associate Director of Risk and Assurance			**Prepared by:**	K Lonergan		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☒	**For noting**	☐	**For discussion**	☐	**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. 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 its high level strategic objectives. Therefore, the purpose of this paper is to provide the Board of Directors with details of those risks that may compromise the achievement of the Trust's high level strategic objectives.

A copy of the 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 at the time of writing this paper.

Strategic Risks

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

There has been no change in score for:

- Risk to delivery of the Trust's Strategic Objective of Delivering Value for Money – remains 20
- Risk to delivery of the Trust's Strategic Objective to Consistently Deliver Excellent Care – remains 20
- Risk to delivery of the Trust's Strategic Objective to be a Great Place to Work – remains 12
- Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service – remains 8
- Risk to delivery of the Trust's Strategic Objective of Fit for the Future – remains 15

At the most recent Education, Training and Research Committee meeting in December 2022, the Committee approved a change in risk score for:

- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – the score was increased from 12 to 20, to reflect the tightening of rules relating to the treatment of deferred income. A plan to mitigate identified risks will need to be developed.

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

Operational High Risks for Escalation to Board

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

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to the recovery of cancer, and non-cancer backlogs.
- Risk ID 1182 (scoring 20) Possible strike action following announcement of national pay award in July 2022, which has been escalated to Board since October 2022. In November 2022, the risk score was increased from 16 to 20 in response to the national ballot outcome for strike action, and strike action remains ongoing.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.
ii. Confirm that through the revised BAF, they are assured that there continues to be an effective and comprehensive process in place to identify, understand, monitor and address current and future risks in line with statutory requirements.

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 Since the last Board of Directors Meeting, there has been no change in score for:

- Risk to delivery of the Trust's Strategic Objective of Delivering Value for Money – remains 20
- Risk to delivery of the Trust's Strategic Objective to Consistently Deliver Excellent Care – remains 20
- Risk to delivery of the Trust's Strategic Objective to be a Great Place to Work – remains 12
- Risk to delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service – remains 8
- Risk to delivery of the Trust's Strategic Objective of Fit for the Future – remains 15

At the most recent Education, Training and Research Committee meeting in December 2022, the Committee approved a change in risk score for:

- Risk to delivery of the Trust's Strategic Aim to Drive Health Innovation through World Class Education, Training and Research – the score was increased from 12 to 20, to reflect the tightening of rules relating to the treatment of deferred income. A plan to mitigate identified risks will need to be developed.

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 that are detailed in Appendix 2 are those that have been presented to Committees of the Board at the time of writing this paper.

2.3 Operational Risk Register

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

- Risk ID 25 (scoring 20), Impact on exit block on patient safety, which has been escalated to Board since December 2020 due to the change in occupancy levels within the Emergency Department at Royal Preston Hospital.

- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to recovery of cancer, and non-cancer backlogs.
- Risk ID 1182 (scoring 20), Potential strike action following announcement of national pay award in July 2022, which has been escalated to Board since October 2022. In November 2022, the risk score was increased from 16 to 20 in response to the national ballot outcome for strike action, and strike action remains ongoing.

3. Financial implications

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

4 Legal implications

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

5. Risks

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

6. Impact on stakeholders

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

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

7. Recommendations

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

i. Note and approve the updates to the BAF.
ii. Confirm that through the revised BAF, they are assured that there continues to be an effective and comprehensive process in place to identify, understand, monitor and address current and future risks in line with statutory requirements.

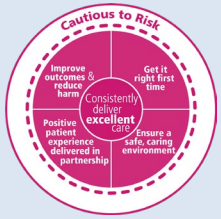
Appendix 1 - Board Assurance Framework 2022/2023 – Risks to achievement of Trust Aims & Ambitions

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Trust Aims

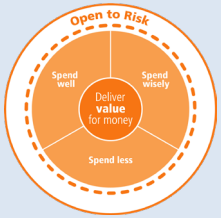
- To provide outstanding and sustainable healthcare to our local communities
- To offer a range of high quality *specialist* services to patients in Lancashire and South Cumbria
- To drive health innovation through world class education, training and research

Trust Ambitions



Appetite Score 1-6

Appetite Score 4-8



Appetite Score 8-12

Appetite Score 8-12

Current principal risks on the Strategic Risk Register – February 2023

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

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

Lancashire Teaching Hospitals NHS Foundation Trust

Strategic Risk Summary

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

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

Board Assurance Framework 2022/2023– Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Key Operational Risk Summary for Escalation to the Boards

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

- **Impact of Emergency Department Block on Patient Safety (Risk ID 25 – Initial Score 20, Current Score 20)** – There remains a challenge with exit block with length of stay in the Emergency Department increasing. The Trust has also seen the impact of exit block with an increase in ambulance handover times. To mitigate the risk of long waits within the ED department and the increase in ambulance handovers, Standard Operating Procedures are in place which describe the processes for patient reviews, reporting of patient harm incidents and clinical governance arrangements. These procedures are being supplemented with a series of system wide improvement actions, including virtual wards, frailty, therapy pathway improvements, which are reflected within the urgent and emergency care transformation plan and reported to Finance and Performance Committee. In July 2022 Cuerden Ward opened creating extra capacity. Finney House opened its Community Healthcare Hub for 32 additional patients on 30 November 2022 with a further 32 beds opening in a phased way, with the aim to reduce occupancy in the ED. Ongoing monthly safety forums remain in place and have an open invite to the board and ED colleagues.

- **Elective restoration (Risk ID 1125 – Initial Score 20, Current Score 20**) - Patients continue to wait for a significant amount of time to receive non-urgent surgery. A plan is in place to eliminate 104+ week waits and reduce waits to 78 weeks by March 2023. Achievement of the plan and performance against the trajectory is reviewed weekly. All specialties have target plans to work to and are being supported through divisional meetings and the wider Performance Recovery Group.

- **Possible strike action following announcement of the national pay award in July 2022 (Risk ID 1182 – Initial score 16, Current Score 20)** In November 2022, the risk score for Strike action increased from 16 to 20 in response to the national RCN ballot outcome for strike action. Strikes have took place since this, further strikes are planned and the risks associated with this are being managed in partnership with staff side, workforce and clinical leaders.

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: 18th January 2023

Risk
There is a risk that we are unable to deliver the Trust's strategic aim of offering excellent health care and treatment to our local communities, as well as the strategic objective of consistently delivering excellent care in inpatient, outpatient and community services due to:
a) Availability of staff
b) High Occupancy levels
c) Fluctuating ability to consistently meet the constitutional and specialty standards and
d) Availability of some services across the system
e) Existing 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

Initial risk Rating 4 x 5 (likelihood x severity) = 20
Current Risk Rating 4 x 5 (likelihood x severity) = 20
Target Risk Rating 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.
- Occupancy levels are in excess of 100%.
- Patients are routinely waiting longer than national standards for treatments and in the Emergency Department.
- Equality Impact Assessment undertaken in response to Internal Critical Incident.
- Adult inpatient experience feedback is identifying room for improvement.
- Estate does not meet HTN standards, limiting consistent adherence to safety and aesthetic estate condition.
- There is national acknowledgement that health inequalities exist in all heath and care systems and contribute to poorer outcomes of citizens.

Risk Rating Tracker

	2021-22			
	Q1	**Q2**	**Q3**	**Q4**
Initial	20	20	20	20
Current	20	20	20	20
Target	1-3	1-3	1-3	1-3

	2022-23			
	Q1	**Q2**	**Q3**	**Q4**
Initial	20	20	20	20
Current	20	20	20	20
Target	1-6	1-6	1-6	1-6

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.

Future Opportunities

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

Controls

- Workstream related strategies and plans in place
  - Always Safety First
  - Clinical Strategy
  - STAR Framework
  - Patient Experience and Involvement Strategy

Gaps in Control

- Integration of services and pathways and effective Place and system-based working ***(Ref CDEC 002)***
- Opportunity to improve productivity through benchmarking and action plans to reduce unwanted variation in existing strategies ***(Ref CDEC 003)***
- Equitable access to health and care is disproportionately more challenging for citizens with protected

Assurances
Internal

- STAR Assurance Framework
- Always Safety First Group
- Safety and Learning Group
- Divisional Governance Structures and arrangements

Gaps in Assurances
None identified.

○ Risk Management Strategy ○ 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 • New Hospitals Programme • Business Case addressing bed demand and capacity in place, which should improve impact on urgent surgery cancellations also.	characteristic or those living in deprived areas. ***(Ref CDEC 007)***	• Divisional Improvement Forums • Safety and Quality Committee • Workforce Committee • Finance and Performance Committee • Education, Training and Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system • CNST internal assurance reporting • Medical Staffing Review Plan in place to strengthen assurance of testing safe medical staffing • Equality Impact Assessment – Critical Incident December 2022. **External** • National Surveys • Clinical Negligence Schemes for Trust • External regulators and benchmarking • Medical Examiner's Office, Perinatal Mortality Tool • Internal Audit • External system assurances, PLACE based arrangements (currently CCG) ICB and PCB • NHS England performance monitoring • Independent Support Team (IST) review	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 001	Develop business case for number of beds required to address demand	Chief Operating Officer	31st October 2022	18th October 2022	Complete	Control	• Demand currently exceeding supply of inpatient beds, thus need to define the number of internal beds required and case for this • Ability for increased occupancy levels to impact on urgent surgery.
CDEC 002	Create a Long term PLACE based Urgent and Emergency Care Strategy	Chief Operating Officer	31St March 2023		Ongoing	Control	• Integration of services and pathways and effective Place and system-based working
CDEC 003	Create a strengthened approach to utilising GIRFT to drive clinical productivity improvements.	Medical Director	31st January 2023		Ongoing	Control	• Opportunity to improve productivity through benchmarking and action plans to reduce unwanted variation in existing strategies
DVFM 002	Review strategies in light of delivering value for money as part of committee cycles of business.	Executive Leads	31st March 2023	**11th October 2022**	Complete	Control	• Opportunity to improve productivity through benchmarking and action plans to reduce unwanted variation in existing strategies.
CDEC 004	Create the Medical Safe Staffing Review plan	Chief Medical Officer	31st October 2022	30th September 2022	Complete	Assurance	• Strengthening assurance process to test safe medical staffing
CDEC 005	Establish baseline of known data and existing work underway to address systemic health inequalities.	Chief Nursing Officer	31st December 2022	30th November 2022	Complete	Assurance	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristic or those living in deprived areas.
CDEC 006	Undertake an equality impact assessment (EQIA) and consider if any identified impacts affect the strategic risk score.	Chief Nursing Officer	31st January 2023	17th January 2023	Complete	Assurance	• Rising infection rates may lead to unsustainable bed occupancy levels and present an increased risk to patient safety and the quality of services.
CDEC 007	Create a local plan to respond to the national Core20PLUS5 approach to equitable healthcare for adults and children.	Chief Nursing Officer	31st March 2023		**NEW**	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristic or those living in deprived areas.

Summary of review – January 2023

- Risk reviewed and update to narrative for rationale for current score.
- Gap in assurance identified (CDEC 006) in relation to the Internal Critical Incident and an Equality Impact Assessment has been undertaken in month which reflects the mitigations and therefore added as an assurance.
- Following completion of CDEC 005, a new action (CDEC 007) has been identified which related to the gap in control related to Health Inequalities

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

Risk ID: 857
Risk owner: Chief Finance Officer
Date last reviewed: 9th January 2023

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

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

Risk Tolerance
8-12

Initial risk Rating 4 x 5 (likelihood x severity) = 20
Current Risk Rating 4 x 5 (likelihood x severity) = 20
Target Risk Rating 8-12

Rationale for Current Score

- The Trust has been placed in segment three for the System Oversight Framework (SOF) – reconfirmed July 2022. Undertakings applied by NHSE to the Trust include the need for the Trust to agree its financial plans with the Integrated Health Board, a requirement to deliver that plan and a supporting need to deliver the associated cost improvement plan. Unless a solution can be found to offset the cost of excess unfunded beds the Trust will fail to meet its financial plan.
- Covid-19 continues to impact on the efficiency of services and the ability to operate under current planning assumptions. A further increase has led to additional costs arising from staff absenteeism.
- NHS England have increased resources to NHS organisations to support the additional costs of inflation. It is expected that inflationary pressures will be particularly prevalent in the second half of the year.
- There is growing international supply chain disruption which is driving costs up and limiting availability.
- Work on the underlying drivers for deficit confirms that there is significant elements of the Trust's overspend which is due to structural challenges, for example prevailing models of care or shortfalls in income recovery. Whilst the Trust needs to deliver on improved efficiency it also needs to find solutions with the ICS to agree the extent of the structural shortfall in resources and to agree a plan to allocate funding or mitigate in other ways.
- Excess pressures on the non-elective pathways have resulting in additional unfunded beds being opened. Despite this additional capacity, the Trust's performance standards are being impacted negatively due mainly to the excess patients requiring admission to hospital.
- The Trust has enforcement undertakings relating to its financial position.
  The ICB is developing a 'route map' to support improved financial performance at the same time operational pressures continue to grow, exacerbated by patients who 'Do Not Meet Criteria to Reside'.
- Increased industrial tension is likely to give rise to additional financial and performance pressures which will further hamper the delivery of VFM. The Trusts ability to mitigate the impact of these tensions is limited, without some further consequence.
- Excess winter pressures are likely to increase financial pressure as the Trust seeks to mitigate the impact of additional attendances.
- Increasing media focus on NHS pressures/waiting times (elective and urgent care), alongside clear national commitments to see improvements in elective waiting times may lead to ambiguous messages on the relative priority given to financial plans/targets

Risk Rating Tracker

	2020-21			
	Q1	**Q2**	**Q3**	**Q4**
Initial	9	9	15	15
Current	15	15	15	15
Target	8-12	8-12	8-12	8-12

	2021-22			
	Q1	Q2	Q3	Q4
Initial	15	20	20	20
Current	20	20	20	20
Target	8-12	8-12	8-12	8-12

	2022-23			
	Q1	Q2	Q3	Q4
Initial	20	20	20	20
Current	20	20	20	20
Target	8-12	8-12	8-12	8-12

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

	Future Risks • The future form and financial flows which will operate within the NHS remain unknown and are wholly subject to external determination. • 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. • The impact of Covid remains uncertain for services. Funding for Covid related issues will be removed in 2023-24 and as such the Trust will need to respond accordingly or find alternative resources to sustain expenditure levels where there is a case to do so. • NHS England ceased funding for the hospital discharge programme at the end of March. The ICS agreed to extend funding. The withdrawal of the funding could further deteriorate system performance and result in additional bed pressures and cost. Rather than closing non recurrently funded bed infrastructure there will be pressure to retain this infrastructure for longer. This is likely to result in an unfunded pressure in 2022-23 which will impact upon the Trust's undertakings. • Workforce supply is likely to impact on the speed of recovery together with impacting on outcomes for patients. • Increasing industrial tensions over pay increases and the cost of inflation may lead to action being taken by staff groups. These risks remain unquantified.	**Future Opportunities** • Benchmarking indicates opportunities remain to reduce waste and the underlying overspend. • There is an opportunity to reduce financial risk through reorganisation, adoption of technologies, automation and the removal of unnecessary duplication and waste. • There remains an opportunity to increase margins through non NHS activities. • There remains opportunity through the ICS and the ICP 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 to better manage patient pathways to reduce hospital attendances. • There remains an opportunity for partners to support more timely discharge from hospital, reducing the overall cost to the taxpayer and improve outcomes.

Controls
• Workstream related strategies in place
  ○ Workforce and OD Strategy,
  ○ Continuous Improvement Strategy
  ○ Clinical Strategy
  ○ Financial Strategy
  ○ IM&T Strategy,
  ○ Estates Strategy,
  ○ Our Big Plan, Annual Business Plan Planning framework established to track delivery of schemes.
  ○ Always safety first
• Scheme of delegation/Standing Financial Instruction
• Accountability Framework
• Long term case for change the New Hospitals Programme
• CCG funding for additional plans in Stroke and Palliative care
• Contract management and activity under regular monitoring
• National Planning Framework and Capital now given to ICS areas.
	Gaps in Control
	• Greater challenge by recruitment panel on rollover use of budget – use less, use more efficiently, be more effective (in development)
	• Vacancy freeze for non-essential posts (in development)
	• Reintroduction of a virement policy to reduce unwarranted discretion in use of budget
		Assurances
		Internal
		• Specialty Performance meetings
		• Divisional Improvement Forums
		• Integrated Performance reporting at Finance and Performance Committee and Board
		• Audit Committee assurance processes to test effectiveness of financial infrastructure and internal control system
		• Temporary monitoring of undertakings internally (The Trust has been placed in segment three for the System Oversight Framework (SOF)).
		• Use of Resources assessments now reported through Finance & Performance Committee.
		• Regular embedded cycle of sharing information relating to the wider programme of change in place
		External
		• Head of Internal Audit Opinion/Going concern review
			Gaps in Assurances
			• There is a need to develop a medium term plan with a supporting financial model to outline the route to recovery. ***DVFM 010***
			• Develop reporting to reflect the benefits of the establishment of the ICB's five key portfolios of change. Focus on system wide solutions to optimise urgent care, restoration, optimise clinical networks, work to reduce duplication in corporate services and work on collaboration opportunities at scale. ***DVFM 010***
			• There is a need to better understand the impact on elective productivity together with movements in the underlying drivers together with plans for improvement. ***DVFM013***

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

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 001	Establish an annual business plan/refresh big plan.	Director of Strategy and Planning	30.04.22	30.04.22	Complete	Control	Planning guidance not reflective of current operational pressures secondary to Covid-19. ***Action now completed***
DVFM 002	Review strategies in light of delivering value for money as part of committee cycles of business.	Executive Leads	31.03.23	11.10.22	Complete	Control	Opportunity to improve on benchmarking and action plans to reduce unwanted variation in existing strategies.
DVFM 003	Re-introduce reporting arrangements for use of resources	Director of Strategy and Planning	31.08.22	31.08.22	Complete	Assurance	Regular schedule of internal Use of Resources assessments
DVFM 004	Review reporting arrangements for efficiency	Chief Financial Officer	30.06.22	30.06.22	Complete	Assurance	Regular schedule of reporting arrangements for efficiency and productivity schemes. ***Action update - provided though the DIF process, CIP and transformation reporting.***
DVFM 005	Recruitment of a PLACE based leader to formalise operational vehicle at PLACE	PLACE Chair	30.09.22	08.09.22	Complete	Control	Limited ability to affect or predict the allocation of funds in social care.
DVFM 006	Review system wide approach to optimising urgent care with ICB and consider the effectiveness of arrangements.	ICB Accountable Officer	31.08.22	31.08.22	Complete	Assurance	The current operational pressures felt by acute medical services are resulting a suboptimal outcome and compromising performance and experience. ***Action update - The ICB has now established a programme to optimise Urgent care with monitoring ongoing to test effectiveness – Programme now in place.***
DVFM 007	Develop reporting for system wide risk relating to restoration plans and the associated financial risks.	Director of Strategy and Planning	31.07.22	31.07.22	Complete	Assurance	There is a risk that the restoration plans fail to deliver across the ICS resulting in additional financial risk to organisations. ***Action update - Reporting is now established through ECRG***.

DVFM 008	Stocktake of senior leadership engagement in place for system decision making processes	Deputy Chief Executive	31.08.22	31.08.22	Complete	Control	Outline the role of the executive and Board members in system wide decision making and transformation processes.
DVFM 009	Share information relating to external meetings and processes with Board members	Company Secretary	31.12.22	31.12.22	Complete	Assurance	Routinely and systematically share information relating to system wide decision making and transformation processes. ***Action update from Company Secretary – the action is complete and is now embedded as standard "Business As Usual" practice***
DVFM 010	Develop a medium term plan with a supporting financial model to outline the route to recovery	Chief Financial Officer and Director of Strategy and Planning	31.03.23		Ongoing	Assurance	Develop reporting to reflect the benefits of the establishment of the ICB's five key portfolios of change. Focus on system wide solutions to optimise urgent care, restoration, optimise clinical networks, work to reduce duplication in corporate services and work on collaboration opportunities at scale.
DVFM 011	Introduce contract monitoring Information	Chief Financial Officer	30.11.22	30.11.22	Complete	Assurance	Reintroduce contract monitoring information to support assurance on patient related delivery and underlying income.
DVFM 012	Report on financial checklists and protocol for financial deterioration	Chief Financial Officer	31.12.22	12.12.22	Complete	Assurance	Provide details of any gaps or processes to meet required obligations.
DVFM 013	Report on elective productivity and plans for improvement	Chief Operating Officer	31.01.23		Ongoing	Assurance	Highlight key drivers in performance and any actions to support improved delivery.

Summary of updates to risk – December and January 2023

- Narrative updates for rationale for current score, future risks and future opportunities.
- Controls and Assurances updated
- 3 actions completed (DVFM 009, DVFM 011 and DVFM 012)
- Within gaps in assurances, update made to Action DVFM 010 aligning to the correct gap in assurance.

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: 9th December 2022

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.

Rationale for Current Score

- Workforce shortages in some key professional groups, which creates vacancies and creates pressure on existing staff in particular registered nurses and some medical specialties
- High turnover of less than 12 months in some staff groups particularly support workers and ability to recruit from local labour market
- Staff engagement score is currently at the national average and has reduced in year.
- Staff advocacy scores currently below the national average and have deteriorated over the last four quarters
- Physical environment, colleague facilities (catering) and car parking cited as a concern by departments and teams for having an impact on morale, wellbeing and ability to work effectively.
- Leadership ability and capacity impacting on levels of staff satisfaction, cultural transformation and workforce metrics in a number of areas.
- High levels of sickness absence related to mental health issues and musculoskeletal injuries and lack of capacity in health and wellbeing service to respond to needs in a timely way.
- Increase pressure from restoration leading to staff burn out post COVID and ability to participate in wider engagement and development activities.
- Gap between the desired and the current culture indicates improvements are needed.
- Staff not feeling valued due to inconsistency in employment offers internally and across the region.
- Impact of cost of living pressures on staff which are further compounded in some grades by implications from pension scheme as a result of levels of contribution levels and tax implications
- Insufficient resource within the Workforce and OD team to deliver change programmes at pace
- Local onboarding processes do not consistently provide new recruits with a positive employment experience.
- National unrest regarding cost of living and national pay deals. Unions currently balloting for strike action

Risk Tolerance
4-8

Initial risk Rating 4 x 5 (likelihood x severity) = 20
Current Risk Rating 4 x 3 (likelihood x severity) = 12
Target Risk Rating 4-8

Risk Rating Tracker

	2021-22			
	Q1	**Q2**	**Q3**	**Q4**
Initial	20	20	20	20
Current	16	16	20	20
Target	6	6	6	6

	2022-23			
	Q1	**Q2**	**Q3**	**Q4**
Initial	20	20	20	
Current	12	12	12	
Target	4-8	4-8	4-8	

Risk score reviewed in light of refreshed risk appetite and risk tolerance in line with the NPSA matrix in May 2022

	Future Risks • Ageing workforce profile in some services, leading to significant gaps post retirements. • Development of new roles may be hindered by inability to fund training posts and service posts simultaneously. • Impact of training and support for international new recruits on current staff and the retention of the new recruits. • Inability to source additional temporary workforce to support restoration and recovery plans • National pay and reward contract negotiations. Strike action likely • Non-delivery of New Hospital Programme impacting on ability to utilise available workforce effectively. • ICS transformations on corporate services benchmarking identified significant opportunity for saving in HR/OD workforce which is in direct contrast to the significant service pressures on the teams and ability to deliver transformational culture and OD programmes • Continued deterioration of the working environment and hygiene factors impacting on staff satisfaction	**Future Opportunities** • There are opportunities to work across the ICS to support workforce supply, i.e., international recruitment, creation of new roles. • Changes to models of care present opportunities to remodel workforce. • Continued opportunity to use the multi professional skills of our workforce in different ways to help tackle specific workforce shortages. • Opportunity to adequately resource an OD programme to increase staff engagement and cultural transformation at pace. • Create a first-class working environment as part of the New Hospitals Programme • Redesign and implementation of more effective and consistent off boarding processes in order to retain a positive perception of leavers with regards to their employment experience.

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

• Workforce and OD strategy related strategies and plans in place
  ○ Trust Values
  ○ Workforce Plan
  ○ Targeted recruitment & plans (international and 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
	• 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)
	• Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision. (GPTW 001)
	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design. (GPTW002)
		Internal
		• Divisional Governance Structure and Arrangements
		• Divisional Improvement Forums (including Part II process to address cultural concerns)
		• Raising Concerns Group
		• Workforce Committee
		• Education Training and Research Committee
		• Safety and Quality Committee
		• Audit Committee assurance processes.
		• Regular schedule of reporting arrangements for cultural risks at Committees of the Board and Board now in place and covered within the Risk Management Policy
		
		<u>External</u>
		• National Surveys and benchmarking including staff satisfaction survey, workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)
		• Internal audit and external reviews e.g.
			[None]

○ Vacancy control panel in place and meeting weekly • 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		• External regulatory oversight e.g., Re-accreditation of Workplace wellbeing charter (5 out of 8 domains sitting as excellent) • rostering review by NHSI indicating excellence in rostering practice	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
GPTW001	Review strategies considering financial pressures and delivering value for money as part of committee cycles of business.	Executive Leads	31st March 2023		Ongoing	Control	• Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking and action plans to reduce unwanted • Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision.
GPTW002	Incorporate transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	Director of Strategy and Planning	31st March 2023		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.
GPTW003	Update Risk Management Strategy to reflect oversight of cultural risks	Assurance and Regulations Manager & Deputy Director of Workforce and OD	31st July 2022	31st July 2022	Complete	Assurance	• Regular schedule of reporting arrangements for cultural risks at Committees of the Board and Board.

Risk updates - December and January 2023

- Amendment in Rationale for Current score regarding Advocacy Scores – these are below the national average.

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: 23rd January 2023

Risk

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

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

Risk Tolerance
8-12

Initial risk Rating: 4 x 5 (likelihood x severity) = 20
Current Risk Rating: 3 x 5 (likelihood x severity) = 15
Target Risk Rating: 8-12

Rationale for Current Score

- Place and System based working are developing both in terms of personnel, roles, governance, strategies, and plans and within this context LTH has reputational/performance challenges that are challenges to our ability to work effectively at both levels
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- Digital transformational will be a major enabler for partnership working, pathway/service integration and ensuring we are fit for future. We have an ambitious Digital Norther Star strategy but delivering this will be a major challenge in terms of resources, organisational change and system working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to meet deliver the services our partners rightly expect and our staff will be focused on immediate operational challenges rather than service and pathway integration. The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.
- 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

	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Initial	20	20	20	20
Current	20	20	15	15
Target	8-12	8-12	8-12	8-12

	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
Initial	20	20	20	
Current	15	15	15	
Target	8-12	8-12	8-12	

Controls	Gaps in Control	Assurances	Gaps in Assurances

• Workstream related strategies in place
  ○ Clinical Strategy
  ○ Digital Strategy,
  ○ Estates Strategy, including New Hospital Programme
  ○ Comms and engagement
• New Hospitals Programme operational groups established and named executive lead.
• Place and system delivery boards established.
• LTHTR executive leads with Place/ICS responsibilities.
	• Integration of services and pathways. ***(FFTF 001, FFTF 003, FFTF 004, FFTF 005, FFTF 006, FFTF 008)***
	• Effective Place and system based working. ***(FFTF 001, FFTF 005, FFTF 007, FFTF 008)***
		Internal
		• Executive Transformation Group
		• Planning Framework updates to Finance and Performance Committee.
		• New Hospitals Programme assurance to Board
		• Audit Committee assurance processes to test effectiveness of infrastructure and internal control system.
		
		External
		• New Hospitals Programme Oversight Group
		• ICS Digital Board
			• 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 002)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
FFTF 001	Link LTHTR strategies with Place, Provider Collaborative and ICS Strategies	Executive Leads	31st March 2023		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 002	Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters	Director of Strategy and Planning	31st March 2023		Ongoing	Assurance	• The Board requires dedicated time to fully discuss the wide range of system issues/changes that will be a key element in our being Fit for the Future
FFTF 003	Ensure maximum LTH influence on/contribution to Place and System working	Executive Leads	31st March 2023		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 004	Develop and deliver Digital Northern Star strategy	Chief Information Officer	31st March 2023		Ongoing	Control	• Integration of services and pathways
FFTF 005	Deliver staff engagement/comms strategy (including reputation monitoring/management)	Director of Communication & Engagement and Chief People Officer	31st March 2023		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 006	Deliver New Hospitals Programme	Chief Finance Officer	31st March 2023		Ongoing	Control	• Integration of services and pathways
FFTF 007	Deliver our Social Value Strategy	Director of Strategy & Planning,	31st March 2023		Ongoing	Control	• Effective Place and system based working.
FFTF 008	Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change	Director of Strategy & Planning, Director of Continuous Improvement & Transformation	31st March 2023		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.

Updates to Risk – January 2023

- FFTF 001 Link LTHTR strategies with wider Place, Provider Collaborative and ICS Strategies: We continue to link our strategies with the developing situation at Place and System level. Brief summaries are given below regarding the development in a range of key system strategies/activities.
    - The Clinical Programme Board (CPB) is meeting monthly with the remit of overseeing the PCB clinical transformation programme. The transformation programme is delivered within a range of specialty based networks. The following suite of documentation is now in place for each specialty based network: Programme plan with milestones, owners, and GANTT chart; Benefit realisation tracker; Risk register; Engagement log/ toolkit
    - The Corporate Collaboration programme is making good progress with defining project scope and establishing frameworks of governance to provide the structure to manage effectively. Each of the Corporate service areas are at different stages. During January a smart sheet will be created for each project to support action tracking and highlight reporting. This will trigger a high level Individual Project Review for all in-scope projects. Detailed programme timeline to be drawn up during January showing the required review approval points for each project. A follow up event to the workshop held on the 25th November is currently being scheduled to drive the move towards a new Target Operating Model.
    - Urgent Care: The Trust continues to work with health and social care organisations across the Central Lancashire system to support improvement. The accelerated delivery of a piece of work to bring together the triage functions for all services that support admission avoidance and hospital discharge has been agreed. A workshop, facilitated by the Continuous Improvement team, took place on 12th January to start co-designing the model. The Trust now has responsibility for the Lancashire Community Healthcare Hub (Finney House) which is part of our response to ongoing pressures within the health and care system. A workshop was held on 19th January with system partners to discuss and agree the continued usage of the Community Healthcare Hub. The workshop was well attended with a high level of commitment from partners to work together to develop a model of care and Business Case. The work will be undertaken as part of the Place UEC Oversight group
    - External support has been commissioned to support the rapid development, set-up and mobilisation of an ICB PMO function, with a target of implementing the function by January 2023.
- FFTF 002 Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters: the strategic element of Board discussions has been strengthened – recent examples include external speakers to update on system working and future topics include system/service integration
- FFTF 003 Ensure maximum LTH influence on/contribution to Place and System working: LTH continue to deliver a very substantial commitment/contribution to system working both at Place and System level eg taking on formal system roles, leading on System/Place projects etc
- FFTF 004 Develop and deliver Digital Northern Star strategy: Groups have been initiated for all three digital northern star themes of infrastructure, corporate and clinical systems and knowledge platforms. Groups are focussing on:
    - Shared ICS wide Infrastructure for Datacentres, End user computer, networks, contracts, printing, and service desk.
    - A single ICS wide EPR with the tender due for release imminently.
    - Shared Knowledge platforms comprised of a single ICS wide provider data warehouse (design and business case development underway) and a single Northwest wide regional secure data environment (SDE). Together these will transform the relationship of health with research and academia, will support workforce recruitment and retention and increase access to and value from NHS data. The region has won a three-year 10M NHS award for the SDE.
- FFTF 005 Deliver staff engagement/comms strategy : The new internal bulletin has been designed and is due to launch 2 February, with stakeholder newsletter to follow before end of the March. Intranet and website development continues with the consultant directory updated and other key sections under review to ensure ease of access. The restructured communications team is aligning more closely with PCB and ICS projects with fortnightly Directors and Heads of Communications meetings in place. We continue to be one of the leading Trusts outside London in terms of proactive media activity with appearances on the One Show, Talk TV, Granada, Sky and North West Tonight as well as interviews with Global Radio; BBC Radio Lancashire and the Lancashire Evening Post. Work is ongoing to enhance the trust environment for staff, patients and visitors with new artwork and messaging in the completed Gordon Hesling entrance and proposals for other areas are under development.
- FFTF 006 Deliver New Hospitals Programme: The national team presented the overarching NHP business case to the Major Projects Review Group on 6th December. A formal response is awaited.
- FFTF 007 Deliver our Social Value Strategy: Working well with all partners. On track to submit level 1 accreditation this financial year, which will inform/be the foundation for our Social Value Quality Kitemark
- FFTF 008 Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change: Our transformational process continues to develop and strengthen with detailed reports/updates given to the Finance & Performance Committee. Progress continues to be made to develop and strengthen our governance and processes in relation to our programmes for Outpatient, Elective and Urgent Care Transformation including. Most significantly a report has been developed to provide a summary of the transformational benefits by the quadruple aims, including financial quantification where applicable. This is a new and developing benefit report but is very much a step in the right direction.

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

Risk ID: 859
Risk owner: Chief Medical Officer
Date last reviewed: 25th January 2023

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

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

Risk Tolerance 6-9

Initial risk Rating: 2 x 4 (likelihood x severity) = 8
Current Risk Rating: 2 x 4 (likelihood x severity) = 8
Target Risk Rating: 6-9

Rationale for Current Score

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

Risk Rating Tracker

2021/22				
	Q1 2021/22	**Q2 2021/22**	**Q3 2021/22**	**Q4 2021/22**
Initial	8	8	8	8
Current	8	8	8	8
Target	8-12	8-12	8-12	8-12

2022/23				
	Q1 2022/23	**Q2 2022/23**	**Q3 2022/23**	**Q4 2022/23**
Initial	8	8	8	
Current	8	8	8	
Target	6-9	6-9	6-9	

Future Risks

- Risk of New Hospital Programme not progressing.
- Commissioning risks to lower volume/low priority services.

Future Opportunities

- ICS networks and collaboration leading to reconfiguration of services
- New Hospitals Programme investment leading to establishment of Lancashire Specialist Hospital which may include additional specialist services.
- Increasing research and innovation profile of specialist services.
- Harnessing innovative ways of working using technology

Controls	Gaps in Control	Assurances	Gaps in Assurances
• Workstream related strategies in place - LTHTR Clinical Strategy - ICS Clinical Strategy - Estates Strategy - Finance Strategy and Plans • New Hospitals Programme • LTHTR Executive leads with Place/ICS responsibilities e.g. Chief Medical Officer located on a number of network bodies e.g. Chair of Cancer Alliance, Chair of Clinical Oversight Group for New Hospitals Programme, Lead Medical Director for the PCB • Quality and safety controls support the retention of specialist services. *Full details of controls associated with quality and safety of specialist services will be noted in the Strategic Risk associated with the Strategic Ambition to provide Consistently Delivering Excellent Care. • ICS Speciality Boards in place for a number of specialist services • Statutory development of the ICS into. • Capital Planning Group arrangements in place to provide structure and organised approach to capital investment	• Inclusion of specialist services within the planning framework ***(SPEC 003)*** • Integration of services and pathway and effective Place and system-based working ***(SPEC 001)***	**Internal** • Speciality Boards • Divisional Governance Structures and Arrangements • Divisional Improvement Forums • Safety and Quality Committee • Finance and Performance Committee • Strengthened updates to Board and Audit Committee regarding Specialised Services risk **External** • Scheduled contractual reviews with Specialised Commissioners including Executive Management Team forums to progress and resolve issues. • New Hospitals Programme Oversight Group • ICS and ICB system delivery Boards	• None documented

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
SPEC 001	Link LTHTR and ICS Clinical strategies with PCB	Chief Medical Officer	31st March 2023			Control	• Integration of services and pathway and effective Place and system-based working
SPEC 002	Include Specialist Services risk within Board Assurance Framework	Deputy Associate Director of Risk and Assurance	30th June 2022	30th June 2022	Completed	Assurance	• Specialised services updates to Board and Audit Committee require strengthening
SPEC 003	Inclusion of specialist services within the planning framework	Director of Strategy	31st March 2023			Control	• Inclusion of specialist services within the planning framework

Updates to risk – January 2023

- Risk reviewed with no significant changes to note.
- Provider Collaborative Board (PCB) are developing the relationship and workstreams with the Integrated Care System (ICS) to ensure appropriate joined up working across the system

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

Risk ID: 860

Risk owner: Chief People Officer

Date last reviewed: 21st November 2022

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	**Initial risk Rating**	2 x 3 (likelihood x severity) = 6
	Current Risk Rating	5 x 4 (likelihood x severity) = 20*
	Target Risk Rating	9-12

Rationale for Current Score

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

Risk Rating Tracker

	2021-22			
	Q1	**Q2**	**Q3**	**Q4**
Initial	6	6	6	6
Current	16	16	16	16
Target	8-12	8-12	8-12	8-12

	2022-23			
	Q1	**Q2**	**Q3**	**Q4**
Initial	6	6	6	
Current	12	12	20*	
Target	9-12	9-12	9-12	

** Recommendation made to December 2022 ETR Committee to increase the risk score to 20 to reflect the tightening of rules relating to the treatment of deferred income.*

Future Risks

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

Future Opportunities

- Continued participation and development of funded COVID/respiratory related research activities.
- Expansion of undergraduate programmes.
- Increase in the use of advanced digital solutions to provide education programmes.
- Maximise opportunities afforded through selection as RePAIR case study site.
- 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.
- Development of our holistic student offer.

	• UK becoming less competitive/losing commercial research trials	• 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 in research and education • Opportunity to manage income generation via Edovation • Potential to expand student placement offer to HEIs within and outside region

Controls	Gaps in Control	Assurances	Gaps in Assurances
• Workstream related strategies in place: ○ Education & Training Strategy ○ Apprenticeship Strategy ○ Digital Education Strategy ○ Research Strategy ○ Our Big Plan, Annual Business Plan Planning framework ○ Workforce & OD Strategy • Ring-fencing of education and research funding. • Divisional education contracts. • NHS Education Contract with HEE. • Policies in place with review cycle. • Business continuity plans in place. • Head of R&I now part of New Hospitals Programme and ICB programme working parties.	• Ongoing losses in research income which necessitate a recovery plan ***(ETR 001)*** • Lack of research personnel embedded in divisions ***(ETR 002)*** • No mechanism to utilise educational income to support capital developments ***(ETR 004, ETR 005)***. • Ability to income generate in current economic climate. ***(ETR 005)*** • Lack of research tariffs ***(ETR 006)*** • Control of in-year adjustments relating to income deferral **(*Incident 98790)* (ETR 006)** **added post-committee*	**Internal** • Sub-committees for education, training and research incorporating risk reviews. • Quality assurance and performance management of education activity. • Learner improvement forum. • Monthly training compliance reports. • Divisional performance reviews • Monthly finance reviews. • Education, Training & Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system. • Board. **External** • Full OFSTED inspection completed August 2022 with 'Good' rating achieved. • ESFA audits • HEE self-assessment return. • Quality Mark and Matrix accreditation. • Annual performance reviews with Manchester Medical School • National Student Surveys. • National Education Trainee Surveys. • STAR accreditation for Clinical Research Facility. • Engagement in range of external forums and committees. • Quarterly strategy meetings with local HEIs • Trust Involvement/leadership in ICS discussions re education and R&I	• None currently identified.

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
ETR 001	Reset research provision to develop an affordable portfolio and refer to this in the refreshed Research and Innovation Strategy.	Head of Research & Innovation	30.04.23		Ongoing	Control	• Ongoing losses in research income which necessitate a recovery plan.
ETR 002	Include desire to implement research roles in divisions within refreshed Research & Innovation Strategy.	Head of Research & Innovation	31.12.22		Ongoing	Control	• Lack of research personnel embedded in divisions.
ETR 003	Embed Research & Innovation and Education leads in NHP and ICB programmes.	Head of Research & Innovation & Deputy Director of Education	01.11.22	04.10.22	Complete	Control	• Lack of research and education representation in NHP and ICB programmes
ETR 004	Include development of international education programmes post-Covid in Education and Training Strategy.	Deputy Director of Education	31.12.23		Ongoing	Control	• No mechanism to utilise educational income to support capital developments
ETR 005	Identify solutions to facilitate and support creation and delivery of a capital programme for education.	Director of Finance	30.04.23		Ongoing	Control	• No mechanism to utilise educational income to support capital developments • Ability to income generate in current economic climate
ETR 006	Identify a plan to mitigate identified risks associated with change in deferred income.	Chief People Officer/Director of Finance	30.04.23		Ongoing	Control	• Control of in-year adjustments relating to income deferral

Summary of Updates - November 2022

- Current score increased from 12 to 20, for ETR Committee approval
- Rationale for current score, narrative of Future Risks and Future Opportunities updated
- Action ETR 0003 marked as completed, leading to a new control measure being identified.
- Assurances updated to include recent OFSTED inspection outcome and ESFA audits
- New gap in control identified related to in-year adjustments relating to income deferral, identified through an incident being reported (ID 98790). A plan to mitigate identified risks will need to be developed.

Chair's Report

Committee:	Safety and Quality Committee
Chairperson and role:	Kate Smyth, Non-Executive Director (25 November) Ann Pennell, Non-Executive Director (06 January)
Date(s) of Committee meeting(s):	25 November 2022 and 06 January 2023
Purpose of report:	To update the Board on the business discussed by the Safety and Quality Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

25 November 2022

Following the meeting held on the 25 November 2022, the Committee conducted a comprehensive review of the scheduled items on the agenda.

The Committee approved the following items:
- Minutes and actions
- Strategic risk register

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

- Safety and Quality Dashboard including Nursing and Midwifery staffing reports for adult inpatients (including the emergency department); maternity; and neonatal and children and young people services.
- Maternity and Neonatal Services Report including CQC Whistleblowing.
- Stillbirth Outlier Report.
- Emergency Department Safe Staffing Report (including Ambulance Peer Data)
- Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services.
- Quarterly serious case thematic review and learning report.
- Clinical Audit Plan Update.
- SSNAP Improvement Plan Update.

06 January 2023

Following the meeting held on the 06 January 2023, the Committee conducted a comprehensive review of the scheduled items on the agenda.

The Committee approved the following items:
- Minutes and actions
- Strategic risk register

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

- Bi-annual Medicines Governance Report.
- Safety and Quality Dashboard including Nursing and Midwifery staffing reports for adult inpatients (including the emergency department); maternity; and neonatal and children and young people services.
- Patient Safety Incident Response Framework Changes.
- Finney House Update.
- Pathway Improvement Work Update for Urgent and Emergency Care.

Items for the Board's attention

The Committee was assured of the actions to manage safe staffing within adult inpatient and Emergency Department and in respect of the actions being taken to address areas for negative escalation and early notification of declining trends. The Committee received the Neonatal, Children and Young People staffing report and were assured that risks were being regularly reviewed, monitored and mitigated. The Clinical Audit Plan update provided the Committee with assurance of the programmes of work that support robust systems and processes for managing Clinical Audit performance. The Committee resolved that the NICE Guidance Improvement Programme of work to deliver enhanced risk maturity that had been impacted by the pandemic, had now been reinvigorated over the preceding few months.	The Chief Nursing Officer provided the Safety and Quality Committee with a summary of the current situation and winter pressures face by the Trust and it was agreed that a written summary would be included as part of the Integrated Performance Report.
Positive escalation	
25 November 2022	**06 January 2023**
- The Committee was assured with the discussions undertaken around the mental health assurance of the response to the NHS England letter that responded to the BBC Panorama Manchester Mental Health Trust programme. - The 62 day Cancer backlog was reduced following the action plan that was implemented to drive improvement. - The planned handover of Finney House to Lancashire Teaching Hospitals and admissions of patients by the end of November. - Improved registered nurse and midwifery staffing fill rates.	- It was confirmed that recruitment had taken place within maternity services leaving a significantly reduced vacancy rate of 3.97 whole time equivalent Midwives. The service has successfully recruited 3 Obstetrics and Gynaecology Consultants and a successful business case had been submitted for the recruitment of 16 international midwives. - The assurance provided to the Committee in the Finney House update following the transfer of the lease to the Trust. The registration approval by the CQC was given on 11 November 2022 and from 30 November Finney House Community Care Hub opened, providing care for patients who no longer meet the criteria to reside in hospital but are unable to progress to their permanent home setting. The Trust was now also responsible for managing the care of the permanent residents and was receiving positive feedback from patients and families. - The Committee received the Bi-annual Medicines Governance update and there had been significant progress made in addressing the recommendations made by the CQC relating to medicines, including those in the CQC national publications and the last Trust CQC visit in April 2022. Excellent results had been gained by adopting continuous improvement

	methodology and strong teamworking between pharmacy, nursing and medical staff.
Negative escalation	
25 November 2022	**06 January 2023**
- The SSNAP compliance rating remained at D. The committee received the plans for recovery and requested a deep dive into thrombectomy at the January 2023 meeting. - The never event presented in the Quarterly Serious Case Thematic Review and Learning Report. - The North West Coast dashboard confirmed that the incidence of stillbirth within Lancashire Teaching Hospitals had been noted to have exceeded the upper parameter in comparison to other North West Coast Trusts for the period September 2021 – August 2022. An independent review of the findings of the thematic reviews to date has been agreed. - Continued high levels of Health Care Assistant vacancies.	- The Committee discussed the risks around the industrial action that was expected from NWAS on 11 January and 23 January, and the RCN industrial action scheduled for 18 and 19 January. The de-brief for the December strikes demonstrated that the plans in place were enacted as well as could be expected and had provided some learnings for next time. There were strike committees with operational oversight arrangements in place. - The operational pressures in the run up to Christmas that included high levels of flu and covid and the increased number of patients not meeting the criteria to reside had led to an increased number of patients and extended lengths of stay in the Emergency Department and ambulance handover delays. An EQuality impact assessment would be discussed at the Board Workshop on 17 January 2023 to allow assessment of any compromises or mitigations that are required to manage patient safety.
Committee to Committee escalation	
25 November 2022	**06 January 2023**
No escalations.	No escalations.
Items recommended to the Board for approval	
25 November 2022	**06 January 2023**
No items for approval.	No items for approval.
Committee Chairs reports received	
25 November 2022	**06 January 2023**
(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Medicines Governance Committee (e) Safety and Learning Group (f) Patient Experience and Involvement	(a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Mortality and End of Life Committee (d) Always Safety First Committee (e) Medicines Governance Committee (f) Safety and Learning Group (g) Patient Experience and Involvement (h) Health and Safety Governance
Items where assurance was provided and/or for information	

25 November 2022	06 January 2023
The Committee received the Exception report from Divisional Improvement Forums and a StEIS Report update for information. The Committee continued to be assured by the action plans to mitigate the risks aligned to the Committee. The Committee received the Stillbirth Outlier Report and were assured of the rigour and scrutiny applied within the clinical audit schedule. The Quarterly Serious Case Thematic Review and Learning Report was presented to the Committee which provided assurance for the management of serious incidents.	The Committee received the Exception report from Divisional Improvement Forums and the Quality Impact Assessment Update. Assurance was provided of the safe staffing within the adult inpatient areas and the actions being taken to address areas for negative escalation and early notification of declining trends. The Committee continued to be assured by the action plans to mitigate the risks aligned to the Committee. The Safety and Quality Committee were assured of the safety and quality standards within the maternity service and that risks were being reviewed, monitored and mitigated where possible. Assurance of the safe management of medicines was confirmed by the Committee and the improvement actions undertaken to address areas where performance indicators that were not met, was noted.
Progress against the Committee's cycle of business	
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 27 January 2023 using Microsoft Teams.	

Recommendation:

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

Appendix 1 – Safety and Quality Committee agenda (25 November 2022)

Appendix 2 – Safety and Quality Committee agenda (06 January 2023)

Safety and Quality Committee

25 November 2022 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Noting	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Noting	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Noting	K Smyth
4.	Minutes of the previous meeting held on 04 November 2022	12.33pm	✓	Approval	K Smyth
5.	Matters arising and action log	12.35pm	✓	Approval	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Approval	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard including Adult Nurse Inpatient Report.	12.50pm	✓	Discussion	C Silcock
7.2	Neonatal, Children and Young People Staffing Report.	1.05pm	✓	Discussion	S Cullen
7.3	Maternity and Neonatal Services Report including CQC Whistleblowing.	1.15pm	✓	Approval	E Ashton
7.4	Stillbirth Outlier Report	1.30pm	✓	Noting	E Ashton
7.5	Emergency Department Safe Staffing Report (including Ambulance Peer Data)	1.40pm	✓	Discussion	S Cullen
BREAK 2.00pm to 2.15pm					
7.6	Quality and Safety of Mental Health, Learning Disability and Autism Inpatient Services	2.15pm	To follow	Noting	S Cullen
7.7	Quarterly serious case thematic review and learning report	2.25pm	✓	Discussion	C Morris
7.8	Clinical Audit Plan Update	2.35pm	✓	Noting	C Morris
7.9	SSNAP Improvement Plan Update	2.40pm	✓	Noting	M Brady/ M Brown

№	Item	Time	Encl.	Purpose	Presenter
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	2.50pm	✓	Approval	K Smyth
8.2	Items for escalation to the Board or to/from other Committees	2.55pm	Verbal	Noting	K Smyth
8.3	Reflections on the meeting and adherence to the Board Compact	2.57pm	✓	Discussion	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums		✓		
9.2	StEIS Report Update – Datix 74012		✓		
9.3	**Chairs' reports from feeder groups**: (a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Always Safety First Committee (d) Medicines Governance Committee (e) Safety and Learning Group (f) Patient Experience and Involvement		✓		
9.4	Date, time and venue of next meeting: *6 January 2023, 12.30pm, Microsoft Teams*	3.00pm	Verbal	Noting	K Smyth

Safety and Quality Committee

06 January 2023 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Noting	A Pennell
2.	Apologies for absence	12.31pm	Verbal	Noting	A Pennell
3.	Declaration of interests	12.32pm	Verbal	Noting	A Pennell
4.	Minutes of the previous meeting held on 25 November 2022	12.33pm	✓	Approval	A Pennell
5.	Matters arising and action log	12.35pm	✓	Approval	A Pennell
6.	Strategic Risk Register	12.40pm	✓	Approval	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard including Adult Nurse Inpatient Report	12.50pm	✓	Discussion	C Silcock
7.2	Maternity Staffing Report	1.00pm	✓	Discussion	E Ashton
7.3	Neonatal, Children and Young People Staffing Report.	1.15pm	✓	Discussion	S Cullen
7.4	Bi-annual Medicines Governance Report	1.25pm	✓	Approval	G Price
7.5	Patient Safety Incident Response Framework Changes	1.40pm	✓	Discussion	C Morris
7.6	Incident 92969	1.50pm	✓	Noting	S Cullen
BREAK 2.00pm to 2.15pm					
7.7	Finney House Update	2.15pm	✓	Noting	S Cullen
7.8	Pathway Improvement Work Update for Urgent and Emergency Care	2.25pm	✓	Noting	A Brotherton
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	2.35pm	✓	Approval	A Pennell

№	Item	Time	Encl.	Purpose	Presenter
8.2	Items for escalation to the Board or to/from other Committees: a) Quality Issues impacting trainee Doctors at CDH	2.40pm	Verbal	Noting	A Pennell S Cullen
8.3	Reflections on the meeting and adherence to the Board Compact	2.47pm	✓	Discussion	A Pennell
9.	ITEMS FOR INFORMATION				
9.1	Exception report from Divisional Improvement Forums		✓		
9.2	Quality Impact Assessment Update		✓		
9.3	**Chairs' reports from feeder groups**: (a) Infection, Prevention and Control Committee (b) Safeguarding Board (c) Mortality and End of Life Committee (d) Always Safety First Committee (e) Medicines Governance Committee (f) Safety and Learning Group (g) Patient Experience and Involvement (h) Health and Safety Governance		✓		
9.4	Date, time and venue of next meeting: *27 January 2023, 12.30pm, Microsoft Teams*	2.50pm	Verbal	Noting	A Pennell

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity and Neonatal Services CNST Validation Report			
Report to:	Board of Directors	**Date:**	2nd February 2023
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert, E. Ashton
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services specifically relating to the ten Clinical Negligence Scheme for Trusts (CNST) maternity safety actions included in year four of the NHS Resolution maternity incentive scheme. This report details an update on the CNST Local Maternity and Neonatal System external evidence verification, prior to the Trust Board submission of the declaration of compliance to NHS Resolution by the 2nd of February 2023.

Since the end of September 2022, the service reported to the Trust Board that it was on track to deliver 10 out of the 10 CNST standards. The Local Maternity Neonatal System (LMNS) external verification exercise undertaken on the 16th of January 2023 confirmed that the evidence provided by the service met the standards required for compliance with all 10 safety actions.

Detailed in the report are 2 exceptions where 1 point has not been met in 2 standards. These relate to Safety Action (SA)5, question 5, part d) and the requirement to provide 1:1 care in active labour and achievement of 100% compliance and SA 6 question 24-part a) relating to Trust Board assurance that it has received data from the organisation's MIS evidencing 80% compliance that 80% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids, within seven days of birth?

Although compliance to these points is not at achieved, the Trust will still pass this standard because the service has submitted an action plan to the Board detailing how it intends to achieve 100% compliance with 1:1 care in active labour and 80% compliance with full course of antenatal corticosteroids, within seven days of birth. The service confirms that relevant action plans have been included within the bi-monthly Maternity Service update reports for oversight and assurance.

The outcome of this review was scrutinised by the Safety and Quality committee who have confirmed they are satisfied with the evidence provided. On that basis the Chief Executive Officer has validated the submission to the Integrated Care Board for submission.

It is recommended that the Board of Directors:

i.	Confirms it is assured of the sign off process and compliance detailed within the report and is satisfied Lancashire Teaching Hospitals will declare compliance with the 10 CNST safety actions.		
Appendix 1 – Action plan safety action 5, element 2 **Appendix 2 – Action plan safety action 6, element 5**			
Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high-quality specialised services to patients in Lancashire and South Cumbria	☒	Great Place to Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For the Future	☒
Previous consideration			
None			

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work within the maternity and neonatal services specifically relating to the ten CNST maternity safety actions included in year four of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. In addition, the paper confirms the current position following the CNST Local Maternity and Neonatal System external evidence verification, prior to the Trust Board submission of the declaration of compliance to NHS Resolution by the 2nd of February 2023.

2. MATERNITY INCENTIVE SCHEME

The Associate Director of Midwifery for the Lancashire and South Cumbria Maternity and Neonatal System (LMNS) visited the service on the 16th of January 2023 to review the service and confirm that the evidence presented met the requirements of all 10 safety actions. The review concluded that the evidence provided by the service has met the standards required for compliance with all 10 safety actions.

Whilst monthly specialty work streams for each safety standard led by Deputy Divisional Midwifery and Nursing Director have continued to monitor and track ongoing progress and the Trust Board receives a bimonthly Maternity Service CNST and Ockenden Report detailing progress against all ten standards, this additional review provides assurance to the Board, prior to the Trust Board sign off of the declaration of compliance to NHS Resolution.

A summary of progress to date regarding the attainment of all ten safety actions is detailed in the progress tracker below. (Table 1).

Table 1 Progress Tracker

Safety Action	Progress Update	RAG Rating	Areas of concern
Safety Action 1 - PMRT	On track		Evidential Requirement met
Safety Action 2 - MSDS	On track		Evidential Requirement met
Safety Action 3 - ATAIN	On track		Evidential Requirement met
Safety Action 4 – Clinical Workforce planning	On track		Evidential Requirement met
Safety Action 5 – Midwifery workforce staffing	On track		Evidential Requirement met
Safety Action 6 – SBLV2	On track		Evidential Requirement met
Safety Action 7 – Maternity Voice Partnership (MVP)	On track		Evidential Requirement met
Safety Action 8 - Training	On track		Evidential Requirement met
Safety Action 9 – Board Assurance	On track		Evidential Requirement met
Safety Action 10 – NHS Resolution	On track		Evidential Requirement met

3. SAFETY ACTION VALIDATION

3.1 PROCESS

To be eligible for payment under the CNST scheme, Trust must confirm achieve all ten maternity safety actions. After internal and external review, submissions are subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number

of qualifying incidents reportable (safety action 10, standard a). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Table 2 provides a summary dataset of all safety actions and confirms that all 139 action and sub actions have been met.

In action number 2 one of the questions is for information purposes only. This asks if over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided. The service is compliant with this question.

Table 2

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Information
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	10	0	0
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	12	0	1
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Yes	19	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	7	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	5	0	0
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?	Yes	28	0	0
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Yes	7	0	0
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	Yes	18	0	0
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes	25	0	0
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	Yes	8	0	0

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Table 3 confirms the overall position for safety action 1. The data entry sheet confirms the individual standards that have been achieved. 11/11 safety action requirements met the standard.

Table 3

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 6 May 2022 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	Was the surveillance information for eligible deaths where required, completed within one month of the death?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Have at least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022, been reviewed using the PMRT, by a multidisciplinary review team?	Yes
5	Were each of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were the reports published within 6 months of death?	Yes
Q7 and Q8 are linked questions		
7	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, were parents told that a review of their baby's death will take place?	Yes
8	If parents have not been informed about the review taking place, were the reasons for this documented within the PMRT review?	Yes
9	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, were parents' perspectives and questions and/or concerns they have about their care and that of their baby sought? This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust.	Yes
10	Have you submitted quarterly reports to the Trust Board from 6 May 2022 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
11	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Table 4 details the requirement for safety action 2, related to the Clinical Quality Improvement Metrics, engagement with the NHSE Digital Child Health and Maternity Programme and implementation of a digital strategy.

Table 4

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	By 31 October 2022, did your Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework?	Yes
2	Was the strategy shared with Local Maternity Systems?	Yes
3	Was the strategy signed off by the Integrated Care Board?	Yes
4	Is a dedicated Digital Leadership in place in the Trust?	Yes
5	Has the Digital Leadership at the Trust engaged with the NHSE Digital Child Health and Maternity Programme?	Yes
6	Was your Trust compliant with at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022?	Yes
Did your Trust's July 2022 data contain:		
7	Height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month?	Yes
8	Complex social factor Indicator (at antenatal booking) data for 95% of women booked in the month?	Yes
9	Antenatal personalised care plan fields completed for 95% of women booked in the month (MSD101/2)?	Yes
10	A valid ethnic category (Mother) for at least 90% of women booked in the month (MSD001)?	Yes
Has the Trust Board confirmed that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:		
11	I. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
Q12 is for information only		
12	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	Yes
13	iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.	Yes

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal (ATAIN) units Programme?

Table 5 details the requirement for safety action 3 related to pathways of care into transitional care to avoid and minimise separation of mothers and babies.

Table 5

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care by Thursday 16 June 2022 at the very latest		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to British Association of Perinatal Medicine (BAPM) transitional care framework for practice ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal Systems (LMNS), commissioner and Integrated Care		
3	Has the pathway of care into transitional care been fully implemented?	Yes
4	Has the pathway of care into transitional care been audited quarterly?	Yes
Audit findings must be shared each quarter. If for any reason, reviews were paused, they must have been recommenced using data from quarter 1 of 2022/23 financial year. Has audit findings been shared with:		
5	The neonatal safety champions?	Yes
6	The LMNS?	Yes
7	The commissioner and Integrated Care System (ICS) quality surveillance meeting?	Yes
8	If your Trust have encountered barriers to achieving full implementation of the policy, has an action plan been agreed and progress overseen by both the board and neonatal safety champions?	Yes
c) A data recording process (electronic and/or paper based) for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.		
9	Is standard (c) in place?	Yes
d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.		
	Q10 and Q11 are linked	
10	Is standard (d) in place? This should be achieved by no later than 16 June 2022.	Yes
11	If not already in place is a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered	N/A

e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.		
12	Is standard (e) in place (as per ODN request)?	Yes
f) Reviews of babies admitted to the neonatal unit continue a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.		
13	Is an audit trail available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly? If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year.	Yes
14	Is an audit trail available which provides evidence that reviews from Monday 18 July 2022 included **all** term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year?	Yes
15	Do you have evidence that the review includes the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there?	Yes
16	Do you have evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting on a quarterly basis?	Yes
g) An action plan to address local findings from the audit of (standard b) Avoiding Term Admissions Into Neonatal units (ATAIN) reviews, and (standard f) been agreed with the maternity and neonatal safety champions and Board level signed off by the Board no later than 29 July 2022?		
17	Is standard (g) in place?	Yes
h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting each quarter following sign off at the Board.		
18	Has progress with the revised ATAIN action plan been shared with the maternity, neonatal and Board level safety champions each quarter, following sign off at the Board?	Yes
19	Has progress with the revised ATAIN action plan been shared with the LMNS each quarter, following sign off at the Board?	Yes
20	Has progress with the revised ATAIN action plan been shared at the ICS quality surveillance meeting each quarter, following sign off at the Board?	Yes

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Table 6 details the requirement for safety action 4 related to medical, neonatal and anaesthetic workforce planning.

Table 6

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Obstetric medical workforce** Have your Trust Board signed off their engagement with the principles outlined in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/?	Yes
	Q2 and Q3 are linked	
2	Was compliance of consultant attendance monitored when a consultant was required to attend in person?	Yes
3	Were episodes where attendance was not possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A
Do you have evidence that your position with the above RCOG document was shared at least once from May 2022:		
4	At Trust Board?	Yes
5	With Board level safety champions?	Yes
6	At LMNS meetings?	Yes
7	**Anaesthetic medical workforce** Do you have evidence of compliance with Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1? The rota should be used to evidence compliance with ACSA standard 1.7.2.1 *(A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)*	Yes
	Q8 and Q9 are linked	
8	**Neonatal medical workforce** Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing?	Yes
9	If the requirement above has not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS and also include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. Do you have evidence of this?	Yes
	Q10, Q11 and Q12 are all linked	
10	**Neonatal nursing workforce** Does the neonatal unit meet the service specification for neonatal nursing standards?	Yes
11	If the requirement above had not been met in both year 3 and year 4 of MIS, has the Trust Board evidenced progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies?	Yes
12	Has the above action plan been shared with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead?	Yes

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety Action 5, Question 5-part d

Have all women in active labour received one-to-one midwifery care?

Table 7 details the requirement for safety action 5 related to midwifery workforce and safe staffing. Question 5-part d) related to the service's ability to provide 1:1 care in active labour is recorded on the data recording sheet as non-compliant.

To note, the service will not fail safety action 5 if compliance is less than 100%. However, there is a requirement to submit an action plan detailing how the maternity service intends to achieve 100% compliance that is completed within the reporting period? The workforce action plan for December 2022 was submitted to the Trust Safety and Quality Board, and the service confirms all actions are completed. Work is ongoing to ensure improved compliance to this standard.

Table 7

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ●The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. -The midwife to birth ratio -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. ● Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.	Yes

3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. Do you have evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status?	Yes
	Q4 is for information only	
4	If you answered **no** to standard c, have you completed an action plan detailing how the maternity services intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board, and includes a timeline for when this will be achieved? Please note, completion of an action plan **will no**t enable the trust to declare compliance with this sub-requirement in year four of MIS.	N/A
	Q5, Q6 and Q7 are all linked	
5	d) Have all women in active labour received one-to-one midwifery care?	No - Action plan in place
6	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	Yes
7	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	Yes
8	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period?	Yes

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Table 8 details the requirement for safety action 6. This relates to the Saving Babies Lives Care Bundle Version 2 (SBLV2).

Requirement 24-part a)
The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators demonstrating that 80% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids, within seven days of birth?

Requirement 24-part a) is recorded on the data recording sheet as non-compliant. Achievement of this sub-standard related to timely administration of antenatal corticosteroids within 7 days of birth has been identified by the MatNeo SIP (Maternity and Neonatal Safety Improvement Programme) as being more difficult to achieve. This relates to the un- predictability of preterm labour, timing of presentation to the service in preterm labour and acceptance of intrauterine transfers who have not been given steroids and give birth soon after transfer in.

To note, the service will not fail safety action 6 if compliance is less than 80%. However, there is a requirement to submit an action plan detailing how the maternity service intends to achieve >80%? The service monitors compliance against question 24 and monthly variance and performance is detailed in the Maternity and

Neonatal Services paper submitted to Trust Board on a bi-monthly basis. The CNST action plan detailing actions for improvement has also been shared with the Trust Board in November 2022.

Table 8

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Do you have evidence that Trust Board level consideration of your organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019? Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.	Yes
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (ICB). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.	Yes
3	The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. Have you completed and submitted this?	Yes
Element 1 - Reducing smoking in pregnancy Standard a*) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.* *Standard b) Percentage of women where CO measurement at 36 weeks is recorded.*		
4	Has the Trust Board received data for **standard a)** from the organisation's Maternity Information System (MIS) evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe)?	Yes
5	Has the Trust Board received data for **standard b)** from organisation's Maternity Information System or has an audit of 60 consecutive cases been provided to demonstrate >80% of women having a CO measurement recorded at 36 weeks?	Yes
6	Is the audit accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement?	Yes
7	If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. Has this been completed?	Yes
Do you have evidence that the Trust Board has specifically confirmed that within their organisation they:		
8	Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.	Yes
9	Have a referral pathway to smoking cessation services (in house or external)?	Yes
10	Have evidence of an audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service?	Yes
4) Have you generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:		
11	Percentage of women with a CO measurement ≥4ppm at booking?	Yes

12	Percentage of women with a CO measurement ≥4ppm at 36 weeks?	Yes
13	Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment?	Yes
Element 2 - *Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)* *If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented* **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.**		
14	Standard 1) Have you provided evidence showing the percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan? The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital If your Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
15	Has the Trust board received data from the organisation's MIS evidencing 80% compliance or has an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records been undertaken and submitted to Board to assess compliance with this indicator?	Yes
Do you have evidence that the Trust Board has specifically confirmed within their organisation:		
16	Standard 2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards? If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
17	Standard 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation? If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	Yes
18	Standard 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation?	Yes
19	Standard 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT)?	Yes

20	Standard 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (ICBs) following advice from the Clinical Network?	Yes
21	Standard 7) You have undertaken a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g., components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above-mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.	Yes
Element 3 *Raising awareness of reduced fetal movement.* A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.**		
	Q22 and Q23 are linked	
22	Have you completed an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM (whichever is the smaller) demonstrating 95% compliance with the element three process indicators?	Yes
23	If the process indicator scores are less than 95% , have you submitted an action plan for achieving >95%?	Yes
Element 4 Effective *fetal monitoring during labour* ***(Please see safety action 8 for fetal monitoring training)***		
You do not need to submit evidence within element 4, as it is included within safety action 8		
Element 5 *Reducing preterm births* *The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.* *If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators.* *The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion.* *A Trust will not fail Safety Action 6 if the process indicator scores for standards a,b,c & d are less than 80%. However, Trusts must have an action plan for achieving >80%.*		
	Q24, Q26, Q27 and Q28 are linked	
24	a) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in-house audit demonstrating that 80% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids, within seven days of birth?	No - Action plan in place

25	b) Has the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids been recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding?	Yes
26	c) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth?	Yes
27	d) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in-house audit demonstrating that 80% of women have given birth in an appropriate care setting for their gestation (in accordance with local ODN guidance)?	Yes
28	If your process indicator scores for standards a,c or d are less than 80%, do you have an action plan for achieving >80%?	Yes
29	Do you have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention?	Yes
	Q30 and Q31 are linked	
30	Do women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided?	Yes
31	If this is not the case, has the board described the alternative intervention that has been agreed with their commissioner (ICB) and that their Clinical Network and has agreed this is acceptable clinical practice?	N/A
32	Has an audit of 40 consecutive cases of women booking for antenatal care been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway? The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local ICBs following advice from the Clinical Network.	Yes
33	Does the risk assessment and management in multiple pregnancy comply with NICE guidance or a variant that has been agreed with local commissioners (ICBs) following advice from the provider's clinical network?	Yes

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Table 9 details the performance against safety standard 7 which relates to maternity Voice partnership and co-production of services.

Table 9

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you submitted Terms of Reference for your MVP? Do they reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems	Yes
2	Do your minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff?	Yes

3	Have you submitted written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme? Remuneration should take place in line with agreed Trust processes.	Yes
4	Have you provided minutes of the MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it?	Yes
5	Do you have written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way.	Yes
6	Do you have evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality	Yes
7	Do you have evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP	Yes

Safety Action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

Table 10 provides the breakdown of staff training by specialty for fetal monitoring and PROMPT. It also confirms that the maternity training needs analysis is benchmarked against the core competency frame work.

Table 10

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you evidence that:		
1	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. should include the following 6 core modules: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support	Yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group has attended an 'in house' one day multi-professional training day, that includes maternity emergencies?		
2	90% of Obstetric consultants?	Yes
3	90% All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota, including GP trainees?	Yes
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	Yes
5	90% of Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)?	Yes

6	90% of Obstetric anaesthetic consultants?	Yes
7	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota?	Yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring?		
8	90% of Obstetric consultants?	Yes
9	90% of all other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
10	90% of GP trainees who have any obstetric commitment to intrapartum care?	Yes
11	90% of midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres (if applicable)?	Yes
12	Are fetal monitoring sessions consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness?	Yes
13	Has the Trust board specifically confirmed that within their organisation 90% of eligible staff have attended local multi-professional fetal monitoring training annually as above?	Yes
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course?		
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% Neonatal junior doctors (who attend any births)	Yes
16	90% of Neonatal nurses (Band 5 and above)	Yes
17	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
18	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.	Yes

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Table 11 details the standard requirement related to sharing of safety intelligence within the service, at Board level, with the LMNS and with the ICS.

Table 11

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Have you submitted evidence of a revised pathway which describes how frontline midwifery, obstetric and Board safety champions share safety intelligence between:		
1	a) each other?	Yes
2	b) the Board?	Yes
3	c) new LMNS/ICS quality group?	Yes

4	d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model?	Yes
Have you submitted evidence of a revised pathway which describes how frontline neonatal Board safety champions share safety intelligence between:		
5	a) each other?	Yes
6	b) the Board?	Yes
7	c) new LMNS/ICS quality group?	Yes
8	d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model?	Yes
Have you submitted evidence that a clear description of the pathway and names of safety champions are visible to:		
9	Maternity staff?	Yes
10	Neonatal staff?	Yes
11	Have you submitted evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues?	Yes
12	Have you submitted evidence that discussions regarding safety intelligence, including staff feedback from frontline champions and engagement sessions?	Yes
13	Have you submitted evidence that discussions regarding safety intelligence, including minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022? NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	Yes
14	Have you submitted evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board?	Yes
15	Have you submitted evidence of progress with actioning named concerns from staff workarounds are visible to maternity staff and reflects action and progress made on identified concerns raised by staff and service users?	Yes
16	Have you submitted evidence of progress with actioning named concerns from staff workarounds are visible to neonatal staff and reflects action and progress made on identified concerns raised by staff and service users?	Yes
17	Have you submitted evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting?	Yes
18	Has a decision been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended? This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent discussion should be included in the trust Board submission.	Yes
Is there Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to:		

19	Active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities	Yes
20	Engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member	Yes
21	clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network?	Yes
22	Utilise insights from culture surveys undertaken to inform local quality improvement plans?	Yes
23	oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement	Yes
24	Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 5th December 2022.	Yes
25	Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022.	Yes

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification Scheme (EN) from 1 April 2021 to 5 December 2022.

Table 12 confirms that the service has reported 100% of the qualifying cases to HSIB and early notification.

Table 12

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported all qualifying cases to HSIB from 1 April 2021 to 5 December 2022?	Yes
2	Have you reported all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022?	Yes
For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that:		
3	The family have received information on the role of HSIB and NHS Resolution's EN scheme	Yes
4	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
Can you confirm that the Trust Board has:		
5	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.	Yes
6	Sight of evidence that the families have received information on the role of HSIB and EN scheme	Yes
7	Sight of evidence of compliance with the statutory duty of candour.	Yes
8	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

09. CONCLUSION

The report confirms as of the 16th January 2023 that following local and external validation by the LMNS Associate Director of Midwifery and review of the safety actions within the year four scheme are compliant with all 139 actions and request.

Detailed in the report are 2 exceptions where 1 point has not been met in 2 standards. These relate to Safety Action (SA)5, question 5, part d) and the requirement to provide 1:1 care in active labour and achievement of 100% compliance and SA 6 question 24-part a) relating to Trust Board assurance that it has received data from the organisation's MIS evidencing 80% compliance that 80% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids, within seven days of birth?

Although compliance to these points is not at achieved, the Trust will still pass this standard because the service has submitted an action plan to the Board detailing how it intends to achieve 100% compliance with 1:1 care in active labour and 80% compliance with full course of antenatal corticosteroids, within seven days of birth. The service confirms that relevant action plans have been included within the bi-monthly Maternity Service update reports for oversight and assurance.

The outcome of this review was scrutinised by the Safety and Quality committee who have confirmed they are satisfied with the evidence provided. On that basis the Chief Executive Officer has validated the submission to the Integrated Care Board for submission.

10. Recommendations

It is recommended that the Board of Directors:

i. Confirms it is assured of the sign off process and compliance detailed within the report and is satisfied Lancashire Teaching Hospitals will declare compliance with the 10 CNST safety actions.

Appendix 1 – Action plan safety action 5, element 2
Appendix 2 – Action plan safety action 6, element 5

Appendix 1: Workforce action plan – Ongoing actions

	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update	Current Status 1 2 3 4
1.	Recruitment and engagement	Plan virtual recruitment event for spring 2022	DMND	~~30.04.22~~ 01.04.22	01.09.22 Recruitment to all ongoing vacancies is ongoing on a rolling basis and a provisional plan for a midwifery engagement event is planned for December 22. 15.12.22 Recruitment event held and further dates to be confirmed.	
2.	Midwifery Continuity of Care	Secure ICS/national funding to deliver continuity of carer action plan	DMND Matrons	30.04.22	16.03.22 Funding stream to be confirmed 16.05.22 Further roll out of MCoC paused currently until staffing meets recommended BR+ standard. 30.8.22 Further guidance received to pause at this time. 21.09.22 Parameters and targets removed for MCoC as per NHSE letter	**N/A**
3.	Well Led	Recruit to Divisional Midwifery and Nursing Director upcoming vacancy	NMAHP Director	~~31.08.22~~ 01.04.23	16.05.22 Job description reviewed for advert 14.06.22 Interview scheduled 07.07.22 Post readvertised 01.09.22 Post not recruited to Interim DMND in post 15.12.22 DMND now recruited.	
4.	Well led	Complete retention tool kit and attend system wide recruitment and retention meetings	Preceptorship and retention lead	01.04.23	19.10.22 Preceptorship lead is working with the Trusts lead to complete the retention toolkit. Meetings with NHS England have been scheduled. 15.12.22 Retention toolkit completed with Trust lead.	
5.	Well led	Recruit to Band 4 MSW practice support worker to support recruitment, professional development and retention.	Practice development lead	01.04.23	19.10.22 National funding secured and expected in October. Job description to be collated and sent for job matching and then recruitment to be undertaken.	

6.	Well led	Recruit to a Safety and Quality midwifery matron to support governance arrangements and PSIRF in line with Ockenden	DMND/DDMND	01.04.23	19.10.22 Funding has been secured and job description written and sent for banding. Plan to recruit in November. 15/12/22 Recruited to Safety and Quality Matron awaiting start date.	
7.	Safe staffing	Recruit to Planned work, capacity, and flow coordinator to enable oversight of elective caesarean sections and induction of labour.	DMND/DDMND	01.04.23	19.10.22 Funding has been secured and job description written and sent for banding. Plan to recruit in November 15/12/22 Recruited to role and awaiting start date.	
8.	Safe staffing	Split ANNB screening coordinator job description as currently workload too high to manage safely. Create ANNB screening coordinator role and fetal medicine lead role	DMND/DDMD	01.04.23	19.10.22 Funding identified and Job descriptions written, and job matched. Plan to recruit in November. 15/12/22 Recruited to ANNB midwife awaiting start date.	
9.	Safe staffing	Participate in the international recruitment initiative	DMND/Matron	~~01.04.22~~ 01.12.23	19.10.22 Actively engaged with regional international recruitment initiative. External funding for 2 international recruits secured. Assessment being undertaken to understand workforce needs over the next 12 months to increase intake of international recruits. 15/12/22 First international recruit received at the training centred anticipated to start in January 23.	

Appendix 2: CNST Overarching Action plan

	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence	Current Status 1 2 3 4
1	CNST 4 SA 6SBLv2	Continuous recording of results from workstreams underway to demonstrate assurance across the parameters set with CNST 4 SA 6 and SBL v2.	Jo Buxton	March 2023	**08.02.22 SBL MatNeo Dashboard** updated monthly with compliance figures across all parameters.	**4**
2	CNST 4 SA 6 SBLv2 Smoke Free Pregnancies	Introduction of in-house smoking cessation service.	Kim Parekh Emma Ashton	March 2023	**14.9.22** In house smoking service to be introduced at the beginning of 2023. **08.11.22** Job descriptions in progress for Health Coaches. Discussions ongoing regarding full implementation of in-house service.	**3**
3	MatNeo SiP CNST 4 SA 6 SBLv2 Element 1	Ensure data demonstrates that 80% CO measurement is recorded at booking for at least 80% of women over a 6-month period	Kim Parekh	Feb 2023	**18.07.22** Monthly report from BadgerNet and manual audit. Results recorded on SBL MatNeo dashboard. **08.11.22** Over 80% compliance rates achieved from September 2022. Monthly audits ongoing.	**4**
4	MatNeo SiP CNST 4 SA 6 SBLv2 Element 1	Ensure data demonstrates that 80% CO measurement is recorded at 36 weeks for at least 80% of women over a 6-month period	Kim Parekh	Feb 2023	**18.07.22** Monthly report from BadgerNet and manual audit. Results recorded on SBL MatNeo dashboard. **08.11.22** Over 80% compliance rates achieved from September 2022.Monthly audits ongoing.	**4**

5	MatNeo SiP CNST 4 SA 6 SBLv2 Element 1	If the process indicator scores for Element 1 are less than 95% Trusts must also have an action plan for achieving >95%	Kim Parekh	Feb 2023	**08.11.22** Action Plan included in monthly report.	**4**
6	MatNeo SiP CNST 4 SA 6 SBLv2 Element 1	Trust board should specifically confirm that within their organisation they: Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.	Gillian Byrne	Feb 2023	**08.11.22** 11/11 CQUINS passed on MSDS national dashboard.	**4**
7	MatNeo SiP CNST 4 SA 6 SBLv2 Element 1	Trust board should specifically confirm that within their organisation they: Have a referral pathway to smoking cessation services (in house or external).	Kim Parekh	Feb 2023	**29.05.22** V3 Smoking in Pregnancy Guideline published.	**4**
8	MatNeo SiP CNST 4 SA 6 SBLv2 Element 1	Trust board should specifically confirm that within their organisation they: Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service.	Kim Parekh	Feb 2023	**08.11.22** Monthly report from Badgernet and manual audit. Results recorded on SBL MatNeo dashboard.	**4**
9	MatNeo SiP CNST 4 SA 6 SBLv2 Element 1	Trust board should specifically confirm that within their organisation they Have generated and reviewed the following outcome indicators within the Trust for January – April 2022: - Percentage of women with a CO measurement ≥4ppm at booking. - Percentage of women with a CO measurement ≥4ppm at 36 weeks.	Kim Parekh	Feb 2023	**08.11.22** Monthly report from Badgernet and manual audit. Results recorded on SBL MatNeo dashboard.	**4**

		- Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36-week appointment.				
10	MatNeo SiP SBLv2 Element 1	Ensure all relevant staff receive training in use of CO monitors and giving Very Brief Advice, monitor numbers trained	Kim Parekh	Feb 2023	**08.11.22** KP Very Brief Advice now added to the PROMPT study day which includes training on CO monitors. All staff attend this training.	**4**
11	MatNeo SiP SBLv2 Element 1	Ensure smoking referral pathway includes feedback and follow up process	Kim Parekh	Feb 2023	**08.11.22** Authorisation request completed for maternity EPR for Quit Squad to enable team to document care directly onto maternity record for DNA and care planning.	**4**
12	MatNeo SiP SBLv2 Element 1	Public Health Midwife to receive specialist training	Kim Parekh	Feb 2023	**02.12.21** Current Public Health Midwife has not completed NCSCT specialist training, plan required **13.09.22** KP- training now completed.	**4**
13	CNST 4 SA 6 SBLv2 Element 2	Achieve 80% compliance for pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20-week scan (e.g. Appendix D)	Andrea Whitehead Jo Buxton	Feb 2023	**07.12.22** Latest report November 2022. Frequency amended to monthly as additional parameter to ensure women with abnormal uterine artery doppler are seen in ANC following scan. Next report due Dec 2022.	**4**
14	CNST 4 SA 6 SBLv2 Element 2	Communicate documentation requirements regarding FGR risks identified at booking and 20 weeks to ensure compliance with action 13 maintained.	Andrea Whitehead	Feb 2023	**04.01.22** Infographic learning material communicated to staff and displayed in Antenatal Clinic.	**4**
15	CNST 4 SA 6 Element 2	Ensure that the management pathway for women who develop additional risk factors after booking such as echogenic bowel and significant bleeding is included in the FGR guideline.	Jo Buxton	Feb 2023	**08.11.22** Requested editable version of FGR guideline and update guidance.	**3**
16	CNST 4 SA 6 SBLv2 Element 2	If there is a delay in the provider Trust Maternity Information System's ability to record these data for action 12 at the time of submission an in-house audit of 40 consecutive cases of	Jo Buxton	Feb 2023	**07.12.22** As above action (13), audit now conducted monthly as additional parameter added to audit, will recommence as quarterly once assurance achieved.	**4**

		women having a 20-week scan using locally available data or case records should have been undertaken to assess compliance with this indicator				
17	CNST 4 SA 6 SBLv2 Element 2	If the process indicator scores for action 13 are less than 95% Trusts must also have an action plan for achieving >95%.	Jo Buxton	Feb 2023	**07.12.22** As above action (13) now monthly audit. Process indicator now >80% target for >3 consecutive months and >95% stretch target for last 3 reported months. Audit now quarterly unless special cause identified. No additional action plan required.	**4**
18	CNST 4 SA 6 SBLv2 Element 2	Trust board should specifically confirm that within their organisation: BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards	Jo Buxton	Feb 2023	**12.09.22** Latest audit report completed September 2022, bi-annual report unless special cause is identified as 100% compliance achieved. Data recorded on SBL MatNeo Dashboard.	**4**
19	CNST 4 SA 6 SBLv2 Element 2	Trust board should specifically confirm that within their organisation: in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation	Tracy Butcher Jo Buxton	Feb 2023	**12.09.22** Element compliance measured within the FGR risk assessment audit. Latest report completed September 2022 and recorded on the SBL MatNeo dashboard, 100% compliance. Now quarterly reports due to consistent assurance. Next report due Dec 2022.	**4**
20	CNST 4 SA 6 SBLv2 Element 2	Trust board should specifically confirm that within their organisation: There is a quarterly audit of percentage of babies born <3rd centile >37+6 weeks.	Andrea Whitehead Jo Buxton	Feb 2023	**08.11.22** Q2 report completed October 2022.	**4**
21	CNST 4 SA 6 SBLv2 Element 2	Trust board should specifically confirm that within their organisation: They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and Management of FGR was a relevant issue (using the PMRT).	Emma Gornall Jo Buxton	Feb 2023	**08.11.22** Q2 report completed October 2022. Percentage of perinatal mortality cases for 2021 where identification and management of FGR identified as an issue recorded in the SBL dashboard.	**4**
22	CNST 4 SA 6 SBLv2 Element 2	Trust board should specifically confirm that within their organisation: Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners	Emma Ashton Jo Buxton	Feb 2023	**27.05.22** Audit report completed March 2022. Yearly audit unless special cause identified as compliance 100%. **08.11.22** Guideline updated, awaiting local ratification. **07.12.22** Guideline reviewed at local guideline meeting and sent for Trust ratification.	**3**

		(CCGs) following advice from the Clinical Network				
23	CNST 4 SA 6 SBLv2 Element 2	Trust board should specifically confirm that within their organisation: They undertake a quarterly review of a minimum of 10 cases of babies that were born < centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems.	Andrea Whitehead Joanne Buxton	Feb 2023	**08.11.22** Q2 report completed October 2022. Findings, themes, and trends to be discussed at ultrasound MDT.	**4**
24	CNST 4 SBLv2 Element 2	Ensure all staff performing SFH measurements are up to date with annual competency in Symphysis fundal height measuring, plotting, interpreting appropriately and referring	Kim Parekh Laura Miller	Feb 2023	**07.12.22** Training compliance figures reported and recorded on SBL MatNeo Dashboard monthly, compliance improving, current compliance across all staff groups is 87%.	**3**
25	CNST 4 SBLv2 Element 2	Implement process to ensure women with FGR identified prior to 34+0 weeks have an agreed pathway for management which includes network fetal medicine input	Emma Ashton Fatimah Soydemir	Feb 2023	**31.05.22** No progress to report, current pathway includes links with Manchester for input as required. **08.11.22** Update requested	**3**
26	CNST 4 SBLv2 Element 2	Data to be shared with the trust board and the LMS in relation to: Publication of FGR detection rates of babies born <3rd at >37+6	Emma Ashton	Feb 2023	**01.10.22** DMND shared Maternity Service update paper with NMBA board.	**4**
27	CNST 4 SBLv2 Element 2	Data to be shared with the trust board and the LMS in relation to:	Emma Ashton	Feb 2023	**01.10.22** DMND shared Maternity Service update paper with NMBA board.	**4**

		Ongoing audit of babies born <3rd centile not detected antenatally				
28	CNST 4 SBLv2 Element 2	Data to be shared with the trust board and the LMS in relation to: Monitoring of babies born >39+6 and <10th centile	Emma Ashton	Feb 2023	**5.8.22** included in Maternity Service Update and reported quarterly to Board. **12.09.22** Q2 report due October 2022. **01.10.22** Maternity Service update report presented at Trust and NMBA board.	**4**
29	CNST 4 SA 6 SBLv2 Element 3	Ensure at least 80% of women booked for antenatal care had received leaflet/information by 28+0 weeks of pregnancy.	Laura Miller	Feb 2023	**08.11.22** Quarterly audit completed August 2022 – compliance 100%	**4**
30	CNST 4 SA 6 SBLv2 Element 3	If the process indicator scores for action 28 are less than 95% Trusts must also have an action plan for achieving >95%.	Laura Miller	Feb 2023	**08.11.22** Action plan not required as 100% compliance.	**4**
31	CNST 4 SA 6 SBLv2 Element 3	Ensure at least 80% of women who attend with RFM have a computerised CTG	Laura Miller	Feb 2023	**08.11.22** Badgernet report completed monthly >95%, results recorded on SBL MatNeo dashboard.	**4**
32	CNST 4 SA 6 SBLv2 Element 3	If the process indicator scores for action 30 are less than 95% Trusts must also have an action plan for achieving >95%.	Laura Miller	Feb 2023	**08.11.22** Fetal monitoring lead reviews all cases when computerised CTG is not used and actions taken to improve compliance if required. Adjusted figure to be included in the AMaT report.	**4**
33	CNST 4 SA 6 SBLv2 Element 4	There should be Trust board signoff that staff training on using their local CTG machines, as well as fetal monitoring in labour is conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational	Laura Miller	Feb 2023	**5.8.22** Full day CTG training benchmarked against CCT, Ockenden. **08.11.22** 90% compliance for Fetal Monitoring Full Day across all staff groups achieved. Training on CTG machines expected to achieve 90% by December 2022 (currently 78%).	**4**

		awareness. 'Intrapartum fetal surveillance training' to meet recommendations of SBLv2.				
34	CNST 4 SA 6 SBLv2 Element 5 MatNeo SiP	Aim to ensure 80% of singleton live births (less than 34+0 weeks) receive a full course of antenatal corticosteroids, within seven days of birth.	Andrea Whitehead Julie Guiver Jo Buxton	Feb 2023	**07.12.22** Monthly report extracted from Badgernet with manual data audit to ensure correct results. Data recorded and performance tracked on SBL MatNeo dashboard.	**4**
35	CNST 4 SA 6 SBLv2 Element 5 MatNeo SiP	If compliance with Action 34 is <80%, conduct deep dive review for learning and improvement.	Jo Buxton	Feb 2023	**07.12.22** 6 consecutive months have shown <80% compliance; deep dive reviews for each month undertaken for assurance	**4**
36	CNST 4 SA 6 SBLv2 Element 5 MatNeo SiP	Procure new Fibronectin Analyser for CDH point of care for ANC	Jo Lambert	April 2023	**07.12.22** Procurement of new fibronectin analyser with point of care process commenced	**3**
37	CNST 4 SA 6 SBLv2 Element 5 MatNeo SiP	Develop Safety Improvement Board for display in each clinical area to communicate key messages including those relating to Preterm Birth Optimisation	Jo Lambert	April 2023	**07.12.22** Safety Improvement board design and development in progress. Draft Board awaiting sign off	**3**
38	CNST 4 SA 6 SBLv2 Element 5	Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.	Andrea Whitehead Jo Buxton	Feb 2023	**07.12.22** Monthly report extracted from Badgernet with manual data audit to ensure correct results. Data recorded on SBL MatNeo dashboard for tracking.	**4**
39	CNST 4 SA 6 SBLv2 Element 5	Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.	Andrea Whitehead Jo Buxton	Feb 2023	**07.12.22** Monthly report extracted from Badgernet with manual data audit to ensure correct results. Data recorded on SBL MatNeo dashboard.	**4**
40	CNST 4 SA 6 SBLv2 Element 5	Percentage of women who give birth in appropriate care setting for gestation (in accordance with local ODN guidance)	Jo Buxton	Feb 2023	**07.12.22** Monthly report extracted from Badgernet with manual data audit to ensure correct results. Data recorded on SBL MatNeo dashboard.	**4**

41	CNST 4 SA 6 SBLv2 Element 5	To update the guidelines regarding antenatal corticosteroids below 34 weeks being a consultant decision	Fatimah Soydemir	Feb 2023	**30.05.22** Email sent to IT Midwife 28.05.22 to request this amendment to the guideline. **14.9.22** Update requested from action lead. Awaiting confirmation of guideline change. **08.11.22** Editable version of guideline requested from IT Midwife, guideline to be updated accordingly.	**3**
42	CNST 4 SA 6 SBLv2 Element 5	Produce QUiPP app user guide to ensure staff are aware of the use of the app to improve care planning for threatened preterm birth	Julie Guiver Jo Lambert	Feb 2023	**30.05.22** QUiPP app user guide produced May 2022.	**4**
43	CNST 4 SA 6 SBLv2 Element 5	If there is a delay in the provider Trust MIS's ability to record Element 5 data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators.	Andrea Whitehead Jo Buxton	Feb 2023	**07.12.22** Monthly Badgernet Unit report. Data recorded on to the SBL MatNeo Dashboard.	**4**
44	CNST 4 SA 6 SBLv2 Element 5	Trust board should specifically confirm that within their organisation: They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife).	Jo Lambert	June 2022	**11.02.22** Consultant obstetrician and midwifery preterm birth lead in place. **5.8.22 Bluebell** guideline on heritage detailing the roles of the midwife sonographer lead and lead obstetrician.	**4**

45	CNST 4 SA 6 SBLv2 Element 5	Trust board should specifically confirm that within their organisation Women at high risk of preterm birth have access to a Specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided.	Julie Guiver Jane Boscolo Ryan Jo Buxton	Feb 2023	**5.8.22** Specialist clinic in place AMAT Audit of compliance ongoing and included in Maternity Services quarterly update to Board. **07.12.22** Latest report December 2022, data recorded on SBL MatNeo dashboard.	**4**
46	CNST 4 SA 6 SBLv2 Element 5	An audit of 40 consecutive cases of women booking for antenatal care to be completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high-risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway.	Jo Buxton	Feb 2023	**07.12.22** Latest report December 2022. Data recorded on SBL MatNeo Dashboard.	**4**
47	CNST 4 SA 6 SBLv2 Element 5	Trust board should specifically confirm that within their organisation Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners Implement referral process to preterm birth clinic	Emma Ashton	Feb 2023	**08.11.22** Guideline updated. Quarterly audits commenced October 2022 to ensure compliance with guideline.	**3**
48	ATAIN (Avoiding Term admissions into Neonatal Unit) CNST 4 SA 3	Reviews of term admissions to the neonatal unit continue quarterly and findings are shared with the Board Level Safety Champions.	Penny Davis Jo Buxton	Feb 2023	**08.11.22** Q2 ATAIN report completed October 2022. Q2 dashboards for ATAIN and TC completed October 2022.	**4**
48	CNST 4 SA 3	Findings of term quarterly term reviews and progress with the ATAIN action plan should be shared with the maternity, neonatal and board level safety champions, LMNS and ICS	Jo Buxton	Feb 2023	**01.10.22** DMND shared Maternity Service update paper with NMBA board.	**4**

		quality surveillance meeting on a quarterly basis.			**08.11.22** CNST reporting slide set shared with Quality Assurance Panel **07.12.22** ATAIN Q2 report presented at Neonatal S&Q 11/11/22, Neonatal Ops Group 16/11/22 and Maternity S&Q 17/11/22.	
50	CNST 4 SA 3	Complete an action plan to address local findings from quarterly audit of TC pathway (completed by TC lead) and the quarterly ATAIN reviews.	Jo Lambert Jo Smith Jo Buxton Penny Davis	Feb 2023	**18.07.22** ATAIN/NTC action plan updated July 2022 and each quarter. **12.09.22** Q2 report and update of action plan due October 2022. **08.11.22** Action Plan updated and shared with Trust Board and NMBA board	**4**

Chair's Report

Lancashire Teaching Hospitals NHS Foundation Trust

Committee:	Education, Training and Research Committee
Chairperson and role:	Professor Paul O'Neill, Non-Executive Director
Date(s) of Committee meeting(s):	13 December 2022
Purpose of report:	To update the Board on the business discussed by the Education, Training and Research Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and for escalation to the Board

Committee Chair's narrative

The Committee conducted a comprehensive review of the scheduled items on the agenda, approved the minutes of the October meeting and noted the status of the action log.

The Committee scrutinised the Core Skills Training report, which provided a summary of compliance status at Trust and Divisional level. The trends showed that Trust compliance targets in 21 out of the 27 mandatory core skills training subjects were achieved or exceeded with trends either holding stable or continuing to increase.

The Committee discussed the PG Medical education report and noted the quality issues impacting trainees in placement at Chorley District Hospital (CDH) and the results of the GMC National Trainee National Training Survey.

The Committee reviewed the Education annual report strategy update (interim review).

The Committee scrutinised the Education income deferral and investment priorities report and acknowledged the situation with regard to deferred income.

The Committee received the Edovation updates and noted this would now be moved to the Lancashire Hospitals Services.

The Committee reviewed the Research & innovation update and received the proposal for a Translational Research Institute to be created at UCLan.

The Committee considered the review of sub-committee effectiveness.

The Committee reviewed and discussed the strategic risk, and agreed the current risk rating should be increased from 12 to 20. The Committee noted positive and negative escalations from the ETR feeder groups - Apprenticeships Strategy and Assurance Committee, Training Compliance and Assurance Committee, Education Delivery and Student Support Committee, Finance Sub-Committee, and Research and Innovation Committee.
Items for the Board's attention
Positive escalation
The proposal for the Translational Research Institute to be created at UCLan. The progress of Edovation progress and inclusion within the LHS Board.
Negative escalation
The quality issues impacting trainees in placement at Chorley District Hospital. The two financial matters around income deferral requirements and investment priorities for 2023-24.
Committee to Committee escalation
The quality issues impacting trainees in placement at Chorley District Hospital be escalated to Safety & Quality Committee.
Items recommended to the Board for approval
None.
Committee Chairs reports received
(a) Education Finance Sub-Committee (b) Apprenticeships Strategy and Assurance Committee (c) Training Compliance and Assurance Committee (d) Education Delivery and Student Support Committee (e) Research and Innovation Committee
Items where assurance was provided and/or for information
(a) Core Skills Training Report
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 14 February 2023 using Microsoft Teams

Recommendation:

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

Appendix 1 – Education, Training and Research Committee agenda (13 December 2022)

Education, Training and Research Committee

13 December 2022 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	1.00pm	Verbal	Noting	P O'Neill
2.	Apologies for absence	1.01pm	Verbal	Noting	P O'Neill
3.	Declaration of interests	1.02pm	Verbal	Noting	P O'Neill
4.	Minutes of the previous meeting held on 11 October 2022	1.03pm	✓	Approval	P O'Neill
5.	Matters arising and action log	1.05pm	✓	Discussion	P O'Neill
6	Strategic risk register review	1.10pm	Verbal	Discussion	P O'Neill
7.	PERFORMANCE				
7.1	Core skills training report	1.15pm	✓	Noting	K Hemsworth
7.2	PG medical education report	1.25pm	✓	Discussion	A Sykes
8.	STRATEGY & PLANNING				
8.1	Education annual report strategy update (interim review)	1.35pm	✓	Decision	K Hemsworth
8.2	Education income deferral and investment priorities report	1.40pm	✓	Decision	K Hemsworth
8.3	Edovation updates (to include annual reports as from 2020-21)	1.50pm	✓	Noting	P Brown
9.	GOVERNANCE AND COMPLIANCE				
9.1	Research & innovation update	2.05pm	✓	Noting	P Brown
9.2	Review of sub-committee effectiveness	2.20pm	✓	Information	K Hemsworth / P Brown
9.3	Strategic risk review and update	2.35pm	✓	Discussion/ Decision	P O'Neill
9.4	Feeder group Chair's reports negative/positive escalations: a) Apprenticeships Strategy and Assurance Committee	2.45pm	✓	Noting	K Hemsworth / P Brown

№	Item	Time	Encl.	Purpose	Presenter
	b) Training Compliance and Assurance Committee c) Education Delivery and Student Support Committee d) Finance Sub-Committee e) Research and Innovation Committee				
9.5	Items for escalation to the board or items to/from other committees	2.55pm	Verbal	Noting	P O'Neill
9.6	Reflections on the meeting and adherence to the Board Construct	2.58pm	✓	Discussion	P O'Neill
10.	ITEMS FOR INFORMATION				
10.1	Date, time, and venue of next meeting: 14 February 2023, 1pm via MS Teams	3.00pm	Verbal	Noting	P O'Neill

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Gender Pay Gap Report							
Report to:	Board			**Date:**	2nd February 2023		
Report of:	Chief People Officer			**Prepared by:**	L Graham		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☒	**For noting**	☐	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to present the findings and recommended actions based on the Gender Pay Gap report for 2022. The gender pay gap for our Trust is now above the threshold for immediate action as specified by the Equality and Human Rights Commission, and so action should be taken to address the issue and close the gap.

In summary it was found that 77% of our workforce is female with 56% of women working fulltime. Women occupy 77% of the lowest paid jobs and 66% of the highest paid jobs. The median gender pay gap was found to be at 6.8% which is no change from 2021. As this is higher than the 5% threshold we need to develop actions to bring about improvements. The median rate of pay and the gender pay gap issue is driven by Medical and Dental workforce, as when we remove this professional group from calculations the gender pay gap reverses in favour of females receiving higher mean and median pay than their male counterparts.

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

It is recommended that:

I. The Board approve the report for external publication

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To offer excellent health care and treatment to our local communities	☐	Consistently Deliver Excellent Care	☐

To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive innovation through world-class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☐
Previous consideration			
Workforce Committee on the 31st January 2023.			

INTRODUCTION

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

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

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

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

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

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

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

THE WORKFORCE PROFILE – GENDER BY BAND AND CONTRACT TYPE

OUR WORKFORCE IS 77% FEMALE AND 23% MALE

56% FEMALES AND 78% MALES WORK FULL TIME

The gender profile of our workforce (Figure 1) continues to be predominantly female. The current (31 March 2022) split within the overall workforce remains consistent with the previous four Gender Pay Gap reports: **77% female, 23% male**. The full-time and part-time split also remains consistent, with the majority of males employed by the Trust working full-time and a nearer equal split between full-time and part-time contract types for females.

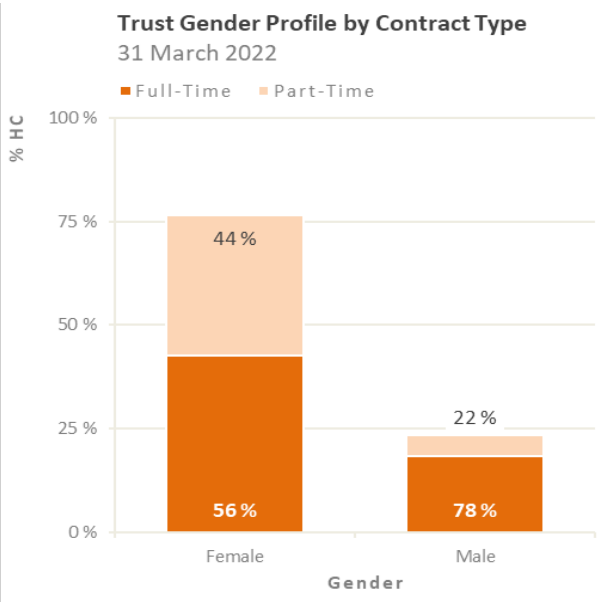


Figure 1: Gender profile by contract type

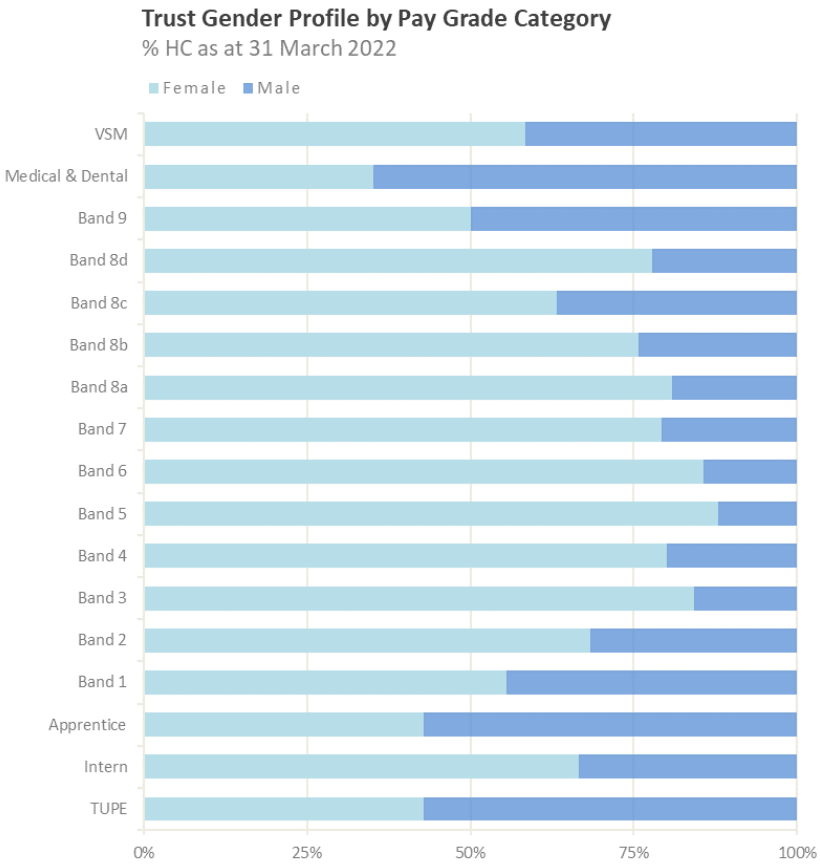


Figure 2: Gender profile by pay grade category

Figure 2 provides an overview of the gender split by pay grade as at 31 March 2022. The gender split is expressed as a percentage of the total workforce within a particular grade, based on headcount.

WOMEN OCCUPY 77% OF THE LOWEST PAID JOBS AND 66% OF HIGHEST PAID JOBS

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

Quartile	2022		2021	
	No. Male | Female	% Male | Female	No. Male | Female	% Male | Female
1 – Lower	502 | 1,681	23% | 77%	467 | 1,654	22% | 78%
2 – Lower middle	494 | 1,689	23% | 77%	457 | 1,665	22% | 78%
3 – Upper middle	379 | 1,804	17% | 83%	385 | 1,736	18% | 82%
4 – Upper	739 | 1,444	34% | 66%	698 | 1,423	33% | 67%
Total	**2,114 | 6,618** (8,732 total)	**24% | 76%**	**2,007 | 6,478** (8,485 total)	**24% | 76%**

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

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

When analysing the percentage split of each gender workforce by quartile, it is evident that a greater proportion of the male workforce occupies the upper quartile (35%). The female workforce is weighted almost equally across the two halves, but with a lower weighting in the upper quartile (only 22%). This will be skewed by the medical and dental grades; please see Appendix A for further analysis.

Table 2 - Gender split by pay grade category

Table 2 illustrates that the minority gender in each pay grade category continues to be male, with the exception of medical and dental, TUPE and apprenticeship grades, although a minor increase in male representation has occurred within bands 2, 3, 4, 5, 7, 8a, 9 and at VSM grade. Band 9 is the only grade to demonstrate gender neutrality. A decline in male representation has occurred within bands 8b, 8c, 8d, and Medical & Dental.

	2022		2021	
Grade Category	**Male**	**Female**	**Male**	**Female**
TUPE	57%	43%	63%	38%
Intern	33%	67%	0%	0%
Apprentice	57%	43%	50%	50%
AfC Band 1 *(closed to new entrants)*	44%	56%	39%	61%
AfC Band 2	32%	68%	30%	70%
AfC Band 3	16%	84%	14%	86%
AfC Band 4	20%	80%	19%	81%
AfC Band 5	12%	88%	12%	88%
AfC Band 6	14%	86%	14%	86%
AfC Band 7	21%	79%	20%	80%
AfC Band 8a	19%	81%	18%	82%
AfC Band 8b	24%	76%	28%	72%
AfC Band 8c	37%	63%	40%	60%
AfC Band 8d	22%	78%	33%	67%
AfC Band 9	50%	50%	46%	54%
Medical & Dental	65%	35%	66%	34%
VSM	42%	58%	40%	60%

OUR GENDER PAY GAP

	Women's earnings are:
Mean gender pay gap in hourly pay	**31.7% lower**
Median gender pay gap in hourly pay	**6.8% lower**
Difference in **mean bonus** payments	**34.0% lower**
Difference in **median bonus** payments	**0%**
Women earn 68p for every £1 earned by Men	

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

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

Looking at the 2022 figures, male staff members earn on average £7.81 per hour more than female staff, which is a £1.67 increase on 2021. As a percentage, men earn 31.7% more than women; an increase of 4 percentage points from 2021.

In combination with Figure 2, it seems that this is a reflection of the reverse gender profile for Medical and Dental grades, which command a higher salary. Excluding the Medical and Dental staff group reveals that 52% of the Trust's male population continues to occupy Band 3 or lower, whereas 48% of the female population occupies Bands 4-6. Band 7 and above is occupied by 14% and 15% of the female and male populations, respectively. Further analysis provided in Appendix 1, found that if the medical and dental workforce were removed from the calculations in Table 3, women would earn more than men. It was found that for non-medical staff women earned £1.01 for every £1 earned by a man. However for medical and dental staff, women earned 85p for every £1 earned by a man.

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

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

Looking at the 2022 figures, the difference in the median pay for males and females is 6.8%. Whilst this indicates no change from 2021, it remains **greater than 5% difference** and so action should be taken to address the issue and close the gap.

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

1.4% OF WOMEN AND 10.6% OF MEN WERE PAID A BONUS

The data presented in tables 5, 6, 7 and 8 details the clinical excellence bonuses paid to staff split by gender and provides the mean and median bonuses paid. The data also shows the clinical excellence awards (CEAs) paid by level of award and defines the proportion of males and female overall who received a bonus.

The findings presented indicate a mean bonus pay gap between males and females of 34% in 2022, an increase from 24.9%. Due to COVID, the usual CEA application and selection process was set again aside last year, with all eligible consultants being awarded an equal payment of £3,818.66. This has resulted in no median bonus pay gap in 2022.

Table 7 details the gender split by level of clinical excellence award. When considering the spread within a gender, and excluding the general CEA awarded to all medical and dental staff, the CEA female population remains significantly weighted at Level 1 (41% cf. 16% male); the CEA male population is weighted more evenly across Levels 1-3, 7 and 9 (72%).

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

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

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

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

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

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

Assessing the bonus-receiving employees that remain in post as at the reporting date against all relevant consultant grade employees, CEAs favoured the male workforce across the full-time and part-time employment categories: 37% and 31%, respectively, of the male consultant workforce are in receipt of a CEA, while only 24% and 10%, respectively, of the female consultant workforce are in receipt of a CEA.

FINANCIAL IMPLICATIONS

None

LEGAL IMPLICATIONS

None

RISKS

The gender pay gap is above the second threshold for action (as specified by the Equality and Human Rights Commission) and action should be taken to address the issue and close the gap.

IMPACT ON STAKEHOLDERS

Not applicable

RECOMMENDATIONS

The gender pay gap is 6.8% which means action should be taken to address the issue and close the gap, as specified by the Equality and Human Rights Commission. It is a challenge to identify clear actions to make a tangible difference, as in part our policies, processes in some cases work against us achieving a fairer gender pay balance. For example we actively encourage our colleagues to work flexibly and aligned to the NHS People Plan we advertise all our vacancies having access to flexible working opportunities from day one. Given flexible working is seen as an employee benefit we want staff to take advantage of this, however it will have a negative impact on the gender pay gap, due to the higher proportion of our workforce being female overall and more females working part time.

Other challenges we face as an organisation is the pipeline of newly qualified candidates coming through degree courses and seeking employment with us. If the Universities are unable to attract higher numbers of males into agenda for change professions and higher numbers of females into medical and dental professions then it makes it more challenging for us to be able to alter our gender split and ultimately the gender pay gap.

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

As we are bound by national terms and conditions, we have little local control over rates of pay our workforce receives. We are aware that our gender pay gap for non-medical staff is more favourable for female colleagues. There are however further actions we could potentially seek to take to support more females into consultant or senior medical roles, however this may take time as the proportion of female medical and dental workforce is slowly growing (increased by 1% in the last 12 months). The actions specifically focussed on the medical and dental workforce include, further promoting flexible working opportunities to male medical and dental colleagues, supporting more female consultants to attend development programmes such as Consultant Stretch to enable them to feel confident and ready to step into senior leadership roles which attract additional salary payments.

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

It is recommended that the Board

I. The Board approve the report for external publication

APPENDIX A – STAFF GROUP STRATIFICATION

MEDICAL & DENTAL – Women earn 85p for every £1 earned by Men (median)

NON MEDICAL & DENTAL – Women earn £1.01 for every £1 earned by Men (median)

In recognition of the large salaries often commanded by medical and dental roles, which are less frequent among non-medical and dental roles, the Gender Pay Gap calculations are further analysed in the context of two distinct staff groupings: Medical and Dental versus non-Medical and Dental. The average and median hourly pay calculations are recorded below in Table A1 along with the associated headcount upon which the calculations are based.

31 Mar 2022	Male	Female	Difference	% Difference	Male : Female
Average £ / hr					
All	£ 24.69	£ 16.87	£ 7.81	31.7 %	£ 1 : 0.68
Medical & Dental	£ 55.39	£ 47.08	£ 8.31	15.0 %	£ 1 : 0.85
Non-Medical & Dental	£ 15.50	£ 15.65	(£ 0.15)	(1.0 %)	£ 1 : 1.01
Median £ / hr					
All	£ 15.64	£ 14.57	£ 1.07	6.8 %	£ 1 : 0.93
Medical & Dental	£ 54.65	£ 43.59	£ 11.06	20.2 %	£ 1 : 0.80
Non-Medical & Dental	£ 13.12	£ 14.26	(£ 1.14)	(8.7 %)	£ 1 : 1.09
Full-Pay Relevant Employee Headcount					
All	2,114	6,618			1 : 3.13 HC
Medical & Dental	487	258			1 : 0.53 HC
Non-Medical & Dental	1,627	6,360			1 : 3.91 HC

Table A1: Summary of 2021/22 Gender Pay Gap calculations for all staff groups, Medical and Dental staff group only, and non-Medical and Dental staff groups.

Medical and Dental female hourly pay is lower than male hourly pay, with women earning 85p for every £1 earnt by men, on average, which is 2p lower than 2021. The median rate has worsened to now be 80p for every male equivalent £1, a reduction of 11p from 2021. The weighting of the medical and dental workforce at consultant grade has decreased by 6 percentage points from 2020, but the same level of gender disparity remains within that grade: 50% of the female medical and dental workforce holds consultant posts (cf. 59% of males), yet they continue to represent less than one-third of the Trust's consultant workforce. Although female representation within the trainee grade has increased by 4.9 percentage points to 42.7%, decreased representation within progressive grades (4.6 and 0.6 percentage points at career / staff and consultant grades, respectively) might signify a continuing social disparity between roles of the sexes as it pertains to family life. Considering contractual hours reveals that 84% of women within this staff group are working full-time (cf.

92% of males), which is an increase of two percentage points from 2021. There is a near equal male / female ratio within the part-time category itself (39 cf. 43 headcount, respectively), which is a decrease from 2021 (4 headcount each).

Excluding medical and dental roles from the calculations results in the Trust's gender pay gap reversing in favour of women, with an average of £1.01 earnt for every £1 earnt by men, consistent with 2021. The median rate is even more favourable, increasing by 1p to £1.09 for every male equivalent £1. The female workforce is almost equally spread across the Trust's hourly pay quartiles, with 24.0% falling in the lowest quartile and gently increasing through the remaining quartiles, reaching 25.8% and 25.6% in the highest two quartiles, respectively. Conversely, the male workforce is notably weighted at the lower end of the hourly pay quartiles (28.8%) and decreases throughout the remaining quartiles, reaching 22.5% in the highest quartile. Table A2, below, provides the headcount of each gender within each quartile.

Non-Medical & Dental	LQ1	LQ2	UQ3	UQ4	Total
Male	469	438	354	366	1,627
Female	1,527	1,560	1,643	1,630	6,360
Total	1,996	1,998	1,997	1,996	7,987

Table A2: 2021/22 hourly pay quartiles from lowest (Q1) to highest (Q4), displaying the number of male and females within each quartile.

Whilst the medical and dental workforce is not the largest in the Trust (8%), it does command the higher salaries and is disproportionately male; a combination that will have been masking the less favourable gender pay gap for men outside of this staff group. Removing the medical and dental staff group allows for a more equitable analysis in terms of achievable salaries for the remaining workforce, however, it means that the largest staff grouping will now dominate the analysis: registered nursing and midwifery staff (32%) and its respective support roles (15%). Thus, it is a possibility that this pay gap inequity might still be illuminating continued low uptake by men of traditionally female roles in the present day, as only 7% of the registered nursing and midwifery workforce is male; its support workforce is 14% male. Estates and Ancillary is the only staff group to have a majority male workforce (56%), but it is weighted with lower-salaried roles. Registered Healthcare Scientists has a near equal ratio (41% male), although this is the Trust's second smallest staff group (3.2%), so its impact on these results is inconsequential.

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside - Non-Executive Director
Date(s) of Committee meeting(s):	20 December 2022
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 22 November 2022, and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

- Financial performance
- Cost Improvement targets and plans
- Operational performance
- Planning framework update covering programmes identified as being of Board level significance
- Strategic risks related to Deliver Value for Money

In addition, the Committee received reports for consideration/discussion regarding the Digital Strategy Update.

Items for the Board's attention

Positive escalation

- The progress of the LTH Digital Strategy
- Favourable outputs of the Corporate Benchmarking
- The Organisation's participation in the National Winter Collaborative

Negative escalation

- Further increased operational pressures across several components with further risks towards winter pressures and the impact on industrial relations.
- Financial pressures arising from operational performance challenges and of being unable to fully recover anticipated income from the ICB to cover 'system gap'. The Committee continued to express concerns about the non-recurrent nature of the in-year cost improvement proposals.

Committee to Committee escalation

The Committee noted the complex tapestry of root cause factors impacting the Trust's continued performance challenges (demand, capacity, productivity, cost efficiency, workforce, and national/regional context), and the need for continued tight inter-related discussions across our committee structures.

- The Committee expressed concerns over the likely additional challenges over coming weeks and asked that the Safety & Quality Committee have assurances in place for the operational challenges with increasing numbers of patients attending the hospital with flu/covid and of the further work to be carried out with increasing numbers not meeting the criteria to reside.

- It was asked that the Board noted that as an organisation, the Trust was taking part in the National Winter Collaborative.

Items recommended to the Board for approval

None recommended

Committee Chair's reports received

- Capital Planning Forum
- Health and Safety Governance Group
- IM&T Strategy Board
- New Hospitals Programme Flash Report
- ICS, ICP, and PCB system update

Items where assurance was provided and/or for information

In addition to the standing agenda items mentioned above, the Committee also received a report in respect of:
Digital Strategy Update - The purpose of the paper was to highlight to the Committee the progress made against each of the themes of the digital strategy, together with emerging high-level risks identified during the last six months.

Progress against the Committee's cycle of business

The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 24 January 2023, via Microsoft Teams

Recommendation:

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

Appendix 1 – Finance and Performance Committee agenda (20 December 2022)

Chair's Report

Committee:	Finance and Performance Committee
Chairperson and role:	Tricia Whiteside - Non-Executive Director
Date(s) of Committee meeting(s):	24 January 2023
Purpose of report:	To update the Board on the business discussed by the Finance and Performance Committee on 24 January 2023. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 20 December 2022, and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

- Financial performance
- Cost Improvement targets and plans
- Operational performance
- Planning framework update covering programmes identified as being of Board level significance
- Strategic risks related to Deliver Value for Money

The Operational Performance report drew attention to the need for robust actions for the achievement of planned levels of activity. It was concluded that more work needed to be done to recover historical levels of productivity and then press on to meet future levels of demand.

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

M9 Contract Report provided an update on the Trust's contractual income position and underlying performance up to the end of December 2022.

The Continuous Improvement & Transformation Update including Cost Improvement Programme Report provided an update on work undertaken in the Transformation and Improvement Programmes in the previous month and provided an update on the Cost Improvement Programme (CIP) position.

Items for the Board's attention

Positive escalation

- Positive benefits being seen with International Nurse Recruitment
- Positive impact of Finney House

Negative escalation

- Future challenges facing cash management and the possibility of having to draw on additional funds
- Requirement to improve levels of productivity

Committee to Committee escalation
The committee noted the complex tapestry of root cause factors impacting the Trust's continued performance challenges (demand, capacity, productivity, cost efficiency, workforce, and national/regional context), and the need for continued tight inter-related discussions across our committee structures. • The Workforce consideration of failing to recruit and issues faced with brand reputation.
Items recommended to the Board for approval
None
Committee Chair's reports received
• Capital Planning Forum • New Hospitals Programme Flash Report • ICS, ICP, and PCB system update
Items where assurance was provided and/or for information
None
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 24 January 2023, via Microsoft Teams

Recommendation:

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

Appendix 2 – Finance and Performance Committee agenda (24 January 2023)

Finance and Performance Committee

20 December 2022 | 2.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	2.00pm	Verbal	Noting	T Whiteside
2.	Apologies for absence	2.01pm	Verbal	Noting	T Whiteside
3.	Declaration of interests	2.02pm	Verbal	Noting	T Whiteside
4.	Minutes of the previous meeting held on 22 November 2022	2.03pm	✓	Approval	T Whiteside
5.	Matters arising and action log	2.04pm	✓	Discussion	T Whiteside
6.	FINANCIAL PERFORMANCE				
6.1	M8 Finance report	2.15pm	✓	Noting	C McGourty
7.	OPERATIONAL PERFORMANCE				
7.1	Performance assurance progress report (inc Theatre Productivity Update)	2.25pm	✓	Discussion	F Button
7.2	M8 Contract Reporting	2.45pm	✓	Noting	J Wood
8.	STRATEGY AND PLANNING				
8.1	Planning Framework Update	2.55pm	✓	Discussion	G Doherty
8.2	Continuous Improvement and Transformation update (including Cost Improvement Programme)	3.15pm	✓	Noting	A Brotherton
8.3	Model Hospital - Corporate Benchmarking	3.30pm	✓	Noting	J Wood
8.4	Digital Strategy Update	3.40pm	✓	Discussion	S Dobson
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic risk register	4.00pm	✓	Discussion	J Wood
9.2	Bi-annual strategic risk review	4.20pm	✓	Discussion	T Whiteside
9.3	Items for escalation to the Board or items to/from other Committees	4.40pm	Verbal	Noting	T Whiteside

№	Item	Time	Encl.	Purpose	Presenter
9.4	Reflections on the meeting and adherence to the Board compact	4.50pm	Verbal	Discussion	T Whiteside
10.	ITEMS FOR INFORMATION				
10.1	Action plans from Divisional Improvement Forums		✓		
10.2	**Chairs' reports**: (a) Capital Planning Forum (b) Health and Safety Governance Group (c) IM&T Strategy Board – *(No meeting held)* (d) New Hospitals Programme Flash Report (e) ICS, ICP, PCB system update (f) Information Governance and Records Meeting		✓		
10.3	Date, time, and venue of next meeting: 24 January 2023, 2.00pm, Microsoft Teams	5.00pm	Verbal	Noting	T Whiteside

Finance and Performance Committee

24 January 2023 | 2.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	2.00pm	Verbal	Noting	T Whiteside
2.	Apologies for absence	2.01pm	Verbal	Noting	T Whiteside
3.	Declaration of interests	2.02pm	Verbal	Noting	T Whiteside
4.	Minutes of the previous meeting held on 20 December 2022	2.03pm	✓	Approval	T Whiteside
5.	Matters arising and action log	2.04pm	✓	Discussion	T Whiteside
6.	FINANCIAL PERFORMANCE				
6.1	M9 Finance Report	2.20pm	✓	Discussion	C McGourty
7.	OPERATIONAL PERFORMANCE				
7.1	Performance assurance progress report	2.40pm	✓	Discussion	F Button
7.2	Winter Plan Update and De-Escalation	3.00pm	Verbal	Noting	F Button
8.	STRATEGY AND PLANNING				
8.1	M9 Contract Report	3.10pm	✓	Noting	J Wood
8.2	Continuous Improvement and Transformation update (including Cost Improvement Programme)	3.20pm	✓	Noting	A Brotherton
9.	GOVERNANCE AND COMPLIANCE				
9.1	Strategic Risk Register	3.30pm	✓	Discussion	J Wood
9.2	Planning Framework Update (inc. Surgery Recovery Plans)	3.50pm	✓	Discussion	G Doherty
9.3	Annual Clinical Services Review	---------	------	Withdrawn	---------
9.4	Operational Plan Update 23/24	4.20pm	✓	Discussion	G Doherty

№	Item	Time	Encl.	Purpose	Presenter
9.4	Items for escalation to the Board or referral to/from other Committees	4.40pm	Verbal	Noting	T Whiteside
9.5	Reflections on the meeting and adherence to the Board compact	4.50pm	✓	Discussion	T Whiteside
10.	ITEMS FOR INFORMATION				
10.1	Action plans from Divisional Improvement Forums *(Dec meetings stood down)*		——		
10.2	**Chairs' reports**: (a) Capital Planning Forum (b) Emergency Preparedness, Resilience and Response (EPRR) Committee – *(stood down)* (c) New Hospitals Programme Flash Report (d) ICS, ICP, PCB system update		✓		
10.3	Date, time, and venue of next meeting: 28 February 2023, 2.00pm, Microsoft Teams	5.00pm	Verbal	Noting	T Whiteside

Chair's Report

Committee:	Charitable Funds Committee
Chairperson and role:	Ms K Smyth, Non-Executive Director
Date(s) of Committee meeting(s):	20 December 2022.
Purpose of report:	To update the Board on the business discussed by the Charitable Funds Committee on 20 December 2022. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee conducted a comprehensive review of the agenda's scheduled items, approved the meeting's minutes on 20 December 2022, and reviewed updates on associated committee actions. Specific reports were received and scrutinised on the following standing agenda items:

- Financial performance
- Cost Improvement targets and plans
- Operational performance
- Planning framework update covering programmes identified as being of Board level significance
- Strategic risks related to Deliver Value for Money

In addition, the Committee received reports for consideration/discussion about the Hospital Charity Update including Baby Beat Appeal and Rosemere Charity Update.

Items for the Board's attention

Positive escalation

- Surface Guided Radiotherapy being delivered towards patient experience and care.
- Approval to proceed with £150k Broadoaks Unit state-of-the-art Play Area
- The £410,000 for the ICS projects in Children and Young People's Mental Health

Negative escalation

None

Committee to Committee escalation

- Audit Committee to assure Charitable Funds Committee was operating within best practice standards and not at risk.

Items recommended to the Board for approval

There were no items recommended to the Board for approval

Committee Chair's reports received
(a) Rosemere Management Committee (b) Trust Charity Management Committee
Items where assurance was provided and/or for information
• Lancashire Teaching Hospital's Charity update including Baby Beat Appeal - The purpose of the report was to provide the committee with an update on the activities and fundraising plans of Lancashire Teaching Hospitals Charity (including Baby Beat and Children's Appeal). • Rosemere Cancer Foundation Charity Report - The purpose of the report was to provide the committee with an update on the activities and fundraising commitments of the Rosemere Cancer Foundation (RCF)
Progress against the Committee's cycle of business
The Committee continues to cover its business work in line with its cycle of business. The next meeting of the Committee will take place on 21 March 2023 Microsoft Teams

Recommendation:

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

Appendix 1 – Charitable Funds Committee agenda (20 December 2022)

Charitable Funds Committee

20 December 2022 | 10.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chairman and quorum	10.30am	Verbal	Noting	K Smyth
2.	Apologies for absence	10.31am	Verbal	Noting	K Smyth
3.	Declaration of interests	10.32am	Verbal	Noting	K Smyth
4.	Minutes of the previous meetings held on 20 September 2022	10.33am	✓	Approval	K Smyth
5.	Matters arising and action log	10.40am	✓	Noting	K Smyth
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Baby Beat Appeal	11.05am	✓	Discussion	P Wilson
6.2	Rosemere Cancer Foundation Charity Update	11.15am	✓	Discussion	D Hill
6.3	Annual Work Plan for Charities	11.30am	✓	Discussion	P Wilson
7.	FINANCE AND PERFORMANCE				
7.1	Financial Update including review of Spending Plans and Balances	10.50am	✓	Noting	B Patel
8.	GOVERNANCE AND COMPLIANCE				
8.1	Items for escalation to the Board or from/to other Committees	11.45am	Verbal	Noting	K Smyth
8.2	Reflections on the meeting and adherence to the Board Compact	11.55am	✓	Discussion	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Feeder Group Chairs' Reports: • Rosemere Management Committee		✓		
9.2	Date, time and venue of next meeting: *21 March 2023, 1.00pm, Microsoft Teams*	12.00pm	Verbal	Noting	K Smyth

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Integrated Performance Report			
Report to:	Board of Directors	**Date:**	2 Feb 2023
Report of:	Executive Team	**Prepared by:**	Executive Directors
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to provide the Board with an update on the Trust's performance as at the end of December 2022, unless otherwise stated.

- **The report reflects the new 2022/23 Big Plan measures agreed by each sub committee.**

Consistently Deliver Excellent Care

Operational Performance

COVID overview

The 1st of December snapshot showed a position of 29 COVID+ inpatients, with 0 in ICU and 1 in EHCW. The position on the 17th of January is, 63 COVID+ inpatients, with 0 in ICU and 4 in EHCW.

We saw increasing numbers of influenza cases with through December. The total number of inpatients with confirmed Flu on 18th January was 13. The placement of patients due to IPC restrictions remains challenging and continues to impact on performance. Improvement in emergency flow, restoration of elective services with clinical priorities, underpinned by the health and well-being of our staff, continue to be high priority for operational delivery.

Emergency care performance headlines:

- Ambulance handover delays over 60 mins increased in December to 350 compared to 320 in November, whilst October's figure was slightly higher than December at 354. Handover delays remain significant and are a high priority, national and local Winter Improvement Collaboratives are in place to address this.

- The Trust continues to remain challenged against the 4-hour standard. Performance is showing a slight increase to 73.5% in December from 72.3% in November. The Trust continues to remain above the national average position, which in December was 65%, and 3rd out of the acute trusts in the North West.

- 12-hour trolley waits have increased in December to 153 from 143 in November. Performance relating to the number of patients waiting over 12 hours (admitted and non-admitted) in ED, November has seen a marginal decrease to 9.5% compared to 9.9% in November, of all people attending ED.

- Occupancy levels continue to remain high. The December occupancy level was showing a decrease to 93.8% compared to November at 96%.

Ambulance handover times remain challenging due to capacity in the emergency department, linked to capacity within the Trust and this pressure remained throughout December. Planned industrial action took place on 21st December with a loss of capacity within North West Ambulance Service. The Trust put additional escalation measures and increased operational support in place to enable 15 minute handover during the period.

In December, 363 patients waited between 30-60 minutes and 350 patients waiting over 60 minutes to be handed over. Reducing ambulance handover delays has been identified as a national priority due to the impact holding patients on vehicles has on their outcomes.

The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) remains high, with 117 patients on 17th January. This reflects broader challenges with community capacity and is impacting on the ability to transfer patients from ED into acute beds.

The Trust continues to work with health and social care organisations across the Central Lancashire system to support improvement. The accelerated delivery of a piece of work to bring together the triage functions for all services that support admission avoidance and hospital discharge has been agreed. A workshop, facilitated by the Continuous Improvement team, took place on 12th January to start co-designing the model.

Funding has been made available nationally to support a reduction in the number of NMCTR patients in acute Trusts. A process is being co-ordinated across Lancashire and South Cumbria. Several proposals to provide additional short-term capacity in Central Lancashire have been put forward for evaluation against the guidance.

In addition to the work, we are doing collaboratively, the Trust has its own internal programme of improvement being delivered through the Flow Operational Group (FOG). The work streams are delivering internal improvements to our systems and processes that will support flow through the organisation. Details of progress with the work streams reporting through FOG is provided in the transformation update. A review of the structure of the workstreams is currently underway with the intention to consolidate existing work into three priority areas.

Elective performance headlines:

- Patients continue to wait for a significant amount of time to receive non-urgent surgery. A plan is in place to eliminate 104+ week waits and reduce waits to 78 weeks by March 2023. Achievement of the plan and performance against the trajectory is reviewed weekly. The December position reflects 19 patients remaining over 104 weeks due to choosing to wait (P6).

- Diagnostics performance beyond 6 weeks for December was 56.92%, with November at 53.62% Urgent and cancer patients are seen within 2 weeks. Performance significantly increased with the 28 Day Faster Diagnostics Standard to 86% in December - 10% higher than the November position of 76% - and 6% above target. The 28-day referral to diagnosis compliance also showed a significant increase to 60% in December compared to November at 53% and October at 47%.

- Endoscopy remains under pressure, Changeology started working with the Trust in October, to review waiting lists and booking processes. A capital bid will provide additional capacity on the Preston site in 23/24.

- From a cancer perspective, 2-week performance in December increased to 53.62% compared to November at 46.48%. Capacity remains challenged. Performance is impacted with particular pressures with skin, colorectal and urology.

- The 62-day performance for December was 43.72%, a significant increase on November at 32.93%. The focus is on backlog reductions to pre-COVID levels and faster diagnosis and the Trust has tumour site specific actions plans that are monitored weekly.

Cancer Recovery

The table below shows how the Trust compares with England averages by tumour group for 62 day performance at week ending 8th January:

Suspected Cancer Type	Total waiting list	Number past day 62	Number past day 62 - DTT	**% of waiting list past day 62**	Change in number past day 62 (4 weeks)	Change in number past day 62 (12 weeks)	**England % waiting list past day 62**
Lower GI	1,140	474	8	**41.6%**	106	61	15.7%
Skin	469	88	45	**18.8%**	-6	-88	11.7%
Urological	243	82	18	**33.7%**	2	20	21.2%
Gynaecological	202	30	11	**14.9%**	11	15	11.7%
Head & neck	181	26	4	**14.4%**	-2	-5	10.6%
Upper GI	89	14	2	**15.7%**	-3	-12	11.5%
Lung	47	8	4	**17.0%**	2	-7	15.1%
Breast	72	4	2	**5.6%**	1	-2	4.7%
Sarcoma	27	4	3	**14.8%**	3	2	16.3%
Brain/CNS	64	2	0	**3.1%**	1	0	6.4%
Children's	5	1	0	**20.0%**	1	1	8.0%
Haematological	2	1	1	**50.0%**	0	-2	18.0%
Other	6	0	0	**0.0%**	-1	0	10.8%
All suspected cancers	**2,547**	**734**	**98**	**28.8%**	**115**	**-17**	**13.5%**

Of the tumour groups, colorectal remains the greatest pressure and a specific update for this area is included in the paper.

NHS England requirement:

The NHS England letter of 25 October 2022 to NHS Trust and Foundation Trust chief executives and chairs set out the following expectation for those Trusts in a tier one regime for cancer:

- Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national programme and current Cancer Waiting Times guidance.

- All patients past 62 days for cancer and 78 weeks for wider elective care should be reviewed and the actions required to progress them to the next step in their pathway prioritised.

- For cancer in particular, Trusts need to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway but should at all times have a **maximum backstop timeframe of 10 days from referral to report**.

- Trusts should undertake a comprehensive review of current turnaround times and what further prioritisation of cancer over more routine diagnostics would be required to meet this backstop requirement.

- Ensure that existing community diagnostic centres (CDCs) capacity is fully utilised by ringfencing it for new, additional, backlog reducing activity, and working with their wider ICS partners to use a single Patient Tracking List (PTLs) across the system

- Trusts should work across their systems to accelerate local approval of business cases CDCs, additional acute imaging and endoscopy capacity; and expedite delivery of those investments once approved, and should continue to explore partnerships with the independent sector to draw on or build additional diagnostic capacity

- Surgical prioritisation should continue to follow the guidance set out in the letter of 25 July, providing ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients. Performance against the 31 day standard from decision to treat to treatment should be used to assess whether the first of these objectives is being met.

- Cancer pathway re-design for Lower GI, Skin and Prostate There are three pathways making up two-thirds of the patients waiting >62 days and where increases over the past year have been the largest: Lower GI, Skin and Urology. Service Development Funding was made available to your local Cancer Alliance to support implementation of these changes and additional non-recurrent revenue funding has also been made available nationally

- Lower GI: Full Implementation of FIT in the 2ww pathway

- Full implementation of teledermatology in the suspected skin cancer pathway

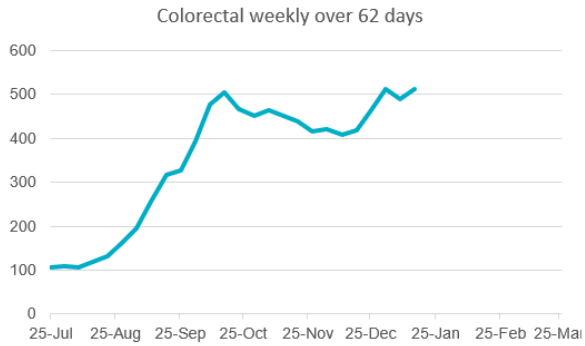
- Full implementation of the Best Practice Timed Pathway for prostate cancer All provider Trusts should implement the national 28-day Best Practice Timed Pathway for prostate cancer, centred on the use of multiparametric MRI (mpMRI) before biopsy.

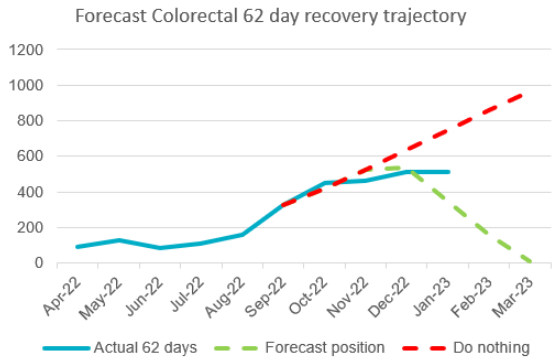
- Providers are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments by March 2023.

- Surgical and theatre productivity It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter.

Colorectal

The total numbers of patients on the Colorectal Cancer list has reduced 1120. The numbers waiting for over 62 days has increased. The PTL distribution shows that there is a continued reduction in the numbers of patients awaiting their first consultation and these patients are now awaiting endoscopy. These patients should move rapidly through this diagnostic phase.





There are a number of actions in place to recover performance, these include:

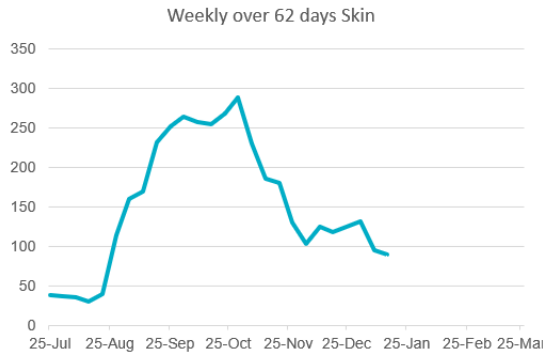
- Insourcing support in place. Discussions ongoing regarding the contractually agreed model of delivery with Medifer.
- Additional OPD capacity - alternatives to increase internal OPD capacity being considered.
- ASP recruitment - Straight to Test commenced 9 January 2023 providing additional capacity and support to 2ww backlog reduction.
- Endoscopy capacity with InHealth commenced 12 December.
- Expectation that the clock stops will start to come through more rapidly after Christmas with increased endoscopy delivery, additional Navigators required and agreed through Cancer Alliance.
- Additional theatre capacity is still required to then treat an estimated additional 40 surgical operations that will be required in January/ February - discussion ongoing across the system for mutual aid to support.

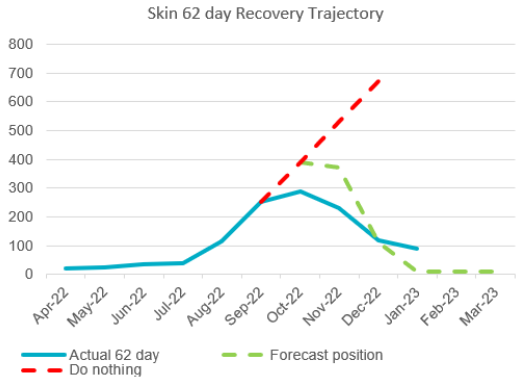
The forecast recovery trajectory for colorectal 62 day has been updated to reflect impact of existing initiatives.

Skin

There has been a small increase in the total numbers of patients on the Skin Cancer list with more patients accepted and awaiting a first appointment date.
The numbers of patients waiting for over 62 days has decreased patients have progressed through the pathway.

There is capacity for 2ww appointments and all 62-day, 31-day and 104-day numbers are reducing.



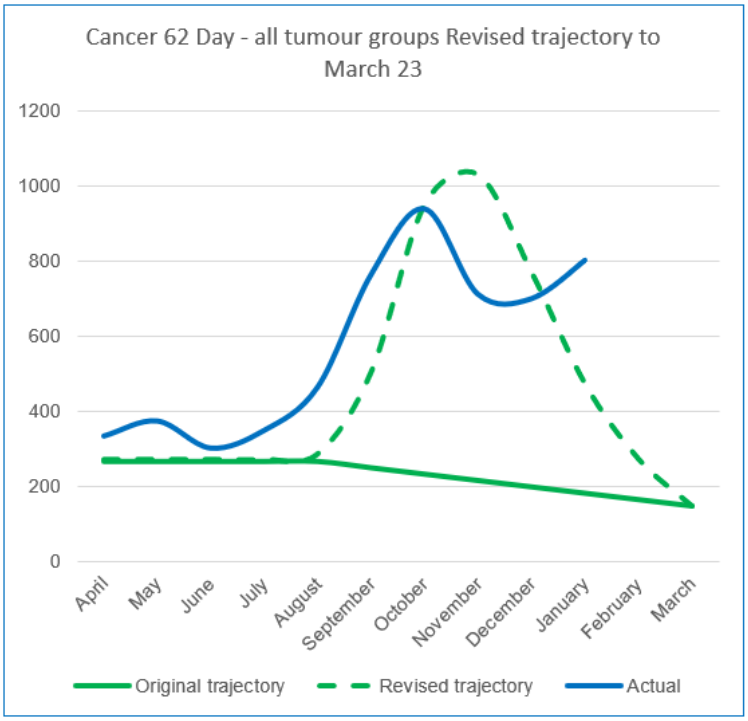


There are a number of actions in place to recover performance, these include:

- Teledermatology commenced on 7th November with funding secured to expand capacity - recruitment of Medical Photographer with ASP for review of clinical photographs.
- Positive recruitment with additional Locum Consultant staffing.
- Outsourcing - GLH are providing additional slots through into 2023 doubling previous capacity and BMI are providing an additional 40 slots per month from January.
- 2 week waits are reducing and now at 3 weeks – expect to be 2ww compliant by the end of January 2023.

The forecast recovery trajectory for skin 62 day has been updated to reflect impact of existing initiatives.

Performance against the overall trajectory for the Cancer 62 day backlog recovery plan, all tumour groups to March 23 is below. The forecast trajectory is to month end and shows an actual position at 15th January against a 31st January trajectory:



Cancer pathway re-design for Lower GI, Skin and Prostate

In relation to the specific asks of Tier 1 Trusts for Lower GI, Skin and Urology pathways*:*

- **Lower GI: Full Implementation of FIT in the 2ww pathway**

  This is in place at the Trust with clinical review of all existing patients awaiting OPD for double fit negative results / no other red flags and removal from 62-day PTL.
  Performance detailed below against indicators relating to the proportion of double negative FIT Test colorectal cancer referrals that underwent a Colonoscopy:

  1) All Patients referred on a Colorectal Cancer Pathway with Double Negative FIT Test, of these the number that underwent a Colonoscopy

Referral Month	Double Negative	Colonoscopy	% Colonoscopy
Apr-22	58	33	56.9%
May-22	70	41	58.6%
Jun-22	71	50	70.4%
Jul-22	76	37	48.7%
Aug-22	83	29	34.9%
Sep-22	87	7	8.0%
Oct-22	70	10	14.3%
Nov-22	78	2	2.6%
Grand Total	**593**	**209**	**35.2%**

  This is having a positive effect on referral demand.

- **Skin: Full implementation of teledermatology in the suspected skin cancer pathway**

  Implementation is co-ordinated across the ICS and Teledermatology started on 7th November, undertaken in the main by medical illustration departments in secondary care.

  Performance detailed below against indicator relating to the proportion of 2-Week Rule Dermatology Attendances undertaken in the Teledermatology Clinic, this has increased from 8% in November:

	Dec-22
Total 2WR Attendances (incl Tele-Derm	646
Attendances at Tele-Derm Clinic	76
Proportion attending Tele-Derm Clinic	12%

- **Full implementation of the Best Practice Timed Pathway for prostate cancer**

  The BPT pathway has been agreed and is due to be fully implemented in 22/23, this has been impacted by capacity issues e.g., consumable supplies for biopsies (now resolved) and capacity for multiparametric MRI (MpMRI) slots.

The Performance Recovery Group continues to monitor performance and work through solutions with action plans reviewed to ensure focus on key areas. Cancer pathway improvement reports through to the Elective Care Transformation Programme Board and will be reported through the transformation update.

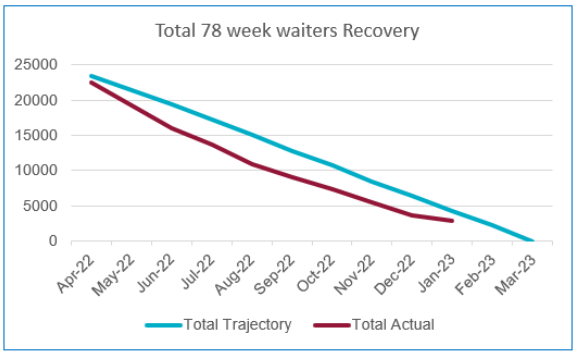
Elective Restoration 104 and 78 weeks

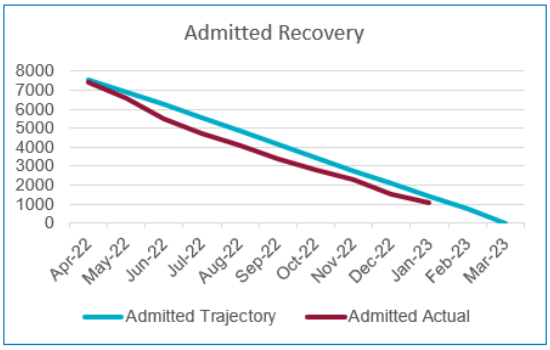
Clearing the +104 and +78 week waits is a priority for the divisional teams with performance under constant review.

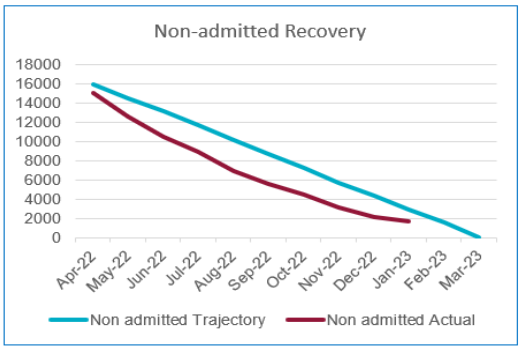
- There are a small number of 104+ww patients within our plan who indicated they do not want their procedure before the end of December (P6). Discussions with these patients have been undertaken by senior managers to attempt to get them dated as soon as possible.

- Additional capacity continues to be required either in-house or through Independent Sector and Mutual Aid, to clear the backlog of long waits.

A 78 week wait trajectory has been set to March 2023 (below). The trajectories below include all existing and potential 78 week waits to 31st March. The overall 78 week reduction trajectory was met in December.

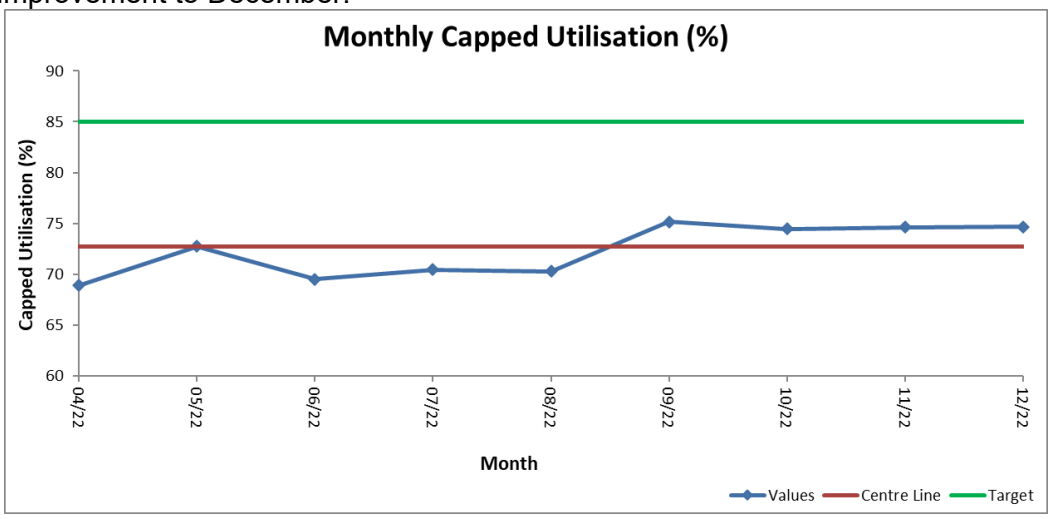






The 78 week trajectory factors in the impact of improved theatre productivity. It is essential that we make best use of available surgical capacity, to drive productivity improvements and protect elective activity through winter.

- The Theatre Efficiency Programme reports progress through the Elective Care Transformation Programme Board and to the Finance and Performance Committee. There has been a sustained improvement to December.



There are a number of risks to delivery of the required reduction in 104 and 78 week waits, these include:

- Workforce - sickness and vacancies
- Industrial action on 18th and 19th January will impact on elective activity.
- Anaesthetists withdrawing from WLIs from 31 January over BMA rate card
- Urgent care pressures – COVID, Flu, NMC2R and poor patient flow impacting negatively across the whole system
- Diagnostic capacity / timeliness – all 78 week patients are being tracked through the diagnostic phase by the end of January.
- Number of complex cases emerging e.g. orthopaedic case requires a specialist mould making that adds delay, high volume of P2s in the Urology cohort, colorectal cases requiring RPH theatres and critical care.

Additional elective actions for the 78 week cohort were detailed in a letter from NHS England, received on 12th January, these include:

- Booking all patients by the end of January
- Validation – 52-week total cohort at 31 March who have not been validated in last 12 weeks by 20th January (5500 patients)
- Waiting List Minimum Data Set - new data field and removal of duplicate entries
- C code implementation
- Tracking and reporting independent sector activity

Validation

Validation and review of patients on our waiting lists is important for the appropriate use of capacity and to provide clean visible waiting lists to ensure timely and orderly access to care.
ChatBot validation is a key part of the 78-week recovery plan and, particularly in respect of the admitted waiting list, has an important role in patient safety through checking in on patients' health status and flagging those that may be deteriorating.
Thousands of patients have been validated through ChatBot, the outcomes are remaining consistent with 10% indicating that they no longer wish to remain on the lists.
A programme of validation is underway in accordance with Tier 1 requirements:

- Phase 1 is complete – 79% of non-admitted patients in the 52-week cohort contacted by 23 December 2022 within the previous 12 weeks, using ChatBot and two-way text reminders for non-responders.
- Phase 2 is underway – cohort of c12,000 patients in the 26-week non-admitted cohort, of which 4,000 have been contacted already, 2,000 have been excluded (had or due to have appointments / cancer patients) leaving c6,000 to be contacted before 24 February.

The additional requirement detailed in the letter of 12th January is to validate all patients in the 52-week cohort by 20th January 2023:

- This is c12,000 patients in the 52 week non-admitted and admitted cohort, of which 4,500 have been contacted already, 2,000 are excluded (had or due to have appointments / cancer patients) leaving c5,500 to be validated; this will be undertaken via ChatBot and digital letters.

Strengthening the current process requires the appointment of 10 WTE band 3 administrative support staff to join the existing validation teams, the first round of recruitment was unsuccessful, and a second round is in progress.
This strengthened and enhanced validation model will enable delivery of the Tier 1 validation plan through a robust service and workforce model that will also be able to respond and deliver the IST recommendations on validation, data quality and good RTT management of waiting lists.

Surgical and diagnostic prioritisation

For cancer in particular, the significant demand for additional diagnostic capacity means that the Trust needs to adhere to the maximum timeframes for diagnostic tests within each tumour-specific Best Practice Timed Pathway but should at all times have a maximum backstop timeframe of 10 days from referral to report.

A comprehensive review of current turnaround times and identification of actions to support further prioritisation of cancer over more routine diagnostics to meet this backstop is being taken through Safety and Quality Committee in January 2023.

Performance against the 31 day standard from decision to treat to treatment will be used to assess whether the first of these objectives is being met. Performance for December was 80.72%, a decrease on the November position of 83.46%. The target is 96%

Outpatient transformation

Progress on the Outpatient Transformation Programme is reported through to the Finance and Performance Committee.

Tier 1 Trusts are asked to continue their work to deliver a 25% reduction in outpatient follow up appointments. The initiatives below will go some way to delivering this target, as well as having the potential to allow for increased activity (reduction in PTL size and improved RTT position) and shorter patient pathways.

- **Patient Initiated Follow Up (PIFU)**

  Whilst the Trust is not yet delivering the 5% PIFU target, positive momentum continues to build with additional services developing and implementing PIFU pathways on a regular basis.

Current PIFU numbers show an average incremental percentage increase over six months of 60%.

Development continues with review of wider PTL validation with the potential to identify further PIFU patients.

- **Specialist advice and referral triage**

  Advice and Guidance (A&G) is already embedded across the Trust alongside several CAS (Clinical Assessment Services) and RAS (Referral Assessment Services).

  The Trust is performing well against the national 16% target

  Ongoing engagement with primary care is required to promote GP usage of A&G. This is being managed by the ICB Referral Optimisation Board.

  Internally the Trust is in the process of implementing additional RAS across several new specialties, including ENT, Diabetes, Immunology, Ophthalmology and Sleep Studies. Development of these services will support clinical triage at the point of referral which will deliver a reduction in outpatient first appointments as well as an improved patient pathway.

  Development of these pathways and progress against delivery is overseen by the Trust Outpatient Transformation Steering Board.

- **Telemedicine outpatient delivery**

  The Trust continues to exceed national targets for the delivery of telemedicine activity. Ongoing promotion of Attend Anywhere continues with a recent user survey undertaken to increase clinical engagement and utilisation of this system

- **DNA reduction**

  The trust historically has had a low DNA rate for outpatient activity when compared to peers and Model Hospital data, however we have seen an increase in DNA rates over the last few months and local and regional DNA reduction projects have commenced.

- **Follow Up reduction**

  In conjunction with the PIFU development and progression, clinical pathways are being reviewed to ensure they do not include non-value added follow up appointments. This work is being manged through the Clinical Prioritisation Group and through the Outpatient Transformation Board

- **Improved administration processes**

  Digital initiatives are developing at pace within the Outpatient Transformation programme including:
  Chatbot rollout
  Robotic Process Automation
  Digital outcome recording
  Self-Check in
  Digital letters deployment
  Patient booking
  E-forms for questionnaires

  Outpatient administration is being reviewed and process mapped to ensure that the patient pathways are managed in accordance with the Patient Access Policy.

Pressure Ulcers
Pressure ulcers remains an area of continued work. Increasing occupancy and length of stay at the start of the patient journey is having an adverse effect on the development of pressures. Mitigating actions including the upgrade of pressure relieving equipment, a continued renewed approach to addressing the increasing incidence has been launched supported by the full roll out of the safety dashboard.

Falls
Falls improvement work continues and incidence remains within warranted variation at this time.

HSMR
Mortality metrics remain stable and within expected parameters.

STAR
STAR continues to perform on target.

INFECTION PREVENTION AND CONTROL

Clostridium *difficile*
The data is demonstrating some recovery following the spike in astronomical data points during June, July and August with the last 4 months data now below the mean and in December a positive special cause variation. However, despite some recovery, this remains as a negative escalation as the cases continue to track above the monthly tolerance and the annual objective has been exceeded. The Safety and Quality committee received a detailed update following the NHS England Infection Prevention and Control review relating to increased incidence of C.*difficile* and they will oversee the progress against these actions.

Always Safety First
The annual target for basic and intermediate safety training has now been met.

A Great Place to Work

Short term sickness absence episodes rose sharply during December, driving an increase in the overall absence rate. This is a typical seasonal trend although we experienced a particularly high level of cold, cough and flu viruses amongst the workforce throughout the month, outweighing the number of colleagues absent due to COVID. This has reduced during January. It is encouraging to see the average duration of mental health and musculoskeletal absence episodes below target. We continue to provide a proactive outreach service for colleagues off sick due to mental health reasons and we will shortly be launching a new, remote access physiotherapy service, for colleagues suffering from musculoskeletal conditions or injuries.

Our international nurse recruitment continues at pace. We have brought over 620 nurses into the Trust in the last 2 years, with 116 of these arriving October to December 22 and a further 40 joining is before March 23. This has had a positive impact on our registered nurse vacancy rate and hopefully we will start to see an associated reduction in registered nurse agency spend as 2023 continues. Our Health Care Support Worker vacancy rate remains a challenge, despite a slight reduction to 15.3% in M8, we continue with our plans on high-volume recruitment and retention . A total of 116 offers were made in November 2022.

At the time of writing the report the Trust is under significant operational pressure with additional bed capacity in the system to cope with the impact of the strike action and surge in ED attendance and demand. We have increased our nursing bank rates to top of band as of December 22 to hopefully encourage an increase in bank fill and to mitigate additional agency spend. We have escalated agency rates in ED and for demand on our site extras rota in response to rates being escalated across the ICS, and to support safe staffing and increase fill over the winter period.

The first beds opened at Finney in November to support discharge and patient flow. We continue to be challenged from a resource perspective. Recruitment volumes and pressures to support the opening of the 3rd phase in the New Year will continue well into the New Year. We are seeing challenges with registered nursing gaps and fill.

Delivering Value for Money

Income and Expenditure

The Trust reports a £14.2m deficit position for YTD Month 9 against £1.7m YTD deficit plan. Overall, the £12.5m variance can be explained mainly through £17.8m (under-delivery against the £26.7m) system funding, £2.0m covid overspends (mainly on absenteeism), £1.6m CIP under-delivery less £9.0m of Financial Recovery Plan measures; with all other issues netting off.

There continues to be a number of pressures in operational budgets associated with staff absence, premium rate spend and international nurse recruitment. There are also challenges for non-NHS income returning to pre-pandemic levels.

Capital Position
Capital expenditure is ahead of plan. This is due to the agreement of the lease on Finney House, which was not in the original plan, and also a result of TIF funded project being ahead of the profile assumed within the plan. No issues are anticipated with achieving the plan for the year. The Trust submitted two Targeted Investment Fund (TIF) bids which were approved in September. A further bid for Community Diagnostics Centre (CDC) was submitted in June and has been approved. All the bids were identified and approved in the Trust budget setting report for 2022/23 identified as requiring support. The Trusts capital programme has been updated accordingly. Further PDC has been made available for specific projects and this is also reflected in the updated capital plan.

Cash Position
The Trust's cash position is being affected by the risks that were noted in the plan and have materialised in the first nine months. A continuation of the revenue deficit will result in a requirement for working capital support and will have an impact on BPPC performance.

Cost Improvement Programme
The Trust has set a plan of 3% recurrent (£15.8m) and 2% non-recurrent (£10.5m) totalling £26.3m for 2022/23. CIP is planned for delivery in equal twelfths.
The Trust has an annual Cost Improvement Plan (CIP) target of 5% or £26.3m; made up of 3% recurrent (£15.8m) and 2% non-recurrent (£10.5m). The planned delivery is profiled equally in twelfths across the year.

Key headlines:
- The CIP position Year to Date (YTD) as at Month 9 (M9) is £18.1m, against a plan of £19.7m, an adverse of variance £1.6m year to date.
- Full year delivery is £26.8m as at M9 (delivered category), of which £9.1m is recurrent.
- The forecast year end position is full delivery of the £26.3m CIP target 22/23 (delivered, low and amber schemes). The Trust is on target to deliver £7.4m recurrent CIP in year and £9.1m full year effect.

Use of Resources
The Trust is in Segment 3.

Segment 3 is where there are significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence.

Segment 3 means the Trust will receive mandated support that is led and co-ordinated by NHS England and NHS Improvement regional teams with input from the national intensive support team where requested.

The Agency spend in 2021/22 was £21.0m, the reduced plan to meet the ceiling is £14.3m and the current outturn forecast is £20.0m. So, the Agency spend at YTD Month 9 is 40% above plan. The reason for this is due to greater vacancies than planned and slower than expected benefits from international recruitment.

Fit for the Future

These qualitative indicators will be reported separately to board within the normal cycle of board business.

It is recommended that:
I. The Board note the contents of the report and the action being taken to improve performance

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

Finance and Performance Committee, Workforce Committee, Safety and Quality Committee

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Our Big Plan

Excellent care with compassion

Always Safety First

Board of Directors
Performance to December 2022

@LancsHospitals

Together

INTRODUCTION

Performance to 31st December 2022

Our Big Plan

Mission

To provide excellent care with compassion

Strategic Aim

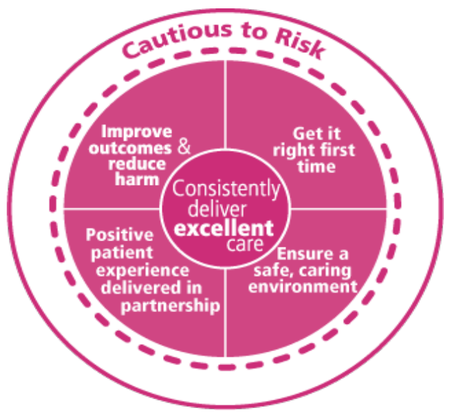
To provide excellent healthcare to our local communities

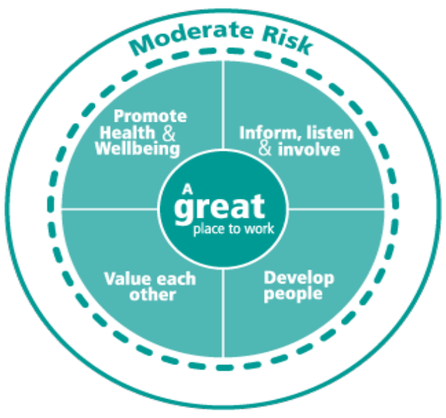
Strategic Aim

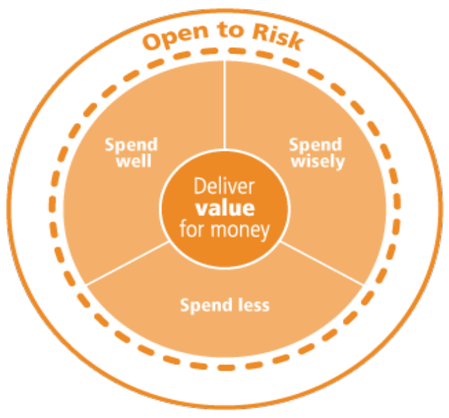
To offer a range of high quality specialist services to patients in Lancashire and South Cumbria

Strategic Aim

To drive innovation through world class education, training and research*








Seeking to Involve


Being Caring and Compassionate


Recognising Individuality


Taking Personal Responsibility


Building Team Spirit

In order to ensure that the we are continually monitoring delivering against our Big Plan, the metrics within the Integrated performance report for the Board of Directors are aligned to the Big Plan 2021/24 outcomes and provide details of performance against the agreed KPIs. Each of the ambitions upon which our Big Plan is founded is aligned to a board sub committee which will undertake more detailed scrutiny of progress in achieving the identified outcome, understand risk and seek assurance against delivery.

Kevin McGee
Chief Executive

Continuously deliver excellent care

Together

Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One – Improve outcomes and prevent harm										
CQC	Big Plan	To achieve an overall rating of good	M | T-D-S | TB-SQ | ALL	Yes	Progress towards CQC rating of good is ongoing					
	Sub Metric	Percentage of Must and Should do's completed			-	-	-	100%	94%	-
Deteriorating Patient	Big Plan	Reduce number of cardiac arrests by 10% (Rate per 1000 beddays)	M | T-D-S | TB-SQ | SC	No			-	0.44	0.58	0.53
Pressure Ulcers	**Key Metric**	**Reduce the number of people developing pressure ulcers by 10% Includes device related pressure ulcers (Rate per 1000 beddays)**		No				3.09	3.51	3.69
	Big Plan	Reduce the number of device related pressure ulcers by 10% (Rate per 1000 beddays)		No				0.62	0.96	0.75
Maternity safety	Big Plan	Maintain compliance with the 10 safety actions for maternity services		No	-	-	-	100.0%	80.0%	-
Children and Young People safety	Big Plan	Develop 10 safety actions for children and young people and achieve compliance		No	10 safety actions created for children and Young people, reported through the Divisional Improvement Forum					
Segment Two – Get it right first time										
Mortality	**Key Metric**	**Continue to achieve a mortality HSMR figure of <100 (Hospital Standardised Mortality Ratio (56 Basket – Adult)**	M | T-D-S | SQ | GS	No	Lower Than Expected - September 2022				78.0	-
	Big Plan	Improve the number of structured judgement reviews undertaken by a further 25%	M | T-D-S | SQ | SC	No	-	-	-	55	54	-
Access Standards	Big Plan	Achieve the Emergency Department within 4 hours target	M | T-D | FPC | FB	No				90.0%	73.5%	76.4%
	Key Metric	**Reduction in patients waiting +12 hours in Emergency Department**	M | T-D | FPC | FB	No				2.0%	9.5%	7.8%
	Key Metric	**Reduction in ambulance turnaround times (Over 60 minutes)**	M | T-D | FPC | FB	No				100.0%	84.2%	89.4%
	Big Plan	Reduction in 52 week waiters (target as per NHSI recovery plans)	M | T-D-S | FPC | FB	No				7295	6693	7434
	Key Metric	**Reduction in 104 week waiters (target as per NHSI recovery plans)**	M | T-D-S | FPC | FB	No				0	19	91
	Sub Metric	Reduction in 78 week waiters (target as per NHSI recovery plans)	M | T-D-S | FPC | FB	No				510	1163	1539
	Big Plan	Cancer - 28 days from referral to diagnosis (completeness)	M | T-D-S | FPC | FB	No			-	80%	86%	95%
	Big Plan	Cancer - 28 days from referral to diagnosis (compliance)	M | T-D-S | FPC | FB					75%	60%	54%
	Key Metric	**Achieve the NHSI 62 day cancer trajectory**	M | T-D-S | FPC | FB	No				85.0%	43.72%	48.6%
Valuing patient time	Big Plan	Maintain the number of patients moved more than 3 times	M | T-D-S | FPC | FB-SC	No			-	69	57	67
	Big Plan	Reduce the number of patients moved after 22:00 by a further 10%	M | T-D-S | FPC | FB-SC	No			-	125	67	111
	Big Plan	Achieve no more than 3% of patients delayed within hospital	M | T-D-S | FPC | FB-SC	No				3%	11.5%	10.5%
	Big Plan	Reduce the number of patients in hospital for longer than 7 days by 10%	M | T-D-S | FPC | FB-SC	No				432	425	428
Cancelled Operations	Big Plan	To reduce the number of operations cancelled for non clinical reasons to 0.8%	M | T-D-S | FPC | FB	No				0.80%	1.65%	0.99%
CRCU capacity	Big Plan	To ensure that the number of patients transferring from high care and critical care areas after 18:00 is reduced by 10%	M | T-D | FPC | FB	KPI Monitored through Specialty Business Unit						
SDEC	Big Plan	To provide same day emergency care services 12 hours per day 7 days per week	M | T-D-S | FPC | FB	No			-	220	444	503
Emergency readmissions (30 days)	Big Plan	To reduce the number of patients re-admitted within 30 days to less than 7.7%	M | T-D-S | FPC | FB	No			-	7.7%	7.6%	6.4%
Pre-procedure elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to surgery to 0.2 days or below	M | T-D-S | FPC | FB	No				0.20	0.32	0.33
Pre-procedure non-elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to planned surgery to 0.6 days or below	M | T-D-S | FPC | FB	No			-	0.60	0.33	0.57
Elective Inpatient Average length of stay (Spell)	Big Plan	To reduce the average length of stay for patients undergoing planned surgery to under 3.4 days	M | T-D-S | FPC | FB	No			-	3.40	3.63	3.06

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	KS = Karen Swindley	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	JW = Jonathan Wood	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	FB = Faith Button	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee	SC = Sarah Cullen	ND = Naomi Duggan

Variation Icon \ Assurance Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Continuously deliver excellent care

Together

2

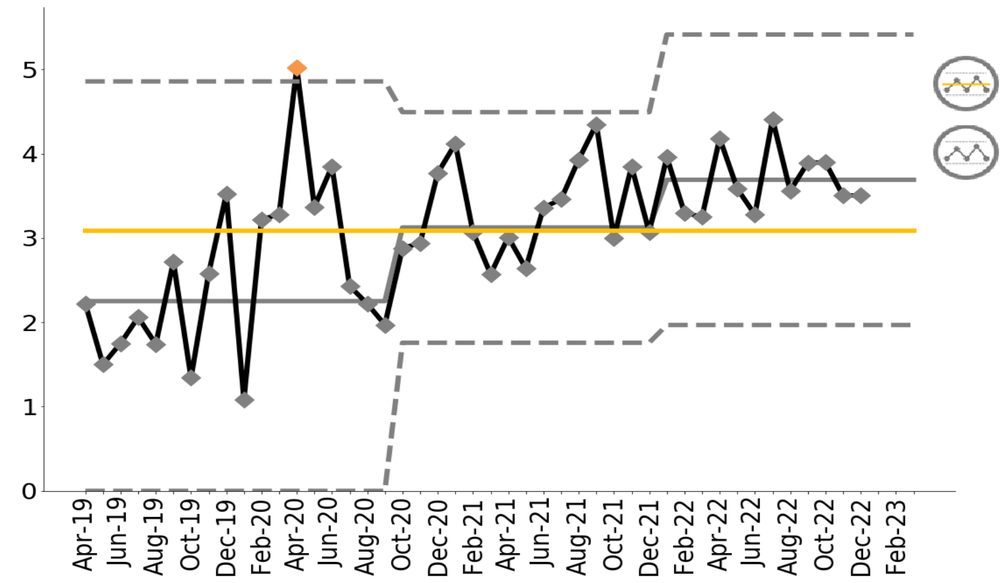
Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment Three – Ensure a safe, caring environment										
STAR	**Key Metric**	**Maintain 75% of Clinical areas with SILVER and above Star accreditation**	M | T-D-S | SQ | SC	No			-	75%	78.1%	75.7%
Falls	Big Plan	Reduce the number of falls by a further 5% - per 1000 bed days	M | T-D-S | SQ | SC	No			-	5.19	5.39	5.84
Infection	**Key Metric**	**Achieve less than the annual tolerance for C.difficile**	M | T-D-S | SQ | SC-GS	Yes	F			10	15	16
	Big Plan	Achieve zero MRSA bacteraemia	M | T-D-S | SQ | SC-GS	No	-	-	-	0	0	-
Safety	Big Plan	Achieve 90% staff trained in basic safety training	M | T-D-S | ETR | KS	No			-	90%	95.0%	90.2%
	Big Plan	Achieve 90% staff trained in intermediate safety training	M | T-D-S | ETR | KS	No			-	90%	90.9%	85.3%
Segment Four – Work in partnership to deliver a positive patient experience										
Complaints	Big Plan	Reduce the number of complaints relating to communication.	M | T-D-S | SQ | SC	No			-	22	14	21
	Big Plan	Reduce the number of complaints sent to the ombudsman.	M | T-D-S | SQ | SC	No	-	-	-	< 1	0	0
	Sub Metric	Total Number of Complaints Received	M | T-D-S | SQ | SC	No			-	47	30	47
	Sub Metric	Increase early resolution through PALS enquiries. (Number of PALs requests)	M | T-D-S | SQ | SC	No				132	212	143
Complaint quality	Big Plan	Introduce satisfaction measures for complaint and PALS responses and establish baseline.	B | T-D-S | SQ | SC	No	-	-	-	TBC	0	7
Patient involvement	**Key Metric**	**Achieve a minimum of 90% of patients reporting their experience of good or very good (including neither good/bad)**	B | T-D-S | SQ | SC	No			-	90%	89%	89%
Candour	Big Plan	Maintain >90% compliance with duty of candour for all moderate and above harm incidents.	M | T-D-S | SQ | SC-GS	No			-	90%	96%	96%

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team
B = Bi-annual	D = Division	W = Workforce Committee	KS = Karen Swindley
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	JW = Jonathan Wood
M = Monthly	C = Cost Centre	FPC = Finance and Performance Committee	FB = Faith Button
		SQ = Safety and Quality Committee	SC = Sarah Cullen
			GS = Gerry Skailes
			GD = Garry Doherty
			SD = Stephen Dobson
			AB = Ailsa Brotherton
			ND = Naomi Duggan

Assurance Icon / Variation Icon	*Will consistently fail target within expected variation*	*Could both pass or fail target within expected variation*	*Will consistently pass target within expected variation*
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

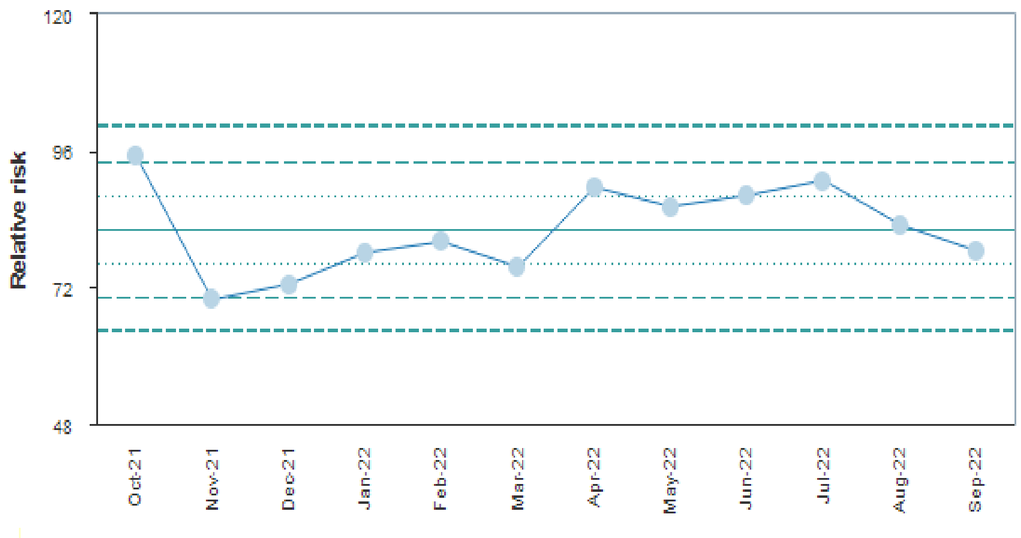
Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days (Including device related pressure ulcers)



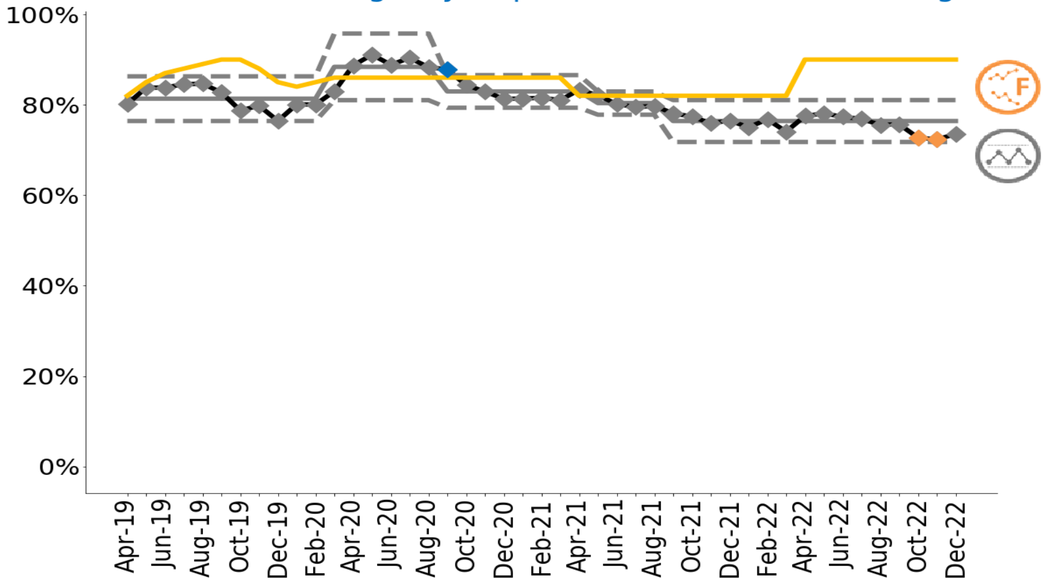
Diagnoses - HSMR | Mortality (in-hospital) | Oct-21 to Sep-22 | Trend (month)

Age (adult/child): Adult

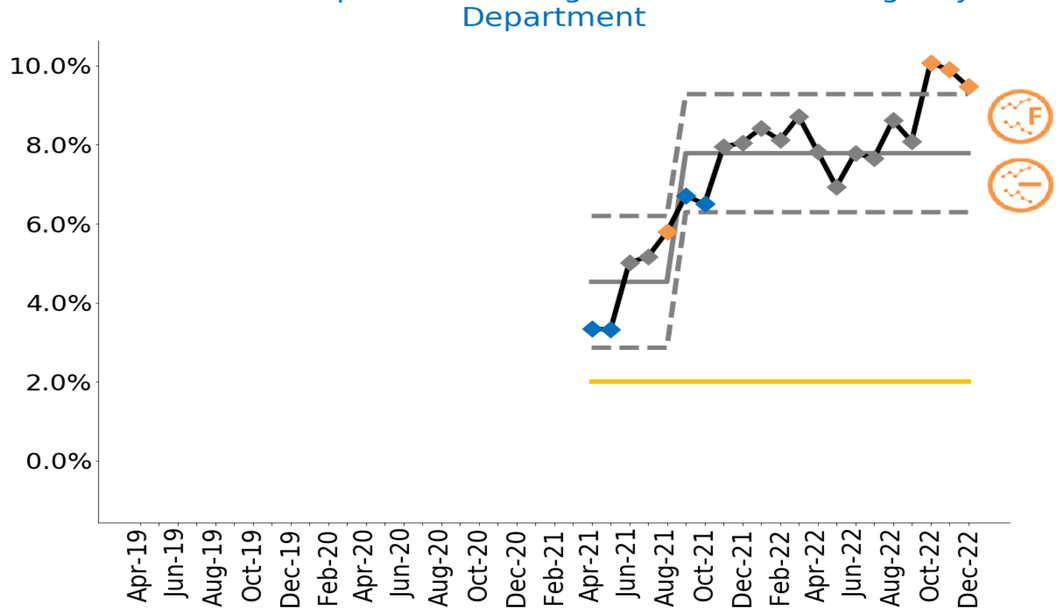
Period: **Month** *Measure*: **Relative risk** *Additional measure*: **No additional measure**



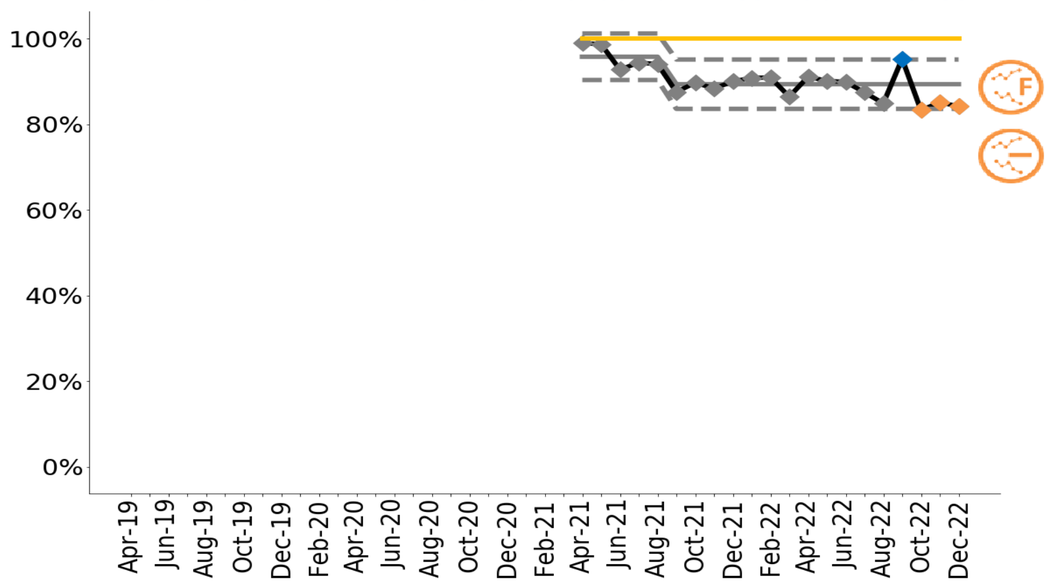
Achieve the Emergency Department within 4 hours target



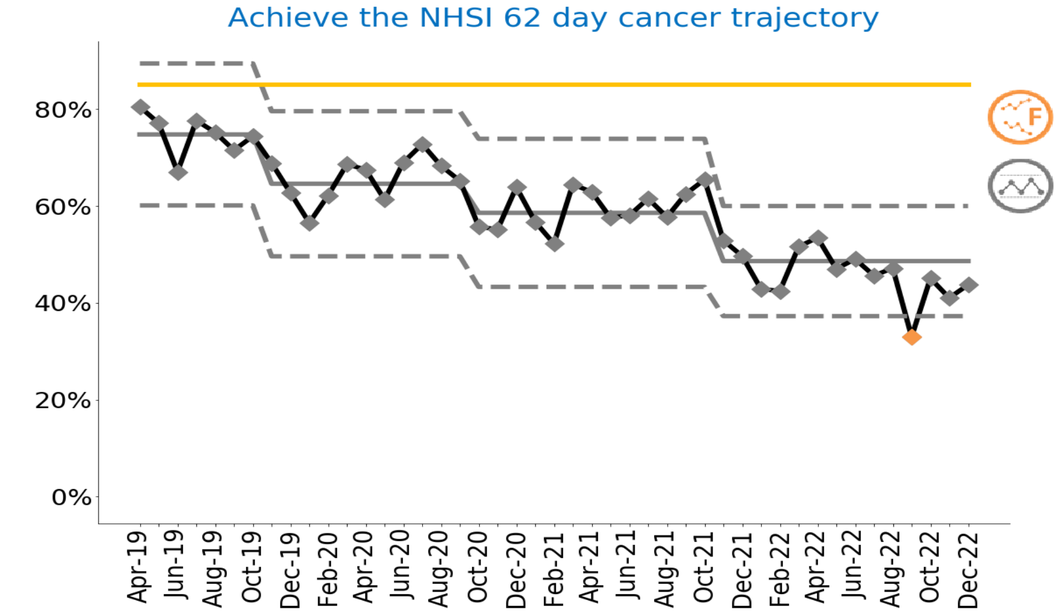
Reduction in patients waiting +12 hours in Emergency Department



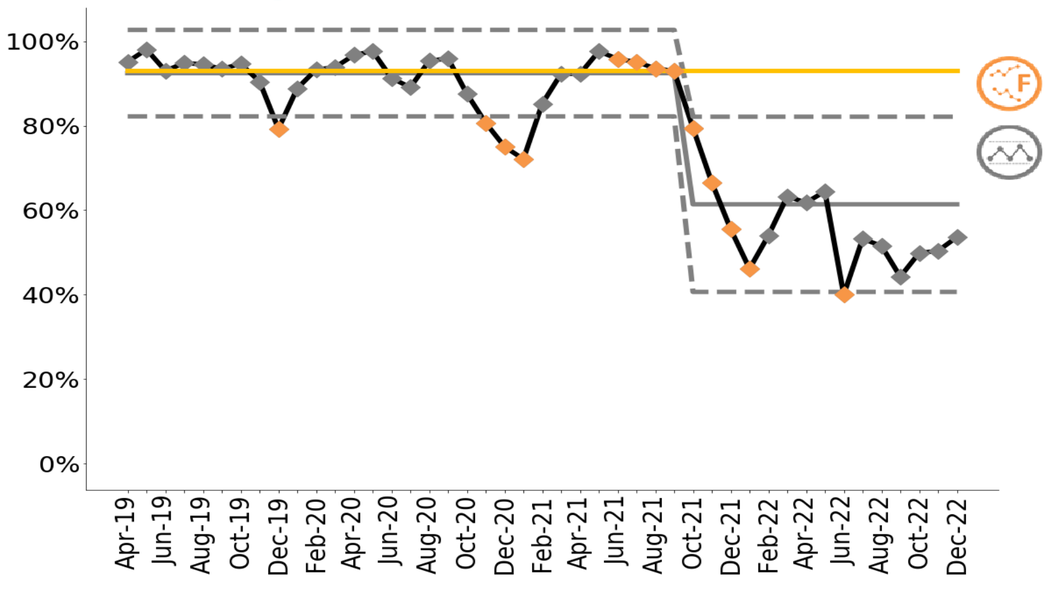
Reduction in ambulance turnaround times - 60 minutes



Achieve the NHSI 62 day cancer trajectory



Urgent GP referrals seen within 2 weeks



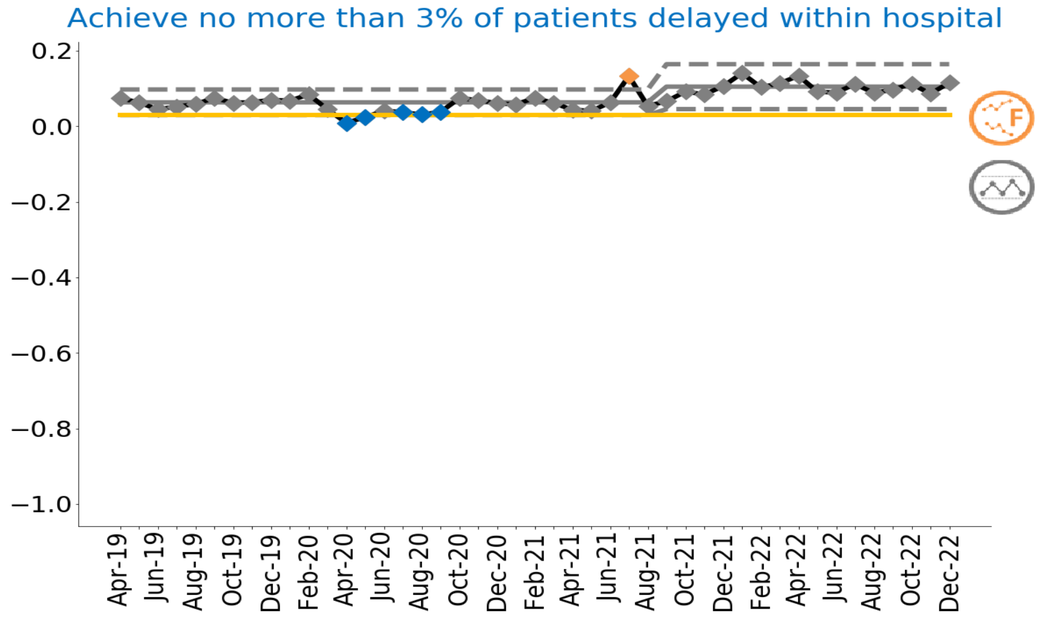
Assurance Icons – How likely are we to hit the set target in future?

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

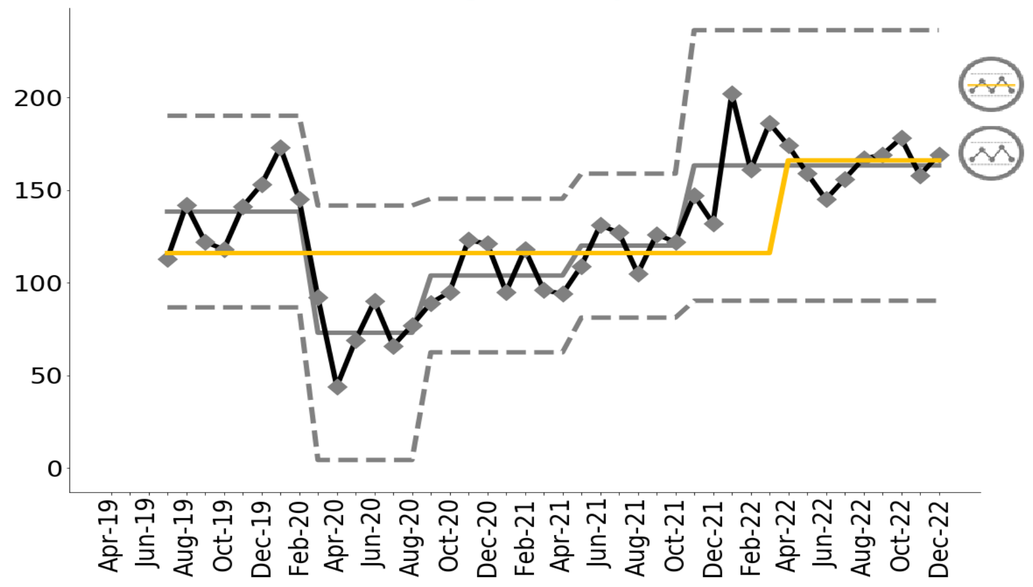
Variation Icons – Is the measure showing signs of change over time?

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

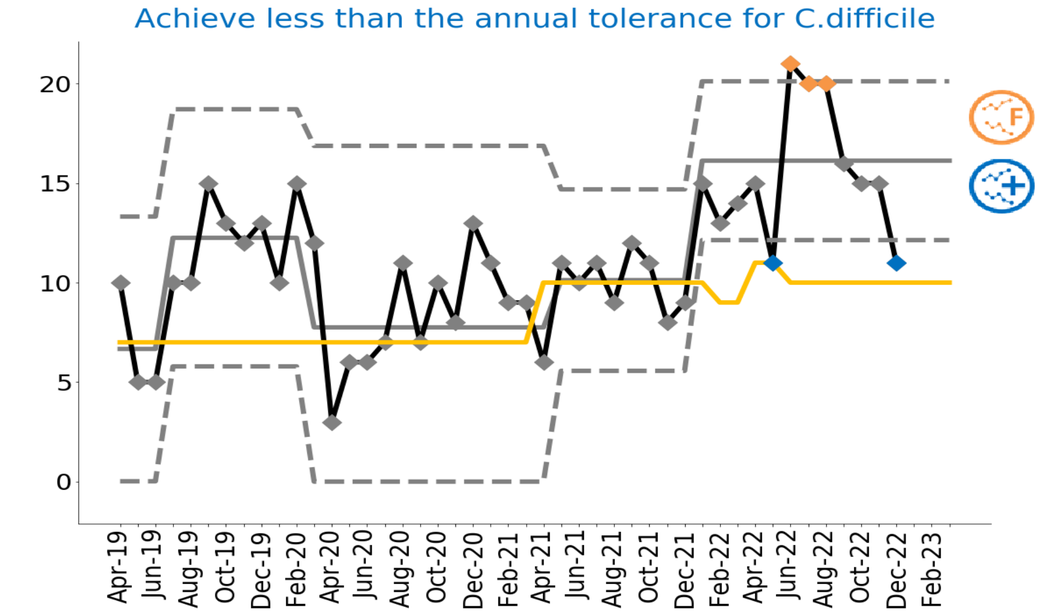
Achieve no more than 3% of patients delayed within hospital



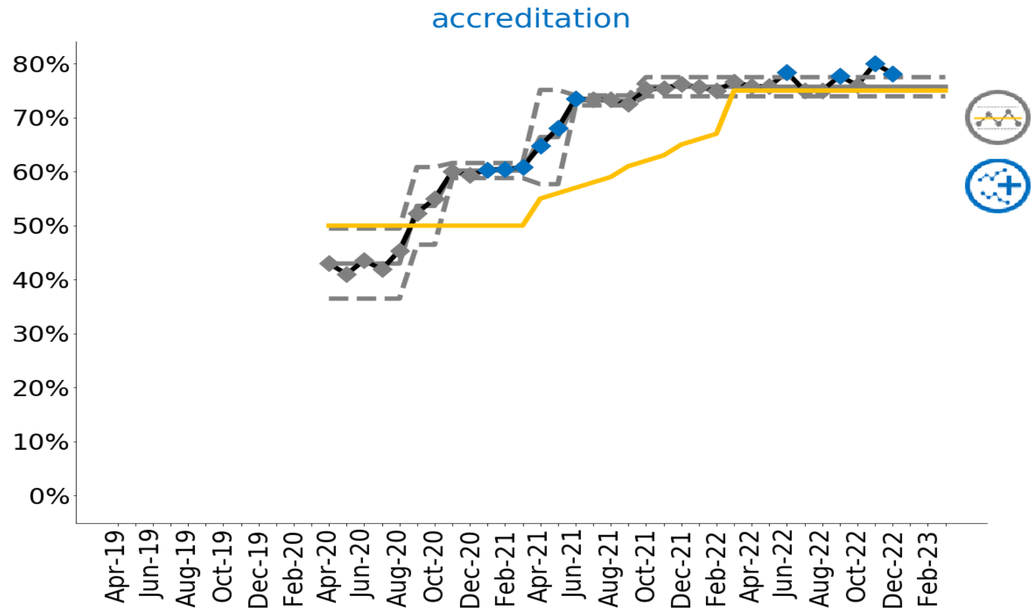
Super Stranded Patient Rate v Improvement Trajectory (21 Days+ Length of Stay)



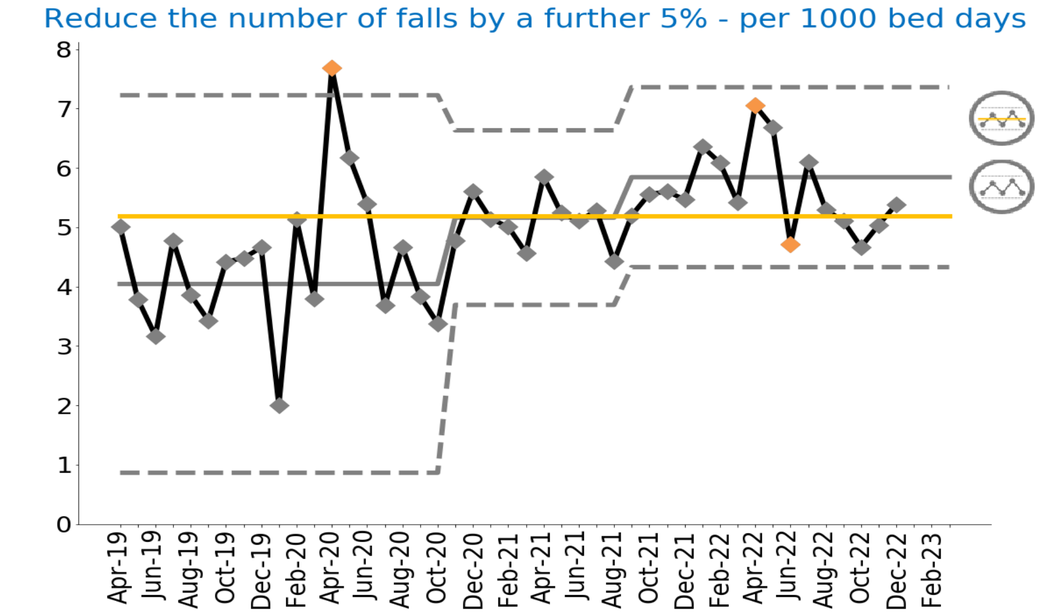
Achieve less than the annual tolerance for C.difficile



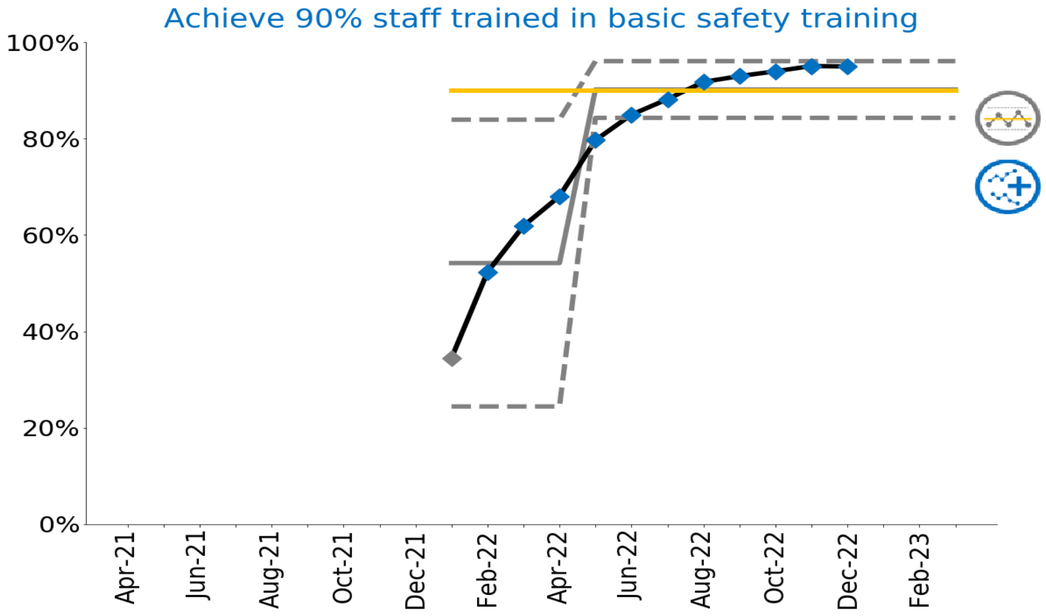
Maintain 75% of Clinical areas with SILVER and above Star accreditation



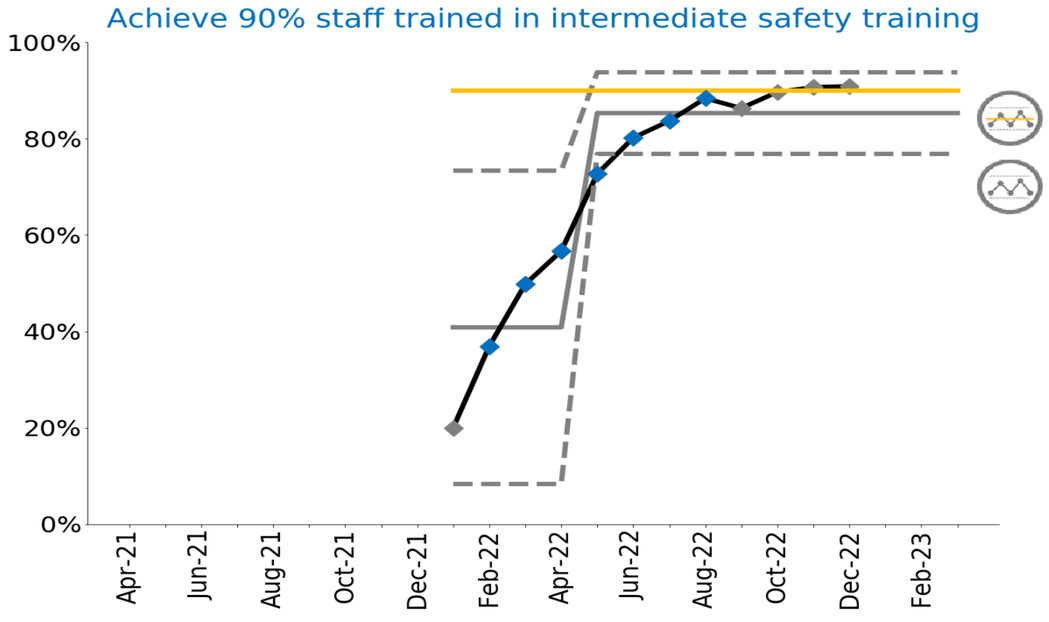
Reduce the number of falls by a further 5% - per 1000 bed days



Achieve 90% staff trained in basic safety training



Achieve 90% staff trained in intermediate safety training



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

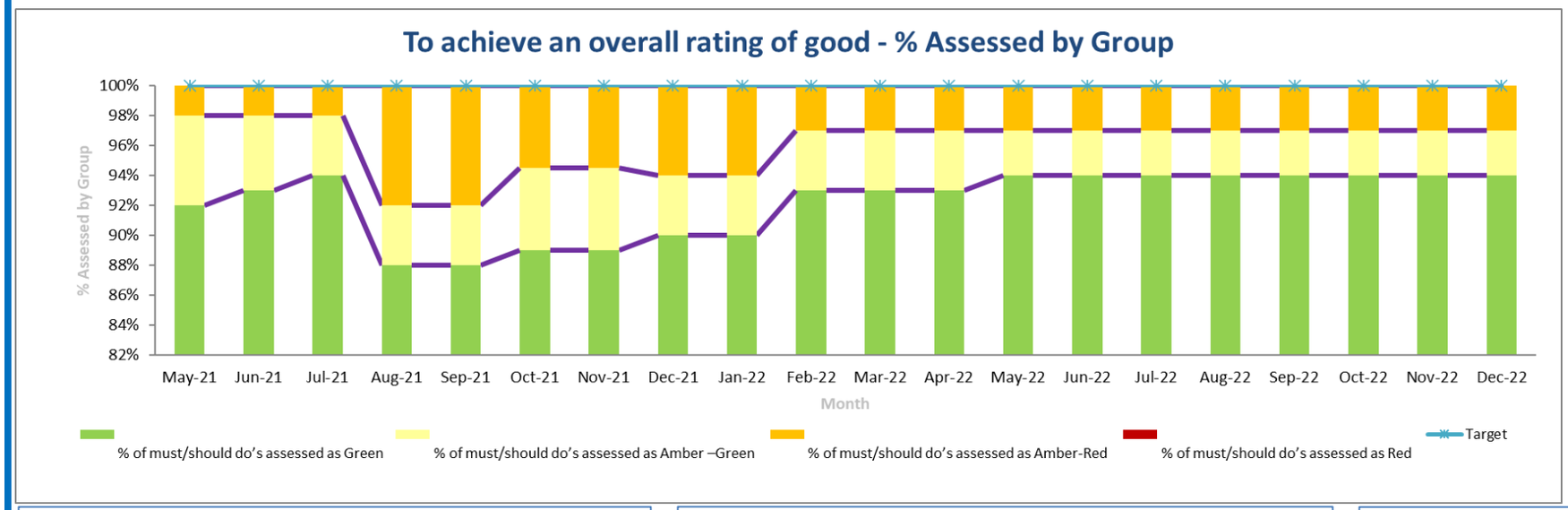
It's possible the target could be either passed or failed within the expected month to month variation of the measure	*The target will be consistently failed within expected variation unless the process is changed*	*The target will be consistently passed within expected variation unless the process is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

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

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

ASSURANCE REPORT - CQC

Together



Current Compliance
Green - 94% Amber/Green - 3% Amber/Red - 3% Red - 0%
Monthly Target
Target Achievement/Assurance

Assurance:

QIP - 2019 Inspection
At the end of December 2022, of the 93 'Must Do's' and 'Should Do's' included in the QIP (2019), 87 (94%) have been assessed as 'Green' i.e. delivered, 3 (3%) as 'Amber-Green' i.e. ongoing and progress made and 3 (3%) as 'Amber-Red' i.e. not currently delivered and risks with delivery. Nil 'Must Do and Should Do's are currently assessed as Red i.e. not expected to deliver at any point in time.

The graphs demonstrate that progress has been made with the Trust on track to deliver 97% of recommendations.

QIP - 2022 Inspection:
There were a total of 16 recommendations in the 2022 Division of Medicine and ED Action Plan. Of these, there are 46 actions derived in the action plan enclosed below. 18 actions are currently assessed as 'Green' i.e., complete. 3 actions are assessed as 'Amber-Green', i.e., not delivered yet, but expected to be delivered within the timescales. There are currently 25 actions marked as 'Amber'. These actions are awaiting commencement or are due to start soon.

Actions:

There are 3 recommendations that are assessed as Amber Green 'i.e. ongoing and progress being made'. These are:

Access & Flow (AF8) - 2019 Surgery - The service should reduce the number of theatre overruns.
Documentation (D&IG7) - 2019 Surgery - The service should complete risk assessments for patients who may be at risk of self-harm.
Staffing (S5) - 2019 Medicine - The trust should continue with plans to recruit to an increased nurse staffing establishment.

There are 3 recommendations that are assessed as Amber Red 'i.e. not currently delivered, and risks with delivery'. These are:

Access & Flow (AF1) – 2019 Urgent and Emergency Care The trust should continue to reduce the time patients wait in the department before receiving treatment or being admitted.
Access & Flow (AF3) - 2019 Urgent and Emergency Care The trust should take appropriate actions to improve waiting times in line with national standards.
Staffing (S3) - 2019 Urgent and Emergency Care - The trust should review its medical staffing so it meets national standards.

Progress:

QIP - 2019 Inspection
Since the last update, the same actions remain Amber-Green and Amber-Red as indicated. However, it's expected there will be progressive actions taken in Quarter 4 that may allow closure of those rated Amber-Green.

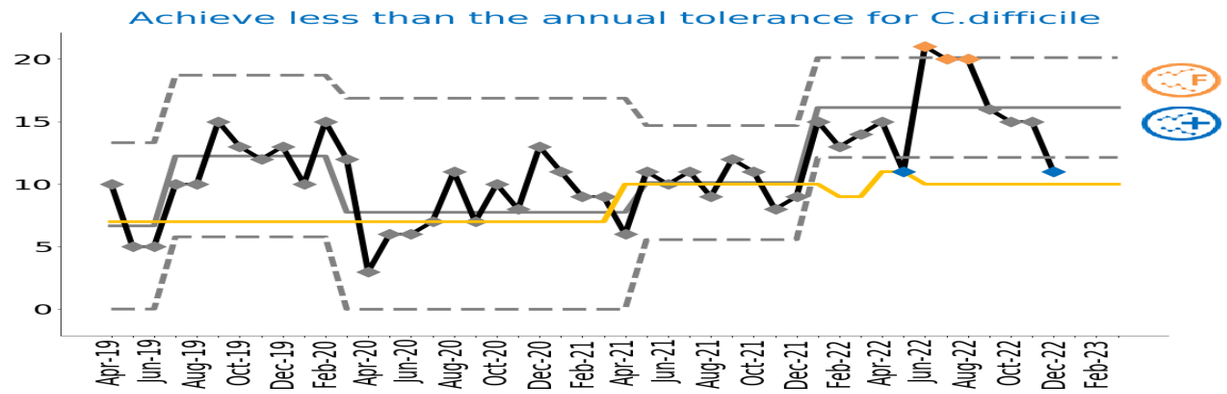
Some of the issues identified as Amber-Red were issues at the most recent inspection and are also linked to High Risks for the organisation. However, there are further planned actions which it is hoped will provide the opportunity for further progress.

QIP - 2022 Inspection:
Progress has been made since the inspection and there are currently 18 out of the 46 identified actions, categorised as green (complete), subject to evidence validation.

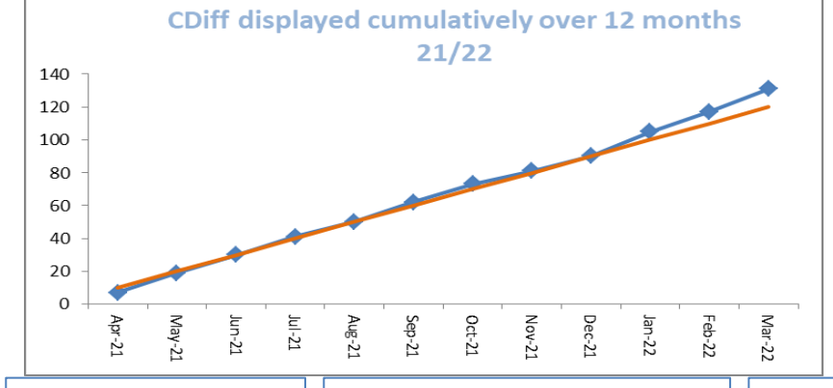
The remaining 28 actions are underway or due to start soon.

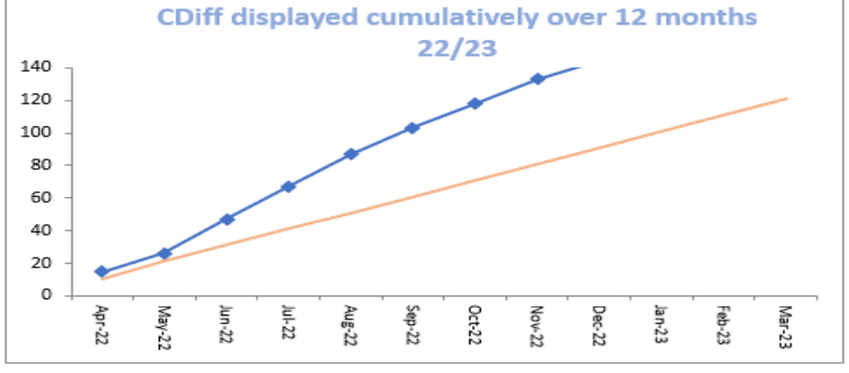
ASSURANCE REPORT - Clostridium Difficile

6



Dec-22
11
Variance Type
Special cause variation
Monthly Target
10
Target Achievement/Assurance
Tolerance is 122, to end of December 2022 this has been exceeded





Background:

Trust Clostridium Difficile infection (CDI) have a revised annual objective of 122 per annum. This was amended from 118 in April 2022

What the chart tells us:

The chart shows a positive special cause variation in month but this remains above the monthly tolerance. The data is telling us that the Trust objective has been exceeded.

Issues:

Current actions to reduce CDI rates need further focus linking the human factors, patient risk factors, environmental and operational factors that contribute

Actions:

CDI action plan in place overseen by IPC committee
Implementation of rapid intestinal testing and agreement that this can be used as date of attrition
Risk assessment implementation and isolation of patients with type 5 stool

Mitigations:

Isolation rooms in place

Purchase of additional redi rooms to isolate patients where needed

Learning from PIRs shared in ASF groups

CDI action plan tracked for assurance of progress

A GREAT PLACE TO WORK
Reviewed monthly / quarterly

Together

Metric Description		Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Sickness Absence	Reduce overall sickness absence to 4.00% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	F	-	-	≤ 4%	7.71 %	5.45 %
	Reduce short-term sickness absence to 1.25% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	F	-	-	≤ 1.25%	3.51 %	1.58 %
	Reduce long-term sickness absence to 2.75% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	F	-	-	≤ 2.75%	4.20 %	3.87 %
Health & Wellbeing	Reduce average duration of psychological health related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-		-	-	≤ 33.18	32.89	40.74
	Reduce average duration of MSK-related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-		-	-	≤ 18.86	15.08	23.30
	Drive forward zero tolerance of violence and aggression toward staff by reducing the number of incidents by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-		-	-	≤ 53	73	47.08
Develop People									
Turnover	Maintain annual staff turnover between 8% and 11% FTE (annual assessment; ESR in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 0.83%	0.76 %	0.73 %
Vacancies	Reduce the number of vacancies by a further 5% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-	F		-	≤ 6%	8.05 %	8.61 %
Appraisals	Maintain 90% HC compliance rate for appraisals	M | T-D-S-C | W | KS	-				≥ 90%	86.86 %	
Mandatory Training	Maintain 90% HC compliance against all core skills training requirements (module compliance reported)	M | T-D-S-C | ETR | KS	-				≥ 90%	95.75 %	
Medical Devices	Achieve 90% HC compliance with medical device training	M | T-D-S-C | ETR | KS	-				≥ 90%	80.93 %	
Inform, Listen and Involve									
Staff Engagement & TED	Increase the number of teams that have undertaken TED by 50% (annual assessment; in-month reported)	M | T-D | W | KS	-			-	≥ 12	9	5.33
	Ensure 70% of our staff would recommend us as a place to work	Q | T-D | W | KS	-			-	≥ 70%	54.67 %	61.79 %

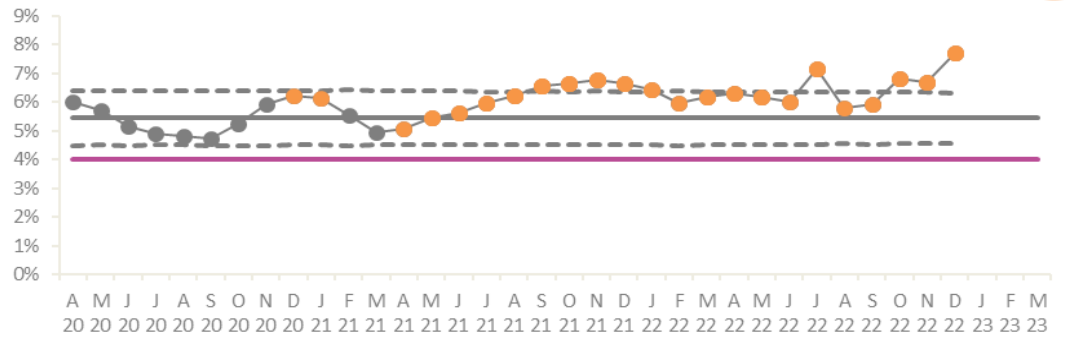
Variation Icon \ Assurance Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Reporting Requirements Key

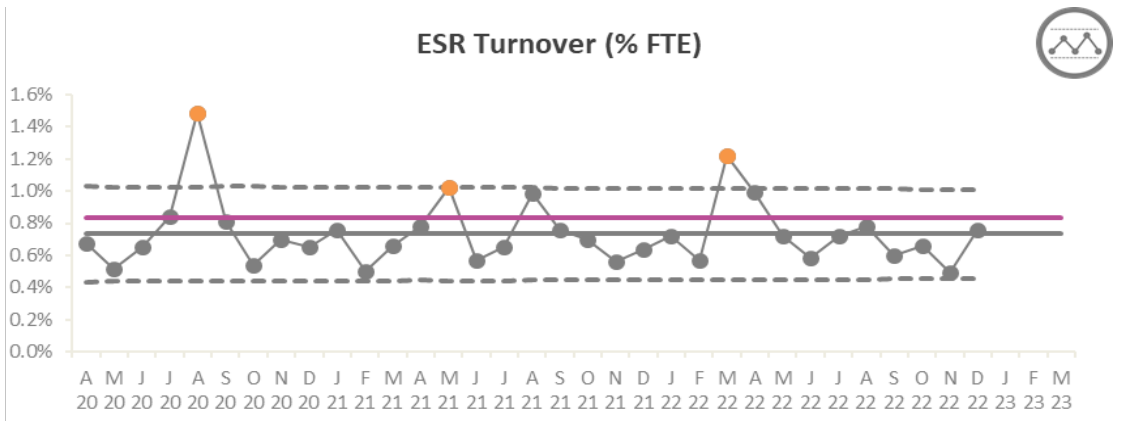
Frequency	Level	Sub-Committee	Responsible Executive
A = Annual	T = Trust	W = Workforce Committee	KS = Karen Swindley
B = Bi-annua	D = Division	ETR = Education, Training & Research Commit	JW = Jonathan Wood
M = Monthly	S = Specialty		All = All Exec Team
Q = Quarterly	C = Cost Centre		

Metric Description		Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Enivronment	Upgrade a further five local staff rest areas	B | T | W | JW							
	Create five agile activity based workspaces	B | T | W | JW							
	Create outdoor recreational space on both the Chorley and Preston sites	B | T | W | JW							
Health & Wellbeing	Increase staff perception that the organisation takes positive action on health and wellbeing to 60%	A | T-D-S-C | W | KS							
	Support staff to stay well by ensuring adequate rest and recuperation in line with working time regulations	B | T-D-S-C | W | KS							
Develop People									
Appraisals	Improve staff perception of the quality of appraisals by 5%	A | T-D | W | KS							
Inform, Listen and Involve									
Just Culture	Reduce further the number of grievances that are managed through formal processes to monitor the move to a just culture	B | T | W | All							
	Reduce the gap between the scores achieved in the annual culture survey between staff perception of the current and desired culture	A | T-D-S | W | All							
Freedom to Speak Up	Ensure all staff accessing the Freedom to Speak Up team are satisfied with how their concerns were managed	A | T | W | KS							
Staff Engagement & TED	Increase the staff engagement score, as measured by the annual staff survey, to 7.5 out of 10	A | T-D | W | KS							
	Ensure 50% of our staff complete the annual staff survey	A | T-D | W | KS							
Value Each Other									
Race Equality	Reduce the number of staff from BAME backgrounds that have personally experienced discrimination at work to be in line with that of their white colleagues	A | T | W | All							
	Increase the number of colleagues from a BAME background in senior roles (AfC Band 8a and above)	A | T | W | All							
Disability Equality	Reduce the number of disabled staff that experience harassment, bullying and abuse from managers to be in line with the experience of non-disabled colleagues	A | T | W | All							
Corporate Social Responsibility	Engage with our local communities through a range of workforce and education programmes	A | T | W | KS							

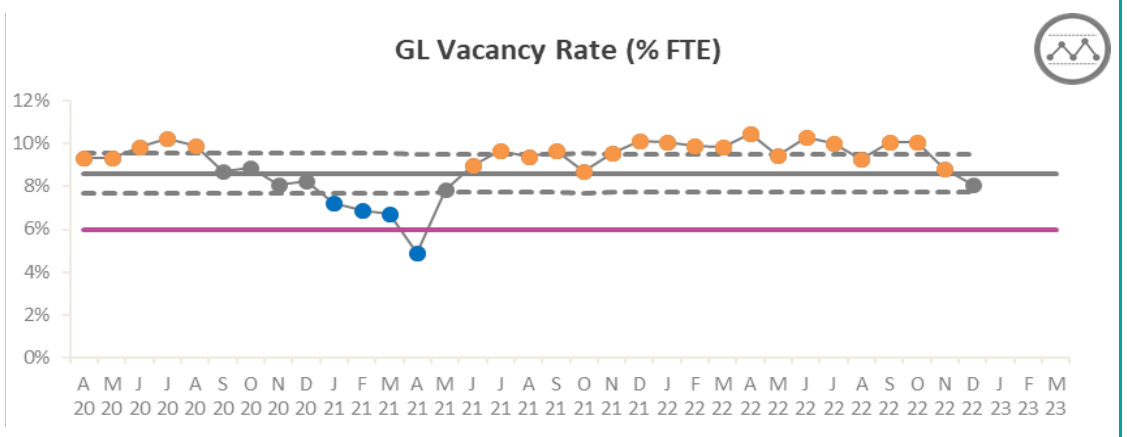
Overall Sickness (% FTE)



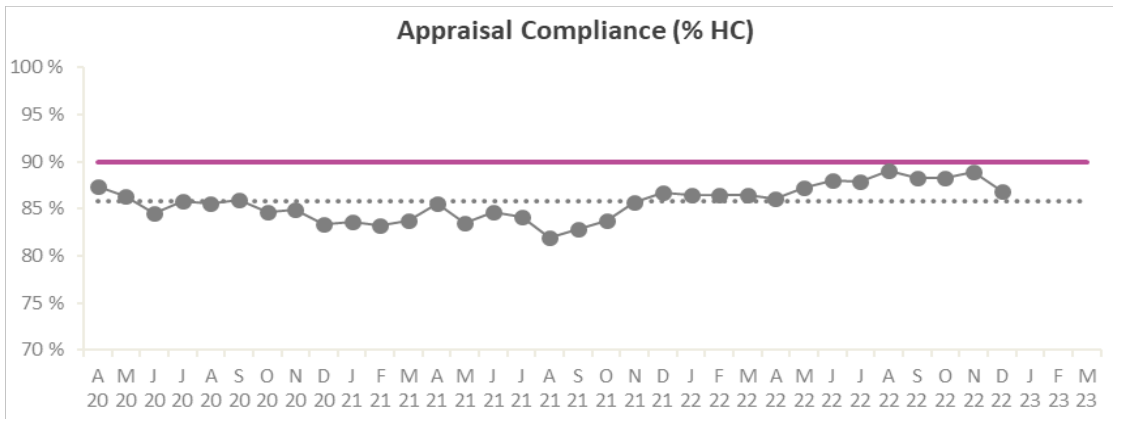
ESR Turnover (% FTE)



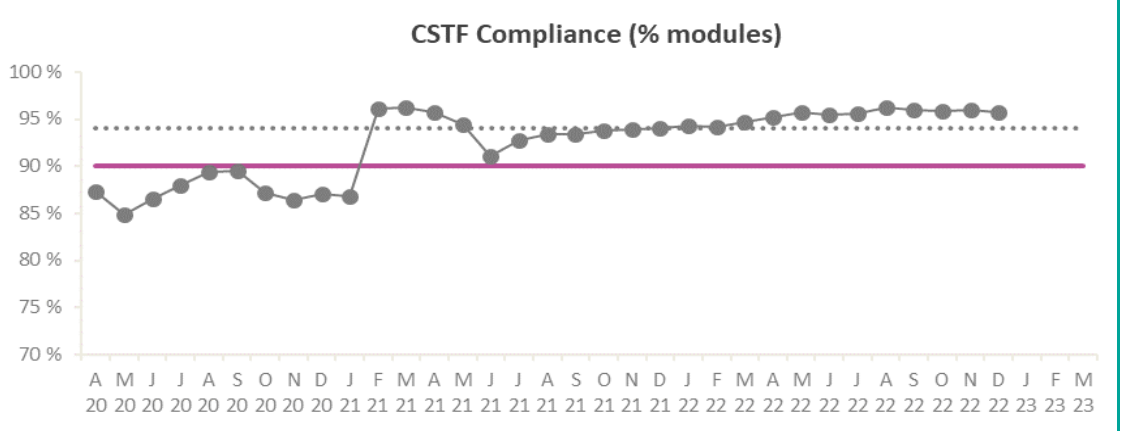
GL Vacancy Rate (% FTE)



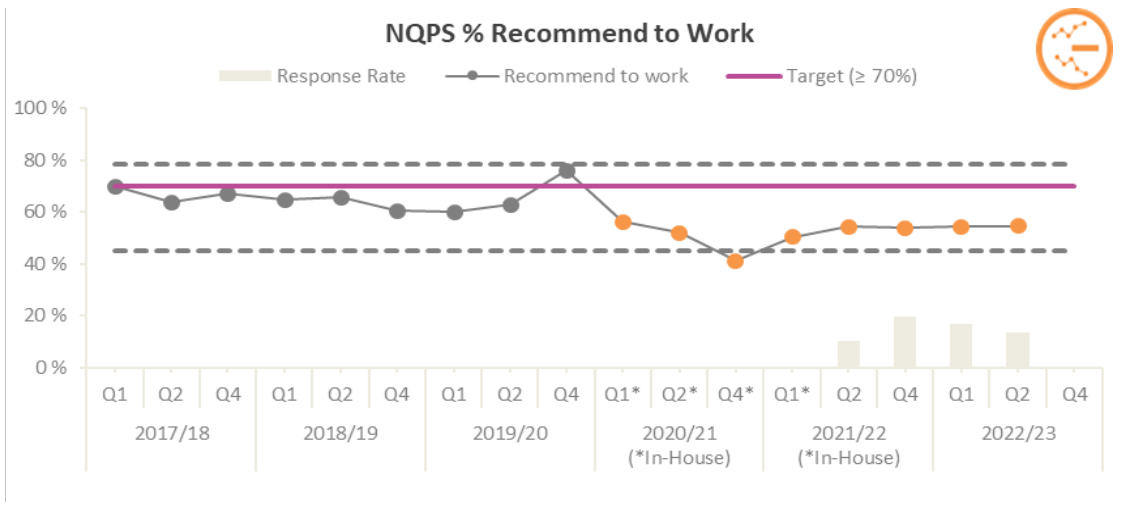
Appraisal Compliance (% HC)



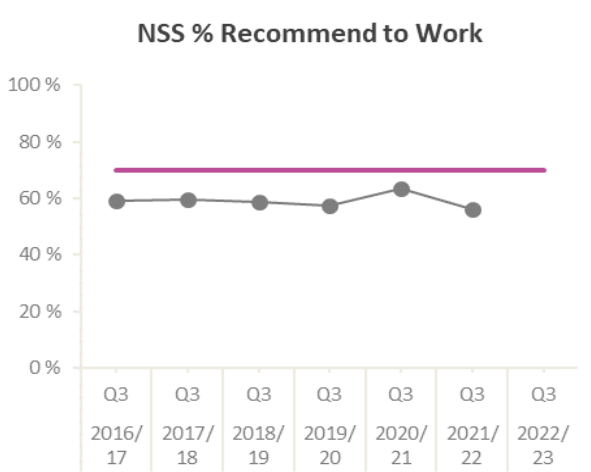
CSTF Compliance (% modules)



NQPS % Recommend to Work



NSS % Recommend to Work

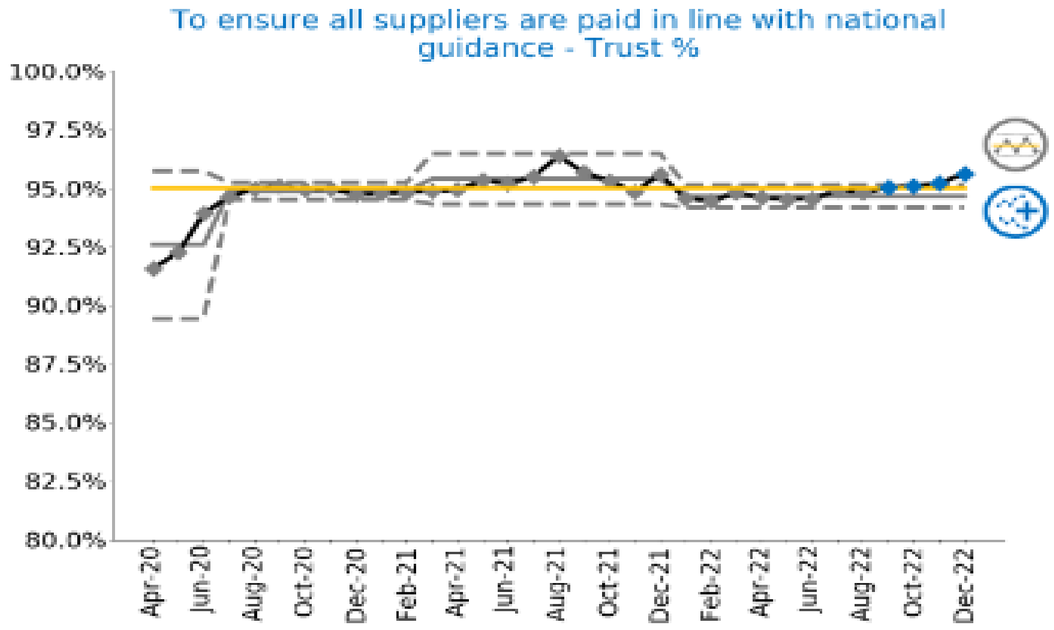


Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One - Spend Less (Economy)												
Agree revenue and capital financial plan with ICB	**Key Metric**	DVFM-1	Agree revenue and capital financial plan with ICB	A | T | TB - FPC | JW	No	-	-	-	Yes	Yes	-
Deliver agreed cost improvement delivery target	**Key Metric**	DVFM-2	To deliver 100.0% of agreed cost improvement target	M | T-D-S | FPC | JW	No	-	-		2195	2403	-
Purchase Price Index and Benchmarking (PPIB) performance	Big Plan	DVFM-3	To be in the top decile of purchase price Index and Benchmarking	A | T | FPC | JW	This indicator will be reported separately to board within the normal cycle of board business						
Segment Two - Spend Well (Efficiency)												
Model Hospital - clinical model	Big Plan	DVFM-4	To ensure each clinical model hospital theme to have a proactive action plan in place and deliver 75% of agreed target (where action plan agreed to be relevant and opportunity exists)	M | T-D-S | FPC | GD	This indicator will be reported separately to board within the normal cycle of board business						
Model Hospital - Daycase: Inpatient ratio	Big Plan	DVFM-5	Achieve day case basket 85%	M | T-D-S | FPC | FB	No	F	-		85.0%	71.3%	77.5%
Model Hospital – length of stay	Big Plan	DVFM-6	To deliver Length of stay over 50th percentile for emergency admissions	M | T-D-S | FPC | FB	No	F			4.4	5.4	5.3
Model Hospital – WAU	Big Plan	DVFM-7	To reduce the Trust's weighted activity unit index to 100.5	A | T | FPC | JW	This indicator will be reported separately to board within the normal cycle of board business						
Did not attend (DNA) rate	Big Plan	DVFM-8	To achieve a DNA rate of less than 6.8%	M | T-D-S | FPC | FB	No	F			6.8%	9.61%	9.54%
New to Follow-Up Rate	Big Plan	DVFM-9	To maintain a new to follow up patient ratio of 2.62	M | T-D-S | FPC | FB	No				2.62	2.65	2.82
Bed Occupancy Rate (Including Escalations)	Big Plan	DVFM-10	To achieve a bed occupancy rate of no higher than 90.0% (SITREP)	M | T-D | FPC | FB	No	F			90%	93.8%	94.3%
Theatres	Big Plan	DVFM-11	To improve theatre efficiency so that in session utilisation rates are no lower than 90%	M | T-D-S | FPC | FB	No	P			90%	74.9%	74.0%
Space utilisation	Big Plan	DVFM-12	To reduce non clinical floor space by 1%	A | T | FPC | JW	This indicator will be reported separately to board within the normal cycle of board business						
OP Follow Ups	Big Plan	DVFM-13	Reduce OP follow ups by 25%	M | T-D-S | FPC | FB	KPI Under Development						
Income	Big Plan	DVFM-14	To ensure that the income recovery processes are maintained in line with guidance and updated to reflect any changes in policy, achieving 100.0% recovery of agreed target	A | T | FPC | JW	This indicator will be reported separately to board within the normal cycle of board business						
Supplier payments	Big Plan	DVFM-15	To ensure all suppliers are paid in line with national guidance	M | T | FPC | JW	No				95%	95.6%	95%
Segment Three - Spend wisely (Effectiveness)												
GIRFT	Big Plan	DVFM-16	To reduce unwarranted variation as identified through GIRFT by 50% of agreed target	Q | T-D | FPC | GS	This indicator will be reported separately to board within the normal cycle of board business						
Non NHS income	Big Plan	DVFM-17	Increase volume and margins from Non NHS sources to deliver 15% margin	A | T | TB - FPC | JW	This indicator will be reported separately to board within the normal cycle of board business						
Controls	Big Plan	DVFM-18	To ensure all budgets deliver 100.0% of agreed target	M | T-D-S-C | FPC | JW-KS	No	-	-	-	<10%	24.01%	-
	Big Plan	DVFM-19	To ensure no posts are recruited to unless there is a corresponding budget	M | T-D-S-C | W | JW-KS	No	-	-	-	100%	100%	-
Agency costs	Big Plan	DVFM-20	To reduce agency costs to 2.9% of the total pay bill	M | T-D-S-C | W | SC-GS	No	-	-		2.9%	4.06%	-
Delivery of Revenue Plan	**Key Metric**	DVFM-21	To ensure 100% delivery of the Trust's revenue programme	M | T | FPC | JW	No	-	-		-1684	-14194	-
Capital	**Key Metric**	DVFM-22	To ensure 100% delivery of the Trust's Capital programme	M | T | FPC | JW	No	-	-	-	14945	31745	-
Buildings Maintenance	Big Plan	DVFM-23	To achieve a zero increase in Critical Infrastructure Risk	A | T | TB - FPC | JW	These indicator will be reported separately to board within the normal cycle of board business						
Improve CQC Use of resources compliance	Big Plan	DVFM-24	Deliver the improvement KPIs outlined in the report – TBC when developed	A | T-D | FPC | JW							
Introduce key supplier net promoter scores for key supplies	Big Plan	DVFM-25	Deliver the improvement KPIs outlined in the framework – TBC when developed	A | T-D | FPC | JW							

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	KS = Karen Swindley	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	JW = Jonathan Wood	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	FB = Faith Button	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee	SC = Sarah Cullen	ND = Naomi Duggan

Variation Icon \ Assurance Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better



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

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

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

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

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Segment One - Transform Services												
Clinical Services Strategy	**Key Metric**	FFTF-1	**To deliver the actions in the clinical services strategy, including addressing the challenges and opportunities of multi-site working.**	B | T-D | TB | GS		▭	▭	▭			
Communication and Engagement	Big Plan	FFTF-2	To deliver the actions in the Communications & Engagement strategy	B | T | FPC | ND		▲	▲	▲			
Digital Health	**Key Metric**	FFTF-3	**Deliver the agreed ICS Digital plan**	B | T | FPC | SD		▭	▭	▭			
Segment Two – System Leadership												
Collaboration and integration at System & Place	**Key Metric**	FFTF-4	**Maximise the effectiveness of system working and develop, agree and deliver the ICB and Provider Collaborative Board annual plan**	Q | T | TB | GD		▭	▭	▭			
Segment Three – Anchor Institute												
Social Value	Big Plan	FFTF-5	Deliver the actions identified in the Trust's Social Value Framework Achieve Level 1 accreditation	B | T | TB | GD		▲	▲	▲			
Segment Four – Develop our Infrastructure												
New Hospitals Programme	**Key Metric**	FFTF-6	**Deliver and implement plans as agreed**	M | T | FPC | JW							
Transforming Emergency flow	Big Plan	FFTF-7	Complete MAU expansion and / or deliver agreed benefits	M | T - D | FPC | GD		▭	▲	▭			
Segment Five – Drive Innovation												
Continuous Improvement & Transformation	**Key Metric**	FFTF-8	**Deliver Year two of the Trust's approved Continuous improvement strategy & review the strategy.**	B | T | TB | AB		▭	▭	▭			
	Key Metric	FFTF-9	**Deliver the agreed Transformation projects**	B | T | TB | AB		▼	▼	▼			
Research	Big Plan	FFTF-10	Deliver the outcomes identified in the Trust's Research Strategy	A-Q | T | ETR | KS		▲	▲	▲			
Education	Big Plan	FFTF-11	Deliver outcomes of the Trust's Education strategy	A-Q | T | ETR | KS		▲	▲	▲			
Innovation	Big Plan	FFTF-12	Further Increase the number of programmes being delivered through the Innovation Pathway	A-Q | T | ETR | KS		▲	▲	▲			

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	KS = Karen Swindley	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	JW = Jonathan Wood	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	FB = Faith Button	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee	SC = Sarah Cullen	ND = Naomi Duggan

Green on track

Amber off track

Red significantly off track/risk to delivery

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Big Plan metrics annual review			
Report to:	Trust Board	**Date:**	02/02/2023
Report of:	Director of Strategy & Planning	**Prepared by:**	Gary Doherty
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to update the Board on the progress to develop our Big Plan metrics.

At our previous meeting the Board received a draft set of metrics. As identified at the time, these metrics needed to be reviewed in the light of the national planning requirements for 2013/24, which were published on the 23rd December 2022. In the light of the national guidance it is proposed that following a discussion at the February Board meeting there are discussions within each Board sub committee in February, followed by further discussions at the Governors workshop and the Board workshop in March, before bringing the final metrics to the April Board.

It is recommended that:

I. *The Board discuss and note the contents of this paper, including the actions needed to finalise the Big Plan metrics*

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

Draft metrics were discussed at the December 2022 Board meeting.

1. **Background / context or introduction**

The Big Plan was launched in April 2019. In order that the Big Plan is a 'live' document, it is important that the metrics are regularly reviewed in light of current performance and the changing environment.

2. **Discussion**

The Big Plan metrics have been discussed during the year by Board members and Governors and were reviewed at the December Board meeting. Following those discussions, the national 2023/24 priorities and operational planning guidance were published on December 23rd (and have subsequently been followed by a number of more detailed technical documents).

The national guidance lays out the following key national tasks

- Recover our core services and productivity
- Make progress in delivering the ambitions in the Long Term Plan
- Continue transforming the NHS for the future

The document contains 31 specific recovery objectives which are listed at appendix 1 in this paper. Each of the specific recovery objectives also has a set of wide-ranging actions required to deliver them – an example of which is shown below using Urgent Care:

UC recovery objectives:

- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24
- Reduce adult general and acute (G&A) bed occupancy to 92% or below

Summary of UC supporting actions:

- Increase physical capacity to reflect demographics and health demand & permanently sustain the 7,000 beds funded through winter 2022/23
- Reduce medically fit to discharge patients
- Increase ambulance capacity & reduce handover delays
- Maintain clinically led System Control Centers
- Deliver the national UEC recovery plan (to be published)

As such both the 31 objectives and the supporting actions need to be reviewed for potential inclusion within the Big Plan metrics.

3. Next steps

The draft metrics brought to the December meeting had been developed/reviewed through our Board subcommittees. Each subcommittee has the opportunity in February to consider the 31 recovery objectives and the supporting actions in order to reach a final draft for the Big Plan metrics. The 7th March Board workshop will then give us the opportunity to review the outputs of those subcommittee discussions and to agree the final draft metrics for our Fit for the Future ambition which are a matter for Board. The workshop will also give us the opportunity to consider the evolving external

strategy/planning process and our responses to it. Governors will be engaged in a workshop in March before bringing the Big Plan metrics to the April Board meeting for final approval.

4. Financial implications

There are no financial implications directly associated with signing off the plan although the operational planning and budget setting process will need to support the delivery of the actions and trajectories contained within it.

5. Legal implications

There are no legal implications directly associated with signing off the plan.

6. Risks

There are no risks directly associated with signing off the plan. Risks associated with delivery of the plan will be articulated in the risk register, and the Big Plan process is a key part of or approach to Risk Management.

7. Impact on stakeholders

Engagement with all key stakeholders has informed the review of the Big Plan Metrics.

8. Recommendations

It is recommended that the Board discuss and note the contents of this paper, including the actions needed to finalise the Big Plan metrics

APPENDIX 1 – National Recovery Objectives

Area	Objective
Urgent Care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Community Health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
Primary Care	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of resources	Deliver a balanced net system financial position for 2023/24
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Mental Health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
	Increase the number of adults and older adults accessing IAPT treatment
	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services

	Work towards eliminating inappropriate adult acute out of area placements
	Recover the dementia diagnosis rate to 66.7%
	Improve access to perinatal mental health services
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
Prevention & Health Inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Continue to address health inequalities and deliver on the Core20PLUS5 approach

Chair's Report

Committee:	Audit Committee
Chairperson and role:	Tim Watkinson, Non-Executive Director
Date(s) of Committee meeting(s):	18 January 2023
Purpose of report:	To update the Board on the business discussed by the Audit Committee on 18 January 2023. The report includes recommended items from the Committee for approval by the Board; items where the Committee has gained assurance; and brings pertinent information to the Board's attention.

Committee Chair's narrative

The Committee received and scrutinised several reports which were standing items on the cycle of business, approved the minutes of the meetings from 22 September 2022, and reviewed updates on associated committee actions:

- Minutes and actions from the previous meeting
- Mersey Internal Audit Agency (MIAA) audit progress report
- Combined internal audit and anti-fraud follow-up summary report
- Counter-fraud progress updates including previous investigations

In addition, the Committee received, discussed, and was assured of reports for:

The Waiting List Management Review was intended to provide assurance that the organisation had effective controls in place for Waiting List Management and had been given a moderate risk rating.

Technical Update- an update to the Health Sector Technical Report

The Committee reviewed and noted the contents of the Losses and Special Payments report which looked at the Losses and Special Payments register and was presented for the nine-month period ending 31st December 2022.

A summary of the Single Tender Waiver Report was provided along with information regarding the spend value of tenders waived and instances where the Trust Standing Financial Instructions (SFIs) had been waived in accordance with the Trust Policy for the period of 1 September 2022 to 31 December 2022.

Committee Risk Review: Great Place to Work, provided the Audit Committee with an overview of the Strategic Risk to be a "Great Place to Work" and aimed to provide assurance that the Strategic Risk had key programmes of work in place to manage/mitigate/reduce the risk which was monitored through Workforce Committee and was reviewed regularly and responded to areas that needed to improve.

Clinical Audit Programme Update provided the Audit Committee with the assurance that robust systems and processes for managing national and local audit activity were in place and were demonstrated by the performance data included.

Annual Accounting Guidance and Year-End Issues provided the Committee with a summary of accounting issues that were required to be considered in the preparation of 2022/23 year-end financial statements.

Strategic Risk Report including High Operational Risk Summary provided the Audit Committee with an overview of the Strategic Risk Register which informed the Board Assurance Framework (BAF) and detailed the risks that may have compromised the achievement of the Trust's high-level strategic objectives.

Well-Led Plan Update provided the Audit Committee with an update on the progress of the Well-Led and Governance Maturity Plan 2021–2023.

Items for the Board's attention

Positive escalation

- Good debate and assurance provided by the Workforce Committee Risk Review
- Good progress was made with the implementation of the Internal Audit Recommendation
- A positive outcome of the HFMA Checklist
- Positive reporting and good progress made with the Clinical Effectiveness review
- The timeliness of Management Responses to the Audit Actions being taken to the Board/Public Board.
- Waiting List Audit, the positive assurances being taken in management and having the ability to address.

Negative escalation

- Risks around the delivery of the Internal Audit Programme (although assurances were received)

Committee to Committee escalation

- Charitable Funds Committee sought advice from the Audit Committee/MIAA to assure that it was operating within best practice standards and not at risk. There was uncertainty around it forming part of MIAA's audit plan but were happy to assist/support on a pro bono basis although unclear if it would be in the form of assurance or advice. The intention was to potentially start work in April with the scope of discussion to be determined.

Items recommended to the Board for approval

There were no items recommended for approval by the Board

Items where assurance was provided and/or for information

Internal Audit Progress Report
Technical Update Report
Losses and Special Payments Report
Committee Risk Review: Great Place to Work
Annual Accounting Guidance & Year End Issues
Clinical Audit Programme Update Report
MIAA Final Audit Reports

Progress against the Committee's cycle of business

The Committee continues to cover its business work in line with its cycle of business.
The next meeting of the Committee will take place on 20 April 2023 @ 10.30am Microsoft Teams

Recommendation:

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

Appendix 1 – Audit Committee agenda (18 January 2023)

Audit Committee

18 January 2023 | 10.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.00am	Verbal	Noting	T Watkinson
2.	Apologies for absence	10.01am	Verbal	Noting	T Watkinson
3.	Declaration of interests	10.02am	Verbal	Noting	T Watkinson
4.	Minutes of the previous meeting held 22 September 2022	10.03am	✓	Decision	T Watkinson
5.	Matters arising and action log	10.04am	✓	Noting	T Watkinson
6.	INTERNAL AUDIT				
6.1	Internal Audit progress report – i. Waiting List Management Review - E Ince) ii. HFMA Getting the Basics Right	10.10am	✓	Discussion	MIAA/ E Ince
6.2	Combined Internal Audit and Anti-Fraud follow-up summary report	10.35am	✓	Discussion	MIAA
7.	EXTERNAL AUDIT				
7.1	Technical update	10.45am	✓	Noting	KPMG
7.2	VFM 22/23 Risk Assessment Update	10.50am	✓	Noting	J Wood/J Foote
7.3	External Audit Plan and Fees	10.55am	✓	Decision	KPMG
8.	COUNTER-FRAUD				
8.1	Counter-Fraud Progress Update (including previous investigations)	11.05am	✓	Noting	MIAA
9.	GOVERNANCE AND COMPLIANCE / OTHER COMMITTEE BUSINESS				
9.1	Losses and special payments report	11.15am	✓	Noting	B Patel
9.2	Single tender waiver report	11.20am	✓	Noting	B Patel
9.3	Committee Risk Review: Great Place to Work	11.25am	✓	Discussion	K Swindley

№	Item	Time	Encl.	Purpose	Presenter
9.4	Annual accounting guidance and year-end issues (including consolidation and going concern)	11.35pm	✓	Noting	B Patel
9.5	Clinical Audit Programme Update	11.45pm	✓	Noting	C Morris
9.6	Strategic Risk Report including High Operational Risk Summary	11.55pm	✓	Discussion	S Regan
9.7	Well-Led Plan Update	12.05pm	✓	Discussion	S Regan
9.8	Items for escalation to the Board or referral to/from other Committees:	12.15pm	✓	Noting	T Watkinson/ J Foote
9.9	Reflections on the meeting and adherence to the Board Compact	12.25pm	✓	Discussion	T Watkinson
10.	ITEMS FOR INFORMATION				
10.1	**MIAA final audit reports**: a. Data Quality Management b. Critical Application – FM First c. Freedom to Speak Up Review		✓		
10.2	Date, time, and venue of next meeting *20 April 2023, 10.30 am, Microsoft Teams*	12.30pm	Verbal	Noting	T Watkinson

The Committee will hold a private meeting with representatives from **internal audit** following the meeting

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Good Governance Institute (GGI) Review			
Report to:	Board of Directors	**Date:**	2nd February 2023
Report of:	Chief Nursing Officer	**Prepared by:**	S. Regan
Part I	✓	**Part II**	

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

Executive Summary:

The Trust has an established Well-Led and Governance Maturity Plan 2021-2023, which was developed to drive improvement in the 'Well-Led' domain of the organisation and the aim to become an 'Outstanding' organisation.

The plan is supported by the Board development plan, which incorporates the Board Safety and Experience programme. It also includes where the Trust has instructed reviews to further guide the Trust in its attempts to become 'Outstanding' in the Well-Led domain.

The purpose of this report is for the Board of Directors to review and adopt the action plan in response to, the Risk and Assurance Review undertaken by the Good Governance Institute (GGI) from February 2022 to November 2022.

GGI shared the final report and recommendations for the Risk and Assurance Review; this was received and accepted by the Board of Directors at a Board Workshop in November 2022. The report was positive about the governance arrangements in place at the Trust and acknowledged that "*The Trust has demonstrated that it values good governance and has sought, and acted upon, external advice. It recognises that it has further to go on its journey of development. We hope that this report provides a road map for the rest of the journey. Our recommendations are practical and aim to achieve incremental progress rather than upheaval*".

In finalising the review, GGI noted that "*The ingredients of good governance are present but require some refinement and improvement. Ours is a supportive, developmental review which maps out a way forward for the Trust*".

The final report identified 26 recommendations for the Trust to consider, which were largely practical and supportive suggestions, recognising the maturing governance arrangements of the Trust. The Trust's response to the recommendations are attached at Appendix 1.

Where recommendations are not being taken forward at this time, the Trust are satisfied that this does not affect any legal, statutory, or regulatory requirements. In the Trust's approach to the management of its governance and risk framework, the Trust recognises that it will need to remain aware of the development of a system-wide approach to the same. The retention of a degree of flexibility to respond to an integrated approach at this time is therefore prudent, and the recommendations will be kept under review.

It is recommended that Board of Directors:

i. Note the outcome of the review from the Good Governance Institute (GGI).
ii. Confirm that they are assured of the Trust's response to the recommendations, and formally adopt the action plan.
iii. Note that completion of the actions will be monitored through the Well-Led and Governance Maturity plan, which is periodically reviewed by the Audit Committee.

Appendix 1 – Action Plan in response to the Good Governance Institute (GGI) Risk & Assurance Review

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

1. Background

1.1 In 2017, NHS England/Improvement (NHSE/I) and the Care Quality Commission (CQC) established a joint Well-Led Framework structured around eight key lines of enquiry which are utilised to consider 'Are services Well-Led?'.

1.2 The CQC carry out inspections of NHS Organisations in England utilising this framework and issue ratings both at core service levels (Medicine, Maternity etc.) and at Trust level. CQC last reviewed the Well-Led domain at the Trust in 2019 and the Trust was rated as 'Good'.

1.3 NHSE/I and CQC strongly encourage providers to use the framework to undertake developmental reviews as part of their own continuous improvement.

2. Discussion

Well Led and Governance Maturity Plan 2021-23

2.1 The Trust has an established Well-Led and Governance Maturity Plan 2021-2023, which was developed to drive improvement in the 'Well-Led' domain of the organisation and the aim to become an 'Outstanding' organisation.

2.2 The plan is supported by the Board development plan, which incorporates the Board Safety and Experience programme. It also includes where the Trust has instructed reviews to further guide the Trust in its attempts to become 'Outstanding' in the Well-Led domain.

2.3 The updated Well-Led and Governance Maturity Plan was presented to Audit Committee in January 2023.

Risk and Assurance Review – Good Governance Institute (GGI)

2.4 As part of the Board's approach to pursuing excellence in Governance and Risk Management, the Good Governance Institute (GGI) were commissioned to undertake a Risk and Assurance Review. The purpose of this report is for the Board of Directors to review and adopt the action plan in response.

2.5 The review took place between February 2022 and November 2022 and the principle objectives were initially to:

- Review the risk management process at a high level.
- Support the trust to ascertain and articulate its risk appetite and risk tolerance.
- Assess how assurance is provided to the Chief Executive as Accountable Officer and to the Board of Directors.

During the process of the review, the scope was extended to include:

- A review of the Senior Leadership Team (SLT) forums and structure, functions and supporting terms of reference.

2.6 The intended outcomes of the review included:

- Applicable risk appetite and risk tolerance statements for the Trust.
- Improved understanding of risk appetite and risk tolerance by committee Chairs and other members.
- Improved committee meetings informed by appropriate use of risk appetite/tolerance to inform decision-making.

- A strong platform for future development aligned to the Trusts strategy.

2.7 During the review, GGI facilitated a Board Workshop as a developmental piece of work to support the refresh of the organisation's view on Risk Tolerance and Risk Appetite. The outputs from this were agreed and incorporated into the Risk Management Policy, which was approved at the Board of Directors Meeting in August 2022.

2.8 GGI shared the final report and recommendations for the Risk and Assurance Review; this was received and accepted by the Board of Directors at a Board Workshop in November 2022. The report was positive and acknowledged that "*The Trust has demonstrated that it values good governance and has sought, and acted upon, external advice. It recognises that it has further to go on its journey of development. We hope that this report provides a road map for the rest of the journey. Our recommendations are practical and aim to achieve incremental progress rather than upheaval*".

2.9 In finalising the review, GGI noted that *"The ingredients of good governance are present but require some refinement and improvement. Ours is a supportive, developmental review which maps out a way forward for the trust".*

2.10 The final report identified 26 recommendations for the Trust to consider, which were largely practical and supportive suggestions, recognising the maturing governance arrangements of the Trust. The Trust's response to the recommendations are attached at Appendix 1. Completion of the actions will be monitored through the Well-Led and Governance Maturity plan, which is periodically reviewed by the Audit Committee.

2.11 Where recommendations are not being taken forward at this time, the Trust are satisfied that this does not affect any legal, statutory, or regulatory requirements. In the Trust's approach to the management of its governance and risk framework, the Trust recognises that it will need to remain aware of the development of a system-wide approach to the same. The retention of a degree of flexibility to respond to an integrated approach at this time is therefore prudent, and the recommendations will be kept under review.

3. Financial implications

3.1 There are no financial implications in implementing the recommendations.

4. Legal implications

4.1 The review did not identify any legislative or regulatory requirements that were not being met and there are no identified legal implications as a result of the Trust's response to this review.

5. Risks

5.1 The review undertaken was risk and assurance focussed. The recommendations and Trust response are included in Appendix 1.

6. Impact on stakeholders

6.1 Robust Risk Management reduces the negative impact on patients and staff and the reputation of the organisation.

7. Recommendations

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

i. Note the outcome of the review from the Good Governance Institute (GGI).
ii. Confirm that they are assured of the Trust's response to the recommendations, and formally adopt the action plan.
iii. Note that completion of the actions will be monitored through the Well-Led and Governance Maturity plan, which is periodically reviewed by the Audit Committee.

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Action Plan – GGI Risk & Assurance Review

Lead:	Simon Regan/Jennifer Foote
Position:	Associate Director of Risk & Assurance/Company Secretary

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Version	Date
1.0	05/01/2023

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
R1	The Trust's risk management strategy and policy should be updated to reflect the new risk appetite and tolerances.	• Risk Management Strategy to be converted to a Policy • Articulate new risk appetite and tolerances within revised document	Hajara Ugradar, Deputy Associate Director of Risk & Assurance	Complete	• Strategy changed to a Policy. • Updated to include new risk appetite and tolerances. • Policy approved at Trust Board of Directors meeting 4th August 2022	4
R2	The new risk appetite and risk tolerance should be widely communicated across the organisation, particularly to those who manage services.	• Share new policy and changes widely.	Hajara Ugradar, Deputy Associate Director of Risk & Assurance	Complete	• Policy and changes shared at Senior Leadership Team (SLT) meeting, Safety and Quality Committee, and Board of Directors. • Updates shared at Governance forum for divisional governance leads.	4
R3	The agreed risk appetite and risk tolerance should be applied as decision support tools and to enable delegation of matters which are clearly within the trust's agreed risk tolerance.	• Develop Risk Appetite & Tolerance Decision Support Document. • Decision Support document to be included as standing part of Committee Cycles of Business.	Simon Regan, Associate Director of Risk & Assurance & Jennifer Foote, Company Secretary	August 2023	• To be developed in line with next policy review and development of strategy (August 2023)	2
R4	The risk management strategy should be re-designated as a policy rather than a strategy.	• Risk Management Strategy to be converted to a Policy.	Hajara Ugradar, Deputy Associate Director of Risk & Assurance	Complete	• Strategy changed to a Policy. • Policy approved at Trust Board of Directors meeting 4th August 2022	4

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
R5	The policy should explain the 'four Ts' (treat, terminate, transfer and tolerate) as the different ways that a risk can be managed, and the circumstances in which each might be appropriate.	• Policy to be updated with this at the next scheduled update (August 2023)	Simon Regan, Associate Director of Risk & Assurance	August 2023	• Scheduled for next update (August 2023)	2
R6	The trust should develop a strategy for risk management in a separate document, setting out its objectives in relation to improving and embedding risk management over the coming years, and including an action plan with clear deadlines. This could be derived from the existing risk maturity plan.	• Develop a strategy for Risk Management	Simon Regan, Associate Director of Risk & Assurance	August 2023	• Scheduled to tie in with policy update (August 2023)	2
R7	The trust should establish a Risk Management Group, chaired by an executive director and with senior membership, to perform the functions currently exercised by the SLT in respect of risk management	• Introduce Risk Management Group • Establish Terms of Reference • Establish cycle of business	Simon Regan, Associate Director of Risk & Assurance	April 2023	• Scheduled to start in April 2023	2
R8	The trust should monitor the implementation of the new process for confidential 'part 2' risks to ensure that confidentiality is maintained, but also to ensure that only matters which are truly confidential are included in this section of the risk register.	• MIAA Audit of the confidential risk process in Q4, 2022/23. • Continue to be monitored by the Executive team at the Divisional Improvement Forums (DIFs)	Simon Regan, Associate Director of Risk & Assurance	March 2023	• MIAA Audit Terms of Reference in draft	2
R9	Those writing and reviewing papers for board committees should carefully consider the	• Report writing sessions have been delivered and are ongoing.	Jennifer Foote, Company Secretary, supported by Associate Director of	July 2023 to have completed all initial	• Report writing sessions have been delivered and are ongoing.	3

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status 1 2 3 4
	level of operational detail which is appropriate for this audience.		Risk & Assurance, and Associate Director of Safety & Learning	sessions and then Ongoing		
R10	As a general rule, reports should speak for themselves so that it is not usually necessary to include supporting documentation with the papers.	• Executive Directors to make the decision on what to include to ensure the balance between assurance and information included. • Explore an appropriate approach to managing the volume of information required to provide assurance supporting the paper presentation.	Jennifer Foote, Company Secretary	July 2023	• Ongoing – exploring MS Teams capabilities and financial position before considering externally supported meeting management system.	2
R11	The cover sheet should be used more consistently to summarise the key points from the paper to which it refers.	This will be covered as part of action in response to R9				
R12	Cover sheets should indicate by whom the paper has been reviewed before arriving at committee, and if it has previously been presented to any other committees or groups.	The current template fulfils this function and no further action is needed.				
R13	The board may wish to include the topics of effective scrutiny, and the difference between management and governance, in its board development programme.	• Topics to be included in the development programme for 23-24.	Jennifer Foote, Company Secretary	July 2023	• The Board Development plan is in the process of being refreshed and updated for 2023/24.	2
R14	The template for chairs' reports should be revised to replace positive and negative escalation with the 3As (Assure, Alert, Advise).	The current template provides for this and allows further flexibility for key issues to be reported. No further action is needed.				

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
R15	The practice of one board committee referring an issue to another should be renamed 'referral' in place of escalation.	• Change of language to identify that issues are 'referred' to another Committee rather than 'escalated'.	Jennifer Foote, Company Secretary	Complete	• Terminology changed and this action is now complete as of December 2022	4
R16	Non-executive directors should sit only on committees of the board and should not be members of management groups/committees.	Reviewed as part of national change to Non-Executive Director (NED) roles. There are some national recommendations, such as Ockenden, which support non-executive involvement in non-committee groups. The Board are satisfied with the posts in place, that are not committee related but will keep these under review.				
R17	A clinical effectiveness group should be established within a revised management committee structure (see recommendation R25).	The Executive Team have considered this and are satisfied that there is an overarching view of performance in the clinical effectiveness domain at Safety & Quality Committee. In the Trust's approach to the management of its governance and risk framework, the Trust will need to remain aware of the development of a system-wide approach to the same. The retention of a degree of flexibility to respond to an integrated approach at this time is therefore prudent and this will be kept under review.				
R18	The terms of reference of feeder groups to board committees other than the Safety and Quality Committee should be reviewed, and the most recent and next review dates should be shown on the terms of reference of each group.	• Update the terms of reference for feeder groups to include review dates	Simon Regan, Associate Director of Risk & Assurance	Jan 2024	• Update in line with relevant groups review date	2
R19	There should be a standard naming convention for board and management committees. The title 'committee' should be reserved for committees of the Board of Directors. The top tier of management committees should be styled 'groups' and the second tier and below as 'forums'.	The Executive Team have considered this and will revisit the naming convention should there be any future changes to the governance structure. In the Trust's approach to the management of its governance and risk framework, the Trust will need to remain aware of the development of a system-wide approach to the same. The retention of a degree of flexibility to respond to an integrated approach at this time is therefore prudent and naming conventions will be kept under review.				

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status (1 2 3 4)
R20	The Senior Leadership Team should develop a cycle of business derived from its terms of reference.	• Cycle of Business to be developed	Jennifer Foote, Company Secretary	Complete	• Cycle of Business complete and in place (December 2022)	4
R21a	The SLT's terms of reference will require review and updating to reflect changes to the management and committee structure recommended elsewhere in this report (see section 8g).	• Terms of reference updated in Dec-22 to reflect current arrangements. • Terms of reference to be reviewed again in line with introduction of Risk Management Group.	Jennifer Foote, Company Secretary	April 2023	• Terms of Reference to be review in April 2023	2
R21b	The SLT should usually be chaired by the Chief Executive.	• Terms of reference updated to reflect the Chief Executive as Chair.	Jennifer Foote, Company Secretary	Complete	• Complete • Terms of reference updated • First meeting held in new format 14th December 2022	4
R22	The trust should consider whether it would be appropriate to establish a separate group, reporting into the SLT with cross-divisional representation, to scrutinise and approve business cases.	The Executive Team have considered this and are satisfied that the arrangements currently in place meet this recommendation. The Strategic Planning Group scrutinises business cases and ensures they are of a standard to be considered for approval at the appropriate forum, either the Executive Management Team, Commissioners, or where values require it, the Board of Directors.				
R23	The trust should consider streamlining the membership of the SLT by requiring only one representative from each divisional triumvirate to attend.	The Executive Team have considered this and recommendation not supported due to the inclusive approach to leadership.				
R24	Management committees (or 'feeder groups' as they are often known at LTHTR) should be constituted as subcommittees of the SLT rather than of board committees, although they would still provide assurance reports to the board committees.	The Executive Team have considered this and are satisfied that there is an appropriate reporting route to the Senior Leadership Team (SLT) and Board sub-committees. In the Trust's approach to the management of its governance and risk framework, the Trust will need to remain aware of the development of a system-wide approach to the same. The retention of a degree of flexibility to respond to an integrated approach at this time is therefore prudent and this will be kept under review as governance arrangements continue to evolve.				

Ref	Recommendation	Key Actions	Lead	Deadline for action	Progress Update	Current Status 1 2 3 4
R25	The structure of management committees for quality and safety should be reconfigured, with a Quality and Governance Steering Group at the top, followed by three groups for patient safety, patient experience and clinical effectiveness.	The Executive Team have considered this and are satisfied that there is currently an effective governance structure with an overarching view of safety, quality, patient experience and effectiveness at Safety & Quality Committee. In the Trust's approach to the management of its governance and risk framework, the Trust will need to remain aware of the development of a system-wide approach to the same. The retention of a degree of flexibility to respond to an integrated approach at this time is therefore prudent and this will be kept under review.				

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Review of Standing Orders and Terms of Reference			
Report to:	Board of Directors	**Date:**	2 February 2023
Report of:	Company Secretary	**Prepared by:**	J Foote
Part I	✓	**Part II**	

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

Executive Summary:

Following the review of the Trust constitution in 2022 a review has been undertaken of the Standing Orders for the Board of Directors and the Terms of Reference of existing Trust and Board Committees to ensure that these are also consistent with statutory requirements and align with the constitution.

The proposed membership of Committees is presented as a separate document to sit alongside ToR.

The Scheme of Delegation and Reserved Powers, and Standing Financial Instructions are currently under review and will be brought for approval to a future meeting of the Board.

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. **Standing Orders**

Standing Orders are the byelaws or rules that the Board makes for the conduct of its business. They are ancillary to the constitution and require only the approval of Board to come into effect. The revised Standing Orders are set out at Appendix 1.

2. **Areas of Revision and Rationale**

Amendment	Rationale
Updated names, terminology and references throughout to comply with Health & Care Act 2022 and other legislation.	Required for the document to be compliant with statute.
Neatening of references and narrative to avoid duplication and allow for clarity of guidance.	The Standing Orders contained a number of areas of duplication and clauses which benefitted from more succinct drafting by Hempsons, but which did not alter the intent.
Additional wording to allow for alternate committee members and chair's approval for in-year amendments to committee membership.	The updated version will allow for a more agile process to respond to issues of quoracy as they may arise.
Removal of s.10 – Tender Regulations	These should sit within the Standing Financial Instructions and have been removed from the revised Standing Orders .

3. **Terms of Reference**

The revised ToR are set out as Appendix 2 to the report. The substance and remit of these remain unaltered. The ToR have been streamlined to remove unnecessary references to administration and business conduct (as these are also referenced in the Standing Orders), checked for consistency of format and house style and reflect revised quoracy provisions.

The Terms of Reference of the Nominations Committee have been revised to reflect its true position as a Committee of the Trust. The revision is now consistent with the requirements of the constitution, whilst continuing to reflect the position of the Trust to allow the Council of Governors to decide on the membership of governors on the Committee.

4. **Committee Membership**

This now sits as a separate document alongside the ToR to allow for in-year changes without the need to amend and approve the ToR. The proposed membership for 2023/24 is set out at Appendix 3.

5. **Financial implications**

Legal costs for advice and drafting by Hempsons.

6. **Legal implications**

The Terms of Reference and Standing Orders are part of the legal framework for the business of the Board.

7. **Risks**

A regular review of all framework documents ensures that the business of the Trust can be undertaken in a compliant and consistent manner.

8. **Impact on stakeholders**

Clear governance framework documents should have a positive impact.

9. **Recommendations**

The Board of Directors is recommended to approve the revised Standing Orders, Terms of Reference and Committee membership as set out as appendices to the report.

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

STANDING ORDERS – BOARD OF DIRECTORS

Excellent care with compassion

@LancsHospitals

CONTENTS

1. INTRODUCTION

1.1 Lancashire Teaching Hospitals NHS FT is a statutory body which became a public benefit corporation on 1 April 2005 following its authorisation as an NHS Foundation Trust.

1.2 The principal places of business of the Trust are:

- Chorley and South Ribble Hospital, Preston Road, Chorley, Lancashire, PR7 1PP
- Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, Lancashire, PR2 9HT

1.3 NHS Foundation Trusts are governed by Acts of Parliament, by their Constitutions and by terms of their provider licences ("the regulatory framework").

1.4 The functions of the Trust are conferred by the regulatory framework. As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

1.5 The regulatory framework requires the Board of Directors to adopt standing orders ("SOs") for the regulation of its proceedings and business.

2. INTERPRETATION

2.1 Save as permitted by law and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of standing orders (on which they shall be advised by the Secretary).

2.2 Any expression to which a meaning is given in the National Health Service Act 2006 ("2006 Act") (as amended) or in any Regulations or Orders made under the Act shall have the same meaning in the interpretation of these standing orders and in addition:

"Accounting officer"	is the officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
"Board of Directors" or "Board"	means the Chair, Non-Executive Directors, and Executive Directors collectively as a body.
"Budget"	means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
"Code of Governance"	means the *Code of governance for NHS provider trusts* (NHS England, October 2022) or any later version of the Code that may be published by NHS England from time to time.
"Council of Governors" or "Council"	means the Council of Governors of the Trust.
"Chair of the Trust" or "Chair"	is the person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" or "Chair" shall be deemed to include the Vice-Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Charity"	means Lancashire Teaching Hospitals NHS Foundation Trust Charity, established by trust deed dated 9 November 1995 as varied (registered charity number 1051194) and the Rosemere Cancer Foundation Charity (registered charity 1131583)
"Chief Executive"	means the chief officer of the Trust.
"Committee"	means a Committee of the Board of Directors or Trust.
"Constitution"	means the Constitution of the Trust.
"Executive Director"	means a member of the Board of Directors who holds an executive office of the Trust.
"Finance Director"	means the chief financial officer of the Trust.
"Funds held on trust"	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept. Such funds may or may not be charitable.
"HSCA"	means the Health and Social Care Act 2012.
"Licence"	means the licence granted to the Trust in accordance with Section 88 of the HSCA.
"Motion"	means a formal proposition to be discussed and voted on during the course of a meeting
"NHS England"	means the body corporate established pursuant to Section 1H(1) of the 2006 Act.
"Nominated officer"	means an officer charged with the responsibility for discharging specific tasks within the standing orders and/or standing financial instructions
"Non-Executive Director"	means a member of the Board of Directors who does not hold an executive office of the Trust, including the Chair.
"Officer"	means an employee of the Trust.
"Secretary" or "Company Secretary"	means a person appointed by the Trust to act independently of the Board, to provide advice on corporate governance issues to the Board and the Chair and to monitor the Trust's compliance with the law, these standing orders and the regulatory framework.
"Senior Independent Director"	is the Non-Executive Director appointed to fulfil the role of senior independent director as described in the Code of Governance.
"SOs"	means these standing orders.

"Trust"	means Lancashire Teaching Hospitals NHS Foundation Trust.
"Vice Chair"	means the Non-Executive Director appointed by the Board of Directors to take on the Chair's duties if the Chair is absent for any reason.

3. THE TRUST

3.1 All business shall be conducted in the name of the Trust.

3.2 All funds received in trust shall be held by the Trust as corporate trustee on behalf of the Charity. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised by the Trust in respect of its exchequer funds.

3.3 The Trust has resolved that certain powers and decisions may only be exercised or made by the board in formal session. These powers and decisions are set out in "reservation of powers to the board" and have effect as if incorporated into these standing orders.

Composition of the Board of Directors

3.4 In accordance with the Constitution the composition of the Board of the Trust shall be:

3.4.1 The Chair of the Trust

3.4.2 Up to 7 other Non-Executive Directors

3.4.3 Up to 6 Executive Directors including:

- the Chief Executive (the Chief Officer)
- the Finance Director (the Chief Finance Officer)
- the Medical Director who shall be a registered medical practitioner or a registered dentist
- a Nursing Director, who is to be a registered nurse or registered midwife.

Appointment of the Chair and Non-Executive Directors

3.5 In accordance with the Constitution, the Chair and the other Non-Executive Directors are appointed and removed by the Council of Governors at a general meeting. A Nominations Committee shall be established, which will be chaired by the Chair or the Vice-Chair or, in their absence, another non-executive director. The Nominations Committee will be constituted in accordance with its terms of reference, as amended from time to time.

3.6 In accordance with the Constitution the Non-Executive Directors of the Trust will appoint and remove the Chief Executive. The appointment of the Chief Executive requires the approval of the Council of Governors.

3.7 In accordance with the Constitution the Board shall establish a committee consisting of the Chair, the Chief Executive, and the other Non-Executive Directors to appoint or remove the Executive Directors (other than the Chief Executive) and the Company Secretary.

Terms of office of the Chair and Non-Executive Directors

3.8 The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors.

Terms and conditions of Executive Directors

3.9 The Board shall appoint a committee of non-executive directors (which shall be known as the Appointments, Remuneration and Terms of Employment Committee of Non-Executive Directors) to decide the terms and conditions of office, including remuneration and allowances, of senior staff.

Appointment of Vice Chair

3.10.1 For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair, the Board of Directors may appoint a Non-Executive Director to be Vice-Chair for such a period, not exceeding the remainder of their term as Non-Executive Director of the Trust, as they may specify on appointing them. If the Chair is unable to discharge their office as Chair of the Trust, the Vice-Chair of the Board of Directors shall be acting Chair of the Trust.

3.10.2 Any Non-Executive Director so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Board of Directors of the Trust may thereupon appoint another Non-Executive Director as Vice-Chair in accordance with SO 3.10.1.

Powers of Vice-Chair

3.11 Where the Chair of the Trust has died or has otherwise ceased to hold office or where they have been unable to perform their duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in these standing orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Vice-Chair.

Appointment of Senior Independent Director

3.12 The Board of Directors will appoint one of the Non-Executive Directors to be the Senior Independent Director, in consultation with the Nominations Committee. The Senior Independent Director shall be available to members and Governors if they have concerns, which contact through normal channels has failed to resolve or for which such contact is inappropriate. They will also have a key role in the appraisal process for the Chair of the Trust. The Senior Independent Director may be the Vice-Chair.

4. MEETINGS OF THE TRUST

Calling meetings

4.1.1 Ordinary meetings of the Trust shall be held at such times and places as the Board may determine.

4.1.2 The Chair may call a meeting of the Board of Directors at any time. Meetings of the Board of Directors may also be called by the Secretary. Four Directors may request the secretary to call a meeting of the Board of Directors by giving written notice to the secretary requesting that a meeting is called and specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after the receipt of such a request. The Secretary shall call a meeting on at least fourteen (14) but not more than twenty-eight (28) days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chair or four Directors shall call such a meeting.

Admission of the public and the press

4.2.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

4.2.2 Attendance at Board meetings carries no right to ask questions or otherwise participate in the meeting.

Conduct of meetings

4.3 The Chair shall give such directions as they think fit in regard to the arrangements for meetings and the accommodation of the public and representatives of the press to ensure that business can be conducted without interruption and disruption. This will include exclusion of the public and press representatives for special reasons and adjournment of the meeting, if required, to enable business to be completed without the presence of the public or press.

Notice of meetings

4.4.1 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen (14) days' written notice of the date and place of every meeting of the Board to all Directors. The notice of the meeting shall specify the business proposed to be transacted at it and shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. The Secretary shall send a written notice to all Directors by e-mail to any e-mail address provided for that purpose by such Director.

4.4.2 Subject to SO 4.4.4, lack of service of the notice on any Director shall not affect the validity of a meeting.

4.4.3 In the case of a meeting called by Directors or the Chair in default of the Secretary, the notice shall be signed either by four Directors or the Chair and no business shall be transacted at the meeting other than that specified in the notice.

4.4.4 In the case of a meeting called by four Directors or the Chair in default of the Secretary, failure to serve a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

4.4.5 Agendas will be sent to the Directors before each meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in the case of emergencies or the need to conduct urgent business.

Setting the agenda

4.5.1 The agenda for all the meetings of the Board will be prepared by the Chair and Chief Executive, assisted by the Secretary.

4.5.2 The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

4.5.3 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least ten clear days before the meeting, subject to SO 4.4.1. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 7 days before a meeting may be included on the agenda at the discretion of the Chair.

Chair of meeting

4.6.1 At any meeting of the Board, the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice-Chair, if there is one and they are present, shall preside. If the Chair and Vice Chair are absent such Non-Executive Director as the Directors present shall choose shall preside.

4.6.2 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from

participating, such Non-Executive Director as the Directors present shall choose shall preside (but see Paragraph 4.20.1 in relation to quorum)

Annual Members' Meeting

4.7 In accordance with the Constitution, the Trust will hold an annual members' meeting within nine months of the end of each financial year.

Notices of Motion

4.8 A Director of the Trust desiring to move or amend a motion shall send a written notice thereof at least seven clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 4.4.3.

Withdrawal of motion or amendments

4.9 The proposer may withdraw a motion or amendment, once moved and seconded, with the concurrence of the seconder and the consent of the Chair.

Motion to rescind a resolution

4.10 Notice of motion to amend or rescind any resolution, which has been passed within the preceding six calendar months, shall bear the signature of the Director who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Board, it shall not be possible for any Director other than the Chair to propose a motion to the same effect within six months. However the Chair may do so if they consider it appropriate.

Motions

4.11.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any consequent amendment to it.

4.11.2 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- an amendment to the motion.
- the adjournment of the discussion or the meeting.
- that the meeting proceed to the next business. (*)
- the appointment of an ad hoc sub-committee to deal with a specific item of business.
- that the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

Chair's ruling

4.12 Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

Voting

4.13.1 If a question is put to the vote, it shall be determined by a majority of the votes of the Directors present and voting on the question. In the case of any equality of votes, the Chair of the meeting shall have a second or casting vote.

4.13.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

4.13.3 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.13.4 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.13.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.13.6 An officer who has been appointed formally by the Board to act up for an Executive Director shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board to represent an Executive Director without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

Participation in meetings

4.14 The members of the Board of Directors may participate in meetings of the Board of Directors by means of telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting.

Minutes

4.15.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

4.15.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.15.3 Minutes shall be circulated in accordance with the Directors' wishes. Where the minutes are a record of a meeting held in public, they shall be made available to the public.

Job-share Executive Directors

4.16 Where a post of Executive Director is shared by more than one person:

- either or both persons shall be entitled to attend meetings of the Board
- either of those persons shall be eligible to vote in the case of agreement between them
- in the case of disagreement between them, no vote shall be cast
- the presence of either or both of those persons shall count as one person for the purposes of SO 4.20 (Quorum)

Suspension of Standing Orders

4.17.1 Except where this would contravene any statutory provision or any related direction, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Directors are present. This shall include at least two Executive Directors and two Non-Executive Directors and a majority of those present must vote in favour of suspension.

4.17.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

4.17.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

4.17.4 No formal business may be transacted while SOs are suspended.

4.17.5 The Audit Committee shall review any decisions to suspend SOs.

Variation and amendment of Standing Orders

4.18 These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 4.8 has been given; and
- no fewer than half of the Trust's Non-Executive Directors vote in favour of amendment; and
- at least two-thirds of the Directors are present; and
- the variation proposed does not contravene a statutory provision or direction

Attendance

4.19.1 The names of the Directors present at the meeting shall be recorded in the minutes.

4.19.2 The minimum level of attendance at meetings of the Board and its Committees (with any absence due to ill health or exceptional circumstances to be recognised) is 75% for all Board members per annum.

Quorum

4.20.1 Four Directors, including at least two Executive Directors (one of whom must be the Chief Executive or their nominee) and at least two Non-Executive Directors (one of whom must be the Chair or the Vice-Chair) shall form a quorum.

4.20.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

4.20.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 8) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

Written resolutions

4.21. The Board of Directors may use the process for proposing/ adopting a written resolution set out in SOs 4.22 and 4.23 to enable them to transact business between meetings of the Board of Directors. This process shall not be used to replace meetings of the Board of Directors.

Proposing written resolutions

4.22.1 At the Chair's request, the Secretary shall propose a written resolution to the Directors.

4.22.2 A written resolution is proposed by giving notice of the proposed resolution to the Directors. Such notice shall stipulate:

(a) the proposed resolution; and

(b) the long-stop date by which the written resolution is to be adopted, which shall be not less than ten (10) days from the date the written resolution is dispatched by the secretary.

4.22.3 Notice of a proposed written resolution must be given in writing to each Director. Notice by e-mail or post is permitted.

Adopting written resolutions

4.23.1 A proposed written resolution shall be adopted when it has been signed and returned to the Secretary by e-mail or post by a majority of the Directors.

4.23.2 For the avoidance of doubt, the proposed written resolution shall lapse if it has not been signed and returned by the requisite number of Directors pursuant to SO 4.23.1 above, by the long-stop date.

4.23.3 Once a written resolution has been adopted, it shall be treated as if it had been a decision taken at a Board of Directors' meeting in accordance with these Standing Orders.

4.23.4 The Secretary shall ensure that the Trust keeps a record, in writing, of all written resolutions for at least six (6) years from the date of their adoption.

5. RESOLUTION OF DISPUTES BETWEEN THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS

5.1 Should a dispute arise between the Council of Governors and the Board of Directors then the disputes resolution procedure set out below shall be followed.

5.2 The Chair, or Senior Independent Director (if the dispute involves the Chair), shall first endeavour, through discussion with governors and Directors or, to achieve the earliest possible conclusion, representatives appointed by them to act on their behalf for these purposes, to resolve the matter to the reasonable satisfaction of both parties. The senior independent director shall also be available to governors and directors if they have concerns which contact through normal channels has failed to resolve or for which normal contact is inappropriate.

5.3 Failing resolution under SO 5.2 above, the Chair or the Senior Independent Director may propose such further steps as they consider appropriate to try and resolve the dispute, for agreement by the parties.

6. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6.1 The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee of Directors or by an Executive Director of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit.

Emergency powers

6.2 The powers which the Board has retained to itself within these Standing Orders (SO 3.3) may in emergency be exercised by the Chief Executive and the Chair. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

Delegation to Committees

6.3 The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees which it has formally constituted. The Board shall approve the Constitution and terms of reference of these Committees or sub-committees.

Delegation to Executive Directors

6.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Executive Directors to undertake the remaining functions for which they will still retain an accountability to the Board.

6.4.2 The Chief Executive shall prepare a scheme of delegation, which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the scheme of delegation which shall be considered and approved by the Board as indicated above.

6.4.3 Nothing in the scheme of delegation shall impair the discharge of the direct accountability to the Board of the Chief Executive or other Executive Director to provide information and advise the Board in accordance with any statutory requirements or requirements of NHS England.

6.4.4 The arrangements made by the Board as set out in the Reservation of Powers to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

7. COMMITTEES

Appointment of Committees

7.1 The Board of Directors may delegate any of its powers to a Committee of Directors.

7.2 The Board may appoint committees consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust for any purpose that is calculated or likely to contribute to or assist it in the exercise of its powers but it may not delegate the exercise of any of its powers to any such committee.

7.4 The standing orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees of the Trust.

7.5 Each Committee of the Trust shall have such terms of reference and powers and be subject to such conditions as the Board shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

7.6 The Board shall approve annually the appointments to each of the Committees which it has formally constituted. Should an amendment to the membership of any Committee be required outside the annual review, the Chair shall authorise such amendment.

7.7 Alternate members may attend meetings of Committees in order to aid quoracy providing the alternate member has the same standing as the member they act for.

7.8 Where the Trust is required to appoint persons to a Committee and/or to undertake statutory functions as required by NHS England, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with applicable statute and regulations and with the guidance issued by NHS England.

7.9 The Committees established by the Board as at the date of this document are:

- Appointments, Remuneration and Terms of Employment
- Audit
- Charitable Funds
- Education, Training and Research
- Finance and Performance
- Safety and Quality
- Workforce

The Board may establish other committees from time to time as it sees fit.

Confidentiality

7.10.1 A member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board or shall otherwise have concluded on that matter.

7.10.2 A Director of the Trust or a member of a Committee shall not disclose any matter reported to the Board or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee shall resolve that it is confidential.

8. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Declaration of Interests

8.1.1 Directors shall comply with the provisions relating to declaration of interests set out in the Constitution. All current Directors shall declare any interests that are required to be declared under the Constitution. Any new Directors who are appointed shall do so on appointment.

8.1.2 If Directors have any doubt as to whether an interest should be disclosed, they should discuss this with the Chair.

8.1.3 At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring. It is the responsibility of each Director to declare any interest that needs to be declared in accordance with the Constitution to the Secretary, in writing, within seven days of such interest arising.

8.1.4 Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

8.1.5 During the course of a Board meeting, if a conflict of interest is established the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on an issue where a conflict is established. If there is a debate as to whether a conflict of interest does exist, the majority will resolve the issue, with the Chair having the casting vote.

8.1.6 SO 8 applies to a Committee of the Board as it applies to the Board and applies to any member of any such Committee (whether or not they are also a Director) as it applies to a Director.

Register of Interests

8.2.1 In accordance with the Constitution, the Secretary will ensure that a register of interests is established to record formally declarations of interests of Directors. In particular the register will include details of all Directorships which have been declared by both Executive and Non-Executive Directors.

8.2.2 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding twelve months will be incorporated.

8.2.3 The register will be available to the public and the Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

9. STANDARDS OF BUSINESS CONDUCT

Policy

9.1 Staff and Directors must comply with the Trust's Code of Business Conduct, the requirements of the regulatory framework (including the Constitution and the Scheme of Delegation) and any guidance and directions issued by NHS England. The following provisions should be read in conjunction with these requirements.

Interest of Directors/Officers in contracts

9.2.1 A Director or officer of the Trust must notify the Chief Executive in writing if it comes to their knowledge that the Trust has entered, or proposes to enter, into a contract in which they have a pecuniary interest, but are not a party to the contract. They will also notify the Chief Executive if they are aware that a co-habiting partner or relative has a pecuniary interest in a contract entered into or proposed to be entered into by the Trust.

9.2.2 An officer must also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a cohabiting partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. A register of declared interests of staff shall be kept and maintained by means of an annual review.

Canvassing of and recommendations by Directors in relation to appointments

9.3.1 Canvassing of Directors of the Trust or members of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

9.3.2 A Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

9.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the Panel or Committee.

Relatives of Directors or Officers

9.4.1 Candidates for any staff appointment shall, when making application, disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

9.4.2 The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a known candidate.

9.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office under the Trust.

9.4.4 Where the relationship of an officer or another Director to a Director of the Trust is disclosed, then SO 8 shall apply.

9.4.5 Relationships to which this standing order applies are those of father, mother, child, grandchild, brother, sister, aunt, uncle, nephew or niece of the member, their spouses or partners living together.

10. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

Custody of seal

10.1 The common seal of the Trust shall be kept by the Company Secretary in a secure place.

Sealing of documents

10.2.1 Before any document is sealed, (as detailed in SO 10.2.2) it must be approved and signed by the Chair (or a Non-Executive Director nominated by them) and authorised and countersigned by the Chief Executive (or an officer nominated by them who shall not be within the originating Directorate).

10.2.2 The common seal must be used for the following documents

(a) contracts for building and engineering works above the limits set out in the scheme of delegation;

(b) leases in accordance with the limits as defined in the Trust's scheme of delegation;

(c) documents executed as a deed

(d) any other documents, having received the appropriate advice e.g. from a solicitor.

Register of sealing

10.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors on an annual basis. (The report shall contain details of the seal number, the description of the document and date of sealing).

11. SIGNATURE OF DOCUMENTS

11.1 Where the signature of any document is required to initiate or defend legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

11.2 The Chief Executive or nominated officers shall be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or Committee to which the Board has delegated appropriate authority.

11.3 For clinical negligence claims the authorised signatory for Court documents is the Nursing Director.

12. MISCELLANEOUS

Standing orders to be given to Directors and officers

12.1 It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within these Standing Orders and the Trust's Standing Financial Instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

Documents having the standing of standing orders

12.2 Standing Financial Instructions and the Scheme of Delegation and Reservation of Powers to the Board shall have the effect as if incorporated into these SOs.

Review of standing orders

12.3 These Standing Orders shall be reviewed every three years by the Trust. The requirement for review extends to all documents having the effect as if incorporated in the SOs.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
APPOINTMENT, REMUNERATION AND TERMS OF EMPLOYMENT (ARTE) COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Appointment, Remuneration and Terms of Employment Committee ("the Committee") is constituted as a standing Committee of the Board of Directors ("the Board").

1.2 The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

1.5 When appointing the Chief Executive, the Committee shall be the Committee described in schedule 7, paragraph 17(3) of the National Health Service Act 2006 ("the 2006 Act"). When appointing the other executive directors, the Committee shall be the Committee described in schedule 7, paragraph 17(4) of the 2006 Act.

2. MAIN PURPOSE

2.1 The Committee shall be responsible for identifying and appointing candidates to fill all the executive director positions on the Board, and also for those posts designated as senior staff posts ("the senior staff"), and for determining their remuneration and other conditions of service.

2.2 The Committee shall be responsible for ongoing review of the performance and remuneration of executive directors and senior staff appointed by the Committee as detailed in section 6 below.

3. RECRUITMENT AND APPOINTMENTS

3.1 The Committee shall:

3.1.1 Agree those posts which will be designated senior staff posts.

3.1.2 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board, and to the Nominations Committee Trust as applicable with regard to any changes.

3.1.3 Give full consideration to succession planning for the Chief Executive and other executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

3.1.4 Be responsible for agreeing to appoint to new Senior posts including the level of remuneration.

3.1.5 Identifying and appointing candidates to fill posts within its remit as and when they arise.

3.16 Approve the hosting of senior posts as may be required as part of any collaborative or system-wide initiative (though this will not extend to the approval of terms and conditions, role specification, candidate requirements, interviewing of candidates and offer of employment).

3.1.6 When a vacancy is identified, the Committee shall consider the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

3.1.7 Ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise.

3.1.8 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

3.1.9 Consider any matter relating to the continuation in office of any executive director, including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

4. REMUNERATION AND TERMS OF EMPLOYMENT

4.1 The Committee shall:

4.1.1 Establish and keep under review a remuneration policy in respect of executive directors and the senior staff.

4.1.2 Consult the Chief Executive about proposals relating to the remuneration of the executive directors and the senior staff.

4.1.3 Receive a formal report from the Chairman on the annual performance of the Chief Executive as part of the annual appraisal process. The report will be used to support decision-making in terms of the annual salary review for the Chief Executive.

4.1.4 Receive a formal report from the Chief Executive on the annual performance of individual executive directors and senior managers' performance as part of the annual appraisal process. The report will be used to support decision-making in terms of the annual salary review for officers identified in section 6 below.

4.1.5 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the executive directors and senior staff, including (without limitation):

4.1.5.1 salary review on an annual basis, including a review of any performance-related pay or bonus

4.1.5.2 other terms and conditions such as benefits (including pensions and cars), allowances, payable expenses and compensation payments.

4.1.6 In adhering to all relevant laws, regulations and Trust policies:

4.1.6.1 establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust;

4.1.6.2 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors and senior managers on locally-determined pay, while ensuring that increases are not made where Trust or individual performance do not justify them; and

4.1.6.3 be sensitive to pay and employment conditions elsewhere in the Trust.

4.1.7 Monitor and assess the output of the evaluation of the performance of individual executive directors and consider this output when reviewing changes to remuneration levels.

4.1.8 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

4.1.9 The Committee shall receive and agree a description of the work of the Committee, its policies and all executive director emoluments in order that these are accurately reported in the required format in the annual report and accounts.

5. MEMBERSHIP

5.1 The membership of the Committee shall consist of all voting Non-Executive Directors.

5.2 The Chair~~man~~ shall Chair the Committee. In his or her absence, the Committee shall be Chaired by the Vice Chair.

5.3 A quorum shall be three non-executive directors, including either the Chair or Vice-Chair.

6. THE EXECUTIVE DIRECTORS AND THE SENIOR STAFF

6.1 The executive directors of the Trust are:

- Chief Executive
- Chief Finance Officer

- Chief Nursing, Midwifery and AHP Officer
- Chief Medical Officer
- Chief Operating Officer
- Chief People Officer

6.2 The senior staff posts are:

- Director of Continuous Improvement
- Director of Strategy and Planning
- Director of Communication
- Chief Information Officer for the ICP
- Company Secretary

7. SECRETARY

7.1 The Company Secretary or nominee shall act as Secretary to the Committee.

8. ATTENDANCE

8.1 Only members of the Committee, the Chief Executive, the Chief People Officer and the Company Secretary have the right to attend Committee meetings.

8.2 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

8.3 Any non-member will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

9. FREQUENCY OF MEETINGS

9.1 Meetings shall be called as required but at least twice in each financial year.

10. MINUTES AND REPORTING

10.2 The minutes of meetings will be circulated with the agenda for approval at the next Committee meeting. Due to the nature of the business discussed by the Committee, circulation of the minutes shall be restricted to Committee members and those in attendance. No officer shall receive any minute as it relates to their own employment or post.

11. PERFORMANCE EVALUATION

11.1 As part of the Board's annual performance review process, the Committee shall review its collective performance.

12. DELEGATED AUTHORITY

12.1 The Committee is authorised by the Board to:

i. investigate any activity within its terms of reference;
ii. seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee; and

iii. obtain independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
iv. Make decisions relating to the remuneration, terms and conditions of service of named senior posts as set out in these terms of reference

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
AUDIT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 In accordance with the Trust's Constitution and as set out in the NHS Foundation Trust Code of Governance, the Board of Directors hereby resolves to establish a Committee of Non-Executive Directors as an Audit Committee.

1.2 The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. MEMBERSHIP

2.1 The Audit Committee of Lancashire Teaching Hospitals NHS Foundation Trust shall consist of at least four of the Non-Executive Directors, not including the Trust Chairman, although he/she can be required to attend meetings where the issues discussed are relevant to the whole Board or to the Chair directly.

3. ATTENDANCE

3.1 The Chief Finance Officer, the Director of Operational Finance, the Company Secretary and the Associate Director of Risk and Assurance shall normally attend meetings.

3.2 At any time (and in any event at least once per year) the Committee shall meet privately with the External and Internal Auditors without any executive board member present.

3.3 The Chief Executive shall be required to attend when the Audit Committee discuss the process for assurance that supports the Annual Governance Statement.

3.4 Other executive directors will be invited to attend as appropriate.

3.4 Minutes shall be taken by the Corporate Affairs Team.

4. AUTHORITY

4.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

4.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

4.3 Where the Audit Committee feels that there is evidence of *ultra vires* transactions, evidence of improper acts or if there are other important matters that the Committee wishes to raise, the Chair of the Committee will raise these at a full meeting of the Board of Directors and, if appropriate, exceptionally to any relevant external agency.

5. DUTIES

5.1 The duties of the Committee are as follows:

5.2 Governance, Risk Management and Internal Control

5.2.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management (including review of the Trust Risk Register) and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

5.2.2 In particular, the Committee will review the adequacy of:

i. all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with Care Quality Commission standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
ii. the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
iii. arrangements for the review of policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements (for the avoidance of doubt, the Committee shall not take primary responsibility for reviewing such policies)
iv. the policies and procedures for all work related to fraud and corruption as set out in the NHS Standard Contract and as required by NHS Counter Fraud Authority.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

5.2.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

5.3 Internal Audit

5.3.1 The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

i. Consideration of the provision of the Internal Audit service, the cost of the audit and any questions or resignation and dismissal.
ii. Review and approval of the Internal Audit and Counter Fraud strategy, operational plan and more detailed programme of work, ensuring that this is consistent with

the audit and counter fraud needs of the organisation as identified in the Assurance Framework.

iii. Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources.

iv. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

v. Annual review of the effectiveness of internal audit.

5.4 **External Audit**

5.4.1 The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

i. Consideration of the appointment and performance of the External Auditor.

ii. Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.

iii. Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

iv. Review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work undertaken in addition to the annual Audit Plan, together with the appropriateness of management responses.

5.4.2 At least once in each five-year period, the Committee shall oversee the market-testing of the external audit contract~~, in conjunction with the Council of Governors~~.

5.4.3 The Committee shall be responsible for making recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of the External Auditor.

5.4.4 The Committee shall also prepare and maintain a policy on the supply of non-audit services to the Trust by the External Auditor.

5.5 **Clinical Audit**

5.5.1 The Committee will receive on an annual basis a written report outlining the progress and completion of actions associated with national, regional and local clinical audits.

5.6 **Counter Fraud**

5.6.1 The Audit Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. In so doing this the Audit Committee will:

i. consider the provision of the LCFS service;

ii. review and approve the annual LCFS work plan;

iii. review the periodic LCFS status reports; and

iv. review and approve the annual LCFS report.

5.7 **Other assurance functions**

5.7.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

5.7.2 These will include, but will not be limited to, any reviews by Department of Health Arms' Length Bodies or Regulators/Inspectors, such as the Care Quality Commission, NHS Resolution and other appropriate agencies, as well as professional bodies with responsibility for the performance of staff or functions such as the Royal Colleges and relevant accreditation bodies.

5.7.3 In addition, the Committee ~~will~~ may review the work of other Committees within the organisation, ~~whose work can~~ in order to provide relevant assurance to the Audit Committee's own scope of work.

5.8 **Management**

5.8.1 The Committee may request and review reports and positive assurances from Directors and managers on the overall arrangements for governance, risk management and internal control.

5.9 **Financial Reporting**

5.9.1 The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

i. the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
ii. changes in, and compliance with, accounting policies and practices
iii. unadjusted mis-statements in the financial statements
iv. significant adjustments resulting from the audit

5.9.2 The Committee ~~should~~ shall also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

6. RELATIONSHIP WITH BOARD/REPORTING ARRANGEMENTS

6.1 The minutes of Audit Committee meetings shall be formally recorded by the Company Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

6.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the effectiveness of risk management in the organisations, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission standards.

6.3 The Committee shall also produce a report for inclusion within the Trust's Annual Report on such areas as may be prescribed by NHSE from time to time.

7. QUORUM

7.1 A quorum shall be three Non-Executive Directors.

8. FREQUENCY OF MEETINGS

8.1 Meetings shall be held not less than four times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

9. REVIEW

9.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
CHARITABLE FUNDS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 Lancashire Teaching Hospitals NHS Foundation Trust is the Corporate Trustee of the group of charitable funds registered with the Charities Commission under the name of Lancashire Teaching Hospitals Charity with the charity registration number 1051194 and under the name of the Rosemere Cancer Foundation Charity with the charity registration number 1131583 (together referred to herein as "the Charities"). The directors of the Corporate Trustee are not Trustees; however, they act on behalf of the Corporate Trustee. The Charities are separate from the Trust and independent of it. The Corporate Trustee can delegate certain powers to agents and/or employees but will always retain the ultimate responsibility for the management of the Charities.

1.2 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Charitable Funds Committee (hereinafter referred to as "the Committee"). The Committee will oversee the Charities' operation on behalf of the Corporate Trustee and report directly to it. Its constitution and terms of reference shall be set out below, subject to amendment from time to time.

1.3 In these terms of reference:

i. "Board" means the Board of Directors as specified in the Trust's Constitution.
ii. "Director" means those directors appointed to the Board by virtue of paragraph 12.2 of the Trust's Constitution.
iii. "Member" refers to a member of the Committee as specified at paragraph 3.1 of these terms of reference.

2. PURPOSE

2.1 The overall purpose of the Committee is to oversee the operation of the Charities to ensure they are managed and operated in accordance with their governing documents and comply with relevant legislation and guidance from the Charities Commission.

2.2 Specifically, the Committee shall:

i. Determine fundraising strategies for the Charities that are aligned with the Trust's priorities.

ii. Consider any application for the creation of any new fund within the Charities or for any re-designation of monies between funds (where in excess of £30,000).

iii. Decide whether donations given with restrictions applied should be accepted by the Charities or whether the Corporate Trustees applies restrictions.

iv. Receive reports detailing the establishment of new funds and all new staff appointments made from charitable funds.

v. Receive reports detailing balances of the charitable funds.

vi. Receive reports on all individual charitable non-pay transactions in excess of £10,000.

vii. Approve expenditure of all individual charitable non-pay transactions valued £30,000 or more. Where there is an urgent requirement for an order to be placed, the equivalent of a quorum may give approval by email and the decision recorded at the next Committee meeting.

viii. Review the spending plans and balances held within individual charitable funds.

ix. Recommend the appointment of Investment Managers to provide investment advice and manage the Charities' investment portfolios.

x. In conjunction with Investment Managers, agree an investment policy which lays down guidelines in respect of:

- the balance required between income and capital growth;
- the balance of risk within the portfolio; and
- any categories of investment which the Corporate Trustee does not wish to include in the portfolio on ethical grounds.

xi. Determine a policy for the distribution, or otherwise, of realised and unrealised gains or losses on investments.

xii. Review the impact on the Charities of changes in legislation both of a charitable and non-charitable nature and make appropriate recommendations to the Trust Board, as Corporate Trustee, as to how any new requirements will be met.

xiii. Ensure compliance with the Trust's Standing Financial Instructions, Financial Control Procedures and Scheme of Delegation.

xiv. Receive audit reports on the Charities' controls.

xv. Review all fundraising developments and existing fundraising efforts.

xvi. Consider and approve the Charities' annual report and accounts.

xvii. Review and approve the annual work plan for the Charities.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

— Three Non-Executive Directors (one of whom shall chair the Committee)
— One Executive Director (or their alternate as defined by Standing Orders)

In attendance:

- Head of Rosemere Cancer Foundation
- Head of Charities
- Operational Finance Director (or their nominated deputy)
- Company Secretary
- Corporate Affairs Officer (minutes)

3.2 A Non-Executive Director shall be the Chair of the Committee.

3.3 ***Quorum***: The quorum necessary for the transaction of Committee business shall be three members including at least two non-executive directors.

3.4 ***Frequency of meetings***: The Committee will, as a minimum, meet quarterly.

3.5 ***Administration***: The Committee shall be supported administratively at the direction of the Company Secretary.

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board of Directors, for an on behalf of the Corporate Trustee, to:

i. Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the exercise of its functions.

ii. Obtain such internal information as is necessary and expedient to the fulfilment of its functions.

iii. Establish subgroups for specific purposes or appeals and receive relevant Chair's reports.

iv. Committee members have delegated powers to ensure that the Charities act within the terms of their governing documents, appropriate legislation, Charities Commission guidance and to provide assurance to the Trust Board that the Charities are properly governed and well-managed across their full range of activities.

5. RELATIONSHIP WITH THE BOARD/REPORTING ARRANGEMENTS

5.1 The Committee will report in writing to the Board the basis for its recommendations. The Board will use that report as the basis for its decisions but shall remain accountable for taking the decision.

5.2 The Chair of the Committee will present a report to the next ensuing meeting of the Board of Directors summarising the decisions of the Committee.

6. REVIEW

6.1 The Committee shall review the effectiveness and performance of the Committee on an annual basis.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
EDUCATION, TRAINING AND RESEARCH COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a ~~Sub-~~Committee of the Board, to be known as the Education, Training and Research Committee (hereinafter referred to as "the Committee"). The Committee is a non-executive body and therefore has no executive powers, save as may be expressly provided within these terms of reference.

1.2 In these terms of reference:

i. "Board" means the Board of Directors as specified in the Trust's Constitution
ii. "director" means those directors appointed to the Board by virtue of paragraph 12.2 of the Trust's Constitution
iii. "member" refers to a member of the Committee as specified at paragraph 4.1 of these terms of reference

2. PURPOSE

2.1 The purpose of the Committee is to provide strategic direction and board assurance in relation to education, training, research and innovation activity.

3. RESPONSIBILITIES

3.1 To give consideration to the strategic direction and funding plans for the Trust in relation to research, education and training and make recommendations to the Board on these matters.

3.2 To consider reports, recommendations and proposals:

- On all research and development activity in the Trust – publications, grants, etc.
- From educational and research work streams
- On national and local priorities to guide activities in relation to education and training and research and development

3.3 Summary reports and action plans in relation to quality assurance reports from external bodies will also be received and reviewed by the Committee.

3.4 To inform the strategic and funding plans for education and training activity in line with service development.

3.5 To inform the strategic and funding plans for research and development.

3.6 To review educational performance within the operational delivery of the Trust's service, ensuring that activity complies with relevant statutory and regulatory frameworks and guidance.

3.7 To review education and training budgets, investment plans and divisional education contracts and consider whether value has been demonstrated.

4. COMPOSITION AND CONDUCT OF THE COMMITTEE

4.1 The Committee shall comprise the following membership:

- Three non-executive directors (one to Chair)
- Two executive directors (as defined at 1.2 of these Terms of Reference)

In attendance:

- Such Directors and other Officers of the Trust as identified for the conduct of business of the Committee
- Company Secretary

4.2 A number of work streams will support the work of the Education, Training and Research Committee in providing Board assurance around a range of activities related to the remit of the Committee, such as through the provision of annual reports and action plans.

4.3 Only members of the Committee and Company Secretary shall be entitled to attend meetings although there is an open invitation for any non-executive director to attend any or all meetings.

4.4 Members with a conflict of interest in any agenda item presented to the Committee shall declare their conflict and withdraw from discussions.

4.5 In the absence of the Chair of the Committee, the remaining members shall elect one of the other non-executive director Committee members present to Chair the meeting.

4.6 ***Quorum***: A minimum of three Committee members, two of whom should be non-executive directors.

4.7 ***Frequency of meetings***: The Committee will, as a minimum, meet six times per year.

4.8 ***Minutes***: The minutes of meetings shall be formally recorded by the office of the Company Secretary.

5. DELEGATED AUTHORITY

5.1 The Committee is authorised by the Board to:

i. Investigate any activity within its terms of reference;
ii. Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee; and
iii. Obtain independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
iv. Approve such policies or initiatives as may be required from time to time within any limits as defined by the Trust Board of Directors.

6. REVIEW

6.1 The Committee shall evaluate its effectiveness and performance of the Committee on an annual basis.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Finance and Performance Committee (herein referred to as "the Committee). The Committee is a non-executive body and therefore has no executive powers, save as may be expressly provided within these terms of reference.

1.2 In these terms of reference:

i. "the Board means the Board of Directors as specified in the Trust's Constitution
ii. "director" means those directors appointed to the Board by virtue of paragraph 12.2 of the Trust's Constitution.
iii. "member" refers to a member of the Committee as specified at paragraph 3.1 of these terms of reference.

2. PURPOSE

2.1 The overall purpose of the Committee is to obtain assurance on behalf of the Board in respect of operational performance, financial performance and planning processes, in particular that the Trust's financial and operational plans are viable and that relevant risks have been identified and mitigated. The Committee will also seek assurance on the effectiveness of the Trust's key processes and key controls as relevant to the Committee's responsibilities.

2.2 Specifically, the Committee shall:

Operational performance

i. Monitor and review the Trust's operational performance against national and local standards and seek assurance on mitigations where activity has deviated from plan.
ii. Monitor agreed activity plans and seek mitigations where there is an adverse variance or a negative trajectory.
iii. Provide assurance that operational performance reporting is robust.
iv. Monitor and review procurement effectiveness including the supplier net promotor scores.

Financial performance

i. Monitor the Trust's performance in relation to finance and 'Use of Resources'[1]. Seek assurance on the mitigations where performance is off track.
ii. Monitor delivery of the capital expenditure programme.

[1] As defined by the Care Quality Commission

iii. Monitor delivery of cost improvement programmes (productivity and efficiency savings) and seek assurance on variances from plan and relevant recovery actions.
iv. Review the cash flow forecasts, liquidity position and aged debt position of the Trust.
v. Assess the financial implications of performance against the Trust's principal contracts.
vi. Assess any proposed borrowing arrangements and make appropriate recommendations to the Board.

Strategy, Planning and Change Delivery

i. Monitor and oversee the effectiveness of the Trust's planning processes and annual business plan supported by:
    a. Reviewing the effectiveness of the Trust's activity planning methodology (approach to planning).
    b. Oversee the preparation and negotiation of annual contracts with commissioners.
    c. Oversee overall contract performance and assurance of contract fulfilment and its associated schedules with reference to:
        - CQUIN achievement;
        - Code of conduct process;
        - service developments;
        - impact of commissioning intentions.
ii. Annual review of the Trust's annual financial plan and ensure that key assumptions are both realistic and explicit.
iii. In line with the annualised planning processed undertake a specialty based review, including derogations, contractual performance of commissioned service.
iv. Monitor and oversee the effectiveness of the Trust's planning framework (quarterly).
v. Monitor and oversee the effectiveness of the specific aligned programmes from the planning framework to seek assurance they remain on track to achieve their stated outcomes.
vi. Act as a point of escalation and assurance on aligned programmes within the planning framework.
vii. Emergency Preparedness, Resilience and Response – monitor and gain assurance on the Trust's business continuity plans to recover and sustain key services in the event of an emergency.
viii. Oversee the development and deployment of the IM&T strategy including issues relating to cyber security.
ix. Oversee digital security risks planning and performance.
x. Oversee information governance planning and performance.
xi. Receive and review regular reports on system working which highlight discussion points and decisions about System, Place and Collaborations pertaining to the Trust to identify potential impacts and delivery upon wider commitments to system partners.

Governance and compliance

i. Review the robustness of the Trust's key processes and key controls in relation to the aligned metrics of the Committee.
ii. Oversee and monitor compliance with NHSE/I oversight framework.
iii. Oversee the strategic risk profile aligned to Committee along with any escalated operational risks to ensure they remain relevant to current threats and that mitigations are adequate (quarterly).

iv. Monitor progress against the agreed risk mitigations ensuring they address the identified gaps in assurance and control.
v. Commission deep dive reviews for any metrics within the Committee's remit to seek additional assurance when needed.
vi. Refer appropriate risk matters to the Audit Committee for their due consideration.

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

- Three non-executive directors of the Trust (one as Chair)
- Three executive directors

3.2 Such officers of the Trust shall attend as required by the Committee for the furtherance of its business, including an expectation of attendance of representatives of operational areas of the Trust. Only members of the Committee shall be permitted to vote.

3.3 ***Quorum***: Three members, at least two non-executive directors and at least one executive director

3.4 ***Frequency of meetings***: The Committee will, as a minimum, meet ten times per year.

3.5 ***Minutes***: The minutes of meetings shall be formally recorded at the direction of the Company Secretary.

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board to:

i. investigate any activity within its terms of reference;
ii. seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee; and
iii. obtain independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
iv. approve such policies and procedures within the remit of the Committee as may be assigned by the Board from time to time

5. RELATIONSHIP WITH THE BOARD/REPORTING ARRANGEMENTS

5.1 The Committee will report in writing to the Board the basis for its recommendations. The Board will use that report as the basis for its decisions but shall remain accountable for taking the decision. Minutes of meetings of the Board shall record such decisions.

6. REVIEW

6.1 The Committee shall evaluate its membership and review the effectiveness and performance of the Committee on an annual basis.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
NOMINATIONS COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Nominations Committee is established as a committee of the Trust pursuant to Clause 12.5 of the Trust Constitution.

2. PURPOSE

2.1 The Committee will:

i. recommend suitable people for appointment to Non-Executive Director positions (including the Chair) to be ratified by the Council of Governors

ii. recommend arrangements for remuneration and related terms and conditions for the Chair and Non-Executive Directors for agreement by the Council of Governors

iii. receive the outcome of appraisals of the Chair and NEDs for scrutiny prior to submission of an overview report to Council.

iv. Act as the proper committee for the consideration of formal complaints made against a non-executive director (including the Chair) as set out in Annex 4 of the Constitution

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

- Trust Chair or Vice-Chair or SID (in the Chair)
- Two public governors
- One staff governor
- One appointed governor

Governors will ordinarily be elected annually to the Nominations Committee by vote of the Council of Governors. Should the Council vote be tied, the membership of the Nominations Committee will be flexed for the term of office to allow an additional governor to be a member of the Committee.

3.2 A nominated deputy shall be identified for the elected and appointed governor members (i.e. one public, one staff and one appointed governor deputy).

3.3 The Committee may require the attendance of other representatives of the Trust as appropriate.

3.4 *Frequency of meetings.* The Committee shall normally meet in order to facilitate the business of the Trust.

3.5 *Quorum.* three Committee members (or their nominated deputies) which must include the Chair, except where the business to be transacted is that of reappointment of the Chair, in which case the Chair will be excluded from the meeting during consideration of the item and the Chair shall be taken by the Vice-Chair or SID.

3.6 *Minutes.* The minutes of meetings shall be formally recorded as directed by the Company Secretary.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
SAFETY AND QUALITY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a ~~Sub-~~Committee of the Board, to be known as the Safety and Quality Committee (hereinafter referred to as 'the Committee'). The Committee is a non-executive body and therefore has no executive powers, save as may be expressly provided within these terms of reference.

1.2 In these terms of reference:

i. "Board" means the Board of Directors as specified in the Trust's Constitution
ii. "director" means those directors appointed to the Board by virtue of paragraph 12.2 of the Trust's Constitution
iii. "member" refers to a member of the Committee as specified at paragraph 4.1 of these terms of reference

2. PURPOSE

2.1 The overall purpose of the Committee is to promote and lead a safety and quality strategy that continues to improve and maintain an 'Always Safety First' culture in which staff are supported and empowered to improve services and care.

2.2 Specifically, the Committee shall:

i. monitor performance delivery of the Trust-wide safety and quality metrics within the any strategic or forward plan and associated sub-measures as defined by the Always Safety First Strategy;

ii. provide the Board of Directors with assurance on the effectiveness of the safety and quality performance management framework and that the patient experience and outcomes of care are optimised by:

- ensuring that adequate structure, processes and controls are in place to promote safety and excellence in the standards of care and treatment;
- monitoring performance against agreed safety and quality metrics, identifying and understanding significant variation and ensuring appropriate and effective response on all services the Trust provides;
- monitoring performance and progress in respect of contractual quality schedules directly and indirectly including those services contracted out to third parties monitoring performance and progress in respect of the quality improvement programme and ensuring compliance with CQC standards and regulatory frameworks; and

- monitoring performance and progress in respect of the Quality Improvement Programme and ensuring compliance with CQC standards and regulatory frameworks.

3. RESPONSIBILITIES

3.1 To co-ordinate delivery of the Trust's Quality Accounts in line with national guidance and present to the Board of Directors.

3.2 To confirm that the Trust considers and, where appropriate, implements recommendations and guidance from external bodies and national enquiries.

3.3 To ensure that internal and external assurance programmes are in place in response to published standards, internal and external reviews, audits and surveys.

3.4 To ensure that clinical audit activity as described within the forward plan is relevant and comprehensive.

3.5 To monitor compliance with the plan and to review performance against nationally recognised clinical standards as demonstrated through national and local clinical audit reports.

3.6 To ensure appropriate responses to NICE and other external bodies including commissioning benchmarking exercises as required.

3.7 To confirm that appropriate action is taken in response to adverse clinical incidents, complaints and litigation.

3.8 To promote and ensure sharing of lessons learned and dissemination of good practice.

3.9 To gain assurance that action plans developed to control identified strategic and operational quality and safety risks are fit for purpose.

3.10 To receive Chair reports from the subgroups set out in paragraph 3.14 below in respect of areas of identified concern, seeking assurance that robust actions have been identified to address/resolve these issues/concerns.

3.11 To inform the Board of Directors where it has significant concerns about standards of care and treatment within the Trust or where it considers any service (or part of it) to be unsafe by use of the risk escalation process contained within the Chair's report.

3.12 To ensure due regard is given to the views of Trust governors, members and stakeholders and there is appropriate involvement in safety and quality programmes via the Council of Governors.

3.13 To provide oversight of any relevant programmes/projects set out in the Trust's Planning Framework.

3.14 To review and gain assurance that the Trust's obligations with respect to health & safety are met and that there are robust plans in place to address any identified weakness (including the approval of remedial action plans).

3.15 To commission, receive and review performance reports and improvement plans from the following groups:

- Infection Prevention and Control Committee
- Safeguarding Board
- Medicines Governance Committee
- Mortality and End of Life Care Committee
- Safety and Learning Group
- Ethics Committee
- Always Safety First Committee
- Patient Experience Improvement Group
- Equality, Diversity and Inclusion Group
- Exception reports from the Divisional Improvement Forums (as necessary) in respect of divisional quality metrics (safety and quality issues)

4. COMPOSITION AND CONDUCT OF THE COMMITTEE

4.1 The Committee shall comprise the following membership:

- Three non-executive directors, one of whom shall be chair
- Three executive directors

4.2 Such officers of the Trust shall attend as required by the Committee for the furtherance of its business. Only members of the Committee shall be permitted to vote.

4.3 ***Quorum***: Three members including at least two non-executive directors and one executive director.

4.4 ***Frequency of meetings***: The Committee will, as a minimum, meet 10 times per year

4.5 ***Minutes***: The minutes of meetings shall be formally recorded at the direction of the Company Secretary

5. DELEGATED AUTHORITY

5.1 The Committee is authorised by the Board to:

i. investigate any activity within its terms of reference

ii. seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee

iii. obtain independent professional advice, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

iv. approve such policies and procedures within the remit of the Committee as may be assigned by the Board from time to time

6. RELATIONSHIP WITH THE BOARD/REPORTING ARRANGEMENTS

6.1 The Committee will report in writing to the Board through its minutes and Chair's report the basis for its recommendations. The Board will use that report as the basis for its decisions but shall remain accountable for taking the decision. Minutes of meetings of the Board shall record such decisions.

6.2 The Quality Account will be presented to the Board of Directors annually. In addition to this, safety and quality performance will be monitored at the Board of Directors bi-monthly as part of the integrated performance report.

7. REVIEW

7.1 The Committee shall evaluate its membership and review the effectiveness and performance of the Committee on an annual basis.

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
WORKFORCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Workforce Committee ("the Committee). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to:

- oversee the development and implementation of the workforce and organisational development strategy for the organisation
- approved delegated human resources policies and procedures relating to contractual or legislative changes on behalf of the Board of Directors
- provide assurance to the Board on the development, implementation and review of the Trust's workforce and organisational development strategy and workforce plan in order to support service improvement and to meet the needs of patients, staff, regulators and commissioners
- develop strategic workforce recommendations for approval by the Board
- monitor performance of workforce metrics within ~~the Big Plan~~ any strategic or other forward plan.

2.2 The main functions of the Committee are to:

i. Contribute to the development of an effective workforce and organisational development strategy and to make appropriate recommendations to the Board for approval
ii. Ensure that the Trust's workforce and organisational development strategy and related policies satisfy relevant national, regional and organisational requirements.
iii. Monitor performance and the data quality of workforce information, seeking assurance on the effectiveness of the workforce performance management framework and ensure relevance to the strategic goals of the Trust's strategic framework
iv. Consider the control and mitigation of workforce-related risks as identified in the Board assurance framework and provide assurance to the Board that such risks are being effectively controlled and managed
v. Approve workforce-related contractual policies under delegated authority from the Board of Directors
vi. Obtain assurances that the Trust's workforce plan supports the development aims of the organisation through the identification of an appropriate workforce model and development plan

vii. Receive Chair reports from the following subgroups in respect of areas of identified concern, seeking assurance that robust actions have been identified to address/resolve these issues/concerns:

- Recruitment Group
- Temporary Staffing Group
- Raising Concerns Group
- Equality, Diversity and Inclusion Group

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall comprise the following membership:

— Three non-executive directors (one to chair)
— Two executive directors

3.2 Such officers of the Trust shall attend as required by the Committee for the furtherance of its business. Only members of the Committee shall be permitted to vote.

3.3 ***Quorum***: Three members, at least two non-executive directors and at least one executive director.

3.4 ***Frequency of meetings***: The Committee will normally meet six times a year.

3.5 ***Minutes***: The minutes of meetings shall be formally recorded as directed by the Company Secretary.

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board to:

i. investigate any activity within its terms of reference

ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee

iii. approve such policies and procedures within the remit of the Committee as may be assigned by the Board from time to time

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS AND ITS COMMITTEES

5.1 The Committee will report in writing to the Board of Directors the basis for its recommendations. The Board of Directors will use that report as the basis for their decisions but would remain accountable for taking the decision. Minutes of the Board of Directors will record such decisions.

6. REVIEW

6.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis.

COMMITTEES OF THE BOARD

CURRENT AND PROPOSED COMPOSITION AND QUORUM

CURRENT ARRANGEMENTS			**PROPOSED ARRANGEMENTS** 23/24			
NED Members	**Other Committee Members**	**In Attendance**	**NED members**	**Executive Directors Members**	**In Attendance**	**Quorum**
Appointments, Remuneration and Terms of Employment (ARTE) Committee ***(2 meetings per annum or as required)***						
All NEDs		Kevin McGee Karen Swindley Jennifer Foote	**All NEDs**	**N/A**	Kevin McGee Karen Swindley Jennifer Foote	Chair or Vice Chair and 2 Non-Executive Directors
Audit Committee ***(4 meetings per annum, May/June meeting dedicated to approval of Annual Report and Accounts)***						
Tim Watkinson ***(Chair)*** **Ann Pennell** **Jim Whitaker** **Tricia Whiteside**		Jonathan Wood Karen Swindley Simon Regan MIAA representatives MIAA Counter Fraud Specialist KPMG representatives	**Tim Watkinson** ***(Chair)*** **Ann Pennell** **Jim Whitaker** **Tricia Whiteside**	**N/A**	Kevin McGee (as required) Jonathan Wood Angela Mulholland-Wells Jennifer Foote Simon Regan MIAA representatives KPMG representatives	3 Non-Executive Directors
Charitable Funds Committee ***(4 meetings per annum - quarterly)***						
Kate Smyth ***(Chair)*** **Victoria Crorken** **Tricia Whiteside**	Sarah Cullen Daniel Hill	Bhimji Patel	**Kate Smyth** ***(Chair)*** **Victoria Crorken** **Tricia Whiteside**	**Sarah Cullen**	Naomi Duggan Daniel Hill Paula Wilson Jennifer Foote Angela Mulholland-Wells	3 members including at least 2 NEDs
Education, Training and Research Committee ***(6 meetings per annum)***						
Paul O'Neill ***(Chair)*** **Victoria Crorken** **Kate Smyth**	Ailsa Brotherton Sarah Cullen Karen Swindley Paul Brown John Howells Madhavi Paladugu Pierre Martin-Hirsch	Alison Gale Louisa Graham Kerry Hemsworth Chris Taylor	**Paul O'Neill** ***(Chair)*** **Victoria Crorken** **Kate Smyth**	**Karen Swindley** **Sarah Cullen**	Ailsa Brotherton Dr Alison Gale Dr Madhavi Paladugu Dr Alison Sykes Catherine Silcock Angela Mulholland-Wells Jennifer Foote Paul Brown Kerry Hemsworth Louisa Graham	3 members including at least 2 NEDs

Finance and Performance Committee *(12 meetings per annum)*						
Tricia Whiteside *(Chair)* **Tim Watkinson** **Jim Whitaker** **Vacancy**	Faith Button Jonathan Wood Karen Swindley 50:50 between Sarah Cullen and Gerry Skailes	Gary Doherty Stephen Dobson Catherine McGourty Ian Ward	**Tricia Whiteside *(Chair)*** **Tim Watkinson** **Jim Whitaker**	**Faith Button** **Jonathan Wood** **Karen Swindley**	Ailsa Brotherton Gary Doherty Stephen Dobson Jennifer Foote Angela Mulholland-Wells Catherine Silcock/Alison Gale	3 members including at least 2 NEDs
Safety and Quality Committee *(12 meetings per annum, no December meeting but additional meeting held first week in January)*						
Ann Pennell *(Chair)* **Paul O'Neill** **Kate Smyth** **Vacancy**	Ailsa Brotherton Faith Button Sarah Cullen Gerry Skailes	Gary Doherty Alison Gale Christine Morris Simon Regan Catherine Silcock Jonathan Wood	**Ann Pennell *(Chair)*** **Paul O'Neill** **Kate Smyth**	**Faith Button** **Sarah Cullen** **Gerry Skailes**	Kurt Bramfitt Angela Mulholland-Wells Jennifer Foote Gary Doherty Alison Gale Christine Morris Simon Regan Catherine Silcock	3 members including at least 2 NEDs
Workforce Committee *(6 meetings per annum)*						
Jim Whitaker **Victoria Crorken** **Kate Smyth**	**Ailsa Brotherton** **Faith Button** **Sarah Cullen** **Karen Swindley**	Kathryn Downey Alison Gale Louisa Graham Rachel O'Brien Catherine Silcock	**Jim Whitaker (Chair)** **Victoria Crorken** **Kate Smyth**	**Sarah Cullen** **Karen Swindley**	Naomi Duggan Alison Gale Emma Ince Angela Mulholland-Wells Jennifer Foote Louisa Graham	3 members including at least 2 NEDs

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Board Safety and Experience Programme			
Report to:	Board of Directors	**Date:**	2 February 2023
Report of:	Chief Nursing Officer	**Prepared by:**	S Cullen
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of the report is to relaunch the Board Safety and Experience programme following the limitations that have occurred following Covid-19 pandemic.

The aim of the programme is to describe a number of methods the Board uses to interact with colleagues and patients to:

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

The safety and experience programme provide an opportunity for meaningful interactions with patients, visitors and colleagues, listening to the experiences of care whilst promoting the values, aims and ambitions of the organisation.

Recommendation
The Board is asked to endorse the revised engagement format.

Trust Strategic Aims and Ambitions supported by this Paper:

Aims	Ambitions

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

1. Introduction

The purpose of the report is to provide an update report on the planned Board Safety and Experience programme. A pack with the format for the visits is prepared for members of the Board and Divisional teams.

2. Background

In line with our Always Safety First Strategy development and part of our Well Led development plan 2021/22 a review of the Board visibility programme was undertaken and agreed by Board in August 2021. Board visibility, renamed as the Board Safety and Experience programme better reflected the purpose of interaction between the Board and colleagues across the organisation. The aim of the programme is to:

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

The approach to the programme has been reviewed further given the impact of Covid-19 and adjusted and future reports will provide a record of Board visibility activity.

Table 1 - Board Safety and Experience programme activity

Workstream	Method	Frequency
Opening events/ recognising achievements	Open invite to Board and Governors **Held virtually or in person**	Responsive events
STAR celebration events	Open invite to Board and Governors **Held virtually or in person**	2-3 annually
Big Room attendance	Board members **Held virtually or in person**	Twice annually
Board Safety and Experience visit	Two members of the Board to meet with staff from the selected departments including divisional management teams with a focus on each division to give the opportunity for a holistic view of services and connections with teams. **Held in person**	Monthly
Maternity and neonatal Safety Champion forum	The Executive and Non-Executive Lead formaternity and neonatal services attend bi monthly forums. **Held virtually or in person**	Bi Monthly
STAR visits	NEDs and Governors open invite to attend STAR visits. Training sessions delivered for Governors. **Held in person**	Once annually
Adhoc visits	Members of the Board are encouraged to spend time in departments across the organisation, this is left to the discretion of the Board member. **Held virtually or in person**	Adhoc

How this programme fit with our strategic aims and ambitions?

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

Image 1 – Our culture counts behaviours

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

3. Conclusion

The Board Safety and Experience programme outlines the approach to ensuring the Board is connected to colleagues and services across the organisation and Board activity underpins key strategic aims. The safety and experience programme provides an opportunity for meaningful interactions with patients, visitors and colleagues, listening to the experiences of care whilst promoting the values, aims and ambitions of the organisation.

4. Recommendation

The Board is asked to endorse the revised engagement format.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Register of Interests

Report to:	Board of Directors	**Date:**	2 February 2023
Report of:	Company Secretary	**Prepared by:**	K Brewin
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

The Board of Directors have a responsibility to declare relevant interests as defined in section 14 of the Trust Constitution.

Those listed within the register (appendix 1) have recently been contacted and confirmed their information, with the exception of one Associate Non-Executive Director where the information remains outstanding.

The register will be published on the Trust's website and will be updated periodically throughout the year should any further interests be declared, or changes be notified to the Office of the Company Secretary.

It is recommended that the Board of Directors:

I. Note the Register of Interests compiled as at 26 January 2023.
II. Note their responsibility to notify the Office of the Company Secretary of any changes to their individual interests.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

1. **Background**

   All Directors have a responsibility to declare relevant interests as defined in section 14 of the Trust Constitution. A list of interests declared is published on the Trust's website and is also available from the Office of the Company Secretary. Information on how to access those details is also included in the Trust's Annual Report.

   The latest information held by the Office of the Company Secretary as at 26 January 2023 is attached as appendix 1. Those listed within the register have recently been contacted and confirmed their information, with the exception of one Associate Non-Executive Director where the information remains outstanding.

   The register will be updated periodically throughout the year should any further interests be declared, or changes be notified to the Office of the Company Secretary.

2. **Financial implications**

   There are no financial implications in respect of the contents of this report.

3. **Legal implications**

   Failure to declare interests is a breach of the Trust's Code of Conduct and could result in disciplinary action being taken.

4. **Risks**

   There is a risk to the Board undertaking its statutory business and adhering to its governance processes if changes to individual interests are not declared or communicated in a timely manner.

5. **Impact on stakeholders**

   There is no impact on stakeholders in respect of the contents of this report.

6. **Recommendations**

   It is recommended that the Board of Directors:

   I. Note the Register of Interests compiled as at 26 January 2023**.**
   II. Note their responsibility to notify the Office of the Company Secretary of any changes to their individual interests.

Board of Directors: Register of Interests – 26 January 2023

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Name	Position	Declared Interest
NON-EXECUTIVE DIRECTORS		
Ms Victoria Crorken	Non-Executive Director	• Group Head of Risk, Compliance and Security – The Co-op Group Ltd • Vice Chair, Board of Governors – Co-op Academy Leeds • Stepdaughter on 12-month pre-registration placement (pharmacist)
Professor Paul O'Neill[1]	Interim Chair	• Emeritus Professor at University of Manchester • General Medical Council Associate – Medical Education
Mrs Ann Pennell	Non-Executive Director	• No interests to declare
Ms Kate Smyth	Non-Executive Director	• Lay Leader at the Yorkshire and Humber Patient Safety Translational Research Centre • Member and volunteer at Calderdale and Huddersfield Foundation Trust • Spouse is a Non-Executive Director of East Lancashire Hospitals NHS Trust • Member of the Cabinet Office Disability Unit - North-West Regional Stakeholder Network • Co-chair of the Disabled NHS Directors Network
Mr Tim Watkinson[2]	Non-Executive Director/Senior Independent Director	• Independent Member of the UK Statistics Authority's Audit and Risk Assurance Committee
Mr Jim Whitaker	Non-Executive Director	• Director of Lancashire Hospitals Services (Pharmacy) Ltd • Employed by BT Enterprise as Head of Strategic Health Programmes, delivering Digital Healthcare Solutions
Mrs Tricia Whiteside[3]	Non-Executive Director	• Daughter working for North-West Ambulance Service • Member of the Integrated Care Board (ICB) Patient Involvement and Engagement Advisory Committee

[1] *Interim Chair with effect from 1 September 2022*
[2] *Senior Independent Director with effect from 20 September 2022*
[3] *Interim Vice Chair with effect from 6 October 2022*

Name	Position	Declared Interest
ASSOCIATE NON-EXECUTIVE DIRECTORS		
Mr Michael Wearden	Associate Non-Executive Director	• Managing Director of Red Rose Recovery Lancashire
Mr Peter Wilson	Associate Non-Executive Director	*No declaration has been made*
EXECUTIVE DIRECTORS (VOTING BOARD MEMBERS)		
Ms Faith Button	Chief Operating Officer	• No interests to declare
Ms Sarah Cullen	Chief Nursing, Midwifery and Allied Health Professionals Officer	• Son is a member of the Administrative Bank • Sister is Clinical Business Manager in the Women's and Children's Division • Trustee at St Catherine's Hospice
Mr Kevin McGee	Chief Executive Officer	• Spouse is the Director of Finance and Deputy Chief Executive at Warrington and Halton Hospitals NHS Trust • Honorary Fellow at the University of Central Lancashire • Partner Member on the Lancashire and South Cumbria Integrated Care Board
Dr Geraldine Skailes	Chief Medical Officer	• No interests to declare
Mrs Karen Swindley	Chief People Officer	• Chair and Trustee of Derian House Children's Hospice • Director of Lancashire Hospitals Services (LHS) Ltd
Mr Jonathan Wood	Chief Finance Officer/Deputy Chief Executive Officer	• Spouse is Director of Finance for Northwest Ambulance Service NHS Trust • Chair of the Finance Committee at Blackburn Cathedral • Chair of the NHS Supply Chain's Northern Customer Board • University of Central Lancashire Medical School Guest Speaker
CORPORATE DIRECTORS (NON-VOTING BOARD MEMBERS)		
Mrs Ailsa Brotherton	Director of Continuous Improvement	• Daughter is a member of the Medical Bank • Honorary Professorial role at University of Central Lancashire
Mr Stephen Dobson	Director of Information Management and Technology (CIO)	• Honorary contract with the University of Manchester • Independent Member of the Audit and Ethics Committee for Lancashire Police
Mr Gary Doherty	Director of Strategy and Planning	• Director of Lancashire Hospitals Services (LHS) Limited • Spouse works for NHS England and NHS Improvement

Name	Position	Declared Interest
Mrs Naomi Duggan	Director of Communications and Engagement	• No interests to declare
Mrs J Foote MBE	Company Secretary	• No interests to declare