Board of Directors

1 August 2024 | 1.00pm | Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital, Preston Road, Chorley Lancashire, PR2 9HT

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	P White
2.	Apologies for absence	1.01pm	Verbal	Information	P White
3.	Declaration of interests	1.02pm	Verbal	Information	P White
4.	Minutes of the previous meeting held on 6 June 2024	1.03pm	✓	Decision	P White
5.	Matters arising and action log update	1.04pm	✓	Decision	P White
6.	Chair's opening remarks and report	1.05pm (5mins: Pres)	✓	Information	P White
7.	Chief Executive's report	1.10pm (10mins: Q&A)	✓	Information	S Nicholls
8.	Patient Story	1.20pm (10mins: Pres) (5mins: Q&A)	Pres	Assurance	S Cullen
9.	Board Assurance Framework	1.35pm (10mins: Disc)	✓	Decision	S Regan
10.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
10.1	Safety and Quality Committee Chair's Report	1.45pm (10mins: Q&A)	✓	Information	K Smyth
10.2	Maternity and Neonatal Services Report	1.55pm (5mins: Q&A)	✓	Assurance	J Lambert
11.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
11.1	Workforce Committee Chair's Report	2.00pm (10mins: Q&A)	✓	Information	V Crorken
11.2	Education, Training and Research Committee Chair's Report	2.10pm (10mins: Q&A)	✓	Information	P O'Neill
12.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
12.1	Charitable Funds Committee Chair's Report	2.20pm (10mins: Q&A)	✓	Information	K Smyth
12.2	Finance and Performance Committee Chair's Report	2.30pm (10mins: Q&A)	✓	Information	T Whiteside
12.3	Integrated Performance Report as at 30 June 2024 including Finance update *(considered by appropriate Committees of the Board)*	2.40pm (10mins: Pres) (10mins Q&A)	✓	Assurance	S Cullen/ N Pease/ J Wood
13.	**FIT FOR THE FUTURE** (STRATEGY AND PLANNING)				
13.1	Single Improvement Plan	3.00pm (10mins: Pres)	✓	Assurance	S Nicholls

№	Item	Time	Encl.	Purpose	Presenter
13.2	New Hospitals Programme	3.10pm (5mins: Pres)	✓	Information	S Nicholls
14.	**GOVERNANCE AND COMPLIANCE**				
14.1	Audit Committee Chair's Report	3.15pm (10mins: Pres)	✓	Information	T Watkinson
14.2	NHSE Enforcement Undertakings	3.25pm (10mins: Pres)	✓	Information	S Regan
14.3	Delegated Authority – EPRR Core Standards Annual Return	3.35pm (5mins: Pres)	✓	Decision	J Foote
15.	**ITEMS FOR INFORMATION**				
15.1	(a) Annual Report and Accounts 2023-24 (b) Quality Account 2023-24 (c) Safeguarding Annual Report (d) Mortality Annual Report (e) Appraisal, Revalidation and Medical Governance Annual Report (f) Freedom to Speak Up and Raising Concerns at Work (including Whistleblowing) Annual Report (g) Fit and Proper Person Annual Review: Confirmation of Completion		✓		
15.2	Date, time and venue of next meeting: *3 October 2024, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital*	3.40pm	Verbal	Information	P White

Board of Directors

6 June 2024 | 1.00pm
Lecture Room 1, Education Centre 1, Royal Preston Hospital

Part I

Present:

Mr P White	Chair
Dr T Ballard	Non-Executive Director
Ms V Crorken	Non-Executive Director
Mr I Devji	Chief Operating Officer
Professor S Nicholls	Chief Executive
Dr G Skailes	Chief Medical Officer
Ms K Smyth	Non-Executive Director *(virtually)*
Mr T Watkinson	Non-Executive Director
Mr J Whitaker	Non-Executive Director
Mrs T Whiteside	Non-Executive Director
Mr J Wood	Chief Finance Officer

In attendance:

Mrs K Brewin	Associate Company Secretary *(minutes)*
Mr G Doherty	Director of Strategy and Planning
Mrs N Duggan	Director of Communications and Engagement
Mrs J Foote	Company Secretary
Mrs L Graham	Deputy Director of Workforce and Organisational Development
Ms C Gregory	Deputy Director of Nursing, Midwifery and AHPs
Ms J Lambert	Interim Divisional Nursing and Midwifery Director *(for item 96/24)*
Mr U Patel	Associate Non-Executive Director
Mr S Regan	Associate Director of Risk and Assurance *(for item 94/24)*

Governors observing: S Heywood, L Purcell, T Ramsay

Observers: K Foster-Greenwood

86/24 Chair and quorum

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

87/24 Apologies for absence

Apologies for absence were received from Mrs A Brotherton, Ms S Cullen, Professor P O'Neill, and Mr N Pease.

88/24 Declaration of interests

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

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

89/24 Minutes of the previous meeting

The minutes of the meeting held on 4 April 2024 were approved as a true and accurate record.

90/24 Matters arising and action log

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

91/24 Chair's opening remarks and report

The report provided a summary of work and activities undertaken during April and May 2024 by the Trust Chair including a resume of the items discussed in the part II Board meeting on 4 April.

The Board was advised that urgent and emergency care was under significant pressure with levels of demand comparable to volumes seen during the winter and patients presenting at the hospital with increasingly complex conditions. This was a feature across the sector and discussions were ongoing to identify what was needed to address the issues along with internal planning to improve flow and reduce long waits and length of stay. The Board's gratitude was extended to Executive Directors recognising the significant challenges being faced at such an early point in the year and appreciation would be cascaded to staff across the organisation.

92/24 Chief Executive's report

The report provided an overview on matters of interest since the previous meeting and the following highlights were provided.

Reference was made to the excellent progress on elective recovery meaning that NHS England (NHSE) had agreed that the Trust would step down from the most intense level of scrutiny in terms of progress on performance (tier 1). Tribute was paid to the operational teams under the leadership of the Interim Chief Operating Officer in delivering such a positive result. However, the Trust was not complacent and remained in tier 1 for cancer although good progress was being made.

Improvement work was continuing to reduce pressures at the front door including elimination of patients being boarded to improve the experience for patients and staff. Recognising the increase in demand at the front door, the Trust would be launching an accelerated discharge initiative which would help with early preparations for winter.

The report contained a range of achievements and recognition for staff at a national, regional, and local level, and the Board recognised the positive work of colleagues across the organisation.

The Integrated Performance Report (agenda item 12.4) outlined the challenges with *C.difficile* infection. To assist with supporting improvements in infection levels, a campaign had been launched at the start of May, 'Bin the Wipes', which aimed to raise

awareness about the effect that wipes and other sanitary items had on the drains and sewer systems in the hospitals.

The Board noted that during previous periods of significant pressure contingency plans had been introduced and tested at system level and queried whether there was an intention to re-test those contingency plans on a similar basis. It was confirmed that some testing had been undertaken locally. Urgent and emergency care was the key concern for the system and the Integrated Care Board (ICB) was leading a piece of work to look at challenges within the system. It was emphasised that the current pressures were exceptional so early in the year and work was ongoing to alleviate the pressures before winter.

93/24 Patient Story

The Board was joined by three representatives from the Division of Diagnostics and Clinical Support who attended to present the patient story. Unfortunately, due to personal reasons, the patient had been unable to attend although was content for the team to share his story.

The patient was an elective admission and was an inpatient at the Trust for 14 days. He normally mobilised with elbow crutches, was admitted to the Critical Care Unit and then Ward 11. During his admission he was very confused and disorientated within the pathway and deconditioned from his baseline function. He was subsequently referred to therapy although due to his ongoing confusion, therapy was difficult to facilitate. His recollection of his period in hospital was hazy due to his confusion and he talked of feeling rushed out, not communicated with and like he was being bundled off to ‘an old people’s home’ when the Community Healthcare Hub (Finney House) was suggested. An overview was provided of the journey the patient would have had if the Community Healthcare Hub had not been available and the potential wait for rehabilitation or decision to admit pathway and provision. Following rehabilitation, the patient described the fantastic care received during his stay in the Community Healthcare Hub and how he felt safe in a clean and tidy environment. He also positively recognised the multidisciplinary approach to his mobility and the individualised care that he received.

The team provided an overview of the shared learning that had been taken by the therapy team around the patient’s feelings including revisiting the patient leaflet available for the Community Healthcare Hub. The team explained that patients admitted to hospital could rapidly decondition which was why it was imperative to prevent admissions for long-term outcomes.

Reference was made to the confusion experienced by the patient and his inability to understand what was being communicated and it was suggested that family members could be able to assist with the messages being delivered. It was explained that managing patient expectations was crucial and at the earliest opportunity it was reinforced that their stay could be up to 28 days. Staff actively tried to involve families and next of kin as soon as possible to inform about discharge decisions and the team had consciously worked on improvements in that area. There was also a need to be clearer regarding the Finney House model to ensure patients did not have the impression it was a care home and consideration would be needed on the branding.

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

94/24 Board Assurance Framework

The report provided details of risks that might compromise the achievement of the Trust's high level strategic objectives. It was noted that the risks were scrutinised by relevant Committees of the Board. The strategic risks detailed in appendix 2 were those that had been presented to Committees or had been reviewed in preparation for the next Committee meeting at the time the Board report was produced. It was confirmed that there had been no changes to the six strategic risk scores since the April Board meeting and three operational risks remained escalated to the Board relating to exit block (risk ID 25); elective restoration (risk ID 1125); and *C.difficile* infection (risk ID 1157). The Board was asked to note that discussions were ongoing by the Safety and Quality Committee regarding the risk around the interventional radiology service.

On 14 May 2024 the Board discussed and reviewed the risk appetite statement and risk tolerance for all strategic risks. Potential changes to the risk appetite and tolerances were explored in detail, however, the Board recommended that the current risk appetite statement and risk tolerances remained appropriate for 2024-25. In addition, two recommendations had been placed before the Board relating to oversight of the strategic risks relating to specialised services and moving the risk to 'controlled' status.

Reference was made to the recommendation for the Board to approve defining the specialist services risk as 'controlled' as it had been static at a risk score of 8 for some time (in line with the Trust's risk tolerance level). It was proposed that a discussion needed to be held first by the Finance and Performance Committee regarding de-escalating the risk. It was understood the ICB Clinical Strategy would be available around September therefore it was agreed that the specialist services risk would be redefined as 'controlled' with the expectation that the risk status would be reviewed when commissioning intentions were clarified later in the year.

Discussion was also held regarding the work being undertaken on the format and structure of the report.

The Board RESOLVED that the updates to the Board Assurance Framework be approved, specifically:

1. **the risk appetite statement and risk tolerances for 2024-25.**
2. **re-alignment of the strategic risks for specialised services and Fit for the Future to the Finance and Performance Committee for oversight from June 2024.**
3. **the strategic risk for specialised services be moved to 'controlled' status with the expectation that this would be reviewed when the ICB commissioning intentions were understood later in the year.**

95/24 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee provided an overview of items discussed at the meetings on 22 March and 26 April 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board. Key highlights included:

- Focus on boarded patients at both meetings and understanding how that practice was eradicated including nursing care provided in corridors due to capacity and demand pressures.
- The cancer care risk had increased from 6 to 16 and the Committee drilled down on the actions being taken to ensure appropriate mitigation was in place.
- Martha's Rule was explored and discussed at both meetings. It was noted the Trust had previously introduced its own local arrangements (Call 4 Concern) and that process had been finessed in line with the new legislation.
- The Committee recognised the positive impact of the Community Healthcare Hub which dovetailed with the patient story at the start of today's Board meeting reinforcing the improvements in patient care and treatment through rehabilitation.
- A presentation received in May from the Director of Infection Prevention and Control and discussion regarding where Trust resources should be prioritised. The Committee recognised there were some significant problems with the Trust's estate and focus on hygiene and national cleaning standards would be important.
- The thrombectomy service had reverted to 5 rather than 7-day cover due to the difficulties recruiting suitably trained Radiographers, the scale and challenge of which was recognised by the Committee. It was noted that thrombectomy required highly specialist treatment and the staffing issues were not unique to the Trust with challenges being felt on a national scale. The Trust had recruited a further Radiologist and progress was being made towards delivering a fully staffed 24/7 service once required staffing levels had been achieved. The Trust continued to work with Specialist Commissioning colleagues to explore any further actions that could be taken to accelerate service provision.

Discussion was held regarding the significant challenges with the Trust's estate and focus that was required on cleaning standards to ensure compliance and control of infection levels. It was noted the Trust was compliant with clinical cleaning standards and improvements were required in general cleaning standards which would need to be delivered within current resources. In terms of the estate it was clear that significant investment was required which would need to be balanced with the intention for a new hospital build therefore broader conversations and thinking would be required on the medium-term estate strategy.

In response to a question regarding whether an infection prevention and control risk assessment had been undertaken relating to boarded patients, it was confirmed that incidents were being monitored, and mitigations were in place in relation to patients identified for boarding. The practice of boarding patients was also included on the risk register.

Reference was made to the assurance provided in the report regarding overall staffing fill rates which in some areas was over 100% and clarification was requested on the trajectory for safe staffing levels along with the rationale for exceeding those levels, bearing in mind the Trust's financial position. It was explained that the aim was to achieve 95% fill rate although that did not take account of movement of staff covering additional areas that had been opened to meet capacity and demand. In response to a question regarding the 109% fill rate at Chorley, the Board was advised that in terms of safety the fill rate was positive due in part to the support being provided to international nurse recruits. It was also noted that the current fill rates had allowed for a significant decrease in agency expenditure.

96/24 Maternity and Neonatal Services Report

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

In relation to CNST, where Trusts were not compliant with a funded establishment based on Birth Rate Plus or equivalent calculations, the Board and relevant Committees of the Board must be aware of the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must also include mitigation to cover any shortfalls. The report outlined those requirements and the Board noted there was a detailed workforce plan in place and that funding solutions were being considered.

In relation to the high still birth rate, the Safety and Quality Committee Chair confirmed there was assurance that those instances were due to highly unusual circumstances outwith the Trust's control. Further work was being undertaken regarding neonatal deaths and learning was being taken. In relation to the five cot closures during the reporting period, the Committee explored the situation and was assured that the cot closures had been appropriately mitigated. The Committee recognised the challenges that remained around staffing levels and the work that would be required as a Trust on the risk.

Reference was made to the Early Pregnancy Loss Bereavement Specialist Nurse which had been funded by the Charitable Funds Committee and Board requested an update on how that role was functioning. It was confirmed that the post had enabled the service to be compliant with many of the standards and was having a positive impact for women, families, and the national agenda around early pregnancy loss.

The Board RESOLVED that it was assured in respect of the safe staffing position within maternity and neonatal services and progress with the recommendations in the CNST MIS through the associated action plans, recognising the ongoing workforce requirements across the perinatal continuum.

97/24 Fuller Review: Phase 1 Recommendations

The report considered the recommendations from the Independent Inquiry into the issues raised by the David Fuller case to provide assurance to the Board that the operating procedures of the mortuary and body stores at both Chorley and Preston hospital sites complied with the Human Tissue Authority's (HTA) standards and guidance.

It was noted the Fuller Inquiry involved two phases. The first examined what happened at Maidstone and Tunbridge Wells NHS Trust with the report published on 28 November 2023 containing 17 recommendations specifically directed to that Trust. The second phase of the inquiry was underway to consider the broader national picture to understand procedures and practices in place across the country to protect the

deceased person: the Trust would respond to any requests to support phase two as required.

The Board was informed that the Trust had reflected on the 17 recommendations in the interest of learning and improvement. It was noted the Trust was inspected by the HTA in March 2023 and the findings identified during the inspection had been closed by the HTA, with a detailed report scrutinised by the Safety and Quality Committee on 31 May 2024. Members of the Executive Management team also visited the mortuaries on both hospital sites and were satisfied with the procedures and practices in place.

The Board welcomed the self-assessment of the Trust mortuaries against the 17 recommendations and asked whether the Trust would consider commissioning external assurance if it was not included in the second phase of the inquiry. It was reiterated that the Trust was inspected by the HTA with the last inspection in March 2023, therefore an external view and assurance had been obtained.

The Board RESOLVED that it was assured of the processes in place within the Trust to protect the safety and dignity of the deceased person following a review of the 17 recommendations identified in the phase one report of the Fuller Inquiry.

98/24 Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports 2024

The reports provided data which would form the submissions and subsequent publication of the 2024 WRES and WDES standards for the Trust, setting out priority areas for action based on analysis of the results which included workforce data and findings from the latest staff survey.

In respect of WRES, the priority areas for action were those which indicated ethnic minority colleagues were being adversely impacted or disadvantaged against specific indicators. The priority areas for action were identified as appointment from shortlisting across all posts; discrimination experienced at work from a manager or colleagues; and increased representation of ethnic minority colleagues in senior, very senior manager, or voting Board member roles.

In respect of WDES, the priority areas for action were those which indicated disabled colleagues were being adversely impacted or disadvantaged against specific metrics. The priority areas for action were identified as likelihood of colleagues with a disability entering the formal capability process; harassment, bullying or abuse from patients, service users, the public, managers, or colleagues; feeling pressure from their manager to come to work despite feeling unwell; and the extent to which colleagues felt the organisation valued their work.

Discussion was held regarding the timescales identified for delivering the actions as some actions requiring urgent delivery had been provided with a 12-month lead in time. It was explained that cultural awareness training was underway to support delivery of the actions and time would be required to embed changed practices as current norms were being challenged. The Trust operated a zero tolerance policy which was being reinforced and from June 2024 training would include topics such as how to be an effective bystander, reinforcing expectations, and how to call out areas of poor practice. Work was also ongoing with some teams where discrimination was not an issue and data would be triangulated for areas where good practice was seen. In response to a

question regarding how the Trust ensured colleagues were confident and assured they had been listened to, it was explained that processes were being strengthened by line managers at local level to ensure feedback was provided.

The Board RESOLVED that the priority areas for action and the external publication of the results of the 2024 WDES and WRES submissions be approved.

99/24 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee provided an overview of items discussed at the meetings on 26 March and 23 April 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board. Key highlights included

- Clinical divisions attended the March meeting to deliver their operational plans and robust discussion was held to provide assurance to the Committee.
- Planning arrangements and funding options to be considered in relation to staff wellbeing and comfort.
- The Committee sought additional assurances across some underperforming areas including patients who did not attend, diagnostics and outpatients, along with revised recovery trajectories for the emergency department.
- A significant shift in-year on the waiting lists and staff were commended for their hard work to move the Trust to a more stable position.
- The Committee endorsed the 2024-25 Annual Plan recognising the high-risk nature of the plan.

100/24 Corporate Objectives 2024-25

The report presented the 2024-25 corporate objectives identifying the key areas for action during the year, including the measures of success, lead Director, and alignment to Committees of the Board to receive assurance on delivery. The intention was to provide guidance for colleagues across the organisation in setting their departmental and individual objectives and the corporate objectives were part of the new system of strategy and planning alongside the Single Improvement Plan and the developing Trust Strategy. As the new system was developed the planning timetable would be brought forward such that the draft corporate objectives would be presented in December for finalisation by March for the coming financial year.

The Board welcomed the document and supported the timescale for the annual corporate objectives in the future. The Board also recognised the document was high level and did not include specific metrics although it was understood those measures would be developed as divisions and departments agreed the deliverables.

Discussion was held regarding the scope of the objectives, how success would be measured and whether the ambition articulated needed to be strengthened. It was explained that there was clarity around the corporate objectives for the first year and the relatively narrow focus was intentional due to the amount of work that would be required, rather than extend the focus more broadly during the first year of delivery. There was also more detailed information in the background on success measures as part of the SIP and Financial Recovery Plan. Issues such as reducing sickness absence to the national average would realise approximately £2m savings and was the overarching target rather than listing specifics as stand-alone objectives. As mentioned, discussions

would start around late September or early October on the objectives for 2025-26. Some Board members felt that it would be helpful to see the corporate objectives tied into the SIP with more specificity in terms of the measures rather than words such as 'improve' which had an element of interpretation.

In response to a question regarding the intentions around the Trust Strategy and what would happen with the current strategy (Our Big Plan), it was explained that the three-year and longer-term 10-year plan were being developed which would replace the current strategy and the challenge would be gathering together all elements to ensure links and alignment to all the plans being developed was clear. A schedule of engagement sessions had been drawn up for internal and external stakeholders, including governors, to ensure broad coverage to capture views and feedback.

Clarification was requested regarding whether the objectives had been articulated and road tested with staff. It was explained that it would have been preferable to engage with staff although there was an element of pressure to develop and present the objectives to the Board as part of the in-year planning cycle. The information would be cascaded using established methods and processes and feedback would be obtained during the engagement sessions which would be helpful when developing the 2025-26 corporate objectives later in the year.

The Board RESOLVED that the corporate objectives for 2024-25 be approved.

101/24 Single Improvement Plan Targets and Measures

The report provided an update on the implementation of the Single Improvement Plan (SIP). Following discussion at the Board Workshop on 14 May, the SIP had been refined to avoid duplication or overlap and now covered five domains (Well Led; Safety, Quality and Clinical Effectiveness; People and Culture; Operational Performance; and Financial Sustainability). The plan also had a significant focus on strategy and planning.

An overview was provided on the new way of working being adopted to increase pace of delivery of the SIP and the benefits identified for each domain. Work was being undertaken to refine the key metrics for each domain and final amendments would be made in light of further feedback received, with the intention to report through relevant Committees of the Board from June 2024. A Place-based section of the SIP was being produced to ensure collaborative working with partners on key shared priorities. Reference was made to the work that would be required on the 10-year plan which would replace the Trust's current strategy (Our Big Plan) and cover broader aspects linked to the SIP including the three-year clinical plan. An external discussion would be needed with colleagues at NHSE as the plan required sign off by the Regional team, the ICB and the Trust. The Board was asked to approve the metrics presented in appendix 1 recognising that as the document was refined some minor changes to the measures would be required.

Discussion was held regarding the process for working with partners in terms of clear measures of success. It was explained that there was reference to that approach within the report and work was ongoing. The Trust would be clear in terms of external support required, both operationally and clinically, and the interventions required from various partners such as the ICB, community and social care. Clarity around commissioning intentions would also be required along with ensuring the Trust was involved in discussions around the ICB planning intentions.

Discussion was also held regarding co-dependencies between the different strands of the SIP and governance arrangements. The Board was advised that from an operational delivery perspective, the Executive Management team met twice per week and a regular session was included on the cycle for the Financial Recovery Plan. In addition, there was an overarching Recovery Board with a direct report to the Trust's Chief Executive. The Executive Directors would be held accountable for delivery and the Executive Directors would hold to account divisional leads with cascade through the line management structure.

In response to a question regarding when the final version of the SIP containing locked down metrics and targets would be available, it was confirmed that the final plan would be available at the end of June.

The Board RESOLVED that:

1. **It was assured on the progress made on development of the Single Improvement Plan.**
2. **The key metrics and targets as presented in appendix 1 be approved recognising that some refinement of the measures was required and that work would be completed by the end of June 2024.**
3. **Monitoring of key metrics through relevant Committees of the Board from June 2024 be supported.**

102/24 Integrated Performance Report as of 30 April 2024

The integrated performance report as of 30 April 2024 provided an overview of key performance indicators aligned to Our Big Plan. Detailed scrutiny of the metrics aligned to the four ambitions was undertaken by respective Committees of the Board. Key messages were highlighted from each of the key ambitions in addition to those already reported by respective Committee Chairs.

Consistently Deliver Excellent Care – starting next week there would be a six-week period focusing on supporting, embedding, and sustaining performance in urgent and emergency care. In respect of elective care, for the first time the Trust was reporting zero on the 65-week waiting list target. Orthodontics and dental services were areas requiring additional scrutiny to ensure compliance with targets and the surgical division was monitoring performance. An overview was provided of the cancer backlog position.

In response to a question regarding meeting performance on cancer pathways, it was explained that the service investigated all patients to determine whether the patient had cancer. Where it was obvious that patients were presenting with cancer then they would immediately be placed on treatment. At present, 75% of patients were informed of their diagnosis within 28 days which allowed the service to focus on those patients with a confirmed cancer diagnosis.

In respect of safety and quality reference was made to *C.difficile* and it was noted the Trust had not yet received the trajectory for 2024-25. Monitoring of compliance continued based on the agreed plan for 2023-24.

Clarification was requested on whether the pressures in the emergency department were fully understood as whilst boarding patients and the Community Healthcare Hub had helped with admission avoidance, the difference in improvement of the 4-hour wait

in the emergency department was minimal (1.4%). Some Board members suggested that the improvement actions that had been introduced should be reviewed to ensure they were delivering the expectation.

It was explained that significant effort was being put into reducing the 4-hour wait position although it was acknowledged that focus may not have been directed to what would have had the biggest impact. The plan was to go back to basics to clearly identify what would be influenced internally and where the Trust needed assistance, including identifying and addressing any unintended consequences of the current approach. Should it be identified that there remained fundamental capacity issues then the Trust would need to go through the formal business case process rather than carry on with the actions being delivered at present. It was further noted that the data was now showing that type 3 performance (urgent care centre) had started to reduce while type 1 activity (emergency department) was increasing. The ICB had commissioned an external company to look at all urgent and emergency care across the system therefore further work would need to be undertaken around Place and System and individual plans would need to be brought together. It was recognised that ultimately the solution would be around partnership working to ensure patients were managed in the way that they would expect. During discussion it was recognised that the Board would also need to look at ambulance handover times as there were pressures in the system relating to Royal Preston Hospital.

Great Place to Work – a sustained downward trajectory had been seen in relation to agency usage and spend which was reporting below the NHSE target. The sickness absence rate had also reduced during month one in line with seasonal trends.

Deliver Value for Money – the Trust was waiting for final approval of the financial plans and had delivered against the plan for month one with a deficit of £3.7m. The Trust continued to have considerable underlying financial pressures to manage with a financial gap of £58m which required mitigation. An overview was provided on the capital and cash position, cost improvement programme, and use of resources.

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

103/24 Audit Committee Chair's report

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

- Positive assurance received regarding delivery of the internal audit plan for 2023-24 and a positive overall conclusion was expected.
- The programme of work to support production and finalisation of the 2023-24 Annual Report and Accounts was on track.
- Good progress had been made on resolving some of the recommendations included in previous audit reports.
- A number of audit reports had been finalised since the Committee meeting in January. The audit on duty of candour was referenced with some recommendations regarding not following procedures in a timely manner, along with some issues

identified in the audit report relating to key financial controls where processes and policies had not always been adhered to. These would be explored further at future meetings.

- The external auditors had identified significant risk around the Trust's financial sustainability and they were working with the Trust in respect of how it moved to a financially sustainable position over a period of time.

It was noted that operational compliance with policy and control processes had also been picked up by the Finance and Performance Committee and was an area of increased scrutiny for Non-Executive Directors within Committees.

104/24 Board Appointments

The report provided an update on the end of terms of office of Jim Whitaker, Michael Wearden and Peter Wilson, together with the subsequent appointments of Uzair Patel to the position of Non-Executive Director for a term of office of three years from 2 July 2024 (Minute 189/23 refers), including a proposal for the appointment of Victoria Crorken as Chair of the Board of Lancashire Hospital Services (LHS) Limited.

The Board formally recorded its thanks to those stepping down for their commitment and service to the Trust during their relevant tenure.

The Board RESOLVED that the appointment of Victoria Crorken to Chair of the LHS Board be approved.

105/24 Items for information

The following reports were received and noted for information:

(a) New Hospital Assurance Committee Chair's Report

(b) Infection Prevention and Control Annual Report 2023-24 and Action Plan 2024-25

(c) Bi-annual Midwifery Staffing Report

(d) Patient Experience Annual Report 2023-24

The Board referred to the significant reduction in the number of complaints received (30%) and queried whether the reason for the decrease was clearly understood. It was explained that focus had been directed to early resolution at local level which was now the mechanism to resolve concerns or issues in real time rather than see them escalating as a formal complaint. In response to a question regarding whether a record was kept of concerns or issues resolved as part of that early resolution process, it was confirmed that records were kept of all complaints, concerns or issues raised. In addition, all areas of the Trust were encouraged to log compliments to provide balance. There was nothing being seen where complaints were received using other access routes such as digital inboxes or social media, which supported the position and the data provided by the Patient Experience and PALS team. The Non-Executive Director Lead for Raising Concerns added that the data on complaints was also scrutinised and linked with Freedom to Speak Up activity.

(e) PSIRF and Annual Report of Incidents Reported to StEIS

Reference was made to the previous reporting on the Strategic Executive Information System (StEIS) where serious untoward incidents were registered and it was noted that the number of incidents had reduced when looking at the data within the PSIRF report. Clarification was requested on whether the reduction in numbers related to how the Trust was now reporting those incidents. It was explained that the Trust was in a transition period in terms of reporting serious untoward incidents and there was a need to capture the learning from the action review. StEIS reporting was different and that information would start to be embedded into future reports.

(f) New Hospitals Programme Q4 Report

At this point the Chair, on behalf of the Board, closed the meeting by paying tribute to Jim Whitaker, Michael Wearden and Peter Wilson for the work they had undertaken during their terms of office. Similarly, the Chief Executive paid tribute to Imran Devji who had stood in as interim Chief Operating Officer since 1 October 2023 and would be moving across to take up a role with the Lancashire and South Cumbria ICB.

106/24 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 1 August 2024 at 1.00pm in the Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital.

Signed: _____

Chair

Date: _____

Action log: Board of Directors (part I) – 6 June 2024

There were no outstanding actions from previous Board meetings and no actions identified during the meeting on 6 June 2024.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Chair's Report			
Report to:	Board of Directors	**Date:**	1st August 2024
Report of:	Chair of the Trust	**Prepared by:**	Rebecca Black System Collaborative Business Manager to CEO
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

Chair's Report

1. Introduction

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

The Immersive Suite
I visited the Immersive Suite on the 13th June with Governor colleagues. During the visit we also met with the Blended Learning Team, a multidisciplinary group that creates engaging, effective, and innovative learning experiences. They work closely with colleagues across the Trust and the ICB to develop tailored learning solutions that meet their specific needs and objectives. By leveraging cutting-edge technologies and industry best practices, they create interactive and immersive content that enhances knowledge retention and learner engagement.

Governors
Following the Governor Elections in March this year I have now had the opportunity to meet with our new governors as part of their induction to the Trust. Our Governor Body represent their local communities and work together to advise and influence how we develop and deliver services. I look forward to working with them as we support the organisation to improve quality of care for our patients.

Part II Board of Directors' meetings – June and July 2024

The items discussed at the 6 June part II Board meeting are outlined below along with a brief resume of the discussions. The Board held two Special part II meetings on 25 June and 5 July and the items discussed have also been summarised below.

6 June 2024:

1. **Trust's Financial Plan** – the Board approved the 2024-25 financial plan for submission to NHS England on 10 June 2024.
2. **Mutually Agreed Resignation Scheme (MARS)** – the Board approved the proposal to introduce a time-limited MARS which would support the Trust's financial recovery plan through providing greater flexibility in creating efficiencies, redesigning services and achieving cost reduction.
3. **Governance Review Task and Finish Group** – the Board received a brief update on progress with the work of the Task and Finish Group.
4. **Staff Suspension Report** – the Board received the up-to-date position regarding staff suspensions.
5. **Minutes of meetings** – the Board received copies of relevant approved minutes from meetings of Committees of the Board.

25 June 2024:

1. **Annual Report and Accounts 2023-24** – the Board received and approved the report following scrutiny and recommendation by the Audit Committee.
2. **Contract renewal** – the Board approved a request for contract renewal costs.

5 July 2024:

1. **One LSC Strategic Collaboration Agreement (SCA)** – the Board had a detailed discussion on the draft SCA for One LSC and agreed the matters that still needed to be addressed prior to final approval.
2. **New Hospitals Programme Land Acquisition** – the Board received an update on the status of arrangements for acquisition of land for the new hospital build.

2. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during April and May 2024.

Date	Activity
June 2024	
3rd June	Lord Victor Adebowale, Chair – NHS Confederation
4th June	Chief Executive, LTHTR
6th June	Board of Directors
11th June	Governor Working Group
11th June	Appointments, Remuneration and Terms of Employment (ARTE)
11th June	Chief Executive, LTHTR
11th June	Provider Chairs
11th June	Non-Executive
12th June	NHS Confed Session
13th June	Governor Visit to the Immersive Suite
13th June	Sarah James, ICB (title)
13th June	Provider Chairs
13th June	Provider Collaboration Board
18th June	Turnaround Director, LTHTR
18th June	System Leaders Oversight Group
21st June	Chairs, Deputy Chairs and Lead Governor
25th June	Chair, ICB
25th June	Chief Executive, LTHTR
25th June	Non-Executive Directors

25th June	Committee Structures
27th June	NHP Partnership Forum
27th June	One LSC SCA Board Engagement Session
July 2024	
5th July	Special P2 Board
16th July	Chief Executive, ICB
16TH July	Introduction meeting – New Governor
16th July	System Leaders Group
18th July	Turnaround Director, LTHTR
18th July	NHS Providers Governor and Non-Executive Director Workshop
18th July	Chief Executive, LTHTR
18th July	Company Secretary, LTHTR
22nd July	Executive Director – Continuous Improvement
23rd July	Chair, ICB
23rd July	Introduction Meetings – New Governors
23rd July	Chief Executive, LTHTR
24th July	Council of Governors Public Meeting
25th July	Board Training Day

3. Financial implications

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

4. Legal implications

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

5. Risks

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

6. Impact on stakeholders

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

7. Recommendations

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

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors' Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	1 August 2024
Report of:	Chief Executive	**Prepared by:**	N Duggan
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable

CHIEF EXECUTIVE'S REPORT

General Election

The July 4 General Election resulted in a new Labour Government with significant change to our local MPs, with Sir Keir Starmer's party winning all bar three of the 17 seats across our patch. Royal Preston Hospital now falls in the constituency of Ribble Valley following the 2023 Periodic Review of Westminster constituencies, and Labour's Maya Ellis was elected, taking the seat from Nigel Evans. Sir Mark Hendrick retained his seat in Preston, while Speaker Sir Lindsay Hoyle won the election in the constituency of Chorley.

I have invited all our new MPs into the Trust to gain a better understanding of the work we do, and to gain their support on important topics such as the New Hospitals Programme.

While there has been a change of Government, and Prime Minister, there is a new Secretary of State for Health and Social Care, in Wes Streeting, who had been shadow secretary, with two new Ministers being appointed – Stephen Kinnock and Karin Smyth.

Global IT outage affects Trust systems

On 24 July, Lancashire Teaching Hospitals, along with partners across the wider Lancashire and South Cumbria healthcare system, were affected by the world wide mass IT outage. This saw significant disruption to a number of systems - most notably HealthRoster and Harris Flex.

Business Continuity Plans were put into place a cross a number of areas whilst a collective effort was made to restore systems and minimise the disruption caused to patients.

Important public messaging was shared across our local communities encouraging patients to attend their appointment as planned, unless they had heard otherwise. Due to safety considerations, a number of elective procedures were cancelled at Royal Preston Hospital, and these will be rescheduled as soon as possible. As you would expect there was extensive press interest in the impact of the outage and the case of a patient whose procedure was cancelled at RPH was widely covered by the national and international media – this has been rearranged and the delay has not affected the outcome for that patient.

Our staff, particularly the digital and EPPR and divisional teams did a fantastic job in re-establishing systems and keeping as many services up and running as possible and I would like to offer my thanks to all those involved.

Improving our financial position – progress report

Throughout June and July, the Trust has been working hard to identify and sign off the full value of the £58m savings plan identified for 2024/25. Whilst not managing to progress 100% of the plan through the necessary gateway process by NHS England's 30th June 2024 deadline, a real focus has been made towards getting all Project Initiation Documents (PIDS) and Equality Impact Assessments (EQIAs) completed for each of our savings schemes to be able to have full assurance of delivery.

To support our financial recovery, we also introduced our Mutually Agreed Resignation Scheme (MARS). This is a time limited scheme under which a colleague may choose to leave their employment in return for a payment. It is not a redundancy or voluntary redundancy scheme - MARS has been developed with the aim of increasing workforce flexibility.

We also highlighted that we would be putting in place additional controls around growing our headcount and expenditure in the short term. Our Executive Team took the decision to both strengthen our vacancy control panel (VCP) processes and freeze or defer recruitment to at least 31 July 2024. We will review the position and decide on if we continue the freeze based on the progress that is being made on living within our overall budget and delivery of our savings plan.

Thank you to all colleagues who has been involved in working on the six-week discharge accelerator scheme. The scheme was focused on getting patients into the right setting of care, first time and reducing discharge delays to help get patients home sooner. The recent focus has been on unlocking our escalation processes to help the Trust work as one to reduce discharge delays and providing a real focus on our assessment unit inclusion, exclusion and referral criteria for the Surgical Assessment Unit, Acute Assessment Unit, Acute Frailty Assessment Unit and Same Day Emergency Care. Getting people home, or to a more appropriate place of care, is one of the best things can do for patients in terms of their recovery, but it also makes financial sense for us too.

The launch of that campaign also tied in nicely with the launch of Pride and Joy at Chorley which is a digital system that enables us to quantify the delays to patient experience. Teams have embraced the system and are using it well, so I would like to say thank you to those who have helped adopt this at real pace. Our Continuous Improvement (CI) team are now focussing on reengagement of the system at Royal Preston Hospital (RPH), to ensure all colleagues understand how to use it, and how we can capture data in the best way.

I understand that Ailsa Brotherton, our Director of Improvement, Research and Innovation, recently visited the medical wards in Chorley to thank staff for the great work they are leading and to hear first-hand how the teams are finding the system and to learn about any challenges and barriers our colleagues are experiencing. The team are in the process of writing up the learning from the and this will be shared via our usual Trust communications and engagement mechanisms.

Trust Strategy

As the Trust builds on our existing strategies to develop a new Trust Strategy for 2024-2030, we are using this great opportunity to consider what really matters over the coming years and where we as a Trust want to get to, working with our partner organisations across Lancashire and South Cumbria. We are engaging with Trust Governors and our system partners to discuss the Strategy from their perspective, and it was essential that we heard from staff across the Trust via our colleague Strategy Engagement Events, which I had the pleasure of opening in the Education Centre at Chorley Hospital on 20 June. It was good to engage with colleagues to hear about how our Trust should be developing to meet the challenges and opportunities of the future and this feedback will inform this important piece of work.

Provider Collaborative appoint new Managing Director

I am delighted to confirm that following a competitive process our Chief Finance Officer and Deputy Chief Executive Jonathan Wood, has been offered and has accepted the new role of Managing Director of the Lancashire and South Cumbria Provider Collaborative.

Our Provider Collaborative has been in place for a number of years now and we have recently undertaken a system wider engagement exercise with members of all LS&C Trust Boards and the wider Integrated Care system to establish how our work can be reframed to ensure we focus on transforming both our clinical and corporate services at pace.

The Managing Director role has been created by reusing existing budgets to give us the capacity we need to drive this work forward. Jonathan will be instrumental in developing and implementing the collaborative's shared objectives and will be providing strategic leadership to drive a wide range of collaborative programmes of work on behalf of the Chief Executives of the five Acute and Mental Health Provider organisations across L&SC. This will include supporting and delivering large-scale transformation initiatives for the benefit of our patients, staff and wider communities and ensuring effective partnership working across the Integrated Care System.

Jonathan will now lead the L&SC PC to deliver on its vision and successfully implement the next stage of our development. He will be a member of the Provider Collaboration Board, System Recovery and Transformation Group and aligned committees and will be working closely with colleagues throughout our health and care system.

Details such as a start date and the arrangements for Jonathan's replacement at LTH are still being finalised and will be communicated in due course, but I know Board will join me in congratulating Jonathan on his new role.

Interim Chief Operating Officer Imran Devji moves on to new ICB role

At our last board meeting, we were able to pass on our thanks to Imran Devji, our Interim Chief Operating Officer, who left the Trust at the beginning of June to start a new role within the Integrated Care Board (ICB), where he will be on secondment as Interim Director for System Acute Clinical Service Recovery.

I'd like to thank Emma Ince, our Deputy Chief Operating Officer, who has stepped up into the role of Interim COO until our new substantive Chief Operating Officer, Katie Foster-Greenwood, joins us in mid-August. Katie has been joining us for key meetings and has been getting to know colleagues around the Trust so is up to speed on key issues and will be able to hit the ground running.

One LSC – Estates and Facilities

Lancashire Teaching Hospitals is working closely with other Trusts across the local Healthcare system to bring together a number of larger, co-ordinated shared central services under the title One Lancashire and South Cumbria (ONE LSC). This is in line with the national direction of travel for shared services.

Our Trust Board has been fully engaged in developing the leadership, governance, and delivery arrangements for One LSC and are working closely with One LSC's Managing Director, Sharon Robson and Programme Director, Margie Burdis, to conclude the final arrangements for the work that needs to happen ahead of a planned October 2024 transfer.

However, following a risk assessed approach, our Trust Board have agreed that our Estates and Facilities service will not be part of the initial transfer to One LSC. This decision will allow us time to conclude our ongoing internal turnaround activity to the satisfaction of the regulator given our particularly ageing and inefficient estate. The team here will continue to work closely with James Maguire, One LSC Chief Officer for Estates and Facilities, to ensure that our Trust contributes to and benefits from the emerging One LSC operating model and our Estates and Facilities colleagues feel included as partners working with One LSC colleagues ahead of a new transfer date at the end of the first year.

It is intended that the rest of our in-scope services will transfer at the planned October transfer date and the One LSC leadership team will be arranging a series of workshops to enable staff to go along, meet the team and ask questions. We will also continue to provide regular updates via our own internal communications and engagement mechanisms.

New Hospitals Programme

Over the last period the New Hospital Programme has focused on progressing the proposed site for a new Royal Preston Hospital. Advisors have completed the due diligence for this phase to demonstrate the viability of the proposed site. This has included further technical surveys, valuations and legals. The required business cases are progressing through the required local and national governance, checks and approvals and it is hoped an update can be provided over the coming months. Whilst a proposed site has been identified, this is subject to a public consultation and the Trust and ICB remain open to alternative sites coming forward. These will be considered and assessed against the existing criteria.

This is a significant and exciting milestone for the NHP and we look forward to announcing the proposed site and embarking on a series of pre-consultation activities where we can hear the views of our patients, population and workforce. The timeline of which will ultimately be determined by the critical dependencies, namely securing the land.

The Programme has also continued engagement with the national NHP team with regard to Hospital 2.0 – an integrated approach to provide optimised, standardised and repeatable solutions for hospital design, construction and operation. A range of documentation has been received for all schemes to review and comment. Whilst a new Royal Preston Hospital is some years away and Hospital 2.0 will continue to evolve, this is a real tangible step and starts to bring the design and workings of future hospitals to life. The Programme looks forward to continuing this valued and collaborative approach with the national NHP team.

National, Regional and Local Recognition

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

- **Celebrating our Internationally Educated Colleagues**

It was a pleasure to be asked to attend a special celebration event for our Internationally Educated Colleagues, along with Deputy Chief Nurse, Catherine Gregory, and Chief Strategy and Planning Officer, Gary Doherty, in Education Centre 1, to thank them for the contributions and sacrifices they have made working for the Trust.

Colleagues - all recruited from outside of Great Britain - received awards to recognise their hard work and commitment to the Trust, while there were presentations speaking about personal experiences, and a marketplace for community events and support.

Following a successful inaugural celebration last year, the event was opened by International Pastoral Support Officer, Lauryn Guest, while we heard a presentation on Allied Health Professional International Recruitment Insight, as Michael Flome, Akinkunmi Omotoso and Aruna Midiyanselage, from Core Therapies, spoke of their experiences of joining the Trust from Ghana, Nigeria and Sri Lanka respectively, before myself, Catherine and Gary, presented all winners with a certificate. It is great to see the impression they and the many other Internationally Educated Colleagues have made at the Trust.

- **Gregg's perfect preparation for Paris Paralympics**

In their final race before the Paralympics in Paris at the end of August/beginning of September, World and two-time European champions Gregg Stevenson and Lauren Rowles maintained their unbeaten run in the PR2 mixed double sculls in Poznan, Poland on the last day of racing at World Rowing Cup III.

Gregg - former Lead Physical Training Instructor and Mental Health Practitioner at the Trust's Specialist Rehabilitation Centre (SMRC) - and Lauren, crossed the finish line over six seconds ahead of Germany, and go into the greatest show on Earth as favourites for the gold medal.

The former Royal Engineer, from Foulridge, remains unbeaten in what is only his second year in the boat. His journey began in 2009 when he was referred to the SMRC, after losing both his legs to an IED blast while on patrol in Helmand Province.

He went on to work at the centre, and still makes regular trips to from East Lancashire for support with his prosthetics – indeed, he was back at the centre two days after winning in Poland for repairs!

- **LEAPS award for two of our teams**

It was great to hear that our Cardio-Respiratory and Respiratory and Sleep Services teams have been recognised for their work by the NHSE/ICB Health Care Science in Lancashire and South Cumbria Network.

They have been awarded with a Learning, Excellence and Achievement for Physiological Science (LEAPS) Award, and Trust Chief Medical Officer, Dr Gerry Skailes, was on hand to present them with their certificates, having both developed and implemented services to provide better care for patients.

The Cardio-Respiratory team were recognised for their work over the last six years, having developed and extended services to benefit patients such as physiologist-led valve clinics, a two-week rule rapid access chest pain clinic, and open access echocardiography for patients with heart failure.

The Respiratory and Sleep Services team, meanwhile, provides high-quality diagnostics and manages referrals from multiple services within the Trust and have introduced a Home Monitoring module in Sleep Service to reduce consultant follow-ups, increasing new appointments and reducing patient waiting times, as well as developing a demand and capacity model with the Trust Business Intelligence Team and NHSE to ensure smart cross-checking and timely diagnostics.

- **Jane is a Team Player!**

Congratulations to Jane Parkinson, who won the Team Player Award at the Lancashire and South Cumbria NHS Health and Social Care Apprenticeship Awards. Jane, Apprenticeship Programmes Trainer at the Trust, was recognised for her hard work and dedication to deliver successful apprenticeships for young talent in the community, and received her award from host and TV presenter, Owain Wyn Evans at Blackpool's Winter Gardens, Blackpool.

The Trust had 20 employees, including Jane, shortlisted across nine categories for the annual event, with Stephanie Higham (Equality and Diversity), Alexandra Rose Redfern (Rising Star T Level), Emily Greenall (Perseverance) and Anu John (Above and Beyond) Highly Commended runners-up in their categories.

Jane, who dedicated her award to her Health Academy colleagues, has been with the Trust 22 years, spending 17 years in Accident and Emergency, now the Emergency Department, as an assistant practitioner, before moving into education.

- **Trust shortlisted for 2024 HSJ Patient Safety Awards**

The HSJ Patient Safety Awards programme is a high profile and hugely respected platform showcasing the work and achievements of the many healthcare professionals who enter, so it was fantastic news to see the Trust's Chorley Children and Young People Surgical Hub Project shortlisted for the Improving Care for Children and Young People Initiative of the Year.

The project established a paediatric elective surgical hub at Chorley and South Ribble Hospital for the first time, moving some of our multispecialty paediatric surgical day case lists from an acute site at Royal Preston Hospital to our existing elective hub, allowing us to treat more children in the same number of theatre sessions, with the added benefit of improved patient, carer and staff experience.

Winners will be announced during the awards ceremony at Manchester Central, on September 16, 2024.

- **Celebrating surgical innovation**

Our colleagues work so hard to deliver outstanding care for our patients, and it was remarkable to read about the story of maxillofacial cancer patient John Farnworth, who has been given a second chance at life after the Trust successfully performed Lancashire and South Cumbria's first-ever ZIP flap procedure. The 81-year-old from Chorley underwent the 12-hour surgery after being diagnosed with cancer involving a large part of his upper jaw, which would have spread and was life-threatening.

The surgery, which was led by Pavan Padaki, Consultant Maxillofacial/Head and Neck Surgeon, accompanied by Consultant Maxillofacial/Head and Neck Surgeon Shakeel Akhtar, involved taking away 80% of the patient's upper jaw and then reconstructing it with a Zygomatic Implant Perforated Flap.

Zygomatic implants - long metal implants – were placed into the cheekbones on both sides, following the resection of the upper jaw. Tissue was then taken from the forearm, along with the artery and vein, and then the skin was sutured to close the whole maxillary defect, with the zygomatic implant perforating this flap of tissue

and protruding into the mouth. The artery and vein supplying the flap of tissue was then sutured to the artery and vein in the neck under the microscope.

The Restorative team, led by Consultant Restorative Dentist, Dr Jenna Trainor, then fixed dentures into the implants, which will greatly improve John's quality of life.

It was described on social media as 'The NHS and Lancashire Teaching Hospitals at their best', and the same could be applied to the Trust's Neurosurgery department, who successfully performed its first complex spinal surgery utilising intraoperative 3D CT and navigation technology.

This state-of-the-art technique involves the use of Stryker's AIRO TruCT - an intraoperative 3D CT scanner – which allows surgeons to obtain high-resolution, real-time images of the spine during surgery, enhancing the ability to place spinal implants with remarkable precision. This reduces the likelihood of errors, minimises tissue damage, and shortens recovery times for patients. Moreover, this technology can significantly decrease the need for follow-up surgeries, ultimately reducing healthcare costs and improving patient satisfaction.

Patient Jason Westcott was the first to undergo this new complex procedure, having been diagnosed with L3/4 spinal stenosis - a narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs – for which he was required to have L3/4 decompression surgery to treat the compressed nerves, pedicle screw fixation and interbody fusion.

Congratulations to neurosurgeon Syed Hashmi, Implementation Lead for the AIRO CT and Navigation System, and his team.

- **High praise from NHSE for Trust's EPRR facilities**

Along with Director of Resilience for NHS England, Stephen Groves, and North West Regional Director of EPRR, Phil Storr, I was recently invited to officially open our recently-refurbished decontamination unit at Royal Preston Hospital by Emergency Preparedness Resilience & Response (EPRR) Manager, Sam Hughes. Both Stephen, Phil and I were impressed with what we saw. As part of the NHS EPRR Core Standards, the Trust must plan for and be prepared to respond to all emergencies, and as part of this have facilities to be able to manage people who may have been exposed to chemicals because of an accident or deliberate release.

On top of that, Stephen and Phil had a visit to the Tactical Incident Coordination Centre (TICC), and the Security Control Room, and Stephen said: "I've been extremely impressed with the way in which Emergency Preparedness is organised in the organisation. The new decontamination facility is excellent and would support good patient care for anybody who is contaminated. The safeguarding elements of the security facility are second to none - I don't think I've seen a system as comprehensive as that, it's superb."

Well done to Sam and all involved.

- **Neurosurgery registrars involved in NIHR scheme**

The Trust have three neurosurgery registrars formally involved in the NIHR Associate Principal Investigator scheme, which enables bright and enthusiastic clinicians to gain experience of having overall responsibility for the running of a clinical research study at their hospital.

Daniel Lewis has just completed his six-month API scheme with consultant neurosurgeon Andrew Alalade for the SC IL-1Ra study; John Usuah has just completed his six-month API scheme with consultant neurosurgeon Kaushik Ghosh for the DENS study; and Frazer O'Brien is currently undertaking the scheme with consultant neurosurgeon Nick Park for the Stop-D study.

All of these studies have run well at LTHTR as a collaboration between the neurosurgery and research and innovation departments, and this speaks very highly towards engagement of neurosurgical trainees with research.

1. RECOMMENDATIONS

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

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Board Assurance Framework (BAF) Risk Report

Report to:	Board of Directors	**Date:**	1st August 2024
Report of:	Associate Director of Risk and Assurance	**Prepared by:**	K Clay
Part I	✓	**Part II**	

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

Executive Summary:

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

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

Strategic Risks

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

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

There has been no change in score for:

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

The risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service is now controlled following agreement at Board in June 2024. However, this will be revisited as commissioning intentions develop.

Operational High Risks for Escalation/De-escalation

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

- Risk ID 25 (scoring 20), Impact of exit block on patient safety, which has been escalated to Board since December 2020 due to the occupancy levels within the Emergency Department at Royal Preston Hospital.
- Risk ID 1125 (scoring 20), Elective Restoration following Covid-19 Pandemic, which has been escalated to Board since June 2021 and relates to the recovery of cancer, and non-cancer backlogs.
- Risk ID 1157 (scoring 20), Increased cases of clostridioides difficile (C.*difficile*) Infection, which has been escalated to Board since April 2024.

- At the Safety and Quality Committee meeting in May 2024, it was agreed to escalate Risk ID 584 - Risk of patient harm due to limited provision of the Neurointervention service including thrombectomy, to the Board of Directors as an operational high risk of concern. Due to the timing of the Committee, it was not possible to include this in the paper for June's Board, however, it was verbally reported to indicate that formal escalation will take place in August 2024. This escalation is in recognition of the increased risk of harm to patients whilst the 7 day Neurointervention services are not in place and sustained.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.
ii. Review and consider accepting the recommendation for operational risk ID 584 (Risk of patient harm due to limited provision of the Neurointervention Service including thrombectomy) to be escalated to the Board of Directors.

Appendix 1 – Board Assurance Framework
Appendix 2 – Strategic Risks

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Committees of the Board in line with cycles of business

1. Background

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

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

2. Discussion

2.1 Board Assurance Framework (BAF)

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

2.2 Strategic Risk Register

2.2.1 There has been no change in score for:

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

2.2.2 The risk to the delivery of the Trust's Strategic Aim of Providing a Range of the Highest Standard of Specialised Service is now controlled following agreement at Board in June 2024. However, this will be revisited as commissioning intentions develop.

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

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

2.3 Operational Risk Register

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

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

- Risk ID 1157 (scoring 20), Increased cases of clostridioides difficile (C.difficile) Infection, which has been escalated to Board since April 2024.

2.3.2 Risk ID 499 (Failure to effectively manage staff absence and achieve trust and national target rate) – had been reference in June 2024's Board paper as a risk which may be escalated to Board from Workforce Committee, due to score increase from 16 to 20 and due to the potential for loss of activity and income and the amount of secondary pressure created. At Workforce Committee in June 2024, it was decided that this risk would not be escalated to Board for oversight at this time, as there have been improvements in the absence position and there is a clear plan in place to support the Trust's financial recovery plan (FRP) which can be overseen by Workforce Committee.

2.3.3 At the Safety and Quality Committee meeting in May 2024, it was agreed to escalate Risk ID 584 - Risk of patient harm due to limited provision of the Neurointervention service including thrombectomy, to the Board of Directors as an operational high risk of concern for oversight. Due to the timing of the Committee, it was not possible to include this in the paper for June's Board, however, it was verbally reported to indicate that formal escalation will take place in August 2024. This escalation is in recognition of the increased risk of harm to patients whilst the 7 day Neurointervention services are not in place and sustained and following recent outcome from Coroner's inquest requiring action. There has been an agreement that the service can move to 7 day working for commissioned hours of 8am – 6pm on 5 out of 6 weekends. However, the service will not be 24/7 and one weekend in 6 will not be covered in commissioned hours.

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

3. Financial implications

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

4 Legal implications

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

5. Risks

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

6. Impact on stakeholders

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

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

7. Recommendations

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

i. Note and approve the updates to the BAF.
ii. Review and consider accepting the recommendation for operational risk ID 584 (Risk of patient harm due to limited provision of the Neurointervention Service including thrombectomy) to be escalated to the Board of Directors.

Appendix 1 - Board Assurance Framework 2024/2025 – Risks to achievement of Trust Aims & Ambitions

Lancashire Teaching Hospitals NHS Foundation Trust

Trust Aims and Ambitions

Current principal risks on the Strategic Risk Register – August 2024

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

Strategic Risks		Risk ID	Initial Score	Risk Appetite	Risk Tolerance	June 2023 Score	Aug 2023 Score	Oct 2023 Score	Dec 2023 Score	Feb 2024 Score	Apr 2024 Score	June 2024 Score	Aug 2024 Score	Change
Risk to delivery of Strategic Aim to offer a range of high quality specialist services to patients in Lancashire and South Cumbria		859	8	Open	6-9	8	8	8	8	8	8	8	CONTROLLED	
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		860	6	Seek	9-12	20	20	20	16	16	16	16	16	→
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities &...	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	855	20	Cautious	1-6	20	20	20	20	20	20	20	20	→
	Risk to delivery of Strategic Ambition: A Great Place to Work	856	20	Open	4-8	16	16	16	16	16	16	16	16	→
	Risk to delivery of Strategic Ambition: Deliver Value for Money	857	20	Open	8-12	20	20	20	20	20	20	20	20	→
	Risk to delivery of Strategic Ambition: Fit for the Future	858	20	Seek	8-12	15	15	15	15	15	15	15	15	→

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

Lancashire Teaching Hospitals NHS Foundation Trust

Strategic Risk Summary

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

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

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

Key Operational Risk Summary for Escalation to the Board

Lancashire Teaching Hospitals NHS Foundation Trust

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

Escalated Risks

- **Impact of Emergency Department (ED) Exit Block on Patient Safety (Risk ID 25 – Initial Score 20, Current Score 20)** – The data measured through the Emergency Department (ED) Dashboard continues to demonstrate a department under significant pressure with sustained attendances and high numbers of patients waiting over 12 hours to be admitted to a ward or mental health facility. Whilst a number of actions have been taken to increase the capacity in response to increasing demand. It is acknowledged at this time that there is a requirement to refresh the approach to UEC plan. The bed reduction programme has been paused due to continued Urgent and Emergency Care pressures leading to boarding and the risk to safety. The Chief Operating Officer has led an assessment of demand and capacity that has identified a 123 bed gap. To resolve this, a number of approaches are progressing and some are in the planning phase, these include internal flow grip and control, virtual capacity, speciality pathway length of stay, community transformation and social care focus on pathway 1,2 and 3 patients. These are captured within the single improvement plan and being overseen through the system UEC board that will now be chaired by LTHTR and Place leader Louise Taylor moving forward in recognition of the addition focus required in this area.

- **Elective restoration (Risk ID 1125 – Initial Score 20, Current Score 20**) - Patients continue to wait for a significant amount of time to receive non-urgent surgery. The plan to eliminate 78 week waits by March 2023 was not achieved due to the displacement of activity during industrial action, however the Trust met its extended target of treating all 78 week waits by the end of March 2024 (with the exception of 11 orthodontics patients who were all provided with a date for treatment between March and April but not yet all treated, which was part of the forecast position). New plans have now been set and include:
  - Elimination of 65 week waits by September 2024.
  - DMO1 at 95% of patient waiting at under 6 weeks for routine diagnostics by March 2025
  - Cancer 28 day faster diagnostic standard at 66% by March 2025
  - Cancer 62 day treatment at 70% by March 2025
  - Elective activity at 107%

  All specialties have target plans to work to and are being supported through divisional meetings and the wider Performance Recovery Group. In addition to this there is an Elective Care Transformation Board established with Executive level leadership which is focusing on delivering:
  - Repatriation of services
  - Diagnostic efficiency
  - Sustainable workforce models
  - Theatre productivity
  - Streamlining elective pathways

- **Increased cases of clostridioides difficile (C.*difficile*) Infection (Risk ID 1157 – Initial score 16, Current score 20)** - The Trust continues to see higher than planned rates of C.difficile infection and whilst a number of actions have been taken and remain ongoing, this risk was recommended at Executive Management Team (in the absence of Senior Leadership Team meeting) and Safety & Quality Committee in February 2024 to be escalated to the Board of Directors for the consideration to be included within the Board Assurance Framework as an escalated risk for oversight. At Board in April 2024, the escalation of this risk was accepted, and the risk is now included within the Board Assurance Framework reports presented at Board. Further material actions taking place including exploring the requirement to fully implement the national cleaning standards at a cost of £1.2m and a structural review of sewage systems within the organisation that may lead to the requirement in the region of £10m to prevent the current leaks associated with a single stack system. NHS England Infection Prevention and Control team are also raising the estate affecting the ability to control infection as a significant concern at this time.

New Escalation

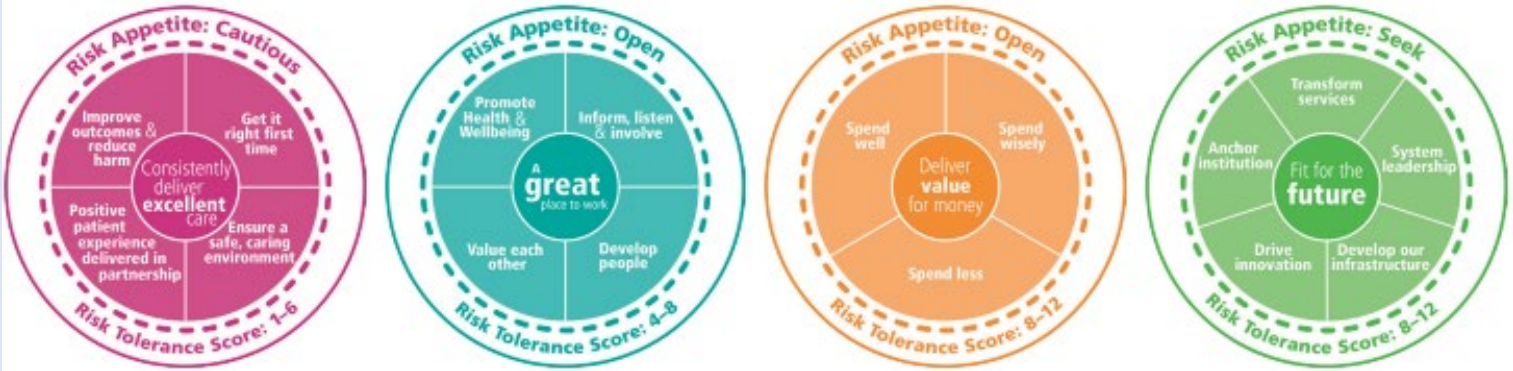
- **Risk of patient harm due to limited provision of the Neurointervention service including thrombectomy (Risk ID 894 – Initial score 8, Current score 20)** - Following increase of the risk score from 15 to 20 and discussion at Safety & Quality Committee in May 2024, it was agreed that the risk would be formally escalated to the Board of Directors as a risk of concern. This escalation is in recognition of the increased risk of harm to patients whilst the 7 day Neurointervention services are not in place. There has been an agreement that the service can move to 7 day working for commissioned hours of 8am – 6pm on 5 out of 6 weekends. However, the service will not be 24/7 and one weekend in 6 will not be covered in commissioned hours.

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

Lancashire Teaching Hospitals
NHS Foundation Trust

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

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



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

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

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

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

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

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Trust Risk Appetite Statement

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

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

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

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

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

Risk ID: 855
Risk owner: Chief Nursing Officer
Date last reviewed: 19th July 2024

Risk

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

This may, result in adverse patient outcomes and experiences.

Risk Appetite:

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

Risk Tolerance

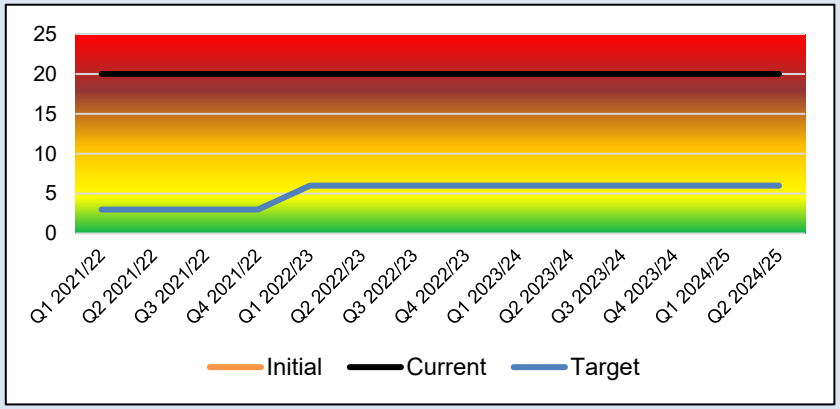
1-6

Rationale for Current Score

- There is currently a reliance on temporary workforce due to sickness levels in excess of 4% and greater than 5% vacancy levels resulting in variation in care delivery.
- The requirement to deliver a Cost Improvement Programme of 7% of addressable spend and overall Financial Recovery Plan in excess of 8.5%.
- Continued deterioration in the backlog maintenance position and the impact on both buildings and equipment.
- Estate does not meet HTN standards, limiting consistent adherence to safety and aesthetic estate standards.
- Occupancy levels are in excess of 95% leading to extended length of stay in the ED and additional patients boarding on inpatient wards.
- Patients are routinely waiting longer than some national standards for treatments and in the Emergency Department.
- Adult inpatient experience feedback is identifying room for improvement.
- The ability to live within the resources available is dependent upon scalable system wide transformation. The foundations for this work remain formative.
- C.*Difficile* rates exceed expected rates and allocated trajectory (managed through Risk ID 1157 – Increased risk score now at 20 associated with C. *difficile* Infection)
- Recognised health inequalities in the communities we serve.
- The CQC rating for the organisation has remained at 'Requires Improvement'.
- There are some specialty services that are considered fragile and this presents a risk to consistent delivery.

Risk Rating Tracker * (Likelihood x Consequence)

Initial: 4x5 = 20 Current: 4x5 = 20 Target: 1-6



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

Future Risks

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

Future Opportunities

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

Controls	Gaps in Control	Assurances	Gaps in Assurances
• Workstream related strategies and plans in place ○ Always Safety First ○ Clinical Strategy ○ STAR Quality Assurance Framework ○ Patient Experience and Involvement Strategy ○ Risk Management Policy ○ Our Big Plan ○ Continuous Improvement Strategy ○ Equality, Diversity and Inclusion Strategy ○ Workforce and OD Strategy ○ Education, Training and Research Strategy ○ Financial Strategy ○ Health and Wellbeing Strategy ○ Communication Strategy ○ Targeted recruitment & plans and temporary staffing arrangements (inc international and healthcare support workers) ○ Safety and Quality Policies and Procedures ○ Workforce Policies and Procedures ○ Health & Safety Plan ○ Operational Plan ○ Restoration and Recovery Plan ○ Safe staffing reviews ○ Safeguarding Board • Accountability Framework • Freedom to Speak Up, Guardian of Safe Working and Person in Position of Trust (PIPOT) arrangements • Safety Forums • GIRFT programme of work. • Capital planning process • EQIA policy and procedures • Transformation programme • Integration of services and pathways and effective system-based working • Confirmation received of progression to the next stage of the NHP in May 2023 • Capital investment case created expand the MAU and SAU. • Health Inequalities delivery plan - Core20PLUS5 adults and children. • Medical device and replacement programme and process in place with increased oversight through Finance & Performance Committee	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups ***(Ref CDEC 020)***. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection ***(Ref CDEC 019).*** • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. ***(Ref CDEC 019)*** • The current environment within medical and surgical assessment units does not meet demand. ***(CDEC 014)*** • The implementation of the national cleaning standards is not yet complete. ***(CDEC 018)*** (02/24 - 25% compliant for domestic standards, 100% compliant for nursing standards.) • The capital required to address backlog maintenance is not sufficient. ***(CDEC 019)*** • The environment and facilities within the children's ward require improvement. (***CDEC 021)*** • The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient. (**CDEC 024)** • There is currently a lack of timely discharge options for patients who are no longer meeting the criteria to reside in hospital leading to extended lengths of stay once medically optimised. **(CDEC 025)**	**<u>Internal</u>** • STAR Assurance Framework • Always Safety First Learning and Improvement Group • PSIRF Oversight group • Divisional Governance Structures and arrangements • Divisional Improvement Forums • Safety and Quality Committee • Workforce Committee • Finance and Performance Committee • Education, Training and Research Committee • Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system • CNST internal assurance reporting • Nurse, Midwifery and AHP safe staffing review annual review and recommendations • Medical Staffing Review Plan in place to strengthen assurance of testing safe medical staffing • Equality Quality Impact Assessment (EQIA) procedure and reporting in place. • Transformation programme Board • Strengthened IPC BAF • Director of Strategy and Planning reports updates on clinical reconfiguration programmes to Finance and Performance Committee. • Bi annual safe nurse staffing assessment completed with inclusion of covering safe staffing recommendations for 2023 Birthrate plus assessment. **<u>External</u>** • National Surveys • Clinical Negligence Schemes for Trust • Validation of year 5 CNST 10 maternity safety actions • External regulators and benchmarking • Medical Examiner's Office, Perinatal Mortality Tool • Internal Audit	• The approach to quality assurance within inpatient areas and specific focus on fundamentals requires strengthening. (***CDEC 022)***

• Planned programme of work commenced focused on fragile services across the ICS.		• External system assurances, PLACE based arrangements, ICB and PCB • NHS England performance monitoring	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 014	Completion of planned expansion of MAU and SAU	Chief Nursing Officer	30 November 2024		Ongoing	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 016	Determine mechanism to fund safe staffing recommendations for 2023 Birthrate plus assessment.	Chief Financial Officer	30 April 2024	6 April 2024	Completed	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 017	Bi annual safe nurse staffing assessment to be undertaken given the time elapsed since previous assessment and changes in operating environment.	Chief Nursing Officer	30 April 2024	6 April 2024	Completed	Assurance	• Inability to progress Chief Nursing Officer safe staffing recommendations due to financial constraints.
CDEC 018	The national cleaning standards implementation requires delivery – Priority 1.	Chief Financial Officer	~~31 August 2024~~ Unable to determine delivery date		Ongoing	Control	• The implementation of the national cleaning standards is not yet complete. 25% compliant for domestic standards, 100% compliant for nursing standards.
CDEC 019	The capital planning group will continue to assess the risks relating to backlog maintenance and determine the priorities from within the capital funding envelope provided.	Chief Financial Officer	ongoing		Ongoing	Control	• The capital required to address backlog maintenance is not sufficient. • The current environment within the ED requires upgrading to reduce the risk of environmental decontamination. • The age and condition of the estate places additional risk associated with the design of clinical services and the control of infection.
CDEC 020	To develop a plan in conjunction with the Director of Public Health, that aligns with the Health and Wellbeing Board's Health Inequalities Plan.	Chief Nursing Officer	~~30 June 2024~~ 31 August 2024		Ongoing	Control	• Equitable access to health and care is disproportionately more challenging for citizens with protected characteristics and those in the CORE20PLUS5 groups.
CDEC 021	To develop a plan to improve environment within the children's ward.	Chief Nursing Officer	31 August 2024		Ongoing	Control	• The environment and facilities within the children's ward require improvement.
CDEC 022	To review STAR and mandated fundamental standard delivery to achieve green and disaggregate inpatient outcomes from outpatients to strengthen assurance.	Chief Nursing Officer	31 August 2024		Ongoing	Assurances	• The approach to quality assurance within inpatient areas and specific focus on fundamentals requires strengthening.

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 023	Further review of the Equality Quality Impact Assessment process.	Chief Nursing Officer	30 June 2024	30 June 2024	Completed	Assurances	• The increasing finance and operational pressures present potential risks to patient and staff safety and experience.
CDEC 024	Undertake analysis of demand and capacity across the UEC pathway to determine capacity required.	Chief Operating Officer	30 November 2024			Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 025	Agree in partnership with LSCFT the approach to transforming physical health community services to improve length of stay in ED and as inpatients.	Chief Nursing Officer	30 September 2024			Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 026	Develop a central Lancashire PLACE Urgent and Emergency care plan.	Chief Operating Officer	31 July 2024	12 July 2024	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 027	Revisit the LTHTR Urgent and Emergency Care plan to reflect system and organisational priorities.	Chief Operating Officer	31 July 2024	19 July 2024	Completed	Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.
CDEC 028	Agree funding approach to Finney House intermediate care service to secure immediate to medium term plan.	Chief Nursing Officer	30 September 2024			Control	• The current UEC plan does not address the demand and capacity deficit leading to long waits within the Emergency department and extended length of stay as an inpatient.

Summary of review – June and July 2024

- The rationale section has been updated to reflect the revised CIP figure changing from 5.5% to 7% of addressable spend and overall Financial Recovery Plan in excess of 8.5%. Also, the delay in safe staffing implementation has been removed from the rationale section, following completion.
- Naming conventions of internal meetings detailed in Assurances changed to reflect introduction of PSIRF Oversight Group and the Always Safety First Learning and Improvement Group
- Additional external assurance documented regarding Validation of year 5 CNST 10 maternity safety actions.
- Action CDEC 018 – delivery date removed as no clear plan to deliver this at this time due to financial constraints. Further actions include; the assurance reporting for compliance against the standards will allow visibility of compliance against the 2007 and 2021 standards. The team are preparing a next phase approach to prioritise high risk areas.
- Action CDEC 020 due date extended – the health inequalities plan has been drafted based on multiple sources of feedback, and system and place priorities - this is currently being circulated for comments. The Marmot team attended the health inequalities meeting in June 2024 to ensure the findings from the Lancashire review are included. The Director of Public Health is joining in July to ensure the appropriate links are in place. Delivery date extended to ensure full partner involvement.
- Following review of children's ward facilities, a new gap in control has been identified with an accompanying new action for the Chief Nursing Officer to develop an estate improvement plan for children's ward (CDEC 021).
- Following a review of the STAR audit outcomes, a strengthened approach to gaining assurance on fundamentals is required, therefore a review of the approach to this has commenced (CDEC 022).
- Action CDEC 023 - EQIA process and documentation refresh is now complete. New policy and process has commenced. Quarterly reports will be received by Safety and Quality Committee. Monthly oversight of completion of schemes delivered, included in financial reporting arrangements.
- Action CDEC 024—added as part of the refreshed approach to UEC. The analysis will support the future clinical and workforce models required to respond to service needs.
- Action CDEC 025 – added to reflect the community transformation work underway to create a model of working together to improve the experience of staff and patients accessing physical health community services.
- Action CDEC 028 – reflects the requirement to secure immediate to medium term funding arrangements for Finney House to secure its position.

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: 1st July 2024

Risk

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

Risk Appetite:

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

Risk Tolerance

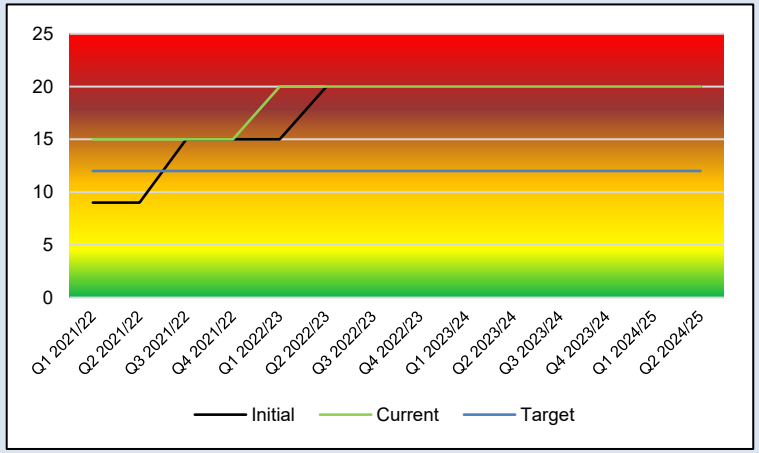
8-12

Rationale for Current Score

- **Undertakings** The Trust is in segment three for the NHS Oversight Framework (NOF). Undertakings applied by NHSE to the Trust include the need for the Trust to agree its financial plans with the Integrated Care Board, a requirement to deliver that plan and a supporting need to deliver the associated cost improvement plan. The Trust must close a gap of £58m in 2024-25. The Trust has enforcement undertakings relating to its financial position. This may result in a move to 'NOF' four.
- **Excess urgent care demand** – Excess flow related demand on the non-elective pathways continues to place pressure on the UEC pathway. Despite additional capacity, the Trust's performance standards are not being met.
- **Industrial relations** – Continuing industrial tension is giving rise to additional financial and performance pressures which will further hamper the delivery of VFM. The Trust's ability to mitigate the impact of these tensions is limited, without some further consequence.
- **Financial recovery (Trust)** – The Trust is unable to deliver a balanced plan for 2024-25 and will aim to rebalance its finances over a three-year period. The Trust has set a challenging financial improvement target for future years, and it needs to ensure that the associated change is managed through an effective equality and quality impact assessment process.
- **Financial Recovery (system)** – In outlining their financial plans all NHS organisations in Lancashire and South Cumbria will be challenged to deliver their financial trajectories. To do so will likely lead to changes in the commissioning and provision of services. Some of these changes will inevitably impact on arrangements with partners which may impact further on delivering value for money.
- **Productivity** – Despite significant transformation programmes, Trust productivity when compared to 2019-20 has decreased. Input costs have essentially risen faster than the measured outputs. This has directly impacted upon value for money.
- **Dependencies** – Whilst there are many improvements to be driven internally, to further improve value for money there are many dependencies on partners, e.g. to develop a clear out of hospital strategy, to help tackle not-meeting criteria to reside, to support the reorganisation of services or to fund the alternatives to hospitalised care.

Risk Rating Tracker (Likelihood x Consequence)

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



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

	Future and Escalating Risks • **Investment** – The Trust in the meantime has an underlying overspend which will need to be addressed. The failure to improve financial performance is likely to impact on future major investment decisions facing the Trust, along with potential future risk of failing to deliver the Trust's challenging FRP. • **Placed based leadership** – The place-based roles are continuing to form and are considered to be pivotal in the optimisation of the health and care 'eco-system'. There is a risk that the evolution of these arrangements do not sufficiently impact on the optimisation processes and that leadership arrangements between sub place, place and system are confusing with unclear accountability. • **Rising demand** – Failure to develop a credible and meaningful urgent and emergency care strategy at system and place to respond to a growing population with increased complexity/comorbidity will result in residents accessing inappropriate services which could impact detrimentally on value for money for public services as a whole. • **Planned care -** The failure to reorganise planned care across the system will result in waste and unwarranted variation, resulting in impact on overall value for money. • **Cost control –** There is a risk that input costs rise faster than activity output further eroding VFM. • **Commissioning decisions –** In light of the wider system financial challenges it is likely that the ICB will need to disinvest in services which are likely to exacerbate the financial and operational challenges if unmitigated. • **National financial framework –** The national framework has now been issued this clarifies that overspending systems will have capital allocations curtailed and will result in top sliced allocations in future periods.	**Future Opportunities** • Benchmarking indicates opportunities remain to reduce waste and the underlying overspend. • There is an opportunity to reduce financial risk through reorganisation, adoption of technologies, automation and the removal of unnecessary duplication and waste. • There is opportunity to participate in the national support offer for NHS IMPACT, which will focus on increasing productivity in priority areas • There remains an opportunity to increase margins through non-NHS activities. • There remains opportunity through the ICS and the place-based arrangements to reduce the unnecessary duplication of NHS services. • There is an opportunity to work with the Provider Collaboration Board to identify and pursue collaboration opportunities at scale. • There remains an opportunity to commission more effective services to mitigate hospital attendances. • There remains a partnership opportunity at system and place to better manage patient pathways and reduce inappropriate demand and unnecessary cost escalation. • There remains an opportunity for partners to support more timely discharge from hospital, reducing the overall cost to the taxpayer and improve outcomes. • To meet increasing demand and complexity the ICB will need to determine what commissioned services will be afforded for its population and whether some services will need wider reconfiguration to support sustainability. • Better understand why relative productivity has decreased and seek to mitigate where possible. • There is opportunity to commission end to end pathways to maximise out of hospital care, closer to home.

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurance**
• Workstream related strategies in place ○ Workforce and OD Strategy, ○ Continuous Improvement Strategy ○ Clinical Strategy ○ Financial Strategy ○ IM&T Strategy, ○ Estates Strategy, ○ Annual Business Plan Planning framework established to track delivery of schemes. ○ Always safety first ○ Urgent and Emergency Care Board ○ ICS Transforming Community Services Programme	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • Service disruption due to ongoing industrial tensions (Managed through operational risk ID 1182 (probability of strike action)) • Inability to sufficiently influence externally impacting directly on services provided by LTH (e.g., partner organisation strategies and decision taking, financial rules for NHS services, NHS wide workforce development and investment and some processes and	**Internal** • Specialty Performance meetings • Divisional Improvement Forums • Performance Review Group • Outpatient Improvement Group • Integrated Performance reporting at Finance and Performance Committee and Board • Audit Committee assurance processes to test effectiveness of financial infrastructure and internal control system • Temporary monitoring of undertakings internally (The Trust has been placed in segment three for the NHS Oversight Framework (NOF)). • Use of Resources assessments now reported through Finance & Performance Committee. • Regular embedded cycle of sharing information relating to the wider programme of change in place	• Inability to demonstrate delivery of key financial and operational metrics ***(DVFM 033)*** • The Urgent and Emergency Delivery Boards are being reset. The ICB is leading a programme of change which should result in better value for money. The benefits require reporting as part of the financial Recovery Plan. ***(DVFM 038)***

• Scheme of delegation/Standing Financial Instruction • Accountability Framework • Long term case for change the New Hospitals Programme • Contract management and activity under regular monitoring • National Planning Framework and Capital now given to ICS areas. • A system wide vacancy and control panel introduced providing additional oversight of the roles that are being recruited to across the system, particularly but not exclusively in non-clinical areas, consultancy, leases and contracts. • A system wide non pay control group has been established with the aim of prohibiting discretionary spend and improving value for money.	decision making at system and PLACE such as priority setting in development and deployment of system and PLACE Urgent and Emergency Care Strategy) • The financial run rate may improve at a slower rate than that which is required. Recovery plans need to ensure that there is sufficient pace or alternative mitigation to drive change quickly and de-risk the financial position appropriately, whilst maintaining a focus on safety. • Delays in planning cycle ***(DVFM036)*** • Embody changes such as EVO into the improvement work to better capture benefits ***(DVFM 037)***	• Report on elective productivity and plans for improvement completed to better understand the impact on elective productivity together with movements in the underlying drivers together with plans for improvement. • A monthly update is provided to the Finance and Performance Committee on the Financial Recovery Programme • Temporary Workforce Controls have been reviewed by internal audit and gained substantial assurance. • A Single Improvement Board has been established, chaired by the CEO which will report into Finance and Performance Committee • Workforce and Digital transformation programmes now designed, and the board has been established, to oversee the implementation. This work will transition as the new single improvement plan is established • Updates on the drivers of financial and operational performance shared with Finance & Performance Committee **External** • Head of Internal Audit Opinion/Going concern review • Benchmarking model hospital/GIRFT • External Auditor review • External system assurances, PLACE, ICB and PCB including a new system improvement board, chaired by the NHS England regional team. • The contract monitoring report is shared with FPC to provide stronger assurances on the underlying trading position and associated activity now reintroduced.	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 010	~~Develop a medium-term plan with a supporting financial model to outline the route to recovery. To be signed off by the Board of Directors. This plan will be a key component of the Single Improvement Plan (see below).~~ Develop Financial Sustainability Plan as part of the single improvement plan. The Trust's Turnaround Director is focussing on maturing the recovery plan for 2024-25. This should be completed by the end of June.	Chief Financial Officer and Director of Strategy and Planning	~~04.04.24~~ 30.06.24	30.06.24	Complete	~~Assurance~~ Control	Agreed organisational plan to ensure improvements in finance & operational performance.
DVFM 033	Review performance and accountability framework **Note:** NHS England have updated their oversight framework. This will delay the delivery of the revised PAF.	Director of Improvement, Research and Innovation	~~30.06.24~~ 30.09.24		Ongoing	Assurance	Inability to demonstrate delivery of key financial and operational metrics
DVFM 034	Develop the People and Culture Plan as part of the Single Improvement Plan and the associated Financial Recovery Plan.	Chief People Officer	30.06.24	06.06.24	Complete	Control	Agreed organisational plan to ensure improvements in finance & operational performance
DVFM 035	Develop an Operational Performance plan as part of the Single Improvement Plan and the associated Financial Recovery Plan.	Chief Operating Officer	30.06.24	06.06.24	Complete	Control	Agreed organisational plan to ensure improvements in finance & operational performance
DVFM 036	To review planning cycle ahead of 2025/2026.	Director of Strategy and Planning	30.09.24		Ongoing	Control	Delays in planning cycle
DVFM 037	Review approach to benefits realisation for programme management and continuous improvement	Director of Improvement, Research and Innovation	30.08.24		Ongoing	Control	Embody changes such as EVO into the improvement work to better capture benefits
DVFM 038	Report of the UEC Delivery Board improvement Programme through the Single Improvement Plan and the Financial Recovery Plan.	Chief Operating Officer	31.07.24		New	Assurance	Provide assurance on externalities and impact on internal programme.

Summary of updates to risk – June and July 2024

- DVFM 010 has now been complete as at the end of June. The Trust needs now to mobilise the delivery of that plan.
- DVFM034 and 035 now complete with agreement of SIP at the Board of Directors meeting on 06.06.24.
- Performance accountability framework action changed from Deputy CEO to Director of Improvement, Research and Innovation. This action has been extended to 30.09.24 due to the publication of the national update to the oversight framework.
- Gap in assurance relating to the UEC programme to be closed through the governance processes highlighted above.

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: 27th June 2024

Risk

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

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

Risk Appetite:

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

Risk Tolerance

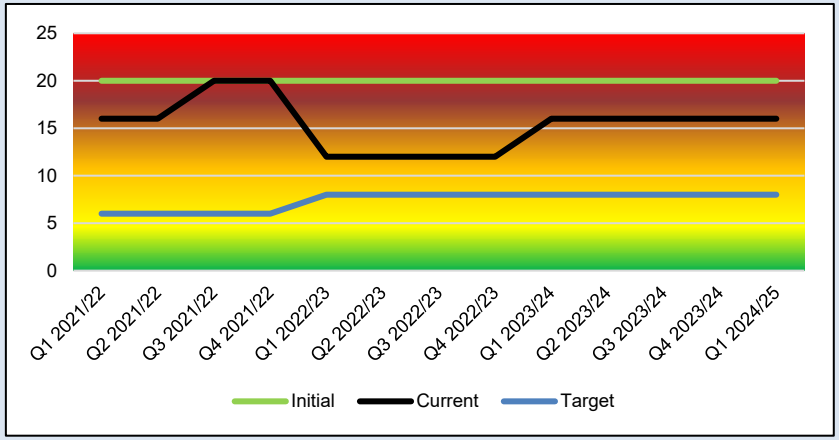
4-8

Rationale for Current Score

- Workforce shortages and some 'hard-to-recruit-to' posts in some specialities and high sickness levels in some key professional groups, creates pressure on existing staff and increases the need for temporary staffing spend.
- Physical environment and colleague facilities (catering) cited as a concern by departments and teams for having an impact on feeling valued, wellbeing and ability to work effectively.
- Leadership ability and capacity impacting on levels of staff satisfaction, cultural transformation and workforce metrics in a number of areas.
- High levels of sickness absence related to mental health issues and musculoskeletal injuries presenting cost and capacity issues.
- Gap between the desired and the current culture indicates improvements are needed.
- The impact of uncertainty and clear direction from One LSC plans is leading to higher levels of turnover, inability to recruit to vacancies, reduced engagement and morale levels in teams potentially affected by the changes, making it difficult to deliver on strategic plans described in Our People Plan.
- Insufficient resource within the Workforce and OD team to deliver change programmes at pace and respond to changing directions from the One LSC programme and ICS -led plans.
- Local onboarding processes within some teams/departments do not consistently provide new recruits with a positive employment experience.
- National unrest regarding cost of living and national pay deals leading to strike action taking place in most professional groups.
- National pay and agenda for change pay scales not offering reward for colleagues with additional experience leading to staff feeling the only option is to negotiate locally.
- We are seeing an increased appetite for the establishment of an engagement with Limited Liability Partnership (LLPs) by some Consultant groups, this takes sensitive navigation and also a requirement that adequate governance is in place to ensure adequate controls and regulation.

Risk Rating Tracker (Likelihood x Consequence)

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



	Future Risks • Ageing workforce profile in some services, leading to significant gaps post retirements. • Development of new roles may be hindered by inability to fund training posts and service posts simultaneously. • Impact of delivery of financial turnaround on staff morale • The lengthy leading time for delivering the New Hospital Programme impacting on ability to utilise available workforce effectively. • Efficiencies anticipated through One LSC are not currently evidence based and pose a risk to the ongoing delivery of corporate services. • One LSC collaboration may de-stabilise some of the Trust's current and existing processes • Continued deterioration of the working environment and hygiene factors impacting on staff satisfaction • Fragility of some services within Workforce and OD identifying potential single points of failure should staff leave.	**Future Opportunities** • Optimising the ability to develop contract flexibility and reciprocal help across Lancashire & South Cumbria footprint. • Changes to models of care present opportunities to remodel workforce. • Continued opportunity to use the multi professional skills of our workforce in different ways to help tackle specific workforce shortages. • Create a first-class working environment as part of the New Hospitals Programme • Redesign and implementation of more effective and consistent off boarding processes in order to retain a positive perception of leavers with regards to their employment experience. • Central services collaboration may provide efficiencies and resilience to some services once in place and embedded. • Optimisation of "Anchor Institution" status.

Controls	**Gaps in Control**	**Assurances**	**Gaps in Assurances**
• Our People Plan - Workforce and OD strategy related strategies and plans in place ○ Single Improvement Plan ○ Trust Values ○ Workforce Plan ○ Attendance Management Reduction Plan ○ Targeted recruitment & plans (international and healthcare support workers) ○ Workforce policies with EIA embedded ○ Health and Wellbeing strategy ○ Just culture ○ Regular temperature checks in place for staff satisfaction, culture, with action plans e.g., Staff Survey, NQPS, HWB, TED, Cultural survey ○ Leadership and Management Programmes ○ Appraisal and mentoring process ○ Workforce business partner model and advice line in place ○ Staff representatives in place, including union representatives, staff governors ○ Vacancy control panel in place and meeting weekly ○ Strike Action Emergency Planning Group weekly meeting	• Limited funding to address all hygiene factors and workforce demand in excess of supply resulting in unsustainable clinical service models/opportunity to improve productivity through benchmarking and action plans to reduce unwanted variation in existing strategies. ***(GPTW001/DVFM002)*** • Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design. ***(GPTW002)*** • Ability to influence the direction of the Provider Collaborative Board with regards to programmes of work, desired impact measures and methods for achieving aims. • Sufficient staffing within Workforce and OD to support work required to deliver transformation and deliver of the Trust's People Plan	**Internal** • Divisional Governance Structure and Arrangements • Divisional Improvement Forums (including Part II process to address cultural concerns) • Single Improvement Plan impact measures • Raising Concerns Group • Workforce Committee • Education Training and Research Committee • Safety and Quality Committee • Audit Committee assurance processes. • Regular schedule of reporting arrangements for cultural risks at Committees of the Board and Board now in place and covered within the Risk Management Policy **External** • National Surveys and benchmarking including staff satisfaction survey, workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) • Internal audit and external reviews. • External regulatory oversight e.g., Re-accreditation of Workplace wellbeing charter (5 out of 8 domains sitting as excellent)	[None identified]

• Equality, Diversity, and Inclusion strategy • Freedom to Speak Up and Guardian of Safe working arrangements • Education & Training strategy • Risk Management Strategy • Health and Safety Plan • Always Safety Strategy • Safe staffing reviews • Our Big Plan • Communications strategy • Accountability Framework • Safety Forums • New Hospitals Programme • Chief People Officer and Deputy/Associate Directors are present at all People and Transformation Meetings at the Provider Collaborative Board		• Rostering review by NHSI indicating excellence in rostering practice	

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
GPTW002	Identify, develop and deliver transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	~~Director of Strategy and Planning~~ Chief Operating Officer	~~31st May 2024~~ Identify & develop: 31st December 2024 Deliver: TBC as schemes developed		Ongoing	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.
GPTW003	Strengthen the planning guidance/requirements in relation to transformational workforce schemes and incorporate the identified schemes within the planning cycle/submissions	Director of Strategy and Planning	30th September 2024		NEW	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.

Risk updates – June and July 2024

- Addition of “Single Improvement Plan and impact measures” and “Attendance Management Reduction plan” to controls.
- Removal of control measure of “Resourcing plan for Workforce and OD staffing to support the delivery of Workforce and OD strategy and meet demands on current service provision included within the revised People Plan launched in April 2023”
- Updated action GPTW002 - As part of the financial recovery programme and associated strategic action plans there is a programme of work which is designed to right size the organisation, review management layers and spans. With the future development of the Trust Strategy, further workforce implications will need to be considered to support the delivery of the strategic aims from a workforce and organisational development perspective once this has been drafted.
- New action GPTW003 identified in relation to strengthening the planning guidance/ requirements in relation to transformational workforce schemes.
- Action DVFM031 relating to strategic decisioning criteria has been stepped down following discussion with the new Chief Executive. The Board of Directors’ approach to utilisation of risk appetite and tolerance will form part of the planned review and refresh of the Board Assurance Framework (BAF). In the meantime, risks continue to be scored in line with the Risk Management Policy and any risk-based decisions will continue to be made in conjunction with the Risk Appetite statement and tolerances set by the Board of Directors.

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: 15th July 2024

Risk

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

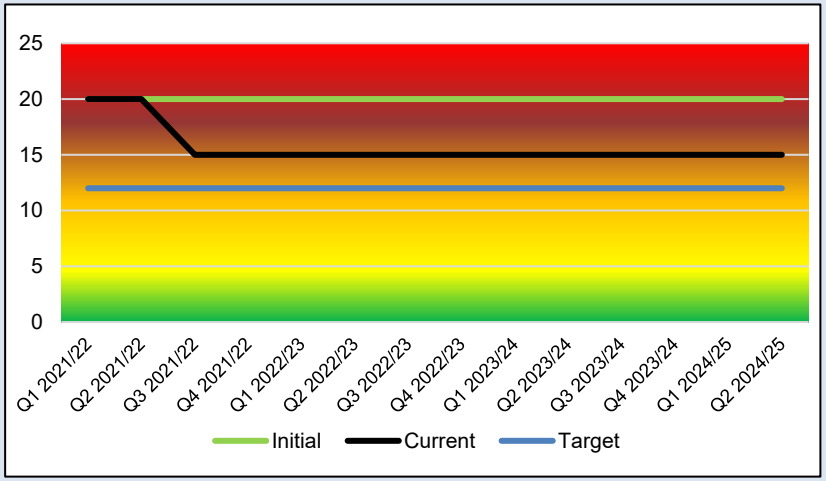
Risk Appetite: Seek – Eager to be innovative and to choose options offering higher rewards, despite inherent business risk.

Risk Tolerance
8-12

Rationale for Current Score

- System working continues to develop but further progress is needed at pace in relation to both the governance of decision making and the clarity and confidence in expected benefit delivery. In order for LTH and the wider system to be fit for the future major transformational change is needed. A number of programmes (e.g. Fragile Services, Central Services) are moving forward but challenges and complexity remain in terms of governance, expected benefit plans and programme delivery. The development of a clear system clinical strategy, a clear set of system commissioning intentions and a robust set of LSC transformational programmes are critical to the mitigation of our fit for the future risk.
- Place based working continues to develop, with discussions underway regarding potential budget devolution for 2024/25 and a number of governance pillars/programmes now established such as the Central Lancashire Executive Oversight Group and the Central Locality Community Services Transformation Programme Board. However, there is still significant work to do for LTH and our partners to fully establish transformational Place based governance and work programmes
- Digital transformation will be a major enabler for partnership working, pathway/service integration and ensuring we are fit for future. We have an ambitious Digital Northern Star strategy but delivering this will be a major challenge and for a number of reasons our transformational programmes in this are not progressing at the rate we had planned.
- Even when a greater level of maturity is reached the delivery of more effective, integrated pathways and services is a major challenge and will require both LTH and its partners to work differently and to successfully balance organisational interests alongside Place/System interests and commitments. In addition to ways of working/partnership culture capacity/time is a major challenge in relation to Place/System working.
- Within Central Lancashire there are a relatively high number of service providers and LTH is the Tertiary Centre for L&SC – as such we have a particular opportunity but also a particular challenge in relation to partnership working.
- LTH has a particular challenge and a particular opportunity in relation to our service configuration and estate – unless we are able to address these, we will be unable to meet delivery of the services our partners rightly expect and our staff will be focused on immediate operational challenges rather than service and pathway integration. The New Hospitals Programme is a once in a lifetime opportunity to work as a system level to access the funding needed to create a high quality, sustainable estate/service configuration.

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



Future Risks

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

Future Opportunities

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

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

Controls	Gaps in Control	Assurances	Gaps in Assurances

• LTH establishing a Single Improvement Plan approach, taking best practice from other Trusts/systems drive transformation at pace
• Workstream related strategies in place
  ○ Clinical Strategy
  ○ Digital Strategy,
  ○ Estates Strategy, including New Hospital Programme
  ○ Comms and engagement
• New Hospitals Programme operational groups established and named executive lead.
• Place and system delivery boards established, where LTHTR continue to link own strategies with Place and System plans. A Central Lancashire Executive Oversight Group has been set up and discussions are underway regarding the options for the Lancashire Place Partnership. The ICB have established a new Recovery Board, with a focus on system wide recovery and transformation
• LTHTR executive leads with Place/ICS responsibilities.
• Director of Communications & Engagement and Head of Communications in roles of SRO and Chairs of professional networks and providing significant contribution to the Provider Collaborative
• Clinical Programme Board (CPB) in place meeting monthly overseeing the PCB clinical transformation programme
• ICB has published 5 Year Joint Forward Plan
• Transformation Programmes developed and being led by Executive Team
• Digital Northern Star working groups in place to deliver the Digital Northern Star programme
• Organisations within Digital Northern Star are sharing information regarding infrastructure digital contracts for a collaborative approach to networking and data centres.
• Improved communications Trustwide and External – HeaLTH matters, In Case You Missed It and Exec Q&A session all put in place to enhance staff engagement and External newsletter reinstated for key stakeholders across our communities.
	• Integration of services and pathways. ***(FFTF 001, FFTF 003, FFTF 004, FFTF 005, FFTF 006, FFTF 008)***
	• Effective Place and system based working. Work is underway within LTH to review our links into/governance in relation to system working both at the level of individual programmes and at a macro level. ***(FFTF 001, FFTF 005, FFTF 007, FFTF 008)***
	• Single Improvement Plan approach still under development. (***FFTF 008)***
	• Fragile Services programme currently still focussed on a "deficit model" and needs to rapidly develop a robust expected benefits plan ***(FFTF 001)***
		<u>Internal</u>
		• Executive Transformation Group
		• Planning Framework updates to Finance and Performance Committee.
		• New Hospitals Programme assurance to Board
		• Audit Committee assurance processes to test effectiveness of infrastructure and internal control system.
		• Strategic element of Board discussions has been strengthened with dedicated sessions to focus on specific strategies
		• Northern Star Programme shared approaches developed leading to £1M in cash realising or cost avoidance savings
		• Online presence seen to increase over the period March 2023 – May 2023 with 23,000 new users to the Trust website in that period demonstrating continuing upward trend of engagement with the local population. Increase in Twitter and Facebook interaction and internal intranet interaction also.
		
		<u>External</u>
		• New Hospitals Programme Oversight Group
		• ICS Digital Board
		• Clinical Programme Board
		• Central Services Board
			• Benefit realisation plans need to be more robust and to explicitly deliver against the quadruple aim ***(FFTF 001, FFTF 003, FFTF 004, FFTF 008)***

Action Plan

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
FFTF 001	Link LTHTR strategies with Place, Provider Collaborative and ICS Strategies	Executive Leads	30th September 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working. • Fragile Services programme currently still focussed on a "deficit model" and needs to rapidly develop a robust expected benefits plan
FFTF 002	Strengthen Board discussions on key strategic issues including relevant ICS/PCB/Place matters	Director of Strategy and Planning	31st March 2024	28th February 2024	Complete	Assurance	• The Board requires dedicated time to fully discuss the wide range of system issues/changes that will be a key element in our being Fit for the Future
FFTF 003	Ensure maximum LTH influence on/contribution to Place and System working	Executive Leads	30th September 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 004	Develop and deliver Digital Northern Star strategy	Chief Information Officer	30th September 2024		Ongoing	Control	• Integration of services and pathways
FFTF 005	Deliver staff engagement/comms strategy (including reputation monitoring/management)	Director of Communication & Engagement and Chief People Officer	30th September 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working.
FFTF 006	Establish new governance arrangements to support the development of the PCBC in conjunction with the programme office and the ICB	Executive Leads	30th September 2024		Ongoing	Control	• Integration of services and pathways
FFTF 007	Deliver our Social Value Strategy	Chief People Officer	30th September 2024		Ongoing	Control	• Effective Place and system based working.
FFTF 008	Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change	Director of Strategy & Planning, Director of Continuous Improvement & Transformation	~~30th June 2024~~ 1st August 2024		Ongoing	Control	• Integration of services and pathways • Effective Place and system based working. • Single Improvement Plan approach still under development

Updates – June and July 2024

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

- **FFTF 001 - link LTHTR strategies with Place, Provider Collaborative and ICS Strategies and FFTF 003 - Ensure maximum LTH influence on/contribution to Place and System working** – Significant work is underway to establish an agreed set of benefits for the system clinical reconfiguration work (and all system programmes). Additional staffing resource is now available at the ICB to drive this forward. The LTH CEO is now chairing the Place Urgent Care Board. Strasys have attended the LTH Exec meeting to discuss the Clinical Blueprint work they are leading. The next system clinical strategy workshop will take place on the 22nd of July. Work is progressing well to develop our Long Term Strategy, including staff engagement events and engagement with key stakeholders. This will be reported to the Board on the 25th July. The PCB have requested a ONE Team approach be implemented to drive system working – see the Planning Control paper for more details.
- **FFTF 004 Develop and deliver Digital Northern Star strategy** – the LTH CIO has been appointed as the Digital Lead for OneLSC and is developing the processes/governance for OneDigital. Options for external support are under consideration with the ICB. Discussions are continuing with the national Digital team regarding the position around current funding (known as "Frontline Digital" funding) and the proposed funding announced in the Spring Budget but this may be affected by the election.
- **FFTF 005 - Deliver staff engagement/comms strategy (including reputation monitoring/management)** – As part of the strategy for the 2024/25 financial year, the new communications approach continues as a rolling programme of activity, increasing engagement opportunities with colleagues. NHP communications and engagement will increase over the summer particularly post-election, with key messages around the clinical model being shared within the organisation and engagement being organised and delivered by the triumvirate. Stakeholders continue to be informed of key successes and challenges in a number of ways – extensive proactive media activity; briefings on specific issues; Trust Matters Magazine; updates at Board; management of reactive media enquiries; VIP visits. Engagement with stakeholders sits in a number of places and strategies within the Trust particularly the Trust CEO and Chair; Executive team and Board members; the Patient Involvement and Engagement team; the Patient Experience and PALS team and Governors.
- **FFTF 008 - strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change** – The process to develop our long term, strategy has commenced and is progressing well. The Trust PMO is now established and discussions are underway to develop proposals to agree the appropriate recurring resources and reporting arrangements. The Single Improvement Plan will go to the August Board meeting for final sign off.

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

Risk ID: 860

Risk owner: Chief People Officer (with input from Deputy Director of Education and Deputy Director of Research & Innovation)

Date last reviewed: 30th May 2024

Risk

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

Risk Appetite:

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

Risk Tolerance

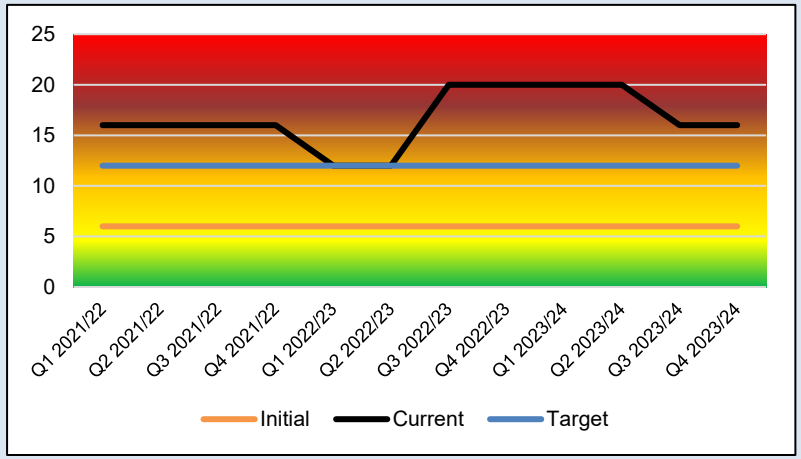
9-12

Rationale for Current Score

- Continuing inability to meet Trust mandatory training targets across all disciplines, which has resulted in continued breaches of CQC regulations.
- A number of areas of Postgraduate Medical Education are being monitored within the NHSE Intensive Support Framework.
- Audit requirements for management of educational income limit flexibility to deliver educational activity which is based on academic years or to support innovative developments funded through income generation.
- Inability to invest educational income in capital development programmes to expand our education infrastructure.
- Ongoing capacity challenges to support education and R&I activity.
- Workforce shortages impacting on capacity and educational quality.
- Evidence of health and wellbeing concerns in student and learner community.
- Ongoing challenges to achieve optimum faculty for specialist teaching requirements.
- Impact of economic climate/loss of work due to diagnostic/aseptic backlogs and difficulties regarding access to diagnostics across the board to support R&I, notably on commercial research income.
- Not meeting compliance in all training subjects and medical device competencies.
- NIHR guidance changes re commercial work and R&I running at reducing loss, year on year, is assisted by the O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist ongoing mitigation. This will assist reductio of system blockages running too many studies post-pandemic.
- There are opportunities to lead on education, innovation and research programmes in NHP and ICB programmes of work.
- Inability to influence essential release of staff for education activity due to service pressures
- Service pressures impacting availability of staff to be released from clinical environments to attend essential and mandatory education and training.

Risk Rating Tracker (Likelihood x Consequence)

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



Future Risks

- NHSE Long Term Workforce Plan will impact education and training pathways for new and emerging roles.
- Potential impact of OneLSC on Education and Training provision at LTH.
- Capacity for effective marketing and communications.
- Potential impact of the New Hospitals Programme on Education and Research estate.
- Impact of the increased allowance for simulated placements for nursing students delivered by HEIs – this could result in a reduction in NMET tariff income.
- Impact of place-based placement allocation systems (currently emerging) – this could result in a reduction in NMET tariff income.
- UK becoming less competitive/losing commercial research trials

Future Opportunities

- Continued participation and development of funded, commercial and UKCRF Network sourced related research activities.
- Expansion of undergraduate programmes.
- Increase in the use of advanced digital/AI solutions to provide education and research programmes.
- Launch of Trust innovation hub and external funding opportunity.
- Development of hi-tech education programmes including robotics and simulation learning.
- Development of joint appointments with HEIs.
- Re-focus of research activity on key national clinical priorities.
- Opportunity to bid for capital to update Health Academies to provide hi tech simulation and education.
- Opportunity for LTH to become apprentice provider for ICS.
- Opportunity to manage income generation via Edovation.
- Potential to expand student placement offer to HEIs within and outside region.
- Provision of a range of educational services to primary care

	• Impact of UGME capacity scoping exercise being undertaken by HEE • Potential income deficit position for education as a result of tariff changes and audit requirements for income deferral • Innovation opportunities may be stifled due to reluctance to accept in-year funding developments where income cannot be flexibly utilised across multiple financial years • Potential impact of shared service development across ICS • Potential reduction in CPD/Workforce Development funding and/or potential bid income.	• Potential to lead a range of education activity as part of ICS shared service development. • Potential to become Centre of Excellence for Technology Enhanced Learning in partnership with NHSE. • O'Shaughnessy Report (2023) encourages more active prioritisation of commercial work which will assist commercial and financial growth

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

• Workstream related strategies in place:
  ○ Education & Training Strategy
  ○ Research Strategy
  ○ Our Big Plan, Annual Business Plan Planning framework
  ○ Workforce & OD Strategy
• Ring-fencing of education and research funding.
• Divisional education contracts.
• NHS Education Contract.
• Policies in place with review cycle.
• Business continuity plans in place.
• Head of R&I now part of New Hospitals Programme and ICB programme working parties.
• Enhanced plans identified within Research & Innovation Strategy to leverage more opportunity to increase funding and assist recovery processes
• Full review of deferred income has been conducted by finance evidencing and ensuring drawdown of income from deferred position/reserves is matched in line with expenditure and the Education Contract on an ongoing basis
• Categorised investment requirements for education infrastructure now in place, which is being worked through with Capital Investment Team
• International education programmes to be incorporated into 2024-27 strategy.
	• Lack of research leads embedded in divisions ***(ETR 007)***	**Internal**
		• Sub-committees for education, training and research incorporating risk reviews.
		• Quality assurance and performance management of education activity.
		• Strategy progress for Research and Education reviewed each year at ETR Committee.
		• Learner improvement forum.
		• Monthly training compliance reports.
		• Divisional performance reviews
		• Paper to include R&I involvement at DIFs and Divisional Boards has been drafted for approval by the CMO
		• Monthly finance reviews with corporate finance team and quarterly with R&I budget holders
		• Education, Training & Research Committee
		• Audit Committee assurance processes to test effectiveness of safety and quality infrastructure and internal control system.
		• Board.
		
		External
		• NHSE Monitoring the Learning Environment review meetings.
		• Full OFSTED inspection completed August 2022 with 'Good' rating achieved.
		• ESFA audits
		• HEE self-assessment return.
		• Matrix accreditation.
		• Annual and interim performance reviews with Manchester Medical School
		• National Student Surveys.
		• National Education Trainee Surveys.
		• STAR accreditation for Clinical Research Facility.
		• Engagement in range of external forums and committees.
		• Quarterly strategy meetings with local HEIs
		• Trust Involvement/leadership in ICS discussions re education and R&I
			• Inability to meet Trust Mandatory Training targets across all disciplines across all divisions ***(ETR 008)***

Action Plan

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

Summary of Updates – May and June 2024

- Review of the risk carried out by Deputy Director of Education and Deputy Director of Research & Innovation.
- Added a gap in assurance around the continued inability to meet Trust Mandatory Training targets across all disciplines across all divisions, which has caused regulatory breaches with the Care Quality Commission in previous inspections on an ongoing basis and presents a risk of further regulatory breaches. There is an action to consider all options to support meeting this and ensuring the Trust's reporting provides the necessary assurances.
- Action DVFM031 relating to strategic decisioning criteria has been stepped down following discussion with the new Chief Executive. The Board of Directors' approach to utilisation of risk appetite and tolerance will form part of the planned review and refresh of the Board Assurance Framework (BAF). In the meantime, risks continue to be scored in line with the Risk Management Policy and any risk-based decisions will continue to be made in conjunction with the Risk Appetite statement and tolerances set by the Board of Directors

Chair's Report to Board		
Chair: Non-Executive Directors Prof Paul O'Neill - (May) Ms Kate Smyth – (June)	Safety and Quality Committee	
Date: 31 May 2024 & 28 June 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	• Maternity and Neonatal Services Report • Fuller Review Phase 1 Recommendations

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	**The continued variation in ability to deliver a 7 day thrombectomy service. Regional and national meetings were being held to address the issues and identify a solution.** **There had been two never events in the ophthalmology department that are being investigated as part of the PSIRF process. Early learning has been identified and acted upon.** **The Committee discussed the factors not yet addressed potentially impacting the ability to reduce C.*difficile* infection rates and noted a number of actions that require resolution including the functionality of the single stack waste system and the inability to expand beyond 15 areas for full roll out of the 2021 domestic cleaning standards.**
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**The Committee identified continued higher than expected rate of sickness within paediatrics and neonatal and referred this to the Workforce Committee for consideration. Assurance was provided that work was ongoing to ensure the sickness absence was managed in line with the policy.** **The Committee discussed the number of patients boarded (outside of a designated bed space) due to an inability to match demand with capacity. The UEC plan continues to be developed to address this. The numbers in June had decreased and this was noted as positive, albeit there was a need to sustain the reduction and then eliminate boarding practice in ED and on the wards.**
ASSURE **Assurance received; Matters of positive note.**	**The committee received assurance reports relating to** **- Management of serious cases and PSIRF update** **- Infection prevention and control** **- Clinical audit** **- Patient Experience and Involvement** **- The Quality account** **- Management of mortality reviews and mortality rates** **- Response to Lucy Letby** **- Safeguarding practices and outcomes** **- Medicines governance**

	- **CQC progress with must and should do actions** **The reports provided an overview of areas of strength and areas that required continued focus.**

Safety and Quality Committee

31 May 2024 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	P O'Neill
2.	Apologies for absence	12.31pm	Verbal	Information	P O'Neill
3.	Declaration of interests	12.32pm	Verbal	Information	P O'Neill
4.	Minutes of the previous meeting held on 26 April 2024	12.33pm	✓	Decision	P O'Neill
5.	Matters arising and action log	12.35pm	✓	Decision	P O'Neill
6.	Strategic Risk Register	12.50pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.55pm	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	1.05pm	✓	Assurance	J Lambert
7.3	a) Children and Young People staffing report b) Paediatric Medical staffing report	1.15pm	✓	Assurance	C Gregory L Wilkinson
7.4	Annual Serious Case Report inc. PSIRF	1.20pm	✓	Assurance	H Ugradar
7.5	Clinical Audit Report	1.30pm	✓	Assurance	S Regan
7.6	Infection Prevention and Control Annual Plan Report	1.40pm	✓	Assurance	D Orr
7.7	Annual Patient Experience and Involvement Report	1.50pm	✓	Assurance	C Gregory
7.8	Thrombectomy Update	2.00pm	✓	Assurance	C Granato
8.	GOVERNANCE AND COMPLIANCE				
8.1	Fuller Phase 1 Recommendations	2.10pm	✓	Assurance	G Skailes
8.2	Annual Quality Account	2.20pm	✓	Decision	C Gregory
8.3	Strategic risk register review	2.35pm	Verbal	Decision	P O'Neill
8.4	Items for referral to the Board or to/from other Committees	2.40pm	Verbal	Information	P O'Neill

№	Item	Time	Encl.	Purpose	Presenter
8.5	Reflections on the meeting and adherence to the Board Compact	2.45pm	✓	Assurance	P O'Neill
9.	ITEMS FOR INFORMATION				
9.1	CQUIN Update		✓		
9.2	Exception report from Divisional Improvement Forums		✓		
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Always Safety First Learning and Improvement Group e) Medicines Governance Committee f) Patient Experience and Involvement g) Health Inequalities Group		✓		
10.0	Date, time and venue of next meeting: *28 June 2024, 12.30pm, Microsoft Teams*	2.50pm	Verbal	Information	P O'Neill

Safety and Quality Committee

28 June 2024 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Smyth
2.	Apologies for absence	12.31pm	Verbal	Information	K Smyth
3.	Declaration of interests	12.32pm	Verbal	Information	K Smyth
4.	Minutes of the previous meeting held on 31 May 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log a) Workforce Referral Response	12.35pm	✓	Decision	K Smyth C Gregory
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Children and Young People staffing report	1.00pm	✓	Assurance	C Gregory
7.3	Annual Mortality, PMRT and LEDER report	1.10pm	✓	Assurance	A Gale
7.4	Annual Safeguarding Report	1.20pm	✓	Assurance	C Gregory
7.5	Annual Medicines Governance Report	1.30pm	✓	Assurance	G Price
7.6	Sub-contract Monitoring Assurance Report	1.40pm	✓	Assurance	A Gammell
7.7	NHSE – Letby Response	1.50pm	✓	Assurance	C Gregory
7.8	CQC Action Plan Update	2.00pm	✓	Assurance	S Regan
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	2.10pm	Verbal	Decision	K Smyth
8.2	Items for referral to the Board or to/from other Committees	2.15pm	Verbal	Information	K Smyth
8.3	Reflections on the meeting and adherence to the Board Compact	2.20pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				

№	Item	Time	Encl.	Purpose	Presenter
9.1	EQIA Report		✓		
9.2	Exception report from Divisional Improvement Forums		✓		
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Always Safety First Learning and Improvement Group e) Medicines Governance Committee f) Patient Experience and Involvement g) Health Inequalities Group h) Health and Safety Governance i) Mortality and End of Life Care Committee		✓		
10.0	Date, time and venue of next meeting: *26 July 2024, 12.30pm, Microsoft Teams*	2.25pm	Verbal	Information	K Smyth

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Maternity and Neonatal Services Safety Report			
Report to:	Boad of Directors	**Date:**	1st August 2024
Report of:	Chief Nursing Officer	**Prepared by:**	Jo Lambert

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

Executive Summary:

The purpose of this report is to provide the Board of Directors with an update in relation to safe staffing and the safety and quality and assurance and oversight programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) within the maternity and neonatal services up until June 2024. In addition, where appropriate obstetric medical and neonatal updates are included in the report for cross triangulation and information.

To support this paper, more detailed information is provided in the perinatal quality surveillance outcomes (PQSO) supplementary information pack (Appendix 1). The new PQSO slide sets provide specified minimum data requirements as defined by NHS England and additional local level indicators to support the safety and quality committee and the Board of Directors to understand safety intelligence associated with safe staffing, clinical indicators, perinatal quality experience, regulation, and clinical escalation. This ensures that appropriate support and check and challenge is applied. Appendix 2 provides the data pack for the 10 MIS standards.

The perinatal quality surveillance data indicates some areas of pressure. Red flags associated with delay in review in maternity triage reflect the gaps within the obstetric trainee and midwifery workforce. Higher than expected sickness absence in the middle grade rota, and a single tier rota system continue to impact on cover and has resulted in additional locum covers being deployed to support gaps within the obstetric workforce.

Clinical indicators which require ongoing monitoring are 3rd and 4th degree tears. In May 2024 there was one reportable maternal death reported to MBRRACE and the Maternity and Neonatal Safety Investigation Branch (MNSI) and has been accepted for investigation.

The fill rates for Registered Midwives (RM) (86% day and 89% night) and Maternity Support Workers (MSW) (80% day and 98% night) in June 2024 demonstrates a sustained, lower than planned fill rate, which is reflected in the year-to-date projection and is synonymous with the established vacancies. All shifts are sent to bank and the service continue to be supported to improve fill rates with agency shifts. As part of responding to the staffing establishment within the unit, the service continues to utilise divert arrangements when appropriate and whilst this mitigates the risk to women, when it occurs, it adversely affects the experience of women who live locally and have chosen to give birth in Lancashire and south Cumbria.

The service continues to note the phased approach to Birth Rate Plus (BR+) requirements and workforce establishment deficits continue to present a risk to the service, these will be considered in line with the plan agreed. The second bi-annual safe staffing review is planned for October 2024.

Close monitoring of the workforce metrics for newly qualified midwife new appointments for October 2024 is ongoing. The vacancy is currently 13.80 WTE which will reduce to 1.16 WTE in October 2024 when the new appointments start in post. (The over offer position is now 0 with 5.2 WTE dropping off as anticipated from the work profiling).

RECOMMENDATIONS

The Board of Directors are asked to:

I. Approve the Maternity and Neonatal Service Update including safe staffing position.
II. Note the CNST update report and recommendations.
III. Confirm it is satisfied a comprehensive level of check and challenge has been applied by the Board level safety champions to understand the performance and pressures affecting the maternity and neonatal service and reflect this in the committee minutes.
IV. Receive the associated action plans for information oversight and assurance**.**

Appendices

1. Perinatal Quality Surveillance Supplementary Pack
2. CNST MIS Information Pack standards 1-10
3. Red Flags
4. Workforce Plan completed.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

1. INTRODUCTION

The purpose of this report is to provide an overview of the safety and quality programmes of work and present the monthly staffing position within the maternity and neonatal services. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators for Board assurance and oversight. The committee is familiar with the requirements for it to receive regular updates relating to maternity and neonatal services. The report therefore includes any immediate priorities or exceptions.

2. MATERNITY INCENTIVE SCHEME (MIS)

The ten safety actions continue to drive standards for safer maternity and neonatal care under the remit of the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries by 50% before the end of 2025.

A summary of the position and progress for CNST MIS year 6 is detailed below. (Table 1). The service remains on track with 8/10 standards, with standard 4 and 5 declared as at risk due to the financial requirements associated with Birth Rate Plus (BR+), Obstetric medical and British Association of Perinatal Medicine (BAPM) recommendations. The remaining 8 standards are on track; however, achievement of all standards is reliant on continued reporting, ongoing check and challenge and Board oversight throughout the reporting period. (See Appendix 2 CNST MIS Information Pack)

Table 1 Details the status of all 10 safety actions and includes supporting information to maintain or achieve the standard.

	Description	Progress	Evidence	Status
Safety Action 1 PMRT	**ARE YOU USING THE NATIONAL PERINATAL MORTALITY REVIEW TOOL (PMRT) TO REVIEW PERINATAL DEATHS FROM 8 DECEMBER 2023 TO 30 NOVEMBER 2024 TO THE REQUIRED STANDARD?**	Since 8th December 2023, there were 10 cases reported, 9 of which are eligible for PMRT review. All cases were notified to MBRRACE-UK within seven working days and surveillance completed within one calendar month of the death. The service is on track to meet the defined thresholds for multi-disciplinary reviews using the PMRT, where 95% are started within two months of the death, and a minimum of 60% of multi-disciplinary reviews are completed and published within six months. As action plans are collated these will be added to future iterations for oversight.	Appendix 2. Table 1 & 2	On track
A weekly failsafe report is generated to confirm that all standards are met. This is supported by a weekly failsafe meeting overseen by the matron for safety and quality.				
Safety Action 2 MSDS	Description	Progress	Evidence	Status
	ARE YOU SUBMITTING DATA TO THE MATERNITY SERVICES DATA SET (MSDS) TO THE REQUIRED STANDARD?	The service has consistently achieved 11 out of 11 CQIMs since 2022 and data integration continues to be undertaken and monitored monthly. This includes valid ethnic category (Mother) for at least 90% of women booked in the month. The validated position for May 2024 is detailed CNST MIS Information Pack standards.	Appendix 2 Table 3	On track
A data report is generated and checked prior to submission of the MSDS data, and this is confirmed at a monthly data meeting by work stream leads.				

Safety Action 3 Transitional Care	Description	Progress	Evidence	Status
	CAN YOU DEMONSTRATE THAT YOU HAVE TRANSITIONAL CARE SERVICES IN PLACE AND UNDERTAKE A QUALITY IMPROVEMENT TO MINIMISE SEPARATION OF PARENTS AND THEIR BABIES?	Pathways of care into transitional care and Avoiding Term admissions to the neonatal unit (ATAIN) continue to be prioritised, jointly agreed, and monitored by the maternity and neonatal teams and guidance is in place which supports a care pathway from 34+0 in alignment with the BAPM Transitional Care (TC) Framework for Practice. The division continues to track performance and monitor outcomes for babies requiring neonatal admission or transitional care a Quality Improvement (QI) initiative to reduce separation related to thermoregulation had been agreed as defined by MIS year 6.	Appendix 2 Table 4	On Track
The Working better together joint multiprofessional group undertakes review of all term admissions (ATAIN) to the neonatal unit and monitors transitional care (TC) activity. TC and ATAIN dashboards are generated, and a quarterly report is submitted to speciality maternity and neonatal safety and quality committee for oversight. This is shared with the LMNS and ICB on a cycle of business.				
Safety Action 4 Workforce	Description	Progress	Evidence	Status
	CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF CLINICAL WORKFORCE PLANNING TO THE REQUIRED STANDARD?	**Obstetric Workforce**. There has been an investment in the obstetric consultant roles and leadership. By August 2024, it is anticipated that the obstetric cover will have increased from 76.5 hours to approximately 88 hours overall. Work is ongoing to review the trainee requirements and to explore moving from a 1 tier to 2 tier rota separating obstetrics and gynaecology to ensure both specialities have strengthened cover.	Appendix 2 Table 6	At Risk
		Neonatal Medical There continues to be a requirement for 2 further consultants to meet BAPM compliance and it is anticipated that effective utilisation of the ORDER programme and the ANNP roles will result in full establishment of the tier 1and 2 rota from September 2024.	Appendix 2 Table 7	At Risk
		Neonatal Nursing: The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard was last presented within the Activity Capacity Demand (ACD) report in the 2022/23. The draft report for 2024/25 has been received, this will be shared in due course. This report confirms that the current establishment meets the requirement for BAPM nurse staffing. However, the report is also expected to indicate that intensive care activity is below expected target because of intra-uterine transfer declines by maternity and neonatal over different periods in the 2023/2024.This will continue to be closely monitored and is expected to improve in line with midwifery staffing vacancies reducing.		On Track
		Anaesthetic To comply with the anaesthetic medical workforce requirements associated with CNST year 6, a copy of the anaesthetic rota for all months during the reporting period is held as evidence for monitoring purposes by the service, confirming that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day. To date the service is 100% compliant with this standard.		On Track
The Board of Directors are accountable for ensuring the fundamental quality standards are delivered, including having the appropriate workforce to deliver safe care. To meet the standard requirements for the obstetric medical workforce, regular audits and reviews are undertaken to provide assurance. The continued commitment to funding phase 2 of Birthrate plus as part of the next staffing review will underpin the delivery of this standard and will reduce the frequency of intrauterine transfers and delays in induction.				

Safety Action 5 Midwifery Staffing	Description	Progress	Evidence Source	Status
	CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF MIDWIFERY WORKFORCE PLANNING TO THE REQUIRED STANDARD?	In line with the Ockenden report and the three-year delivery plan for maternity and neonatal services (March 2023) trust boards must provide evidence (documented in board minutes) of funded establishment being compliant with outcomes of birthrate plus (BR+). As detailed in previous safe staffing reports there is requirement to invest in the registered midwifery workforce. This will be considered as part of the scheduled safe staffing review in October 2024.	Appendix 2	At Risk
Several actions have been taken to explore innovate ways to support ongoing recruitment. This has included workforce profiling and over offering during key times in the academic calculator This has provided a viable solution to fill vacancies and reduce the ongoing agency and bank overspend. The Registered Midwife Degree Apprenticeship (RMDA)has been approved in July 2024 to support a pilot scheme for 2 maternity support workers to enrol as student midwives. This is a significant long term recruitment strategy which supports the “growing your own workforce”.				
Safety Action 6. Saving Babies Lives V3 (SBLV3)	Description	Progress	Evidence	Status
	CAN YOU DEMONSTRATE THAT YOU ARE ON TRACK TO ACHIEVE COMPLIANCE WITH ALL ELEMENTS OF THE SAVING BABIES’ LIVES CARE BUNDLE VERSION THREE (SBLV3)?	The service continues to make progress against the 5 elements of the SBLV3 care bundle and is 90% compliant with the 70 cumulative actions and this was externally verified by the LMNS/ Integrated Care Board in July 2024. At the end of the reporting period there is an expectation that the LMNS/ICB will confirm the position or actions required to achieve 100%. In addition, Trusts must provide a signed declaration from the Executive Medical Director declaring that Saving Babies’ Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	Appendix 2 Table 8 & 9	On Track
There is a programme of improvement work focused on SBLV3, each of the 6 elements has a named obstetric or medical lead. Areas of focus and actions are detailed in appendix 2.				
Safety Action 7	Description	Progress	Evidence Source	Status
	LISTEN TO WOMEN, PARENTS AND FAMILIES USING MATERNITY AND NEONATAL SERVICES AND COPRODUCE SERVICES WITH USERS.	The Maternity and Neonatal Voices Partnership (MNVP) and the maternity and neonatal services continue to work on the priorities defined within the joint work plan into 2024. An updated work plan will be shared in October 2024 once approved by the MNVP group and LMNS executive group in July 2024. 15 steps walk round has been undertaken in April 2024 and the draft report received for factual accuracy. The outcome will be shared in due course. Quarterly MNVP meetings continue held between service users and providers to collect safety intelligence and feedback in line with MIS year 6.	NA	On Track
The MNVP lead and Deputy Divisional Midwifery and Nurse Director meet monthly to review priorities and action feedback. The MNVP lead attends maternity and neonatal safety champions and safety and quality committee as key membership. (As defined in MID year 5 and 6.				
Safety Action 8	Description	Progress	Evidence Source	Status
	CAN YOU EVIDENCE THE FOLLOWING 3 ELEMENTS OF LOCAL TRAINING PLANS AND ‘IN-HOUSE’, ONE DAY MULTI PROFESSIONAL TRAINING?	The service confirms that the full Training Needs Analysis (TNA) standards continue to be fully aligned with version 2 of the Core Competency Framework (CCF) and the programme of training has been shared with the Divisional Safety Champions and MNVP lead. **PROMPT** Compliance with PROMPT and pool evacuation is not yet at the required standard for the Obstetric trainee group. Current compliance is 88% and equates to 3 doctors. Although all staff were booked on training, recent industrial action affected attendance at training. All colleagues have been re-booked. **BASIC NEONATAL LIFE SUPPORT** Compliance of the neonatal and medical newborn life support is tracked in line with MIS year 6. An action plan to ensure all staff groups are	Appendix 2 Table 10	On Track

<table>
<tr><td></td><td></td><td>90% is ongoing. Challenges with recording compliance via training and analytics has been escalated to the executive safety champions. Data can be found in appendix 2. Areas of focus are neonatal nurses and Specialist Trainees level 5 and above. Dates are booked in July 24.</td><td></td><td></td></tr>
<tr><td colspan="5">Training requirements are tracked via maternity safety and quality monthly, and actions taken to ensure all staff groups have achieved 90% by the end of the reporting period. All staff groups defined in the CCF V2 are 90% for fetal monitoring, PROMPT, and basic neonatal life support with the exception of except for 3 trainees for PROMPT).</td></tr>
<tr><td>Safety Action 9</td><td>Description</td><td>Progress</td><td>Evidence</td><td>Status</td></tr>
<tr><td></td><td>CAN YOU DEMONSTRATE THAT THERE IS CLEAR OVERSIGHT IN PLACE TO PROVIDE ASSURANCE TO THE BOARD ON MATERNITY AND NEONATAL, SAFETY AND QUALITY ISSUES?</td><td>The expectation of the Trust Board is that discussions regarding safety intelligence are continuing to take place monthly.

Analysis of the Perinatal Quality Surveillance (PQSO) continues monthly and is detailed in appendix 1. The Board scrutinises this alongside insights from the board-level perinatal safety champions. The safety champions bi-monthly meetings and monthly safety walk rounds provide additional valuable, first-hand source of safety intelligence that is used to consider when actions or response is required. The Board Safety Champions are also supporting the perinatal leadership team to better understand and local cultures, including identifying. and escalating safety and quality concerns and offering relevant support where required</td><td>Appendix 2 Table 11</td><td>On Track</td></tr>
<tr><td colspan="5">The Safety Champions meeting is chaired by the Chief Nurse and attended by the Board Non-Executive Director (NED). This meeting has a formal agenda and terms of reference and review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys and listening events, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback are standing agenda items. The service also confirms that Board Safety Champion(s) meet with the Perinatal leadership team at a minimum of bi-monthly. and that any support required of the Trust Board has been identified and is being implemented.</td></tr>
<tr><td>Safety Action 10</td><td>Description</td><td>Progress</td><td>Evidence</td><td>Status</td></tr>
<tr><td></td><td>HAVE YOU REPORTED 100% OF QUALIFYING CASES TO MATERNITY AND NEWBORN SAFETY INVESTIGATIONS (MNSI) PROGRAMME AND TO NHS RESOLUTION'S EARLY NOTIFICATION (EN) SCHEME FROM 8 DECEMBER 2023 TO 30 NOVEMBER 2024?</td><td>The service confirms that it has reported all qualifying cases to MNSI reporting 100% compliance to the standard. It also confirms that it complies with Regulation 20 of the Health and Social Care Act 2008 in relation to appropriate and timely Duty of Candour (DOC).

<table><tr><th>Timeframe</th><th>New MNSI referrals</th></tr><tr><td>Quarter four 2023- 2024</td><td>3 referrals</td></tr><tr><td>Quarter one 2024 - 2025.</td><td>No referrals</td></tr></table></td><td>Appendix 2 Table 12</td><td>On Track</td></tr>
<tr><td colspan="5">A quarterly report is collated on AMAT to confirm that all qualifying cases have been report in line with MIS year 6.</td></tr>
</table>

THE PERINATAL QUALITY SURVIELLENCE DASHBOARD- PART 2

Maternity staffing metrics are displayed on the perinatal quality surveillance table (PQST) each month as part of the safety reporting which is submitted to the Safety and Quality Committee for oversight which is also presented to the Board of Directors. The new format using statistical process control (SPC) provided in the Board supplementary information pack, provides an improved platform for interpreting the statistical significance of data points each month. It also includes regional or national comparator data where this is available. This has replaced the Red, Amber, Green (RAG) tables previously used.

CLINICAL SAFETY INDICATORS

STILLBIRTH

The stillbirth rate continues to be monitored monthly by maternity Safety and Quality Committee. In May and June 2024 there were no stillbirths. This is the second consecutive month where the service has not reported any stillbirths.

There was one case reported to MBRRACE UK which was a late pregnancy loss diagnosed at 23+5 weeks gestation. The mother had been transferred to the Trust for regional neurology and maternal medicine centre care. There was a history of early onset fetal growth restriction and suspected fetal anomaly. The PMRT review of the case is currently ongoing and is shared with the referring Trust.

NEONATAL HYPOXIC-ISCHEMIC ENCEPHALOPATHY (HIE)

Moderate Neonatal Hypoxic-ischemic encephalopathy diagnosed on Magnetic resonance imaging (MRI) will be included on the PQS dashboard going forward to illustrate the impact of antenatal or intrapartum hypoxia on perinatal outcomes. This will be included from September 2024.

BOOKING BY 9+6 and 12+6

Booking compliance is on an upward trajectory and since February 24 compliance has been above the target of 50% and 90%. This positive position is due to the early bird pilot and improved administration processes. It is anticipated however that there will be a potential decline in performance in July 24 due to administration workforce gaps affecting timely booking. It is expected that this will resolve as all administration posts have now been filled.

3RD AND 4TH DEGREE TEAR

The incidence of 3rd and 4th degree tears is above the target range and several actions are ongoing to improve outcomes. The service has identified a lead obstetrician from June 2024 and midwife for pelvic health who are working with the team to raise awareness and deliver training. Table 2 details the current training compliance and the Local Maternity and Neonatal System (LMNS) have mandated that all staff have training on reducing obstetric anal sphincter injury (OASI). The service is also working towards the stretch target recognising the improvements needed.

Table 2 OASI compliance by staff group.

Form of Training for OASI	Consultants	Midwives	Trainee's ST/FY
Presentation (mandated)	**13/15 87%**	**180/185 95%**	**20/20 100%**

Simulation (Stretch target)	**8/15 53%**	**109/180 61%**	**12/20 63%**

PERINATAL QUALITY GOVERNANC AND REGULATION

MATERNAL DEATH

In May 2024 there was one reportable maternal death associated with early pregnancy and ruptured ectopic pregnancy. Sadly, the woman presented into the Emergency Department in cardiac arrest. A coronal PM has been undertaken and findings suggest a cause of ectopic pregnancy. The women had not yet self-referred for care to either the early pregnancy unit or maternity. It is not yet known if the pregnancy was confirmed. The case has been referred to MNSI and MBRRACE and consent to investigation agreed by the family.

PERINATAL QUALITY GOVERNANCE EXPERIENCE AND REGULATION

CARE QUALITY COMMISION (CQC)

Since the CQC report in 2023 there are several longer-term should do actions that remain overdue related to induction of labour and maternity triage. The updated position is included in the table 3 below.

Table 3 CQC ongoing actions

Must/Should Do	Action	Update
The service **should** ensure they monitor delays in the induction of labour process and all reasons for the delays are documented.	Recommended uplift in staffing in line with BirthRate Plus presented to Trust Board and ICB for approval of maternity staffing uplift	**Phase 1 of BR+** approved Awaiting phase 2 uplift. Induction of labour SOP being updated to reflect pathway for delay in induction.
	Update the induction of labour guideline to detail monitoring processes	The Induction of labour guideline is being updated and is awaiting publication.
The service **should** improve the culture where staff feel listened to.	RCOG Each Baby Counts escalation toolkit Improvement Project to be implemented across service	Each Baby Counts project ongoing behaviour workshops and Leadership days ongoing.
	Listening events for all speciality groups arranged facilitated by the organisational development team.	Listening events Completed and leadership days ongoing
The service **should** ensure the maternity assessment service has the right number of qualified staff and the triage telephone line is answered and monitored by a trained midwife.	Implement new telecommunications software to support management of calls coming through triage and the ability to monitor dropped calls	Costing received for telecoms call waiting system. Meeting arranged to confirm next steps with operational teams. Local interim solution and call tracking continues. Current system in place to alert a missed call and initiate a call back.
	Recommended uplift in triage staffing as assessed by BirthRate Plus presented to Trust Board and ICB for approval of maternity staffing uplift. This will enable telephone triage to be separated from clinical area as recommended by BSOTS. Area for relocation has already been identified.	**Phase 1 of BR+** approved and maternity Support workers deployed to Triage. Awaiting phase 2 uplift
	Business case being compiled to uplift obstetric staffing so that appropriate obstetric review can be achieved in the correct timeframes.	2 tier obstetric rota required. Rota cover for 9-5 in place

NHS RESOULTION EARLY NOTIFCATION REVIEW

On the 13 December 2023, NHS Resolution wrote to the Trust to advise that a thematic review of the cases reported by the Trust to the Early Notification (EN) scheme between 1st April 2017 and 29th February 2024, would be undertaken. The Trust were advised that the thematic review was being undertaken in response to two factors which are detailed below.

- the number of incidents reported to the EN scheme from the Trust had increased significantly and by birth rate for 2022/23, was 0.19%, greater than twice the national rate of 0.06% and the regional rate of 0.07%.
- the Care Quality Commission (CQC) downgraded the 'overall' and 'safe' rating for maternity at Royal Preston Hospital from "good", to "requires improvement" in November 2023. The 'safe' domain for maternity was also downgraded to "requires improvement" at Chorley and South Ribble Hospital.

The thematic review included the time from the on 13 December 2023 and ended on 29 February 2024 with the feedback, outcome and recommendations presented to the organisation on 18 June 2024. NHS Resolution identified thirty-seven incidents which had been reported to the Early Notification scheme between 1st April 2017 and 29th February 2024, of these incidents twenty-three were considered for inclusion within the thematic analysis, fifteen cases were excluded. The findings of the thematic analysis focused on 11 area's and identified both good practice and areas for learning. A paper has been collated detailing the actions already taken and the assurance measures that remain in place and this will be presented to the Safety and Quality Committee in July 2024.

SAFE STAFFING

The fill rates for Registered Midwives (RM) (86% day, 89% night) and Maternity Support Workers (MSW) (80% day and 98% night) in June 2024 demonstrates a sustained, lower than planned fill rate, which is reflected in the year-to-date projection and is synonymous with the established vacancies. This is synonymous with the established vacancies. The establishment tracker continues to monitor current midwifery staffing levels and the overall projected position. This includes monitoring drop off rates for the newly qualified midwife new appointments for October 2024. The vacancy is currently 13.80 WTE which will reduce to 0.96 WTE in October 2024 when the new appointments start in post. (The over offer position is now 0 with 5.2 WTE withdrawing from offer) and the service will continue to re-offer to all posts with an aim of reducing towards a vacancy trajectory of zero. It is anticipated the over offer approach will enable the service to have no vacancies.

The monthly midwife to birth ratio is currently calculated using the number of Whole Time Equivalent (WTE) midwives employed and the total number of births in month. This is the contracted Midwife to birth ratio. The reporting of the contracted ratio is a useful measure to assess the recruitment and retention of midwives to the service although will show small fluctuations due to this as well as changes in birth numbers each month. This has been recalculated in month to reflect the staff in post and is included in the PQS (appendix 1) for oversight.

RED FLAGS

The incidence of maternity red flags continues to be monitored by the maternity service. In addition, the red flags are added to the associated risks on the register for additional oversight by the Division. The service reported 145 maternity red flag Datix incidents in the month of May 2024 and 195 in the month of June 2024. The breakdown by category is provided in appendix. The highest number of red flags for both May and June 2024 were reported in the category of delays in review in the maternity assessment suite (MAS). In May 2024 there were 38 red flag incidents reporting a wait of more than fifteen minutes for review by a midwife following presentation to MAS and 20 reported in June 2024. In addition, in May 2024, 31 incidents to report a wait time of more than thirty minutes for review by an obstetrician following presentation to MAS were submitted and 43 incidents were reported in this category in June 2024. All incidents have been linked to the active risk on the risk register and there is an ongoing service development action plan pertaining to MAS, none of the incidents were known to be associated with patient harm.

WORKFORCE

The service continues to seek responsive solutions to recruitment of midwives. Table 4 details those undertaken and ones which are ongoing. The 2023/24 workforce action plan is now completed and ongoing actions associated with BR+ will be moved to the new people culture and workforce plan. (Appendix 4)

Table 4 Responsive recruitment and retention initiatives

Workforce recruitment and retention initiatives	Narrative
International Recruitment	8 international colleagues in post.
Apprentice Midwives Degree Programme (RMDA) (local midwife grow your own workforce)	Paper approved by executives following funding agreement by the ICB to backfill 2 RMDA for 3 years.
Over offer profiling and 30-hour contracts	The service was given executive approval to over offer to RM posts during key times in the academic calendar. All newly qualified midwives offered 30 hours contract to increase head count and reduce requirement to go back out to advert by increasing hours to full time if vacancy is evident
Recruitment Advert	Filming for the maternity and neonatal recruitment video being undertaken 1.08.2024.

OBSTETRIC WORKFORCE

There has been ongoing investment in the obstetric workforce since 2022 pertaining to the consultant and leadership roles in obstetrics and the current position is that by August 2024 the number of hours of acute cover will increase from 76.5 hours to 88 hours. This investment has also enabled several specialist roles to be employed for maternal and fetal medicine as well as leadership and clinical director PA's. It is recognised however that to provide wide oversight and obstetric medical rota cover that the service is exploring how the rotas are organised with the aim of converting to a two-tier model. This would aim to reduce delays in the review of both obstetrics and gynaecology particularly out of hours and increased oversight of both the early pregnancy service and maternity triage. A review of the middle grade requirements is ongoing by the Clinical Director, and this will inform future requirements.

CLINICAL ESCALATION

DELAYS IN INDUCTION OF LABOUR

To demonstrate the ongoing impact of established vacancies, the uptake of mutual aid during the induction of labour process is included in the Perinatal Quality Surveillance slide set. During times of high acuity, women who require induction or who are being induced but are delayed, are offered transfer to alternative providers for augmentation of labour. Whilst mutual aid is part of the Northwest clinical escalation policy and is usually facilitated within the Lancashire and South Cumbria region, the impact of transfer should not be underestimated. In May 2024 two women transferred care at the start of the induction process because of high activity and reduced midwifery staffing. There was 0 in June 2024.

INTRAUTERINE TRANSFER (IUT) NEONATAL AND MATERNITY

The service continues to collect data related to inability to accept intrauterine transfers (IUT). To provide wider triangulation of the operational pressures on the maternity and neonatal service, the maternity specific safety and quality matrix includes a separate breakdown of all IUTs declined by maternity and those declined by the neonatal unit.

In total the number of IUTs declined by the maternity and neonatal service in May 2024 was 5 and none were reported for June 2024. In May two requests were declined by NICU due to neonatal service capacity or staffing. Three IUT requests were declined by the maternity service due to capacity or staffing.

In addition, during May 2024 there were two in utero transfers of antenatal mothers from the Trust to other organisations for level three neonatal intensive care cots due to neonatal service capacity issues, none were reported for June 2024.

CLOSURES OR DIVERTS

In the months of May and June 2024 there were no maternity diverts however, there was one instance of neonatal unit closure in both May and June 2024.

WELL-LED

PERINATAL CULTURE

The service awaits the findings of the SCORE survey and leadership coaching sessions are ongoing to prepare to socialise and consider the results across the teams. A Local action plan had also been created as part of the divisional people plan to explore relationships and improve safety culture and the progress of these actions are being monitored by the Executive safety Champions Listening events undertaken earlier in the year highlighted the need for improved communication, escalation and team working across teams and in response the service has designed bespoke leaders' sessions for band 6-8 midwives and consultants. The Clinical escalation Royal College of Obstetrics work is also progressing well with the content evaluated positively. The committee will receive an updated of the SCORE findings and associated actions in due course.

MILESTONE ACTIONS

The NHS Race Observatory national Continuous improvement project continues, and the team were asked to present findings to date to an NHS webinar. Language profiling to translate the early bird public health sessions into most spoken versions is ongoing with Romanian, Urdu, Arabic and Polish being the top 4.

The service has also been selected to work cross provider with Manchester Foundation Trusts and AQUA. The project is focused on an evidence base around the choice and personalisation strategy, aligned to the Three-Year Delivery Plan for Maternity and Neonatal services.

A charity bid was recently submitted to NHS Charities Together - Innovation Fund and the service is pleased to confirm that it has been shortlisted to compete in the final round of the process. Lancashire Teaching Hospitals is down to the last 6 from 69 applications.

Several international visits have been hosted by the maternity service over the last 6 months. As a Beacon centre with 4 places of birth, Lancashire Teaching hospitals, many requests for engagement and advice are received. Midwives from Hong Kong, Sweden and New Zealand visited the maternity service to gain insights into maternity services. The feedback from the visiting delegates was over whelming positive.

3. CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report confirms the position against the workstreams set out by the CNST NHS Resolution for year 6 and confirms that although the service remains on track that performance and reporting must be sustained throughout the reporting period to declare 100% compliance overall.

The perinatal quality surveillance dashboard and the red flag reporting indicates pressure points related to staffing levels across maternity and obstetrics. Specifically, the induction of labour pathway, postnatal care and timely review in triage and this must be acknowledged.

A plan to present the outstanding BR + safe staffing requirements as part of the October 2024 biannual staffing review is in place and a further 10.14 WTE midwives is required.

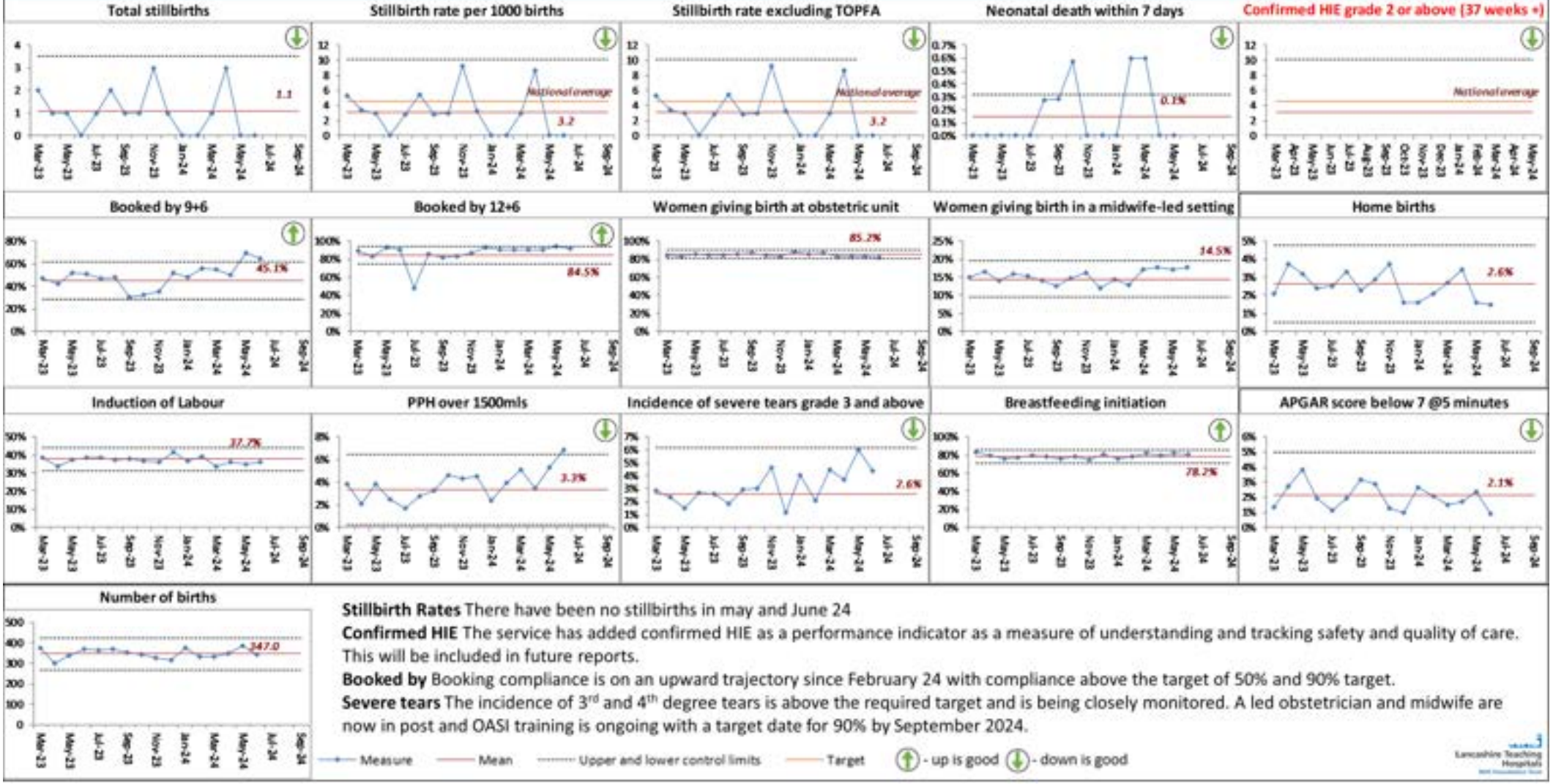
4. RECOMMENDATIONS

The Board of Directors are asked to:

I. Approve the Maternity and Neonatal Service Update including safe staffing position.
II. Note the CNST update report and recommendations.
III. Confirm it is satisfied a comprehensive level of check and challenge has been applied by the Board level safety champions to understand the performance and pressures affecting the maternity and neonatal service and reflect this in the committee minutes.
IV. Receive the associated action plans for information oversight and assurance.

Perinatal Quality Surveillance Dashboard Information Pack Appendix 1

Clinical Safety Indicators



Stillbirth Rates There have been no stillbirths in may and June 24

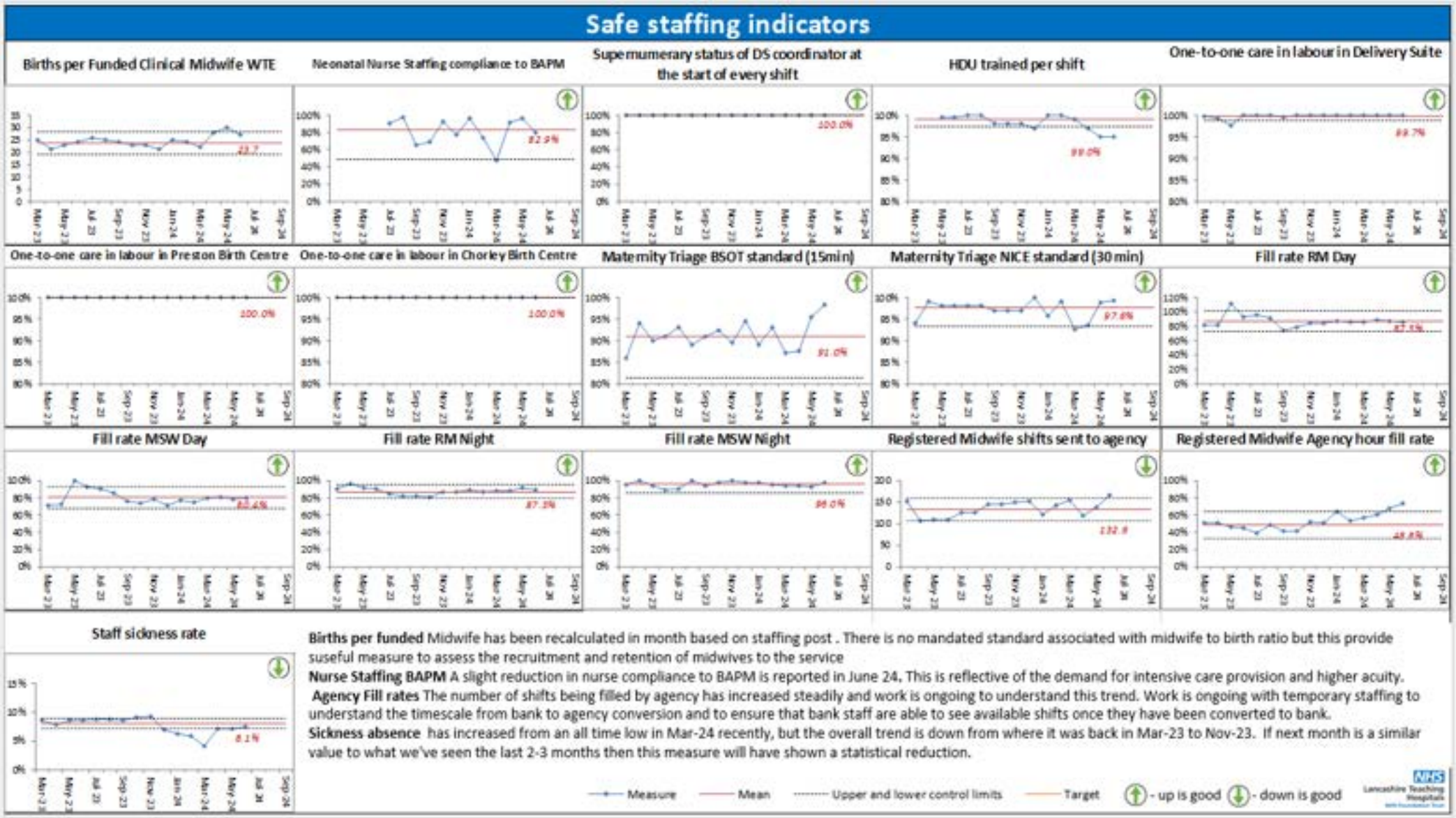
Confirmed HIE The service has added confirmed HIE as a performance indicator as a measure of understanding and tracking safety and quality of care. This will be included in future reports.

Booked by Booking compliance is on an upward trajectory since February 24 with compliance above the target of 50% and 90% target.

Severe tears The incidence of 3rd and 4th degree tears is above the required target and is being closely monitored. A led obstetrician and midwife are now in post and OASI training is ongoing with a target date for 90% by September 2024.

Maternal Death In May 2024 there was one case of maternal death associated with early pregnancy and ruptured ectopic pregnancy. Sadly the woman was brought into the Emergency Department in cardiac arrest. A coronal PM has been undertaken and findings suggest a cause of ectopic pregnancy. She had not self referred for care in early pregnancy unit or maternity. It is not know yet whether she had confirmed a pregnancy. The case has been referred to MNSI and MBRRACE and consent to investigation agreed by the family.
Compliments Recording and reporting compliments has been included in the dashboard for the first time to provide a breadth of patient safety intelligence.

Safe staffing indicators



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

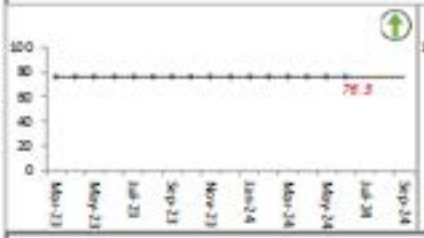
Nurse Staffing BAPM A slight reduction in nurse compliance to BAPM is reported in June 24. This is reflective of the demand for intensive care provision and higher acuity.

Agency Fill rates The number of shifts being filled by agency has increased steadily and work is ongoing to understand this trend. Work is ongoing with temporary staffing to understand the timescale from bank to agency conversion and to ensure that bank staff are able to see available shifts once they have been converted to bank.

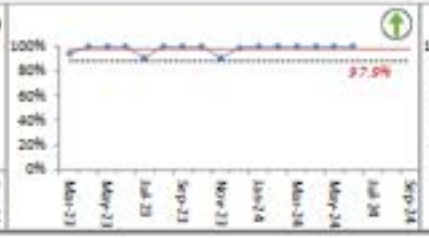
Sickness absence has increased from an all time low in Mar-24 recently, but the overall trend is down from where it was back in Mar-23 to Nov-23. If next month is a similar value to what we've seen the last 2-3 months then this measure will have shown a statistical reduction.

Obstetric Medical Staffing

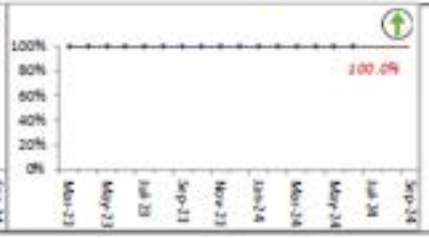
Number of Consultant hours on obstetric unit



RCOG obstetric benchmarking compliance



24-hour acute obstetric medical staffing fill rate



Consultant hours in the obstetric unit. The service continues to invest in consultant funding and by September 2024 it is expected that new appointments will be in post and that hours compliance will increase to 88%.

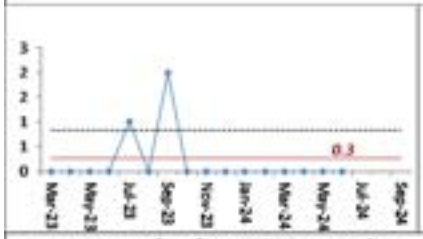
RCOG attendance remains at 100%

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

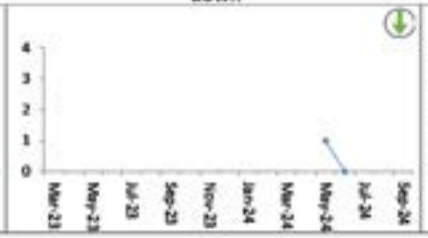
Measure — Mean ····· Upper and lower control limits — Target ↑ - up is good ↓ - down is good

Clinical Escalation

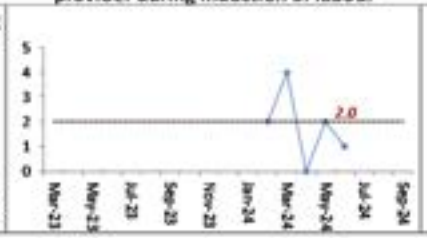
Maternity Diverts



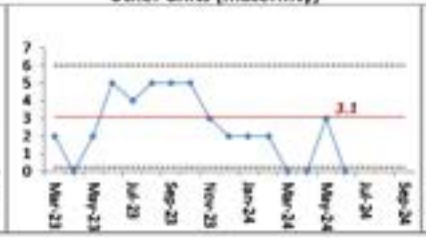
Number of times home birth service stood down



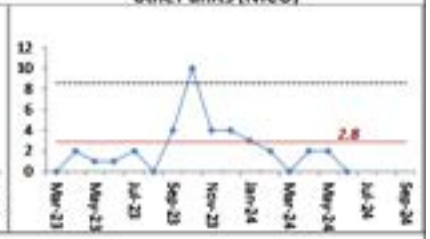
Women who transfer to an alternative provider during induction of labour



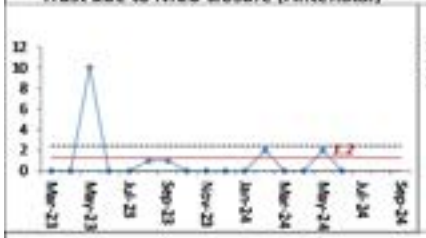
In- utero transfers declined to accept from other units (maternity)



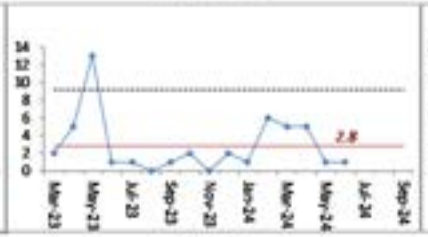
In- utero transfers declined to accept from other units (NICU)



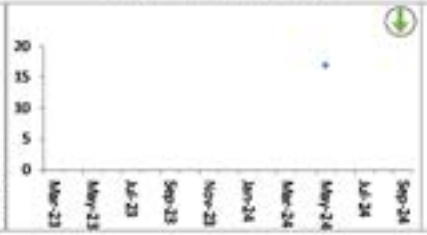
In- utero transfers from LTHTR to another Trust due to NICU closure (Antenatal)



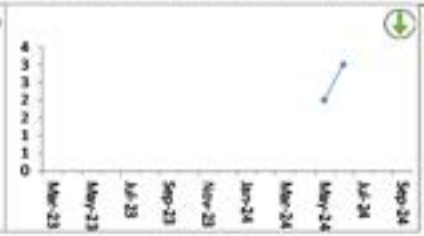
NICU Closure



Delay in inductions (New)



Elective sections stood down (New)



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

In- Utero Transfers (IUT) Staffing levels continue to impact on the ability to accept intrauterine transfers across both maternity and neonatal services. This requires close ongoing monitoring and MDT decision making when a transfer may not be accepted due to acuity and or staffing.

NICU Closure There has been an increase in closures associated with intensive care cot capacity since February 24 linked to higher sickness absence. This appears to have settled in May but will continue to be monitored by the neonatal leads.

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

Appendix 2 CNST MIS Year 6 Information Pack Table

Safety Action 1 PMRT MIS 1 Tracker CNST Year 6
Table 1

Table 1: Perinatal Mortality Tool progress tracker

REQUIRED STANDARD (Standard A) *	Compliance score		RAG
Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days.	Notification	10/10	
	Surveillance	9/9	
Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	On Track	9/9	
REQUIRED STANDARD (Standard C) *			
Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	On track	Commenced within 2 months. 9/9	
		Completed within 6 months: On track.	
REQUIRED STANDARD (Standard D) *			
Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	April 2024		
	July 2024		

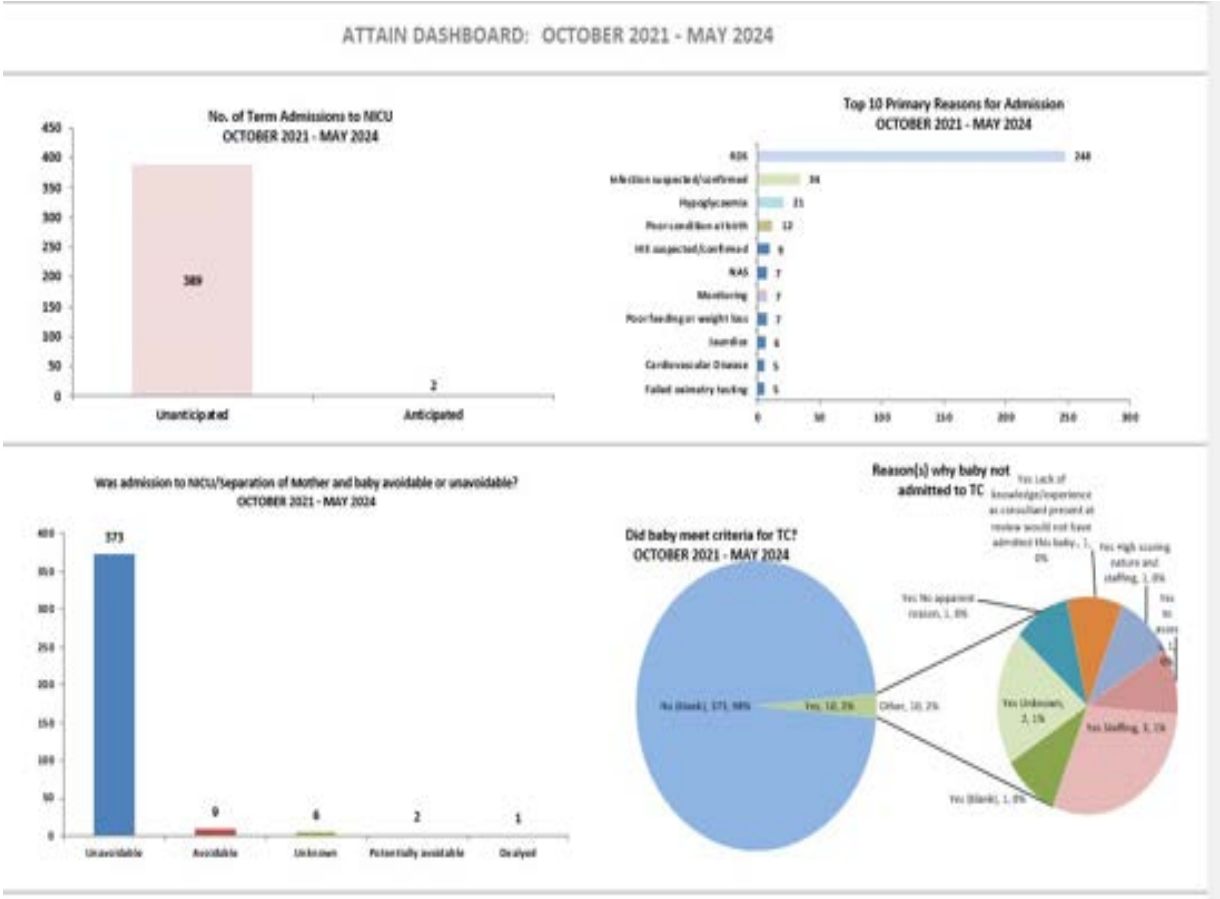
***Exclusions:** If the surveillance form needs to the assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.

Safety Action 1 PMRT MIS 1 Tracker CNST Year 6
Table 2

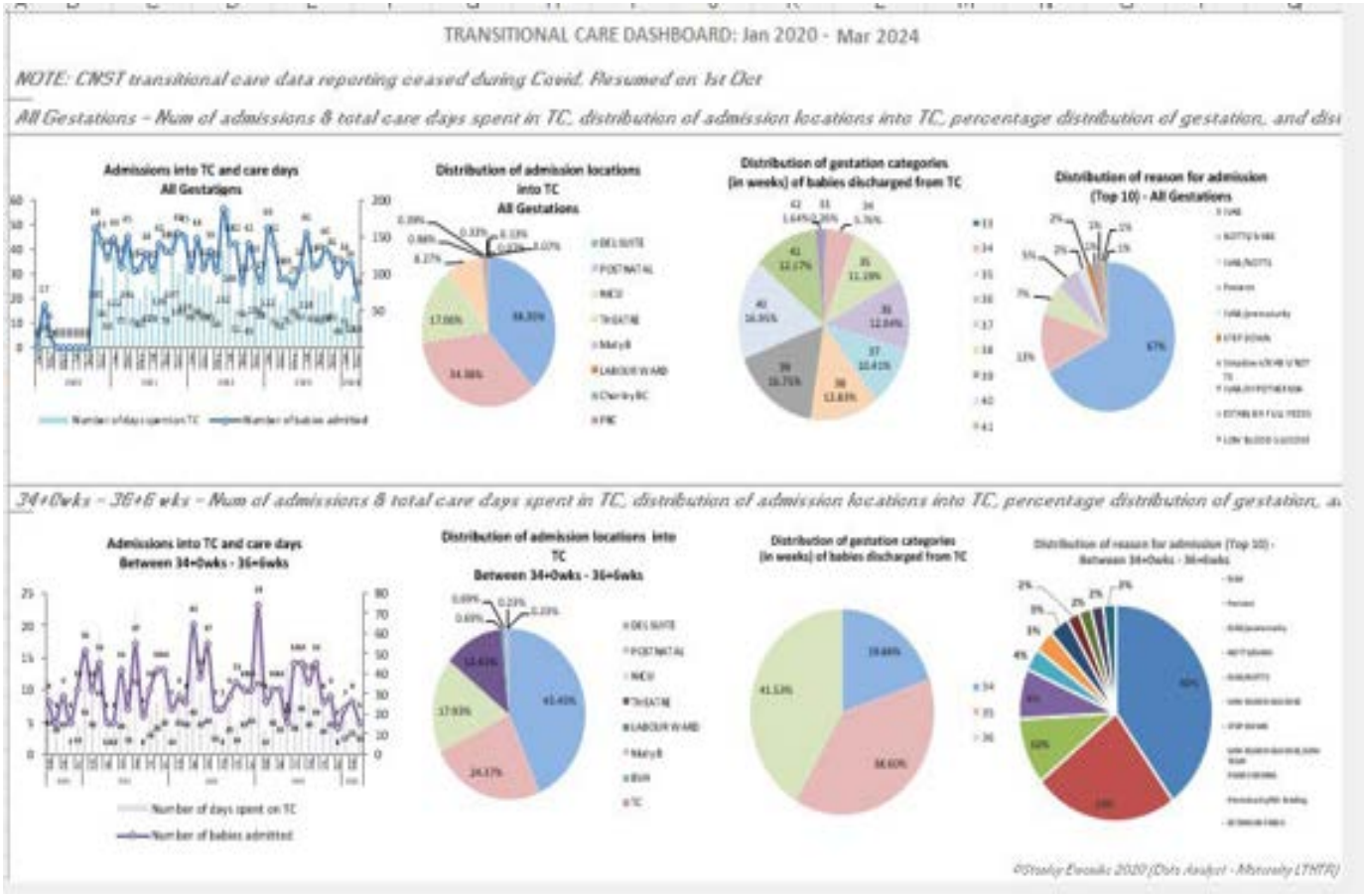
ID (Datix/PMRT)	Gestation	Stillbirth/ Neonatal death	Narrative	PMRT upload date	PMRT ref	Parents informed	Report drafted within 6 months	Actions ongoing
150075	24+5	Neonatal death	In-utero transfer from BVH for level three neonatal care.	Yes	91767	Yes	Yes	
151211	39+3	Neonatal death	Compassionate reorientation of care following the initiation of therapeutic cooling treatment.	Yes	91936	Yes	Review ongoing, deadline not yet met.	Referred to MNSI for external investigation. StEIS reported. Formal DOC provided to the family.
151421	22+6	Neonatal death	Triplet 2. Extreme prematurity.	Yes	91959/2	Yes	Review ongoing, deadline not yet met	
154632	41+5	Neonatal death	Admitted to MAS with reduced fetal movements, terminal bradycardia identified on admission. Category one caesarean section, baby born in poor condition. Cooling commenced but decision made to compassionately reorientate care to palliative.	Yes	92488	Yes	Review ongoing, deadline not yet met	Referred to MNSI and StEIS reported. Formal DOC provided to the family.
154842	24+3	Antepartum stillbirth	Admitted with reduced fetal movements and FDIU diagnosed.	Yes	92519	Yes	Review ongoing, deadline not yet met	AAR performed; to proceed with PMRT investigation.
154826	27+5	Neonatal death	Admitted with spontaneous onset of labour, placental abruption identified on admission. Vaginal breech birth with entrapment of the aftercoming head.	Yes	92532	Yes	Review ongoing, deadline not yet met	AAR performed; to proceed with PMRT investigation.
158232	33	Antepartum stillbirth	Multiple pregnancy, twin one feticide for complex congenital anomaly at St Mary's hospital. Admitted unwell one week after the feticide and FDIU diagnosed.	Yes	92922	Yes	Review ongoing, deadline not yet met	AAR performed, to proceed with PMRT investigation. St Mary's hospital Manchester sharing PMRT review.
158565	26+3	Antepartum stillbirth	Baby known to have an antenatally diagnosed exomphalos. Admitted via the emergency department with abdominal pain, FDIU diagnosed on admission to maternity.	Yes	93059	Yes	Review ongoing, deadline not yet met	AAR performed, to proceed with PMRT investigation.

Safety Action 2 MSDS Data Status Report Table 3

Safety Action 3 ATAIN Dashboard October 2021-May 2024 Table 4



Safety Action 3 Transitional Care Dashboard Jan 2020-May 2024
Table 5



Safety Action 4 Obstetric Medical Requirements
Table 6

REQUIRED STANDARD OBSTETRIC MEDICAL	PROGRESS	EVIDENCE
NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota.	On Track	Checked on employment by CD. 6 monthly Audit. Held on MS Team Channel
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)	On Track	Checked on employment by CD. 6 monthly Audit. Held on MS Team Channel
c. hold a certificate of eligibility (CEL) to undertake short-term locums.	On Track	Checked on employment by CD. 6 monthly Audit. Held on MS Team Channel
Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.	On Track	Maternity and Neonatal Board Report Safety Champions
Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.	On Track	6 monthly local AMAT audit
Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further nonattendance		Monitored via PQST and audited locally monthly

Safety Action 4 Neonatal Medical Workforce Requirements to meet BAPM standards Table 7

Current Medical Staffing (Based on a 1/7 rota)	May 2024	BAPM requirement 1/8 rota	Workforce requirement to meet BAPM 1/8	Compliance
Consultant n=9	9/9	1/8 rota	2 consultants-required	Business case required.
Tier 2 n=7	4.6/7	1/8 rota	From Sept 24 transition to 1/8. Will be compliant	ORDER Programme 2 WTE ANNP's 8a-8b.
Tier 1 n=7	7/7	1/8 rota	From Sept 24 transition to 1/8	ANNP and FY2.

Safety Action 6 Saving Babies Lives Progress
Table 8

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

Safety Action 6 Saving Babies Lives Progress Table 9

Summary of the Actions outstanding to meet minimum targets May 2024		
Element	Standard	Progress
Element 1	Smoking statue recorded at booking and 36 weeks at each antenatal appointment	Upward improvement trajectory noted minimum target 80% 37% in August 23 now 52%. In house service only just fully established. Awaiting national change to Badger Net to solve reporting issue.
	Referral to tobacco service	Referral rates improved since in house service implemented in January 2024. (from 36% to 71%)
	Percentage of smokers who set quit date and remain a non-smoker at 36 weeks	Actions ongoing with health coaches to embed and document change in process (New MIS year 6)
Element 4	Improve fresh eyes compliance	System level standard to be set with 4 providers to agree on minimum audit standards. LTHTR set higher than others in the LMNS. Current compliance 50% needs to ne at 80% to declare compliance. Test of change ongoing.
Element 5	Standardised documentation regarding preterm birth counselling.	Improvement expected with the introduction of neonatal BadgerNet as compliance is taken from NICU system not maternity. Work ongoing to ensure standards are documented and can be retrieved from Badger Net.
Element 6	Training for medical and nurse leads in diabetes	2 consultants and one diabetes nurse to undertake training and standard will be achieved.

Safety Action 8 Training Compliance
Table 10

	MIDWIVES	CONSULTANTS	DOCTORS	COMPLIANCE PERCENTAGE OVERALL
CTG update (Delivered as part of PROMPT or attendance at CTG meeting)	98% *176 compliant out of 179*	100% *11 compliant out of 11*	100% *18 compliant out of 18*	99% (Increase 1%) *205 compliant out of 208*
Fetal Monitoring training Attendance at full day fetal monitoring training	99% *175 compliant out of 176*	91% *10 compliant out of 11*	100% *18 compliant out of 18*	99% (Same) *203 compliant out of 205*
GAP/GROW	93% *167 out of 179*	91% *10 out of 11*	94% *17 out of 18*	93% (Increase 1%) *194 compliant out of 208*
Human Factors (attended PROMPT or fetal monitoring)	99% *177 out of 179*	100% *11 out of 11*	88% *23 out of 26*	98% (Same) *211 compliant out of 216*

	NICU Nurses	CONSULTANTS	ANNP's	JUNIOR DOCTORS	COMPLIANCE PERCENTAGE OVERALL
Neonatal Basic life support	82 % *67 compliant out of 82*	100% *9 compliant out of 9*	100 % *6 compliant out of 6*	100 % *11 compliant out of 11*	86 % *98 compliant out of 114*
NLS (3 year) certification medical staff.	NICU Nurses	CONSULTANTS	ANNP's	ST5 and above as per BAPM/MIS	COMPLIANCE PERCENTAGE OVERALL
	99 % *81 compliant out of 82*	100 % *9 compliant out of 9*	100 % *6 compliant out of 6*	80 % ***4 compliant out of 5*	95 % *19 compliant out of 20*

NB: The service aligns the TNA for neonatal resuscitation requirements to year 6 MIS (initial and updated) and BAPM standards.

	MIDWIVES	CONSULTANT	DOCTORS	ANAESTHETISTS	MATERNITY SUPPORT WORKERS	COMPLIANCE OVERALL
OBSTETRIC EMERGENCIES (PROMPT)	98% 176 out of 179	91% 10 out of 11	88% 23 out of 26	100% 24 out of 24	98% 44 out of 45	97% (Same) *277 compliant out of 285*
Pool Evacuation	99% *177 out of 179*	100% *11 out of 11*	85% *22 out of 26*	96% 23 out of 24	91% 41 out of 45	96% (Increase 1%) 274 out of 285

Safety Action 9 Safety Champion Action Log Table 11

28/06/2024 – **Safety Champion walkaround action log** Tim Ballard, NED, visited Delivery Suite and Neonatal Unit

Date	Decision/action agreed	Forum	Action Owner	Actions	RAG
28/06/2024	Installation of scavenger units in progress on Delivery Suite to improve ventilation whilst Entonox in use. Should staff be fitted with Nitrous Oxide Detectors (NOD) for monitoring purposes?	Safety Champions Walkaround	Interim Deputy Divisional Nursing and Midwifery Director	03.07.2024 NODs not required within the Delivery Suite workplace as annual schedule of exposure testing in place. This provides assurance that workplace exposure limits are not exceeded to safeguard staff and maintain compliance. Action closed	
28/06/2024	Timely access to theatre space in the event of an emergency	Safety Champions Walkaround	Clinical Business Manager	03.07.2024 Awaiting completion of Theatre 4. Theatre availability and capacity on risk register and monitored via S&Q.	
28/06/2024	Auto recording of CTG's in BadgerNet stops for 10 minutes every night at midnight, requiring staff to make manual records in that time frame	Safety Champions Walkaround	Digital Midwife	03.07.2024 E -mail to HR to detail action and request resolution	
28/06/2024	Community use of iPads unreliable requiring staff to make manual records	Safety Champions Walkaround	Digital Midwife/Midwifery led Services Matron	03.07.2024 E -mail to HR & LT to review and understand issue.	
28/06/2024	Current rotation pattern of midwives discussed and some feeling of lack of feeling part of a team as regularly working in different areas.	Safety Champions Walkaround	Preceptorship Lead Midwife/Midwifery Led Services Matron	03/07/2024 E -mail to SD & LT to review current staffing model and rotation in -line with staff feedback. Several listening events have also been held on a regular basis and pathway changes made to support flexible working in response to feedback	
28/06/2024	Accuracy of training compliance figures for APLS and BLS within neonatal unit team	Safety Champions Walkaround	Chief Nursing Officer	03/07/2024 CNO update - Paper submitted to Education Committee with plan to address. To be monitored through education, training and workforce committee	

Safety Action 10 MNSI Cases Table 12

MI number	Case Summary	Early Notification applicable	Early notification completed	Status of HSIB investigation	Final HSIB report sent to legal team.	Duty of Candour
36750	The mother attended the maternity assessment suite with reduced fetal movements and irregular uterine activity. Fetal heart rate monitoring was commenced which was assessed to be abnormal and a decision was made for category one caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated for 72 hours, the post cooling MRI showed moderate HIE.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes
36837	The mother attended the maternity assessment suite with reduced fetal movements for 24 hours and irregular uterine activity. Fetal heart rate monitoring was commenced which was assessed to be abnormal and the mother was transferred to the delivery suite for intrapartum care. Following transfer to delivery suite the CTG deteriorated, and a decision was made for caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated however, a decision was made to reorientate the baby's care to palliative and a compassionate extubation was performed. The baby died shortly after.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes
36948	The mother attended the with reduced fetal movements and irregular uterine activity, the mother was due for induction of labour that day. An abnormal fetal heart rate pattern was detected on admission and the mother was transferred urgently for a category one caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated but after 24 hours a decision was made to compassionately reorientate care to palliative and the baby died shortly after.	Yes	Yes	Investigation ongoing.	Investigation ongoing.	Yes

APPENDIX 3 RED FLAGS

Red flag Reporting Metrics	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	April 24	May 24	Jun 24
Delay in time critical activity	17	50	43	34	38	23	10	28	51	38	16	24	36
Missed or delayed care> 60 mins in washing or suturing	1	2	0	0	0	0	1	1	0	1	0	2	1
Failure for women to receive the medication required.	0	0	0	0	0	1	0	0	0	0	0	0	3
>30-minute wait for pain relief.	0	3	2	3	0	1	0	1	1	0	0	4	3
Lack of full examination when woman presents in labour.	0	0	1	1	1	1	0	1	0	1	0	0	2
>2-hour delay in induction?	4	30	10	16	10	7	0	23	9	18	9	16	20
Delay in recognition of and action of abnormal signs.	0	0	2	0	0	4	0	1	0	1	0	2	0
Inability to provide one to one care in labour?	0	7*	0	1	0	0	0	0	0	0	0	3	4
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS													
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)			5	21	18	13	1	12	18	29	43	38	20
>30-minute wait for obstetric triage.	15	29	29	25	11	10	5	9	15	12	30	31	43
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	0	1	0	0	0	1	0	4	1	0	0	1	2
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)	3	24	5	15	8	19	0	23	18	12	5	0	30
Was there a delay in transfer once labour was established? (New parameter Oct 22)	1	3	1	1	1	1	0	2	1	2	0	3	3
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)	0	0	1	0	0	1	0	0	0	0	0	1	2
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	0	0	1	0	0	1	0	0	0	0	0	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	0	7	1	3	1	1	0	0	1	1	0	1	1
Has there been any cancelled or delayed community work? (New parameter Oct 22)	177	31	4	85	14	5	0	28	38	28	95	12	13
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)							0	19	18	2	9	7	12
Total numbers of red flags	**218**	**187**	**105**	**205**	**103**	**90**	**17**	**156**	**170**	**146**	**207**	**145**	**195**

APPENDIX 4 WORKFORCE ACTION PLAN COMPLETED

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
1	**Review temporary staffing solutions.**	Introduce Thursday 11am weekly operational planning meeting between the ward managers and matrons. Sickness absence should also be discussed during the meetings.	Matrons	~~01.05.2023~~ ~~01.06.2023~~ ~~01.08.2023~~ ~~1.12.2023~~ 20.04.2024	24.04.2023 To commence week beginning 15.05. 2023.First meeting planned. 03.07.2023 First meeting held. Template to be revised and the regular meetings to be set up. 18.09.2023 Action ongoing. 13.11.2023 Action continues to be explored and monthly finance and workforce meetings continue. 20.04.2024 Operational matrons meeting set up to oversee workforce planning. Matron of the day introduced to manage day to day issues. Action closed.	
		Develop a midwifery staffing team's channel.	Matron for complex midwifery care	01.05.2023	24.04.2023 JG to provide MR with a list of people to be added to the team's channel. 15.05.23 List collated and teams' channel open. 18.09.2023 Action completed.	
		Develop a weekly staffing meeting template to record meetings and actions.	Matron for complex midwifery care	~~01.05.2023~~ ~~07.07.23~~ ~~01.08.2023~~ 1.12.2023	24.04.2023 Draft template to be updated by MR. 03.07.2023 Template trialled and to be revised. 18.09.2023 Action ongoing. 13.11.2023 Action stood down as no longer applicable.	
		Consideration of an on-call system for the unit.	Matrons	~~30.06.2023~~ 01.09.2023	24.04.2023 Offer on-call shifts as a volunteer temporary arrangement to staff. Draft an expression of interest for staff. Considered and excluded	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
		Consult summer leavers to understand if they will consider deferring end date.	Matron for midwifery led services	30.06.2023	24.04.2023 Staff have been consulted and majority are going to new positions. Action closed.	
		Request 10WTE agency midwives block booking for 6-month period.	Chief Nursing Officer	06.07.23	03.07.23 - Request made through temporary staffing and agency recruitment for block booking ongoing based on unfilled shifts through top October 2023. 18.09.2023 Options reviewed and agency booked when possible. Agency fill rates included in the perinatal Surveillance table. Action Closed	
		Explore use of registered Nurses from critical care within maternity services.	Chief Nursing Officer	31.07.23	03.07.23 -Request made of critical care team for nursing staff to support when appropriate and in line with "Safe practice principles for adult nurses working as part of multidisciplinary teams (MDT) in Maternity Services" published by NHS England on 25th May 2023. Options for other nurse roles within maternity services to be explored. 18/09/2023 continuous review of alternative bookings via nursing and critical care. Action closed	
		Publicise bank shifts within and external to the unit	Recruitment team	06.07.23	03.07.23 -Request made of recruitment. 18/09/2023 Action completed	
		Additional shifts created for band 2 and 3 shifts to provide support on reduced fill rate shifts.	Deputy Midwifery and Nursing Director	ongoing	03.07.23 - In place. 18/09/2023 Action completed	
		Bank midwifery advert agreed with Chief Nursing Officer	Chief Nursing Officer	ongoing	3.07.2023 Advert for bank midwives published.	
2	**Utilisation next 3 months**	Review Newly Qualified Midwife (NQM) preceptorship clinical rotation plan to identify any possible rotations which could be better utilised within the service.	Team leaders	~~30.04.2023~~ 31.05.2023	24.04.2023 Shifts have potentially been identified in ANC – assessment to be completed to identify prioritisation of the clinical areas to receive the additional staffing. 15.05.2023 Scoping of hours undertaken. Unable to progress at this time as movement of NQM from ANC will potentially impact on essential planned work re-organisation. Action closed.	
		Review of the birth centre staffing models because of the current birth rates within midwifery led services.	Matron for midwifery led services	30.06.2023	24.04.2023 review is ongoing. Potential for the third person to be a "floating midwife". 15.05.2023- Matron for MLS reviewed percentage of births in co-located birth centre. Plan to reduce staffing to 2 per shift from 3 per shift from the 10th of June 2023. Action closed.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
		Identify and consider potential withdrawal of non-essential services.	Divisional midwifery and nursing director.	30.05.2023	24.04.2023 identify the non-essential services. 15.05.2023 Unable to identify any non-essential services at present. Non-viable option. Action closed.	
		Identify areas of the service that could be distributed to other staff groups.	Public Health Midwife	~~30.06.2023~~ ~~31.07.23.~~ 1.11.2023	15.05.2023 To explore vaccination services. Potential for a nurse to administer vaccines. Public health midwife liaising with LMNS to consider wider system options. 18/09/2023 Action ongoing. 13.11.2023 Options continue to be reviewed by LMNS. No further options at present stood down	
		Telephone consultation/ virtual services for differed visits.	Matron for midwifery led services	30.05.2023	24.04.2023 Scoped whether there is appetite for a leaver to stay and complete hybrid virtual working. Non-viable option. Action closed.	
		Determine which specialist midwives can be utilised to work clinical shifts during anticipated summer pressures.	Senior management team	~~30.04.2023~~ 30.05.2023	24.04.2023 Specialist midwives identified: screening midwives, midwifery practice educator, preceptorship and retention lead, public health midwife, infant feeding and potentially service development midwife. 15.05.2023 8 specialists will contribute 1 day a week to ANC, Maternity A, B and DS from the 10.06.2023 Action Closed.	
		Consult specialist midwives regarding the preferrable pattern of clinical working (i.e.) 2 days per week or one block week.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting 25.04.2023. 15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		All managers to have time to lead reduced to days per week during anticipated summer pressures.	Matrons	30.05.2023	24.04.2023 to be discussed at the band 7 meeting. 15.05.2023. All managers and team leaders to increase clinical shifts from 1 day per week to 2 days per week from 10.06.2023.	
		Consult team leaders and ward managers regarding the preferrable pattern of clinical working.	Matrons	30.06.2023	15.05.2023 Matrons have emailed individuals affected and arranged a meeting regarding booking into vacant shifts. Action closed	
		Consider rationalisation of meeting schedule.	Deputy DMND	~~30.06.2023~~ ~~01.08.2023~~ ~~1.12.2023~~ 5/01/2024	15.05.2023 Review speciality meetings to consider rationalisation and defined attendance over months of June, July, August and September 23. 18/09/2023 Action ongoing.13.11.2023 Action deadline extended to reflect ongoing action. 19.12.2023 Rationalisation exercise undertaken, and action completed.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
3	**Birth rate plus data utilisation**	Review the latest birth rate plus data and complete a paper for board.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 Paper to be shared with chief nurse and then presented to board for review. 15.05.2023 Paper to be presented as part of bi-annual staffing review in May 2023 26.05.23 Biannual staffing report presented to S&Q. Action closed	
		Trust Board to share findings of BR+ assessment with ICB	Chief Nursing Officer	~~1.12.2023~~ ~~1.02.2024~~ ~~31.3.2024~~ 31.3.2025	18.09.2023 Br+ Paper approved for sharing and consideration with the ICB and LMNS. 13.11.2023 Action ongoing deadline extended. 19/12/023 Awaiting outcome from ICB discussion action ongoing. Deadline date added. 20.04.2024 Phase 1 of BR+ approved by Board and transacted into the budget for recruitment. Phase 2 to be proposed as part of the second bi-annual report. Action date extended to reflect ongoing work. Progress against action to be monitored via the Maternity and Neonatal Board report. Action closed	
		PWR data review to be undertaken to ensure accurate midwifery staffing establishment reported to NHSE.	Divisional midwifery and nursing director	1.11.2023	25.08.2023 PWR Data review meeting arranged, and discrepancies noted with national data published. Escalated to national team via Regional Associate lead Midwife. Awaiting update. 13.11.2023 Action Completed	
		Complete the training for the ward acuity tool.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.23	24.04.2023 date agreed for training with the external providers. Staff to attend currently being agreed. 15.05.2023 Ward managers assigned to attend, and additional staff released if possible. Session will be recorded for use later. App not working at this time action paused	
		Launch the acuity tool across the ward areas.	Matron for complex midwifery care	~~30.06.2023~~ 31.11.2023	24.04.2023 to be launched in June 2023 following completion of training. Action paused as above.	
4	**Roster management**	Meet with the health roster term to specify supernumerary tiles which will not be included in the unfilled rate.	Matron for complex midwifery care	30.06.2023	24.04.2023 MR has met with health roster team. Health roster team to review request and feedback. 15.05.2023 Email request for speciality meeting. 30.06.2023 Supernumerary tiles now in place. Action closed	
		Matron review of roster templates to ensure that templates reflect the establishment for each area.	Matrons	01.07.2023	15.05.23 Meeting to be arranged with e-roster team to confirm templates reflect staffing requirements. Awaiting update that all areas reviewed. Action completed.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
		Meet with team leaders/ ward managers regarding summer annual leave planning. Reiteration that maximum allowance is 17%.	Matron for complex midwifery care	30.04.2023	24.04.2023 MR has pulled the roster reports and confirmed that the annual leave is booked and does not exceed the maximum requirement. Action closed	
		Creating a new cost centre for preceptees or team midwives	Finance BP	~~31.07.23~~ 1.12.2023	15.05.2023 Finance BP to create new cost centre. Update awaited. 18/09/2023 Action ongoing. 13.11.2023 Cost Centre created. Action completed	
		Unused roster hours to be reviewed by the matrons at sign off.	Matrons	30.04.2023	24.04.2023 Healthroster to be reviewed as part of monthly sign off with each area to utilise un-filled shifts. Action closed	
		Maternity ward B roster to be reviewed for balance. Review MSW staffing ratios across day and night.	Matron for complex midwifery care	30.05.2023	24.04.2023 MR to discuss with HA. 15.05.2023 Staffing gaps have been reviewed to reflect the service requirement. Action closed	
		Consider options for assessing and balancing staff numbers across whole service and develop plan for June-October 2023.	Matrons	30.05.2023	15.05.2023 Matrons to meet to review establishments and confirm plan for distribution of staff across the areas with highest establishment gaps. 03.07.23 – This is now done on a weekly basis. Action closed	
5	**Recruitment**	Continuation of the preceptorship lead midwife post for further 11 months.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 awaiting confirmation from finance. JG has completed the workforce form for the extension. Action closed	
		Recruit up to 16 international recruits.	Preceptorship and retention leader midwife	~~30.07.2023~~ 31.12.2023	24.04.2023 – 3 currently in post, 2 coming to the testing centre in May 2023. Awaiting further information. Recruitment ongoing. 15.05.2023 Deadline date extended to reflect ongoing recruitment plan. 01.07.23 – 4 RM in post. Action ongoing. 18.09.2023 Local recruitment for international recruitment in house commenced. 13.11.2023 Paper collated to consider continued funding for international recruitment. 20.04.2024 International recruitment closed, and no further funding allocated in 2024. Alternative options for apprenticeship scheme being considered. Action closed	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
		Undertake a workforce profile of maternity leave, sickness and conversion rate from interview to recruitment to consider over offering	Divisional Midwifery and Nursing Director	30.06.2024	20.04.2024 NEW Position paper to be collated with finance and HR to scope workforce profile and request over offering to improve conversion rates. 09.06.24 Over offer paper collated and presented to executive board. Over offer of 5 WTE agreed. Action Closed	
		Vacancy and maternity leave tracker to be overseen workforce committee.	Matrons	~~30.05.2023~~ 30.06.23	24.04.2023 – two external recruits successfully made week commencing 17.04.2023. 15.05.2023 Deadline date extended to reflect ongoing and continuous monitoring of vacancies. 30.06.2023 Item to be added to workforce committee in July 2023. Workforce action tracker in place. Action closed.	
		Recruitment to delivery suite core team.	Matron for complex midwifery care	30.05.2023	24.04.2023 – shortlisting has been completed awaiting date for interview. 15.05.2023 Core team recruited. Action closed	
		Recruitment to the birth centre core team.	Matron for midwifery led services.	30.05.2023	24.04.2023 – successfully completed	
		Recruitment to the Mat A/B ward core team.	Matron for midwifery led services.	31.08.23	01.07.23 - Advert out currently. Action closed	
		Recruitment to the caesarean section team as core (1.6 WTE).	Matron for complex midwifery care	~~30.05.2023~~ 30.06.2023	24.04.2023 – advert for the team has been completed and approved by EA. Advert to go to vacancy control this week. 15.05.2023 Shortlisting outcome awaited. Deadline extended. 01.7.23 – recruited to successfully.	
		Associate leader positions to be considered.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – stand down as non-viable at present time.	
		Band 5 advertisement to be released.	Matron for midwifery led services	~~30.04.2023~~ ~~30.06.2023~~ 01.09.2023	24.04.2023 – advert has been approved by EA and RC. Currently with vacancy control anticipated release 28.04.2023. 15.05.2023 Shortlisting in progress. Deadline extended. 01.07.23 – continuous adverts out. Action closed	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
		Recruitment open day for band 5 midwives.	Matrons	~~30.05.2023~~ ~~31.07.2023~~ 1.12.2023	24.04.2023 – to be organised once the vacancy is released. 15.05.2023 Consider whether open day or engagement of new starters required. 01.07.23 – ongoing next recruitment event to be confirmed.18.09.2023 events ongoing.	
		Consider recruitment to the band 4 practice development post once the funding becomes available.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ ~~1.12.2023~~ 20.05.2024	24.04.2023 – awaiting outcome of funding. 15.05.2023 Update awaited. 01.07.23 – paper to LMNS submitted and awaiting final approval to recruit. 18.09.2023 funding awaited Awaiting outcome of funding overall. 13.11.2023 Notification of funding confirmed by LMNS awaited. 20.04.2024 MSW for practice development in post.	
		Paper to be presented to Executive Board to support the apprenticeship (RMDA) pilot scheme.	Divisional midwifery and nursing director	31.07.2024	09.07.24 Paper being presented at executives meeting to approve the RMDA pilot. Approved. Action closed	
		Band 3 allocation to be reviewed across the service.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ ~~1.12.2023~~ 31.1.20234	24.04.2023 – needs finance review. Long term funding of the roles needs to be reviewed. 01.07.23 – Birth rate plus report taken to Board May 2023. 18.9.2023 Additional band 3 recruitment undertaken for MAS. Funded 4.6 WTE Action closed	
		Increase consultant obstetricians by 3 WTE to support demand and capacity and increase in complexity	Divisional Director and Deputy Medical Director	~~01.01.2024~~ 30.06.2024	03.07.23 Demand and capacity assessment has taken place and business case has been created to discuss with finance. Business case will support 98 hours obstetric cover, antenatal clinics, caesarean section list, induction of labour and maternity triage. 18.9.2023 action ongoing.13.11.2023 Paper taken to F&P to seek funding. 20.04.24 Funding and recruitment ongoing. 1 consultant out to advert and 1 further is required to achieve 96 hours. Action ongoing and deadline date extended. 09.06.2024 Action monitored via operational team action stood down. 1 WTE vacancy only. 88 hour cover of the obstetric roster achieved.	
6	**Retention** **Flexible working**	Line manager to have conversations with all staff about flexible working opportunities. Flexible Working Toolkit available	All Managers	1.11.2023	30.06.2023 Flexible working conversations to be included in appraisals and as part of team meetings. Action completed	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
7	**Retention Seeking Feedback**	To seek feedback from staff via TED surveys, listening events, team meetings	All Managers	~~31.09.2023~~ 31.01.2023	30.06.2023 All areas to undertake a TED survey and develop local ways to seek feedback from teams. 18.09.2023 Awaiting confirmation that all areas have signed up to TED. 13.11.2023 Part of the W&C people plan deadline extended. 20.04.2024 Score Survey ongoing to seek feedback across the maternity and neonatal continuum. 20.04.2024 Midwifery and trainee listening events undertaken and joint presentation and action plan ongoing in line with the people plan. Action closed.	
8	**Retention Retain, Reward and Recognise – Staff Satisfaction**	Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.03.2023	30.06.2023 Monthly thank you awards nominated by the band 5 team for a team member who offering supportive mentorship and professional support.	
		Utilise resources from Review and Celebrate Success tools to help enhance feeling valued and recognised.	Preceptorship and retention Lead Midwife	31.10.2023	17.04.2023 Shining Star award. A monthly award for outstanding kindness and team work continues	
		Engage in Microsystems Coaching Programme via CI team.	Divisional midwifery and nursing director	31.10.2023	17.04.2023 Divisional Engagement with flow and micro coaching programmes. 18.9.2023 Staff identified to complete flow coaching. Action ongoing. 13.11.2023 Leaders identified to attend coaching programme. Action Closed	
		Opportunities for development and career progression available via CPD funding work streams	Divisional midwifery and nursing director	31.10.2023	30.03.2023 CPD requests submitted. HDU courses, NIPE, PMA, Fetal monitoring speciality training, maternal medicine. ANNB ARC. Action complete	
9	**Retention Engagement**	Alternate month mobile coffee catch up with leadership team visiting clinical areas scheduled for 12 months.	Leadership Team	31.03.2024	30.06.2023 Mobile coffee catch up sessions ongoing.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
10	**Retention of Students**	Link with the LMNS 2-day course to be facilitated by university to link with colleges for perspective midwives.	Divisional midwifery and nursing director	~~30.06.2023~~ ~~01.01.2024~~ 30.06.2024	24.04.2023 – awaiting further information. 15.05.2023 Action ongoing. 18.09.2023 Actions continue. 13.11.2023 Meeting arranged with LMNS workforce committee and UCLAN 16.11.2023. 20.04.2024 Schedule of student's sessions being developed with education team. Action ongoing.	
					20.04.2024 NEW Student profiling with Cumbria and Edge Hill universities to offer 3rd year students who live in PR postcode elective placements at LTHTR.	
		Explore continuation of funding for midwifery clinical placement facilitator.	Divisional midwifery and nursing director	30.05.2023	24.04.2023 – awaiting further information to meet. 15.05.2023 Meeting arranged for 19.05.23 to discuss PEF funding. 03.07.23 – Meeting held and funding continued for PEF with other funding streams being explored therefore action closed	
11	**Retention Health and wellbeing**	Maternity conference to be organised for 15/06/2023 for current midwives and maternity support workers.	Matron for midwifery led care	30.06.2023	24.04.2023 – progressing well. Agenda in development. 15.05.2023 Planning on track 15.06.2023 – Maternity conference delivered as planned	
		Establish and agree the PMA offer.	Divisional midwifery and nursing director	~~30.05.2023~~ ~~01.09.2023~~ ~~1.01.2023~~ 30.06.2024	24.04.2023 – date to meet with PMA's to be arranged. 15.05.2023- Meeting with DMND to be confirmed. 01.07.23 – Trust structure agreed for PNA/PMAs. 5 PMA trained. Staffing limiting activity. To remain on workplan and meeting to be arranged with PMAs to agree development of this service. 1.09.2023 Additional £11,00 funding agreed via a bid for backfill for establishing PMA's 13.11.2023 Action ongoing. 19/12/2023. 2 further places with funding confirmed. Total PMA's – 13. Deadline extended. 20.04.2024 Re- launch planning meeting arranged for 22.04.2024. meeting to be arrange with the regional midwife to support planning.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
					Action extended. Action moved to the maternity and neonatal culture plan.	
		International day of the midwife – cups and biscuits for the clinical areas/ teams.	Deputy divisional nursing and midwifery director.	30.05.2023	24.04.2023 – Cup designs have been developed and order placed. 15.05.2023 Mugs and biscuits distributed to all areas. Celebrated IDM 2023. Action closed	
		Expansion of the unit coordinator role to include ward and area managers.	Matrons	~~30.05.2023~~ 30.06.2023	24.04.2023 – to discuss with ward managers. Action deadline extended. No further progress. Action stood down	
		Introduce de-brief tool to support hot de-briefing.	S&Q matron	~~30.05.2023~~ ~~31.08.2023~~ ~~1.12.2023~~ 31.3.2023	24.04.2023 – EH to explore hot debrief tool and feedback at the next meeting. 15.05.2023- Options for debrief ongoing. Deadline extended.18.09.2023 13.11.2023 Action ongoing. 19/12/2023 Hot and cold debrief training and core offer discussed and escalated at LMNS serious incident panel for wider collaboration and discussion of training for midwifery staff. March on stress via NWAS also to be considered. Action extended. 20.04.2024 TRIM training funded for trauma informed support and plans to train 25 PMA teams ongoing. Date extended.	
		OD department to develop division wide action plan with ideas for action which are specific to each area	OD leads	~~01.09.2023~~ 1.12.2023	03.07.23 – Meeting held with OD lead for division and area action plans to be developed. 18.09.2023 Draft action plan in place and awaiting confirmation. Action ongoing13.11.2023 Divisional People Plan developed. Action closed.	
12	**Correlation between staffing and safety intelligence**	Monitor safety data daily, including red flags, BR plus acuity, coordinator feedback at safety huddles, PALS, service user feedback, governance systems.	Divisional midwifery and nursing director	Ongoing	Systems in place. Daily monitoring	
		Monthly oversight of safety and quality metrics through the maternity safety dashboard to safety and Quality group in division and Board.	Divisional midwifery and nursing director	Ongoing	Systems in place	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
13	**Well Led**	Trust development programme based on ward manager and matron handbook to develop leadership capability and capacity.	Chief Nursing Officer	~~30.09.23~~ ~~1.1.2023~~ ~~31.3.2023~~ 30.06.2024	Chief Nurse leading.18.09.2023 awaiting update of plan.13.11.2023 Action ongoing. 19/12/2023 work ongoing to consider actions required. Date extended. 20.04.2024 in house leadership day being planned with OD. Draft content developed. Action extended. 09.06.24 Local leadership days developed and planned. Action closed.	
		To undertake a training needs analysis of the leaders and managers within the Division, understanding who has completed which development programme, where additional tailored support can be provided and who may need performance management intervention.	OD and Divisional Board to commit & enable attendance	~~1.11.2023~~ ~~31.12.2023~~ ~~31.3.2024~~ 30.09.2024	30.06.2023 Scoping work to understanding of level of capability and confidence in department. What development support is needed, how expectations are communicated and reinforced to improve management effectiveness across the Division. 18.09.23 Action ongoing. 13.11.2023 Actions ongoing with divisional people plan. Date extended. 20.04.2024 Wide corporate band 7 leadership programme being developed. Action extended. 09.06.24 Action moved to align with the Divisional People plan.	
		To set up a Band 7 Action Learning set where leaders come together monthly to have the headspace, facilitated support, consultancy support to identify how to make improvements in team engagement and staff satisfaction, enabling them to develop actions plans which improve colleague experience	OD and Divisional Board to commit & enable attendance	~~31.10.2023~~ ~~31.03.2024~~ 30.06.2024	30.06.2023 Action Learning groups to be set up from October 2023 after new recruits in post. 18.09.2023 Action ongoing. 13.11.2023 Deadline extended. 19/12/2023 As part of the RGOG escalation project culture workshops to commence in 2024 to include Band 7 coordinators. Action ongoing. 20.04.2024 in house leadership day being planned with OD. Draft content developed. Action extended. 09.07.2024 Leadership days and clinical escalation workshops now in progress for band 6 core, 7,8 and consultants. Action closed.	
		Based on the findings of the training needs analysis consider the delivery of a series of bespoke leadership ‘away days.	OD and Divisional Board to commit & enable attendance	~~30.09.2023~~ ~~31.03.2024~~ 30.06.2024	30.06.2023 Agree bespoke series of meetings following review of leadership TNA and from listening to feedback from the team. 18.09.2023 Action ongoing. 13.11.2023 Deadline extended. 20.04.2024 in house leadership day being planned with OD. Draft content developed. Action extended. 09.07.2024 Leadership days now in progress for band 6 core, 7,8 and consultants. Action closed.	

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (Document or hyperlink)	Current Status 1 2 3 4
		To improve the quality of appraisal conversations/paperwork, objective and development planning in appraisal. This will be achieved by all appraisers attending the Appraisal Masterclass.	OD and Divisional Board to commit & enable attendance	31.03.2024	30.06.2023 Improved appraisal quality audit rating. • Increased use of 360 feedback in appraisal. • Increased number of appraisals with objectives and personal development plan completed. • Increased scores benchmarked against the 2022 National Staff Survey for questions relating to having a quality appraisal. 18.09.2023 Action ongoing. 13.11.2023 People Plan developed by OD. Therefore, action closed.	
		Increased capacity within senior midwifery team through creation of: - Deputy Divisional midwifery and Nursing Director - Creation of Safety and Quality matrons - Creation of the Specialist Midwife for maternal medicine - Creation of the Planned work, capacity, and flow co-ordinator - Enhanced antenatal and newborn screening leadership capacity	Chief Nursing Officer	~~31.04.23~~ 01.09.23	03.07.23 – All posts recruited.	

Chair's Report to Board		
Chair:	**Workforce Committee**	
Date(s): **13 June(Jim Whitaker)** **9 July(Victoria Crorken)**	**Agenda attached for information**	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
Include current score – in trend column show an arrow going up / down or static.	→	**Corporate level staff survey action plan** **Medical appraisal report**

ALERT

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

The Guardian of Safe Working annual report raised continued concerns about senior cover at Chorley, although a focused action plan was in place.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

The annual employee services report confirmed that the Trust payroll and employee services function remained in scope for TUPE transfer into One LSC in October 2024. There was still debate around how the One LSC pay model would be delivered and whether this would be run internally using the existing LTH client payroll model or through ELFS hosted service. It was agreed that a watching brief was required on the situation but there was a One LSC Board workshop planned for 3 July, and this could be taken forward then as part of those wider discussions.

The annual workforce advice update report advised of the increased number of complex cases and the demands on the Workforce Advice Team.

The medical appraisal report showed a lack of quality assurance within the appraisal process this year due to workload, but an action plan was in place for this to be restored.

ASSURE

Assurance received;
Matters of positive note.

The workforce and organisational development integrated performance report review provided assurance that agency usage continued to reduce.

The job planning report for medical and dental for 23/24 provided assurance that by 1 April 2025 the Trust would be in a strong position with a target to get most plans signed off by the first quarter.

The annual health and well-being strategy report evidenced the successful re-accreditation of the Workplace Wellbeing Charter mark, with a rating of 'excellence' in five out of eight standards.

Workforce Committee

13 June 2024 | 9.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	9.00am	Verbal	Information	J Whitaker
2.	Apologies for absence	9.01am	Verbal	Information	J Whitaker
3.	Declaration of interests	9.02am	Verbal	Information	J Whitaker
4.	Minutes of the previous meeting held on 18 March 2024	9.03am	✓	Decision	J Whitaker
5.	Matters arising and action log • SQC referral • FPC referral	9.05am	✓	Assurance	J Whitaker
6.	Strategic risk register review	9.15am	Verbal	Assurance	J Whitaker
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	9.20am	✓	Assurance	K Downey
8. STRATEGY DELIVERY					
8.1	Annual workforce plan sign-off	9.30am	Verbal	Assurance	N Pease
8.2	Job planning	9.45am	✓	Assurance	A Gale
9. TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE					
9.1	Annual employee services report	9.55am	✓	Assurance	K Downey
10. TO BE WELL LED					
10.1	Annual appraisal update	10.10am	✓	Assurance	L Graham
11. TO CREATE A POSITIVE ORGANISATIONAL CULTURE					
11.1	Annual Freedom to Speak Up Report	10.20am	✓	Assurance	L Graham
12. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
12.1	Staff survey report and action plan	10.30am	✓	Assurance	L Graham

№	Item	Time	Encl.	Purpose	Presenter
13.	GOVERNANCE AND COMPLIANCE				
13.1	Strategic risk report	10.40am	✓	Decision	S Regan
13.2	Reflections on the meeting and adherence to the Board construct	10.50am	✓	Information	J Whitaker
13.3	Items for escalation to the Board or items to/from other committees	10.55am	Verbal	Information	J Whitaker
14.	ITEMS FOR INFORMATION				
14.1	Exception report from the DIFs		✓	Information	
14.2	Feeder group Chair's reports: a) Temporary Staffing Group		✓	Information	
14.3	Date, time, and venue of next meeting: *9 July 2024 1.00pm via Microsoft Teams*	11.00am	Verbal	Information	J Whitaker

Workforce Committee

9 July 2024 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	V Crorken
2.	Apologies for absence	1.01pm	Verbal	Information	V Crorken
3.	Declaration of interests	1.02pm	Verbal	Information	V Crorken
4.	Minutes of the previous meeting held on 13 June 2024	1.03pm	✓	Decision	V Crorken
5.	Matters arising and action log	1.05pm	✓	Assurance	V Crorken
6.	Strategic risk register review	1.10pm	Verbal	Assurance	V Crorken
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	1.15pm	✓	Assurance	K Downey
8. TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE					
8.1	Annual workforce advice update report	1.25pm	✓	Assurance	R O'Brien
9. TO BE INCLUSIVE AND SUPPORTIVE					
9.1	Annual health and well-being strategy report	1.35pm	✓	Assurance	R O'Brien
10. TO BE WELL LED					
10.1	Medical appraisal report	1.45pm	✓	Assurance	A Gale
11. TO CREATE A POSITIVE ORGANISATIONAL CULTURE					
11.1	Just Culture strategic aim update report	1.55pm	✓	Assurance	L Graham
12. GOVERNANCE AND COMPLIANCE					
12.1	Committee effectiveness review	2.05pm	✓	Decision	J Foote
12.2	Guardian of Safe Working annual report	2.15pm	✓	Assurance	D Kendall

№	Item	Time	Encl.	Purpose	Presenter
12.3	Strategic risk report	2.30pm	✓	Decision	S Regan
12.4	Reflections on the meeting and adherence to the Board construct	2.40pm	✓	Information	V Crorken
12.5	Items for escalation to the Board or items to/from other committees	2.45pm	Verbal	Information	V Crorken
13.	ITEMS FOR INFORMATION				
13.1	Exception report from the DIFs		✓	Information	
13.2	Feeder group Chair's reports: a) Temporary Staffing Group		No report	Information	
13.3	Date, time, and venue of next meeting: *10 September 2024 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	V Crorken

Chair's Report to Board		
Chair: Professor Paul O'Neill	Education Training and Research Committee	
Date(s): 11 June 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

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

ALERT

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

Nothing to alert.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

The Committee noted concerns regarding the safe operation of the Paediatric department in terms of compliance with Advanced Paediatric Life Support (APLS) training. A cross committee referral was made to Safety and Quality Committee regarding possible mitigations and actions to provide assurance.

The Committee noted the low scores related to bullying and undermining in the recent NETS survey and a cross committee referral was made to Workforce Committee.

ASSURE

Assurance received; Matters of positive note.

The annual income and expenditure accounts (education and training) was presented, which provided greater assurance around finance.

The committee effectiveness review was undertaken, and it was agreed that the Committee had discharged its duties effectively during the last year.

Education, Training and Research Committee

11 June 2024 | 11.30am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.30am	Verbal	Information	P O'Neill
2.	Apologies for absence	11.31am	Verbal	Information	P O'Neill
3.	Declaration of interests	11.32am	Verbal	Information	P O'Neill
4.	Minutes of the previous meeting held on 13 February 2024	11.33am	✓	Decision	P O'Neill
5.	Matters arising and action log	11.35am	✓	Decision	P O'Neill
6	Strategic risk register review	11.40am	Verbal	Assurance	P O'Neill
7.	PERFORMANCE				
7.1	Core skills training report	11.45am	✓	Assurance	L O'Brien
7.2	Quality surveillance report	12.00pm	✓	Assurance	L O'Brien
7.3	Clinical supervision annual report	12.10pm	✓	Decision	S Cullen
8.	GOVERNANCE AND COMPLIANCE				
8.1	Committee effectiveness review	12.25pm	✓	Decision	J Foote
8.2	Annual income and expenditure accounts (education and training)	12.35pm	✓	Decision	R Patel
8.3	Strategic risk report including cycle of business	12.45pm	✓	Decision	S Regan
8.4	Items for referral to the board or items to/from other committees	12.50pm	Verbal	Information	P O'Neill
8.5	Reflections on the meeting and adherence to the Board Construct	12.55pm	✓	Assurance	P O'Neill
9.	STRATEGY AND PLANNING				
9.1	Research annual showcase	1.00pm	✓	Information	P Brown
10.	ITEMS FOR INFORMATION				

№	Item	Time	Encl.	Purpose	Presenter
10.1	Review of research sub-committee effectiveness including terms of reference.		✓	Information	P Brown
10.2	Feeder groups Chair's reports negative/positive escalations: a) Apprenticeships Strategy & Assurance Committee b) Training Compliance and Assurance Sub-committee c) Education Quality & Performance Sub-Committee d) Research and Innovation Sub-Committee		✓	Information	L O'Brien / P Brown
10.3	Date, time, and venue of next meeting: 13 August 2024, 1pm via MS Teams	1.30pm	Verbal	Information	P O'Neill

Chair's Report to Board		
Chair: K Smyth	Committee: Charitable Funds Committee	
Date(s): 18 June 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

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

ALERT

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

None

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- After in-depth consideration, a decision was made not to support the video telemetry funding request due to the current funding envelope. The decision was not a definitive ethical rejection and it was noted that there may be an opportunity to reapply in the future.

ASSURE

Assurance received; Matters of positive note.

- Thorough and positive discussion on the investment strategy including significant scrutiny of the methodology including risk, tolerance and future progression.

Charitable Funds Committee

18 June 2024 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chairman and quorum	1.00pm	Verbal	Information	K Smyth
2.	Apologies for absence	1.01pm	Verbal	Information	K Smyth
3.	Declaration of interests	1.02pm	Verbal	Information	K Smyth
4.	Minutes of the previous meetings held on 19 March 2024	1.03pm	✓	Decision	K Smyth
5.	Matters arising and action log	1.04pm	✓	Decision	K Smyth
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Baby Beat	1.05pm	✓	Decision	D Hill
6.2	Rosemere Charity update	1.15pm	✓	Decision	D Hill
6.3	Investment strategy and investment review including ESG annual performance report. *(invite Brewin Dolphin)*	1.25pm	✓	Assurance	B Patel
7.	FINANCE AND PERFORMANCE				
7.1	Finance update including review of spending plan and balances	1.35pm	✓	Assurance	B Patel
7.2	Video Telemetry funding Decision	1.45pm	✓	Decision	D Hill
8.	GOVERNANCE AND COMPLIANCE				
8.1	Items for referral to the Board or from/to other committees	1.55pm	Verbal	Information	K Smyth
8.2	Reflections on the meeting and adherence to the Board Compact	2.00pm	✓	Information	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Rosemere Management Committee Chair's report		✓		
	Date, time and venue of next meeting: *17th September 2024, 1.00pm, MS Teams*	2.05pm	Verbal	Information	K Smyth

Chair's Report to Board		
Chair: T Whiteside	Committee: Finance and Performance	
Date(s): 28 May 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

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

ALERT

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

- Although the M1 financial target was achieved, the CIP target was missed. The Committee acknowledged that work had been mobilised as part of the Single Improvement Plan (Financial Recovery Plan) to adjust to a more realistic phasing of CIP benefits.
- Resetting the VFM risk – although the risk articulation at level 20 remained an appropriate reflection of the current situation for VFM, there remains further work to reflect the impacts from the Single Improvement plan in driving control improvements and determining any additional mitigation actions.
- Work to review BAF risks of Specialist Services and Fit for the Future, following the recent Board delegation to FPC, needs to be progressed.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The difficult operating environment prevails impacting on Trust performance and creating continued financial pressures, including those of cash drawings. This remains an area of close scrutiny as the Single Improvement Plan is locked down and its measures of success are defined.
- The Committee emphasised the importance of evidencing the affordability of all decision making across the Trust and maintaining focus on addressing root cause factors impacting Services' breakeven position. Recognising the need to avoid additional unaffordable financial commitments as a solution to any given problem that would add further financial pressures, whilst also protecting against the risk of unintended consequences Work was reported as in-progress to strengthen the internal controls as part of the Finance Recovery Plan, which covers the Planning Framework (PMO) and its suite of change control improvements.
- Specific discussions were held on Outpatients' follow-up and DNAs, which remain an area of continued focus and further assurances are being sought on Stroke pathways adjusting their income controls.

ASSURE

Assurance received; Matters of positive note.

- The Committee noted positively the current position with respect to theatre productivity, whilst recognising the need to be more clinically innovative and ambitious across specialties and learning from others to drive further improvement opportunities.
- A System Improvement Board had been established which would entail working with system partners in a different way. This is being supported by both the ICB and NHS England and provides a clear line of escalation to garner support the Trust may need to overcome difficulties as they arise.

Chair's Report to Board		
Chair: T Whiteside	Committee: Finance and Performance	
Date(s): 25 June 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

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

ALERT

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

- **Single Improvement Plan -** as plans continue to evolve, seeking assurance on the 3-year journey prior to Board update in August to assure full interlock with the forward delivery outlook, addressing performance improvements sought and balancing the impact on staff, patients and partners.
- **Financial Risk –** as the Single Improvement Plan (SIP) is finalised and the draft undertakings are clarified, further consideration of the VFM risk mitigations will be required to give adequate assurance that collectively the actions will bring the Trust back into appetite and protect against anticipated headwinds.
- **Risk of unintended consequences –** continued scrutiny applied on the adequacy of the control environment (policy and processes), with focus on EQIA and Project Management Office during a period of intense change and operational pressure.
- **Governance Arrangements –** need to remain vigilant around the continued evolution of governance arrangements, to ensure sustained scrutiny upon delivery which the Trust is dependant, whilst balancing the allocation of resources supporting those programmes of work.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Boarding** – focused discussion on the planned reduction of boarded patients, acknowledging progress to return to a commissioned bed base over the summer, whilst recognising the need to reinvigorate efforts coming into winter to reduce risk of reoccurrence.
- **Performance Accountability Framework** – work has commenced on PAF development.
- **Finney House** - Strategic and financial work ongoing around the future position of Finney House in providing intermediate (step up & down) and residential care for the local community.

ASSURE

Assurance received;

- **Operational Pressures** – recognising the challenging operating environment and continued pressures, assured that significant work was being conducted to address all the current performance shortfalls in pulling together a complex suite of key programmes within the SIP and working closely with commissioners and system partners.
- **Financial Recovery Plan** - significant work undertaken in drawing together a comprehensive plan with support

Matters of positive note.

from the Turnaround Director, while recognising the substantial risk currently carried in the plan and the mitigation actions outlined.

- **Annual Information Governance Submission & Annual Review –** assured of the adequacy of the Trust control environment to protect patient and colleague data.
- **Data Quality Report** - The Committee was partially assured; specific points of clarity were sought on data coding related to income recovery, as well as the need to have the risk appropriately reflected in the Board Assurance Framework (BAF).

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Finance and Performance Committee

28 May 2024 | 09.00 am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	09.00am	Verbal	Information	T Whiteside
2.	Apologies for absence	09.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	09.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 23 April 2024	09.03am	✓	Decision	T Whiteside
5.	Matters arising and action log	09.05am	✓	Decision	T Whiteside
6	Strategic Risk Review	09.10am	✓	Assurance	J Wood/S Regan
7.	FINANCIAL PERFORMANCE				
7.1	M1 Finance Report	09.25am	✓	Assurance	C McGourty
7.2	Grip and Control Assessment	09.40am	✓	Assurance	C McGourty
8.	OPERATIONAL PERFORMANCE				
8.1	Performance Assurance Progress Report	09.50am	✓	Assurance	I Devji
8.2	Theatre Productivity Update	10.05am	✓	Assurance	I Devji
8.3	Diagnostic Performance	10.15am	✓	Assurance	I Devji
8.4	Outpatients Update to include DNA	10.25am	✓	Assurance	G Skailes
9.	STRATEGY AND PLANNING				
9.1	Financial Recovery Plan Update	10.35am	✓	Assurance	J Wood
9.2	Single Improvement Plan	10.50am	✓	Information	A Brotherton

9.3	Planning Framework Update	11.05am	✓	Assurance	G Doherty
9.4	Strategy Formulation	11.20am	✓	Assurance	G Doherty
9.5	Stroke Post-Business Case Review	11.30am	✓	Assurance	G Doherty
9.6	CI Update & EVO presentation	11.40am	✓	Information	K Bramfitt
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items for escalation to the Board or items to/from other Committees	11.50am	Verbal	Information	T Whiteside
10.2	Reflections on the meeting & adherence to the Board Compact	11.55am	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Community Healthcare Hub Report		✓		
11.3	Contract Performance		✓		
11.4	**Chairs' reports**: (a) ICS, ICP, PCB System update (b) Capital Planning Forum – not submitted. (c) SIRO/AIO Working Group (d) CSESC Update (e) ELFs Management Notes		✓ ✓ ✓ ✓ ✓		
11.5	Deficit Protocol Controls Overview		✓		
11.6	Date, time and venue of next meeting: *25 June 2024 09.00am – 12.00pm Microsoft Teams*	12.00pm	Verbal	Information	T Whiteside

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Finance and Performance Committee

25 June 2024 | 09.00 am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	09.00am	Verbal	Information	T Whiteside
2.	Apologies for absence	09.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	09.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 28 May 2024	09.03am	✓	Decision	T Whiteside
5.	Matters arising and action log: a) Supplier on-time payments (esp. smaller orgs) b) Cross -Committee Referral: From FPC to WFC - negative escalation from Women & Children's DIF: a) OD training needed analysis to inform development plan. b)Sickness review could be better Trust wide. It was advised that a paper had gone to the Education Training and Research Committee about changes to resuscitation training and the matter had been resolved. There had already been a 'deep dive' in Women's & Children's as there was an inordinate amount of sickness but there had been a trajectory of improvement.	09.05am	✓	Decision	T Whiteside
7.	STRATEGY AND PLANNING				
7.1	Planning Framework Update	9.10am	✓	Assurance	G Doherty
7.2	Single Improvement Plan	9.25am	✓	Information	A Brotherton
7.3	Financial Recovery Plan	9.40am	✓	Assurance	J Roberts
7.4	Planning Framework Review	10.10am	✓	Assurance	G Doherty
7.5	Financial plan update	10.25am	✓	Information	J Wood

7.6	Performance and Accountability Framework	10.35am	✓	Information	A Brotherton
COMFORT BREAK					
8.	FINANCIAL PERFORMANCE				
8.1	M2 Finance Report	10.50am	✓	Assurance	C McGourty
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report	11.05am	✓	Assurance	E Ince
9.2	Community Healthcare Hub - review financial aspects of the Community Healthcare Hub report and the long term strategy for Finney House	11.20am	✓	Assurance	S Cullen
10.	GOVERNANCE AND COMPLIANCE				
10.1	Annual Information Governance Submission and Annual Review	11.30am	✓	Decision	S Dobson
10.2	Data Quality Assurance Report	11.40am	✓	Assurance	S Dobson
10.3	Items for escalation to the Board or items to/from other Committees	11.50am	Verbal	Information	T Whiteside
10.4	Reflections on the meeting & adherence to the Board Compact	11.55am	✓	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Chairs' reports**: (a) ICS, ICP, PCB System update (b) Capital Planning Forum (c) IG & Records Committee (d) CSESC Update		✓ ✓ ✓ ✓		
11.4	Deficit Protocol Controls Overview		✓		
11.5	Cyber Security Update		✓		
11.6	Strategic Risk Review		✓		
11.7	Date, time and venue of next meeting: *23 July 2024 09.00am – 12.00pm Microsoft Teams*	12.00pm	Verbal	Information	T Whiteside

Board of Directors Report

Integrated Performance Report			
Report to:	Board of Directors	**Date:**	1st August 2024
Report of:	Executive Team	**Prepared by:**	Executive Directors
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to provide the Board with an update on the Trust's performance as at the end of June 2024, unless otherwise stated.

• The report reflects the 2024/25 Big Plan measures agreed by each sub-committee.

Consistently Deliver Excellent Care

Performance commentary

Access Standards - Emergency Care Performance:

- 4 Hour ED performance is showing an improved position, with June 24 at 71.0%, compared to May 24 at 68.1%. The Trust is below the national average position of 74.6%.

- A monthly improvement trajectory in relation to the 4-hour standard has been agreed for 2024/25, with an expected improvement to 78% during March 2025. The trajectory is based on delivery of an improvement plan relating to: time to 1st treatment; timely review of diagnostics; investigations; and improved access to assessment areas. A key delivery dependency of the trajectory is a reduction of patients not meeting the criteria to reside (NMCTR) to 5% (42 patients) against the against the actual 10.2% (88 patients). The Trust continues to experience pressure from an urgent and emergency care pathway perspective, which is understandably impacting on performance. Key issues include:

    - Lack of assessment space due to escalation within the emergency department including corridor care.
    - Exit block due to lack of G&A beds including 88 patients on average (10.2% against the national target of <5%) not meeting the criteria to reside in an acute Trust but unable to leave hospital with the right support.

4 Hour Trajectory: 2024/25

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

- Performance relating to the number of patients waiting over 12 hours (admitted and non-admitted) in ED reduced by a further 2% in June to 7.5% from 9.5% in May 2024.

- In June, 330 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a decrease of 141 from last month. 55 patients waited over 60 minutes to be handed over from NWAS to the Trust in June 24, a significant improvement from 299 in May. Ambulance handover delays remain a high priority and a local improvement collaborative is in place.

- The occupancy metric has been updated to reflect the new requirement to *reduce adult general and acute (G&A) bed occupancy to 92% or below*, with Trust occupancy for June of 93%, a decrease compared to last month's position of 95%. This is consistent with an improvement in flow pressures.

- On average 17 patients were boarded each day across both sites during June with 520 associated bed days. This is a significant reduction compared to the May position of 31 patients. These are predominantly medical patients requiring admission to an acute medical ward. The Urgent and Emergency Care Improvement Plan has identified the reduction in boarding as the first priority aligned to the delivery of improvement.

- The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) has decreased from last month's position of 11.1% to 10.2% in June 24. There has been good utilisation of available capacity in the Home First service, and changes to the commissioning model for the Community Healthcare Hub (CHH) at Finney House.

Unfunded capacity and operational changes – Bed Capacity:

There have been a no new changes to processes and services, previous changes have been maintained including Finney House, Virtual Ward, reprofiling of space in the Emergency Department to create an Acute Assessment Unit and an update to the organisational response to demand related escalation. This has enabled the following changes to be put in place:

Ward/Area	Impact	Delivery Date	Status
Closure of Avondale	Reduction of 28 G&A beds	Mar-23	Completed
Closure of Cath Lab & RAU	Reduction of 14 G&A beds	May-23	Completed – require COO/CMO approval to open
Closure of acute ward	Reduction of 17 G&A beds	Jul-23	Completed
Establishment of Acute Assessment Unit	Reduced ED footprint, reducing long waits in ED	Apr-23	Completed
No overnight escalation into Same Day Emergency Care	Reduced need for additional staffing, protects SDEC function	May-23	Completed
No ED escalation into CT wait area in hours	Reduced need for additional staffing, protects CT function	Jun-23	Completed
Closure of additional acute ward	Reduction of 11 G&A beds	Oct- 24	Emergency pathway pressures have delayed delivery – realigned against UEC improvement plan for 24/25
Co-location of Mental Health Urgent Access Centre (MHUAC)	Reduced cubicle space in ED, improved environment for patients awaiting MH assessment/treatment	Oct-24	Outcome of capital bid awaited – joint LSCFT/LTH proposal being developed
MAU/SAU Development	Right-sizing MAU and SAU to improve UEC pathways and increase direct access	2024/25	Capital bid successful – delivery underway

The Trust continues to work with health and social care organisations across the Central Lancashire system to support improvement.

Following a data driven diagnostic commissioned by the ICB and undertaken by (PSC), the system Urgent and Emergency Care Delivery Board submitted a plan, with quantified deliverables and expected financial impact for 24/25 on 28th June that addresses the opportunities identified for Central Lancashire within the diagnostic.

Aligned to system plans, the Trust has its own internal programme of improvement being delivered through the Single Improvement Plan. The urgent and emergency care programme within the operational performance portfolio of the single improvement plan spans three areas: inflow; flow and community collaborative. An accelerator programme is being delivered over 6 weeks and started on 10th June with additional resources aligned to support faster delivery. The ICB has committed resource to support the delivery of the plan with the Director of System Coordination and Flow aligned to the Trust for two days a week.

There is a new risk regarding the planned GP collective action, the impact of this on the Trust is currently being assessed with ongoing monitoring of Advice and Guidance activity, referral volumes and presentations to ED and UTC.

Access Standards - Elective restoration

65 and 78 Week Access Standards

Maintaining 78 week clearance and clearing 65-week waits is a priority for the divisional teams with performance under daily review.
The Trust achieved 0 over 78 weeks at the end of June 24 and has shown a continued reduction in over 65 week waiters with the aim of eliminating 65 week waiters by the end of September 2024. However pressures are currently being experienced in Orthodontics, Special Care Dentistry, Colorectal Surgery and Ocular Plastics. There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits.

- The end of June over 78 week position was 0. This continued delivery represents a significant milestone for the Trust, having reduced the number from a high in July 23 of 138. Focus is now on maintaining the maximum wait at under 78 weeks and reducing the 65 week cohort to the end September 2024. Additional focus on identifying next steps for all patients is in place with risks addressed through Divisional PTL meetings and the Performance Recovery Group.

- There is a system level piece of work underway to support the position with Orthodontics and East Lancashire Hospitals Trust have offered mutual aid to system partners to support long waits across Lancashire and South Cumbria.

- A co-ordinated approach is being taken with HMP to support bookings for prisoners awaiting treatment. All prisoner potential 78 week waiters at year end were all treated in April with 0 risks identified in the June cohort. This is an area requiring further work to address health inequalities within this cohort of patients. The Trust has actively sought NHSE support and a joint plan is in place to improve access.

- The 65-week snapshot position at the end of June is 338, split 150 Admit and 188 non admit. This is a slight increase of 21 compared to the May position of 317. The current position represents a significant achievement considering the 65 week cohort starting point in 2023 was over 29,000 patients.

There are a number of risks to delivery of the required reduction in the number of patients waiting in excess of 65 weeks, these include:

- Further industrial action during 2024/25 impacting on activity
- Workforce - sickness and vacancies
- Anaesthetist capacity
- Urgent care pressures – NMC2R (approximately 10% of G&A bed base) and poor internal patient flow
- Number of complex cases and particular pressures in Orthodontics and with accommodating prisoners.

Access Standards – Diagnostic Waits

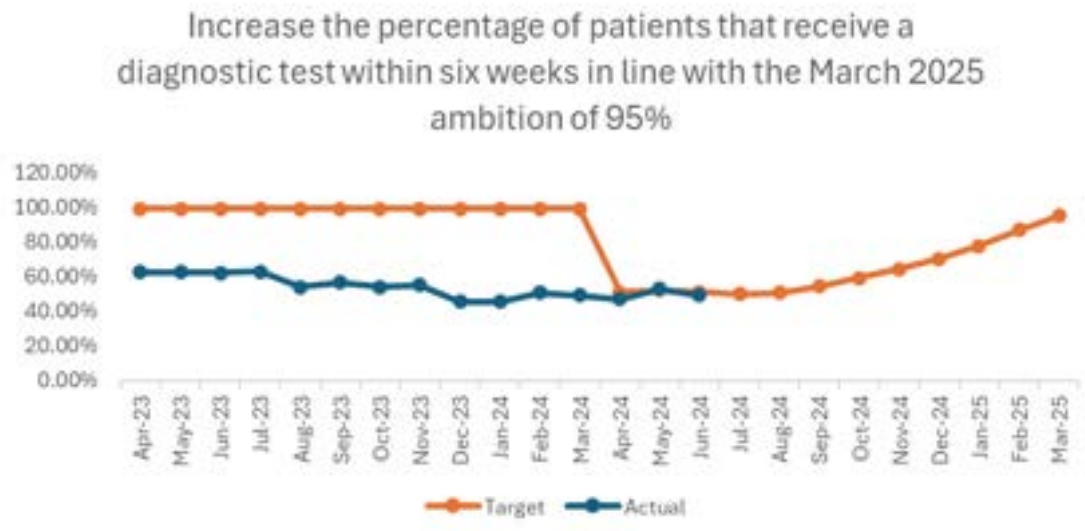
- Diagnostics performance beyond 6 weeks was 50.7% in June, an increase of 3.6% waiting over 6 weeks compared to the May position of 47.1%. The increase has predominantly been in Echocardiography and scope procedures (see surveillance impact below). Urgent and cancer patients are prioritised and seen within 2 weeks. The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. In order to support NOUS capacity in the short term, outsourcing arrangements are in place. A business case for capacity to clear the backlog is being progressed, together with longer term plans as part of the single improvement plan, to ensure capacity meets demand at modality level going forwards.

- Endoscopy remains pressured with a further delay to increased service capacity relating to the modular.

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

2024/25 DM01 Compliance Trajectory:

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Under 6 Week DM01 Trajectory	51.2%	52.1%	51.0%	49.9%	50.8%	54.6%	59.1%	64.2%	70.4%	77.8%	87.0%	95.0%
Under 6 Week DM01 Performance	46.9%	52.9%	49.3%									



- **Diagnostic Surveillance Patients**

  - Surveillance diagnostics are tests that are planned for a specific date or need to be repeated at a specific frequency. Patients listed in this way should be booked in for an appointment at the clinically appropriate time and should not have to wait a further period after this time has elapsed. As per national guidance surveillance tests were excluded from the DM01 waiting list position. All Trusts were asked to complete an assessment of the number of surveillance (planned) patients that are currently waiting in excess of 6 weeks past their expected admission date and add these pateints to the PTL at the end of Q1 and Q2.

  - Relevant patients have now been moved to the active DM01 waiting list and have been reflected in the month end June 2024 position, leading to a slight deterioration of 1-2% in the compliance percentage for June 2024. The Endoscopy Polyp task and finish group is working alongside this to identify patients on the surveillance pathway with the highest clinical risk so their procedure can be expedited.

  - The Trust has established an internal working group to develop the operational processes supporting the movement of patients onto the active waiting list with changes to be reflected into the Trusts Patient Access Policy.

Access Standards 2024/25 - Cancer Recovery:

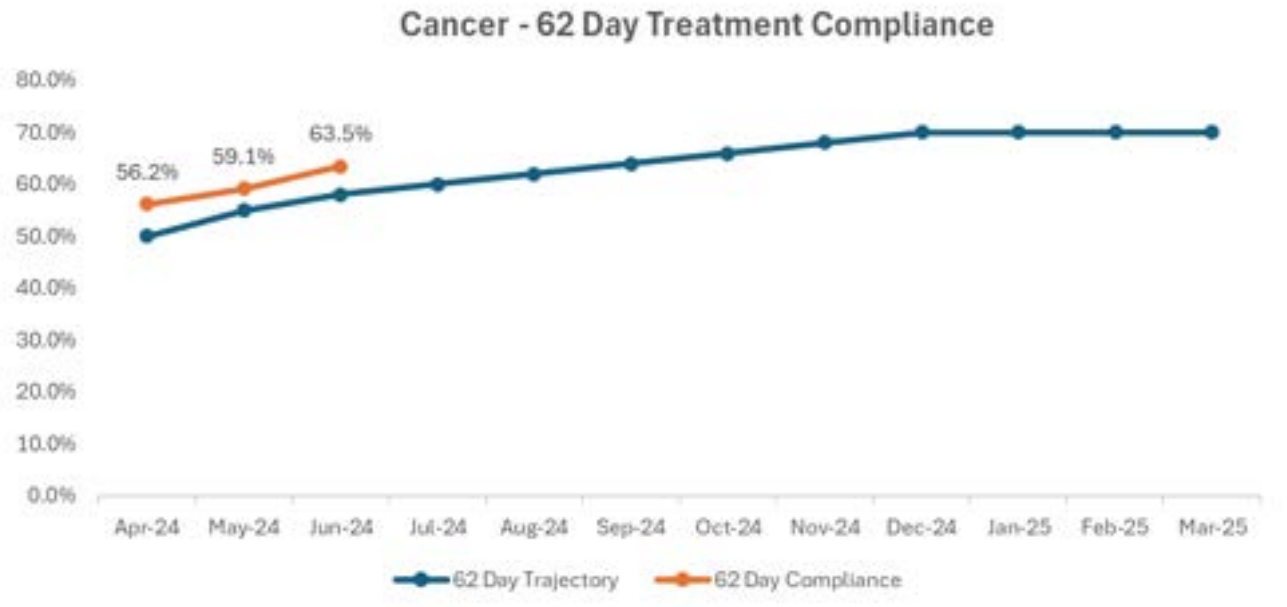
In 2024/25 the Trust will be monitored against 2 key cancer standards:

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

62 Treatment Compliance

The Trust has set a performance trajectory to achieve 70% compliance by end December 2024. Performance in June 2024 was 63.5%, above the monthly trajectory.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
62 Day Trajectory	50.0%	55.0%	58.0%	60.0%	62.0%	64.0%	66.0%	68.0%	70.0%	70.0%	70.0%	70.0%
62 Day Compliance	56.2%	59.1%	63.5%									



Cancer tumour site plans form part of the cancer workstream within the Single Improvement Plan reporting into the Operational Performance portfolio.
Whilst Cancer performance is improving there are a small number of tumour groups with the greatest collective contribution to current performance challenges, an update on progress is detailed below. All tumour sites have improvement plans to achieve performance targets, this years plans required investment and the teams have achieved £1.5M additional funding to support the plans via bids to Cancer Alliance and National Cancer Team.

- **Colorectal**
  The Colorectal pathway has been redesigned. The front end of the pathway is performing well with a Rapid Diagnostic Clinical triage occurring for each patient by day 6 of the referral being received. The improvement in Colorectal has been the biggest contributor in positive movement against the FDS standards, however, whilst there has been positive movement against the FDS standard, colorectal are below trajectory of 77%, and are currently at 44.5% compliance for June. The speciality has produced an action plan to improve 62 day compliance and FDS standard. There are a residual number of 62 day patients that are currently being resolved. When the remaining 62 day clearance is completed, ongoing, sustained 62 day compliance with trajectory is expected and to be achieved by March 2025.

- **Urology**
  The Urology pathway has been redesigned, by training ACPs to undertake the front end of the pathway. This has improved the front end of the pathway however Urology is below FDS trajectory of 77% achieving 43.2% in June. A deep dive report into Urology was provided to Tier 1, which highlighted the factors in not meeting compliance is mainly due to reporting time of biopsy. To support additional capacity a successful bid was made to the National Cancer team which has provided £200k funding to support further outsourced activity. Additionally, a gap analysis is being undertaken in histopathology, specifically relating to prostate biopsies, commissioned by the cancer alliance. Following results of this, any actions arising will be fed into the urology action plan.

- **Skin**

  The skin pathway is undergoing redesign to reduce reliance on additional capacity and reduce the number of appointments required for each patient. Performance against FDS and 2 week waits is good, with the tumour site on target to continue achieving FDS. Whilst performance metrics are good, the redesign meeting held in March was focussed on improving patient experience. The skin pathway have implemented a twice weekly PTL meeting which is patient focussed and action driven. Since implementation the number of patients waiting above 62 days has reduced. The Cancer Alliance have invested in an eDerma model and are rolling out centralised virtual triage, this is not expected to adversely impact internal Skin pathway plans.

28 Day Faster Diagnosis Standard

Performance compared to the Cancer FDS trajectory to March 2025 is shown below. The 2024/25 Operational Plan sets out the targets for the coming year with a focus on 28 day faster diagnosis compliance and improvement to 77%. Tumour specific trajectories and action plans have been developed to support delivery. Performance to the end June was 76.6% compared to the expected performance of 77%, there is continued validation of the position until deadline for submission for June on 1st August 2024.

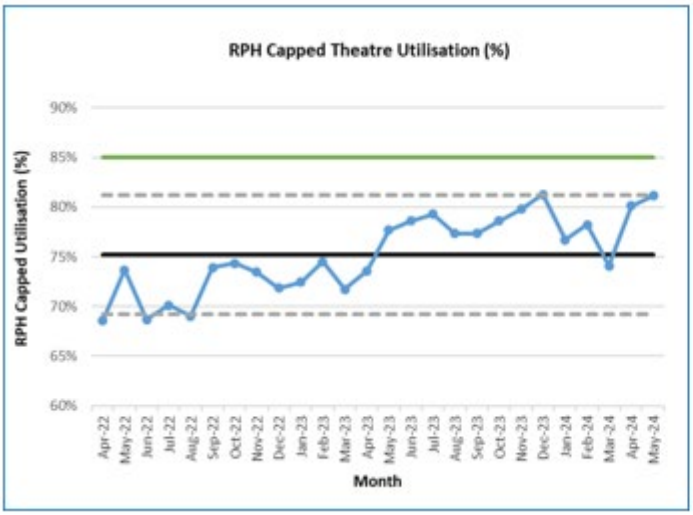
The trajectory has been reprofiled to a flat 77% as this is achievable now and there is an ambition to sustain performance at this level, supporting the removal of the Trust from Tier 1 for Cancer.

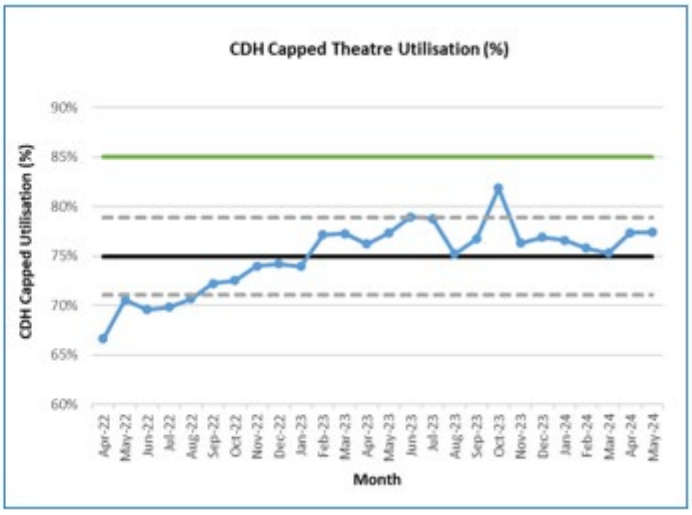
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
28 Day FDS Trajectory	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%
28 Day FDS Compliance	73.4%	76.1%	76.6%									

Theatre Efficiency Programme

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

- The current capped theatre utilisation rates are shown below indicating an improving and consistent capped performance at CDH until Dec 23, but has shown recovery in April 2024. Performance on the RPH site further deteriorated in March. Further consistency checks is in progress against the Model Hospital data which places the Trust in the top quartile. Paediatric Surgery has successfully moved to CDH and the national team has commended this achievement.





Outpatient transformation

The Outpatient Improvement Programme is led by the Chief Medical Officer and is a key part of the productivity workstream within the Financial Recovery Plan. The plan is focussed on reducing follow ups, reforming triage before appointment bookings and digital opportunities.

Next Steps

1. Continued deliver of the Single Improvement Plan for UEC, elective care, diagnostics, and cancer.
2. Continued focus on achievement of performance expectations in relation to cancer, long waiting patients and diagnostics as detailed in this report.
3. Review and reflection of changes to the governance arrangements supporting delivery of the single improvement plan and the resources to support delivery.

1. Financial implications

Noted in the narrative if relevant and included in the update provided in the contract and finance reports.

2. Legal implications

None to note.

3. Risks

There are a number of risks to delivery of the required reduction in the number of patients waiting in excess of 65 weeks, these include:

- Further industrial action
- Workforce - sickness and vacancies
- Anaesthetist capacity
- Urgent care pressures – COVID, Flu, NMC2R and poor patient flow
- Number of complex cases and capacity pressures at specialty level

4. Impact on stakeholders

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

Recommendations

It is recommended that:

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

Safety and Quality

Pressure Ulcers
The pressure ulcer data demonstrated a positive shift in April 2023 with 7 data points below the mean, this continues to be maintained with a most recent positive special cause variation data point. The introduction of Purpose T in February 2024 has been an opportunity to refresh the improvement plan using evidence based national guidance to inform risk assessment, management, training, patient and carer involvement in safety and prevention of pressure ulcers. The improvement work continues in this area with additional leadership through the deputy Chief Nurse. The mandated risk assessment standards have now been built into STAR.

Falls
The falls data demonstrated a positive shift in April 2023 with 7 data points below the mean, this has been maintained. The improvement plan for falls continues and is monitored through the divisional always safety first groups. The improved staffing fill rates have continued with adult and children services.

HSMR
Mortality metrics remain stable and within expected parameters.

STAR
STAR Quality assurance accreditation Gold awards have been held in June and July. Teams that celebrated as achieving Gold standards included

- SECU
- Dermatology CDH
- Dialysis Unit CDH
- Birth Centre CDH
- Core Therapies
- OMFS
- Neurosurgery High Care Unit
- Fracture Clinic RPH
- Maternity A
- Ward 24
- Bleasdale
- Ward 4
- Oral Max Fax RPH

The Big plan for STAR standard is being consistently achieved for departments achieving silver and above.
The safety and quality committee monitors the monthly assurance audits that underpin the overall accreditation programme.
As a result of analysis of progress, a decision mas been made to mandate the achievement of some fundamentals standards, this approach has now gone live with the aim of driving improvements within the high risk ward areas. It is expected this will adversely affect the positive outcomes in some areas initially with the aim of leading to an improved position.

Clostridium *difficile*
The detailed work associated with strengthening the multifactorial approach to reducing C.difficile continues. In 6 of the last 7 months the position has demonstrated lower or within expected variation. Whilst this still continues to exceed the set trajectory, there is an indication that some improvement may be becoming evident. The gap in cleaning standards continues to present the most significant risk relating to this, given this position, an explicit section on this area is outlined below. In addition to this, a drain survey has now been undertaken and presented to the ICB and NHS England, indicating the significant deterioration of the drains that are undoubtedly contributing to the position. To mitigate this a 'bin the wipes' campaign has demonstrated > 30% reduction in blockages and the purchase of 3 UV light machines will now mean that areas that cannot be fogged due to the construct of the environment or patient occupancy levels can be treated with UV light which offers a comparable effect on removing spores from the estate environment. To gain additional assurance NHS England IPC lead and the IPC medical

director will visit the trust in July to check and challenge the actions in place, review the IPC Board Assurance Framework and provide feedback.

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

Care Quality Commission

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

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

Of the 75 actions identified within the action plan, 52 actions have been assessed as green (i.e. delivered) and 21 actions have been assessed as amber (i.e. on track for delivery) demonstrating a significant amount of progress to date. Two actions have been stood down as no longer applicable.

A Great Place to Work

A key organisational priority in 2024/25 is to reduce sickness absence levels to alleviate staffing pressures, and the associated costs of temporary cover. Although we saw reductions in sickness absence during M01 and M02, in line with seasonal trends, the absence rate increased again in M03. A weekly task and finish group has been established to drive our absence reduction plan and monitor progress; and this will report through the Financial Recovery Programme governance structure. A MIAA audit around absence management is also in progress. Our annual health and wellbeing survey is currently live and the feedback we receive will help us to better understand the factors affecting workforce wellbeing and the needs for support.

Our agency costs for the Trust remain under 3.2% of the overall pay bill. We are continuing with ICS rate card reduction plans for nursing and are not seeing any significant risk in relation to fill. There continues to be no off-framework agency usage and no non-clinical agency usage within the organisation, with a complete freeze placed on non-clinical agency requests.

As part of the Trust's Financial Recovery Plan, a revised vacancy factor savings target has been implemented for FY2425 of £12m. Divisions are identifying posts that can be held and we have introduced new vacancy control criteria. We have an executive-led exceptions process for critical patient-safety posts. EQIAs are required for all posts under consideration so that risks are fully considered. Additional ICB-level vacancy controls also remain in place for some posts. As a result of these controls, we have seen an increase in the vacancy rate over recent months.

Delivering Value for Money

Income and Expenditure

The Trust has submitted the final plan in line with the NHSE control total and has delivered a favourable position against a plan of £15.5m for month 3, a deficit of £15.3m. The Trust continues to have considerable underlying financial pressures to manage and a financial recovery plan target of £58m to deliver.

Capital Position

Capital expenditure in the year to date at £16.7m is £3.0m less than plan.

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

Cash Position

The Trust has not required cash support in the year to date and does not forecast a requirement in Q1. Forecasts suggest that cash support from DHSC will be required in Q2 of 2024/25 and an approval to access such support has been received from the Board of Directors. Submissions to NHSE/DHSC were submitted in line with their Q2 cash deadlines.

Financial Recovery Plan Target

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

In month 3 the Trust has delivered £4.3m year to date, which is above plan of £3.3m however 57% of this was non-recurrent. Annually £9.5m; (£6.9m recurrently) has been delivered towards the £58m target which is 16%.

Use of Resources

The Trust is in Segment 3.

Segment 3 is where there are significant support needs against one or more of the six national oversight themes and in actual or suspected breach of the licence.

Segment 3 means the Trust will receive mandated support that is led and co-ordinated by NHS England regional teams with input from the national intensive support team where requested.

The Agency spend in month 3 was £2.6m, 2.6% of pay expenditure. This compares favourably to the agency cap of 3.2% of pay expenditure which has reduced from the cap of 3.7% in 2023/24.

Fit for the Future

These qualitative indicators will be reported separately to board within the normal cycle of board business.

It is recommended that:
I. The Board note the contents of the report and the action being taken to improve performance.

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

Previous consideration

Finance and Performance Committee, Workforce Committee, Safety and Quality Committee

Excellent care with compassion

Always Safety First

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Board of Directors

Performance to June 2024

INTRODUCTION

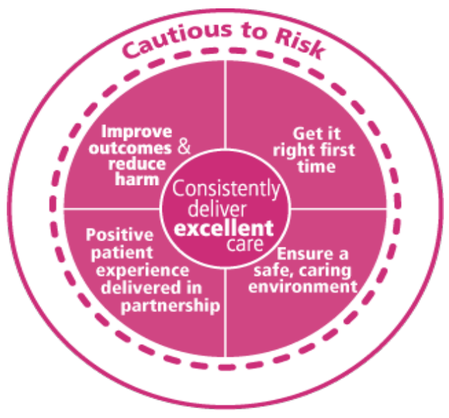
Performance to 30th June 2024

Mission

To provide excellent care with compassion

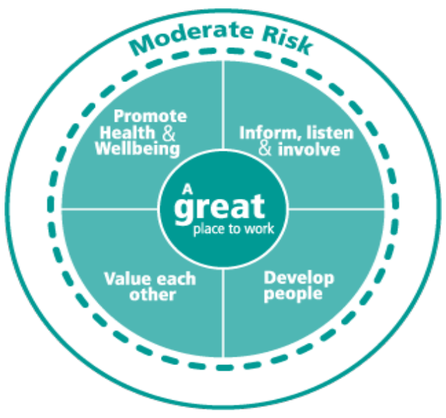
Strategic Aim

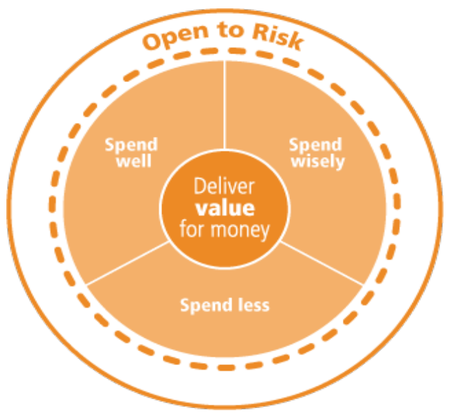
To provide excellent healthcare to our local communities



Strategic Aim

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





Strategic Aim

To drive innovation through world class education, training and research*

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.

Chief Executive

Continuously deliver excellent care

Together

Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One – Improve outcomes and prevent harm										
CQC	Big Plan	To achieve a rating of good with one outstanding service	M | T-D-S | TB-SQ | ALL	Yes	Progress towards CQC rating of good is ongoing					
	Sub Metric	Percentage of Must and Should do's completed			-	-	-	-	65.0%	-
Pressure Ulcers	**Key Metric**	**Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days** (Rate per 1000 beddays)	M | T-D-S | TB-SQ | SC	No	F			1.68	2.96	3.01
	Big Plan	Reduce the number of device related pressure ulcers by 10% - per 1000 bed days (Rate per 1000 beddays)		No				0.21	0.81	0.75
Maternity safety	Big Plan	Maintain compliance with the 10 safety actions for maternity services		No	-	-	-	100.0%	80.0%	June 2024
	Big Plan	Deliver year 1 of the national maternity & neonatal improvement plan		Delivery Plan in place						
Children and Young People safety	Big Plan	Develop 10 safety actions for children and young people and achieve compliance		10 safety actions created for children and Young people, reported through the Divisional Improvement Forum						
Contribute to PLACE Adult and Children CORE20 PLUS 5 strategy	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – Adults and maternity. Deliver year 1 actions		Delivery Plan in place						
	Big Plan	Develop a plan to respond to CORE20 PLUS 5 – CYP. Deliver year 1 actions		Delivery Plan in place						
Segment Two – Get it right first time										
Mortality	**Key Metric**	**Continue to achieve a mortality HSMR figure of <100 (Hospital Standardised Mortality Ratio (56 Basket – Adult)**	M | T-D-S | SQ | GS	No	Lower Than Expected				63.5	-
Access Standards	**Key Metric**	**Achieve the Emergency Department within 4 hours target**	M | T-D | FPC | FB	No				71%	71.0%	68.7%
	Key Metric	**Reduction in patients waiting +12 hours in Emergency Department**	M | T-D | FPC | FB	No	F			8%	7.5%	10.7%
	Key Metric	**Reduction in ambulance turnaround times - seen within 15 minutes**	M | T-D | FPC | FB	No	F			45.0%	37.3%	34.5%
	Key Metric	**Reduction in ambulance turnaround times - seen within 30 minutes**	M | T-D | FPC | FB	No				81%	83.2%	73.9%
	Key Metric	**Reduction in ambulance turnaround times - 60 minutes**	M | T-D | FPC | FB	No				87.0%	86.5%	96.0%
	Key Metric	**Achieve agreed trajectory for reducing 52 week waiters**	M | T-D-S | FPC | FB	No	F			2004	2493	3019
	Key Metric	**Eliminate waits over 65 weeks for elective care by March 2024**	M | T-D-S | FPC | FB	No	F			226	338	1016
	Key Metric	**Eliminate waits over 78 week waiters**	M | T-D-S | FPC | FB	No	F			0	0	48
	Key Metric	**Achieve Cancer - 28 day FDS**	M | T-D-S | FPC | FB					77%	76.5%	72.9%
	Key Metric	**Merged Cancer treatments started within 2 months of urgent referral**	M | T-D-S | FPC | FB	No				58%	63.5%	56.0%
	Key Metric	**Moving or discharging 5% of outpatient attendances to a PIFU pathway**	M | T-D-S | FPC | FB	No	P			5%	2.24%	2.20%
	Key Metric	**Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels - @ March 2024**	M | T-D-S | FPC | FB	No	F			-25%	-13.67%	-1.36%
	Key Metric	**Reduce adult general and acute (G&A) bed occupancy to 92% or below**	M | T-D-S | FPC | FB	No				95%	93%	94%
	Key Metric	**Achieve 5% of patients in hospital who no longer meet the criteria to reside**	M | T-D-S | FPC | FB-SC	No				10.0%	10.2%	8.7%
SDEC	Big Plan	Divert 10 ambulances a day from ED (to SDEC or the appropriate service; SAU, MAU AAU, 2hr UEC response) (Target of 1924 ambulance arrivals per month based on a reduction of 10 amulance arrivals per day on 2022/23 actuals)	M | T-D-S | FPC | FB	No	F			1924	2442	2417
Pre-procedure elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to planned surgery	M | T-D-S | FPC | FB	No				0.15	0.22	0.33
Pre-procedure non-elective bed days	Big Plan	To reduce the number of days patients spend in hospital prior to unplanned surgery	M | T-D-S | FPC | FB	No				0.50	0.26	0.66
Elective Inpatient Average length of stay (Spell)	Big Plan	To reduce the average length of stay for patients undergoing planned surgery	M | T-D-S | FPC | FB	No				3.3	2.83	3.1
Cancer	Big Plan	Full implementation of Teledermatology in the suspected skin cancer pathway	M | T-D-S | FPC | FB	No				80%	70.99%	82.45%
	Big Plan	Full implementation of the Best Practice Timed Pathway for prostate cancer	M | T-D-S | FPC | FB	No	No Patients Currently on this Pathway					

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	JW = Jonathan Wood	GD = Gary Doherty
Q = Quarterly	S = Specialty	ETR = Education, Training & Research Committee	FB = Faith Button	SD = Stephen Dobson
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	SC = Sarah Cullen	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee		

Variation Icon \ Assurance Icon	F – Will consistently fail target within expected variation	Could both pass or fail target within expected variation	P – Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

Continuously deliver excellent care

Together

Metric Description			Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment Three – Ensure a safe, caring environment										
Falls	Big Plan	Reduce the number of falls by a further 5% - per 1000 bed days	M | T-D-S | SQ | SC	No	F			3.72	4.46	4.57
Infection	**Key Metric**	**Achieve less than the annual tolerance for C.difficile**	M | T-D-S | SQ | SC-GS	Yes	F		-	10	11	16
	Big Plan	Achieve zero MRSA bacteraemia	M | T-D-S | SQ | SC-GS	No	-	-	-	0	0	Last reported case Sept 2023
Safety	Big Plan	Maintain 90% staff trained in level 1 safety training	M | T-D-S | ETR | NL	No	P		-	90%	98.8%	98.1%
	Big Plan	Achieve 90% executive and senior leaders safety training	M | T-D-S | ETR | NL	No	P		-	90%	95.4%	94.5%
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	17	13
Patient involvement	**Key Metric**	**Achieve a minimum of 90% of patients reporting their experience of good or very good (including neither good/bad)**	B | T-D-S | SQ | SC	No			-	90%	91.2%	89.5%
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%	86.0%	96.0%
Safe Staffing	Big Plan	Maintain Registered Nurse and Midwife fill rates of > 90%	M | T-D-S | SQ | SC-GS	No			-	95%	100.8%	98.5%

Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive	
A = Annual	T = Trust	TB = Trust Board	All = All Exec Team	GS = Gerry Skailes
B = Bi-annual	D = Division	W = Workforce Committee	JW = Jonathan Wood	GD = Gary Doherty
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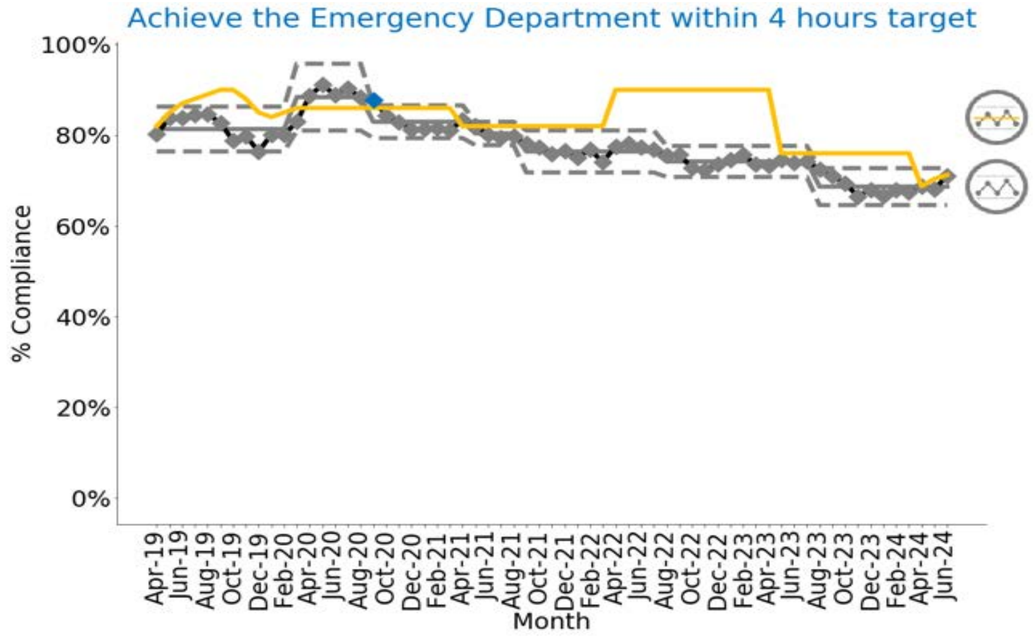
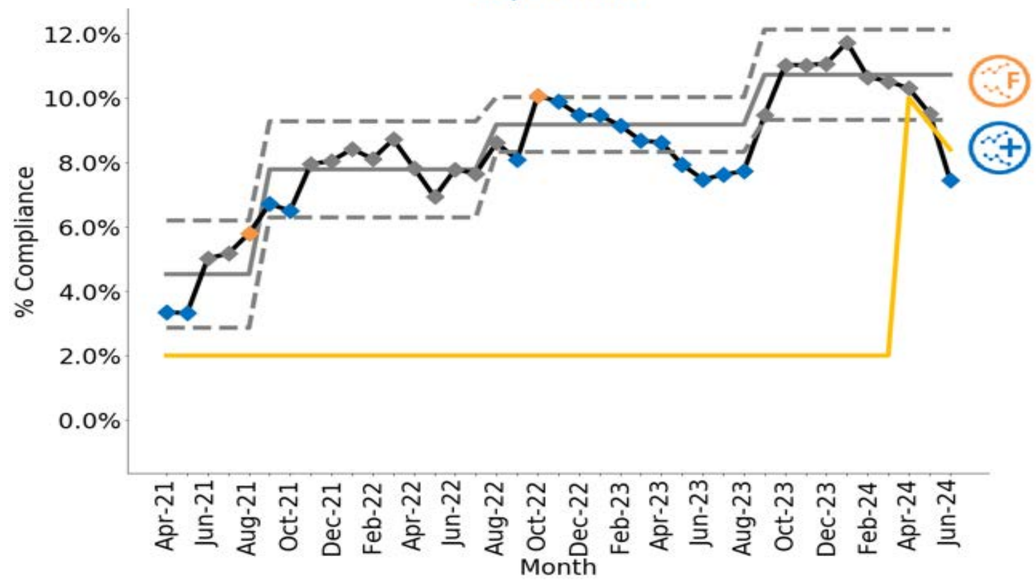
M = Monthly	C = Cost Centre	FPC = Finance & Performance Committee	SC = Sarah Cullen	AB = Ailsa Brotherton
		SQ = Safety & Quality Committee	NL = Nicki Latham	

Variation Icon \ Assurance Icon	*Will consistently fail target within expected variation*	*Could both pass or fail target within expected variation*	*Will consistently pass target within expected variation*
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
Normal variation – no recent change	Failing target and no change happening. Process review needed. May need exception report	Close to Target and no change. Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and no change happening
Recent positive pattern in the data	Failing the target but getting better May need exception report	Close to Target and getting better Check additional performance flag to say if mainly above or below target. May need exception report	Passing target and getting better

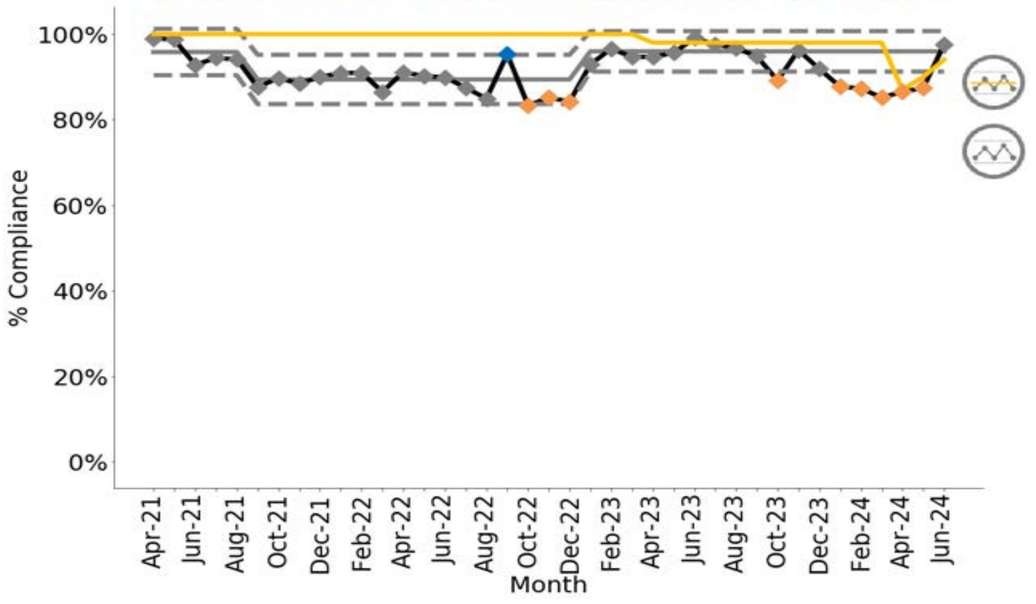
Achieve the Emergency Department within 4 hours target



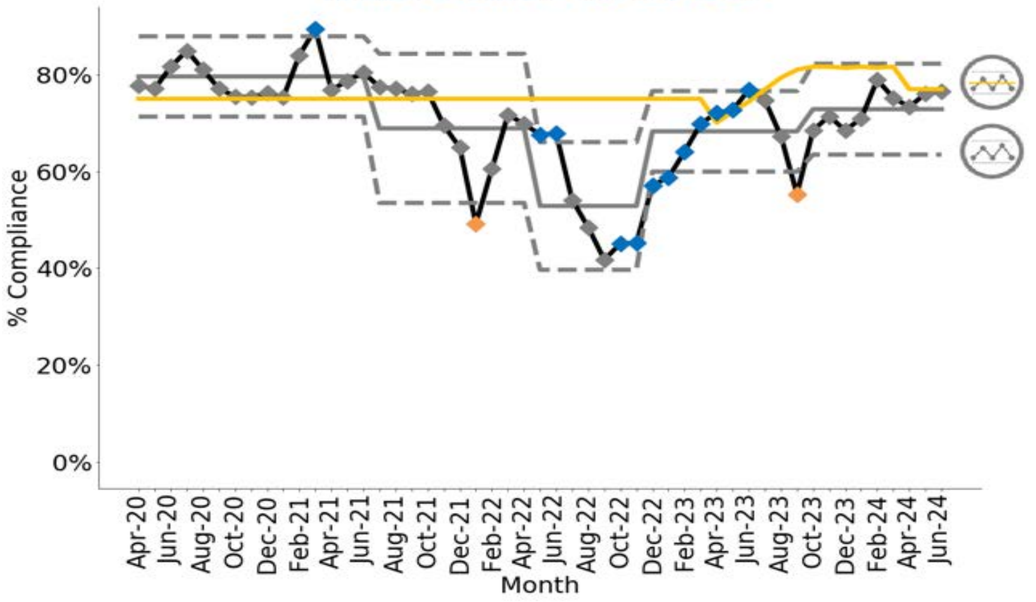
Reduction in patients waiting +12 hours in Emergency Department



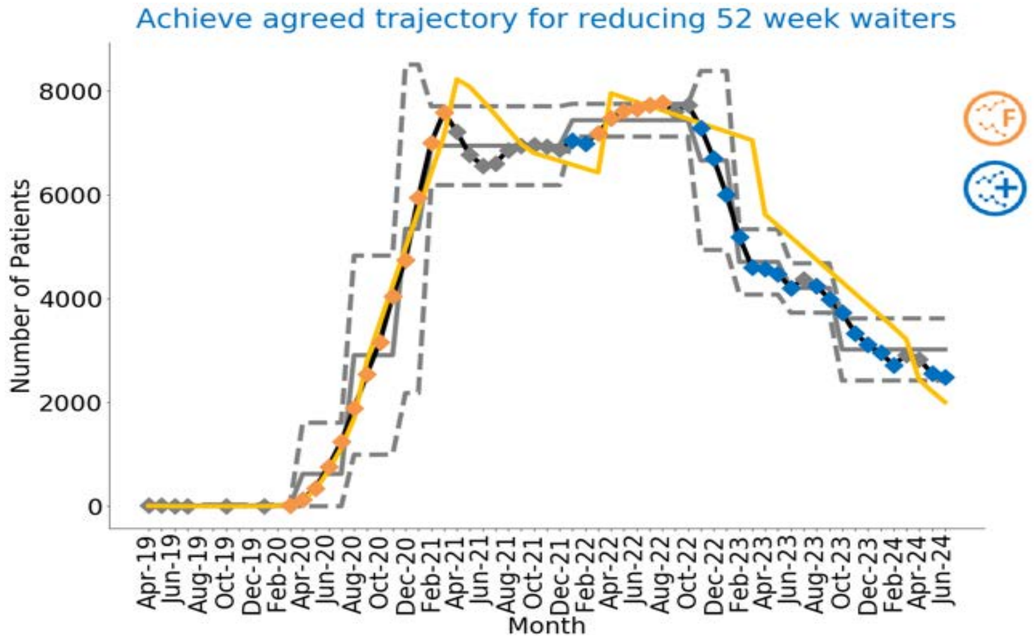
Reduction in ambulance turnaround times - 60 minutes



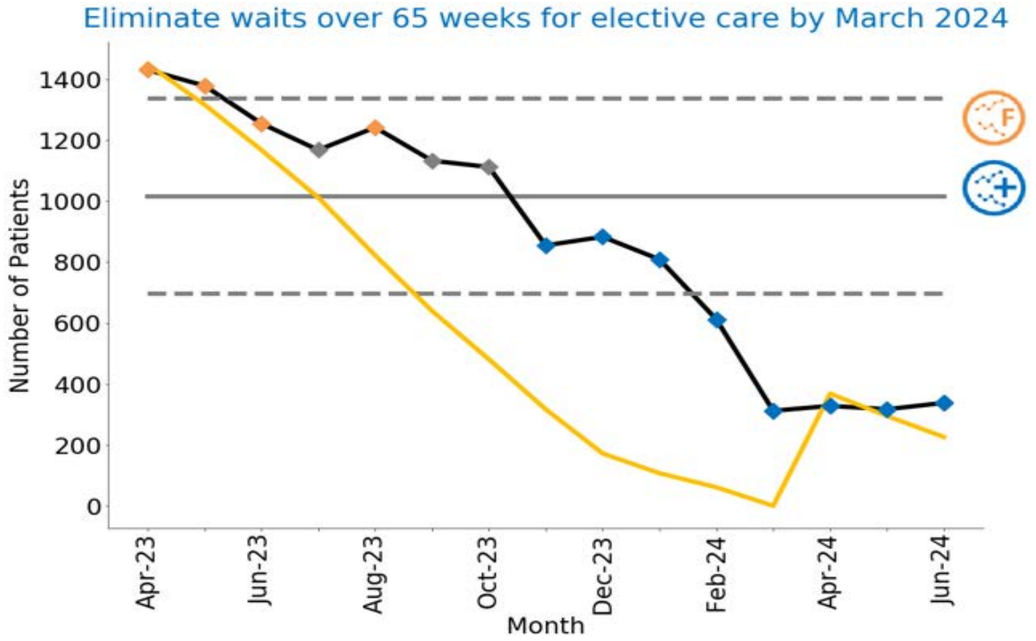
Achieve Cancer - 28 day FDS



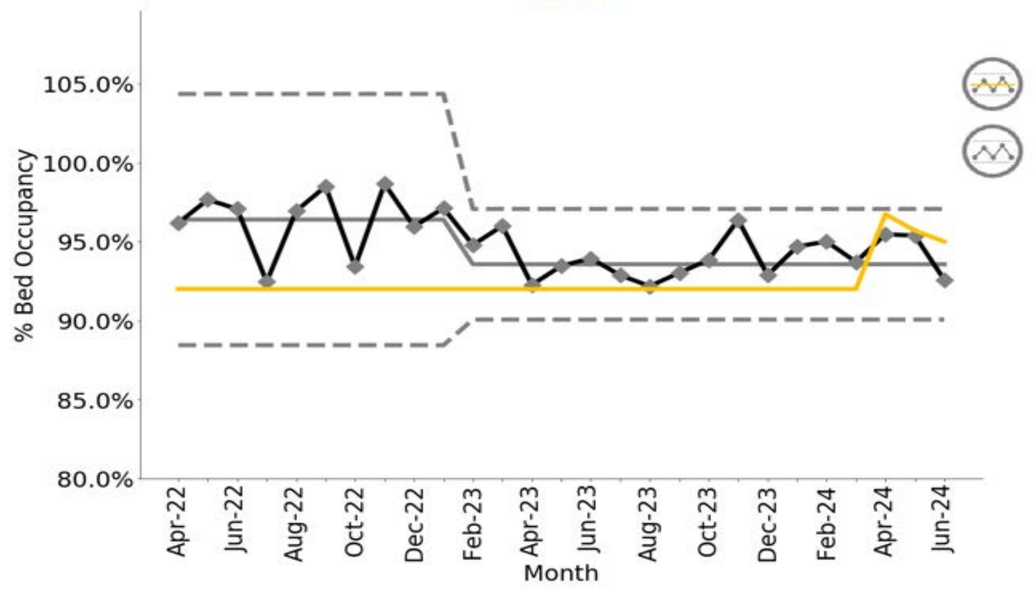
Achieve agreed trajectory for reducing 52 week waiters



Eliminate waits over 65 weeks for elective care by March 2024



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



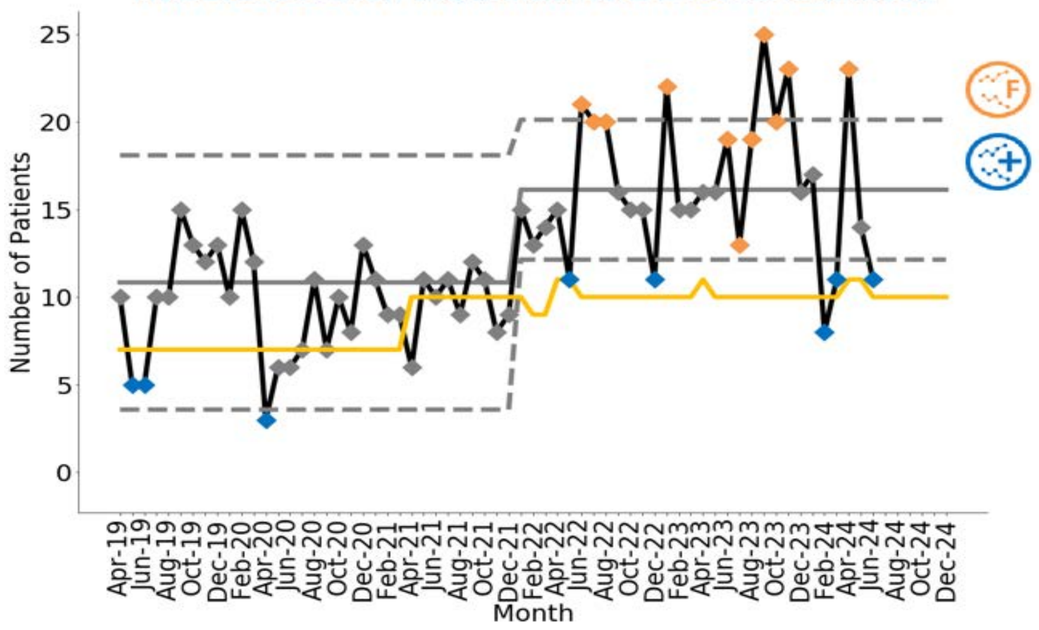
Assurance Icons – How likely are we to hit the set target in future?

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

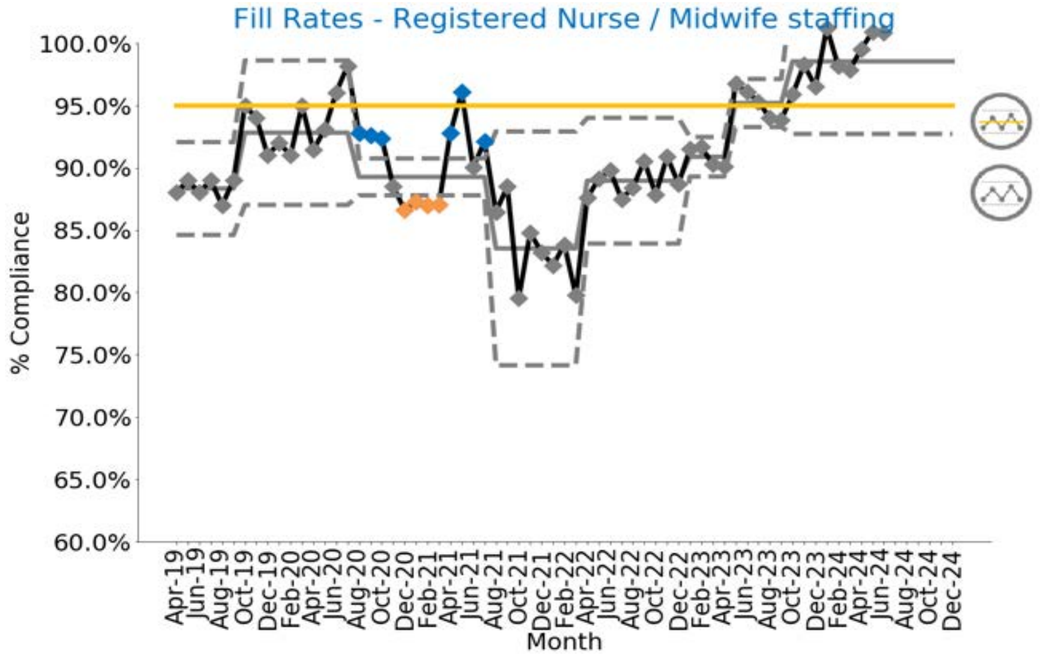
Variation Icons – Is the measure showing signs of change over time?

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

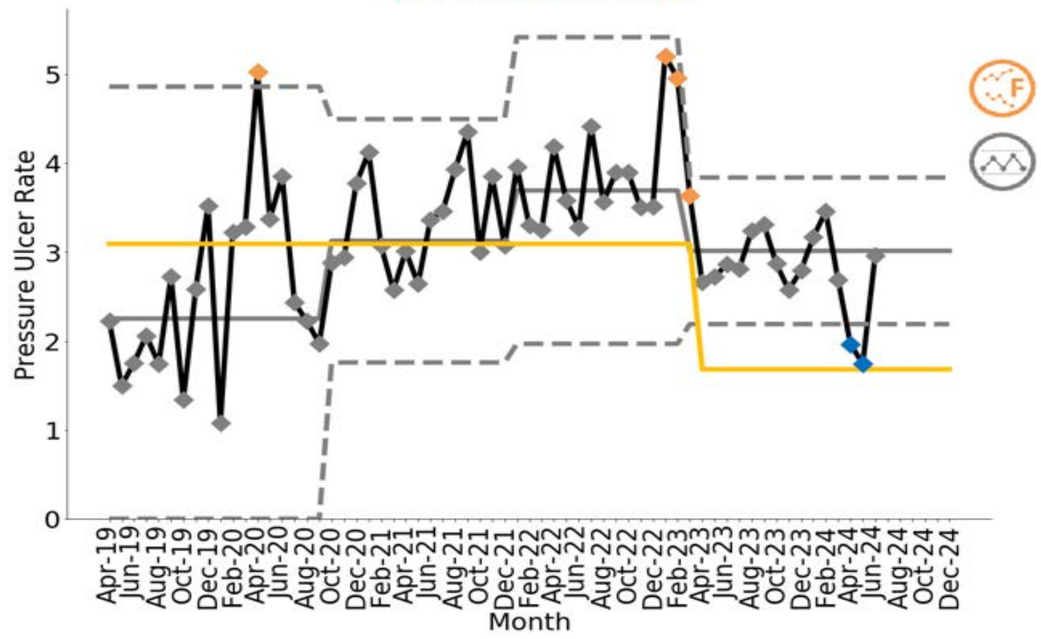
Achieve less than the annual tolerance for C.difficile



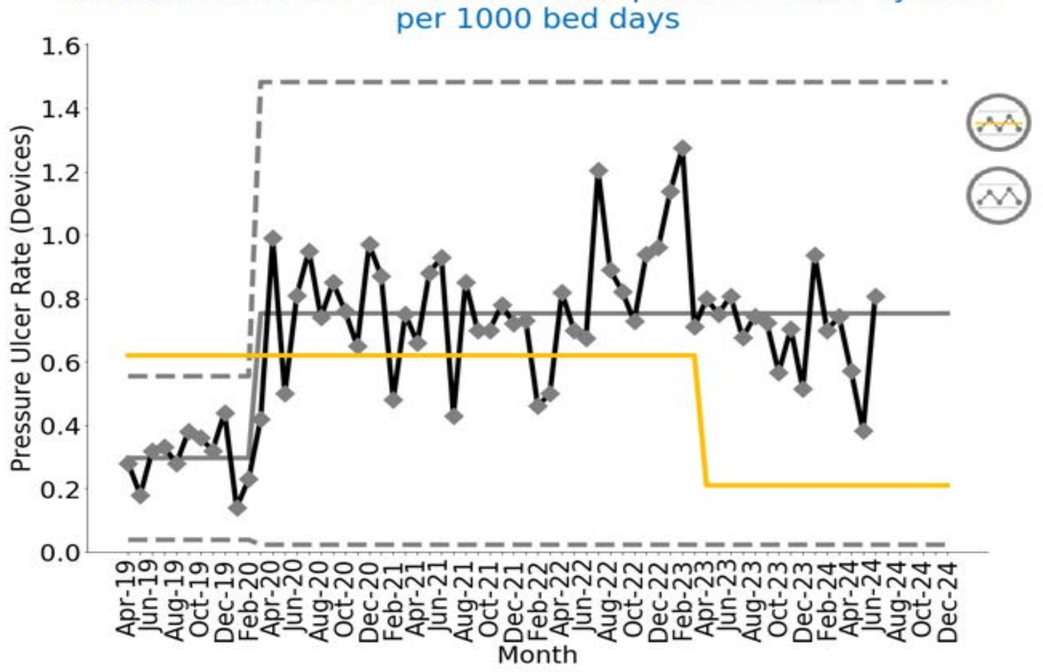
Fill Rates - Registered Nurse / Midwife staffing



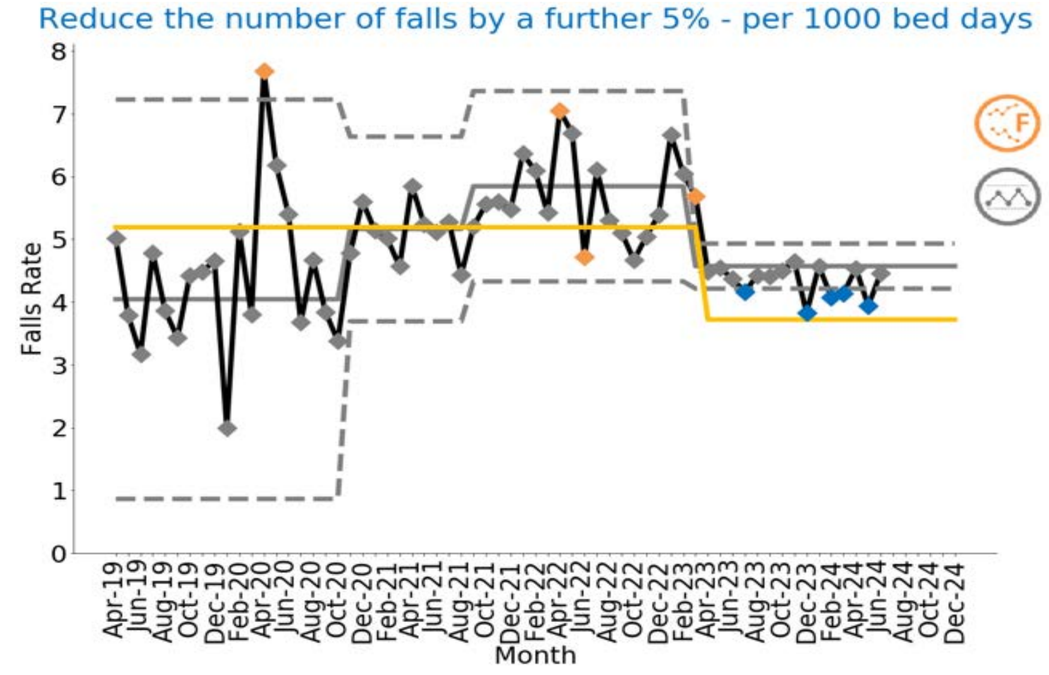
Reduce the number of people developing pressure ulcers by 10% - per 1000 bed days



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



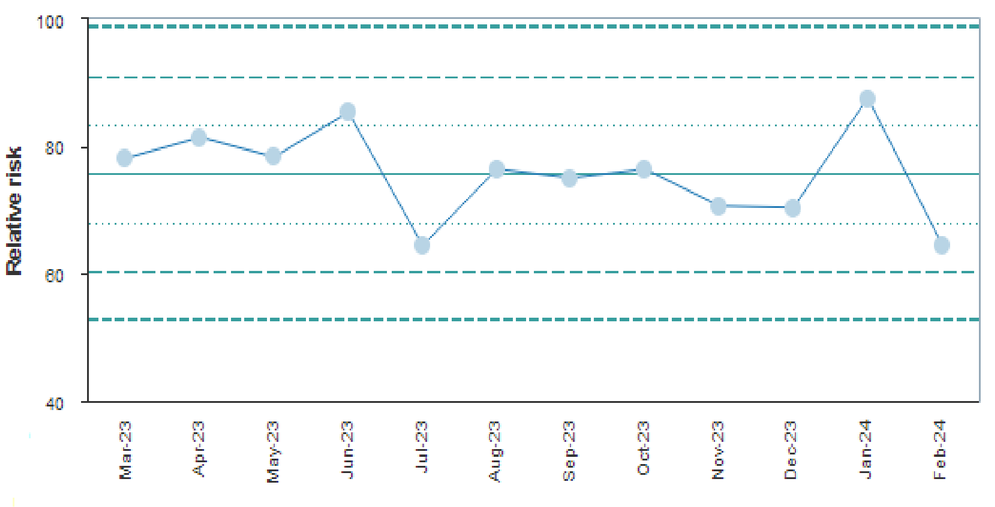
Reduce the number of falls by a further 5% - per 1000 bed days



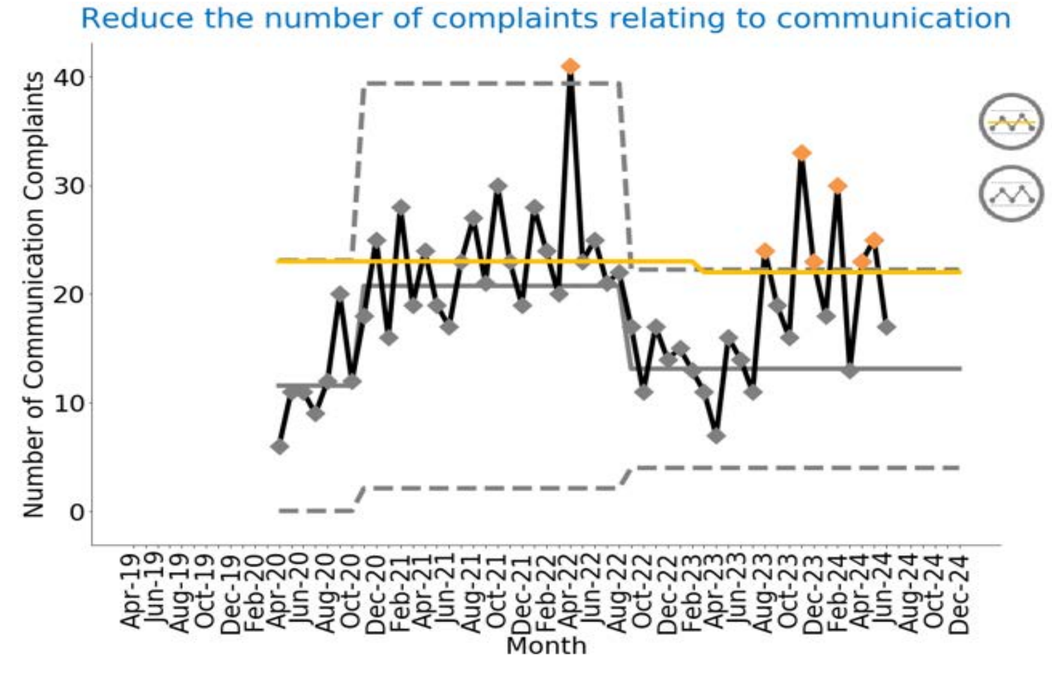
Diagnoses - HSMR | Mortality (in-hospital) | Mar-23 to Feb-24 | Trend (month)

Age (adult/child): 'Adult'

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



Reduce the number of complaints relating to communication



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

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

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

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

A GREAT PLACE TO WORK
Reviewed monthly / quarterly

Together

Metric Description		Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Promote Health and Wellbeing									
Sickness Absence	Reduce overall sickness absence to 5.00% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 5%	5.93 %	6.47 %
	Reduce short-term sickness absence to 1.75% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 1.75%	2.17 %	2.56 %
	Reduce long-term sickness absence to 3.25% FTE (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 3.25%	3.76 %	3.91 %
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	-			-	Pending	1.77 %	1.50 %
	Reduce average duration of MSK-related absences by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	Pending	0.98 %	0.82 %
	Drive forward zero tolerance of violence and aggression toward staff by reducing the number of incidents by a further 10% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 73	95	80.42
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%	0.72 %	0.70 %
Vacancies	Reduce the number of vacancies by a further 5% (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 6%	6.56 %	9.13 %
Time to Hire	Time to Hire (Advert Closed --> Start Date) AfC (annual assessment; in-month reported)	M | T-D-S-C | W | KS	-			-	≤ 71	53	70.34
Appraisals	Maintain 90% HC compliance rate for appraisals	M | T-D-S-C | W | KS	-				≥ 90%	86.85 %	
Mandatory Training	Maintain 90% HC compliance against all core skills training requirements (module compliance reported)	M | T-D-S-C | ETR | KS	-				≥ 90%	94.40 %	
Medical Devices	Achieve 90% HC compliance with medical device training	M | T-D-S-C | ETR | KS	-				≥ 90%	88.05 %	
Inform, Listen and Involve									
Staff Engagement & TED	Increase the number of teams that have undertaken TED by 15% (annual assessment; in-month reported)	M | T-D | W | KS	-			-	≥ 17	7	14.42
	Ensure 60% of our staff would recommend us as a place to work	Q | T-D | W | KS	-			-	≥ 60%	55.39 %	61.79 %

Assurance Icon / Variation Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
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

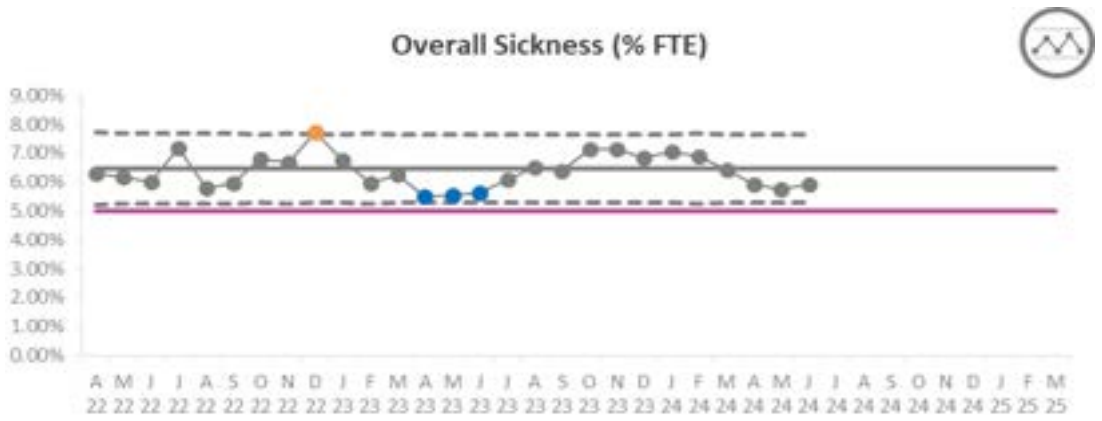
Reporting Requirements Key

Frequency	Level	Sub-Committee	Responsible Executive
A = Annual	T = Trust	W = Workforce Committee	KS = Karen Swindley
B = Bi-annual	D = Division	ETR = Education, Training & Research Committee	JW = Jonathan Wood
M = Monthly	S = Specialty		All = All Exec Team
Q = Quarterly	C = Cost Centre		

A GREAT PLACE TO WORK
Reviewed via committee cycles of business

Together

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


Overall Sickness (% FTE)
9.00%
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
22 22 22 22 22 22 22 22 22 23 23 23 23 23 23 23 23 23 23 23 24 24 24 24 24 24 24 24 24 24 24 24 25 25 25


ESR Turnover (% FTE)
1.2%
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
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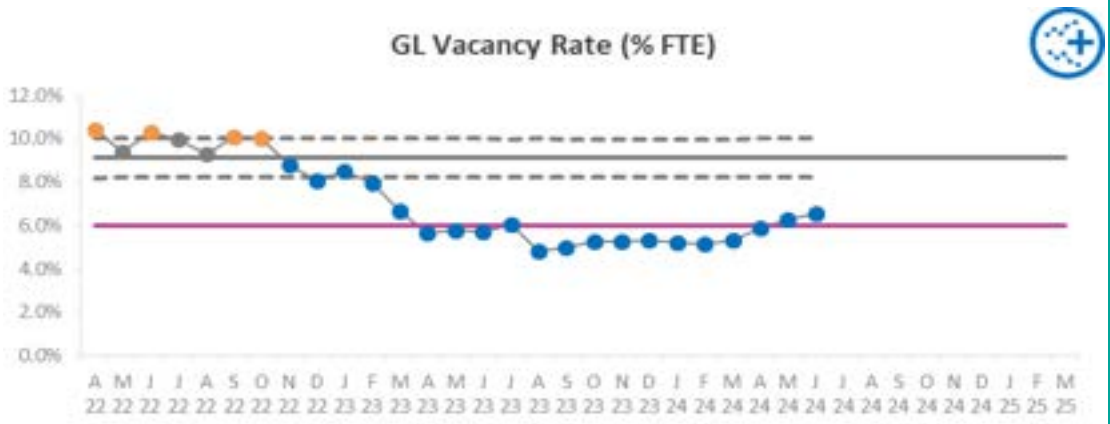
GL Vacancy Rate (% FTE)
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
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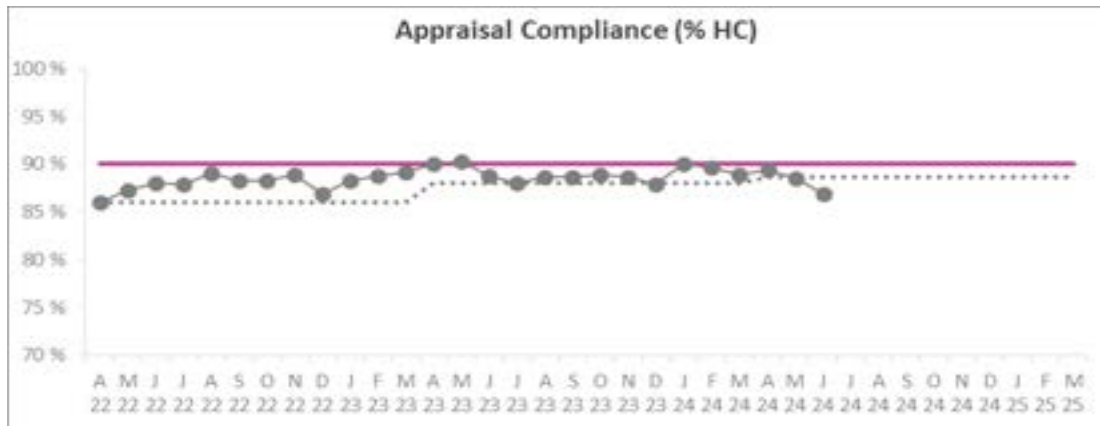
Appraisal Compliance (% HC)
100 %
95 %
90 %
85 %
80 %
75 %
70 %
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
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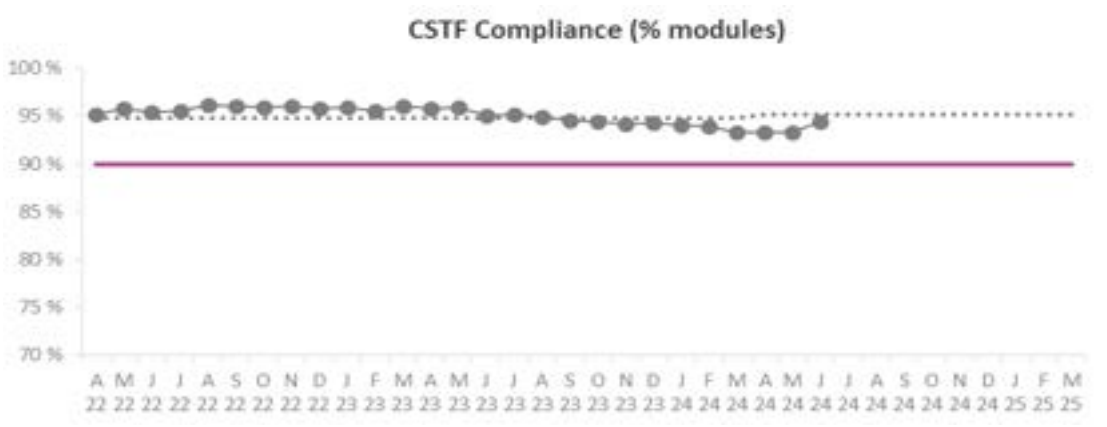
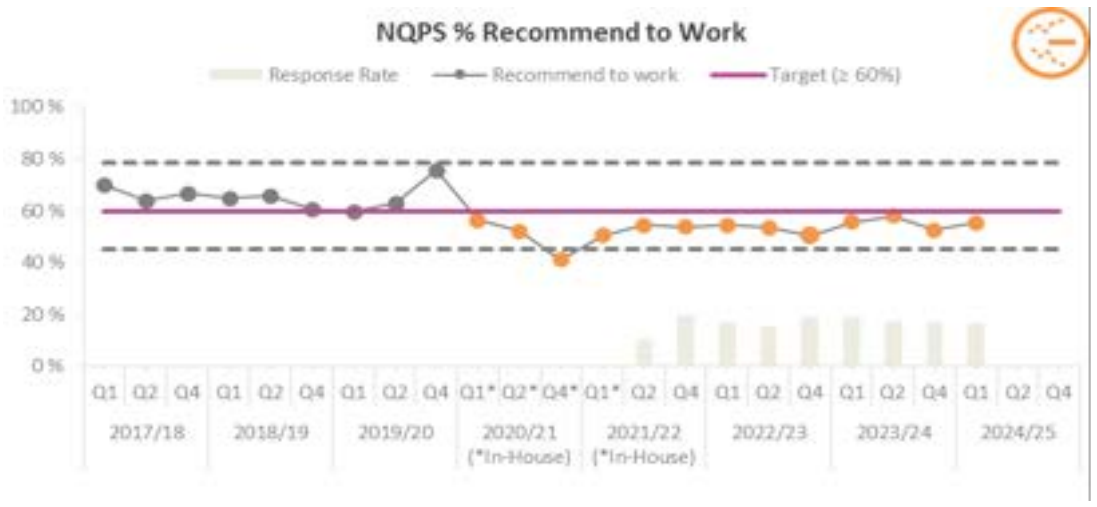
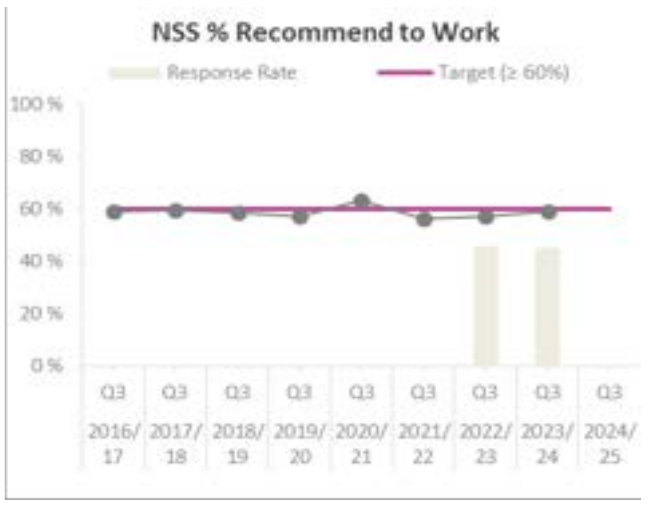

CSTF Compliance (% modules)
100 %
95 %
90 %
85 %
80 %
75 %
70 %
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M
22 22 22 22 22 22 22 22 22 23 23 23 23 23 23 23 23 23 23 23 24 24 24 24 24 24 24 24 24 24 24 24 25 25 25


NQPS % Recommend to Work
Response Rate
Recommend to work
Target (≥ 60%)
100 %
80 %
60 %
40 %
20 %
0 %
Q1 Q2 Q4 Q1 Q2 Q4 Q1 Q2 Q4 Q1* Q2* Q4* Q1* Q2 Q4 Q1 Q2 Q4 Q1 Q2 Q4 Q1 Q2 Q4
2017/18
2018/19
2019/20
2020/21 (*In-House)
2021/22 (*In-House)
2022/23
2023/24
2024/25


NSS % Recommend to Work
Response Rate
Target (≥ 60%)
100 %
80 %
60 %
40 %
20 %
0 %
Q3 Q3 Q3 Q3 Q3 Q3 Q3 Q3 Q3
2016/17
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
2023/24
2024/25

Deliver Value for Money

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Exception Report to Sub Committee	SPC Assurance	SPC Variation	Target Concern	Trust Target	Reporting Month Value	Mean
Segment One - Spend Less (Economy)												
Agree revenue and capital financial plan with ICB	**Key Metric**		Deliver 100% of the agreed targeted reduction in our underlying financial deficit	A | T | TB - FPC | JW	This indicator is reported separately agreed at Trust level at budget setting							
Deliver agreed cost improvement delivery target	**Key Metric**		To deliver 100% of agreed cost improvement target	M | T-D-S | FPC | JW	No	-	-	-	3313	4295	-
Procurement	-	-	Number of single tender waivers							32 June (cumul 58)	
Segment Two - Spend Well (Efficiency)												
Bed Occupancy Rate (Including Escalations)	Big Plan		Reduce adult general and acute (G&A) bed occupancy rate	M | T-D-S | FPC | FB	No				95%	92.6%	93.6%
Theatre Efficiency	Big Plan		RPH - Theatre capped utilisation rates are no lower than 80%	M | T-D-S | FPC | FB	No	-	-	-	80%	80.0%	-
	Big Plan		CDH - Theatre capped utilisation rates are no lower than 85%	M | T-D-S | FPC | FB	No		-	-	85%	74.9%	-
GIRFT (Model Hospital)	Big Plan		Achieve 85% day of surgery using BADs Procedures - GIRFT	M | T-D-S | FPC | FB	No			-	85%	87.2%	85.5%
OP Follow Ups	Big Plan		Reduce outpatient follow ups by a minimum of 25% against 2019/20 activity levels - **March 2024**	M | T-D-S | FPC | FB	No	F			-25%	-13.67%	-1.36%
Supplier payments (BPPC)	Big Plan		To ensure all suppliers are paid in line with national guidance	M | T | FPC | JW	No			-	95%	91.0%	-
Segment Three - Spend wisely (Effectiveness)												
Agency costs	Big Plan		Reduce agency costs to 3.7% of the total pay bill	M | T-D-S | W | SC-GS	No	-	-	-	3.7%	2.54%	-
Delivery of Activity and Revenue Plan	**Key Metric**		To ensure 100% delivery of the Trust's activity and revenue programme	M | T | FPC | JW	No	-	-	-	-15482	-15297	-
Capital	**Key Metric**		To ensure 100% delivery of the Trust's Capital programme	M | T | FPC | JW	No	-	-	-	19671	16694	-

Reporting Requirements Key

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		SQ = Safety & Quality Committee	SC = Sarah Cullen	

Variation Icon \ Assurance Icon	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	Failing Target and Getting Worse Exception Report Needed	Close to Target and Getting Worse. Check additional performance flag to say if mainly above or below target Exception Report Needed	Passing target but getting worse. Exception report needed
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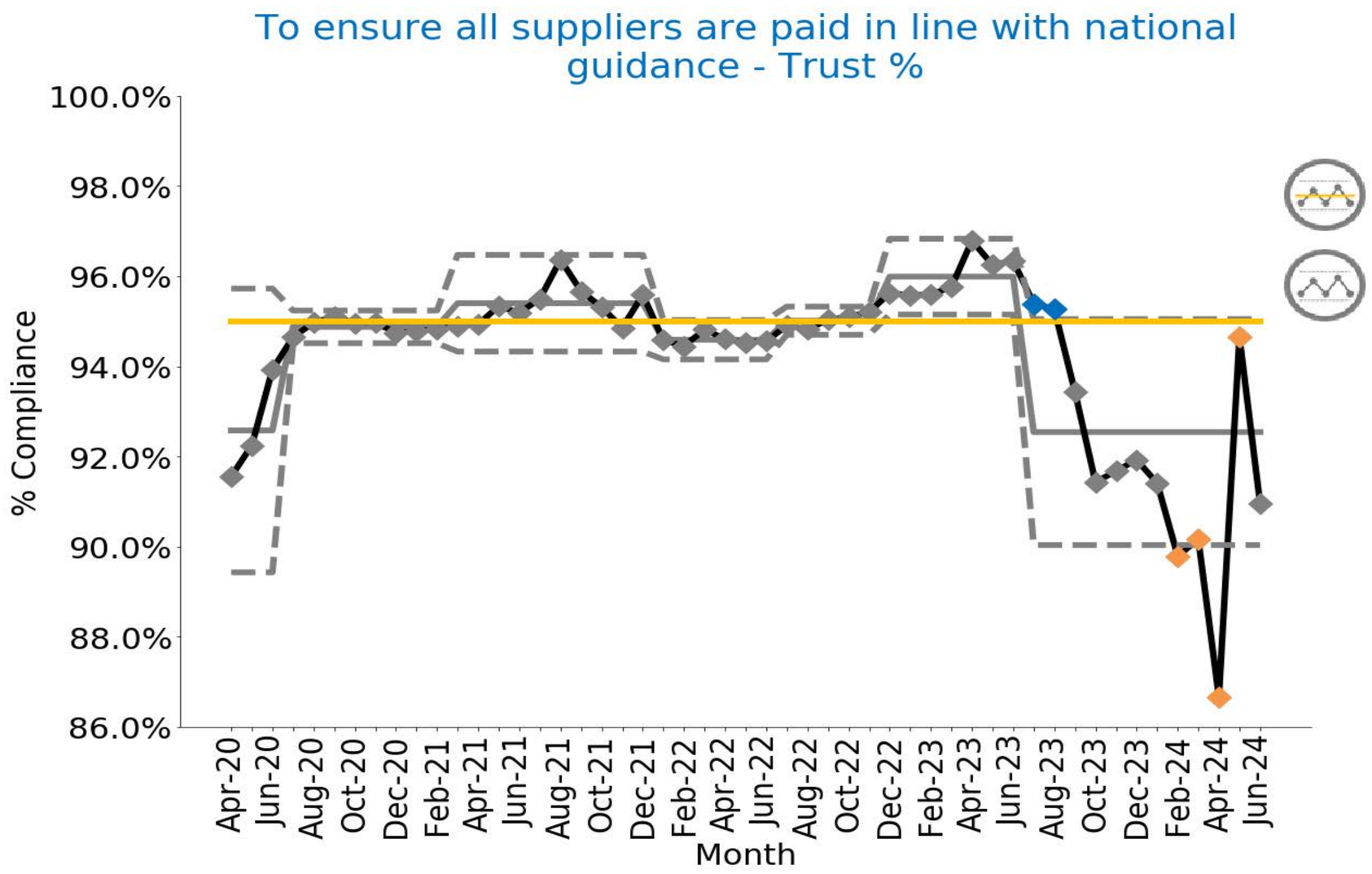

Assurance Icons – How likely are we to hit the set target in future?

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

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

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

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Segment One – Strategy and Transformation											
Clinical Services Strategy	Big Plan	FFTF-1	To deliver the 24/25 actions in the LTH clinical services strategy, including addressing the challenges and opportunities of multi-site working:	B | T-D | TB | GS							
			To provide outstanding, sustainable healthcare to our local communities and in our tertiary services								
			To drive health innovation through world class education, teaching and research								
			System working in a new NHS landscape								
Outpatients Transformation	**Key Metric**	**FFTF-2**	**Deliver the 24/25 actions and outcomes from the agreed Transformation Plan including:**	M | T | FPC | GS							
			Deliver Personalised Outpatient Care (Patient Initiated Follow up & Patient Stratified Follow Up)								
			Referral optimisation and demand management								
			Deliver our follow up reduction target to drive the outpatient element of our Financial Improvement Plan								
Elective Care Transformation	**Key Metric**	**FFTF-3**	**Deliver the 24/25 actions and outcomes from the agreed Transformation Plan**	M | T | FPC | ID							This is under review and to be aligned with the Trust clinical services strategy.
			Deliver agreed national waiting list improvement targets and productivity benchmarks								Good progress made as part of Tier 1 exit plan.This also aligns with the internal transition from stabilising services to perform and then further transformation through the Single Improvement Plan.
			Develop our elective strategy to include repatriation of activity from the independent sector and other regions, and the maximisation of our surgical hub capacity								This will be incorporated into the service triangulation programme at specialty level to inform capacity for repatriation as we stabilise, perform and transform,
			Deliver our planned care financial targets in support of the Financial Improvement Plan								This is incorporated within the Single Improvement Plan ensuring robust governance through streamlining improvement plans.
Urgent and Emergency Care Transformation	**Key Metric**	**FFTF-4**	**Deliver the 24/25 actions and outcomes from the agreed Transformation Plan including:**	M | T | FPC | AB							In progress and aligned to the Single Improvement Plan
			Focus on pre hospital pathway/front door to include integrated mental/physical health services and a 40% reduction in ambulance conveyances								Continued work programme and review of Same Day Emergency Care demand and capacity to improve ambulance flows outside of ED.
			Reduce Lengths of stay by 10% reduction in LoS on 10 pilot wards and reduce Not Meeting Criteria to Reside reduced to 5% (system aim)								System leadership group relaunched on the 1st March and work programme for place being developed with immediate, medium and long term plans.
			Deliver agreed financial benefits to support Financial Improvement Plan								This is being integrated within the Trust's Single Improvement Plan. Focus on quarter 4 maintained to manage the year end position.
Unwarranted Variation	Big Plan	FFTF-5	Deliver the 24/25 actions and outcomes from the agreed Transformation Plan including:	M | T | FPC | GD							This programme has been replaced with the Value Based Improvement Programme
			Fully establish and embed the programme governance								
			Undertake deep dive reviews into the 9 identified priority specialities, agreeing and deliver the consequent improvement plans								
			Deliver agreed financial benefits to support Financial Improvement Plan								

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Financial Improvement Plan	Big Plan	FFTF-6	Deliver the 24/25 actions and outcomes from the agreed Improvement Plan:	M | T | FPC | JW							Governance reset
			Fully embed FIP governance & reporting								Governance reset
			Fully embed FIP delivery framework								Governance reset
			Develop and agree 3 year FIP								There remain gaps in the bottom up delivery plans
Segment Two – Place Based Partnership											
Collaboration and Integration at Place	**Key Metric**	**FFTF-7**	**Fully establish the required governance structure and processes for Place based working, agree and deliver the 24/25 agreed Place strategies, actions and outcomes**	Q | T | TB | GD							Governance has been established but is currently under review
			Agree a comprehensive set of priorities & programmes								
			Deliver the Core20PLUS5 action plan and outcomes								Clinical and operational leads idneitfied for each of the clinical areas of CORE20PLUS5, the broader health inequalities plan to support this is in draft and under review at this time.
			Deliver the Frailty improvement action Plan & Outcomes								
Social Value	Big Plan	FFTF-8	Building on our Social Value Framework, work with partners to develop a Social Value Strategy driving a place based focus on equality, wider determinants of health, poverty and social capital:	B | T | TB | GD							
			Review and refresh Green Plan and deliver agreed actions/metrics								Update report on April Board meeting
			Prepare for Level 2 Social Value Quality Mark accreditation application in 2024/25								
			Deliver the Core20PLUS5 action plan and outcomes								The social value contribution towards CORE20PLUS5 continues to progress in line with the plan.

Metric Description				Reporting Frequency | Level | Sub-Committee | Responsible Executive	Target	Current Rating	Position @ Q1	Position @ Q2	Position @ Q3	Position @ Q4	Comment
Segment Three – System Working												
ICB Joint Forward Plan	**Key Metric**	**FFTF-9**	**Deliver the 24/25 actions and outcomes from the agreed JFP. Work with ICB to:**	Q | T | TB | GD		N/A	N/A				
			Finalise the JFP			▲	▲				JFP signed off by the ICB Board
			Align strategies and plans with the JFP priorities			▲	▲				
			Develop detailed delivery plans			▬	▬				
Clinical Collaboration	Big Plan	FFTF-10	Deliver the 24/25 actions and outcomes from the agreed Clinical Collaboration work plan including:	M | T | FPC | GS		▬	▬				
			Develop & deliver implementation plans for new models of care in Vascular, Head & Neck, Urology, Stroke and Elective Hubs			▬	▬				Variation between programmes
			Agree next set of specialties for the implementation of new models of care and develop implementation plans			▬	▬				
			Undertake challenged services review of fragile and financially challenged services, and deliver agreed action plans			▬	▬				
Central Services Collaboration	Big Plan	FFTF-11	Deliver the 24/25 actions and outcomes from the agreed Central Services Collaboration work plan including:	M | T | FPC | JW		▬	▬				
			Target Operating model agreed and mobilised			▬	▬				
			Phase 1 transactional services (Payroll and General Ledger provision) underway			▲	▲				
			Bank and Agency Collaborative proposal sign off/implementation			▲	▲				
Digital Northern Star / EPR Convergence	Big Plan	FFTF-12	Deliver the 24/25 actions and outcomes from the agreed Digital/EPR work plan	M | T | FPC | SD-GD		▬	▬				Pre-market engagement underway.
			EPR tenders evaluated, and preferred supplier awarded								Procurement to be restarted
			Digital Convergence programme governance reviewed and revised			▲	▲				Systems map completed. Programme plan in development.
			Implement Secure data Environment			▬	▬				UHMB and LTH connected to L&SC data lake. LTH data flowing. Information governance process for remaing trusts to be finalised.
Elective Recovery	Big Plan	FFTF-13	Deliver the 24/25 actions and outcomes from the agreed ECRG work plan – maximise system working to deliver:	M | T | FPC | GD		N/A	N/A				Actions delivered but due to industrial action targets will not be met
			National waiting times targets			▬	▬				Actions delivered but due to industrial action targets will not be met
			National productivity targets			▬	▬				
			Surgical Hub Strategy			▲	▲				On track to be deleivered/agreed
New Hospitals Programme	Big Plan	FFTF-14	Milestones and metrics to be finalised following further discussions with national teams	M | T | FPC | JW							

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		SQ = Safety & Quality Committee		

Green Delivering actions and outcomes
Amber On track to recover actions & outcomes
Red Significantly off track with actions & outcomes

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Single Improvement Plan

Performance Pack
June 2024

SIP PROGRAMME STRUCTURE

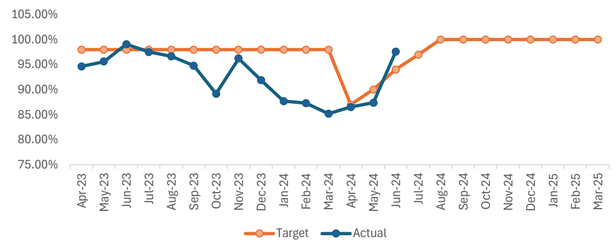
Well Led	People & Culture	Safety, Quality and effectiveness	Financial Sustainability	Operational Performance
Clear Vision and Strategy	Attract, Recruit and Resource	Deliver Annual Safe Staffing Requirements	3 Year FRP – Identify and Develop	UEC In Flow
Information Improvement	Engage, Retain, Reward &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

Single Improvement Plan - Board - OPERATIONAL KPI's

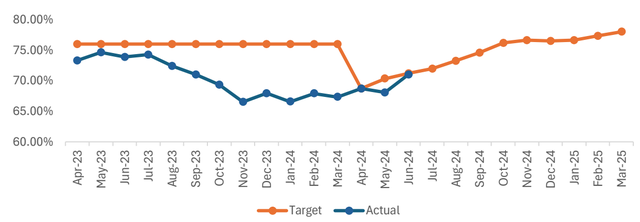
Programme	Monthly Indicators	Year End Target	Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
UEC In Flow	Compliance with 60 minute ambulance turnaround time target	100%	**Target**	87.00%	90.00%	94.00%	97.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
			Actual	86.53%	87.39%	97.60%									
	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	78.00%	**Target**	68.73%	70.36%	71.23%	71.98%	73.29%	74.60%	76.19%	76.65%	76.50%	76.65%	77.38%	78.03%
			Actual	68.7%	68.1%	71.0%									
	Maximum wait of 12 hours as Total Time in Department	2.00%	**Target**	10.00%	9.20%	8.40%	7.60%	6.80%	6.00%	5.20%	4.40%	4.00%	4.00%	3.00%	2.00%
			Actual	10.3%	9.5%	7.5%									
	Bed occupancy to 92%	92.00%	**Target**	96.74%	95.70%	95.00%	95.00%	94.60%	94.00%	93.50%	93.00%	93.50%	93.50%	92.80%	92.00%
			Actual	95.47%	95.38%	92.58%									
	Number of boarded patients	0	**Target**	38	19	10	0	0	0	0	0	0	0	0	0
			Actual	38	31	17									
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside to 5%	5.00%	**Target**	12%	11%	10%	9%	8%	7%	5%	5%	5%	5%	5%	5%
			Actual	11.00%	11.11%	10.20%									
Elective (diagnostics)	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	77.85%	**Target**	51.18%	52.05%	51.00%	49.93%	50.82%	54.59%	59.13%	64.23%	70.39%	77.85%	87.04%	95.03%
			Actual	46.90%	52.94%	49.32%									
Elective (long waits)	52 week waits	0	**Target**	2434	2214	2004	1763	1543	1303	1062	824	656	468	243	0
			Actual	2823	2561	2493									
	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	0	**Target**	368	295	226	146	73	0	0	0	0	0	0	0
			Actual	328	317	338									
	Eliminate >78 week waits	0	**Target**	5	0	0	0	0	0	0	0	0	0	0	0
			Actual	5	0	0									
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped	85.00%	**Target**	76.55%	77.28%	78.01%	78.74%	79.47%	80.20%	80.93%	81.66%	82.39%	83.12%	83.85%	84.58%
			Actual	80.28%	79.80%	77.34%									
Elective (Cancer)	Improve performance against the headline 62-day standard to 70% by March 2025.	70.00%	**Target**	50.00%	55.00%	58.00%	60.00%	62.00%	64.00%	66.00%	68.00%	70.00%	70.00%	70.00%	70.00%
			Actual	56.23%	59.11%	63.46%									
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.	77.00%	**Target**	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%
			Actual	73.32%	76.09%	76.47%									

Single Improvement Plan Board - OPERATIONAL CHARTS

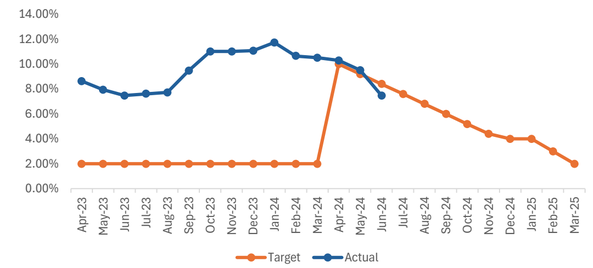
Compliance with 60 minute ambulance turnaround time target



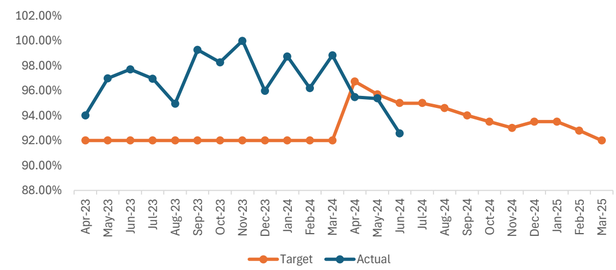
Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025



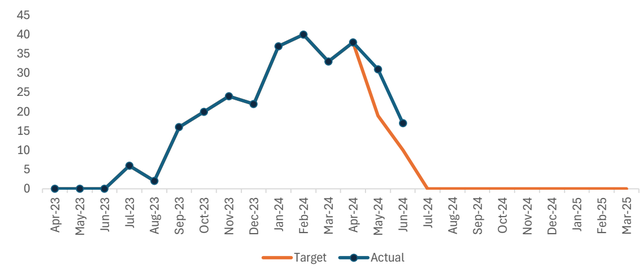
Maximum wait of 12 hours as Total Time in Department



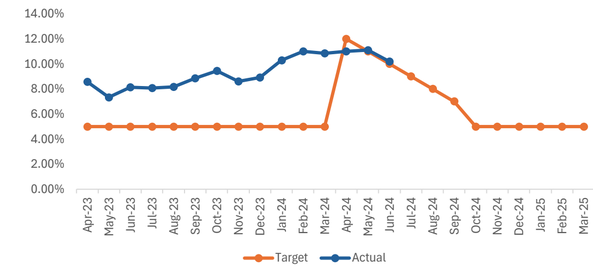
Bed occupancy to 92%



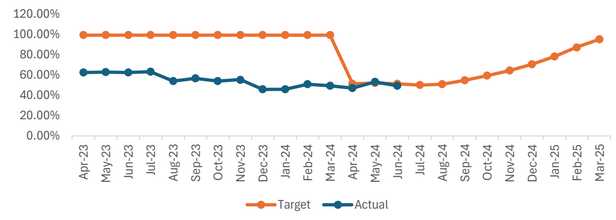
Number of boarded patients



Reduce not meeting criteria to reside to 5%

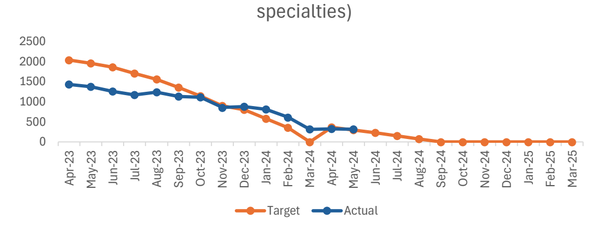


Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%

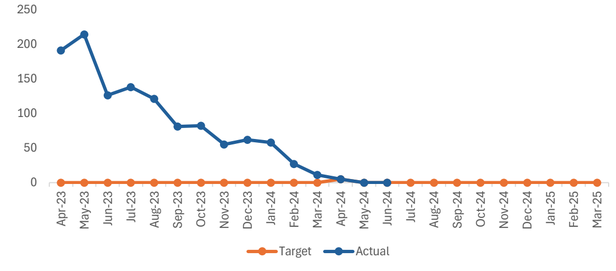


52 week waits

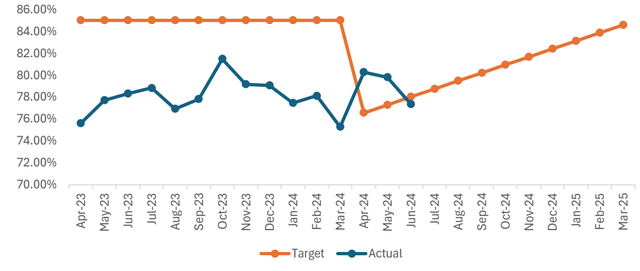
Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)



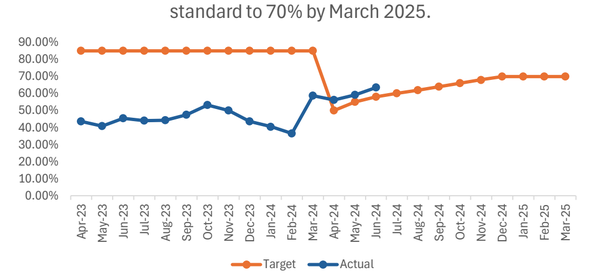
Eliminate >78 week waits



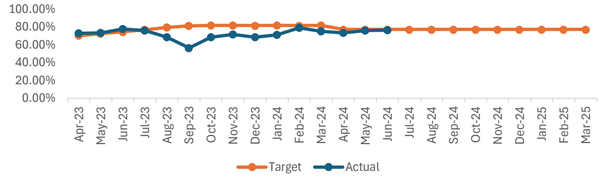
85% theatre utilisation - aggregate - Capped



Improve performance against the headline 62-day standard to 70% by March 2025.



Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.

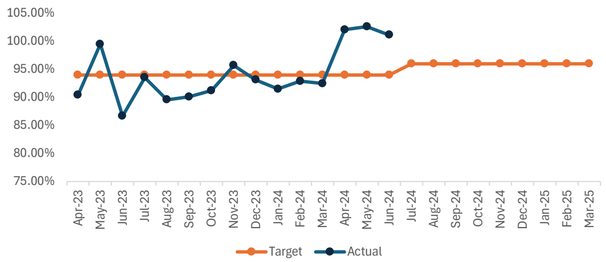


Single Improvement Plan - Board - SAFETY, QUALITY & EFFECTIVENESS KPI's

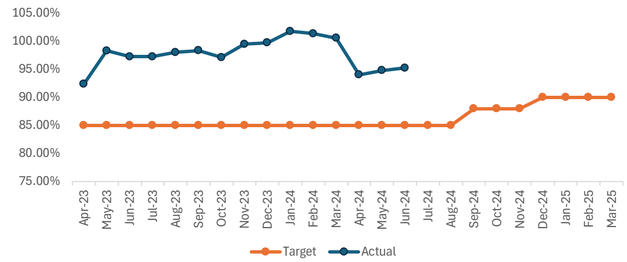
Programme	Monthly Indicators	Year End Target	Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Deliver Annual Safe Staffing Requirements	Overall Fill rate Registered Nurse (RN) and Health Care Assistant (HCA)	Fill rate >95% RN and HCA	Target	94.00%	94.00%	94.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
			Actual	102.09%	102.63%	101.16%									
	Overall Fill Rate Registered Midwife (RM) and Maternity Support Worker (MSW)	Fill rate >90% RM and MSW	Target	85.00%	85.00%	85.00%	85.00%	85.00%	88.00%	88.00%	88.00%	90.00%	90.00%	90.00%	90.00%
			Actual	94.04%	94.79%	95.27%									
Patient Experience and Involvement	Complaints per 1000 bed days	set same per 1000 bed rate as is current position (May-24 Actual used)	Target	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29
			Actual	1.14	1.29	1.08									
	STAR Accreditation all trust	116 green, 8 amber (Currently 75% in S&Q)	Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
			Actual	92.00%	92.00%	93.00%									
C Difficile Improvement	Performance against national trajectory - no more than 122 Hospital Acquired cases (2009)	122 - Final target 24/25	Target	11	11	10	10	10	10	10	10	10	10	10	10
			Actual	23	14	11									
Always Safety First	Hospital Standardised Mortality Ratio (56 Basket – Adult)	Target lower than expected or as expected	Target												
			Actual	66.3	81.6	63.5									
	Pressure Ulcers per 1000 beds days (Stage 2 and above)	5% reduction Last years OT - 5% profile to reflect less in summer more in winter.	Target	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68
			Actual	1.96	1.74	2.96									
Maternity	Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	Maintain compliance with the 10 safety actions for maternity services?	Target	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
			Actual	80%	80%	80%									
	Perinatal - Number of Stillbirths	Full definition to be confirmed	Target	0	0	0	0	0	0	0	0	0	0	0	0
			Actual	3	0	0									

Single Improvement Plan - Board - SAFETY, QUALITY & EFFECTIVENESS CHARTS

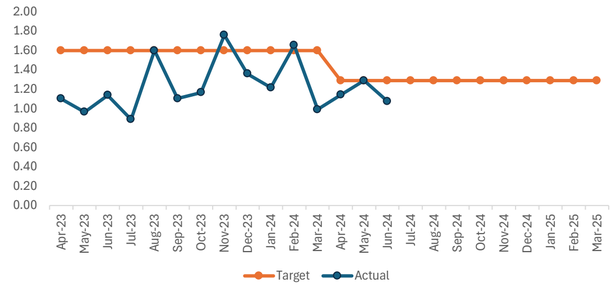
Overall Fill rate Registered Nurse (RN) and Health Care Assistant (HCA)



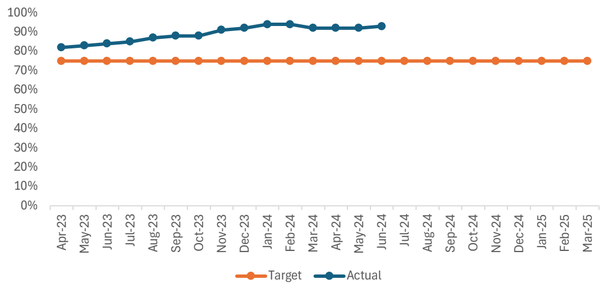
Overall Fill Rate Registered Midwife (RM) and Maternity Support Worker (MSW)



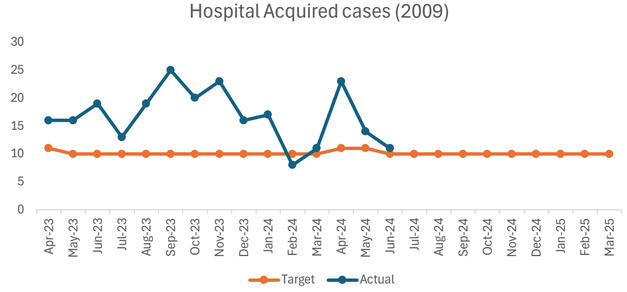
Complaints per 1000 bed days



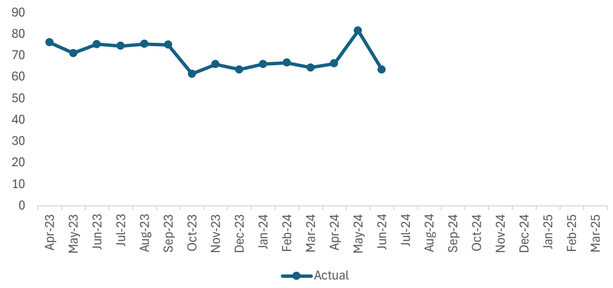
STAR Accreditation all trust



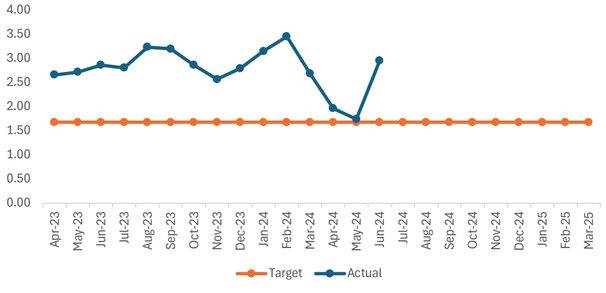
Performance against national trajectory - no more than 122 Hospital Acquired cases (2009)



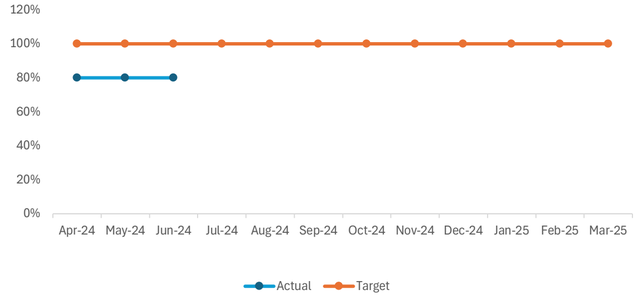
Hospital Standardised Mortality Ratio (56 Basket – Adult)



Pressure Ulcers per 1000 beds days (Stage 2 and above)



Maintain compliance with 10 CNST Safety Actions

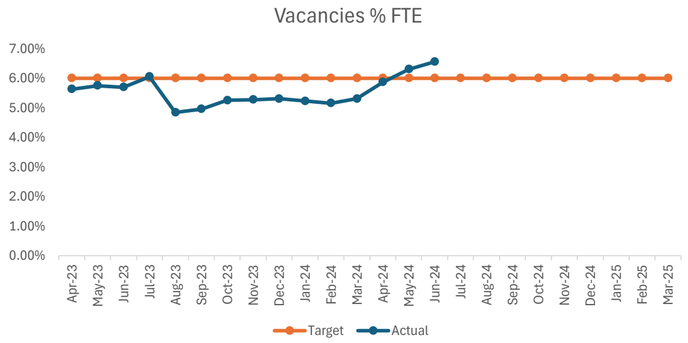


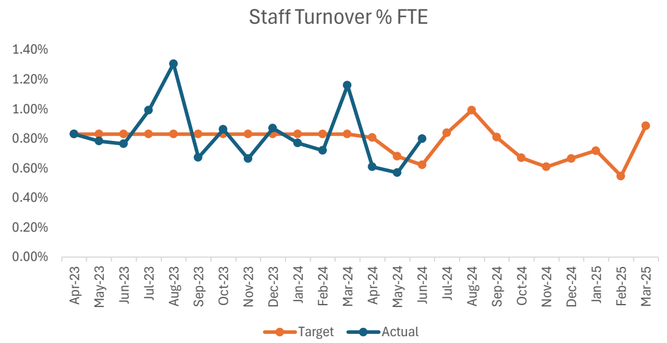
Perinatal - Number of Stillbirths

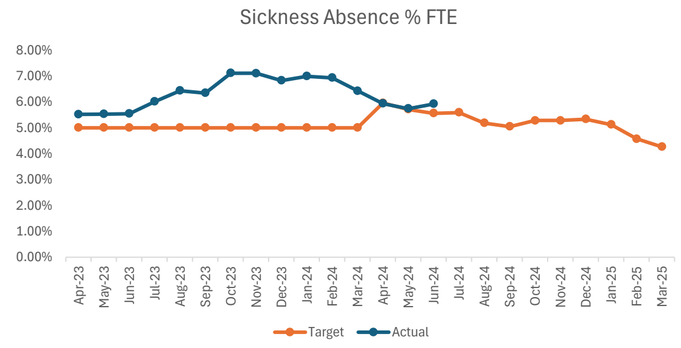
Single Improvement Plan - Board - PEOPLE & CULTURE KPI's

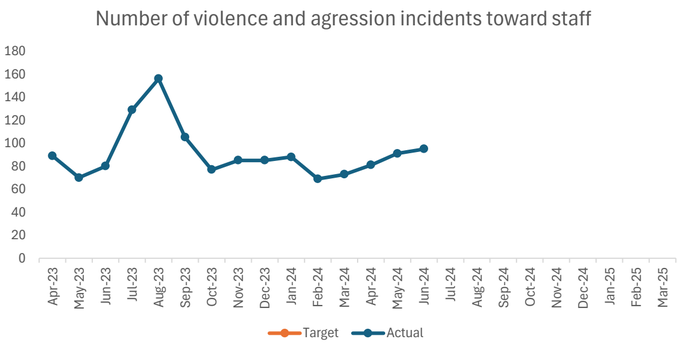
Programme	Monthly Indicators	Year End Target	Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People & Culture	Vacancies % FTE (source : general ledger)	≤ 6% FTE	**Target**	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
People & Culture			**Actual**	5.87%	6.30%	6.56%									
People & Culture	Turnover % FTE (annual assessment; ESR in-month reported)	8-11% FTE (annualised)	**Target**	0.81%	0.68%	0.62%	0.84%	0.99%	0.81%	0.67%	0.61%	0.67%	0.72%	0.55%	0.89%
People & Culture			**Actual**	0.61%	0.57%	0.80%									
People & Culture	Sickness Absence % FTE (annual assessment; in-month reported)	≤ 5.24% FTE (annualised)	**Target**	5.96%	5.71%	5.57%	5.59%	5.18%	5.05%	5.28%	5.28%	5.33%	5.12%	4.57%	4.27%
People & Culture			**Actual**	5.94%	5.74%	5.93%									
People & Culture	Number of violence and agression incidents toward staff (annual assessment; in-month reported)	TBC (10% reduction)	**Target**												
People & Culture			**Actual**	81	91	95									
People & Culture	Core Skills Mandatory Training compliance (module compliance reported)	≥ 90%	**Target**	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
People & Culture			**Actual**	93.30%	93.35%	94.15%									
People & Culture	Appraisal completion and appraisal quality audit results. (monthly and annual measures)	Above 90%	**Target**	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
People & Culture			**Actual**	89.36%	88.51%	86.85%									
Programme	**Quarterly Indicators**	**Year End Target**	**Month**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**
People & Culture	Staff Survey: Recommend Trust as place to work (quarterly metric)	≥ 60%	**Target**	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%
People & Culture			**Actual**	TBC											

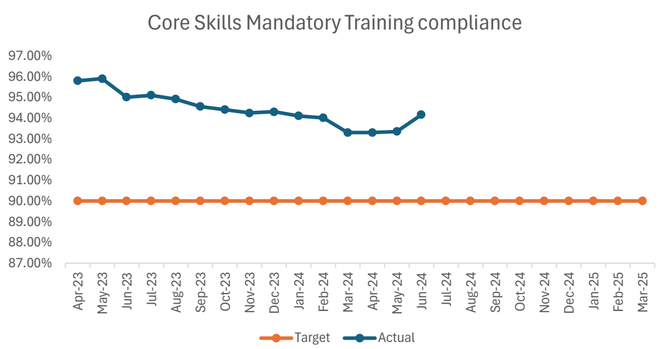
Single Improvement Plan - Board - PEOPLE & CULTURE CHARTS

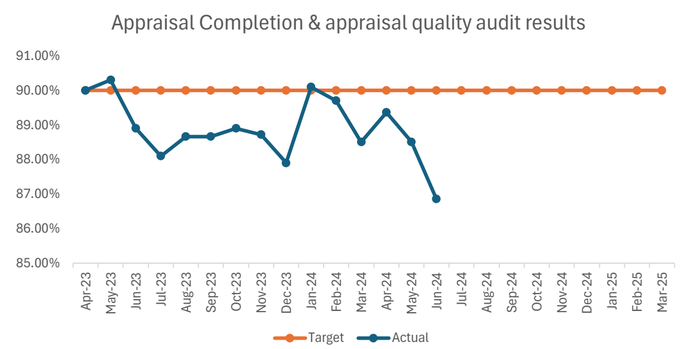












Single Improvement Plan - Board - FINANCE KPI's

Programme	Monthly Indicators	Year End Target	Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Financial Sustainability	I&E Normalised run rate		Target	-3675	-5326	-6482									
			Actual	-3675	-5236	-6297									
	FRP schemes delivery		Target	155	286	2872									
			Actual	1663	1025	1607									

Single Improvement Plan - Board - FINANCE CHARTS

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Single Improvement Plan Update			
Report to:	Board of Directors	**Date:**	1 August 2024
Report of:	Chief Executive	**Prepared by:**	A Brotherton
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to inform and update the board on the implementation of the Single Improvement Plan.

There has been significant progress since the last Board meeting with 100% of the financial recovery programme now having been identified with £58.2m of savings going through the sign off gateways. 39% of the programme is now risk rated as a low risk or in delivery (fully signed off), 45% of the programme is rated as medium risk (awaiting EQIA sign off) and 16% of the programme remains high risk or currently sits in the Trust idea hopper. The team has modelled three potential FRP scenarios. The best case scenario will see the Trust delivering its full plan and there is no gap to mitigate, but risk adjusted modelling of scenarios (based on the FRP gateways) highlights the Trust's most likely scenario is to have a gap of £15.8m (27%) which will still need to be mitigated. This means that the Trust needs to remain focused on the identification of additional schemes as much as delivering the established programme to mitigate slippage in delivery.

Significant work has been undertaken in each domain of the Single Improvement Plan and the project ratings for progress are presented in Appendix 1. Weekly Executive led huddles continue to support teams to deliver the priority programmes of work and the progress reported to the Single Improvement Plan portfolio board, chaired by the Chief Executive. A new Single Improvement Plan performance report has been developed (Appendix 2).

A Business case has been developed for the creation of a Programme Management Office to ensure sufficient capacity and capability to design and deliver the programmes and monitor progress.

The Board is asked to:

I. Review and discuss the progress made on the Single Improvement Plan.
II. Note the progress made on setting key metrics for monitoring at board level.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☒
Previous consideration			
Not applicable			

1. Context

The Trust has committed to the delivery of a three year Single Improvement Plan, which incorporates the financial recovery plan. The plan has five domains; Well-led, Safety, Quality and Effectiveness, Operational Performance, People and Culture and Financial Sustainability. Detailed plans have been developed and Executive leads are now leading weekly huddles to ensure the programmes are on track and to provide support to the teams to overcome any barriers.

Within the financial recovery programme, which is the current priority for delivery, there are five priority programmes and the divisional delivery (Figure 1). Whilst these programmes have been selected for the first phase of work because of the significant financial benefit, they also reflect our priorities from a safety and quality perspective and include improving Urgent and Emergency Care flow and demand, elective and diagnostics and key safety and quality improvements including improving Clostridium Difficile rates.

The Single Improvement Plan has been shared with the System Improvement Board and our exit criteria from the system improvement board will be discussed and are expected to be approved at the July System Improvement Board on 30th July 2024. This involves developing and finalising an agreed suite of metrics that will be reported to and monitored by the System Improvement Board. Although work has been completed to design the measures for the Single Improvement Plan (see Single Improvement Plan performance report), these will be updated as required to reflect all the measures that will be monitored by the System Improvement Board to ensure Board oversight of these metrics. Feedback was provided in the Finance and Performance committee held on 23rd July 2024 regarding development of measures that relate to strategic priorities and further work is now planned to update our integrated performance report, with input from the NHS England 'Making Data Count' lead. The proposal will be developed and discussed with Board.

2. Discussion

This paper outlines the progress made in two distinct phases; (i) the Financial Recovery Programme as our first wave of SIP delivery programmes and (ii) progress with the design and oversight of the three year Single Improvement Plan.

Review of Financial Governance and Development of the Financial Recovery plan

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

- The deadline set for full sign-off of the FRP programme by NHS England was 30th June 2024. Although the Trust have unfortunately missed this deadline; there is clear evidence of schemes being progressed through the FRP sign-off gateways with the aim of full sign off by the end of July 2024.

- There has been significant progress since the last Board with 100% of the programme now having been identified with £58.2m of savings going through the sign off gateways.

- 39% of the programme is now risk rated as a low risk or in delivery (fully signed off), 45% of the programme is rated as medium risk (awaiting EQIA sign off) and 16% of the programme remains high risk or currently sits in the Trust idea hopper.

- The team has modelled three potential FRP scenarios. The best case scenario will see the Trust delivering its full plan and there is no gap to mitigate, but risk adjusted modelling of scenarios (based on the FRP gateways) highlights the Trust's most likely scenario is to have a gap of £15.8m (27%) which will still need to be mitigated. This means that the Trust needs to remain focused on the identification of additional schemes as much as delivering the established programme to mitigate slippage in delivery.

- The FRP phasing shows that 46% of all savings are to be delivered in Q4 24/25. This represents a significant risk to this year's programme as well risk to 25/26 planning process.

- The current value of the FRP schemes remains broadly the same but through the validation of the programme we have removed over £15m of double counts, identified schemes which will not deliver or where the start dates or phasing have been overestimated. The validation process will continue until all PIDs are signed off and all Trust-wide high impact schemes are allocated to the divisions.

- Month 3 FRP position suggests that YTD, the Trust has overdelivered on its FRP by £0.98m; however, almost half of the savings are non-recurrent which reflects the fact that the programme was in development.

- Overall, less than 10% of the 24/25 FRP programme is classed as non-recurrent, which is unusually low and means that savings will continue to deliver in future years. The FYE of the savings identified is over £70m which reflects the Trust not having a plan in place at the start of 2024/25. This should have a positive impact on the mid-term financial plan for the Trust.

- The analysis of the source of the FRP efficiencies shows that 53% (£30.8m) of the schemes relate to pay, 25% (£14.7m) to non-pay and 22% (£12.7m) is generated through additional income. It is broadly expected that the income source would be slightly lower and the pay element slightly higher to provide more sustainable foundation for future years.

- The Trust cannot deliver this plan on its own and will need system support. There are £5.0m of system efficiencies planned from the Recovery and Transformation workstream (specific details not due until end of July 2024) and a further £5.0m of system procurement savings through LPC.

Delivery of the Trust's 3 year Single Improvement Plan.

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

- ***Updated the detailed plans on a page*** – further work has been undertaken to finalise the detailed plans on a page, especially in the well-led section for the enabling workstreams; digital, Business Intelligence, Continuous Improvement, Estates and Communications.

- ***Development of the SIP Performance report*** – Executive leads have undertaken further work to finalise the measures and trajectories that will be reported to Board and the BI team have developed the SIP measures report which will enable the Board to track progress (See attached). Feedback is sought from the Board members regarding suggestions for improvement before the final version is shared which incorporates the SIB Exit measures (see below).
- ***SIB Exit Criteria*** – a meeting has been held with the regional NHS England team and the ICB to finalise the metrics for the System Improvement Board exit criteria. Final comments have been sought on the amended metrics by NHS England colleagues and the final metrics should be signed off at the SIB Board meeting on 30th July 2024. Work will then be completed to review the exit criteria and add in any key metrics to the SIP report (where metrics are not reported elsewhere).
- ***Weekly huddles*** – have continued to be held though some have had to be stepped down due to competing priorities, especially in relation to prioritising the FRP as the first priority SIP programmes to be delivered.
- ***Leadership forums and team briefings*** – progress in key areas of the SIP, including Urgent and Emergency care, have been shared with the leadership team and in July's team brief and a SIP Communication plan has been developed.

Development of a Programme Management Office

A Business Case has been developed by the Turnaround Director which is now progressing through the approval's process. The establishment of a PMO will also require approval from the ICB as it is anticipated this will require external recruitment given the skills and expertise needed to establish and run an effective PMO function with the required capacity and capability in programme and project management given the scale and pace of the programmes that need to be delivered.

Collaborative working with System Partners

Work has continued to progress with system partners to deliver the priorities in the Singel Improvement Plan.

A detailed UEC Place delivery plan has now been developed by partners within Central Lancashire and reported to the UEC delivery Board. This will be shared with Board when finalised; the team are currently incorporating the feedback from the UEC Delivery Board.

The work to transform the approach to physical health services also continues to develop in line with the clinical strategy. The Clinical Strategy approved by Board in March 2022 and the refreshed Clinical Strategy presented to Board in December 2023 both included the community services ambition, with our strategic priority being to address longstanding UEC risks and deliver sustainable high quality services. In 2023 the ICB identified the highest performing parts of the LSC footprint have an integrated community and acute trust offer. The team is working with partners to develop a joint way of 'integrated' working with a view to developing a joint plan going forward to explore integration. The proposal for 2024/25 is to create an alliance model, shared approach to leadership and risk to develop our services 'as if' integrated. A Community delivery plan and measurement strategy is currently in development with future work being focused on seeking support of ICB and NHS England regional colleagues for the proposed direction of travel.

3. Financial implications

Financial sustainability is a key element of the plan. Some programmes may require additional investment to realise the full benefit, this detail will be developed as the work progresses as required.

4. Legal implications

None

5. Risks

Risks derived from individual projects and plans are being detailed and risk registers developed in line with our risk management policy.

6. Impact on stakeholders

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

Recommendations

The Board is asked to:

i) Review and discuss the progress made on the development and delivery of the Single Improvement Plan
ii) Note the progress made on setting key metrics for monitoring at board level

Appendices

Appendix 1: SIP Heatmap: RAYG rating of the projects

Appendix 2: SIP Performance Report

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Single Improvement Plan

Performance Pack
June 2024

SIP PROGRAMME STRUCTURE

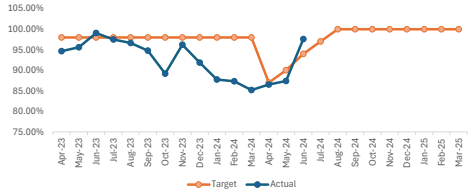
Well Led	People & Culture	Safety, Quality and effectiveness	Financial Sustainability	Operational Performance
Clear Vision and Strategy	Attract, Recruit and Resource	Deliver Annual Safe Staffing Requirements	3 Year FRP – Identify and Develop	UEC In Flow
Information Improvement	Engage, Retain, Reward &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

Single Improvement Plan - Board - OPERATIONAL KPI's

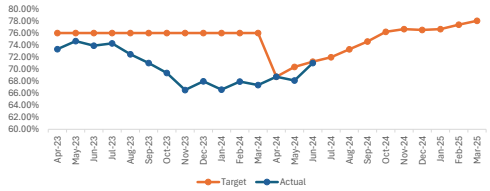
Programme	Monthly Indicators	Year End Target	Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
UEC In Flow	Compliance with 60 minute ambulance turnaround time target	100%	Target	87.00%	90.00%	94.00%	97.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
			Actual	86.53%	87.39%	97.60%									
	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	78.00%	Target	68.73%	70.36%	71.23%	71.98%	73.29%	74.60%	76.19%	76.65%	76.50%	76.65%	77.38%	78.03%
			Actual	68.7%	68.1%	71.0%									
	Maximum wait of 12 hours as Total Time in Department	2.00%	Target	10.00%	9.20%	8.40%	7.60%	6.80%	6.00%	5.20%	4.40%	4.00%	4.00%	3.00%	2.00%
			Actual	10.3%	9.5%	7.5%									
	Bed occupancy to 92%	92.00%	Target	96.74%	95.70%	95.00%	95.00%	94.60%	94.00%	93.50%	93.00%	93.50%	93.50%	92.80%	92.00%
			Actual	95.47%	95.38%	92.58%									
	Number of boarded patients	0	Target	38	19	10	0	0	0	0	0	0	0	0	0
			Actual	38	31	17									
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside to 5%	5.00%	Target	12%	11%	10%	9%	8%	7%	5%	5%	5%	5%	5%	5%
			Actual	11.00%	11.11%	10.20%									
Elective (diagnostics)	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	77.85%	Target	51.18%	52.05%	51.00%	49.93%	50.82%	54.59%	59.13%	64.23%	70.39%	77.85%	87.04%	95.03%
			Actual	46.90%	52.94%	49.32%									
Elective (long waits)	52 week waits	0	Target	2434	2214	2004	1763	1543	1303	1062	824	656	468	243	0
			Actual	2823	2561										
	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	0	Target	368	295	226	146	73	0	0	0	0	0	0	0
			Actual	328	317										
	Eliminate >78 week waits	0	Target	5	0	0	0	0	0	0	0	0	0	0	0
			Actual	5	0	0									
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped	85.00%	Target	76.55%	77.28%	78.01%	78.74%	79.47%	80.20%	80.93%	81.66%	82.39%	83.12%	83.85%	84.58%
			Actual	80.28%	79.80%	77.34%									
Elective (Cancer)	Improve performance against the headline 62-day standard to 70% by March 2025.	70.00%	Target	50.00%	55.00%	58.00%	60.00%	62.00%	64.00%	66.00%	68.00%	70.00%	70.00%	70.00%	70.00%
			Actual	56.23%	59.11%	63.46%									
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.	77.00%	Target	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%	77.00%
			Actual	73.38%	76.12%	76.63%									

Single Improvement Plan Board - OPERATIONAL CHARTS

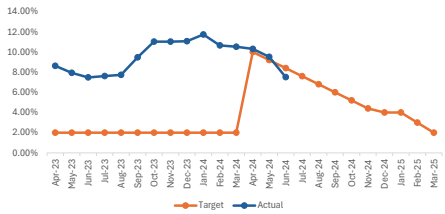
Compliance with 60 minute ambulance turnaround time target



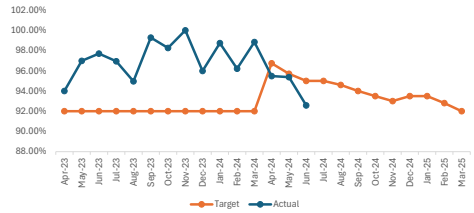
Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025



Maximum wait of 12 hours as Total Time in Department

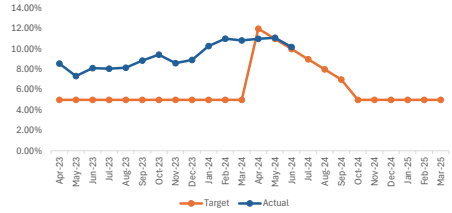


Bed occupancy to 92%

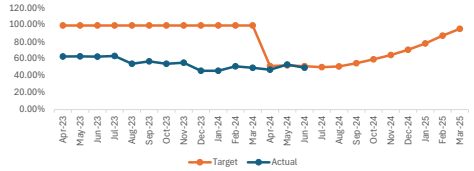


Number of boarded patients

Reduce not meeting criteria to reside to 5%

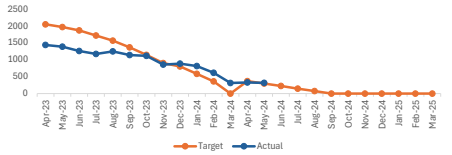


Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%

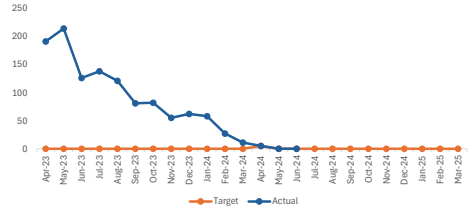


52 week waits

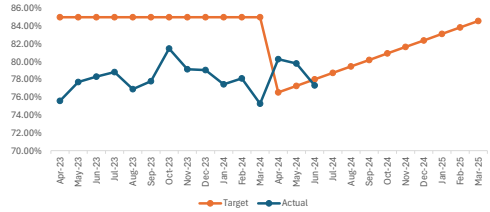
Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)



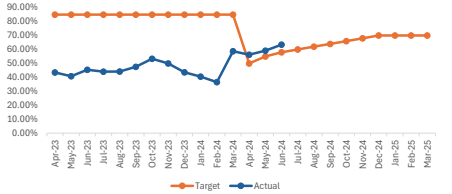
Eliminate >78 week waits



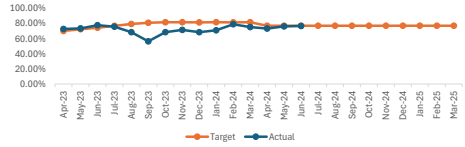
85% theatre utilisation - aggregate - Capped



Improve performance against the headline 62-day standard to 70% by March 2025.



Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026.

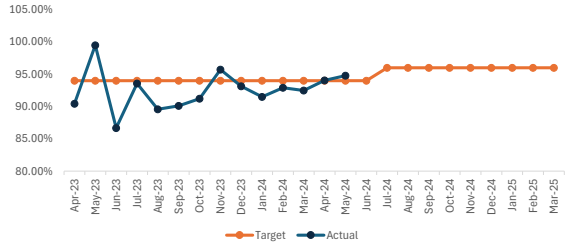


Single Improvement Plan - Board - SAFETY, QUALITY & EFFECTIVENESS KPI's

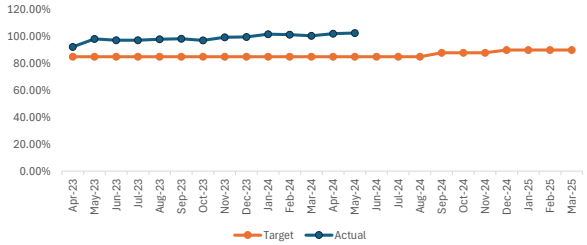
Programme	Monthly Indicators	Year End Target	Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Deliver Annual Safe Staffing Requirements	Overall Fill rate Registered Nurse (RN) and Health Care Assistant (HCA)	Fill rate >95% RN and HCA	Target	94.00%	94.00%	94.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
			Actual	94.04%	94.79%										
	Overall Fill Rate Registered Midwife (RM) and Maternity Support Worker (MSW)	Fill rate >90% RM and MSW	Target	85.00%	85.00%	85.00%	85.00%	85.00%	88.00%	88.00%	88.00%	90.00%	90.00%	90.00%	90.00%
			Actual	102.09%	102.63%										
Patient Experience and Involvement	Complaints per 1000 bed days	set same per 1000 bed rate as is current position (May-24 Actual used)	Target	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29	1.29
			Actual	1.14	1.29										
	STAR Accreditation all trust	116 green, 8 amber (Currently 75% in S&Q)	Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
			Actual	92.00%	92.00%										
C Difficile Improvement	Performance against national trajectory - no more than 122 Hospital Acquired cases (2009)	122 - Final target 24/25 TBC	Target	11	11	10	10	10	10	10	10	10	10	10	10
			Actual	23	14	11									
Always Safety First	Hospital Standardised Mortality Ratio (56 Basket – Adult)	within expected range	Target												
			Actual	48.5	64.4										
	Pressure Ulcers per 1000 beds days (Stage 2 and above)	5% reduction Last years OT - 5% profile to reflect less in summer more in winter.	Target	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68	1.68
			Actual	1.96	1.81										
Maternity	Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	Maintain compliance with the 10 safety actions for maternity services?	Target	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
			Actual	80%	80%										
	Perinatal - Number of Stillbirths	Full definition to be confirmed	Target	0	0	0	0	0	0	0	0	0	0	0	0
			Actual	3	0										

Single Improvement Plan - Board - SAFETY, QUALITY & EFFECTIVENESS CHARTS

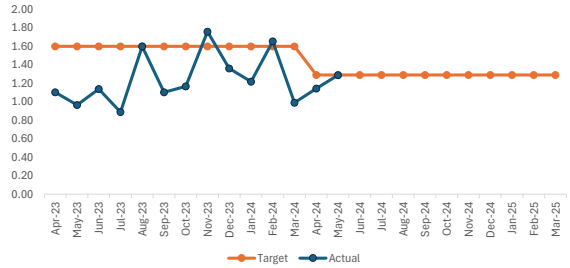
Overall Fill rate Registered Nurse (RN) and Health Care Assistant (HCA)



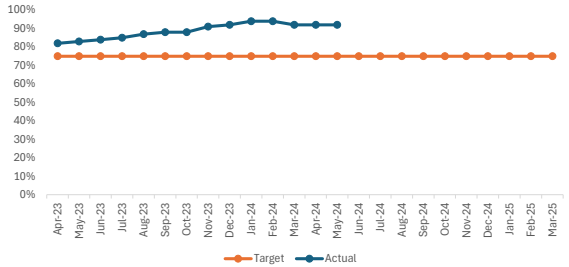
Overall Fill Rate Registered Midwife (RM) and Maternity Support Worker (MSW)



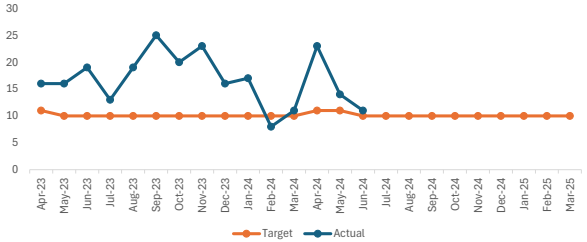
Complaints per 1000 bed days



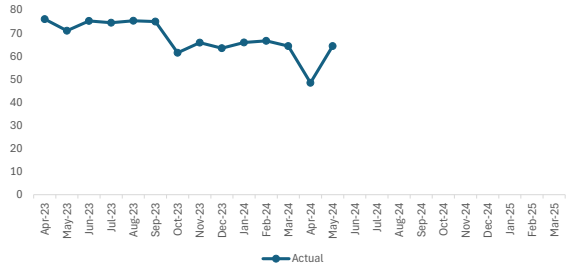
STAR Accreditation all trust



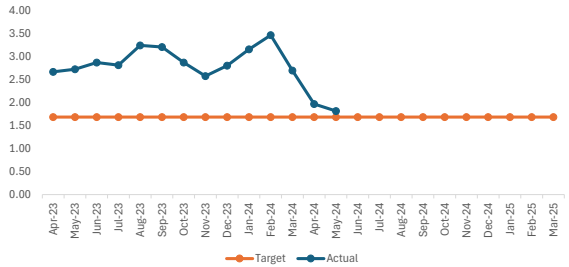
Performance against national trajectory - no more than 122 Hospital Acquired cases (2009)



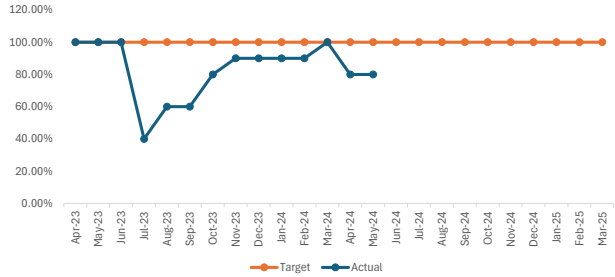
Hospital Standardised Mortality Ratio (56 Basket – Adult)



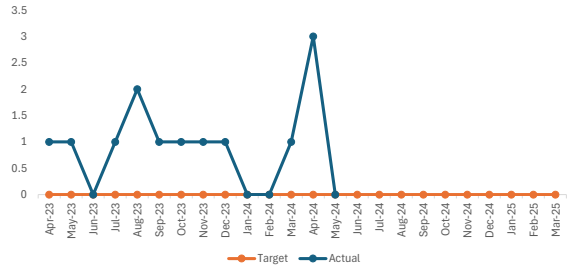
Pressure Ulcers per 1000 beds days (Stage 2 and above)



Maintain compliance with 10 CNST Safety Actions



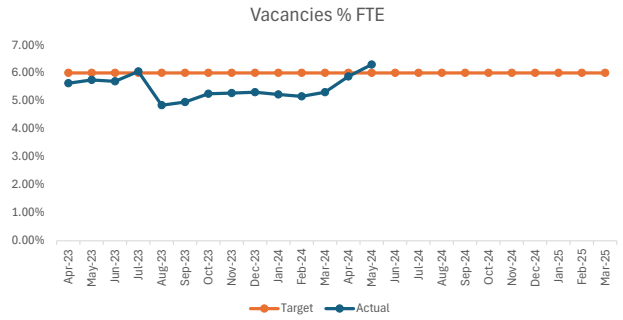
Perinatal - Number of Stillbirths

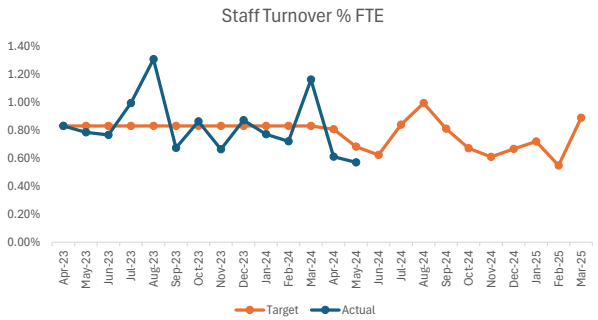


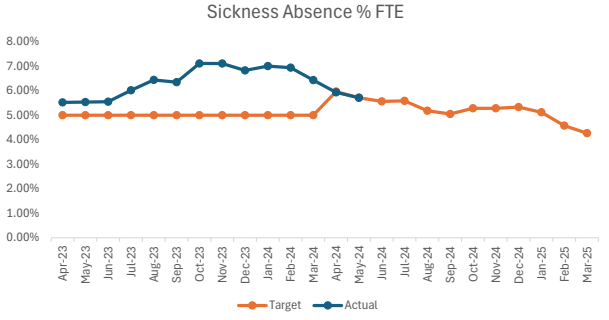
Single Improvement Plan - Board - PEOPLE & CULTURE KPI's

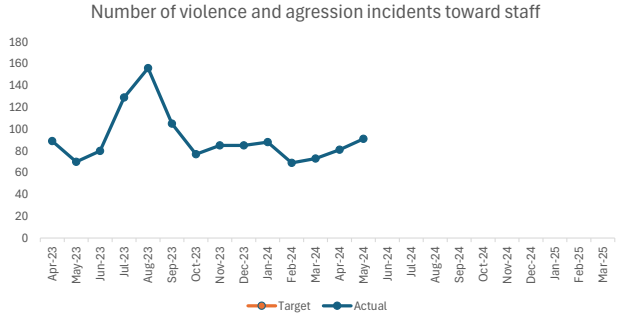
Programme	Monthly Indicators	Year End Target	Month	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
People & Culture	Vacancies % FTE (source : general ledger)	≤ 6% FTE	Target	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
People & Culture			Actual	5.87%	6.30%										
People & Culture	Turnover % FTE (annual assessment; ESR in-month reported)	8-11% FTE (annualised)	Target	0.81%	0.68%	0.62%	0.84%	0.99%	0.81%	0.67%	0.61%	0.67%	0.72%	0.55%	0.89%
People & Culture			Actual	0.61%	0.57%										
People & Culture	Sickness Absence % FTE (annual assessment; in-month reported)	≤ 5.24% FTE (annualised)	Target	5.96%	5.71%	5.57%	5.59%	5.18%	5.05%	5.28%	5.28%	5.33%	5.12%	4.57%	4.27%
People & Culture			Actual	5.93%	5.71%										
People & Culture	Number of violence and agression incidents toward staff (annual assessment; in-month reported)	TBC (10% reduction)	Target												
People & Culture			Actual	81	91										
People & Culture	Core Skills Mandatory Training compliance (module compliance reported)	≥ 90%	Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
People & Culture			Actual	93.30%	93.35%										
People & Culture	Appraisal completion and appraisal quality audit results. (monthly and annual measures)	Above 90%	Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
People & Culture			Actual	89.36%	88.51%										
Programme	**Quarterly Indicators**	**Year End Target**	**Month**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**
People & Culture	Staff Survey: Recommend Trust as place to work (quarterly metric)	≥ 60%	Target	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%	60.00%
People & Culture			Actual												

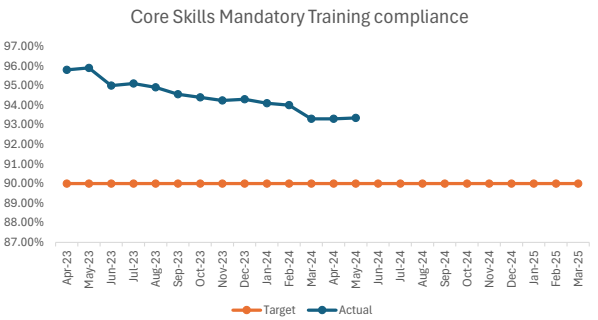
Single Improvement Plan - Board - PEOPLE & CULTURE CHARTS

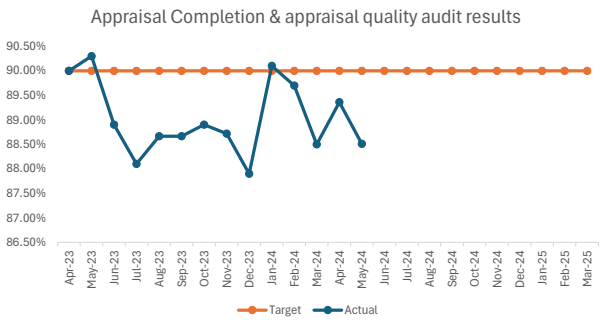












Board of Directors Report

New Hospitals Programme			
Report to:	Board of Directors	**Date:**	1st August 2024
Report of:	Chief Executive	**Prepared by:**	R Malin
Part I	✓	**Part II**	

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

Executive Summary:

Over the last period the New Hospital Programme (NHP) has focused on progressing the proposed site for a new Royal Preston Hospital. Advisors have completed the due diligence for this phase to demonstrate the viability of the proposed site. This has included further technical surveys, valuations and legals. The required business cases are progressing through the required local and national governance, checks and approvals and it is hoped an update can be provided over the coming months. Whilst a proposed site has been identified, this is subject to a public consultation and the Trust and Integrated Care Board remain open to alternative sites coming forward. These will be considered and assessed against the existing criteria.

This is a significant and exciting milestone for the Programme and we look forward to announcing the proposed site and embarking on a series of pre-consultation activities where we can hear the views of our patients, population, and workforce. The timeline of which will ultimately be determined by the critical dependencies, namely securing the land.

The Programme has also continued engagement with the national NHP team with regard to Hospital 2.0 – an integrated approach to provide optimised, standardised and repeatable solutions for hospital design, construction and operation. A range of documentation has been received for all schemes to review and comment. Whilst a new Royal Preston Hospital is some years away and Hospital 2.0 will continue to evolve, this is a real tangible step and starts to bring the design and workings of future hospitals to life. The Programme looks forward to continuing this valued and collaborative approach with the national NHP team.

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			

Chair's Report to Board		
Chair: T Watkinson	Committee: Audit	
Date(s): 21st June 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
N/A		2023-24 Annual Report and Accounts without issue

ALERT

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

The Committee have asked the Finance and Performance Committee to oversee the issues relating to the Data Quality PIFU report.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

Consideration was given to some unadjusted audit errors and assurance was received that these were not material, therefore the Committee was confident to recommend the accounts for approval. The Committee recognised the Trust needed to consider the transactions leading to the unadjusted audit errors was based on the advice and requirements from NHSE and the wider system. A similar situation had occurred in previous years and the matter would again be raised with the appropriate bodies.

ASSURE

Assurance received; Matters of positive note.

- The Committee expressed confidence in its own effectiveness, concluding that the committee's review processes are robust and that it is successfully fulfilling its duties.
- Substantial assurance from MIAA in their Head of Audit Opinion.
- Unqualified opinion provided by KPMG on the Trust's financial statements with no significant weaknesses in value for money arrangements.
- Recommendation to the Board of the 2023-24 Annual Report and Accounts without issue.

Audit Committee

21 June 2024 | 10.00am-12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.00am	Verbal	Information	T Watkinson
2.	Apologies for absence	10.01am	Verbal	Information	T Watkinson
3.	Declaration of interests	10.02am	Verbal	Information	T Watkinson
4.	Minutes of the previous meeting held on 3 May 2024	10.03am	✓	Decision	T Watkinson
5.	Matters arising and action log	10.05am	✓	Decision	T Watkinson
6.	Internal audit progress report	10.10am	✓	Assurance	MIAA
7. ANNUAL REPORT AND ACCOUNTS 2023-24					
7.1	Head of Internal Audit Opinion 2023-24	10.20am	✓	Assurance	MIAA
7.2	(a) Draft ISA 260 (b) External audit annual report 2023-24 (c) External Audit Opinion	10.30am	✓	Assurance	KPMG
7.3	(a) Draft financial accounts 2023-24 (b) List of movements from circulated accounts	10.45am	✓	Assurance	B Patel
7.4	Management representation letter: financial accounts 2023-24	11.00am	✓	Decision	KPMG
7.5	Draft Annual Report	11.10am	✓	Assurance	J Foote
7.6	Review of draft Annual Governance Statement (see pages 78 to 96)	11.20am	----	Assurance	J Foote
7.7	Approval of Audit Committee annual report 2023-24 (see pages 104 to 107)	11.30am	----	Assurance	T Watkinson
7.8	Recommendation of 2023-24 Annual Report and Accounts to Board of Directors	11.40am	Verbal	Decision	T Watkinson
8. Governance and Assurance					
8.1	Supplier Payments Process – Internal Controls	11.50am	✓	Assurance	B Patel
8.2	Committee Effectiveness Review	12.00pm	✓	Information	T Watkinson

№	Item	Time	Encl.	Purpose	Presenter
8.3	Items to alert, assure and advise to Board or refer to other committees	12.10pm	Verbal	Information	T Watkinson
8.4	Reflections on the meeting and adherence to the Board Compact	12.15pm	✓	Information	T Watkinson
8.5	LSC Audit Chairs' Briefing	12.20pm	Verbal	Information	T Watkinson
9. ITEMS FOR INFORMATION					
9.1	Strategic Risk Report		✓		
9.2	NHS FT Code of Governance compliance		✓		
9.3	Final Internal Audit Plan 24/25		✓		
9.4	**MIAA final audit reports**: a) Risk Management b) Data Quality Review - PIFU c) Mental Capacity Assessments & Rapid Tranquilisation Review d) BC & DR arrangements		✓ ✓ ✓ ✓		
9.5	Overseas Visitor Write Offs		✓		
9.5	Date, time and venue of next meeting: *19 September 2024, 10.30am, Microsoft Teams*	12.30pm	Verbal	Information	T Watkinson

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

NHS England Enforcement Undertakings

Report to:	Board of Directors	**Date:**	1st August 2024
Report of:	Chief Nursing Officer	**Prepared by:**	S Regan
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

The purpose of this paper is to provide the Board of Directors with details of the Replacement Enforcement Undertakings issued to the Trust by NHS England, and the Trust's response.

The Trust was considered to be in breach of its Provider Licence previously in 2015, 2018 and most recently in December 2021, which have remained in place.

Revised enforcement undertakings were accepted in December 2021 following annual deficits of £50.4m in 2018/19 and £58.4m in 2019/20 (excluding funding from the Provider Sustainability Fund). The financial position in 2020/21 and 2021/22 was distorted due to financial support provided by the government during the COVID-19 pandemic. However, the Trust was still considered to have a significant underlying deficit during these years that would require addressing once the system returned to normal funding arrangements.

Since this point, the Trust has reported an annual deficit of £35.6m for 2023/24 and there is a further deficit planned for 2024/25. Additionally, NHS England have identified quality, performance and patient safety intelligence that suggest fundamental and significant issues relating to governance and leadership.

The Care Quality Commission carried out an unannounced inspection May 2023 to July 2023 of urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine and surgery at Royal Preston Hospital. A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions. CQC also inspected the well led key question for the Trust overall, with the inspection report published on 24 November 2023.
The Licensee was rated as follows:

Overall trust quality rating:	Requires Improvement	
Are services safe?	Requires Improvement	
Are services effective?	Requires Improvement	
Are services caring?	Good	
Are services responsive?	Requires Improvement	
Are services well-led?	Requires Improvement	

The Trusts overall well led rating was downgraded from good to requires improvement at this inspection and was found to have breached a number of the relevant regulations and the report sets out the action the Trust must take to ensure compliance with the relevant legal requirements. The Trust has remained in Requires Improvement since 2014.

NHS England formally notified the Trust that it has reasonable grounds to suspect that it is in breach of the conditions of its provider licence, and draft Replacement Enforcement Undertakings were issued to the Trust on 1st July 2024.

The Trust notified NHS England that it accepted the Replacement Enforcement Undertakings on 4th July 2024 and the final Enforcement Undertakings were issued to the Trust on 9th July 2024. A copy of the undertakings can be found at Appendix 1 and these supersede the undertakings agreed in December 2021.

NHS England is therefore now accepting revised financial undertakings and new quality undertakings to reflect the current position. The financial undertakings in this document replace the previous undertakings, some of which are no longer appropriate due to the passage of time and changes in the Licensee's circumstances. The Trust has prepared a response to the undertakings, which are to be presented to the System Improvement Board (SIB) for approval on 30th July 2024. A copy is attached at Appendix 2.

The Single Improvement Plan (SIP) is the overarching improvement plan for LTH and contains, within each of the programmes of work, improvement plans focused on the priorities of the organisation. This includes the financial recovery plan, the CQC Quality Improvement plan and the Undertakings action plan.

There are a number of documents that require agreement with NHS England in line with the undertakings, these will be presented to the System Improvement Board. These include the:

- Enforcement Undertakings Delivery plan
- LTH financial recovery plan
- Single Improvement plan
- Quality Improvement plan (Response to CQC must and should do's)

The undertakings action plan will be monitored and reported to Board through the Single Improvement Plan and provides a direct response to the specific NHS England undertakings.

It is recommended that Board of Directors:

i. Note the Enforcement Undertakings.
ii. Note the improvement plan submitted to the System Improvement Board (SIB) for approval.

Appendix 1 – Lancashire Teaching Hospitals NHS Foundation Trust: Final Replacement Enforcement Undertakings
Appendix 2 – Trust's response to the Enforcement Undertakings

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. Background

1.1 The purpose of this paper is to provide the Board of Directors with details of the Replacement Enforcement Undertakings issued to the Trust by NHS England, and the Trust's response.

1.2 In June 2015, Monitor imposed additional licence conditions on the Trust following concerns over leadership and governance evidenced, inter alia, by a forecast deficit of £46.8m for 2015/16.

1.3 In May 2018, NHS Improvement (acting as Monitor) accepted enforcement undertakings from the Trust under section 106 of the Act following reported annual deficits of £25m in 2016/17 and £37.6m in 2017/18, with a forecast deficit of £46.4m for 2018/19.

1.4 Revised enforcement undertakings were accepted in December 2021 following annual deficits of £50.4m in 2018/19 and £58.4m in 2019/20 (excluding funding from the Provider Sustainability Fund). The financial position in 2020/21 and 2021/22 was distorted due to financial support provided by the government during the COVID-19 pandemic. However, the Trust was still considered to have a significant underlying deficit during these years that would require addressing once the system returned to normal funding arrangements.

1.5 Since this point, the Trust has reported an annual deficit of £35.6m for 2023/24 and there is a further deficit planned for 2024/25. Additionally, NHS England have identified quality, performance and patient safety intelligence that suggest fundamental and significant issues relating to governance and leadership.

1.6 The Care Quality Commission carried out an unannounced inspection May 2023 to July 2023 of urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine and surgery at Royal Preston Hospital. A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions. CQC also inspected the well led key question for the Trust overall, with the inspection report published on 24 November 2023.

1.7 The Licensee was rated as follows:

Overall trust quality rating:	Requires Improvement	
Are services safe?	Requires Improvement	
Are services effective?	Requires Improvement	
Are services caring?	Good	
Are services responsive?	Requires Improvement	
Are services well-led?	Requires Improvement	

2 The Trusts overall well led rating was downgraded from good to requires improvement at this inspection and was found to have breached a number of the relevant regulations and the report sets out the action the Trust must take to ensure compliance with the relevant legal requirements. The Trust has remained in Requires Improvement since 2014.

2. Discussion

2.1 Breach of Licence

2.1.1 NHS England formally notified the Trust on 1st July 2024 that it has reasonable grounds to suspect that it is in breach of the following conditions of its provider licence:

2023 Licence	Summary of condition
NHS2(5)(a) to (d) and (f)	The Licensee shall establish and effectively implement systems and/or processes: (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence.
NHS2(6)(a) to (d) and (f)	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) the collection of accurate, comprehensive, timely and up to date information on quality of care; (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.
NHS2(7)	Appropriate Board members and staff to ensure compliance with the licence conditions.
CoS3	Standards of corporate governance and financial management.

2.2 Undertakings

2.2.1 Draft enforcement undertakings were received by the Trust on 1st July 2024. The Trust agreed to accept the undertakings on 4th July 2024, and the final enforcement undertakings were issued to the Trust on 9th July 2024.

2.2.2 A copy of the undertakings can be found at Appendix 1. These undertakings supersede any of the undertakings agreed in December 2021 that remain in place.

2.2.3 The Trust has prepared a response to the undertakings, which are to be presented to the System Improvement Board (SIB) for approval on 30th July 2024. A copy is attached at Appendix 2.

2.2.4 The undertakings action plan will be monitored and reported to Board through the Single Improvement Plan and provides a direct response to the specific NHS England undertakings.

3. Financial implications

3.1 The trusts financial position has contributed to the requirement for enforcement action.

4 Legal implications

4.1 The Trust is in breach of its provider licence. Any further breaches or failure to respond to the enforcement undertakings could result in further enforcement action.

5. Risks

5.1 The Trust is in breach of its provider licence, which presents a risk of further enforcement action.

6. Impact on stakeholders

6.1 The actions necessary to comply with the enforcement undertakings may impact stakeholders positively should the areas for improvement be rectified.

6.2 The potential negative impact of any financial decisions is reviewed as part of the Trust's EQuality Impact Assessment (EQIA) process. All final decisions are taken by the Executive Team with oversight through Safety and Quality Committee, a Committee of the Board.

7. Recommendations

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

I. Note the Enforcement Undertakings.
II. Note the improvement plan submitted to the System Improvement Board (SIB) for approval.

NHS England

Ref MG HH 2024-07-09

Silas Nicholls
Chief Executive Officer
Lancashire Teaching Hospitals -
NHS Foundation Trust ("the Licensee")
Royal Preston Hospital
Sharoe Green Lane
Fulwood
Preston
PR2 9HT

Dr Michael Gregory
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

england.businessoffice-nw@nhs.net

09 July 2024

By email

Dear Silas

Lancashire Teaching Hospitals NHS Foundation Trust: Final Replacement Enforcement Undertakings

Thank you for your letter of 4 July 2024 confirming acceptance of the amended Draft Replacement Enforcement Undertakings.

I am pleased to enclose the final version of the Replacement Enforcement Undertakings (Appendix A) for signing by the Trust within the next seven days.

We look forward to continue working with the Trust in its commitment to improve services and outcomes for patients in respect of quality and finance and will monitor improvements made via the System Improvement Board.

Please do not hesitate to contact me or a member of my team, should you wish to discuss the content of this letter or any related issues in more detail.

Yours sincerely

Dr Michael Gregory

Interim Regional Director (North West)

NHS England

Appendix A

REPLACEMENT ENFORCEMENT UNDERTAKINGS

LICENSEE:

Lancashire Teaching Hospitals NHS Foundation Trust ("the Licensee")
Royal Preston Hospital
Sharoe Green Lane
Fulwood
Preston
PR2 9HT

DECISION

NHS England, on the basis of the grounds set out below, and having regard to its Enforcement Guidance, has decided to accept from the Licensee the enforcement undertakings specified below pursuant to its powers under section 106 of the Health and Social Care Act 2012 ("the Act").

BACKGROUND

In June 2015, Monitor imposed additional licence conditions on the Licensee following concerns over leadership and governance evidenced, inter alia, by a forecast deficit of £46.8m for 2015/16.

In May 2018, NHS Improvement (acting as Monitor) accepted enforcement undertakings from the Licensee under section 106 of the Act following reported annual deficits of £25m in 2016/17 and £37.6m in 2017/18, with a forecast deficit of £46.4m for 2018/19.

Revised enforcement undertakings were accepted in December 2021 following annual deficits of £50.4m in 2018/19 and £58.4m in 2019/20 (excluding funding from the Provider Sustainability Fund). The financial position in 2020/21 and 2021/22 was distorted due to financial support provided by the government during the COVID-19 pandemic. However, the Licensee was still considered to have a significant underlying deficit during these years that would require addressing once the system returned to normal funding arrangements.

Since this point, the Licensee has reported an annual deficit of £35.6m for 2023/24 and has a planned deficit of £21.9m for 2024/25, which excludes the non-recurrent allocations.
Additionally, there is evidence through triangulation by NHSE of quality, performance and patient safety intelligence that suggest fundamental and significant issues relating to governance and leadership.

The Care Quality Commission carried out an unannounced inspection May 2023 to July 2023 of urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine and surgery at Royal Preston Hospital. A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions. CQC also inspected the well led key question for the Trust overall, with the inspection report published on 24 November 2023. The Licensee was rated as follows:

Overall trust quality rating:	Requires Improvement	
Are services safe?	Requires Improvement	
Are services effective?	Requires Improvement	
Are services caring?	Good	
Are services responsive?	Requires Improvement	
Are services well-led?	Requires Improvement	

The Licensee was found to have breached a number of the relevant regulations and the report sets out the action the Licensee must take to ensure compliance with the relevant legal requirements. The Licensee has remained in Requires Improvement since 2014.

NHS England is therefore now accepting revised financial undertakings and new quality undertakings to reflect the current position. The financial undertakings in this document replace the previous undertakings, some of which are no longer appropriate due to the passage of time and changes in the Licensee's circumstances.

GROUNDS

1. Licence

1.1 The Licensee is the holder of a licence granted under section 87 of the Act.

2. Breaches

2.1 NHS England has reasonable grounds to suspect that the Licensee has provided and is providing health care services for the purposes of the NHS in breach of the following conditions of its licence:

2023 Licence	Summary of condition
NHS2(5)(a) to (d) and (f)	The Licensee shall establish and effectively implement systems and/or processes: (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of health care professions; (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); ((f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence.
NHS2(6)(a) to (d) and (f)	The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure: (a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

	(c) the collection of accurate, comprehensive, timely and up to date information on quality of care; (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; ((f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.
NHS2(7)	Appropriate Board members and staff to ensure compliance with the licence conditions.
CoS3	Standards of corporate governance and financial management.

3. Finance

3.1 In particular, the Licensee:

3.1.1 has reported an annual deficit of £ (35.6) m for 2023/24.

3.1.2 set a deficit plan for 2024/25 of £ (22) m.

3.1.3 has a significant underlying deficit of concern.

3.2 The matters set out above demonstrate a failure of financial governance arrangements and financial management by the Licensee, including, in particular:

3.2.1 a failure by the Licensee to adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

(a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

3.2.2 a failure to establish and effectively implement systems and/or processes:

(a) to ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively; and

(b) for effective financial decision-making, management, and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern)

4. Quality

4.1 The Licensee:

4.1.1 Has been subject to a series of quality concerns relating to patient safety, the environment, medical staffing levels and competency of staff as reflected at the CQC Inspection .

4.1.2 Was inspected by CQC between May to July 2023. The inspection included urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine and surgery at Royal Preston Hospital. A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions. The Licensee was inspected overall in relation to the well led question. The Licensee was rated overall as Requires Improvement, with Safe, Effective, Responsive and Well led as Requires Improvement and Caring as Good. The findings from this inspection demonstrated a significant number of breaches of the relevant regulations.

4.2 The matters above and those specifically set out below, arising from the CQC inspection, demonstrate a failure to establish and implement effective governance arrangements including, in particular, a failure to establish and effectively implement systems and/or processes to:

(a) ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

(b) ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Care Quality Commission;

(c) ensure that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(d) ensure that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(e) ensure that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care.

4.3 The specific matters referred to above are:

(a) a failure by the Licensee to ensure that patient identifiable information is not visible to visitors to the Urgent and Emergency Care Unit.

(b) a failure by the Licensee to ensure that risk assessments are fully completed for patients attending the Urgent and Emergency Care Unit with mental health needs and mitigating actions to limit identified risks are implemented.

(c) a failure by the Licensee to ensure patients receive antimicrobials in line with the national guidelines.

(d) a failure by the Licensee to improve compliance for resuscitation training for medical and nursing staff and compliance for sepsis training for medical staff.

(e) a failure by the Licensee to continue to take actions to improve referral to treatment waiting time performance in line with national standards.

(f) a failure by the Licensee to take actions to improve the number of patients receiving clinical assessment and daily review by a senior decision maker within target timescales.

(g) a failure by the Licensee to ensure that checks of consumables are completed including integrity of packaging and within expiry dates.

(h) a failure by the Licensee to ensure patients with a mental health concern are cared for in a room that is free from objects that could be used to self - harm.

(i) a failure by the Licensee to ensure equipment is secure, suitable for the purpose for which it is being used and properly maintained. This includes but is not limited to emergency equipment and firefighting equipment.

(j) a failure by the Licensee to ensure that staff complete patient records accurately and in a timely manner.

(k) a failure by the Licensee to ensure that patient records are kept secure.

(l) a failure by the Licensee to ensure they have enough medical staff to keep patients safe.

(m) a failure by the Licensee to ensure staff receive appropriate training as is necessary to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support and pool evacuation training, resuscitation and sepsis training.

(n) a failure by the Licensee to ensure staff complete mandatory training in accordance with the relevant schedule and receive sufficient training, supervision and appraisal to perform their duties competently.

5. General

5.1 In addition, the matters outlined above demonstrate:

5.1.1 a failure to ensure the existence and effective operation of systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the licence conditions.

5.1.2 a failure to establish and effectively implement systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licensee's operations.

5.1.3 a failure to establish and effectively implement systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the conditions of its Licence, including but not limited to systems and/or processes for escalating and resolving quality issues.

6. Need for Action

6.1 NHS England believes that the action, which the Licensee has undertaken to take pursuant to these undertakings, is action to secure that the breaches in question do not continue or recur.

7. Appropriateness of Undertakings

7.1 In considering the appropriateness of accepting in this case the undertakings set out below, NHS England has taken into account the matters set out in its Enforcement Guidance.

NHS England

UNDERTAKINGS

NHS England has agreed to accept, and the Licensee has agreed to give the following undertakings, pursuant to section 106 of the Act. These undertakings supersede any of the undertakings agreed in December 2021 that remain in place.

1. Financial Planning

1.1 The Licensee will deliver the Licensee's 2024/25 Financial Plan unless otherwise agreed.

1.2 The Plan should be consistent with the medium-term system plan currently in production, which sets out a trajectory for the Integrated Care System to achieve underlying financial balance by 2026/27.

1.3 The Licensee will keep the Financial Plans and their delivery under review. Where matters are identified which materially affect the Licensee's ability to meet the requirements of paragraph (1.1), whether identified by the Licensee or another party, the Licensee will notify NHS England as soon as practicable and update and resubmit the Financial Plan within a timeframe to be agreed with NHS England.

2. Distressed Funding

2.1 Where interim support financing or planned term support financing is provided by the Secretary of State for Health and Social Care to the Licensee pursuant to section 40 of the NHS Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.

2.2 The Licensee will comply with any reporting requests made by NHS England in relation to any financing provided or to be provided to the Licensee by the Secretary of State for Health and Social Care pursuant to section 40 of the NHS Act 2006.

3. Quality of Care

3.1 The Licensee will take all reasonable steps to address and rectify the breaches identified in the CQC report dated 24 November 2023 within such timescales to be agreed with NHS England. The Licensee will agree any amendments to the Quality Improvement Plan with NHS England and the ICB.

3.2 The Licensee will develop and submit to Lancashire and South Cumbria ICB and NHS England, a Quality Improvement Plan detailing actions which it will take to ensure compliance with paragraph 3.1 above, including key milestones and timelines, for approval by NHS England and the ICB.

3.3 Specifically, and in line with the actions set out as required in the CQC report, the Licensee will ensure the Quality Improvement Plan includes actions that will ensure robust governance processes in relation to timely identification and management of risk including processes for shared learning.

3.4 The Licensee will, as part of the Quality Improvement Plan, set out a workforce strategy to ensure sufficient numbers of suitably qualified, competent and experienced staff are available to enable them to meet all regulatory requirements.

3.5 The Licensee will ensure that its oversight and assurance processes in relation to the delivery of the actions in the Quality Improvement Plan are robust. The Licensee will demonstrate progress against the Plan in line with the agreed timelines through the Licensee's internal governance arrangements and enabling external oversight by the ICB and NHS England. Progress against the Quality Improvement Plan will be presented monthly to the System Improvement Board (SIB) until otherwise agreed with NHS England and the ICB.

3.6 The Licensee will keep the Quality Improvement Plan and its delivery under review. Where matters are identified which materially affect the Licensee's ability to meet the requirements of paragraph 3.1, whether identified by the Licensee or another party, the Licensee will notify the ICB and NHS England as soon as practicable and update and resubmit the amended Quality Improvement Plan for NHS England and ICB approval within the timeframe agreed with NHS England and the ICB.

3.7 The Licensee will ensure that the Plan is updated as necessary, with the agreement of NHS England and the ICB, to include any quality related recommendations from external independent investigations.

3.8 The Licensee will take all reasonable steps to deliver the Quality Improvement Plan, in accordance with the timeframes set out in the Plan, unless otherwise agreed with NHS England.

The Licensee will work in partnership with the Provider Collaborative and ICB to support the timely delivery of the System Clinical Strategy.

4. Reporting

4.1 The Licensee will provide regular reports to NHS England on its progress in meeting the undertakings set out above.

4.2 The Licensee will attend SIB meetings, or, if NHS England stipulates, conference calls, at such times, and with such attendees, as may be required by NHS England, to discuss its progress in meeting the undertakings. The SIB meetings will take place once a month unless NHS England otherwise stipulates, at a time and place to be specified by NHS England and with attendees specified by NHS England.

4.3 Upon request, the Licensee will provide NHS England with the evidence, reports or other information relied on by its Board in relation to assessing its progress in delivering these undertakings.

4.4 The Licensee will comply with any additional reporting or information requests made by NHS England.

The undertakings set out above are without prejudice to the requirement on the Licensee to ensure that it is compliant with all the conditions of its licence, including any additional licence condition imposed under the Act and those conditions relating to:

- compliance with the health care standards binding on the Licensee; and
- compliance with all requirements concerning quality of care.

Any failure to comply with the above undertakings will render the Licensee liable to further formal action by NHS England. This could include the imposition of discretionary requirements under section 105 of the Act in respect of the breach in respect of which the undertakings were given and/or revocation of the licence pursuant to section 89 of the Act.

Where NHS England is satisfied that the Licensee has given inaccurate, misleading or incomplete information in relation to the undertakings: (i) NHS England may treat the Licensee as having failed to comply with the undertakings; and (ii) if NHS England decides so to treat the Licensee, NHS England must by notice revoke any compliance certificate given to the Licensee in respect of compliance with the relevant undertakings.

LICENSEE

Signed (Chair or Chief Executive of Licensee)

Dated:

NHS ENGLAND

Signed (North West Regional Director)

Dated:

Ref	NHS England Enforcement Undertakings Workstream	Assigned to	Status	Evidence	Narrative Update	Milestone target end date	Q1 24/25 Apr	May	Jun	Q2 24/25 Jul	Aug	Sep	Q3 24/25 Oct	Nov	Dec	Q4 24/25 Jan	Feb	Mar
1	**Financial Planning**																	
1.1	**The Licensee will deliver the Licensee's 2024/25 Financial Plan unless otherwise agreed.**																	
1.1.1	Appoint a Turnaround Director.	Silas Nicholls	Complete	JR in post.		31.5.24												
1.1.2	Develop a financial recovery plan (FRP) for 2024/25 that is approved by ICB/NHS England System Improvement Board.	Jitka Roberts	In Progress/ On track	Financial recovery Plan		30.06.24												
1.1.3	Achieve approval of FRP through ICB/NHS England	Jitka Roberts	In Progress/ On track			31.07.24												
1.1.4	Deliver the Financial Recovery Plan	Jitka Roberts	In Progress/ On track			31.03.25												
1.1.5	Monitor delivery of FRP, utilising the performance and accountability framework.	Jonathan Wood	In Progress/ On track			31.03.25												
1.1.6	**Deliver the Trust Financial Plan**																	
1.1.7	Deliver Month 3 2024/25 plan	Jonathan Wood	Complete	Financial Plan Month 3		30.06.24												
1.1.8	Deliver Month 4 2024/25 plan	Jonathan Wood	In Progress/ On track	Financial Plan Month 4		31.07.24												
1.1.9	Deliver Month 5 2024/25 plan	Jonathan Wood	Not Started	Financial Plan Month 5		31.08.24												
1.1.10	Deliver Month 6 2024/25 plan	Jonathan Wood	Not Started	Financial Plan Month 6		30.09.24												
1.1.11	Deliver Month 7 2024/25 plan	Jonathan Wood	Not Started	Financial Plan Month 7		31.10.24												
1.1.12	Deliver Month 8 2024/25 plan	Jonathan Wood	Not Started	Financial Plan Month 8		30.11.24												
1.1.13	Deliver Month 9 2024/25 plan	Jonathan Wood	Not Started	Financial Plan Month 9		31.12.24												
1.1.14	Deliver Month 10 2024/25 plan	Jonathan Wood	Not Started	Financial Plan Month 10		31.01.25												
1.1.15	Deliver Month 11 2024/25 plan	Jonathan Wood	Not Started	Financial Plan Month 11		28.02.25												
1.1.16	Deliver Month 12 2024/25 plan	Jonathan Wood	Not Started	Financial Plan Month 12		31.03.25												
1.1.17	**Deliver Financial Recovery Plan**																	
1.1.18	Deliver Month 3 2024/25 Financial Recovery Plan	Jitka Roberts	Complete	Financial recovery Plan		30.06.24												
1.1.19	Deliver Month 4 2024/25 FRP plan	Jitka Roberts	In Progress/ On track			31.07.24												
1.1.20	Deliver Month 5 2024/25 FRP plan	Jitka Roberts	Not Started			31.08.24												
1.1.21	Deliver Month 6 2024/25 FRP plan	Jitka Roberts	Not Started			30.09.24												
1.1.22	Deliver Month 7 2024/25 FRP plan	Jitka Roberts	Not Started			31.10.24												
1.1.23	Deliver Month 8 2024/25 FRP plan	Jitka Roberts	Not Started			30.11.24												
1.1.24	Deliver Month 9 2024/25 FRP plan	Jitka Roberts	Not Started			31.12.24												
1.1.25	Deliver Month 10 2024/25 FRP plan	Jitka Roberts	Not Started			31.01.25												
1.1.26	Deliver Month 11 2024/25 FRP plan	Jitka Roberts	Not Started			28.02.25												
1.1.27	Deliver Month 12 2024/25 FRP plan	Jitka Roberts	Not Started			31.03.25												
1.2	**The Plan should be consistent with the medium term system plan currently in production, which sets out a trajectory for the Intergrated Care System to achive underlying financial balance by 2026/27.**	Jonathan Wood	In Progress/ On track			31.3.26												
1.3	**The Licensee will keep the financial plans and their delivery dates under review. Where matters are idenitfied which materially affect the licensees ability to meet the requirements of paragraph (1.1), whether idenitfied by the licencee or another party, the Licensee will notify NHS England as soon as practicable and update and resubmit the Financial Plan within a timeframe to be agreed with NHS England.**	Jonathan Wood	In Progress/ On track			31.3.25												
2	**Distressed Funding**																	
2.1	**Where interim support financing or planned term support financing is provided by the Secretary of State for Health and Social Care to the Licensee pursuant to section 40 of the NHS Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.**																	
2.1.1	Prepare a cash flow statement linked to 24/25 Plan showing the need for financial support on month by month basis	Jonathan Wood	In Progress/ On track			31.03.25												
2.2	**The Licensee will comply with any reporting requests made by NHS England in relation to any financing provided or to be provided to the Licensee by the Secretary of State for Health and Social Care pursuant to section 40 of the NHS Act 2006.**																	
2.2.1	Reports provided as requested.	Jonathan Wood	In Progress/ On track			31.03.25												
3	**Quality of Care**																	
3.1	**The Licensee will take all reasonable steps to address and rectify the breaches identified in the CQC report dated 24 November 2023 within such timescales to be agreed with NHS England. The Licensee will agree any amendments to the Quality Improvement Plan with NHS England and the ICB.**																	
3.1.1	Create a Quality Improvement Plan in response to the CQC must and should do's.	Sarah Cullen	Complete	Quality Improvement Plan	Completed and approved Board.	Date Board approved												
3.1.2	Provide Q1 progress update on delivery of Must and should do's.	Sarah Cullen	Complete			30.06.24												
3.1.3	Provide Q2 progress update on delivery of Must and should do's.	Sarah Cullen	Not Started			30.09.24												
3.1.4	Provide Q3 progress update on delivery of Must and should do's.	Sarah Cullen	Not Started			31.12.24												
3.1.5	Provide Q4 progress update on delivery of Must and should do's.	Sarah Cullen	Not Started			31.03.25												
3.1.6	Agree timescales for delivery of Single Improvement Plan with NHS England.	Silas Nicholls	Complete		Presented to SIB June 2024	30.06.24												
3.1.7	Agree timescales for delivery of Quality Improvement Plan with NHS England.	Silas Nicholls	In Progress/ On track		To be presented at SIB – July 2024.	31.07.24												
3.1.8	Demonstrate ward to board quality assurance mechanisms are in place to monitor ongoing must and shoulds (where applicable) and maintan quality standards.	Sarah Cullen	In Progress/ On track	STAR quality Assurance annual report.	Item for future deep dive.	31.07.24												
3.1.9	Demonstrate robust Equality Quality Impact Assesment processes and policy are in place.	Sarah Cullen	Complete	EQIA policy EQIA quarterly report		30.6.24												
3.2	**The Licensee will develop and submit to Lancashire and South Cumbria ICB and NHS England, a Quality Improvement Plan detailing actions which it will take to ensure compliance with paragraph 3.1 above, including key milestones and timelines, for approval by NHS England and the ICB.**																	
3.2.1	Submit CQC Quality Improvement Plan to NHS England and the ICB for approval.	Silas Nicholls	In Progress/ On track		To be presented at SIB – July 2024.	31.07.24												
3.3	**Specifically, and in line with the actions set out as required in the CQC report, the Licensee will ensure the Quality Improvement Plan includes actions that will ensure robust governance processes in relation to timely identification and management of risk including processes for shared learning.**																	

Ref	Workstream	Assigned to	Status	Evidence	Narrative Update	Milestone target end date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
3.3.1	Develop new risk management strategy.	Sarah Cullen	Complete	Risk Management Strategy	Complete. Risk Management Strategy approved at the Board of Directors meeting 01.02.24.	01.02.24												
3.3.2	Implement new Risk Management Group to be chaired by the Chief Executive.	Sarah Cullen	Complete	TOR Risk Management group	Complete. Risk Management Group started March 2024.	31.03.24												
3.3.3	Implement PSIRF including revised governance structures.	Sarah Cullen	Complete	PSIRF implementation plan PSIRF governance structure	Complete. PSIRF fully implemented March 2024.	31.03.24												
3.4	**The Licensee will, as part of the Quality Improvement Plan, set out a workforce strategy to ensure sufficient numbers of suitably qualified, competent and experienced staff are available to enable them to meet all regulatory requirements.**																	
3.4.1	Provide progress reports against the 6 strategic priorities within the People Plan.	Neil Pease	In Progress/ On track	1. To attract, recruit and resource. 2. To engage retain, reward and recognise. 3. To create apositive organisational culture. 4. To be well led. 5. To support the Health and well being of colleagues. 6. To be consciously inclusive in what we do.		31.3.25												
3.4.2	Submission of the 2024/25 workforce plan.	Neil Pease	Complete			31.4.24												
3.4.3	Demonstrate compliance with Nurse, Midwifery and AHP Workforce safeguards.	Sarah Cullen	Complete	Annual Adult safe Staffing report. Annual Maternity Safe Staffing report. AHP Safe staffing report.	Bi- annual safe staffing processes in place with annual safe staffing report approved Board in April 2024. Birthrate plus phase 1 staffing investment approved by Board April 2024. AHP workforce strategy in place and biannual review presented to Board in February 2024.	30.04.24												
3.4.4	Demonstrate compliance with Nurse, Midwifery and AHP Workforce safeguards through submission of evidence to NHS England nursing and midwifery review.	Sarah Cullen	Complete		NHS England Nursing and Midwifery workforce review undertaken 5.7.24.	31.07.24												
3.5	**The Licensee will ensure that its oversight and assurance processes in relation to the delivery of the actions in the Quality Improvement Plan are robust. The Licensee will demonstrate progress against the Plan in line with the agreed timelines through the Licensee's internal governance arrangements and enabling external oversight by the ICB and NHS England. Progress against the Quality Improvement Plan will be presented monthly to the System Improvement Board (SIB) until otherwise agreed with NHS England and the ICB.**																	
3.5.1	High level monthly update on progress against the CQC QIP to be included in the Safety & Quality Dashboard, presented at Safety and Quality Committee.	Sarah Cullen	Complete	IPR	An update on progress is included the Safety & Quality Dashboard on a monthly basis at Safety and Quality Committee	31.03.25												
3.5.2	Detailed quarterly CQC QIP update to Safety and Quality Committee. Q1	Sarah Cullen	Complete	Quality Improvement Plan update report 28.6.24	Quarterly update paper to Safety and Quality Committee added to the cycle of business.	30.06.24												
3.5.3	Detailed quarterly CQC QIP update to Safety and Quality Committee. Q2	Sarah Cullen	In Progress/ On track		Quarterly update paper to Safety and Quality Committee added to the cycle of business.	30.09.24												
3.5.4	Detailed quarterly CQC QIP update to Safety and Quality Committee. Q3	Sarah Cullen	In Progress/ On track		Quarterly update paper to Safety and Quality Committee added to the cycle of business.	31.12.24												
3.5.5	Detailed quarterly CQC QIP update to Safety and Quality Committee. Q4	Sarah Cullen	In Progress/ On track		Quarterly update paper to Safety and Quality Committee added to the cycle of business.	31.03.25												
3.5.6	Single Improvement Plan governance arrangements to be finalised.	Silas Nicholls	Complete	SIP report Board June 2024	Program and board arrangements in place. SIP programmes each have identified Executive leadership in place. SIP Board chaired by CEO.	30.06.24												
3.5.7	Single Improvement Plan																	
3.5.8	Single Improvement Plan update provided to System Improvement Board Month 2	Ailsa Brotherton	Complete		SIP presented Month 2.	31.05.24												
3.5.9	Single Improvement Plan update provided to System Improvement Board Month 3	Ailsa Brotherton	Complete		Focused meeting on finance and workforce.	30.06.24												
3.5.10	Single Improvement Plan update provided to System Improvement Board Month 4	Ailsa Brotherton	In Progress/ On track		SIP presented Month 4	31.07.24												
3.5.11	Single Improvement Plan update provided to System Improvement Board Month 5	Ailsa Brotherton	Not Started		SIP presented Month 5	31.08.24												
3.5.12	Single Improvement Plan update provided to System Improvement Board Month 6	Ailsa Brotherton	Not Started		SIP presented Month 6	30.09.24												
3.5.13	Single Improvement Plan update provided to System Improvement Board Month 7	Ailsa Brotherton	Not Started		SIP presented Month 7	31.10.24												
3.5.14	Single Improvement Plan update provided to System Improvement Board Month 8	Ailsa Brotherton	Not Started		SIP presented Month 8	30.11.24												
3.5.15	Single Improvement Plan update provided to System Improvement Board Month 9	Ailsa Brotherton	Not Started		SIP presented Month 9	31.12.24												
3.5.16	Single Improvement Plan update provided to System Improvement Board Month 10	Ailsa Brotherton	Not Started		SIP presented Month 10	31.01.25												

Ref	Workstream	Assigned to	Status	Evidence	Narrative Update	Milestone target end date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
3.5.17	Single Improvement Plan update provided to System Improvement Board Month 11	Ailsa Brotherton	Not Started		SIP presented Month 11	28.02.25												
3.5.18	Single Improvement Plan update provided to System Improvement Board Month 12	Ailsa Brotherton	Not Started		SIP presented Month 12	31.03.25												
3.6	**The Licensee will keep the Quality Improvement Plan and its delivery under review. Where matters are identified which materially affect the Licensee's ability to meet the requirements of paragraph 3.1, whether identified by the Licensee or another party, the Licensee will notify the ICB and NHS England as soon as practicable and update and resubmit the amended Quality Improvement Plan for NHS England and ICB approval within the timeframe agreed with NHS England and the ICB.**																	
3.6.1	Notify NHS England and the ICB of any matters which may materially affect the Trust's ability to deliver the CQC Quality Improvement Plan and/or the Single Improvement Plan.	Silas Nicholls	In Progress/ On track	CYP Roundtable review ICB feedback.	Progress will be monitored and NHS England and the ICB will be notified as required.	31.03.25												
3.7	**The Licensee will ensure that the Plan is updated as necessary, with the agreement of NHS England and the ICB, to include any quality related recommendations from external independent investigations.**																	
3.7.1	The Trust will update the CQC Quality Improvement Plan and/or the Single Improvement Plan as necessary in response to recommendations/external independent investigations.	Silas Nicholls	In Progress/ On track	a) Regulation 28 action plan b) CYP Roundtable Feedback c) NHS Resolution Maternity response.	a) Regulation 28 response progressing in line with plan. b) CYP roundtable event held on 3.7.24. Awaiting formal feedback from ICB. c) NHS Resolution feedback session held, summary received, response to this in preperation.	31.03.25												
3.8	**The Licensee will take all reasonable steps to deliver the Quality Improvement Plan, in accordance with the timeframes set out in the Plan, unless otherwise agreed with NHS England.**																	
3.8.1	Delivery of the CQC Quality Improvement Plan will be led by the Chief Nursing Officer in conjunction with lead Executive Directors for each area. The Quality Improvement Plan has Executive Leads in for each must and should do.	Sarah Cullen	Complete	QIP Report 28.6.24.	Progress will be monitored and NHS England and the ICB will be notified of any potential deviations / alterations to the plan, as required each quarter.	30.06.24												
3.8.2	Delivery of the CQC Quality Improvement Plan will be led by the Chief Nursing Officer in conjunction with lead Executive Directors for each area. The Quality Improvement Plan has Executive Leads in for each must and should do.	Sarah Cullen	In Progress/ On track		Progress will be monitored and NHS England and the ICB will be notified of any potential deviations / alterations to the plan, as required each quarter.	30.09.24												
3.8.3	Delivery of the CQC Quality Improvement Plan will be led by the Chief Nursing Officer in conjunction with lead Executive Directors for each area. The Quality Improvement Plan has Executive Leads in for each must and should do.	Sarah Cullen	In Progress/ On track		Progress will be monitored and NHS England and the ICB will be notified of any potential deviations / alterations to the plan, as required each quarter.	31.12.24												
3.8.4	Delivery of the CQC Quality Improvement Plan will be led by the Chief Nursing Officer in conjunction with lead Executive Directors for each area. The Quality Improvement Plan has Executive Leads in for each must and should do.	Sarah Cullen	In Progress/ On track		Progress will be monitored and NHS England and the ICB will be notified of any potential deviations / alterations to the plan, as required each quarter.	31.03.25												
3.9	**The Licensee will work in partnership with the Provider Collaborative and ICB to support the timely delivery of the System Clinical Strategy.**																	
3.9.1	Continue to work in collaboration with the Provider Collaborative and Integrated Care Board (ICB) to deliver the System Clinical Strategy.	Gerry Skailes	Complete			30.04.24												
3.9.2	Participate in the Strasys planning event, contributing towards the development of a blueprint for the future.	Gerry Skailes	Complete			30.06.24												
3.9.3	Collaborate on the fragile services workstream leading to progress. Update Q1	Gerry Skailes	In Progress/ On track			30.06.24												
3.9.4	Collaborate on the fragile services workstream leading to progress. Update Q2	Gerry Skailes	Not Started			30.09.24												
3.9.5	Collaborate on the fragile services workstream leading to progress. Update Q3	Gerry Skailes	Not Started			31.12.24												
3.9.6	Collaborate on the fragile services workstream leading to progress. Update Q4	Gerry Skailes	Not Started			31.03.25												
3.9.7	Develop Lancashire place UEC plan	Emma Ince	Complete	UEC Place plan		31.07.24												
3.9.8	Deliver Urgent and Emergency Care plan, evidenced through Single Improvement Plan updates.	Emma Ince	In Progress/ On track		Reporting to UECDB	31.07.24												
3.9.9	Deliver Urgent and Emergency Care plan, evidenced through Single Improvement Plan updates.	Emma Ince	In Progress/ On track		Reporting to UECDB	31.10.24												
3.9.10	Deliver Urgent and Emergency Care plan, evidenced through Single Improvement Plan updates.	Emma Ince	In Progress/ On track		Reporting to UECDB	31.01.25												
3.9.11	Develop a plan to progress intergration of physical health community services with Lancashire and South Cumbria Foundation Trust.	Sarah Cullen	In Progress/ On track	Community Services update presentation. July 2024	Executive to Executive held 24.6.24 Agreed priorities and intergrated leadership function to progress physical health community services transformation.	30.06.24												
3.9.12	Develop detailed community physical health services plan .	Sarah Cullen	In Progress/ On track			31.05.24												
3.9.13	Provide quarterly updates on progress of the community physical health plan. Q2	Sarah Cullen	Not Started			30.09.24												
3.9.14	Provide quarterly updates on progress of the community physical health plan. Q3	Sarah Cullen	Not Started			31.12.24												
3.9.15	Provide quarterly updates on progress of the community physical health plan. Q4	Sarah Cullen	Not Started			31.03.25												
3.9.16	Partcipate in the commissioned PSC system analysis	Emma Ince	Complete			30.06.24												
4	**Reporting**																	
4.1	**The Licensee will provide regular reports to NHS England on its progress in meeting the undertakings set out above.**																	
4.1.1	Trust to provide reports / updates on progress against this plan to NHS England through the System Improvement Board.	Silas Nicholls	In Progress/ On track	Enforcement Undertakings delivery plan		31.05.24												
4.1.3	Provide update on progress against the Trusts response to the undertakings. Month 4	Sarah Cullen	In Progress/ On track	Enforcement undertakings action plan		31.07.24												

Ref	Workstream	Assigned to	Status	Evidence	Narrative Update	Milestone target end date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
4.1.4	Provide update on progress against the Trusts response to the undertakings. Month 5	Sarah Cullen	Not Started			31.08.24												
4.1.5	Provide update on progress against the Trusts response to the undertakings. Month 6	Sarah Cullen	Not Started			30.09.24												
4.1.6	Provide update on progress against the Trusts response to the undertakings. Month 7	Sarah Cullen	Not Started			31.10.24												
4.1.7	Provide update on progress against the Trusts response to the undertakings. Month 8	Sarah Cullen	Not Started			30.11.24												
4.1.8	Provide update on progress against the Trusts response to the undertakings. Month 9	Sarah Cullen	Not Started			31.12.24												
4.1.9	Provide update on progress against the Trusts response to the undertakings. Month 10	Sarah Cullen	Not Started			31.01.25												
4.1.10	Provide update on progress against the Trusts response to the undertakings. Month 11	Sarah Cullen	Not Started			28.02.25												
4.1.11	Provide update on progress against the Trusts response to the undertakings. Month 12	Sarah Cullen	Not Started			31.03.25												
4.2	**The Licensee will attend SIB meetings, or, if NHS England stipulates, conference calls, at such times, and with such attendees, as may be required by NHS England, to discuss its progress in meeting the undertakings. The SIB meetings will take place once a month unless NHS England otherwise stipulates, at a time and place to be specified by NHS England and with attendees specified by NHS England.**																	
4.2.1	Trust to attend System Improvement Board (SIB) Month 1	Silas Nicholls	Complete			30.04.24												
4.2.2	Trust to attend System Improvement Board (SIB) Month 2	Silas Nicholls	Complete			31.05.24												
4.2.3	Trust to attend System Improvement Board (SIB) Month 3	Silas Nicholls	Complete			30.06.24												
4.2.4	Trust to attend System Improvement Board (SIB) Month 4	Silas Nicholls	In Progress/ On track			31.07.24												
4.2.5	Trust to attend System Improvement Board (SIB) Month 5	Silas Nicholls	Not Started			31.08.24												
4.2.6	Trust to attend System Improvement Board (SIB) Month 6	Silas Nicholls	Not Started			30.09.24												
4.2.7	Trust to attend System Improvement Board (SIB) Month 7	Silas Nicholls	Not Started			31.10.24												
4.2.8	Trust to attend System Improvement Board (SIB) Month 8	Silas Nicholls	Not Started			30.11.24												
4.2.9	Trust to attend System Improvement Board (SIB) Month 9	Silas Nicholls	Not Started			31.12.24												
4.2.10	Trust to attend System Improvement Board (SIB) Month 10	Silas Nicholls	Not Started			31.01.25												
4.2.11	Trust to attend System Improvement Board (SIB) Month 11	Silas Nicholls	Not Started			28.02.25												
4.2.12	Trust to attend System Improvement Board (SIB) Month 12	Silas Nicholls	Not Started			31.03.25												
4.3	**Upon request, the Licensee will provide NHS England with the evidence, reports or other information relied on by its Board in relation to assessing its progress in delivering these undertakings.**																	
4.3.1	Trust to provide reports / updates on progress against this plan to NHS England.	Silas Nicholls	In Progress/ On track			31.03.25												
4.4	**The Licensee will comply with any additional reporting or information requests made by NHS England.**																	
4.4.1	Trust to provide reports / respond to information requests made by NHS England.	Silas Nicholls	In Progress/ On track			31.03.25												

Key	
Not Started	
In Progress/ On tra	All actions on track
Complete	Delivered with evidence in place.
Off Track/ Recovera	Actions off track, plan to deliver within revised timescale
Off Track/ At Risk	Not complete/late to deliver with no recovery plan in place

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Request for Delegated Authority to Submit Emergency Preparedness, Resilience & Response Core Standards Annual Assurance Returns

Report to:	Board of Directors	**Date:**	1 August 2024
Report of:	Interim Chief Operating Officer (Accountable Emergency Officer)	**Prepared by:**	S Hughes
Part I	√	**Part II**	

Purpose of Report

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

Executive Summary:

The purpose of this report is to request the board of directors to delegate authority to the Finance and Performance Committee to submit the Emergency Preparedness Resilience and Response (EPRR) annual core standards assurance return prior to formal board approval.

Granting delegated authority to the Finance and Performance Committee to submit the EPRR annual core standards assurance return will:

- Ensure timely submission and alignment with NHSE's check and challenge process, preventing any retrospective changes that may cause embarrassment.
- Allow a smoother and more efficient submission process, mitigating the risk of delays.
- Align our practices with those of other trusts that have already adopted this approach, demonstrating that it is a beneficial and accepted practice within the sector.

It is recommended that the board delegates authority to the Finance and Performance Committee to submit this year's and future years' EPRR annual core standards assurance returns prior to formal board approval.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable

1. Background

Following last year's EPRR core standards annual assurance return and subsequent NHSE check and challenge process, it was recommended to amend our compliance rating, leading to a retrospective change that caused some embarrassment.

2. Discussion

To prevent this from recurring, the following actions are proposed:

1. **ICB Site Visit**:
   - The ICB will conduct a two-day site visit in September to meet with the EPRR Manager, discuss the Trust's proposed EPRR core standards self-assessment, and review and audit the supporting evidence.
   - This visit will provide an opportunity for discussions between the EPRR Manager and the ICB Head of EPRR to confirm the acceptance of the narrative and supporting evidence or allow for further evidence submission as needed, ensuring the proposed core standards compliance levels are fully supported before the Trust's formal submission to the ICB and onward to NHSE.

2. **Amended Sign-off Process:**
   - After discussions with Alison Whitehead, Head of EPRR for the ICB, it has been confirmed that our annual compliance rating can be submitted before board approval if delegated authority has been approved by the board.

To enable this, the future process would be as follows:

1. LTHTr Core Standards self-assessment and compliance rating approved by the EPRR Committee members (August/September).
2. LTHTr Core Standards self-assessment and compliance rating signed off by the AEO prior to submission to F&P (September).
3. LTHTr Core Standards self-assessment and compliance rating presented to F&P for approval to submit to the ICB (September).
4. LTHTr Core Standards self-assessment and compliance rating submitted to the ICB for approval (End of September).
5. L&SC Core Standards self-assessment and compliance rating submitted by the ICB to NHSE for approval (December).
6. LTHTr Core Standards self-assessment and compliance rating and EPRR Annual Report presented to F&P for approval to progress to the board (December).
7. LTHTr Core Standards self-assessment and compliance rating and EPRR Annual Report presented to the board for retrospective approval (January).

Granting delegated authority to the Finance and Performance Committee to submit the annual core standards assurance return will:

- Ensure timely submission and alignment with NHSE's check and challenge process, preventing any retrospective changes that may cause embarrassment.
- Allow a smoother and more efficient submission process, mitigating the risk of delays.
- Align our practices with those of other trusts that have already adopted the delegated authority approach, demonstrating that it is a beneficial and accepted practice within the sector.

Moving forward it is recommended that the board delegates authority to the Finance and Performance Committee to submit this year's and future years' EPRR annual core standards assurance returns prior to formal board approval, as outlined above. This change will improve the efficiency and reliability of our submission process and enhance our compliance with NHSE requirements.

3. Financial implications

'None'

4. Legal implications

'None'

5. Risks

'None'

6. Impact on stakeholders

Not applicable

7. Recommendations

It is recommended that the board delegates authority to the Finance and Performance Committee to submit this year's and future years' EPRR annual core standards assurance returns prior to formal board approval.

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Annual Report and Accounts 2023-24							
Report to:	Board of Directors			**Date:**	1 August 2024		
Report of:	Company Secretary			**Prepared by:**	K Brewin		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☐	**For information**	☒		

Executive Summary:

The Annual Report and Financial Accounts for 2023-24, including the Annual Governance Statement, were laid before Parliament on 25 July 2024, in accordance with the statutory deadline and following the process for e-laying this year outlined by the Department of Health and Social Care.

The report is attached and can also be viewed on the Trust's website using the following link:

https://www.lancsteachinghospitals.nhs.uk/annual-reports

The Board is asked to receive the report for information.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

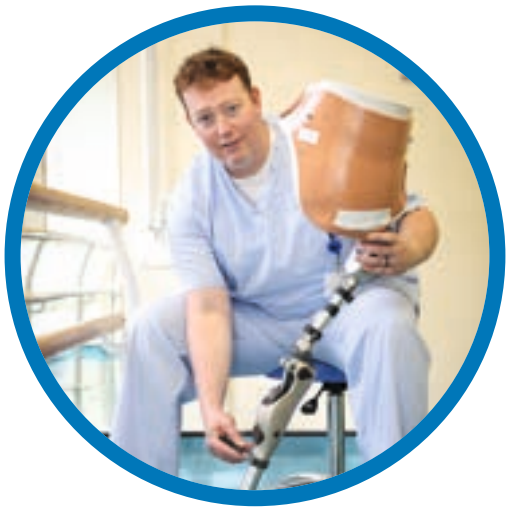
Audit Committee (21 June 2024)
Board of Directors (25 June 2024)

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2023–24



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Always Safety First

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Lancashire Teaching Hospitals NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2023–24

Presented to Parliament pursuant to schedule 7,
paragraph 25(4) (a) of the National Health Service Act 2006

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This symbol indicates that more information is available on our website:

www.lancsteachinghospitals.nhs.uk

CHAIR'S AND CHIEF EXECUTIVE'S WELCOME

Dear Stakeholder,

Having joined the Trust in August 2023 and January 2024 as Chair and Chief Executive respectively, we are proud of the services that Lancashire Teaching Hospitals delivers for the people of Lancashire and South Cumbria and are pleased to share our Annual Report and Accounts 2023/24 which showcases many positive aspects of our work whilst highlighting the areas we need to improve upon to provide the excellent care we aspire to.

We must begin with a sincere 'thank you' to everyone who has contributed to the achievements, targets and developments highlighted in this report. This includes the work of former Chief Executive, Kevin McGee, who retired from the Trust in August 2023 after 38 years in the NHS and Faith Button for her spell as Interim Chief Executive before taking up a new role outside our local healthcare system. We must also thank Non-Executive Director Paul O'Neill who stood in as acting Chair between November 2022 – August 2023.

Year-on-year, our colleagues work tremendously hard against a backdrop of increasing service demand and a challenging elective restoration programme following the pandemic. They continue to go the extra mile for each other, and our patients, and for that we are truly grateful. We would also like to acknowledge the work of our volunteers and council of governors who devote many hours of their own time without expecting any reward or recognition and our Trust is far stronger as a result of their contribution.

Finally, a heartfelt thank you must go out to our local communities who have once again displayed extraordinary support towards our hospitals and our charities. Listening to patients, families and carers when things do not go well as well as when they do helps us shape our services of the future and we are grateful to all those who have taken the time to give us their feedback.

It has been a tough year. High demand for Urgent and Emergency Care services has been a trend throughout 2023/24 across our providers in Lancashire and South Cumbria as well as the wider healthcare system nationally. Patients experiencing long waits, receiving care in our corridors, boarding on wards and the continuous strain on our workforce is not sustainable, nor the care or experience that our communities and colleagues deserve. This remains a top priority going into 2024/25 alongside continuing the work to reduce our elective waits and cancer restoration.

In November 2023, the Care Quality Commission (CQC) announced the results of inspections carried out at both Royal Preston and Chorley and South Ribble Hospitals. These included unannounced inspections of urgent and emergency services at both our hospital sites; and of medical care and surgery at Royal Preston as part of the CQC's continual cycle of checks. There was a focused inspection of maternity services at both hospitals as part of the CQC national maternity inspection programme. In addition, inspectors also undertook a well-led inspection of the Trust.

Overall, the Trust remained rated as requires improvement – the same rating as we received after the 2019 pre pandemic inspection. Whilst this is not where we all want to be, we believe that this is a fair reflection of our position and the challenges facing us, some of which are described above. In Lancashire and South Cumbria, the collective health system has an ambition for all Providers to be rated as good overall by the CQC and we remain committed to achieving this within our Trust. Although there is still more work to do, we are confident that we have strong plans in place and the right teams to deliver them.

One of the most significant dilemmas across the wider NHS and social care system is the continued increase in demand on patient services at a time when there are many competing demands on the public purse. At Lancashire Teaching Hospitals, the cost of delivering our services and delivering patient care has been greater than the income received for a number of years now, resulting in a significant gap in our finances. There has been a huge effort from all of our clinical and corporate divisions to improve this situation and at the end of the financial year 2023/24 we reported a financial improvement of £36.9m through our cost improvement plans (CIP) – the highest value in the Trust's history.

However, even with this level of improvement, we still have a significant financial gap, and it is our responsibility to reduce this at pace. We are therefore implementing a comprehensive Financial Recovery Programme aimed at continuing to deliver high quality services to patients whilst resetting the approach we have to managing our finances leading to a stabilised position over the next three years.

In addition to our financial plans, we are also developing a 3-year Single Improvement Plan which will help us target our efforts into the kind of larger transformation plans that will help us shape services round the future needs of our populations and help us to truly embrace the exciting opportunities available to us as part of the New Hospitals Programme. We are also working closely with our wider system on the transformation of both clinical and central service across the Lancashire and South Cumbria Integrated Care System with the aim of driving up quality by sharing skills and best practice, pooling our resources and standardising the way we work to reduce variation and duplication. We want to ensure patients have equal access to the same high-quality care wherever they live. We also want our colleagues to have the same high-quality experience wherever they work. More than the sum of our parts, by working together all of the trusts benefit and will achieve more for our patients, communities and colleagues than if we worked separately.

There has of course been much to be proud of both nationally and locally. On 5 July 2023, we were delighted to join our partners nationally to celebrate 75 years of the National Health Service. Treating over a million people a day in England, the NHS touches all of our lives. When it was founded in 1948, the NHS was the first universal health system to be available to all, free at the point of delivery. Today, nine in 10 people agree that healthcare should be free of charge, more than four in five agree that care should be available to everyone, and that the NHS makes them most proud to be British. As part of the day's celebration, we were delighted to welcome ITV to Royal Preston Hospital to showcase the Trust on a national level.

Celebrating successes is important to us and throughout the year we have been pleased to acknowledge the numerous achievements of our colleagues and departments. This includes becoming the first Trust in the UK to implement the latest navigation bronchoscopy technology to locate and diagnose challenging peripheral lung tumours to introducing a new low complexity day surgery service for children based at Chorley and South Ribble Hospital. You can read about more major service developments on page 42.

Alongside these developments, the Trust is also working towards delivering it's net zero NHS target in line with its Green Plan launched in the previous year. As a leading local employer and anchor institution in Lancashire and South Cumbria, Lancashire Teaching Hospitals has a significant social, economic and environmental impact on the local community during its day-to-day activities. The Trust is committed to ensuring that it makes a positive impact, or at least reduces any negative impact that it has on the local community. This is one of the reasons why the Trust has made several pledges to ensure that it delivers on its commitments by gaining the Social Value Quality Mark Level 1 accreditation. As part of the accreditation, the Trust has made several pledges to promote employment, training and work experience opportunities with local people, procure goods and services from local suppliers, reduce its environmental impact, and work with local partners to improve inclusion, health and wellbeing and representation from local people in the work of the Trust. You can find out more about this work on page 21.

The NHS in Lancashire and South Cumbria welcomed the Government's May 2023 announcement of two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary as part of a rolling programme of national investment in capital infrastructure beyond 2030. In addition, Furness General Hospital in Barrow will benefit from investment in improvements. The existing Preston and Lancaster sites will remain in place and deliver services to our population until new hospital facilities are opened. The local NHS will continue to keep communities involved and provide further updates as more information becomes available. Further detailed work is underway to assess the viability of potential locations for new hospital builds and more information is available on page 94.

Thank you once again to our communities, partners and key stakeholders for your ongoing support of your local NHS.

Peter White
Chair
25 June 2024

Professor Silas Nicholls
Chief Executive
25 June 2024

Lancashire Teaching Hospitals NHS Foundation Trust

PERFORMANCE REPORT 2023–24

OVERVIEW OF PERFORMANCE

The purpose of this report is to inform the users of the Trust of its performance and to help them assess how the Directors have performed in promoting the success of the Trust.

This report is prepared in accordance with sections 414A, 414C and 414D of the Companies Act 2006 (as inserted/amended by the Companies Act 2006 except for sections 414A(5) and (6) and 414D(2) which are not relevant. For the purposes of this report, we have treated ourselves as a quoted company. Additional information on our forward plans is available in our operational plan on our website. Information on any mandatory disclosures included within this report is provided on pages 72 to 75.

The accounts contained within this report have been prepared under a direction issued by NHS England (NHSE) under the National Health Service (NHS) Act 2006.

Who we are

Lancashire Teaching Hospitals NHS Foundation Trust was established on 1 April 2005 as a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003. We are registered with the Care Quality Commission (CQC) without conditions to provide the following regulated activities:

- diagnostic and screening services
- maternity and midwifery services
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury
- management of supply of blood and blood-derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- vaccination hub satellite service
- accommodation for persons who require nursing or personal care

We are a large acute Trust providing district general hospital services to over 395,000 people in Chorley, Preston and South Ribble and specialist care to 1.8m people across Lancashire and South Cumbria.

Our mission is to always provide excellent care with compassion which we do from four facilities:

- Chorley and South Ribble Hospital
- Royal Preston Hospital
- Specialist Mobility and Rehabilitation Centre (based at Preston Business Centre)
- Finney House Community Healthcare Hub

We are a values-driven organisation. Our values were designed by our staff and patients and are embedded in the way we work on a day-to-day basis:

- **Caring and compassionate:** We treat everyone with dignity and respect, doing everything we can to show we care.
- **Recognising individuality:** We respect, value, and respond to every person's individual needs.
- **Seeking to involve:** We will always involve you in making decisions about your care and treatment and are always open and honest.
- **Team working:** We work together as one team, and involve patients, families, and other services, to provide the best care possible.
- **Taking personal responsibility:** We each take personal responsibility to give the highest standards of care and deliver a service we can always be proud of.

We believe that to provide the best care, we need continually to improve the way in which we provide services. If we are to be the best, we need continually to seek improvement and embrace change, empowering our teams to develop ideas and drive them forward. We have adopted a Continuous Improvement approach and developed a strategy to support this.

Our strategic objectives are:

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

The delivery of excellent services to our local patients through the provision of district general hospital services is at the core of what we do. To achieve this, we need to ensure we focus on meeting key quality and performance indicators so our patients can be assured of safe and responsive services.

As well as providing healthcare for our local patients, we are proud to be the regional centre for a range of specialist services. These services include:

- Adult Allergy and Clinical Immunology
- Cancer (including radiotherapy, drug therapies and cancer surgery)
- Disablement services such as artificial limbs and wheelchairs
- Major Trauma
- Neurosciences including neurosurgery and neurology (brain surgery and nervous system diseases)
- Renal (kidney diseases)
- Specialist vascular surgery

Our portfolio of services will continue to develop as the strategy for the provision of services across our region is developed, but the delivery of specialist services will remain at the heart of our purpose and the decisions we take in our day-to-day activities will be taken in the context of ensuring we remain as the Lancashire and South Cumbria Integrated Care System (ICS) specialist hospital.

When we were established in 2005, we were the first Trust in the county to be awarded 'teaching hospitals' status. We believe that developing the workforce of the future is central to delivering high quality healthcare into the future. We are a local leader in respect of our education, training, and research and as the only National Institute for Health and Care Research (NIHR) Clinical Research Facility in Lancashire and South Cumbria, and a leading provider of undergraduate education, we will continue to drive forward the ambitions described in our education and research strategies.

Our business model

The governance structure of a Foundation Trust is prescribed through legislation and is reflected within our Constitution. All Foundation Trusts are required to have a Board of Directors and a Council of Governors as well as a membership scheme, which is open to members of the public and staff who work at the Foundation Trust. Members vote to elect governors and can also stand for election themselves. The Council of Governors is responsible for representing the interests of the general public and staff in the governance of the Trust. It remains the responsibility of the Board to design and then implement agreed priorities, objectives, and the overall strategy of the organisation. Governors have an important role in making the Trust publicly accountable for the services it provides. They bring valuable perspectives and hold Non-Executive Directors to account for the performance of the Board.

Our strategic framework

Integrated Care System in Lancashire and South Cumbria

The Trust is part of the Lancashire and South Cumbria Integrated Care System (ICS). The role of the ICS is to join up health and care services, improve people's health and wellbeing, and to make sure everyone has the same access to services and gets the same outcomes from treatment. The ICS also has the duty to monitor and manage how money is spent and make sure health services work well and are of high quality.

Lancashire and South Cumbria ICS has a clear vision outlining a strong community focus working in harmony with a high performing hospital system. To achieve this the Lancashire and South Cumbria ICS supports multi-professional teams across health and social care working within agreed protocols and pathways and within aligned financial incentives to deliver clear and mutually agreed goals and targets for the benefit of local communities.

The work of the ICS is directed by the Integrated Care Board (ICB). Since July 2022 NHS Lancashire and South Cumbria Integrated Care Board (ICB) has held responsibility for planning NHS services, including primary care, community pharmacy and those previously planned by Clinical Commissioning Groups (CCGs).

Lancashire Place

Lancashire Place has a large population spread across a large geographical footprint. Due to its size it is divided into three sub-localities: North, Central and East Lancashire. The area of Central and West Lancashire covers the main district general hospital services delivered by Lancashire Teaching Hospitals covering the areas of Chorley, Preston, and South Ribble (as well as West Lancashire).

The vision of Lancashire Place is 'Living Better Lives in Lancashire', with the ambition to help the citizens of Lancashire to live longer, healthier, and happier lives. This will be achieved in partnership with the Lancashire and South Cumbria ICB and the five provider trusts by improving health and care services through integration and addressing health and wellbeing inequality across the Lancashire Place.

During 2023–24 an effective Lancashire Place Partnership (Board) has been established. The Partnership has approved the Lancashire Place Plan for 2024–25 developed with significant collaboration from the ten Health and Wellbeing Partnerships and guided by the three Integrated Place Leads and three Clinical and Care Professional Leads. A data-led approach has been used to select key priorities, including targets that the Board will use to measure performance.

Priorities for 2024–25 are linked to the wider Transforming Care in the Community Programme and the ICB agreed transformation programmes of Creating Health Communities, Integrated Neighbourhood Working and Enhanced Care at Home. Locality based plans are also being developed for each of the three priorities to reflect local need in response to this work.

Our principal issues and risks

The Trust continues to identify potential risks to achieving its strategic aims and ambitions as part of established organisational governance processes. The Board Assurance Framework (BAF) is used to identify the strategic risks to the Trust alongside actions being taken to mitigate them. This enables the Board of Directors to evaluate whether there are the appropriate controls in place to operate in a manner that is effective in driving the delivery of the Trust's strategic objectives.

The Annual Governance Statement, contained on pages 78 to 96, further outlines the Trust's approach to risk management. The Trust continues to support risk mitigation strategies to deal with the recovery and restoration of services and the evolving external environment, and will continue to engage and strengthen relationships with patients, staff, public and strategic partners to ensure long-term sustainability in the delivery of its strategic objectives.

The organisational culture is built on trust, openness, transparency and empowerment with clear lines of accountability and responsibility, underpinned by continuous learning and improvement.

The Annual Governance Statement also includes the Trust's system of internal control which is designed to manage risk within the organisation. The Trust continues to perform well against a number of standards and metrics. However, it is acknowledged that there has been under performance in some key metrics including, but not limited to Clostridium difficile, 12-hour Emergency Department metrics and access targets, which were in part impacted by industrial action. The Trust remains focused on embedding a continuous improvement approach within the organisation and continues to work closely with system partners where support is required externally.

Our performance

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified in the NHS compliance framework and the acute services contract.

The NHS continued to face significant challenges in 2023–24. Performance, both emergency and elective has been impacted with operational pressures, including the impact from periods of industrial action and infection prevention and control measures experienced through the year resulting in non-compliance to a number of key national standards.

Whole health economy system pressures in response to increased demand resulted in high bed occupancy throughout the year with the need to focus both on non-elective activity and elective recovery as mandated nationally. The number of patients not meeting the criteria to reside remained high throughout the year, though a positive impact was seen from the introduction of the Community Healthcare Hub at Finney House providing additional out of hospital bed capacity. This, together with increased demand resulted in significant capacity pressures. Workforce capacity to undertake elective activity has been significantly impacted by industrial action throughout the year.

A health economy system wide action plan, and local Trust action plans are in place to address the urgent care system pressures; with identified primary, community and social care initiatives/schemes delivering a level of sustainability across the health economy. In 2023–24 the Trust took a lead role in bringing together operational delivery of key transformational work streams identified and prioritised by all system partners: a Community Healthcare Hub at Finney House, providing health led community bed capacity; the introduction of Virtual Wards; and a single point of access bringing together 2-hour Crisis Response, Virtual Ward, Same Day Emergency Care and Ambulance services to support people to stay safe at home.

During 2023–24 the Trust has:

- Continued to refine and improve the offer from the Community Healthcare Hub at Finney House, providing 64 health led time-limited community beds, reducing medicine bed capacity in hospital as a result.
- Established an Acute Assessment Unit to reduce time spent in the Emergency Department ahead of the delivery of increased Medical Assessment Unit capacity.
- Increased the Virtual Ward bed base for Frailty, Respiratory and Acute Medicine.
- Enhanced internal escalation measures, including Full Capacity Protocol, surge and boarding to support ambulance handovers and capacity in the Emergency Department
- Continued clearance of the >65-week backlog and elimination of >78-week waits for elective care.
- Compliance against the cancer >62-day backlog at 150 patients, exceeding the trajectory of 180 and below the fair shares of 151.
- Tumour site pathway improvements particularly in colorectal services.

The Trust has failed to achieve its objectives in relation to a range of measures within the risk assessment framework including: the 4-hour standard for Accident and Emergency; and the overall 18-week incomplete access target. The significant growth in the number of long waiters in both Referral to Treatment and cancer pathways was directly impacted by the COVID-19 pandemic and the reduction in elective activity during periods of industrial action with the prioritisation of urgent elective activity as part of the elective restoration plan. The Trust has focused on 2023–24 for recovery and stabilisation to support performance improvement from Q2 2025–26. Significant progress has been made with both cancer 62-day performance, performance against the 28-day faster diagnosis standard and reductions in our longest waits to no more than 78 weeks for elective care, with an elimination of waits over 104 weeks unless patients are choosing to wait longer for treatment.

Performance Analysis

The summary position detailing performance in 2023–24 is shown in the table below:

ANNUAL REPORT 2023–24
KPI'S 2023–24 COMPARED TO 2022–23

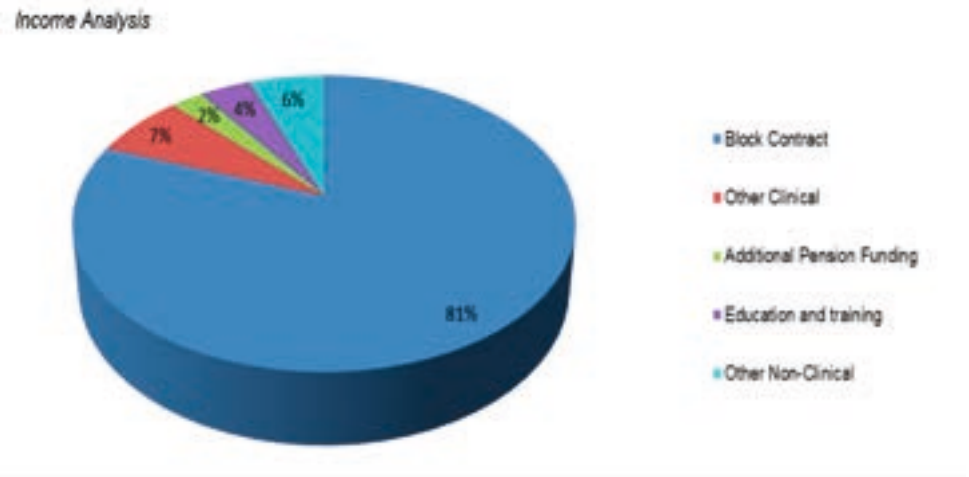
Indicator	2022–23	2023–24	Current Period	Comparison
A&E - 4 hour standard	75.3	70.4	% - Cumulative to end Mar 2024	Deteriorated
Cancer - 2 week rule (All Referrals) - New method	58.6	83.5	% - Cumulative to end Mar 2024	Improved
Cancer - 2 week rule - Referrals with breast symptoms	82.2	91.0	% - Cumulative to end Mar 2024	Improved
Cancer - 31 day target	83.3	84.4	% - Cumulative to end Mar 2024	Improved
Cancer - 31 Day Target - Subsequent treatment – Surgery	59.3	58.2	% - Cumulative to end Mar 2024	Deteriorated
Cancer - 31 Day Target - Subsequent treatment – Drug	96.8	98.4	% - Cumulative to end Mar 2024	Improved
Cancer - 31 Day Target - Subsequent treatment – Radiotherapy	82.3	87.1	% - Cumulative to end Mar 2024	Improved
Cancer - 62 day Target	43.2	56.0	% - Cumulative to end Mar 2024	Improved
Cancer - 62 Day Target - Referrals from NSS (Summary)	29.2	29.9	% - Cumulative to end Mar 2024	Improved
28 day faster diagnosis standard – compliance	57.5	71.5	% - Cumulative to end Mar 2024	Improved
MRSA	0	0	% - Cumulative to end Mar 2024	Maintained
C.difficile Infections	196	203	% - Cumulative to end Mar 2024	Deteriorated
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	50.5	55.0	% - Cumulative to end Mar 2024	Improved
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 104 Weeks	5	0.0	End March 2024 census position	Improved
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 78 Weeks	130	11.0	End March 2024 census position	Improved
% of patients waiting over 6 weeks for a diagnostic test	50.44	45.6	% - Cumulative to end Mar 2024	Improved

Our finances

Income Generation

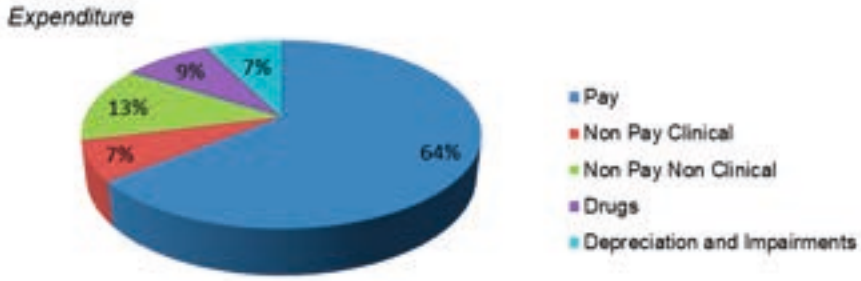
During 2023–24 the Trust generated income from patient care, including through a block contract of £731m (2022–23: £689m), an increase of 6% from 2022–23.

A further £79m (2022–23: £79m) was generated from other income sources which includes training levies, research funding, car parking, catering and retail outlets and from providing services to other organisations.



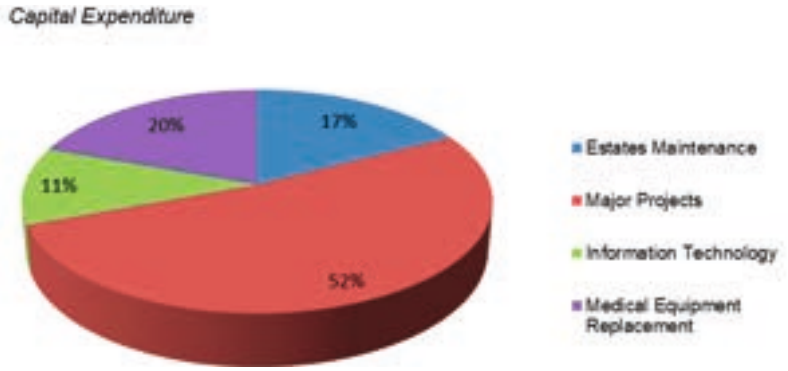
Expenditure

Operating expenditure (excluding impairments) for the year was £868m (2022–23: £779m), the graph below shows the main categories of expenditure at the Trust. The main reason for the rise in costs can be attributed to the asset impairments, pay awards, inflationary cost increases, and restoration of elective and outpatient activity.



Capital Investment

In 2023–24 £57m excluding leases (2022–23: £50m) was invested in the Trust's capital programme to maintain and improve the asset base of the Trust as illustrated in the chart below. Major projects completed in year included the new facilities to increase elective capacity such as additional theatres, additional Endoscopy capacity, an additional thrombectomy biplanar, and a remodelling of the Medical and Surgical Assessment Units. £21m was spent on new and replacement medical equipment.



Forward Look

The operational and financial planning process for 2024–25 has been developed in line with the expectations set out in the national planning guidance. The key focus of the guidance is to:

1. **Recover core services and productivity**
2. **Make progress in delivering the key ambitions in the Long-Term Plan**
3. **Continue transforming the NHS for the future**

The key requirements of the national guidance include the following::

- Improve A&E waiting times to >77% of patients seen within 4 hours by March 2025
- Maintain the peak increase in capacity agreed through operating plans in 2023–24
- Eliminate waits of over 65 weeks for elective care by September 2024
- Eliminate waits of over 52 weeks for elective care by March 2025
- Improve cancer performance against the 62-day standard to 70% by March 2025
- Improve cancer performance against the 28-day Faster Diagnosis Standard to 77% by March 2025
- Increase the percentage of patients that receive a diagnostic test within six weeks to 95% by March 2025
- Deliver a balanced net system financial position for 2024–25

The Trust's financial plans for 2024–25 have been based on the 2024–25 national planning guidance. As part of the Lancashire and South Cumbria ICS our focus is driving towards financial sustainability over a three-year period. For 2024–25 the Trust's financial plan has been agreed as part of the wider Lancashire and South Cumbria ICS system plan.

To build a financially sustainable Trust for the future, there will be a focus on cost improvement, productivity, and service transformation through system collaboration. A financial recovery plan target of 7% for 2024–25 has been agreed with the ICB and the Trust has identified and allocated risk rated targets to divisions and activities. To support delivery of an ambitious financial recovery programme the Trust has dedicated programme management support and a Programme Management Office. Schemes are monitored and reported on a weekly and monthly basis through the Trust's governance process. The Trust continues to work in partnership within the ICS and Central Lancashire Integrated Care Partnership and is part of the new hospital programme looking at site development in future years.

Better Payment Practice Code

We aim to treat all suppliers ethically and to comply with the BPPC target, which states that we should aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. For 2023–24 we paid 74% of invoices to this timescale.

	NHS		NON-NHS		TOTAL	
	No.	Value £'000	No.	Value £'000	No.	Value £'000
Invoices paid within 30 days	1,489	119,397	54,970	343,036	56,459	462,433
Invoices not paid within that 30 day period	624	6,477	18,983	46,071	19,607	52,548
Total Invoices	**2,113**	**125,874**	**73,953**	**389,107**	**76,066**	**514,981**
BPPC (%)	**71**	**95**	**74**	**88**	**74**	**90**
Total amount of any liability to pay interest						4

Reconciliation of underlying trading position for year ending 31 March 2024

The Trust delivered an accounting deficit for the year of £67.9m (2022–23: £19.0m). After adjustment for accounting movements relating to impairment charges and income and expenditure for donated assets, the Trust delivered a revised trading deficit of £35.6m (2022–23: £20.8m).

	Group	
	2023–24	2022–23
	£000	£000
Deficit for the year	(67,924)	(19,003)
Add back income and expenditure impairments	31,889	(1,426)
Add back losses on transfers by absorption	0	0
Remove net donated income	374	(763)
Remove DHSC centrally procured inventories (donated)	94	408
Revised trading surplus/(deficit)	**(35,567)**	**(20,784)**

Going concern

These accounts have been prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Guidance from the Department of Health and Social Care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. The Trust has not been informed by NHS England that there is any prospect of its dissolution within the next twelve months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis.

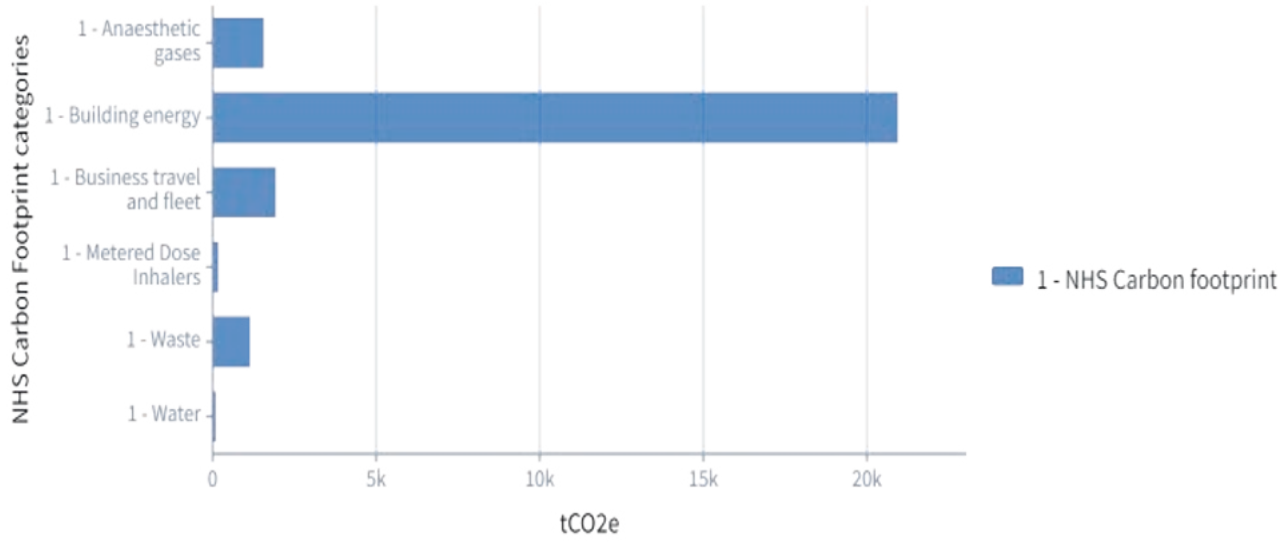
The Trust remains in a deficit position and will need to work with its partners across the local healthcare system, Provider Collaborative Board (PCB) and the ICB to achieve efficiencies and maximise the use of its assets to achieve a sustainable financial balance.

Task force on climate-related financial disclosures (TFCD)

In 2022, the Trust Board approved a three-year Green Plan in support of the NHS Strategy on 'Delivering a net zero National Health Service'. The plan focuses on drivers of change and sources of carbon emissions across the Trust.

Our Green Plan was developed utilising the 'Sustainable Development Assessment Tool' (SDAT) to assess our baseline position and to drive action plans for improvement. However, in July 2022 the SDAT was decommissioned and subsequently replaced by the 'Green Plan Support Tool' (GPST). The self-assessment support tool enables benchmarking against the national average in ten key areas. The most recent self-assessment shows the Trust benchmarks above the national average in nine out of ten areas with only one area below the national average.

The latest data published on the GPST for our Trust's contribution to the NHS Carbon Footprint (tCO2e) is illustrated below, with the most significant area being attributed to Building energy, business and travel, and Anaesthetic gases:



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

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

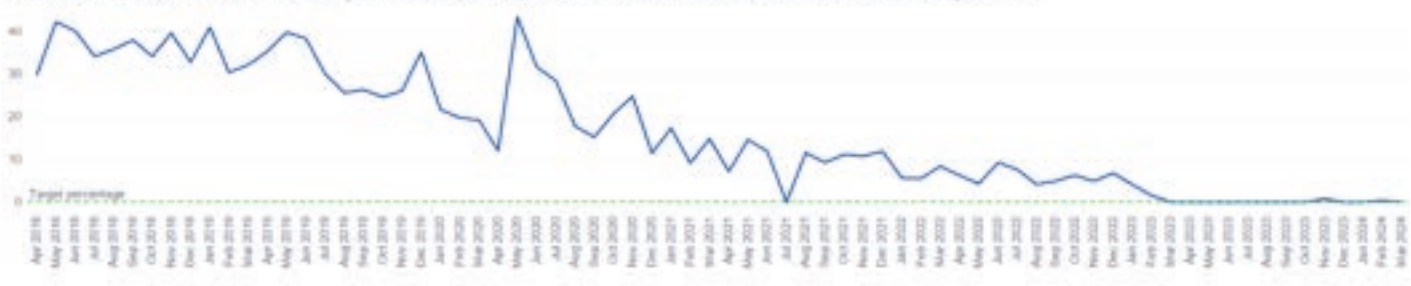
The table below shows our total carbon dioxide emissions from the baseline period to latest published 2022 data.

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

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

Desflurane as a percentage (%) of all volatile anaesthetic gases

Litres of desflurane divided by the litres of all volatile anaesthetic gases issued by trust pharmacy system (Note: this includes waste and returns). A downward trend shows a lower usage of



Some of the key headlines regarding our Green Plan achievements include:

- Reduction of paper generation by over 2m sheets per year as a result of digital programmes.
- Significant increase in cloud computing footprint removing 80% of onsite servers by the end of Q1 (20224–25) reducing our overall CO2 emissions.
- Increased utilisation of virtual appointments from around 48k in 2019–20 to 134k in 2023–24 (+180%) meaning less patients travelling to hospital.
- Significant improvements in waste sent to landfill with:
  - ◊ 615 tonnes of waste recycled (includes estimated confidential waste paper recycling)
  - ◊ 5 tonnes of waste decomposted
  - ◊ 1,036 tonnes of waste recovered (includes estimated food waste disposed of by anaerobic digestion and other domestic wastes by energy from waste)
  - ◊ 2.5 tonnes of waste re-use (furniture and equipment through the Trust's reuse portal Warp-it).
- The Trust has been successful in securing a £650,000 grant for energy-efficient LED lighting with plans for installation at both hospital sites.
- A £16m bid has been made via the Public Sector Decarbonisation Scheme to Salix Finance for heat decarbonisation, which is primarily targeted at the Trust's gas consumption and Solar Photovoltaic generation. If successful, the Trust share of the funding will be £2m.

- Training has been delivered 'For a Greener NHS – Delivering Net Zero at LTHTR'. Going forward we will consider how to further increase awareness throughout the Trust by either making the e0learning package part of mandatory training or incorporating it into induction.

The Trust's Green Plan is monitored on a regular basis through the governance arrangements for our Social Value Framework under the 'Planet' theme as illustrated below.

We also report nationally on a quarterly basis via the Greener NHS Data Collection and Greener NHS Fleet Data Collection submissions. The Board received yearly updates on progress against our agreed Green Plan and received an update on 4 April 2024. The Board would consider all relevant plans/performance in the context of our agreed Green Plan. The Trust management team is responsible for delivering our agreed Trust plans including our agreed Green Plan.

Social, community and human rights

The Apprenticeships and Widening Participation team is dedicated to fostering careers and generating employment opportunities within the local community. They collaborate with a range of organisations, including the ICB, local colleges, Department of Work and Pensions, Princes Trust, Lancashire County Council, children in care, charities, and business networking groups.

The table below provides a brief overview of the range of programmes we provide and the outcomes for 2023–24:

Programme	Description	Outcomes 2023–24
Pre-Employment Programme	8-week programme to support long-term unemployed people within our community back into employment.	19 participants 13 completed 11 employed with the Trust
Reboot	Targeted at 'job ready' candidates providing a 4-week programme to equip participants with knowledge, skills and enhanced understanding combined with direct observation in the workplace setting for their preferred role or career.	24 participants 19 completed 7 employed within the Trust
Ready, Steady, Apply	A three-day classroom-based programme to support candidates who struggle with the application process. The programme offers guidance and interview tips, guaranteeing candidates an interview upon successful completion.	46 participants 35 completed 18 employed within the Trust
Preston Widening Access Programme	Disadvantaged students who aspire for a career in Medicine are provided with support to help them gain knowledge and experience to assist with their application for a place to study at Manchester University. This programme is in its tenth year.	15 participants 14 guaranteed interviews Outcomes to be confirmed in 2024
Work Familiarisation Programme	A six-week programme for students with learning difficulties and disabilities to gain an insight into the world of work. Following completion, participants can opt to take part in more formal work experience opportunities. To date, approximately 1000 learners have completed it.	15 participants 15 completions
Work Experience Placements	Offers placement opportunities to individuals of all ages from across the region to gain first-hand insight into clinical (learners aged 16 and over) and non-clinical roles (learners aged 14–15) across the Trust.	Approximately 100 participants
Inspiring Careers	Virtual clinics helping school and college students to gain interview skills, application form writing skills and advice on career pathways, and attendance at a range of careers events at local high schools and colleges.	3 events held over several days
Careers Events	These events are held at various colleges, high schools and within our very own LIFE centre to promote healthcare professions.	349 learners attended. The team visited 44 sites across the region

Counter fraud

We have a policy in respect of countering fraud and corruption which includes contact details of the national helpline and a local independent counter fraud officer. The Trust has an accredited anti-fraud specialist provided by Mersey Internal Audit Agency (MIAA) and they deliver the service in line with NHS Counter Fraud Authority's standards.

Health and safety performance

The Trust's policy is to safeguard the health and safety of all its employees, patients, visitors, and anyone who may be affected by Trust activities by ensuring the Trust is compliant with the Health and Safety at Work Act (1974). This is the primary legislation covering occupational health and safety in the United Kingdom (UK) and defines the fundamental structure and authority for the regulation and enforcement of workplace health, safety, and welfare in the UK.

The overall responsibility for leading and implementing health and safety arrangements rests with the Chief Executive and the Board of Directors. The Board fulfils its obligations through the designated Director responsible for health and safety, the Chief Nursing Officer. The Director of Estates and Facilities has management responsibility for physical health and safety and the Associate Director of Safety and Learning for delivering health and safety governance.

The Trust has an appointed Health and Safety Manager who is the designated Trust competent person with the necessary qualifications as defined in the requirements of the Management of Health and Safety at Work Regulations. They have the significant remit to review and manage health and safety governance operationally across the hospital sites. The Health and Safety Manager is supported by subject matter experts within the Trust and through responsible officers whose role it is to co-ordinate and lead health and safety within their own area or service. These roles are supported with a programme of training to further upskill the Trust in health and safety management.

Prohibition or enforcement notices

The Trust has not received any prohibition or enforcement notices during the year.

Overseas operations

The Trust does not have any subsidiaries overseas.

This Performance Report is signed on behalf of the Board of Directors by:

Professor Silas Nicholls
Chief Executive
25 June 2024

Lancashire Teaching Hospitals NHS Foundation Trust

ACCOUNTABILITY REPORT 2023–24

DIRECTORS' REPORT

The Directors present their annual report on the activities of Lancashire Teaching Hospitals NHS Foundation Trust.

This Directors' report is prepared in accordance with:

- sections 415, 416 and 418 of the Companies Act 2006 (section 415(4) and (5) and sections 418(5) and (6) do not apply to NHS Foundation Trusts) as inserted by SI 2013 (1970)
- Regulation 10 and Schedule 7 to the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008. All the requirements of schedule 7 applicable to the Trust are disclosed within the report
- additional disclosures required by the Treasury's Financial Reporting Manual
- additional disclosures required by NHSE in its Annual Reporting Manual

Our Board of Directors

Our Board of Directors is a unitary Board and has a wide range of skills with a number of Directors having a medical, nursing or other health professional background. The Non-Executive Directors have wide-ranging expertise and experience, with backgrounds in finance, audit, IT, estates, commerce, quality and service improvement, health and social care, risk, governance and regulation, and education. The Board is balanced and complete in its composition, and appropriate to the requirements of the organisation. The respective roles and responsibilities of Board and Council, the types of decisions made and matters reserved or delegated are set out in the constitution and standing orders of the Board.

Please note that (I) indicates that the Non-Executive Director is considered independent.

Non-Executive Directors

Peter White, Chair

Appointment: 1 August 2023 to 31 July 2026

Peter joined the Trust in August 2023 and is also Chair of North West Ambulance Service (NWAS) NHS Trust, the largest combined urgent and emergency care service in the UK. Peter has been a non-executive in a national housing association and chaired their neighbourhood services committee, where he was responsible for gaining assurance relating to safety and performance. Peter was instrumental in developing the organisation's approach to risk management and performance monitoring.

Originally from Leyland and now a resident of the Ribble Valley in Lancashire, Peter enjoyed a varied career policing all areas of Lancashire from 1983 until his retirement in 2013, most of his operational policing career centred around Preston, South Ribble, Chorley and West Lancashire before being promoted to senior positions including Head of Uniform Specialist Operations, Commander of Preston division, head of the force's corporate change programme and finally Assistant Chief Constable responsible for the People portfolio. In these senior roles Peter led the delivery of multi-agency approaches to gun and gang crime, transformation of services in response to budget cuts and latterly the development and implementation of wellbeing and diversity strategies that subsequently supported the development of strategies at a national police level.

Professor Paul O'Neill, Non-Executive Director (I)

Appointment: 4 March 2019 to 3 March 2025

Paul is Professor Emeritus at the Manchester University and formerly a Consultant Physician at Manchester Foundation Trust with special interests in elderly care and stroke medicine. He has been the Head of School and Deputy Dean for the Faculty of Medical and Human Sciences. He received a National Teaching Fellowship and has published extensively in medical education and clinical research, as well as co-authoring six books. Internationally, Paul was a member of Faculty for the Harvard-Macy medical educators programme and acts as an education consultant internationally. On behalf of the Medical Schools Council, he led the work on devising a new selection

system for the Foundation Programme implemented in 2012. He has an interest in patient and public involvement in medical education and established the Doubleday Centre for Patient Experience at Manchester. In 2013, he was awarded the President's Medal of the Academy of Medical Educators for his achievements. Paul continues to work extensively for the General Medical Council in quality assuring undergraduate and postgraduate medical education. Paul is the Chair of the Trust's Education, Training and Research Committee. His appointment fulfils the Trust's establishment order requirement for a university representative.

Paul was appointed Interim Chair on 1 September 2022 until 31 July 2023.

Tim Watkinson, Non-Executive Director (I)

Appointment: 1 April 2016 to 31 March 2025

Tim is a qualified accountant with over 25 years' experience in senior audit positions in the public sector. He was previously the Group Chief Internal Auditor for the Ministry of Justice and prior to that was a District Auditor with the Audit Commission, including terms of office in Lancashire County Council, Preston City Council and Chorley Borough Council. Tim has led national teams and taken a lead role for the Audit Commission in the development of methodology for improving the performance of local authorities. Tim has experience of working in major accountancy firms providing audit and consultancy services to the public sector including the NHS. He has also been employed as an accountant and a Chief Internal Auditor within the NHS.

Tim was appointed as the Senior Independent Director (SID) on 20 September 2022. He continues as the Chair of the Trust's Audit Committee. He is also the Non-Executive Board lead for Freedom to Speak Up and a member of the Rosemere Management Committee. Outside the Trust, Tim is an independent member of the UK Statistics Authority's Audit and Risk Assurance Committee.

Dr Tim Ballard, Non-Executive Director (I)

Appointment: 1 October 2023 to 30 September 2026

Tim was born and brought up in Lancashire and after qualifying in medicine he went into general practice in 1988. He was a GP trainer for about 25 years and was an Examiner for 21 years for the membership examination of the Royal College of GPs (RCGP) and for a period led the Simulated Surgery module assessing the consultation skills of doctors. Tim was a nationally elected member of Council at the RCGP for 12 years and served as Vice Chair at the RCGP from 2013 to 2016.

Since 2016 Tim has been a National Clinical Advisor at the Care Quality Commission (CQC) giving clinical advice to the commission around the areas of general practice, independent primary care, online and digital health, as well as supporting CQC inspections. Tim is a keen advocate for environmental sustainability especially as it relates to healthcare.

Tim is the Board-level Ockenden Maternity Safety Champion.

Victoria Crorken, Non-Executive Director (I)

Appointment: 24 January 2022 to 23 January 2025

Victoria is an experienced senior leader within public sector and commercial environments. With 26 years' operational policing experience in Lancashire Constabulary, she has a deep understanding of the complex socio-economic and health challenges within local communities and has developed collaborative cross-sector partnerships to tackle inequality. Currently the Senior Security, Compliance and Risk Manager for the Co-op Group Ltd, Victoria led the transformational change of the Crime, Security, Regulatory Compliance and Business Resilience strategy and her particular areas of expertise are stakeholder partnership collaborations, governance, risk management and regulatory oversight. Victoria has an MBA from the University of Central Lancashire Business School.

Kate Smyth, Non-Executive Director (I)

Appointment: 4 February 2019 to 3 February 2025

Kate is a chartered town planner and worked in planning and economic development for many years in local authorities across the North West. She then ran her own consultancy business for 25 years specialising in economic development and disability and has extensive experience working in the public and community and voluntary sectors. From 2012 to 2019, she was the Lay Member (Patient and Public Involvement) at Calderdale Clinical Commissioning Group. Kate was also the equality lead and the lead for deprivation, poverty and housing. From 2010 to 2019, she was an independent Board member (latterly, the Deputy Chair) at Kirklees Neighbourhood Housing and the Equality Champion. She is currently a Lay Leader at Yorkshire and Humber Patient Safety Research Collaboration researching safe care in the home. In 2019 was appointed to the North West Regional Stakeholder Network, established by the Cabinet Office Disability Unit. In the autumn of 2020 Kate co-founded the Disabled NHS Directors Network and she has been a co-Chair since March 2021. Kate is the Chair of the Trust's Charitable Funds Committee and Safety and Quality Committee. In 2023 Kate was appointed to serve on the ICB People Committee.

Jim Whitaker, Non-Executive Director (I)

Appointment: 3 July 2017 to 1 July 2024

Jim is an experienced Executive currently working at BT Enterprise, where he is Director of Project Management. During his career, Jim has led many large-scale IT transformation programmes for customers in the UK and abroad; these have typically been high complexity and operationally critical in nature. He has worked with customers in many sectors including Government, Defence, Investment Banking and Retail. Jim is a Chartered IT Professional with the British Computer Society and holds project management qualifications, which include APM RPP, MSP and Prince 2. His areas of expertise are strategic planning, managing change, governance, and risk management. Jim is the Chair of the Trust's Workforce Committee.

Tricia Whiteside, Non-Executive Director (I)

Appointment: 9 September 2019 to 8 September 2025

Tricia is a transformational leader with a wealth of financial services experience having held senior leadership roles within large Fortune 500 and FTSE100 organisations. Her experience gathered over 25 years includes owning aspects of global control frameworks and assuring compliance to the expected standards of control, establishing Strategic Change Portfolios, operational delivery of integration programmes following organisational mergers/ acquisitions and led upon significant business transformation. Over the last 11 years she successfully established her consultancy business which provided interim management support, with focus on setting up new operational functions and building sustainable internal capabilities, creating portfolios of strategic change to improve operational performance and financial stability, strengthening governance and control regimes, consulting on risk management strategies, and positively responding to increased regulatory scrutiny. Tricia is the Chair of the Trust's Finance and Performance Committee.

Tricia was appointed Acting Vice Chair from 1 September 2022 until 31 July 2023.

Associate Non-Executive Directors (non-voting)

Uzair Patel, Associate Non-Executive Director (I)

Appointment: 1 October 2023

Uzair is a Chartered Accountant and senior finance professional with deep and wide-ranging experience across global banking in a range of technical and commercially focused roles. He is a board member of Torus Foundation supporting communities in Liverpool and the surrounding areas. He was previously a board member at the national domestic-violence and abuse charity, Safe Lives, as well as Chair of Audit and Risk at King's College London Students' Union. He was co-creator of the award-winning #ThisIsMe mental-health campaign at Barclays and across the City of London in partnership with the Lord Mayor of London. He read Biomedical Sciences at King's College London with a focus on neuroscience and pharmacology.

Michael Wearden, Associate Non-Executive Director (I)

Appointment: 10 June 2022 to 9 June 2024 (two-year fixed term)

Michael is a values-driven leader with significant strategic experience of working within the Third Sector, driving business transformation and managing diverse teams in the delivery of health-related programmes across the North West. He is currently Managing Director of Lancashire charity Red Rose Recovery, the largest Lived Experience Recovery Organisation in the country and has over 15 years' experience in developing and managing innovative programmes that support people of all ages, backgrounds and complex needs from across the UK to flourish and create a positive impact on individual wellbeing and life changes.

Michael is also Non-Executive Director for Lancashire-based CIC U-Develop and Founder and Director of MWD Consultants which supports various Health and Wellbeing voluntary, community, faith and social enterprise (VCFSE) sector organisations from across the North of England to grow and thrive.

Peter Wilson, Associate Non-Executive Director (I)

Appointment: 16 June 2022 to 15 June 2024 (two-year fixed term)

Executive Directors

Professor Silas Nicholls, Chief Executive

Permanent post – appointment from 8 January 2024

Silas is an experienced Chief Executive and NHS leader who began his NHS career as a graduate management trainee. He has since held a wide range of general management posts, including commissioning roles in health authorities, management of community services and extensive hospital management experience.

Silas has held a number of Chief Executive posts since 2016 and joined Lancashire Teaching Hospitals in January 2024.

In addition to his Chief Executive role, Silas is the Chair of the North West Leadership Academy.

In January 2024 he was awarded the title of Professor of Leadership and Healthcare Management – Institute of Medicine, University of Bolton.

Sarah Cullen, Chief Nursing Officer

Permanent post – appointment from 1 August 2019

Sarah is a Registered Nurse with experience in a variety of nursing and operational roles in a broad range of specialties. Sarah spent 18 years of her career at University Hospitals of Morecambe Bay and joined Lancashire Teaching Hospitals in 2017 as the Deputy Nursing, Midwifery and AHP Director becoming the Executive Nursing, Midwifery and AHP Director in 2019. Sarah is the Executive lead with responsibility for the hospital charity, clinical governance, maternity, children and safeguarding. She is also a trustee of the post graduate education charity.

Imran Devji, Interim Chief Operating Officer

Interim post – appointment from 1 October 2023 (one year fixed-term)

A local resident in Lancashire, Imran is our Interim Chief Operating Officer with 31 years' experience in the NHS initially as a critical care nurse progressing on to commissioning, service improvement, community service director, acute divisional director, and Deputy Chief Operating Officer roles across integrated care organisations mainly in London and the South. Imran is passionate about leadership in health care championing patient safety and colleague wellbeing to deliver quality care.

Gerry Skailes, Chief Medical Officer

Permanent post – appointment from 1 March 2018

Gerry graduated from Guys Hospital in London and spent the early years of her medical training in London and the South Coast before moving to the Christie Hospital to undertake specialist training in Clinical Oncology. She was appointed as a Consultant at Royal Preston Hospital in 1997 with an interest in treating lung and gynecological cancers. She has held a number of leadership roles within the Trust and North West region including Clinical Lead for the Lancashire and South Cumbria Cancer Alliance and Deputy Medical Director of the Trust. Gerry continues to work as a Consultant in Oncology undertaking a weekly acute oncology ward round and is actively involved in a number of the ICP and ICS Committees. Gerry was appointed as the Trust's full-time Medical Director from March 2018 and is also our Caldicott Guardian.

Jonathan Wood, Chief Finance Officer/Deputy Chief Executive

Permanent post – appointment from 1 August 2019

After graduating, Jonathan joined the North Western financial management training scheme in 1992 where he worked with a number of Health Authorities within Greater Manchester. Since qualifying he has worked for a number of NHS organisations, including Salford Royal, the North West Strategic Health Authority, East Lancashire Hospitals NHS Trust and Leeds Teaching Hospitals NHS Foundation Trust. He has supported a number of hospital developments over the years and enjoys working with teams in resolving complex problems.

Executive Directors (non-voting)

Ailsa Brotherton, Director of Continuous Improvement and Transformation

Permanent post – appointment from 1 December 2017

Ailsa joined the Trust in 2017 from Manchester Foundation Trust where she was the Director of Transformation for the Single Hospital Programme. Prior to this Ailsa was the Clinical Quality Director for the North of England with the Trust Development Authority/NHS Improvement. She has also held a post-doctoral senior research fellow post, has a Masters in Leadership (Quality Improvement) from Ashridge Business School, and is a Health Foundation Generation Q Fellow. Ailsa has extensive experience of designing and delivering quality improvement and large-scale change programmes. Last year, Ailsa was awarded an honorary professorship in the School of Health and Wellbeing at the University of Central Lancashire and is working with our academic partners to ensure all our improvement programmes are evidence based and evaluated. Ailsa is a member of the national Improvement Directors' network, as well as a registered dietitian.

Stephen Dobson, Chief Information Officer

Permanent post – appointment from 1 April 2020

Stephen joined the Trust in April 2020 from Greater Manchester's Health and Care Partnership where he was the Chief Digital Officer. Prior to this Stephen spent eight years as Chief Information Officer for Wrightington, Wigan and Leigh NHS Foundation Trust. He has also spent over 10 years working for Pfizer Pharmaceuticals within the USA and UK within a variety of roles including Pharmacogenomics, Clinical Trials, Informatics and Knowledge Management. Stephen has a PhD in Molecular Genetics and extensive experience leading digital programmes.

Gary Doherty, Chief Strategy and Planning Officer

Permanent post – appointment from 30 January 2022

Gary joined the Trust in February 2020 and is an experienced NHS leader having worked in operational and planning roles at a range of levels including Chief Executive. He has over 25 years NHS experience and has worked in both the English and Welsh NHS, mainly in hospital provision but also at a regional level for the Department of Health.

Naomi Duggan, Director of Communications and Engagement

Permanent post – appointment from 1 April 2020

Naomi joined the Trust in April 2020 having previously undertaken a similar role at University Hospitals of North Midlands from October 2015 where she was a member of the Board and Executive team. Prior to this, Naomi has held senior communications and engagement roles at Tameside and Glossop Primary Care Trust, Oldham Metropolitan Borough Council and within private sector retail.

Naomi has run her own consultancy business and after her first degree she started her career as a Management trainee on the Blue Chip British Coal Corporation graduate scheme. Naomi has worked on a number of transformational projects for the NHS including Better Care Together in Morecambe Bay and Healthier Together in Greater Manchester, as well as controversial retail schemes which needed positive engagement to win the hearts and minds of a range of key stakeholders in order to secure planning permission and political and community support.

A graduate of Leeds University, Naomi has an MBA from Leeds University Business School, a Postgraduate certificate in Marketing from Sheffield Business School and the Chartered Institute of Marketing Diploma. She is also a member of the Chartered Institute of Public Relations.

Jennifer Foote MBE, Company Secretary

Permanent post – appointment from 1 July 2022

Jennifer joined the Trust in July 2022 and has extensive experience of corporate governance across the public sector, including working as part of the Further Education Commissioner's Team in the Department of Education as a National Leader of Governance.

Jennifer was awarded the MBE in 2017 for services to governance.

Neil Pease, Chief People Officer

Permanent post – appointment from 1 December 2023

Neil brings over 25 years of NHS experience, transitioning to Lancashire Teaching Hospitals after serving nearly four years at Nottingham University Hospitals NHS Trust as Executive People Director and Chief People Officer. Before that, he held executive roles at University Hospitals of Derby and Burton NHS Foundation Trust and Northern Lincolnshire and Goole Hospitals NHS Foundation Trust.

With a degree in Sports Medicine from Glasgow University, Neil shifted his focus to education and organisational development, pioneering clinical simulation in palliative care education. His journey includes roles at NHS Hull and a stint as Director of Strategic Development at Hull Kingston Rovers Rugby League Club. He holds a Professional Doctorate from Sheffield Hallam University in organisational development and anthropology.

Board members whose term of office ended during 2023–24

The following Board members stepped down during 2023–24:

Faith Button, Chief Operating Officer**	1 May 2019 to 16 February 2024
Nikki Latham, Interim Chief People Officer	1 June to 30 November 2023
Kevin McGee, Chief Executive	1 September 2021 to 30 September 2023
Ann Pennell, Non-Executive Director	7 January 2019 to 31 May 2023
Karen Swindley, Chief People Officer	1 November 2011 to 31 May 2023

** Interim Chief Executive from 1 October 2023 to 7 January 2024.

Appointment and removal of Non-Executive Directors

Appointment and, if appropriate, removal of Non-Executive Directors is the responsibility of the Council of Governors. When appointments are required to be made, usually for a three-year term, the Trust Nominations Committee oversees the process and makes recommendations to the Council as to appointments. The procedure for removal of the Chair and other Non-Executive Directors is laid out in our Constitution which is available on our website or on request from the Company Secretary.

Division of responsibilities

There is a clear division of responsibilities between the Chair and the Chief Executive. The Chair ensures the Board has a strategy which delivers a service that meets the expectations of the communities we serve, and that the organisation has an Executive team with the ability to deliver the strategy. The Chair facilitates the contribution of the Non-Executive Directors and their constructive relationships with the Executive Directors. The Chief Executive is responsible for leadership of the Executive team, for implementing our strategy and delivering our overall objectives, and for ensuring that we have appropriate risk management systems in place.

Review of Effectiveness

All Non-Executive Directors completed satisfactory individual appraisals of their performance for 2023–24 in March and April 2024. This was reported through to Council in April 2024. Executive Directors undertook parallel reviews, reported through to the Appointments, Remuneration and Terms of Employment (ARTE) Committee.

A Committee effectiveness review is undertaken annually in order for the Board to receive assurance that all Committees have discharged their collective responsibilities.

Declaration of interests

All Directors have a responsibility to declare relevant interests, as defined within our Constitution. These declarations are made to the Company Secretary, reported formally to the Board, and entered into a register which is available to the public. The register is also published on our website and a copy is available on request from the Company Secretary.

Independence of Directors

The role of Non-Executive Directors is to bring strong, independent oversight to the Board and all Non-Executive Directors are currently considered to be independent. The Board is made up of a majority of independent Non-Executive Directors who have the skills to challenge management objectively. There is also a strong belief in the importance of ensuring continuity of corporate knowledge, whilst developing and supporting new skills and experience brought to the Board by new Non-Executive Directors.

Decisions on reappointments of Non-Executive Directors are made by the Council of Governors. A reappointment of a Non-Executive Director beyond six years is based on careful consideration of the continued independence of the individual Director and recognising the need to introduce new skills to the Board. Non-Executive Directors who are appointed beyond six years are always subject to annual reappointment, and the maximum term of office is nine years in aggregate, in line with the Trust's Constitution.

Board meeting attendance summary 2023–24

PRESENT	06/04/2023	01/06/2023	03/08/2023	05/10/2023	07/12/2023	01/02/2024	A	B	Percentage of meetings attended
VOTING NON-EXECUTIVE DIRECTORS									
Peter White			P	P	P	P	4	4	100%
Tim Ballard				P	P	P	3	3	100%
Victoria Crorken	P	P	P	Ab	P	Ab	6	4	67%
Paul O'Neill	P	P	P	P	P	P	6	6	100%
Ann Pennell	P						1	1	100%
Kate Smyth	P	P	P	P	P	P	6	6	100%
Tim Watkinson	P	P	P	P	P	P	6	6	100%
Jim Whitaker	P	P	Ab	P	Ab	P	6	4	67%
Tricia Whiteside	P	P	P	Ab	P	P	6	5	83%
VOTING EXECUTIVE DIRECTORS									
Faith Button	P	P	P	P	P	Ab	6	5	83%
Sarah Cullen	P	P	P	P	P	P	6	6	100%
Nikki Latham		P	P	Ab			3	2	67%
Kevin McGee	P	P	P				3	3	100%
Silas Nicholls						P	1	1	100%
Gerry Skailes	P	P	P	P	P	Ab	6	5	83%
Karen Swindley	P						1	1	100%
Jonathan Wood	P	P	P	P	P	P	6	6	100%
NON-VOTING ASSOCIATE NON-EXECUTIVE DIRECTORS									
Uzair Patel				P	P	Ab	3	2	67%
Michael Wearden	Ab	Ab	P	P	P	Ab	6	3	50%
Peter Wilson	Ab	P	Ab	Ab	Ab	Ab	6	1	17%
NON-VOTING EXECUTIVE DIRECTORS									
Ailsa Brotherton	P	P	P	P	Ab	P	6	5	83%
Imran Devji				P	P	P	3	3	100%
Stephen Dobson	Ab	Ab	Ab	P	P	Ab	6	2	33%
Gary Doherty	P	P	Ab	P	P	P	6	5	83%
Naomi Duggan	P	P	P	P	P	P	6	6	100%
Neil Pease					P	P	2	2	100%

P = Present | Ab = Absent | A = Maximum number of meetings the Director could have attended | B = Meetings attended

Evaluating performance and effectiveness

The CQC last undertook a Well Led inspection at the Trust in 2023 and rated the Trust as 'Requires Improvement' for Well Led.

Further information on performance and effectiveness can be found in the Annual Governance Statement, at pages 78 to 96.

The Modern Slavery Act 2015

The Trust has zero tolerance to slavery and human trafficking and is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our service. The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and, as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles. The summary below sets out the steps the Trust takes to ensure that slavery and human trafficking is not taking place in our supply chains or in any part of our service:

- **Assessing risk related to human trafficking and forced labour associated with our supply base:** we do this by supply chain mapping and developing risk ratings on labour practices of our suppliers to understand which markets are most vulnerable to slavery risk.
- **Developing a Supplier Code of Conduct:** we will issue our Supplier Code of Conduct to our existing key suppliers as well as those that are in a market perceived to be of a higher risk (for example, catering, cleaning, clothing and construction). The Supplier Code of Conduct will also be included within our tendering process. We will request confirmation from all our existing and new suppliers that they are compliant with our Supplier Code of Conduct.
- **Monitoring supplier compliance with the Act:** we will request confirmation from our key suppliers that they are compliant with the Act.
- **Training and provision of advice and support for our staff:** we are further developing our advice and training about slavery and human trafficking for Trust staff through our Safeguarding Team to increase awareness of the issues and how staff should tackle them.
- **Monitoring contracts:** we continually review the employment or human rights contract clauses in supplier contracts.
- **Addressing non-compliance:** we will assess any instances of non-compliance with the Act on a case-by-case basis and will then tailor remedial action appropriately.

Political donations

The Trust has neither made nor received any political donations during 2023–24.

Directors' declaration

All directors have confirmed that, so far as they are aware, there is no relevant audit information of which the auditor is not aware and that they have taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information. All directors understand that it is their responsibility to prepare the annual report and accounts, and that they consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable, and to provide the information necessary for patients, regulators and other stakeholders to assess the performance of Lancashire Teaching Hospitals NHS Foundation Trust, including our business model and strategy.

If you would like to make contact with a director, please contact the Company Secretary by email: **company.secretary@lthtr.nhs.uk** or telephone **01772 522647**.

Also available on our website:

Register of directors' interests
Director biographies
Statement on the division of responsibilities between Chairman and Chief Executive

QUALITY IMPROVEMENT

Below highlights some of the key developments made by the Trust to improve service quality and an overview of the Trust's arrangements in place to govern service quality. Additional information on quality is available in our 2023–24 Quality Account which will be available on the Trust website at the end of June 2024 and within our Annual Governance Statement (pages 78 to 96).

Continuous Improvement

The Trust's Continuous Improvement (CI) Strategy has been delivered throughout the year and has supported a number of key programmes as outlined below. A new CI strategy will be developed and launched through 2024.

The Lancashire and South Cumbria Flow Coaching Academy is now well established, delivering three cohorts and a fourth is currently in progress. 77 Flow Coaches have been trained and have applied the methodology in the following Big Rooms: Brain Tumour, Breast Reconstruction, Cauda Equina Syndrome, Chemotherapy, Colorectal, Deconditioning, Deteriorating Patients, Do No Attempt Cardiopulmonary Resuscitation, Eating Disorders, Emergency Mental Health, Enhanced Care, End of Life, Endoscopy, Ears Nose and Throat, Entry to Emergency and Urgent Care Frailty, Falls Prevention, Gynaecology, Inflammatory Bowel Disease, Inpatient Avoidance, Inpatient Pre-operative Pain Management, Lung Cancer, Kidney Care, Major Trauma, Neurology (Headache), Neonatal, Nutrition, Pain Management (Spine), Pneumonia, Pre-operative and Prehabilitation, Radiotherapy, Respiratory, Sepsis, Stroke and Vascular Surgery.

A fourth cohort is due to complete the programme in June 2024, adding a further 12 Flow Coaches and a further six Big Rooms will be established. These Big Rooms are: Alcohol and Tobacco, Central Venous Access, Day of Surgery Admission, Paediatric Epilepsy, Soft Tissue Knee Injury and Surgical Admissions Unit.

The Lancashire Microsystem Coaching Academy programme has now delivered six cohorts and a seventh cohort is currently in training. With 65 areas trained in the Microsystem Coaching Academy methodology and 121 Coaches, the addition of the seventh cohort will see a further 19 areas and 19 Coaches skilled up and working on local level improvements.

Over the last 12 months we have worked collaboratively with our ICS and health care partners to test a new approach to deliver system-level improvement across our Lancashire and South Cumbria footprint. Working in partnership with the Emergency Engineering Design Centre at Cambridge University we have delivered a programme as an ICS system with a focus on Frailty. We used the Engineering Better Care model to develop and test new ways to deliver healthcare for this population group. More locally across central Lancashire the team participating in the programme have focused their efforts on reducing conveyance from care homes to the Emergency Department by working with place and system partners to develop more joined-up support services and pathways to mitigate the need for Emergency Department attendance and support patients to live well and age well. The learning and outputs from this programme have been developed and integrated into the 2024 GP Quality Contract, supporting standardised identification, assessment, and care planning for our over 65 population living with Frailty.

There has been a continued focus throughout the year on building CI capability across the organisation through the delivery of the CI Building Capability Strategy in line with the NHSE report and dosing formula for provider organisations for year on of the strategy.

CI support has been provided to several of the divisions and corporate teams with the design, testing and implementation of improvement priorities in response to specific requests (outside the formal improvement programmes), often in response to organisational pressure. In year, this has included:

- HandsFirst Two (National Quality Improvement Collaborative with the Royal College of Surgeons)
- The Lancashire and South Cumbria Neck of Femurs (#NOF) Quality Improvement Collaborative
- The Hospital Handover Collaborative (regional collaborative with North West Ambulance Service and the Advancing Quality Alliance)

- Core20Plus5 Reducing Health Inequalities (national collaborative with NHS and the Institute for Health Care Improvement)
- The Race and Health Observatory and IHI Learning Action Network (national collaborative with NHS and the Institute for Health Care Improvement)
- Supporting the Patient Experience team to drive improvements in patient experience, including participating in the Imperial College and Health Foundation Scale, Spread and Embed Research Project.
- Supporting the Trust's Always Safety First Strategy delivery and improvement programmes aimed at reducing avoidance harm through the development of highly reliable systems and processes.
- Supporting pharmacy to use a CI methodology to improve compliance to prescribing oxygen and development of a prioritisation process.
- Supporting the development of a waste programme within a number of divisions
- Supporting organisational flow through the following initiatives utilising the Theory of Constraints:
  - ◊ Co-ordinating the Lancashire and South Cumbria Together Improvement Weeks in response to operational pressures
  - ◊ Improvement project in maternity triage assessment unit: a patient flow improvement programme

Always Safety First

The Always Safety First Strategy is the Trust's response to the National Patient Safety Strategy, facilitating improvement in safety metrics across the organisation. We are in year three of the strategy this year. The Board continues to recognise the benefits of embedding a culture of continuous improvement across our organisation, supporting staff to design, test, embed and sustain changes that benefit patients and the local population. This is reliant on building capacity and capability lead improvement.

Always Safety First is based on proactive regular review of our safety metrics and safety intelligence to inform our priorities, improvement co-designed with our staff and patients, shared governance, collaborative working across divisions and clinical specialties, and learning to improve. Our work is underpinned by a real-time safety surveillance system making our data visible from Ward and the Emergency Department to Board.

Research participation in clinical research

2023–24 has been a record year for the number of patients recruited during that period to participate in research, approved by a Research Ethics Committee, completed at Lancashire Teaching Hospitals. The team in the Centre for Health Research and Innovation recruited 3,421 patients to National Institute for Health Research (NIHR) portfolio adopted studies in this period. The Trust recruited a further 483 participants to non-portfolio studies. In total, there are currently 190 open research studies recruiting patients at the Trust. The return to a more balanced, pre-pandemic style portfolio has steadily seen commercial trials at 13% of the mix from 9% at the end of the pandemic.

PATIENT EXPERIENCE

The Trust's current Patient Experience and Involvement Strategy runs from 2022 to 2025. The strategy was developed and co-produced with patients, families, carers, governors, and staff who also contributed to setting the improvement actions. The strategy sets the tone to listen more and act on patient experiences, listening to patients and families when things do not go well and when they do go well. The views of patient groups who represent those with protected characteristics have actively been sought recognising the importance of intersectionality when considering the feedback.

The Patient Experience and Involvement Strategy has strong links with a range of Trust strategies including the Equality Diversity and Inclusion Strategy, the new Single Improvement Plan, and the Mental Health, Learning, Disability, Dementia and the Autism Strategies.

The Patient Experience and Involvement Strategy is divided into three sections:

1. **Insight** – improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information.

2. **Involvement** – equip patients, colleagues, and partners with the skills and opportunities to improve patient experience throughout the whole system.

3. **Improvement** – design and support improvement programmes that deliver effective and sustainable change.

The ambition of the strategy is to involve our patients and communities to co-produce and deliver services that have been formed collaboratively as equal partners. Year two of the strategy has continued to build on the firm foundations introduced in year one and raised the profile of the patient voice further.

Complaints and Concerns

Comparator data for Complaints 2021–2024

Year	Complaints received	Increase/reduction
2021–22	580	+ 219
2022–23	487	- 93
2023–24	355	-132

Source: LTHTR Datix

During 2023–24 the Trust received 355 formal complaints, a decrease of 132 from 2022–23. In year the backlog of complaints from the COVID-19 pandemic was addressed and all were closed. The complaint performance has been monitored throughout the year and patients receiving a response within 35 or 60 days increased from 50% in April through to 79% in March with an average for the year of 75% compliance. It is the intention of the team to return to and maintain the Trust target of 90% in 2024–25.

Of the 355 complaints received between April 2023 to March 2024, 285 (80%) related to care or services provided at the Royal Preston Hospital, 65 (18%) to care or services provided at Chorley and South Ribble Hospital, 1 (0.2%) to care or services provided by Preston Business Centre, and 4 (1.8%) to care and services provided at Finney House Community Healthcare Hub. There were no cases which were outside of the 12 months' timescale set out under the NHS Complaints Procedure.

Number of complaints by division 2023–24:

Division	Number (%)	Division	Number (%)
Medicine	150 (42%)	Women and Children's Services	43 (12%)
Surgery	129 (36%)	Diagnostics and Clinical Support	27 (8%)
Estates and Facilities	1 (0.5%)	Corporate Services	5 (1.5%)

Source: LTHTR Datix

Trend of ratio of complaints per patient contact 2021–24:

Year	No of complaints	Total episodes	Ratio of complaints to patient contacts
(inpatient/outpatient)	Ratio of complaints to patient contacts	717,213	1:1,987
2021–22	580	821,526	1:1,416
2022–23	487	849,328	1:1,744
2023–24	355	871,231	1:2,454

Source: LTHTR Datix

During this financial year there were 334 cases due to be closed. The outcome of these can be broken down into the following outcomes 17 (5.9%) of the complaints had been upheld. 180 (53.89%) were partly upheld and 127 (38.02%) were not upheld. 10 cases remain open at the end of the year.

Top 3 themes from complaints by division:

Division	Themes
Diagnostic and Clinical Support	1. Confidentiality or communication 2. Treatment/procedure 3. Nursing care
Women and Children	1. Confidentiality or communication 2. Treatment/procedure 3. Staff behaviour or attitude
Medicine	1. Confidentiality or communication 2. Treatment/procedure 3. Nursing care
Surgery	1. Treatment/procedure 2. Confidentiality or communication 3. Nursing care

The Parliamentary Health Service Ombudsman

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved.

Between the period April 2023 to March 2024 there were 10 cases referred to the PHSO; three were partly upheld and seven are ongoing. During this period, the PHSO sent final reports for three cases which were opened prior to April 2023 and the outcome of these were that two were not upheld and one was partly upheld. There was one further case referred to the PHSO prior to April 2022, which is still under investigation by the PHSO, and a final decision is yet to be reached.

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2023–24 a total of 3,871 compliments and thank you cards were received by wards, departments, and through the Chief Executive's Office. There has been a 45% increase in the number of compliments received during the year and departments are being encouraged to actively log compliments on the Datix system. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions.

Patient Experience Feedback

Friends and Family Test

The Friends and Family Test (FFT) is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

A target of 90% is set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department. Maternity has achieved this in Q1 and Q4, Day case and outpatients have consistently achieved more than 90% in all four quarters, inpatients and the Emergency Department are under the target percentage in all four quarters.

Although not a national requirement, the Trust undertakes surveys in CYP Services to ensure an equitable approach to measurement of experience. Children and young people using the urgent and emergency pathways are reporting less favourable experiences. The day case and outpatient departments are demonstrating positive performance. The neonatal service has maintained a sustained performance of 100%.

Friends and Family response rate

Expanding the methods used to collect feedback is important if we are to understand what matters to patients. The response rate is an area we set out to improve and the data below demonstrates this has been achieved with a total of 11,359 more valuable pieces of feedback than what was collected in 2022–23.

It is not yet possible to view this feedback through the lens of protected characteristics and deprivation however, work is underway to capture this.

Year	QR codes/ online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2021–2022	1,468	2,829	3,684	36,128	44,109
2022–2023	2,905	6,788	4,421	37,070	51,184
2023–2024	3,016	10,944	2,112	46,471	62,543

In the year 2023–24 there has been a positive increase in the response rates overall of 22.19% on the previous year. Increases have been realised with QR codes/online surveys, paper surveys and SMS test surveys. There has been a reduction in the telephone surveys which in part may be due to an increase in online and mobile preferences for service users.

National Patient Survey Results

Maternity Survey

The Maternity survey is based on a sample of maternity service users who had a live birth between 1 and 31 March 2023. In the 2023 survey the Trust was ranked 18 out of the 61 participating Trusts. Compared to the 2022 survey results, the Trust ranked 19 out of 65 Trusts. The response rate for the 2023 survey was 39% compared to the 2022 survey response rate of 44%.

National Inpatient Survey

Compared to the national inpatient survey in 2021, the Trust remains in the same position, with no areas identified as significantly better or significantly worse in 2022 (the most recent available data). The Trust is now ranked 50 out of the 70 Trusts. This compared to the 2021 survey where the Trust was ranked 55 out of 73 Trusts surveyed.

Emergency and Urgent Care Survey

The Urgent and Emergency Care Survey is carried out every 2 years. The previous survey was undertaken in 2020. The purpose of the survey is to understand what patients think of the care they have received within a Type 1 Emergency Department.

The results demonstrated an improved position for the Emergency Department compared to the last National survey in 2022.

Cancer Survey

The survey results were published July 2023. The overall score for care at our Trust was 9 out of 10, which is higher than previous years.

Common themes that require improvement across the range of cancer services include:

- Hospital care confidence in staff particularly within Head and Neck, Gynaecology and Upper Gastrointestinal
- Discussions with patients about research
- Information regarding immunotherapy

Areas where LTH has scored positively are:

- All teams scored highly for privacy when receiving results.
- All teams scored highly regarding support from main contact.
- All teams scored highly for review of care plans with patients.
- All teams scored highly in the Treatment section.

Patient Experience and Involvement

In the last 12 months the patient experience and involvement group has continued to develop and grow. The aim of the group is to have full representation from people that have protected characteristics. The group is well represented by all divisions, patients, third sector partners, charities, and advocacy groups, and focuses on patients, families and carers feedback. Stories are presented and heard from each division and data and metrics are shared to ensure learning. Quarterly reports are presented by each division giving an oversight of all aspects of patient experience across the hospitals.

The organisation remains committed to involving and engaging with our local partners and communities and this is a key thread within our strategy. Patient groups and forums include:

Patient Experience and Involvement Group	Maternity Voices Partnership
Patient Information Group	Preston Dystonia/Migraine Group
Cancer Patient Information Group	Critical Care Former Patients and Relatives Support Group
Carers Forum	Renal Strategy Group
Cancer Patient and Carers Forum	Tracheostomy Patient Forum
Specialist Mobility Rehabilitation Centre Mobility Matters	Lancashire Learning Disability and Autism Partnership
Specialist Mobility Rehabilitation Centre Complex Regional Pain Syndrome	Patient Research Group
Youth Forum	Saheliyaan Asian Ladies Forum
Visually Impaired Forum	

Patient forums help us to learn and engage with our service users. They give us the opportunity to understand the experiences felt by our patients and families and work together to ensure the pathways and services are designed to meet expectations.

Carers

Our Carers forum was established in early 2021 and is an example of how partnership working with patients and carers can improve and develop our services. The forum developed in collaboration with Lancashire Carers Service, with attendance and input from external partners.

Hospital Guides

The volunteer role is an important part of our network, enabling us to gather real time feedback from our service users. Following feedback this year we saw the recruitment of volunteer Hospital Guides to help our patients and visitors navigate our sites.

Patient Experience Champions

In 2023 Patient Experience Champions were introduced into all clinical departments across the organisation with over 170 staff trained to provide support to colleagues in relation to patient experience.

Patient Safety Partners (PSP) and Maternity and Neonatal Voices Partnership Chair

Patient Safety Partners (PSPs) are a new and evolving role developed by NHS England to help improve patient safety across the NHS. In November 2023 we welcomed three PSPs to the organisation. The PSPs join the established role of the MNVP Chair and provide a clear patient voice, advocating for patients and working with services alongside our staff, patients, families, governors and carers to influence and improve safety and experience across our range of services.

Equality, Diversity and Inclusion

The Equality, Diversity and Inclusion Strategy is the golden thread that runs through the Patient Experience and Involvement Strategy. It is vitally important that as part of this strategy we are consciously inclusive in everything we do. As part of being wholly inclusive and diverse we need to ensure we gather as much information from the patient voices of those who are seldom heard, so a real focus on those with protected characteristics whilst using friends and family feedback, Datix and PSIRF as well as working alongside our health inequalities agenda. This will enable us to really understand the true diverse voices of the patients.

MAJOR SERVICE DEVELOPMENTS

Despite significant challenges across the Lancashire and South Cumbria healthcare system due to winter pressures, sustained demand for our services and the effects of industrial action, we continued to implement a number of major service developments during 2023–24. The developments have benefited both patients and colleagues, helping to alleviate pressure on our emergency care pathways, reduce elective waits and improve flow across our sites.

These developments are testament to the resilience of our hard-working and dedicated colleagues and key partners who have remained committed to improving our services for the communities we serve. The major developments during the past year are outlined below:

Sir Lindsay Hoyle officially launches expansion of Clinical Health Psychology Services

The expansion of the Clinical Health Psychology Service was launched in May 2023 with a ribbon-cutting event by Sir Lindsay Hoyle, Member of Parliament for Chorley and Speaker of the House of Commons. The aim of the service is to offer help and support to adult patients with psychological distress that they may experience as a result of chronic and life-changing physical health conditions or injuries, such as cancer or severe spinal injury.

Future plans for the service are to continue to improve access to mental health support for long-term conditions and use it as a role-model service for other Trusts, demonstrating the benefits of co-located services and integrated care in the NHS.

UK-first for cutting-edge Lung Vision Bronchoscopic Navigation System

In June 2023, the Lancashire Teaching Hospitals became the first Trust in the UK to implement Lung Vision – the latest navigation bronchoscopy technology to locate and diagnose challenging peripheral lung tumours in a minimally invasive, safe fashion through an advanced tracking and navigation system.

Lung Vision enables doctors using a bronchoscope to examine inside a patient's lungs in real time, penetrating deeper and reaching areas they were previously unable to reach to take biopsy samples.

The Trust engaged widely with partners, colleagues and the Rosemere Cancer Foundation Charity, who funded the equipment, to manage the process of bringing the system to the UK.

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

A new Regional Hyper-Acute Stroke Unit (HASU) was opened in June 2023, bringing experts and equipment under one roof to help reduce death rates in stroke patients.

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

Waiting lists for children on the decrease thanks to new surgery offer

July 2023 saw the opening of a new low complexity day surgery service for children based at Chorley and South Ribble Hospital. The pop-up service, which operates once every two weeks from Rawcliffe Ward, was created to improve efficiency, experience and the number of children waiting for elective treatment.

The service brings together paediatric, anaesthetic and surgical teams to perform a range of procedures including dental, maxillofacial, ophthalmology, plastic surgery and ear, nose and throat.

Finney House celebrates its first anniversary

Finney House celebrated its first birthday in November 2023, marking one year since the Trust took over the facility to run a Community Healthcare Hub designed to accommodate patients who no longer need specialist hospital care.

In its first year the Community Healthcare Hub saw over 1,500 admissions and helped 70% of patients return home with support – in turn helping the local healthcare system to support discharge, patient flow and ease pressure on ambulance crews.

New breast pain clinic launches in Central Lancashire

The NHS in Lancashire and South Cumbria launched a new breast pain clinic to support people in Central Lancashire in November 2023. The clinic provides examinations and advice to patients suffering from breast pain in Preston, Chorley and other parts of Central Lancashire and aims to reduce anxiety and worry for many patients who might otherwise have been unnecessarily referred for hospital tests on a cancer pathway.

Trust upgrade robotic system to speed up prescription processing

A replacement robotic system has been installed in the Trust Pharmacy departments, to help both Royal Preston and Chorley and South Ribble Hospitals speed up prescription processing to get medication to patients faster. The update to the Royal Preston Hospital's Pharmacy department comes on the back of upgrading the system at Chorley and South Ribble Hospital and now complete, it will save valuable time for the Pharmacy team and bring greater efficiency to pharmacy processes.

Trust unveils newly refurbished Gynaecology and Early Pregnancy Assessment Unit

In January 2024, the Trust opened its newly refurbished Gynaecology and Early Pregnancy Assessment Unit at Royal Preston Hospital, helping to enhance and improve care for women and families experiencing early pregnancy or complications.

The £90,000 scheme to redesign the Gynaecology Assessment Unit, received significant support from Baby Beat – part of Lancashire Teaching Hospitals Charity – who contributed £30,000.

This initiative is part of the broader women's health improvement programme to enhance the care for women and families experiencing early pregnancy or acute gynaecological complications including miscarriage and baby loss.

STAKEHOLDER RELATIONS

Lancashire Teaching Hospitals is part of the Lancashire and South Cumbria ICS, a partnership of organisations that come together to plan and deliver joined up health and care services to improve the lives of people who live and work in the area.

Each ICS includes an ICB and an Integrated Care Partnership (ICP). The Lancashire and South Cumbria ICB is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in our geographical area. The ICP is a statutory committee jointly formed between the ICB and all upper-tier local authorities that fall within the ICS area. The ICP brings together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population, with membership determined locally.

In 2023–24, there have been many examples of collaborative work across the local health and care system against key priorities including, but not exclusive to, urgent and emergency care, discharge and elective care recovery and delivering a challenging budget, amongst others.

Examples of key stakeholder relations is set out below:

Lancashire and South Cumbria Provider Collaborative

The five NHS Trusts in Lancashire and South Cumbria formed a Provider Collaborative in 2021 with the aim of better supporting patient care, creating a great place to work and reducing duplication to ensure the very best value for taxpayers' money.

This is more important than ever given the widening health inequalities within our communities; rising demand for services; pressure on quality of care and patient safety; significant financial debt; and the health and wellbeing of our colleagues.

A number of LTH executive colleagues are Senior Responsible Officers for various projects within the Collaborative.

A key part of our collaboration is the creation of 'One LSC' (One Lancashire and South Cumbria), whereby the five Trusts in Lancashire and South Cumbria will run central services together under a collaborative partnership. This is in line with a national direction of travel, however Lancashire and South Cumbria is ahead of many systems in terms of the maturity of its proposals.

In addition, significant collaboration is underway to transform clinical services and improve outcomes, safety, and efficiency across the healthcare system. The plan contains three key elements to drive forward transforming care in hospitals:

(a) rolling programme to address fragile services;

(b) rolling programme of service reconfigurations; and

(c) production of Clinical Configuration Blueprint and delivery roadmap.

This reconfiguration aims to make best use of some of our specialist staff working as part of clinical networks to provide consistent and high-quality care for the communities we serve.

Lancashire and South Cumbria Pathology Service

Currently there are pathology services at each of the acute hospital laboratory locations within the Lancashire and South Cumbria ICS with a duplication of some pathology services across the area. In addition to the duplication of testing, activity (tests) data for the four trusts shows variances in delivery of pathology services in terms of estate utilisation, cost, and workforce between these providers.

Throughout 2023–24 work has been progressing on a business case to support the Pathology Service to establish a clinical model and delivery framework that will support working as one service. It describes network priorities that will deliver transformation and ensure that by 2025 the service is operating as a NHSE defined mature network.

In April 2023, the four acute Trusts in Lancashire and South Cumbria agreed to delegate certain strategic matters in relation to Pathology Services to the Provider Collaborative Board Joint Committee. Equally, in September 2023, Professor Anthony Rowbottom was appointed to the substantive Managing Director position for the Pathology Service after almost a year of leading the network on an interim basis.

Local Networks

The Trust continues to support equality, diversity, and inclusion across its workforce with established Inclusion Ambassador Forums, including Living with Disabilities Forum, LGBTQ+ Forum, and Ethnicity Forum. The Forums help provide a voice, give support, are a place for colleagues to raise issues, review policies and procedures, provide ideas and educate colleagues to truly embrace and celebrate difference. The Forums have Board-level sponsors and help promote Lancashire Teaching Hospitals as an inclusive employer. These are complimented with wellbeing-specific forums such as the Menopause Champions, Carers' Forum, and a recently established Endometriosis Awareness group.

We understand that it is important that our patients, their loved ones, and the local population are involved in decision-making about the care and services that we provide. The Patient Experience and Involvement Group provides a platform for staff to engage and consult with patients and the public to identify their needs. A number of local community groups are welcomed to the group including Deafway, n-Compass, Alzheimers Organisation, HealthWatch, AccessAble and others. The Trust has several service-user groups and forums covering all different aspects of patient care an example of which is our Cancer Patient and Carers forum.

National Networks

Executive team members have maintained their memberships in professional networks throughout the year to ensure partnership working at a national level. This has enabled shared learning nationally to implement best practice for our local population and included shared learning with the wider networks from innovation and best practice adopted within our Trust.

The Director of Continuous Improvement and Transformation, Ailsa Brotherton, has joined NHS England's National Improvement Board which brings together executives, directors, clinical leadership, and expert improvement science input to create the context in which continuous improvement is systematically used throughout the NHS to deliver better patient and staff outcomes. The Board will agree a small number of shared national priorities which, NHS England working collaboratively with providers and systems, will focus our improvement led delivery work with national coordination and regional leadership.

Kate Smyth has continued in the position of co-Chair of the Disabled NHS Directors' Network which represents NHS leaders with disabilities. Formed in autumn 2020, it is open to all disabled Board or equivalent members (non-executive or executive) of NHS organisations and other providers on NHS services (including Community Interest Companies). In September 2023, NHSE published the Workforce Disability Equality Standard statistics for 2022 which included a case study of the Trust's Living with Disability Ambassador Forum, which was co-written by Kate who is a great champion and advocate for disabled rights.

Many colleagues also hold professorships with academic institutions including the Chief Executive, Silas Nicholls, who in January 2024 was awarded the title of Professor of Leadership and Healthcare Management – Institute of Medicine, University of Bolton.

REMUNERATION REPORT

The NHS Foundation Trust annual reporting manual requires NHS Foundation Trusts to prepare a remuneration report in their annual report and accounts. The reporting manual and NHSI requires that this remuneration report complies with:

- Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3), section 421(3) and (4) and section 422 (2) and (3) do not apply to NHS Foundation Trusts
- Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations")
- Parts 2 and 4 of Schedule 8 of the Regulations as adopted by NHSI in the reporting manual
- Elements of the NHS Foundation Trust Code of Governance.

REMUNERATION COMMITTEES

There are two Committees which deal with the appointment, remuneration and other terms of employment of our directors. The Nominations Committee, a Committee of the Trust, is concerned with the Chair and other Non-Executive Directors. The ARTE Committee, as a Committee of the Board, deals with the pay and conditions of senior Executives.

Nominations Committee

The Committee comprises the Chair (except where there is a conflict of interest in relation to the Chair's role, when the Vice Chair or Senior Independent Director will attend), two public governors, one staff governor, and one appointed governor. The members have a nominated deputy who attends in their place if they are unable to attend. The Company Secretary advises the Committee as appropriate, and the Chief Executive is invited to attend all meetings. The Terms of Reference of the Committee are publicly available on application.

The Council of Governors appoint the members of the Nominations Committee for a two-year period and elections are held to replace any Committee member who ceases to be a governor following the annual governor elections or retirement of a governor in-year.

The composition of the Committee during 2023–24 is detailed in the attendance summary below.

Nominations Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Peter White, Chair	2	2	100%
Professor Paul O'Neill, Interim Chair	1	1	100%
Tim Watkinson, Senior Independent Director	1	1	100%
Alistair Bradley, Appointed Governor	4	3	75%
Steven Doran, Staff Governor	4	2	50%
Steve Heywood, Public Governor	4	4	100%
Janet Miller, Public Governor	4	4	100%
Substitutes: not required			

A = Maximum number of meetings the member could have attended | B = Meetings attended

Work of the Committee

During 2023–24, the Committee met on four occasions which enabled it to:

- Receive feedback on the outcome of the Chair's appraisal for 2022–23.
- Receive feedback on the outcome of the Non-Executive Directors' appraisals for 2022–23.
- Consider and recommend to the Council of Governors the appointment of the Chair.
- Receive, consider, and recommend to the Council of Governors re-appointment of two Non-Executive Directors whose terms of office were due to come to an end during 2023–24.
- Support the shortlisting and interview process for the Non-Executive Director appointments.
- Consideration and recommendation to the Council of Governors the Non-Executive Director appointments.

The search for the Non-Executive and Associate Non-Executive Director appointments during the year (which was an open advertisement process) was supported internally at no extra cost.

The Committee was committed to ensuring that vacancies during the year reached the widest possible audience, and that the selection process reflected the high standards of the Trust's approach to equality, diversity and inclusion. The Committee utilised the ability to appoint to a non-voting Associate Non-Executive position as a pro-active succession planning mechanism for the position of Audit Chair and to address further the diversity balance against all protected characteristics on the composition of the Board.

Appointments, Remuneration and Terms of Employment (ARTE) Committee

All Non-Executive Directors are members of the Committee. The Chief Executive and Chief People Officer are normally in attendance at meetings of the Committee, except when their positions are being discussed. The Company Secretary also attends meetings as appropriate to provide advice and expertise and the Committee has the option to seek further professional advice as required.

During 2023–24 the Committee was supported by Gatenby Sanderson in the recruitment search for the Chief Executive Officer at a total cost of £25,060.

ARTE Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Peter White	5	4	80%
Tim Ballard	2	1	50%
Victoria Crorken	7	6	86%
Paul O'Neill	7	6	86%
Kate Smyth	7	7	100%
Tim Watkinson	7	5	71%
Jim Whitaker	7	2	29%
Tricia Whiteside	7	6	86%

A = Maximum number of meetings the member could have attended | B = Meetings attended

Work of the Committee

During 2023–24, the Committee met on seven occasions. The Committee meetings involved a range of business in line with its terms of reference which enabled it to::

- Consider and approve the plan for recruitment of the substantive Chief People Officer.
- Receive feedback on the outcome of the Executive Directors' appraisals for 2022–23.
- Undertake the annual Committee effectiveness review.
- Consider and approve the interim arrangements for the Chief Executive and agree the plan to recruit to the substantive post.
- Approval of the arrangements for the Interim Chief Executive post including interim backfill arrangements for the Chief Operating Officer.
- Receive and approve the recommendation to appoint the substantive Chief People Officer.
- Receive and approve the recommendation to appoint the substantive Chief Executive.
- Consider and approve the plan for recruitment of the substantive Chief Operating Officer, including extension of the interim arrangements during the period of recruitment.

ANNUAL STATEMENT ON REMUNERATION

At Lancashire Teaching Hospitals, we understand that our Executive remuneration policy is key to attracting and retaining talented individuals to deliver our business plan, whilst at the same time recognising the constraints that public sector austerity measures bring.

In line with the Trust's agreed policy, the pay award for VSM posts was made in line with the recommendation of the Senior Salary Review Board in its annual report on Senior Salaries 2023.

Peter White
Chair of the Appointments, Remuneration and Terms of Employment Committee

SENIOR MANAGERS' REMUNERATION POLICY

As detailed in the Chair's statement above, the remuneration policy is designed to attract and retain talented individuals to deliver the Trust's objectives at the most senior level, with a recognition that the policy has to take account of the pressures on public sector finances.

This report outlines the approach adopted by the ARTE Committee when setting the remuneration of the Executive Directors and the other Executives who have authority or responsibility for directing or controlling the major activities of the organisation. The following posts have been designated as fitting this criterion by the ARTE Committee and are collectively referred to as the senior Executives within this report:

Executive Directors

- Chief Executive
- Chief Finance Officer/Deputy Chief Executive
- Chief Nursing Officer
- Chief Medical Officer
- Chief Operating Officer

Other Executives

- Chief People Officer
- Director of Communications and Engagement
- Director of Continuous Improvement
- Director of Strategy and Planning
- Chief Information Officer
- Company Secretary

Details on membership of the ARTE Committee and individual attendance can be found on page 47 of this report.

Our policy on Executive pay

Our policy on the remuneration of senior Executives is set out in a policy document approved by the ARTE Committee. When setting levels of remuneration, the Committee considers the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health and Social Care. In addition, the Committee considers the need to ensure good use of public funds and delivering value for money. The maximum of any component of senior managers' remuneration is determined by the ARTE Committee.

Each year, the Chief Executive undertakes appraisals for each of the senior Executives, and the Chair undertakes the Chief Executive's appraisal. The results of these appraisals are presented to the ARTE Committee, and they are used to inform the Committee's discussions. The Committee considers matters holistically when considering Executive remuneration, such as the individual Executive's performance, the collective performance of the Executive Team and the performance of the organisation as a whole.

The remuneration package for senior Executives comprises:

Salary: As determined by the ARTE Committee and reviewed annually

Senior Executives do not receive any additional benefits that are not provided to staff as part of the standard Agenda for Change contract arrangements. No senior Executives have tailored arrangements outside of those described above.

The remuneration package for Non-Executive Directors comprises:

Salary: As determined by the Council of Governors and reviewed in line with the national guidance on remuneration of Non-Executive Directors. Current rates are:

- £13,000 p.a. for Non-Executive Directors
- £6,500 p.a. for Associate Non-Executive Directors
- £2,000 p.a. as additional responsibility payment payable to the Vice Chair, Senior Independent Director and Ockenden Champion
- £55,000 p.a. for the Chair

Additional benefits:

- Gym membership discounts with NHS identification
- Access to NHS staff benefits offered by retailers
- Onsite therapies at discounted rates
- Salary sacrifice schemes

There is no provision for bonuses to be paid to any senior manager within the Trust.

All senior Executives are employed on contracts with a six-month notice period. In the event that the contract is terminated without the Executive receiving full notice, compensation is limited to the payment of salary for the contractual notice period. No additional provision is made within the contracts for compensation for early termination and there is no provision for any additional benefit, over and above standard NHS pension arrangements, in the event of early retirement. In line with all other employees, senior Executives may have access to mutually agreed resignation schemes (MARS) where these have been authorised.

Our Non-Executive Directors are requested to provide three months' notice in the event that they wish to resign before their term of office comes to an end. They are not entitled to any compensation for early termination.

During the year no Executive Director, Non-Executive Director or Very Senior Manager received a payment for loss of office.

ANNUAL REPORT ON REMUNERATION

Business expenses

As with all staff, we reimburse the business expenses of Non-Executive Directors and senior Executives that are necessarily incurred during the course of their employment, including sundry expenses such as car parking and transport costs such as rail fares.

The expenses paid to Directors (both Executive and Non-Executive) during the year were:

	2022–23	2023–24
Total number of Directors in office as at 31 March:	22	23
Number of Directors receiving expenses:	8	5
Aggregate sum of expenses paid to Directors (£00s):	£2,190	£1,837

Salary and pension contributions of all Directors and senior Executives

Information on the salary and pension contributions of all Directors and senior Executives is provided in the tables on the following pages. The information in these tables, and in the remainder of this remuneration report, has been subject to audit by KPMG LLP. Additional information is available in the notes to the accounts.

Each of the Chief Executive's, the Chief Finance Officer's and the Chief Medical Officer's salary is above £150,000 per annum but within or below the national average, when benchmarking against other Trusts. In order to ensure the level of remuneration paid by the Trust is reasonable, on an annual basis we carry out a rigorous process of benchmarking against all other Trusts (including Trusts with comparable income, with comparable headcount, by Trust type and by region). We also take into account the individual Executive's performance, the collective performance of the Executive Team and the performance of the organisation as a whole. Furthermore, we consider the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health and Social Care. Taking such factors into account, the ARTE Committee considers the remuneration for the Chief Executive, the Chief Finance Officer and the Chief Medical Officer to be reasonable.

Remuneration Report 2023–24

		2022–23				2023–24			
Name	**Title**	**Salary and Fee** (bands of £5,000)	**Taxable Benefits** (to the nearest £100)	**All pension related benefits** (bands of £2,500)	**TOTAL of all items** (bands of £5,000)	**Salary and Fees** (bands of £5,000)	**Taxable Benefits** (to the nearest £100)	**All pension related benefits** (bands of £2,500)	**TOTAL of all items** (bands of £5,000)
		£'000	**£**	**£'000**	**£'000**	**£'000**	**£**	**£'000**	**£'000**
Silas Nichols	Chief Executive Officer (from 8 January 2024)	0	0	0	0	55–60	300	0	55–60
Faith Button	Interim Chief Executive Officer (from 1 October 2023 to 7 January 2024)	0	0	0	0	65–70	0	35.0–37.5	105–110
Kevin McGee	Chief Executive Officer (left 30 September 2023)	270–275	5,800	0	275–280	150–155	0	0	150–155
Faith Button	Chief Operating Officer (Interim CEO as above, left 16 February 2024)	150–156	1	75.0–77.6	225–231	105–110	0	80.0–82.5	185–190
Imran Devji	Interim Chief Operating Officer (from 1 October 2023)	0	0	0	0	70–75	0	77.5–80.0	150–155
Jonathan Wood	Chief Finance Officer / Deputy Chief Executive Officer	175–180	0	50.0–52.5	230–235	185–190	1,200	0	185–190
Geraldine Skailes	Chief Medical Officer	205–210	0	152.5–155.0	360–365	215–220	1,200	0	220–225
Sarah Cullen	Chief Nursing Officer	145–150	4,800	50.0–52.5	200–205	150–155	4,800	2.5–5.0	160–165
Neil Pease	Chief People Officer (from 1 December 2023)	0	0	0	0	45–50	0	0	45–50
Nicki Latham	Interim Chief People Officer (from 1 June to 30 November 2023)	0	0	0	0	70–75	0	0	70–75
Karen Swindley	Chief People Officer (left 31 May 2023)	140–145	0	5.0–7.5	145–150	20–25	0	0	20–25
Stephen Dobson	Chief Information Officer	115–120	0	27.5–30.0	145–150	120–125	0	10.0–12.5	130–135
Gary Doherty	Director of Strategy and Planning	140–145	0	0	140–145	145–150	0	0	145–150

Naomi Duggan	Director of Communications and Engagement	115–120	0	35.0–37.5	155–160	120–125	0	0	120–125
Ailsa Brotherton	Director of Continuous Improvement	115–120	0	30.0–32.5	145–150	120–125	0	0	120–125
Angela Mulholland-Wells	Operational Director of Finance (from 17 October 2022)	55–60	0	15.0–17.5	70–75	125–130	0	30.0–32.5	160–165
Jennifer Foote	Company Secretary (from 1 July 2022)	80–85	0	12.5–15.0	95–100	115–120	0	27.5–30.0	140–145
Peter White	Chair (from 1 August 2023)	0	0	0	0	35–40	0	0	35–40
Paul O'Neill	Interim Chair (from 1 September 2022 to 31 July 2023) / Non-Executive Director	35–40	0	0	35–40	25–30	0	0	25–30
Ebrahim Adia	Chair (left 31 August 2022)	20–25	0	0	20–25	0	0	0	0
Tricia Whiteside	Acting Vice Chair (from 6 October 2022 to 31 July 2023) / Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
Tim Watkinson	Senior Independent Director (from 20 September 2022) / Non-Executive Director	15–20	0	0	15–20	15–20	0	0	15–20
Ann Pennell	Non-Executive Director (left 31 May 2023)	10–15	0	0	10–15	0–5	0	0	0–5
James Whitaker	Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
Kate Smyth	Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
Victoria Crorken	Non-Executive Director (from 24 January 2022)	10–15	0	0	10–15	10–15	0	0	10–15
Tim Ballard	Non-Executive Director (from 1 October 2023)	0	0	0	0	5–10	0	0	5–10
Peter Wilson (1)	Associate Non-Executive Director (from 16 June 2022)	5–10	0	0	5–10	5–10	0	0	5–10
Michael Wearden	Associate Non-Executive Director (from 10 June 2022)	5–10	0	0	5–10	5–10	0	0	5–10
Uzair Patel	Associate Non-Executive Director (from 1 October 2023)	0	0	0	0	0–5	0	0	0–5

Notes:
(1) Peter Wilson has chosen not to accept remuneration for his role. The amount disclosed is the amount that would have been received.
All members have been in post for the whole year unless otherwise stated
Non-Executive Directors do not receive any pensionable remuneration

Pension benefit:

	2023–24							
	Real increase in pension at pension age (bands of £2,500)	**Real increase in pension lump sum at pension age** (bands of £2,500)	**Total accrued pension at pension age at 31 March 2024** (bands of £5,000)	**Lump sum at pension age related to accrued pension at 31 March 2024** (bands of £5,000)	**Cash Equivalent Transfer Value at 1 April 2023**	**Real increase in Cash Equivalent Transfer Value** (CETV)	**Cash Equivalent Transfer Value at 31 March 2024**	**Employer's contribution to stakeholder pension**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Silas Nicholls Chief Executive Officer (1)	0	0	0	0	0	0	0	0
Faith Button Chief Operating Officer / Interim Chief Executive (5)	2.5–5.0	50.0–52.5	55–60	150–155	806	333	1,244	0
Kevin McGee Chief Executive Officer (2)	0	0	0	0	0	0	0	0
Jonathan Wood Chief Finance Officer / Deputy Chief Executive	0	25.0–27.5	70–75	195–200	1,465	91	1,728	0
Geraldine Skailes Chief Medical Officer	0	30.0–32.5	105–110	290–295	2,226	197	2,684	0
Sarah Cullen Chief Nursing Officer	0	35.0–37.5	40–45	105–110	527	194	794	0
Imran Devji Interim Chief Operating Officer	5.0–7.5	0	50–55	60–65	868	0	928	0
Neil Pease Chief People Officer (3)	0	0	0	0	0	0	0	0
Nicki Latham Interim Chief People Officer (6)	0	0	25–30	0	668	0	488	0
Stephen Dobson Chief Information Officer	0.0–2.5	0	30–35	0	375	88	517	0
Ailsa Brotherton Director of Continuous Improvement	0.0–2.5	0	70–75	0	954	121	1,188	0
Naomi Duggan Director of Communications and Engagement	0	0	25–30	0	359	54	466	0
Gary Doherty Director of Strategy and Planning (4)	0	0	0	0	0	0	0	0
Jennifer Foote Company Secretary	0.0–2.5	0	0–5	0	22	22	62	0
Angela Mulholland-Wells Operational Director of Finance	0.0–2.5	0	5–10	0	35	22	78	0

Notes:

(1) Silas Nicholls has chosen not to be covered by the NHS pension arrangements during the reporting year having opted out of the scheme in September 2020.

(2) Kevin McGee has chosen not to be covered by the NHS pension arrangements during the reporting year having opted out of the scheme in April 2021.

(3) Neil Pease chose not to be covered by the NHS pension arrangements during the reporting year, having opted out of the scheme in November 2018.

(4) Gary Doherty chose not to be covered by the NHS pension arrangements during the reporting year, having opted out of the scheme in October 2017.

(5) Faith Button left employment with the Trust in February 2024 and her pension entitlement has only been provided up to 29 February 2024.

(6) Nicki Latham left employment with the Trust in November 2023 and her pension entitlement has only been provided up to 30 November 2023.

Fair pay disclosure

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest-paid director in our organisation against the 25th percentile, median and 75th percentile of total remuneration of our organisation's workforce.

The banded remuneration of the highest-paid director in Lancashire Teaching Hospitals NHS Foundation Trust in the financial year 2023–24 was £250,000 – £255,000 (2022–23, £270,000 – £275,000). This is a change between years of -7.3% (2022–23, 3.8%) following the appointment of a new Chief Executive Officer in January 2024. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Set out below, the total remuneration of the employee at the 25th percentile, median and 75th percentile, is further broken down to disclose the salary component. The pay ratio shows the relationship between the remuneration of the highest paid director in Lancashire Teaching Hospitals NHS Foundation Trust against each percentile of the remuneration of the organisation's workforce.

Pay ratio information table

	2023–2024			2022–23		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
Total remuneration (£)	24,745	32,865	45,496	23,830	31,380	44,029
Salary component of total remuneration (£)	24,745	32,865	45,496	23,830	31,380	44,029
Pay ratio information	10.2	77	5.5	11.4	8.7	6.2

In 2023–24, 12 (2022–23, 2) employees received remuneration in excess of the highest-paid director in 2023–24. Remuneration ranged from £25 to £316,652 (2022–23, £20 to £303,297).

Total remuneration includes salary and non-consolidated performance-related pay but not severance payments or benefits in kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The benefit in kind pay information was not available during the preparation of the annual report disclosures but is considered to be negligible to the total remuneration cost.

The average percentage change from the previous financial year for salaries and allowances (based on total for all employees on an annualised basis, divided by full time equivalent number of employees; (both excluding the highest paid director) for employees of the Trust as a whole is 5.4% (2022–23, 7.4%). On the same basis, the average percentage change from the previous financial year for performance pay and bonuses payable is up 44.0% (2022-23 down 18.4%) due to clinical excellence award payments.

The Group Accounting Manual requires temporary agency staff to be included within the above median pay disclosures. Temporary agency staff costs equated to £20.6m in the year (2022-23, £22.2m). We have included information from our main agency staffing provider that amounts to £18.6m to calculate a meaningful annualised cost per temporary staff member for 2023-24 but some of this information was not available for the prior year.

This Remuneration Report is signed on behalf of the Board of Directors by:

Professor Silas Nicholls
Chief Executive
25 June 2024

STAFF REPORT

Our people

As at 31 March 2024, we employed 10,323 substantive members of staff. This number is broken down as shown in the below table; note that some staff hold roles that fall under different staff groups, thus the figures in the below table do not sum to the stated distinct headcount.

Staff Group	Headcount
Additional Clinical Services	2,156
Additional Professional, Scientific and Technical	218
Administrative and Clerical ***(including NEDs)***	2,173
Allied Health Professionals	703
Estates and Ancillary	906
Healthcare Scientists	276
Medical and Dental ***(excluding Lead Employer Doctors)***	857
Nursing and Midwifery Registered	3,042

A comparison of our workforce over the past three financial years is provided in the table below, and our staff turnover can be accessed via the information published by NHS Digital at the following link:
NHS workforce statistics - NHS Digital

	2023–24 HC	% of Total HC	2022–23 HC	% of Total HC	2021–22 HC	% of Total HC
Age (years)						
Under 20	63	0.6 %	74	0.7 %	57	0.6 %
20 - 29	1,849	17.9 %	1,853	18.6 %	1,778	19.0 %
30 - 39	2,800	27.1 %	2,713	27.2 %	2,359	25.2 %
40 - 49	2,332	22.6 %	2,176	21.8 %	2,091	22.3 %
50 - 59	2,143	20.8 %	2,140	21.5 %	2,157	23.0 %
60 - 69	1,071	10.4 %	961	9.6 %	890	9.5 %
70 and over	65	0.6 %	57	0.6 %	47	0.5 %

Ethnicity						
BAME: Asian	2,167	21.0 %	1,964	19.7 %	1,637	17.5 %
BAME: Black	361	3.5 %	334	3.3 %	196	2.1 %
BAME: Mixed	158	1.5 %	157	1.6 %	141	1.5 %
BAME: Other	152	1.5 %	156	1.6 %	144	1.5 %
White: Other	313	3.0 %	294	2.9 %	267	2.8 %
White: UK & ROI	7,043	68.2 %	6,935	69.5 %	6,897	73.5 %
Not Stated	129	1.2 %	134	1.3 %	97	1.0 %
	2023–24 HC	**% of Total HC**	**2022–23 HC**	**% of Total HC**	**2021–22 HC**	**% of Total HC**
Gender						
Male	2,473	24.0 %	2,309	23.2 %	2,200	23.5 %
Female	7,850	76.0 %	7,665	76.8 %	7,179	76.5 %
Recorded Disability	567	5.5 %	477	4.8 %	396	4.2 %

As at 31 March 2024, the gender split of our Board of Directors (including voting Non-Executive Directors) was eight male and five female. The gender split of our senior executives, as defined by the Appointments, Remuneration and Terms of Employment Committee, was six male and five female, with an average age of 54 years.

As an organisation we are required to publish our Gender Pay Gap report annually. The report can be accessed on our website.

The Trust is required to publish the ethnic diversity of its Board and senior managers in its annual Workforce Race Equality Standard (WRES) report, in which indicator nine assesses how far the Board reflects the ethnic diversity of the Trust's workforce. The data held by the Trust as submitted in the WRES report is set out below:

	Measure	# BME	% BME	# White	% White	# Unknown/Null	% Unknown/Null	Total
Total Board members	Headcount	1	4.55%	20	90.91%	1	4.55%	22
of which: Voting Board members	Headcount	0	0.00%	12	92.31%	1	7.69%	13
Non Voting Board members	Auto-Calculated	1	11.11%	8	88.89%	0	0.00%	9
of which: Exec Board members	Headcount	0	0.00%	10	90.91%	1	9.09%	11
Non Executive Board members	Auto-Calculated	1	9.09%	10	90.91%	0	0.00%	11
Difference (Total Board - Overall workforce)	Auto-Calculated		-23%		20%		3%	
Difference (Voting membership - Overall Workforce)	Auto-Calculated		-27%		21%		6%	
Difference (Executive membership - Overall Workforce)	Auto-Calculated		-27%		20%		8%	

Attendance management

Sickness absence data is reported on a calendar year basis (January to December 2023)::

Figures Converted by Department of Health to Best Estimates of Required Data Items:	
Average FTE 2023	8,939
Adjusted FTE days lost (to Cabinet Office definitions)	125,782
Average sick days per FTE	14.1
Statistics published by NHS Digital from ESR Data Warehouse:	
FTE days available	3,291,354
FTE days recorded sickness absence	206,110

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse
Period covered: 1 January 2023 to 31 December 2023

The 12-month average sickness absence rate for the period 1 January to 31 December 2022 was 6.30%; a marginal improvement compared to 6.46% in the previous year. The split of this between short-term sickness (less than 28 days) and long-term sickness (28 days or more) was broadly consistent with the previous year. The annualised short-term absence rate was 2.30% compared to 2.47% in 2022 and the long-term absence rate was 4.00% compared to 3.98% in 2022.

We continue to observe several colleagues experiencing complex or serious health conditions and this makes it challenging to support some individuals back to work. Our psychological wellbeing service for colleagues has focused on increasing accessibility, with self-booking options introduced and outreach calls made to individuals off sick due to mental ill-health. An equality impact assessment has also been undertaken to help us better understand barriers to access. The closure of the Lancashire and South Cumbria Resilience Hub has impacted on waiting times for our internal service and we are working with colleagues from the Provider Collaborative to develop the service specification for future mental health pathways.

Flu and COVID-19 vaccination uptake was disappointing in our 2023–24 campaign, with our lowest flu vaccination uptake for several years and reflects a downward national trend amongst frontline healthcare workers. We noted a particularly high peak of short-term absence due to seasonal viruses in the last three months of 2023; educational strategies around the importance of vaccination are being reviewed ahead of the 2024–25 vaccination programme.

Developing a wellbeing culture is the overall aim of our health and wellbeing strategy, which requires a holistic approach. Over the last year, we have supported leaders to make wellbeing pledges, trained managers in holding wellbeing conversations, increased the diversity of our Health and Wellbeing Champion cohort, embedded Schwartz Rounds, refurbished more break areas with the support of charitable funding, and commenced a continuous improvement programme around preventing and reducing violence and aggression. In 2023, we were also re-accredited with the Workplace Wellbeing Charter. This external benchmark of our health and wellbeing offer and approach will help to inform our priorities for the next 12 months. In particular, we will be expanding our support offer for colleagues around alcohol and substance misuse, developing rehabilitation pathways for colleagues returning from long-term sickness, and identifying options further to embed physical activity at work.

Occupational Health

As in previous years, in 2023–24 there were three services making up our Occupational Health offer for our workforce:

1. The service related to pre-employment screening, management referrals, immunisations, health surveillance and support for needle-stick injuries was provided by Wellbeing Partners (our joint venture with Wrightington, Wigan and Leigh NHS Foundation Trust).

2. The Occupational Health Physiotherapy Service is delivered in-house with professional leadership from our Core Therapies Team. The service exists to provide rapid access assessment and treatment for colleagues suffering from musculoskeletal injuries or conditions.

3. Psychological Wellbeing Services are also provided in-house by our team of Clinical Psychologists, Cognitive Behavioural Therapists, Counsellors, and Psychological Wellbeing Practitioners. The service has been the subject of national case studies of best practice, and we continue to see positive outcome data with colleagues experiencing reductions in measures of anxiety, depression, and burnout post-therapy.

Equality Diversity and Inclusion

To support our vision of providing Excellent Care with Compassion, we have an Equality, Diversity and Inclusion (EDI) Strategy 2021–26. The aspiration behind the strategy is to "be consciously inclusive in everything we do for our colleagues and communities". Through this we commit to treating everyone we meet; patients, their families, carers, colleagues, temporary workers, volunteers, and colleagues from other organisations with dignity, respect, kindness and understanding.

The strategy outlines a set of five principles which aim to provide a framework of ideas and options to create systematic changes, these are:

1. Demonstrating collective commitment to equality, diversity and inclusion

2. Being evidence-led and transparent

3. Recognising the importance of lived experiences

4. Being representative of our community

5. Bringing about change through education and development

We have undertaken a review of our workforce profile by ethnic group and pay band so we can understand where minority ethnic colleagues may be experiencing barriers to career progression. The greatest representation of minority ethnic colleagues in non-clinical roles are in band 2 and below (below band 1 tend to be apprentices) and in band 8c (16.7% of band 8c colleagues are from an ethnic minority background). With the exception of colleagues in band 2 or below, ethnic minority colleagues are underrepresented across all other bands when compared against the overall non-clinical ethnic minority workforce (17.8%).

From a clinical workforce perspective, the highest percentage of minority ethnic colleagues can be found in band 5 roles (44.6%) which could, in part, be due to extensive international recruitment in the last couple of years. With the exception of apprentices and band 5 clinical roles, minority ethnic colleagues are underrepresented in all other bands when compared against the overall clinical minority ethnic workforce (29.5%).

From a medical and dental workforce perspective, the highest percentage of minority ethnic colleagues can be found in trainee roles (71.4%). Minority ethnic colleagues are underrepresented at Consultant level and above, when compared against the overall medical and dental minority ethnic workforce.

Over the last 12 months, we have included a requirement for interviews for roles banded 8a and above to demonstrate the legacy of past EDI work they have undertaken. Over the next quarter we will focus on reviewing our recruitment, selection and induction processes from end to end, with the aim of identifying processes which could be open to bias and define actions required to eliminate bias and encourage diversity throughout each stage of the process.

We will also schedule and deliver Cultural Awareness sessions and EDI Masterclasses to equip leaders and managers with the skills, competence and confidence to have conversations with colleagues about ethnicity, religion, disability, sexuality or generational differences aligned to their experience of work. As well as enabling them to understand what additional needs colleagues may have and how they may be able to support them to fulfil their potential.

Staff engagement and consultation

Staff engagement

Staff engagement is at the heart of what creates and supports a positive organisational culture. Our aim is to create a positive experience of work for all our colleagues, where they feel engaged with their role, their team, and our vision as a Trust.

Organisations that have higher levels of staff engagement deliver better patient care. Staff engagement remains a priority for us as a Trust to enable us to deliver high quality services, achieve our financial plans and support future organisation change and transformation programmes.

As part of our People Plan Strategy, we are working to find new ways to help our people feel they are valued, that they belong and that they are able to make a difference. This helps to support high performance, so staff go the extra mile for our patients and services and helps us to retain our talent, with individuals wanting to stay working for us and build their future with us.

As part of our strategic aim to be a great place to work, our annual programme of work includes measuring, understanding and taking action to deliver improvements in staff engagements, satisfaction and overall experience of work.

This is delivered through the following methods:

Annual National Staff Survey

This takes place between October to November each year with all colleagues invited to participate including temporary bank colleagues. Once embargo is lifted, results are cascaded across the organisation for action to be taken at every level.

As a Trust we develop a corporate level action plan to address key themes which support organisational-wide changes along with progressing the existing People Plan strategic actions. This year, we have also used the results to identify teams from each division to offer enhanced support as part of a more proactive approach to raise levels of staff engagement and satisfaction.

National Quarterly Pulse Survey

This shorter survey is undertaken electronically (in quarters one, two and four) with all colleagues invited to participate. It provides an opportunity for colleagues to share their feedback at more regular times throughout the year as opposed to one off survey.

The response rate for this engagement method is typically lower than the annual staff survey and whilst this is not unique to our Trust (nationally Trusts achieve a response rate around 10%) we can see we are performing better, achieving between 15–19% across the quarters.

A priority to us in 2024–25 will be to consider how we can utilise this survey further to enable us to align this with our People Plan strategic aim of ‘Creating a Positive Organisational Culture’.

We have begun to consider the development of a culture dashboard which would add value and complement the Staff Survey by providing more granular and real-time insights into cultural metrics, enabling targeted interventions and continuous improvement efforts.

This could enable us to continue our focus on applying a more proactive approach so we are able to align our resources, skills, and priorities with the parts of the organisation most in need of cultural support.

Team Engagement and Development Tool

The internal TED tool has been used across the organisation for the last eight years and is designed to be used by team leaders to enable them to have a conversation about their teams' level of effectiveness and engagement. It supports team and individual engagement by providing staff with the opportunity to share their feedback and collectively identify solutions as part of the team development action plan.

As part of our work with NHSE to enable the TED tool to be used with other Trusts we are also able to complete additional data analysis to examine the relationship between the use of the TED tool and the process and delivery of improved organisational performance in satisfaction and engagement as measured by the NHS Staff Survey.

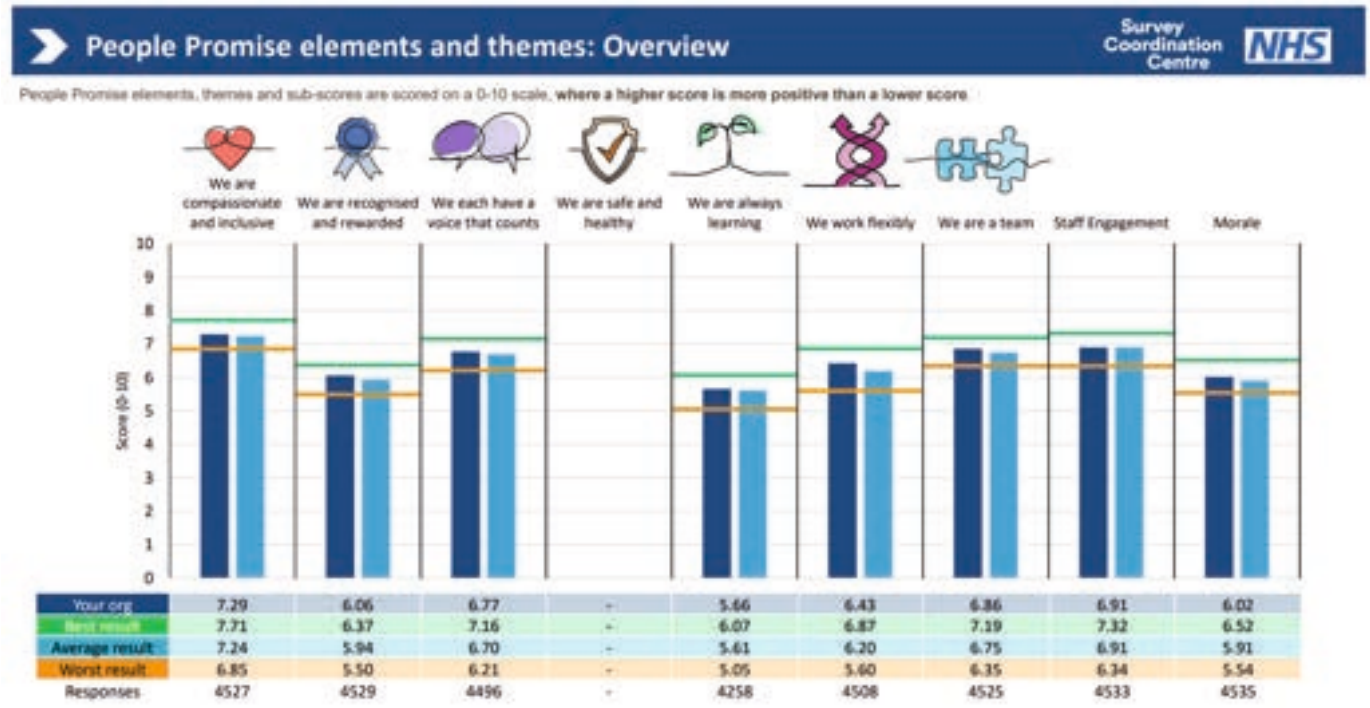
The analysis has found that where we have increased TED completion, we typically have higher levels of staff satisfaction across the People Promise elements and are more likely to be at or above the national average. We can also see that higher levels of TED completion are found to have a positive impact on team working questions and line manager effectiveness as measured in the national Staff Survey.

NHS Staff Survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in nine indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The Trust's response rate to the 2023 survey was 45%. This is a 2% increase from the 2022 survey (47%) and meets the national average (45%) in our benchmarking group (Acute and Acute and Community Trusts).

Scores for each indicator together with that of the survey benchmarking group are presented below.



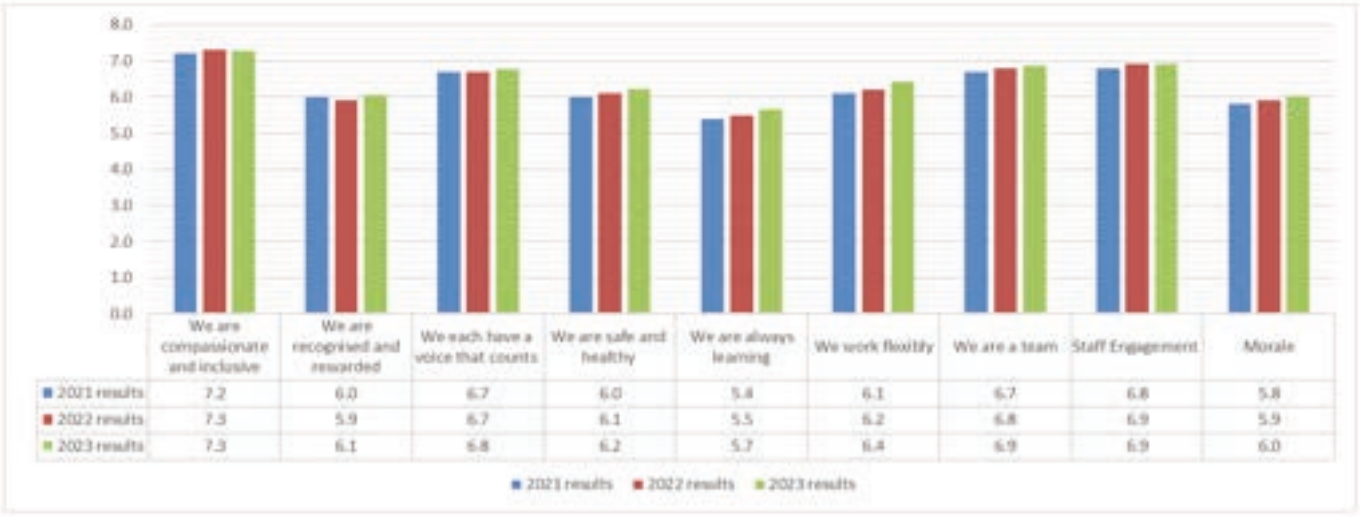
As indicated in the summary above, our position (navy blue bar) shows that we are above the national average for all elements except one (Staff Engagement measure) for which we have met the national average. (Note: 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com for more details.)

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

It is pleasing to see that some of the corporate level actions taken following last year's results appear to be demonstrating impact in this year's results. Examples include an increased focus on recognition, further work to embed our flexible working policy and toolkit, the new focus on zero tolerance training and toolkit and increase promotion of our learning and development offer across the Trust and Divisional Workforce Committees.

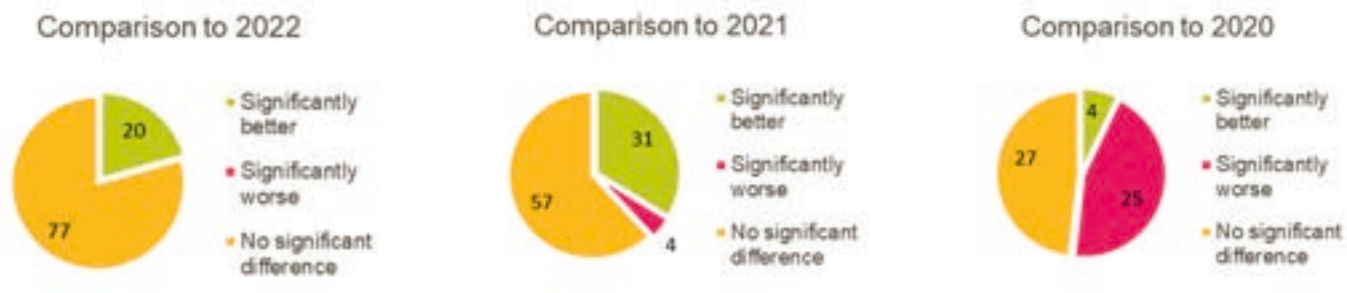
Looking at the data over the last three years (since the People Promise was launched) the graph below demonstrates that we are showing a positive trend across all the People Promise measures, staff engagement and morale.

Staff Survey – People Promise Measure Results (2021–23)



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

In summary, out of the 97 comparable questions, 83 have shown improvements, 2 remained the same and 12 declined. The pie charts below show how our 2023 question scores have compared against previous years.



2023 Staff engagement scores

The scores below detail the overall staff engagement score for 2023 and the breakdown of sub-scores which measure the three facets of engagement (motivation, involvement, and advocacy). The table shows a comparison of our scores against our previous years and the national average for this year.

The table below shows that for staff engagement we have seen improvements in all except two questions which have deteriorated in comparison linked to motivation and involvement, but advocacy shows declining scores for two out of the three questions.

Description	Organisation 2020	Organisation 2021	Organisation 2022	Organisation 2023	National Average
Motivation	**7.2**	**7.0**	**7.1**	**7.2 ↑**	**7.0 ↑**
I look forward to going to work.	**56.8%**	51.6%	55.2%	**57.0% ↑**	**55.0% ↑**
I am enthusiastic about my job.	74.2%	68.7%	70.2%	**71.3% ↑**	**69.4% ↑**
Time passes quickly when I am working.	77.3%	75.6%	74.5%	**75.6% ↑**	**72.3% ↑**
Involvement	**6.8**	**6.9**	**7.0**	**7.0 ↑**	**6.9 ↑**
There are frequent opportunities for me to show initiative in my role.	73.8%	74.9%	75.7%	**76.5% ↑**	**73.7% ↑**
I am able to make suggestions to improve the work of my team / department.	76.7%	73.8%	74.7%	**75.0% ↑**	**71.4% ↑**
I am able to make improvements happen in my area of work.	55.7%	53.9%	56.5%	**57.2% ↑**	**56.4% ↑**
Advocacy	**7.0**	**6.6**	**6.6**	**6.6 ●**	**6.7 ↑**
Care of patients/ service users is my organisation's top priority.	78.9%	72.6%	72.8%	**72.5% ↓**	**74.8% ↓**
I would recommend my organisation as a place to work.	63.6%	56.2%	57.2%	**59.4% ↓**	**60.5% ↓**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	69.1%	61.8%	59.9%	**58.3% ↓**	**63.3% ↓**
Overall Staff Engagement Score	**7.0**	**6.8**	**6.9**	**6.9 ●**	**6.9 ●**

To summarise the staff engagement findings:

- In the many areas, our results show that we are continuing to make improvements and we are above the national average benchmarking data. Whilst our overall staff engagement score has been sustained, we remain on the national benchmark.
- The engagement questions relating to 'motivation' show some encouraging increases which are above national average and are an area of strength in our results. Alongside this, the 'we are recognised and rewarded' and 'morale' scores have been identified as significantly higher in the significance testing section of our 2023 Staff Survey Benchmark Report.
- The engagement questions relating to 'involvement' show improvements in all three questions in comparison to our 2022 results and in comparison to the national average.
- The engagement questions relating to 'advocacy' remains an area of focus for us. Whilst overall the score has remained static in this sub theme, there is work to be done to improve how colleagues feel regarding whether they would recommend the organisation as a place of work and if a friend or relative needed treatment they would be happy with the standard of care. Both these questions are below the national average for our benchmarking group.
- Looking at sub-questions lined to advocacy, we can see increases when asked if staff would recommend our Trust as a place to work and year-on-year improvements, however when asked if staff are happy with the standard of care provided by this organisation the results are showing a downward trend.
- The Staff Survey free text comments also show us that we need to support colleagues to feel more recognised and valued for their contribution at the Trust and support team members to feel more involved in changes and team decision-making.

Future priorities and targets

Whilst the overall 2023 results are positive, showing us where we are continuing to make progress, they also help us to understand our priorities and key areas we need to pay attention to over the next 12 months.

Many actions will continue to be delivered by the Workforce and Organisational Development team as outlined in Our People Plan which identifies our key strategic aims and deliverables. Alongside these our priority areas include:

1. Address experiences of personal safety, i.e. discrimination, bullying, harassment, aggression by further embedding our zero tolerance approach and implement the NHS Sexual Safety Charter to support colleagues to feel safe at work.

2. Explore and scope options there may be to improve key hygiene factors such as access to kitchen, break areas, car parking solutions, catering, dilapidated estate, etc.

3. Continue to embed our new recognition offers at a corporate level and increase local level recognition to support all colleagues to feel rewarded, recognised, and valued despite internal resourcing/financial challenges.

4. Support key manager practices such as one-to-one's, appraisals and involving teams in decision-making and continue to invest in leadership and management development.

5. Work to address the different perceptions of the quality of care and find ways to increase feelings of advocacy across teams for provision of high-quality care.

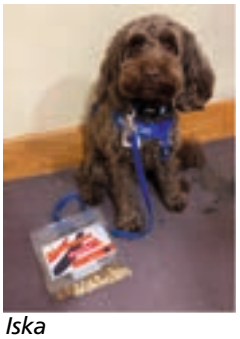
Volunteers

Our volunteers provide a huge service to the Trust, giving up their time to provide support to our patients, families, visitors and staff. Many of our volunteers support us because of a personal connection to our hospitals or because they want to give something back. For others, it is an opportunity to develop new skills, knowledge, and experience to support their employability prospects.

Volunteer roles and activities undertaken during 2023–24

- Ward volunteering – involving befriending patients on the ward and supporting staff with tasks such as making and distributing hot drinks to patients and ensuring shelves are stocked.
- Information desk – situated at our main entrances, they assist patients and visitors who need directions to find where they need to be.
- Hospital guides – taking patients and visitors to the wards or departments they need and sitting with them to keep them company while they wait.
- Gardening – a few wards are lucky enough to have access to a garden area, so we have volunteers who come in and make a real difference by maintaining them.
- Chaplaincy – these volunteers work with the Chaplaincy staff and regularly visit wards. They seek to create a calm and comforting environment in which individual needs can be recognised, valued and safeguarded. The Chaplaincy team can help nurture wellbeing, foster hope and support people through the transitions which accompany a period of ill health.
- Baby Beat – volunteers staff the shop based on the maternity wards to raise funds selling lots of different items from beautifully knitted clothing to snacks and drinks.
- Rosemere – these volunteers run the café based in the Rosemere Cancer Centre at Royal Preston Hospital.
- Hospital Radio – we have radio stations that cover both Preston and Chorley and broadcast 24 hours a day either live or pre-recorded shows.
- Volunteer dogs – we now have three specially trained dogs and their volunteer handlers have been visiting wards and departments and are so very appreciated by our patients and staff.

Bentley



Iska

Casper

We have Iska and Casper who are patient therapy dogs (PAT dogs) and they visit patients and staff on request weekly. We also have Bentley, who is a health and wellbeing dog and supports staff weekly. The feedback on all our dogs is so positive with staff commenting on the uplift in morale and wellbeing feeling. They are booked through our volunteer office.

Colleagues and networks

To stay in touch with colleagues across networks, we continue to attend regular virtual meetings with the National Association of Voluntary Service Managers as well as accessing all the resources available on the NHSE Futures Platform. This has enabled us to discuss and share ideas, best practice and the hear what others up and down the country are doing which helps us evolve each other's services.

There are monthly volunteer questions and answers forums supported by NHSE with Trusts across the country attending which we attend and contribute to.

Our new Volunteers Manager is also creating networks more locally with Trusts in our area to share ideas and best practice, as well as other local external voluntary organisations.

Learning and Development

During 2023–24, the Education Directorate made significant strides, contributing substantially to enhancing skills and acquiring knowledge across various domains. This report encapsulates key achievements, initiatives, and areas for further consideration.

Professional Education Development

The Professional Education Development team exhibited remarkable growth and impact during the year. Key accomplishments included:

- Sustained delivery of the Registered Nurse Degree Apprenticeship, resulting in 83 successful learner graduations.
- Acknowledgement of the Registered Nurse Degree Apprenticeship with a nomination for the Student Nursing Times Award, underscoring the unwavering commitment to excellence.
- Successful inauguration of the Practice Based Pathway in partnership with the University of Central Lancashire, facilitating enrolment of 60 learners.
- Delivery of 54 clinical skills sessions for University of Bolton nursing students.
- Supporting the development of 32 Trainee Nurse Associates who are due to qualify in 2024–25.
- Delivery of training support for 69 internationally recruited nurses.

Clinical Skills Education team

The Clinical Skills Education team continues to play a pivotal role in ensuring the Trust meets its legal obligations by equipping staff and students with the necessary expertise for safe, effective and compassionate patient care. Highlights from the year 2023–24 include:

- Delivering over 2,272 training sessions with 24,311 learner interactions, encompassing critical areas such as Resuscitation, Simulation, and Healthcare Assistant induction.
- Introduction of innovative programmes such as the Advanced Skills programme for Enhanced Care areas and Motivational Interviewing courses.
- Successful completion of the resuscitation defibrillator replacement programme and seamless implementation of the MyKit check scheme, augmenting efficiency and safety protocols.
- In addition to regular courses like Resuscitation and Mask Fit Testing, the team also delivered specialised courses such as Simulation, Surgical Simulation, and Return to Training programmes.

Student Training and Placement Support

The Student, Trainee and Placement Support (STPAS) team is responsible for providing comprehensive support and pastoral care to learners within the Trust.

Undergraduate and postgraduate support

- Successfully placed 1,462 students that included student nurses, undergraduate medical students, trainee nursing associates, Allied Health Professionals, Midwives and many others.
- Expanded placement provision by recruiting 13 GP surgeries.
- Development of personalised support sessions and targeted interventions for learners, coupled with proactive promotion of the services at Continuous Professional Development sessions and inductions.
- Development of enhanced induction sessions for locally employed and international doctors, and medical students.
- Introduction of an annual awards ceremony for the undergraduate medical education teams.
- Delivery of 16 Skills in Practice courses to support International Medical Graduates settle into their first training posts in the UK.
- Delivery of 308 inductions for new doctors.

- Review of 218 portfolios as part of the Annual Review of Competency.
- Hosted the Specialised Foundation Programme Showcase for specialised trainees, foundation leads and educators from across the Northwest.

Projects delivered

The STAPS team understands that the creation of a comprehensive learning experience requires development of a conducive learning environment. In this endeavour, they delivered or developed the following:

- Bespoke Educator Training for Registered Nurses, Midwives, Nursing Associates and Operating Department Practitioners.
- Practice Assessor Training for 263 established staff members.
- A Reducing Pre-registration Attrition and Improving Retention project, which included provision of 12 learning sessions (including Simulation) to a total of 267 learners. This was well received and presented at a regional NHSE conference.
- Learner Portfolio to support both learners and educators in practice on how to access resources and evidence learning for assessment.
- Developed a robust reporting system for Doctors in Training compliance, resulting in being placed at number one in the Northwest for Core Skills Training compliance rates.
- Secured NHSE funding to support the development of Speciality and Specialist grade doctors.

Apprenticeships

During 2023–24, the team offered a range of apprenticeships targeted towards workforce supply and skills gaps, and the outcomes include:

- Graduation of 42 Level 3 Senior Healthcare Support Worker (SHSW) apprentices.
- Graduation of 47 Level 3 Learning Mentor (LM) apprentices.
- Introduction of a Level 4 Learning and Skills Mentor apprenticeship.
- Recruitment of 51 new apprentice colleagues.
- Funded for 67 apprenticeships across clinical and non-clinical pathways from the levy.
- Recruitment of 19 T-Level students from Runshaw college and 4 from Preston college.

National recognition

Our Apprenticeship team has been recognised as delivering an outstanding education service. Notable achievements include:

- Highest performing NHS apprenticeship training provider in the Northwest.
- Ranked fourth nationally against other NHS providers, with the ambition to rise further.
- Our learner Qualification Achievement Rate (QAR) has consistently scored above the national average; 81.3% versus 54.6% (national average).
- SHSW QAR of 89.4% versus 50.2% (national average)
- Learning and Skills Mentor QAR of 87% versus 49.7% (national average)
- Our colleagues have been involved in apprenticeship trailblazer groups, advising on the development of new programmes.
- The team has been asked to present at the Association of Employment and Learning Providers National Apprenticeship Conference in response to the high QAR.

Awards

The Trust received appreciation at various prestigious awards ceremonies:

- Finalist at the Red Rose Awards 2023 in the Commitment to Skills category.
- Finalist at the Be Inspired Business Awards (BIBA) 2023 in the Educational Establishment of the Year and Apprenticeship Team of the Year categories.
- Highly Commended at the NHS Lancashire and South Cumbria Apprenticeship Awards
- Six apprentices were finalists at the NHS Lancashire and South Cumbria Awards:
- The Apprenticeship Team colleagues received 14 nominations at the Health Academy Awards in June 2023.

Training and compliance

The Training and Compliance team is committed to providing the highest quality of care to patients and a safe and effective work environment for our colleagues through the provision of mandatory training, which is based on the national Core Skills Training Framework and other national legislation.

The Trust has made significant strides in achieving mandatory training compliance. The number of subjects meeting target compliance of 90% completion has improved from the baseline of 9 out of 26 (2020–21) to 21 out of 33 subjects (February 2024). This includes achieving 95% compliance in Information Governance and 90% compliance across other nationally mandated subjects. While this is a positive trend, the Trust is actively working to improve compliance in the remaining 12 subjects. In addition, the Trust introduced two new training topics for all staff in May 2023. Learning Disability, Autism and Neurodiversity, and Speak Up for all staff, achieving the target of 90% for both topics within 5 months.

Innovation

The Training and Compliance team continuously strive for improvement and enhancement in the way training is delivered and recorded, notably achievements include:

- Transferring paper-based Medical Device compliance recording to an e-learning platform that enables individualised tracking of compliance and automates reminders to colleagues upon expiration. This system led to a 2.5% improvement in the figures. This system is being expanded to include all clinical competencies.
- Centralisation of training data from the divisions, which has improved requirement visibility and enabled targeting of areas that require greater focus.
- The team is piloting a novel blended learning approach for preceptorship training, designed to facilitate the smooth integration of new staff into their roles. This method will provide educators and managers with enhanced insights into trainee progress, leading to improved training effectiveness.
- The Skills Passport Programme is an initiative the team is leading on behalf of the Lancashire and South Cumbria ICS with the aim of developing an ICS-level common mandatory training framework, to support an ICS-level agreement on required training and associated training levels for practitioners, developing a model that supports skills and training transferability across the ICS, enhances staff mobility and offers the potential to deliver cost efficiencies through an integrated service delivery model.

Leadership and collaboration

The team has garnered recognition as a leader in e-learning delivery and compliance, both locally and nationally. They share training resources with healthcare providers across the UK and have been acknowledged by NHSE for excellence in immersive technology. The Trust remains at the forefront of technological innovation, exploring the potential integration of AI-powered marking for e-learning workbooks.

Actionable insights and collaboration

Action planning has been a key focus over the past year. Processes have been reviewed and updated and in collaboration with clinical divisions improved tracking and management of action plans. This joint effort ensures that improvement activities are completed, and external quality standards are met.

Learner feedback and engagement

Introduction of combined continuous professional development and learner feedback sessions has been well received by our nursing learners. This innovative approach resulted in a significant increase in feedback compared to the previous year. This approach will be implemented in other areas during the next year.

Commitment to quality education is reflected in the Trust's strong performance on national surveys. In 2023–24, learner participation rates exceeded regional averages for both the General Medical Council survey (84%, 3.34% above regional average) and the National Education and Training survey (437 completions, a 14.32% increase from the previous year).

Supporting operational excellence

Recognising the importance of strong governance for department effectiveness, the Education Governance team has completed several operational reviews during 2023–24 and supported delivery of some key initiatives, including:

- Review of external education contracts and service level agreements.
- Review of education policies to ensure currency and relevance.
- Full refresh of consolidated education income and expenditure profile.
- Introduction of Education Matters newsletter.
- Operational support of the regional Targeted Placement Expansion Programme.

Staff Costs

			2023–24	2022–23
	Permanent	Other	Total	Total
	£0	£0	£0	£000
Salaries and wages	387,942	36,181	**424,123**	398,945
Social security costs	42,322	3,948	**46,270**	42,277
Apprenticeship levy	1,957	183	**2,140**	1,989
Employer's contributions to NHS pensions	61,232	5,712	**66,944**	59,653
Pension cost – other	141	13	**154**	233
Other post-employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	20,642	**20,642**	22,210
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**493,594**	**66,679**	**560,273**	525,307
Recoveries in respect of seconded staff	-			-
Total staff costs	**493,594**	**66,679**	**560,273**	525,307
Of which				
Costs capitalised as part of assets	2,548	346	**2,894**	3,661

Consultancy costs	
2023–24	2022–23
£0	£0
0	5,000

Average number of employees (WTE basis)

			2023–24	2022–23
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,023	103	**1,126**	**1,101**
Ambulance staff	0	0	**0**	**3**
Administration and estates	1,582	64	**1,646**	**1,437**
Healthcare assistants and other support staff	2,860	395	**3,255**	**3,270**
Nursing, midwifery and health visiting staff	2,709	233	**2,942**	**2,749**
Nursing, midwifery and health visiting learners			**0**	**-**
Scientific, therapeutic and technical staff	791	15	**806**	**771**
Healthcare science staff	247	11	**258**	**252**
Social care staff	0	0	**0**	**-**
Other	32	0	**32**	**34**
Total average numbers	**9,244**	**821**	**10,065**	**9,616**
Of which:				
Number of employees (WTE) engaged on capital projects	47	4	**51**	59

Pensions/retirement benefits and senior employees' remuneration

Accounting policies for pensions and other retirement policies and details of senior employees' remuneration are set out in the notes to the accounts and on pages 50 to 54 of this report.

Off-payroll arrangements

Table 1:
Highly paid off-payroll worker engagements as at 31 March 2024 earning at least £245 per day or greater:

Number of existing engagements as of 31 March 2024	2
Of which:	
Number that have existed for less than one year at time of reporting	2
Number that have existed for between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ending 31 March 2024 earning £245 per day or greater:

Number of off-payroll workers engaged during the year ended 31 March 2024	2
Of which:	
Not subject to off-payroll legislation *	2
Subject to off-payroll legislation and determined as in-scope of IR35 *	0
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0

** A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.*

Table 3: For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024:

Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed Board members and/or senior officials with significant financial responsibility during the financial year. This figure must include both off-payroll and on-payroll engagements	0

Staff exit packages

	2023–24			2022–23		
Exit packages cost band including any special payment element	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	3	1	4	5	-	**5**
£10,000 - £25,000	1	-	1	2	1	**3**
£25,001 - £50,000	-	-	0	1	-	**1**
£50,001 - £100,000	-	-	-	-	-	**-**
£100,001 - £150,000	-	-	**-**	-	-	**-**
£150,001 - £200,000	-	-	**-**	-	-	**-**
>£200,000	-	-	**-**	-	-	**-**
Total number of exit packages by type	**4**	**1**	5	**8**	**1**	**9**
Total resource cost	**£29,000**	**£8,000**	**£37,000**	**£84,000**	**£16,000**	**£100,000**

Exit packages: non-compulsory departure payments

	2023–24		2022–23	
	Payments Agreements Number	Total Value of Agreements £000	Payments Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	8	1	16
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**1**	**8**	**1**	**16**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

Value of special severance payments approved by NHS Improvement

No special severance payments were submitted to NHSI for approval in 2023–24.

Facilities and Time Off for Union Representatives

The 2023–24 collation and reporting of facilities and time off for union representatives falls outside of the timing of this report. Based on 2022–23 however the organisation had a headcount of 56 local trade union representatives, equating to 50.84 whole-time equivalents. Two of these were seconded into our Partnership team for 100% of working hours. Of the remaining representatives:

- There were no representatives who had between 51% and 99% of their working hours as facilities time
- 27 representatives had between 1% and 50% of their working hours as facilities time
- 27 representatives had 0% of their working time as facilities time

The hours spent totalled 3,300.9 and of these 633.5 hours (19.19%) were for paid trade union duties. The total cost of facility time was £81,109.05, representing 0.02% of the pay bill.

DISCLOSURES SET OUT IN THE NHS FOUNDATION TRUST CODE OF GOVERNANCE

The purpose of the code of governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice but requires a number of disclosures to be made within the annual report.

The code of governance for NHS provider trusts contains guidance on good corporate governance. NHSE, as the healthcare sector regulator, is keen to ensure that NHS Foundation Trusts have the autonomy and flexibility to ensure their structures and processes work well for their individual organisations, whilst making sure they meet overall requirements. For this reason, the code is designed around a 'comply or explain' approach.

The new code has been in place since 1 April 2023 and sets out a common overarching framework for the corporate governance of NHS providers (being NHS trusts and NHS foundation trusts), reflecting developments in UK corporate governance and the development of integrated care systems. The Trust is committed to the principles of the Code, which is supported by its robust internal governance arrangements, meets the statutory disclosure requirements in this annual report and also adheres to all other 'comply or explain' requirements.

Comply or explain

NHSE recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for non-compliance with the code should be explained. This 'comply or explain' approach has been in successful operation for many years in the private sector and within the NHS Foundation Trust sector. In providing an explanation for non-compliance, NHS Foundation Trusts are encouraged to demonstrate how its actual practices are consistent with the principle to which the particular provision relates.

Whilst the majority of disclosures are made on a 'comply or explain' basis, there are other disclosures and statements (which we have termed 'mandatory disclosures' in this report) that we are required to make, even where we are fully compliant with the provision.

Mandatory disclosures

Code ref.	Summary of requirement	See page(s):
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	12, 40–42, 78–96
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce	13, 57–61
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements	13, 44–45, 78–96
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	99–100

Code ref.	Summary of requirement	See page(s):
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	25–32, 46–54
B.2.13	The annual report should give the number of times the board and its committees met, and individual director attendance for board and mandatory committees.	32, 46–47, 107
B.2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	31, 97–101
C.2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	47
C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	31–32
C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience	25–30
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Not applicable
C.4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports	46–48, 55–56
C.5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	102–103
D.2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	104–107

Code ref.	Summary of requirement	See page(s):
D.2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy	33
D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report	88–89
D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report	78–96
D.2.9	The annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	19, 77, 94, 105
E.2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	98–99
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report	98–100, 102–103
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations	97–98
FT ARM	The Task force on climate-related financial disclosures (TFCD) NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. The phased approach incorporates the disclosure requirements of the governance pillar for 2023/24.	19–21
FT ARM	The Directors' report should include details of company directorships and other significant interests held by directors or governors which may conflict with their management responsibilities.	25–31, 92, 98

'FT ARM' indicates that the disclosure is required by the NHS Foundation Trust Annual Reporting Manual rather than the code of governance.

Other disclosures in the public interest

NHS Foundation Trusts are public benefit corporations and it is considered to be best practice for the annual report to include 'public interest disclosures' on the Foundation Trust's activities and policies in the areas set out below.

Summary of disclosure	See page(s):
Actions taken to maintain or develop the provision of information to, and consultation with, employees.	59–61
The foundation trust's policies in relation to disabled employees and equal opportunities.	58–59
Information on health and safety performance and occupational health.	23, 58
Information on policies and procedures with respect to countering fraud and corruption.	106
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.	18
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year.	Not applicable
Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas.	Not applicable
Any other public and patient involvement activities.	36–41
The number of and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Note 5.2 to the accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Note 2.5 to the accounts
A statement that the NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.	19
Sickness absence data.	57
Details of serious incidents involving data loss or confidentiality breach.	94–95

Voluntary disclosures

We have also included a number of 'voluntary disclosures' (as defined by the Foundation Trust annual reporting manual) in this report. These can be found as follows:

Summary of disclosure	See page(s):
Sustainability / environmental reporting	19–21, 92
Equality reporting	55–56, 92
Slavery and human trafficking statement (Modern Slavery Act 2015)	33

NHS OVERSIGHT FRAMEWORK

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

(a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care; access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

(b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS Foundation Trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

NHSE placed the Trust in segment 3. This segmentation information is the Trust's position as at November 2021. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHSE website.

On 12 November 2021 enforcement undertakings were revised and these were formally accepted by the Trust on 2 December 2021. For details of the enforcement undertakings and the Trust's progress made against them, please see the Annual Governance Statement.

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the accounting officer of Lancashire Teaching Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHSE.

NHSE in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Lancashire Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Lancashire Teaching Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHSE including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Professor Silas Nicholls
Chief Executive
25 June 2024

ANNUAL GOVERNANCE STATEMENT 2023–24

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibility as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Lancashire Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and accountability

The Chief Executive has overall responsibility for ensuring that effective risk management systems are in place within the Trust, for meeting all statutory requirements, and for adhering to guidance issued by NHSI and other regulatory bodies in respect of risk and governance. The Chief Executive ensures the work of the Committees of the Board, including sub-groups, is reviewed by the Board of Directors.

The Trust has the capacity to handle risk through delegated responsibilities in place as defined in the Scheme of Reservation and Delegation of Powers, and the Risk Management Policy, both of which are approved by the Board of Directors. The Policy outlines the Trust's approach to risk, accountability arrangements and the risk management process including identification, analysis, evaluation and approval of the risk appetite and tolerance.

Accountability arrangements for risk management in 2023–24:

(a) The Board of directors has overall responsibility for ensuring robust systems of internal control, encouraging a culture of risk management, routinely considering risks and defining its appetite for risk.

(b) Committees of the Board scrutinise those risks that fall within their terms of reference on behalf of the Board of Directors, recommending new or revised risks to the Board as appropriate.

(c) The Audit Committee on behalf of the Board of Directors ensures that the Trust's risk management systems and processes are robust.

(d) For the majority of 2023–24, the Senior Leadership Team meeting was responsible for reviewing risks relevant to its remit and advising all Committees of the Board on potential/existing strategically significant risks, as well as liaising with the Divisional Boards and Groups to ensure the consistency of risk reporting and also overseeing the Trust's Risk Register.

(e) In February 2024, the Board of Directors approved a new Risk Management Strategy 2024–27 and as outlined in the Strategy, a new Risk Management Group started in March 2024, chaired by the Chief Executive, and this meeting is now responsible for risk management arrangements across the Trust.

(f) The Chief Executive, as the Trust's Accountable Officer, has overall responsibility for the risk management processes, the Risk Management Strategy 2024–27, and Risk Management Policy.

(g) The Chief Nursing Officer, Chief Medical Officer, and Company Secretary, supported by the Associate Director of Risk and Assurance, Associate Director of Safety and Learning, and Deputy Chief Nursing Officer, advises the Trust Board on all matters relating to governance, risk and quality.

(h) Each member of the Executive Team has responsibility for the identification and management of risks within their executive portfolios.

(i) The Chief Finance Officer/Deputy Chief Executive has responsibility for ensuring that the Trust has sound financial arrangements that are controlled and monitored through financial regulations and policies.

(j) The Chief Information Officer is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs reporting.

(k) The Nominated Individual with the CQC is the Chief Nursing Officer.

The BAF and Risk Register have been regularly scrutinised and reviewed through the Trust's governance structure and have been subject to internal and external reviews. The Trust's strategic intentions, policies, procedures and supporting documentation are openly accessible via the intranet for all staff to reference.

The existing organisational management structure and Risk Management Policy illustrates the Trust's commitment to effective governance and quality governance, including risk management processes.

There is a central risk management team and a centralised health and safety team, supported by divisional governance and risk teams, led by a Lead Clinical Governance and Risk Manager in each division.

As Accounting Officer, the Chief Executive has overall accountability for risk management within the Trust, however the Risk Management Policy describes the responsibility of every member of staff to recognise, respond to, report, record and reduce risks while they are undertaking work for the Trust.

Training and learning

Trust policies are available on the Trust's intranet and staff are encouraged to participate in the consultation of new and updated policies.

Risk management training is provided through the Datix training programme, available to all staff. Training for individual roles continues to be identified by managers and agreed with staff through personal development plans. Divisional governance teams also deliver localised risk management training for their services and for those who have requested additional support.

Incident reporting training is provided, and additional risk management training is delivered to staff who manage risks. There is additional risk management and incident management training available for staff on a monthly basis.

Mandatory training for all staff reflects essential training needs and includes risk management processes such as health and safety, fire safety, infection prevention and control, safeguarding children and vulnerable adults, patient safety for all staff, information governance, moving and handling, conflict resolution, fraud and bribery in the NHS, and equality, diversity and human rights.

Monitoring of training compliance and escalation arrangements are in place via the Education, Training and Research Committee, and the Divisional Improvement Forums to ensure that the Trust maintains good performance and can ensure targeted action in respect of areas or staff groups where performance is not at the required level. Where performance is below expected levels, the Trust Executive team oversees tailored support for the divisions and corporate teams in line with the Accountability Framework to underpin sustainable improvement and delivery of plans, objectives and required outcomes.

During 2023–24, a risk maturity workshop took place with Executive and Non-Executive Directors and subsequently the Board reviewed and approved the continued use of the risk appetite statement and tolerances that were developed during 2022–23.

As part of the newly approved Risk Management Strategy 2024–27, the training needs analysis for risk management is being refreshed and it is intended this will be implemented and monitored in the new financial year, upon approval.

As a learning organisation, the Trust takes an Always Safety First approach and has a strategy which seeks to

ensure good practice is identified and shared via corporate and divisional governance arrangements using multiple mediums, learning from mortality reviews, complaints, incidents and claims to reduce the risk of repeated issues. The Board of Directors receives assurances from the Safety and Quality Committee relating to the management of all serious untoward incidents, including Never Events.

The risk and control framework

Risk management is a fundamental part of operational working and service delivery. As set out in the Risk Management Policy, it is the responsibility of all employees and requires commitment and collaboration of both clinical and non-clinical staff.

The development of effective risk management across the organisation is underpinned by clear processes and procedures which include:

(a) a new Risk Management Strategy 2024–27;

(b) the Trust's Risk Management Policy;

(c) the organisational process for risk identification and analysis;

(d) a definition of significant risk and acceptable risk within the organisation;

(e) organisational risk management structures;

(f) the development and application of risk registers within the organisation;

(g) incident reporting;

(h) the accountability and responsibility arrangements for risk management; and

(i) the Board Assurance Framework.

Throughout the reporting period the Safety and Quality Committee, Finance and Performance Committee, Workforce Committee and Education, Training and Research Committee were the Committees of the Board charged with scrutinising the arrangements in place for specific areas of risk. They are supported by a number of sub-groups, including, but not limited to:

- Senior Leadership Team meeting
- Risk Management Group (introduced in March 2024)
- Divisional Management Groups
- Health and Safety Governance Group
- Infection Prevention and Control Committee
- Medicines Governance Group
- Patient Experience and Involvement Group
- Safeguarding Board
- Mortality and End of Life Group
- Safety and Learning Group (replaced by the Patient Safety Incident Response Framework [PSIRF] Oversight Panel in 2024 in line with the Trust's implementation of PSIRF)
- Capital Planning Forum
- Information Governance Forum
- Emergency Preparedness, Resilience and Response Group
- Always Safety First Group (replaced by the Always Safety First Learning and Improvement Group in 2024 in line with the Trust's implementation of PSIRF)
- Raising Concerns Group

These arrangements are supported by the work of the Audit Committee which receives assurances on the effectiveness of the risk management framework annually through the Head of Internal Audit Opinion. This is based on an internal audit programme which tests key aspects of the Trust's governance arrangements through a series of risk-based reviews undertaken throughout the year, which are also reported to the Audit Committee.

The Risk Management Policy

The policy defines risk in the context of clinical, health and safety, organisational, business, information, financial or environmental risk and also provides a definition of risk management. It details the Trust's approach to:

- the provision of high-quality services to the public in ways aimed at securing the best outcome for all involved. To this end, the Trust ensures that appropriate measures are in place to reduce or minimise risks to everyone for whom we have a responsibility;
- the implementation of policies and training to ensure that all appropriate staff are competent to identify risks, are aware of the steps needed to address them, and have authority to act;
- management action to assess all identified risks and the steps needed to minimise them. This comprises continuous evaluation, monitoring and reassessment of these risks and the resultant actions required;
- the designation of Executive leads with responsibility for implementation of the policy and the execution of risk management through operational and monitoring committees;
- action plans to maintain compliance with regulatory standards, which contribute to the delivery of the risk control framework; and
- the process by which risks are evaluated and controlled throughout the organisation. In support of the Risk Management Policy, a range of supplementary policies exist that provide clear guidance for staff on how to deal with concerns, complaints, claims, accidents and incidents on behalf of patients, visitors or themselves.

To ensure consistency, risks are systematically identified using a standardised approach. The potential consequence and likelihood of the risk occurring are scored and the sum of these scores determines the level in the organisation at which the risk is reported and monitored to ensure effective mitigation. Risk control measures are identified and implemented to reduce the potential for harm. A target risk score is created and monitored through the risk management process. In recognition that a risk may not be eliminated, this score must be set at the lowest tolerable level.

Each division has governance arrangements in place including a systematic process for assessing and identifying risk in line with the policy. Risk assessments are undertaken and this information is utilised to populate the relevant divisional risk register via our online system. Risks are continually reassessed and upon implementation of mitigating actions, where it is considered that the mitigation provides a tolerable level of risk in line with the Trust's risk appetite, the risk can be considered controlled. The responsibility for the management and control of a particular risk rests with the division concerned.

Risks were escalated to the Senior Leadership Team meeting when an action to control a particular risk fell outside the control or responsibility of that division, or where local control measures were considered to be potentially inadequate, require significant financial investment or the risk was rated as high. The Senior Leadership Team was able to escalate a particular risk to the appropriate Committee of the Board for further consideration when required and the Committee could in turn choose to escalate an operational risk to the Board of Directors for oversight. In March 2024, the Risk Management Group was initiated and assumed the responsibility for risk management arrangements, taking this over from the Senior Leadership Team meeting.

The Trust has in place a BAF which is designed to provide a structure and process to enable the Trust to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives and is made up of two parts: the **Strategic Risk Register** those risks that threaten the delivery of the strategic objectives and are not likely to change over time; and the **Operational Risk Register**, those risks that site on the divisional and corporate risk registers and may affect and relate to the day-to-day running of the organisation. They mainly affect internal functioning and delivery and are managed at the appropriate level within the organisation.

Responsibility for reviewing and updating the strategic risk and providing assurance to the Board on the controls and mitigations in place is retained by the relevant Executive Director. The BAF is also presented in full to the Audit Committee at each meeting once approved by the Board.

All operational risks are categorised in line with the Trust aims or ambitions that they predominantly impact upon. Any higher scoring operational 15+ risks are also presented to Committees of the Board to which the strategic aims or ambitions are aligned.

At the end of 2023–24, the risk profile of the Trust remains similar to that at the end of March 2023 with 489 overall risks in March 2024 compared to 488 in March 2023 and 85 high risks in March 2024 compared to 92 in March 2023. High risk themes continue to be reflective of the following:

- Financial challenges
- Increased demand
- Use of escalation areas
- Suboptimal capacity to meet targets/manage backlog following COVID-19
- Staffing challenges
- Physical environment/estate being suboptimal
- Mental health care provision

There is a continued focus on risk maturity and this is being achieved through the continued embedding of risk management within the Trust by various means, including:

- The development of a new Risk Management Strategy 2024–27.
- The Risk Management Policy, which is available to all staff through the Trust's intranet.
- Effective use of the strategic and operational risk registers at both divisional and corporate levels, and the BAF.
- Compliance with the mechanisms for the reporting of all accidents and incidents using an online incident reporting system.
- Ensuring that there is a robust process in place to escalate all risks, including divisional risks, with a rating of 15+ to Committees of the Board and the Board, if required.
- Embedding the use of dashboard, including themes, risk appetite, heat-maps, trajectory of risk and qualitative narrative on actions and mitigations.
- Automated governance dashboards for each division, providing easy access and removing the need for manual creation of dashboards. These are monitored as part of the Accountability Framework in Divisional Improvement Forums, with a specific risk section.
- Strengthening of divisional accountability processes through Divisional Improvement Forums and the Accountability Framework through Divisional Boards challenging performance of risk at Clinical Business Unit and Specialty Business Unit level.
- Continued training at all levels of the organisation in line with the National Patient Safety Strategy.
- The identification of local priorities as part of the Trust's transition from the Serious Incident Framework 2015 to the PSIRF in October 2023.
- The Trust has fully implemented PSIRF in 2023–24, having taken a phased approach to ensure capacity and capability to manage this change, which was supported by the ICB.
- Actively monitoring all serious incidents at the Safety and Quality Committee on a quarterly basis, and the Board annually.
- For the majority of 2023–24, the Senior Leadership Team meeting was used as a forum to discuss risk and share learning from the management of risks cross divisionally with the Executive team. This was achieved through presentation of a high risks report which contained key performance indicators each month alongside divisional and corporate risk registers on a cyclical basis.
- A new Risk Management Group started in March 2024, chaired by the Chief Executive, and this meeting is now responsible for the risk management arrangements across the Trust.

- Engaging with the Board of Directors using risk information to drive the Board workshop programme.
- Using outcomes from complaints, incidents, claims, Safety Triangulation Accreditation Review (STAR) visits and internal and external reviews, to mitigate future risks and aggregating these to identify Trust-wide risks.
- Connecting performance across the Trust at Board, Committee, Divisional and Specialty level using integrated performance reports which provides Ward to Board reporting that includes a range of metrics encompassing each of the elements of Our Big Plan by strategic ambition and includes quality, operation, finance, and workforce.
- Creating an open and accountable reporting culture whereby staff are encouraged to identify and report risk issues.
- Report cover sheets are linked to the Trust strategic aims and ambitions.
- Information within specific reports are categorised by and presented by strategic ambitions, for example, the Chief Executive's report and integrated performance report.
- Risks within Committee papers are connected to strategic risks within the BAF.
- Freedom to Speak Up Guardian and champions in place for staff to raise concerns. The team is promoted within the Trust and any concerns are triangulated with other processes for management, improvement, and shared learning.
- Use of an equality quality impact assessment policy which links to the planning framework and outlines the requirements of divisional management and Board members in assessing and monitoring the impact of service changes.

Risk Appetite

The Trust's Risk Appetite Statement was reviewed and discussed at a workshop with the Board of Directors in May 2023, and approved at the Board of Directors meeting in June 2023, with no changes from the previous year. The Risk Appetite Statement outlines the level of risk what the Trust is prepared to accept, after balancing the potential opportunities and threats a situation presents. In addition, the Trust's risk tolerance levels were also updated to outline the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives.

The Risk Appetite Statement set by the Board is as follows:

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

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

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

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

Quality Governance

The Trust has strong quality governance arrangements in place, which are overseen by the Safety and Quality Committee. There is a thorough cycle of business in place to ensure assurance is received about safety, patient experience and effectiveness.

A suite of quality metrics aligned to the Trust's strategic objective to Consistently Deliver Excellent Care are provided in Our Big Plan on a monthly basis to track performance which support the Committee in understanding areas to focus attention. This is replicated in other Committees of the Board where versions of Our Big Plan metrics are aligned to the relevant strategic objective overseen by the Committee. The Board of Directors also receive an overview of Our Big Plan metrics related to all strategic objectives.

This approach is replicated at divisional level with a detailed set of key performance indicators aligned to Our Big Plan, split by strategic objective, produced for divisions. These are considered as part of Divisional Improvement Forums which are chaired by a member of the Executive team as part of the Accountability Framework.

Safety, Quality and Patient Experience

The Trust has in place a range of mechanisms for managing and monitoring risks in respect of safety and quality including

- An Always Safety First Strategy 2021–24, which outlines the Trust's response and approach to implementing the National Patient Safety Strategy published in 2019 and updated in 2021.
- A Patient Experience and Involvement Strategy 2022–25, which sets out the approach to involving patients, service users and their carers.
- A Risk Management Strategy 2024–27, which sets out the approach to improving risk maturity in the organisation.
- New processes and meeting structures following the transition to the PSIRF.
- The introduction of three Patient Safety Partners for the first time in the organisation who sit alongside the Maternity Neonatal Voices Partnership chair to provide the voice of the patient during meetings and activities of the Trust.
- A Safety and Quality Committee which meets monthly and is chaired by a Non-Executive Director.
- Publication of an Annual Quality Account (Report) as a separate document to the Annual Report.
- Arrangements and monitoring processes to ensure ongoing compliance with National Institute for Health and Care Excellence (NICE) guidance and service accreditation standards.
- The Chief Medical Officer has an identified Deputy Chief Medical Officer who is the Trust lead for mortality and reports regularly to the Safety and Quality Committee in respect of mortality.
- Safety Triangulation Accreditation Review (STAR) Quality Assurance Framework is operated in all clinical departments.
- A Board Safety and Experience Programme is in place to maintain Board visibility and contact with staff delivering services.

- A safe staffing dashboard is in place to monitor nurse and midwifery staffing levels across all wards and departments and a monthly staffing report is presented to the Safety and Quality Committee through the mandated safe staffing report. This is triangulated with measures of harm (for example hospital acquired infections) and patient experience (friends and family test) for maternity services, children and neonatal services and adult inpatients, including the Emergency Department.
- The Trust routinely considers and acts upon the recommendations of national quality benchmarking exercises, such as national patient surveys and other national publications, for example reports from the Health Services Safety Investigations Body (HSSIB).
- The Trust acts upon patient feedback from complaints and concerns and from feedback from patient and public involvement representatives such as Healthwatch and Trust governors.
- Patient and staff stories are presented to the Board of Directors and actions and lessons learned are widely shared.
- There is a process for the management of all patient safety and medical device alerts, prescribing and drug alerts, field safety notices, estates and facilities alerts, service disruption alerts and all alerts that arise as a result of actions identified by NHSI, or other national bodies are acted upon.
- Where appropriate, risk alerts are made to partner organisations in line with statutory responsibilities, such as for safeguarding purposes.
- Operational and quality breaches are discussed at the relevant operational and governance forums and ICB meetings with remedial action plans enacted.

Patient Safety Incident Response Framework (PSIRF)

In line with the requirements of the National Patient Safety Strategy, the Trust commenced the transition from the Serious Incident Framework to the PSIRF on 6 November 2023.

In advance of the transition to PSIRF, the Trust sought to identify local priorities as part of the development of a Patient Safety Incident Response Plan (PSIRP). The Trust reviewed a range of information held within the organisation including:

The Trust also engaged with a range of stakeholders including staff, governors, patient representatives and the ICB.

As a result of the analysis and engagement undertaken, the Trust identified and agreed five local priorities:

1. Delayed recognition of a deteriorating patient due to gaps in monitoring (including all pregnant women)
2. Delayed, missed or incorrect cancer diagnosis
3. Prescribing or administration error or near miss of anticoagulation medication
4. Adverse discharge due to gaps in communication or misinformation
5. Delay in responding to a critical pathology finding

A PSIRF policy and the Trust's PSIRP was developed and approved at the Board of Directors meeting in October 2023. The Trust plans and policies were also endorsed by the ICB Quality Committee on 18 October 2023.

Implementation of PSIRF was undertaken in two phases:

- Phase 1 was implemented on 6 November 2023 and included implementation of patient safety incident investigations for any patient safety events that met national and local priorities.

- Phase 2 was implemented on 25 March 2024 which included implementation of all learning responses.

Revised governance processes were developed, including the implementation of a new meeting structure in early 2024. Progress with implementation of PSIRF continues as our revised governance approach matures and this is monitored by the Safety and Quality Committee.

Clinical Effectiveness

With respect to clinical audit, the Trust has an annual clinical audit and effectiveness plan that is developed and agreed for the forthcoming year, which incorporates national mandatory audits, corporate audits, audits associated with Trust-wide priorities including those linked to the national and locally agreed PSIRF priorities, audits of national policies and guidelines, as well as other audits commissioned specifically in response to areas of identified risk and concern. The Chief Medical Officer has an identified Deputy Chief Medical Officer who is the Trust lead for Clinical Audit and Effectiveness.

The Audit Committee and the Safety and Quality Committee both receive clinical audit and effectiveness reports to provide assurance that the Trust has effective controls in place and is responsive to areas of concern, which may have been highlighted through the audit process, as well as audit outcomes which demonstrates best practice against defined standards. The clinical audit and effectiveness reports also provide evidence that health professionals are providing care that is both evidence-based and up-to-date.

Capacity and Flow Waiting

The NHS continued to be faced with significant pressures in 2023–24 and like all other NHS Trusts across the country Lancashire Teaching Hospitals remained challenged by non-elective demand for services, and periods of industrial action. As a result, performance across the board, both emergency and elective continued to be impacted with operational pressures experienced through the year resulting in non-compliance in relation to a number of key standards.

Whole health economy system pressure in response to increased demand resulted in high bed occupancy throughout the year, together with the requirement to recover and restore services. A system-wide action plan remains in place to address the urgent care capacity and demand pressures; with identified primary, community and social care initiatives/schemes delivering a level of sustainability.

During 2023–24 the Trust put in place a range of measures:

- Continued to refine and improve the offer from the Community Healthcare Hub at Finney House, providing 64 health led time-limited community beds, reducing medicine bed capacity in hospital as a result.
- Established an Acute Assessment Unit to reduce time spent in the Emergency Department ahead of the delivery of increased Medical Assessment Unit capacity.

- Increased the Virtual Ward bed base for Frailty, Respiratory and Acute Medicine.
- Enhanced internal escalation measures, including Full Capacity Protocol, surge and boarding to support ambulance handovers and capacity in the Emergency Department.

Alongside internal work, the Trust continued to undertake collaborative work with other partners in the local health economy through:

- A health economy-wide action plan to address the urgent care system and pressures; with identified primary and social care initiatives/schemes expected to deliver a level of sustainability.
- A range of continuous improvement and transformational work streams that include patient onflow, and flow.
- The Flow Coaching Academy, applying team coaching skills and improvement science at care pathway level to improve patient flow and experience through the healthcare system.
- We recognise that the longevity of system resilience is dependent on all stakeholders across our local health economy and we anticipate that there will be continued operational and subsequent compliance issues against key access targets during 2024–25 with the development and delivery of the Trust's new Single Improvement Plan.

STAR Quality Assurance Framework

The Trust ensures assurance of delivery of CQC standards and recommendations through the Trust's STAR Quality Assurance Framework which provides evidence of the standard of care delivery, including what works well and where further improvements are required through:

- STAR monthly reviews – 17 audit questions are undertaken by the Matron or professional leads; peer reviewed for each area.
- STAR accreditation visits – an in-depth, unannounced CQC-style audit is undertaken by the Quality Assurance team with support from staff, governors, and volunteers from across the Trust. Follow-up to the visits is risk stratified depending on the outcome of the previous review.
- Ward/clinical department to Board reporting arrangements on STAR outcomes.

Data Quality and Security

The Trust has a clear focus on data quality. Performance information is triangulated with other known information to identify any areas of weakness and where data requires further exploration, specific reviews are undertaken. The Trust is regularly audited on data quality and in the last few years has been audited by MIAA on referral to treatment waiting lists and its data quality framework and has been audited by Grant Thornton on its clinical coding quality. The Trust is also audited each year for its data security and prevention tool kit submissions which includes both security and data quality components.

The Trust is also monitored monthly through the national data quality maturity index which looks at the quality of both the commissioning data sets and Waiting List National Minimum Dataset submissions.

The Trust has a risk, scoring 15, related to the potential for a cyber-attack. The risk is reviewed and updated monthly as controls are continuously improved. All eligible Windows servers and workstations have been onboarded to enhanced national threat detection and monitoring systems. Cyber recovery solutions have been procured to protect critical server backups and over 11,000 staff members have been onboarded to multi-factor authentication, thus protecting Trust email and applications. The Trust continues to meet NHSE alerts and received substantial assurance for its most recent Data Security and Prevention Tool Kit assessment.

Principal Risks

The most significant risks that threaten the achievement of the Trust's aims and ambitions are identified within the BAF, alongside controls and assurances which describe how the Trust manages and mitigates these risks.

The BAF is the mechanism by which the Trust evaluates the risks that could impact on the achievement of the Trust's strategic objectives.

During 2023–24, there were six principal risks:

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

All risks that make up the BAF are subject to review by the respective lead Executive Director and are aligned to Our Big Plan and the underpinning enabling strategies to ensure correlation between the risks and strategic aims and ambitions. These are robustly monitored by the Board and Committees of the Board to ensure that the Board is informed about the principal risks faced by the Trust.

Operational High Risks escalated to Board:

During 2023–24, there have been three operational high risks escalated to the Board within the BAF. These are:

- **Impact of exit block on patient safety** which has been escalated to the Board via the Safety and Quality Committee since December 2020 but remains a risk with long lengths of stay in the Emergency Department and high ambulance handover times. To mitigate this risk, Standard Operating Procedures are in place which describe the processes for patient reviews, reporting of patient harm incidents and associated clinical governance arrangements. These procedures have been supplemented with a series of actions, including virtual wards, frailty, therapy pathway improvements and the continued use of Finney House Community Healthcare Hub, which was acquired in 2022. Monthly safety forums are also in place to identify further opportunities to improve flow and reduce long waits in the Emergency Department.
- **Elective restoration following the COVID-19 pandemic** which has been escalated to the Board via the Safety and Quality Committee since June 2021. Whilst patients have continued to wait for a significant among of time to receive non-urgent surgery, progress was made in this financial year. 104+ week waits have been eliminated for patients except for those patients that were unavailable for treatment and chose to wait longer. The Trust also sought to eliminate 78-week waits in this financial year and although this was delayed by industrial action, it was achieved by the end of March 2024, except for a small number of patients in the orthodontic specialty who have received a data for treatment in April 2024.

- **Impact of strikes on patient safety following announcement of the national pay award and the probability of ongoing strikes** which has been escalated to Board via the Safety and Quality Committee since October 2022. Over the last 12 months, strikes have taken place for junior doctors and consultants. The risks associated with ongoing strikes have been effectively managed in partnership with staff side, workforce, and clinical leaders with evidence of significant planning undertaken and learning implemented from previous strikes. As a result, it was recommended that this risk was de-escalated from the Board of Directors on 1 April 2024, and this was accepted.

During the year, the Internal Audit opinion on the Trust's BAF supporting process noted:

- The BAF is structured to meet NHS requirements.
- Governance, reporting, and scrutiny arrangements surrounding the BAF were clearly defined. Arrangements were subject to review and approval by the Board.
- Processes in place to update the BAF were robust. The Board and Audit Committee were engaged with the BAF.
- The organisation considers risk appetite regularly and the risk appetite is used to inform the management of the BAF.
- The BAF is visibly used by the organisation.
- The BAF clearly reflects the risks discussed by the Board.

Well Led

The Trust, as a whole, reviews its own leadership and governance arrangements periodically, in line with the requirements of NHSI that providers carry out developmental reviews.

Following the CQC Well Led inspection in 2019, the Trust developed a Well Led and Governance Maturity Plan to drive improvement in the Well Led domain of the organisation and this incorporated recommendations from a review undertaken of the divisional governance arrangements by the Quality Governance lead from the Nursing Directorate at NHSE/I which identified the Trust as an exemplar organisation in October 2020, a Risk Maturity Self-Assessment tool supported by Mersey Internal Audit Agency (MIAA), and a MIAA developmental Well Led review in February 2021. In addition, two external consultants were engaged from July 2021 to November 2022. Firstly, an external leadership consultant undertook a series of development sessions with the Board. Secondly, the Trust commissioned a Risk and Assurance review by an external provider from February to November 2022 and an action plan was developed in response to the findings.

The Trust chose not to commission any further external reviews in terms of leadership, governance, or risk management in 2023–24 as a result of the unannounced inspection by CQC between May and July 2023, which incorporated a Well Led inspection, and the subsequent publication of the report in November 2023.

Although all core services across the Royal Preston and Chorley hospital sites were rated as good for Well Led, the overall Well Led rating for the Trust declined from good to requires improvement. The inspection and outcome is covered in more detail under the Care Quality Commission section of the Annual Governance Statement.

Effectiveness of Governance and Risk Maturity

The effectiveness of the Trust's governance structures continued to be internally tested during 2023–24 via the process of internal and external audit, inspections, national audits, and national staff surveys.

The Trust chose not to commission any external reviews in terms of governance or risk management in 2023–24 following the unannounced inspection by the CQC between May and July 2023, which incorporated a Well Led inspection, and the subsequent publication of the report in November 2023.

In 2022–23, an external provider undertook a Risk and Assurance review commissioned by the Board of Directors from February to November 2022. The review was positive about the risk and governance arrangements at the Trust and did not identify any legislative or regulatory requirements that were not being met. One of the recommendations included introducing a new Risk Management Strategy across the Trust.

A new Risk Management Strategy 2024–27 was discussed and approved at the Board of Directors meeting in February 2024. The strategy sets out the approach to further enhancing risk management at the Trust over the next three years.

MIAA undertook a review of the risk management at the Trust in this financial year as part of the internal audit plan and this received High Assurance.

Head of Internal Audit Opinion 2023–24

The overall opinion for the period 1 April 2023 to 31 March 2024 provides Substantial Assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Compliance with the NHS foundation trust licence condition 4 (FT governance)

The Board undertakes a review of its effectiveness annually. It has not identified any principal risks to compliance with provider licence condition FT4. This condition covers the effectiveness of governance structures, the responsibilities of Directors and Committees, the reporting lines and accountabilities between the Board, its Committees and the Executive team. The structures and reporting frameworks in place have allowed it to discharge its responsibilities throughout the year during a period of change in the positions of both Chair and Chief Executive Officer.

The Board is satisfied with the timeliness and accuracy of information to assess risks to compliance with the Foundation Trust's licence and the degree of rigour of oversight it has over performance.

Workforce

To ensure that short, medium, and long-term workforce strategies and staffing systems are in place, the Trust has an annual workforce plan in place aligned to the operational planning cycle with a focus on resourcing strategies to fill long-term or hard to fill workforce gaps.

This is reviewed and approved by the Finance and Performance Committee, Workforce Committee, signed off by the Executive team and commended to the Board. The workforce plan takes into account changes to services, investment and cost improvement plans, recruitment issues, turnover, and predictive workforce supply. It also considers external factors that may influence services, including commissioning strategies, service transformations, nursing acuity reviews and local workforce challenges such as gaps in establishment, retention issues, roles which are difficult to fill, new roles, training opportunities and apprenticeships. Workforce growth is included in plan where this has been fully financially approved. However, ultimately the workforce plan must produce a deliverable plan within the approved financial envelope.

To balance workforce supply and demand, workforce plans and regular skills gap analysis have taken place to inform localised or profession-specific recruitment and retention plans. These plans detail the programme of activity to reduce gaps through proactive campaigns around hard to fill posts.

Actions have also been identified to look at opportunities to work across the ICS to support workforce supply.

Recruitment trajectories are monitored and reviewed by the Workforce Committee for key staff groups such as nurses and healthcare support workers. There continues to be a focus on reducing premium spend, filling hard to fill medical posts and health care support worker recruitment.

Public stakeholders

We recognise that risk management is a two-way process between healthcare providers across the health economy. Issues raised through our internal risk management processes that impact on partner organisations are discussed in the appropriate forum so that the required action can be agreed.

We have also introduced three Patient Safety Partners to the organisation for the first time in 2023–24, as advocated in the NHS Patient Safety Strategy. The Patient Safety Partners regularly attend meetings of the Trust to provide the voice of the patient, including at the PSIRF Oversight Panel, and at the Always Safety First Learning and Improvement Group where issues of patient and organisational risk are discussed. We have an active Patient Experience and Involvement Strategy and understand the importance of listening to those with lived experience when considering changes to the services we deliver.

Care Quality Commission

The CQC carried out an unannounced inspection of Lancashire Teaching Hospitals NHS Foundation Trust between 31 May and 4 July 2023.

As part of their inspection CQC carried out:

- Unannounced inspections of Urgent and Emergency Care on both hospital sites, Medical Care at Royal Preston Hospital and Surgery at Royal Preston Hospital. This was part of CQC's continual checks.

- Focused inspection of Maternity on both hospital sites. This was part of CQC's national maternity services inspection programme.

- An inspection of how Well Led the Trust is overall.

The overall rating for the Trust was again rated requires improvement. Safe, effective and responsive were also again rated requires improvement. Caring remained good, and Well Led declined from good to requires improvement.

From a site ratings perspective, Chorley and South Ribble Hospital saw a decline in safe from good to requires improvement and a decline in its overall site rating from good to requires improvement. The site ratings for Royal Preston Hospital remained unchanged at requires improvement.

In the core service inspections there was:

- A decline in the Safe domain across three core services (Maternity at both hospital sites and Urgent and Emergency Care at Chorley and South Ribble Hospital) from good to requires improvement.

- A decline in Effective in one core service (Urgent and Emergency Services at Royal Preston Hospital) from good to requires improvement and an improvement in one core service (Surgery at Royal Preston Hospital) from requires improvement to good.

- No changes in the Caring domain.

- A decline in the Responsive domain in one core service (Surgery at Royal Preston Hospital) from good to requires improvement.

- An improvement in Well Led in one core service (Medical care at Royal Preston Hospital) from requires improvement to good.

Although all core services across the Royal Preston and Chorley and South Ribble hospital sites were rated as good for Well Led, the overall Well Led rating for the Trust declined from good to requires improvement and CQC confirmed this was due to the findings in Maternity and Urgent and Emergency Care, elective recovery, financial challenges, and stability of the Board following retirement of the Chief Executive and challenges in recruiting to a substantive Chair. Since the inspection a number of key Board appointments have been made including a new Chief Executive, Chair, and Chief People Officer.

In total, the Trust received 54 recommendations in the form of Must Do's and Should Do's (18 Must Do's and 36 Should Do's). Some recommendations were duplicated across the different core services.

A number of examples of outstanding and good practice were noted within the report, including in relation to governance where it was noted that leaders operated effective governance processes, throughout the service and with partner organisations.

On 7 December 2023 the Trust submitted an action plan to CQC in response to the inspection findings (i.e. Must Do's and Should Do's, and any associated actions). Progress against the action plan is monitored by the Safety and Quality Committee.

The Foundation Trust is fully compliant with the registration requirements of the CQC.

Declarations of Interest

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff, as defined by the Trust's Policy TP-200 Code of Conduct, within the past twelve months and as required by the Managing Conflicts of Interest in the NHS guidance.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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Equality and Diversity Legislation

Control measures are in place to ensure that all the organisation's obligations under equality and diversity legislation are complied with.

As required through the NHS Standard Contract the Trust completes and publishes compliance against the Workforce Race Equality Standard and the Workforce Disability Equality Standard.

Greener NHS Programme

The Foundation Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

We have continued to develop our systems and processes to help us deliver an improvement in the financial performance, including:

- Trust-wide commitment to the adoption of a Continuous Improvement approach, which has involved undertaking extensive staff engagement to identify priorities for improvement and is informing the development of a system-wide Continuous Improvement Strategy for the whole health economy;
- approval of the annual budget by the Board;
- monthly Finance and Performance Committee meetings to ensure Directors meet their respective financial targets reporting to the Board;
- monthly Divisional Improvement Forums attended by members of the Executive team to ensure that Divisions meet the required level of performance for key areas including financial targets;
- enhanced grip and control activities for both requisitions and filling of vacancies by the Vacancy Control Panel, by ensuring established vacancy prior to recruitment and review of budgets before approval to recruit;
- improvements have been made to the business planning processes with a clearer separation of business cases with a return on investment and net funding which might be required for a development or safety and quality issue;
- we have further strengthened setting our financial recovery plan targets at specialty level with the use of our patient level costing information;
- monthly reporting to the Board of Directors on key performance indicators covering finance and activity; quality and safety; and workforce targets through the Integrated Performance Report; and
- the Trust continues to have in place a 'Quality Impact Assessment' and robust governance systems that require clinical approval of all cost improvement programme schemes that have a clinical impact.

Financial Sustainability

During the 2023–24 financial year the Trust delivered a deficit (adjusted financial performance) of £35.6m. Ongoing changes to the financial regime for Trusts with the shift away from activity based payment to block income contracts have helped give greater certainty over income levels. However existing expenditure trends continue in that usage of agency staff at premium rates, and significant operational pressures remain in place, particularly in urgent and emergency care services. Additional non-recurrent income that was provided to meet excess demand on urgent and emergency care pathways are being withdrawn by NHSE. This means that the Trust is planning its budgets for 2024–25 and beyond to include the assumption that significant financial improvement over multiple years is required to deliver breakeven.

The continuing after effects of the pandemic and associated operational pressures in 2023–24 have led to the need for material savings to be delivered, and these have been made on a largely recurrent basis. Alongside, the Trust has received significant additional income to support the recovery post-pandemic.

At the end of 2023–24 there remained two outstanding areas in relation to our existing enforcement undertakings to the regulator:

i. Long term sustainability: With respect to the Trust's long-term sustainability, both clinically and financially, we recognise that sustainable financial balance needs to come through engagement with the wider health economy. This requires not only the Trust to achieve service efficiencies but to maximise the use of its sites and support the wider transformational change in service delivery. The Trust is an active participant in the ICS delivery boards which aim to implement improved and robust pathways of care across the system. We are also working within the ICS on specific projects to maximise efficiency opportunities working with multiple partners. We along with local and system partners are seeking sustainable solutions through the New Hospital Programme where we are working towards producing a range of options for the future provision of services. We will then complete a pre-consultation business case containing evidence of the work undertaken through the solution design process, following which a formal public consultation will be required.

ii. Funding conditions and spending approvals: With respect to this undertaking the Trust will endeavour to adhere to the terms and conditions relating to financing that is provided, will comply with reporting requests that are made by NHSE, and will comply with any spending approvals processes that are deemed necessary by NHSE.

New Hospitals Programme

The NHS in Lancashire and South Cumbria welcomed the Government's May 2023 announcement of two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary as part of a rolling programme of national investment in capital infrastructure beyond 2030. In addition, Furness General Hospital in Barrow will benefit from investment in improvements.

The existing Preston and Lancaster sites will remain in place and deliver services to our population until new hospital facilities are opened. The local NHS will continue to keep communities involved and provide further updates as more information becomes available.

Further detailed work is underway to assess the viability of potential locations for new hospital builds for both Royal Preston Hospital and Royal Lancaster Infirmary and to develop the required business cases.

In August 2023, a series of national New Hospital Programme roadshow events visited Preston, as Government representatives arrived to discuss the next steps for building two new hospitals in our region. Lord Markham CBE and Department of Health and Social Care representatives were able to hear directly from patients, colleagues, and wider stakeholders in the various sessions.

For the latest news, information, and ways to get involved, visit https://newhospitals.info.

Going Concern

Guidance from the Department of Health and Social Care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. There are no such conversations regarding this Trust and as such it is regarded as a going concern.

Trust Clinical Strategy

In support of the Integrated Care System Strategy published by the ICB, the Trust is supporting clear governance arrangements for the planning and delivery of the Trust's Clinical Strategy. This in turn enhances the requirements for the CQC's assessment on Use of Resources as it acts as an enabler for best use of public sector investment to be considered on a population health outcomes basis incorporating the wider determinants of health with the Trust recognised as an anchor institution. The Trust is committed to the development of ICB arrangements as it seeks to deliver improved health and wellbeing of local communities, joined-up care closer to home and safe and sustainable, high-quality services and reduce inequalities. However, the Trust is cognisant of the challenges associated with any proposed reconfiguration and the interdependences and risks which may impact on the Trust as a result of decisions outside the Trust's control being made at an ICB level.

Information Governance

The confidentiality and security of information regarding patients, staff and the Trust is maintained through governance and control policies, all of which support current legislation and is reviewed on a regular basis. Personal information is, increasingly, held electronically within secure IT systems. It is inevitable that in a complex NHS organisation a small number of data security incidents occur. The Trust is diligent in its reporting and investigation of such incidents, in line with statutory, regulatory, and best practice obligations. Any incident involving a breach of personal data is handled under the Trust's risk and control framework, graded and the more serious incidents are reported to the Department of Health and Social Care and the Information Commissioner's Office (ICO) where appropriate.

The Trust experienced two externally reportable serious incidents in the 2023–24 period, one of these incidents reached the reporting criteria and was sent to the ICO. For all incidents full internal processes were followed and both incidents were reported using the Data Security and Protection Toolkit (DSPT).

As part of our annual assessment, the DSPT is reviewed annually and updated to ensure Trust standards are aligned with statutory obligations. The status for the 2022–23 DSPT is 'standard met'. The Trust has submitted the baseline assessment for 2023–24 and is working towards the final submission which is due on 30 June 2024.

The Trust has established a dedicated information risk framework with Information Asset Owners throughout the organisation which is embedded with responsibilities in ensuring information assets are handled and managed appropriately. There are robust and effective systems, procedures, and practices to identify, manage and control information risks. Alongside training and awareness, incident management is part of the risk management framework and is a mechanism for the immediate reporting and investigation of actual or suspected information security breaches and potential vulnerabilities or weaknesses within the organisation. This will ensure compliance in line with the UK General Data Protection Regulations and the Data Protection Act 2018.

Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance Records Committee which is accountable to the Finance and Performance Committee. The Information Governance Committee is chaired by the Chief Medical Officer who is also the Caldicott Guardian. The Board appointed Senior Information Risk Owner is the Chief Finance Officer.

The Information Governance Management Framework brings together all the statutory requirements, standards, and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development of the Information Governance Management Framework is informed by the results from DSPT assessment and by participation in the Information Governance Assurance Framework.

Data Quality and Governance

The Trust has a clear focus on data quality and good quality information is vital to enable individual staff and the organisation to evidence they are delivering high quality care.

As such a Data Quality Assurance team, via the Trust's Data Quality Policy and Framework, continuously monitor data looking for, correcting, and feeding back to divisional teams for improved data capture on areas such as:

- Outpatient appointments
- Inpatient/Outpatient commissioning services
- GP information
- Patient demographic data (addresses, date of birth, etc.)
- NHS numbers
- Visits
- Discharge dates
- Length of stay information
- Duplicates

In addition, a separate team validates waiting lists to ensure future events are correctly associated with their original referrals. This involves a combination of algorithmic and human validation with further checks on data consistency performed by the national team as data is submitted. Validated data is updated onto the Trust's electronic patient record.

An external data quality audit in 2023 looking at clinical coding identified areas of focus for ED treatment and investigation code and outpatient procedure code reporting with a recognition that coding in admitted patient care is low risk and supported by good processes.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Safety and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, includes:

- The Head of Internal Audit Opinion for 2023–24 that Substantial Assurance can be given that there is an adequate system of internal control.
- The Assurance Framework and the monthly performance reports, which provides evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives, have been reviewed.
- The internal audit plan which is risk-based and reported to the Audit Committee at the beginning of every year. Progress reports are then presented to the Audit Committee on a regular basis with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, raise any areas of concern at the Board. Minutes of the Audit Committee and a Committee Chair's report are considered at Board meetings.
- Internal audit's review on the BAF and the effectiveness of the system of internal control as part of the annual internal audit plan to assist in the review of effectiveness, which concluded the Trust's BAF is structured to meet the NHS requirements, is visibly used by the Board, and clearly reflects the risks discussed by the Board.
- The Board undertakes bi-monthly reviews of the BAF, and the Committees of the Board at each meeting undertake detailed scrutiny of assurance received or gaps identified in relation to risks assigned to that particular Committee.
- The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management, 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.
- The Executive Directors and senior managers meet on a weekly basis and have a process whereby key issues such as performance management, action plans arising from external reviews, and risk management are considered both on a planned timetable and an ad-hoc basis if there is a need.
- All relevant Committees have a clear timetable of meetings, cycles of business and a clear reporting structure to allow issues to be raised.

Conclusion

In conclusion, my review confirms that Lancashire Teaching Hospitals NHS Foundation Trust has an adequate system of internal control and that there have been no significant control issues at the Trust in 2023–24. Where control issues have been identified, action has been taken or action/ improvement plans are in place to address such issues.

The Trust Board recognises the challenges that the Trust faces to make the necessary service improvements and achieve financial sustainability which will require both a continuous focus by the Trust and a collaborative approach for solutions across the health system. The challenges the Board has focused on to deliver the Trust's aims and ambitions are robustly articulated in the strategic risk register that underpins the BAF in line with the Risk Management Policy.

This Annual Governance Statement is signed on behalf of the Board of Directors by

Professor Silas Nicholls
Chief Executive
25 June 2024

COUNCIL OF GOVERNORS' REPORT

The Council of Governors comprises elected and appointed governors who represent the interests of the members and the wider public. It also has an important role in holding Non-Executive Directors of the Board to account.

The Council of Governors has an essential function in influencing how the Trust develops its services to meet the needs of patients, members, and the wider community in the best way possible. The Council needs to be assured the Trust Board has considered the consequences of decisions on other partners within their system, and the impact on the public at large.

At the end of 2023–24, the Council comprised 28 governor seats, of which: 18 are elected governors who represent the public constituency; five are elected governors who represent the staff constituencies; one is appointed by our University partnership organisations (University of Central Lancashire, Lancaster University and University of Manchester); and four are appointed by local authorities (being Lancashire County Council, Preston City Council, Chorley Council and South Ribble Borough Council).

Elections

The governor election process takes place between January and March each year, and governors generally serve a three-year term of office, beginning in April. At the end of March 2024, the terms of office of three public governors and one staff governor (representing non-clinical staff) came to an end. Vacancies for the University partnership governor, one public governor, and three staff governors (representing doctors and dentists; other health professionals and healthcare scientists; and unregistered healthcare and support workers) remained vacant during the year. There were also three seats vacated following in-year resignations. On 22 March 2024 it was announced that eight public and four staff governors had been elected to their respective constituencies meaning 27 of the 28 governor seats have been filled. Work is ongoing with local Universities to appoint the partnership governor.

Ahead of this year's election process, various governor recruitment activities were undertaken to promote the role of the governor, including, issuing dedicated pre-election mailing to all members; advertising governor vacancies within the 'Trust Matters' magazine and advertising on media screens at both hospital sites; two pre-election workshops were held with the Chair and Company Secretary to encourage members to stand for election; and social media was used to highlight the election opportunities. The Chair and Company Secretary also posted videos on the Trust's website outlining the role and expectations of a governor.

Council of Governors Subgroups

Two governor subgroups are in place to consider specific issues in more detail than is possible at formal Council meetings. The subgroups focus on care and safety, and membership/public engagement. Both the subgroups have clear terms of reference and report their activities to formal Council of Governors' meetings. Each subgroup also has a Non-Executive Director in attendance. In addition, the Council nominates governors as members of the Trust's Nominations Committee.

Understanding the views of Governors and Members

Directors develop an understanding of the views of governors and members about the organisation through attendance at the Annual Members' Meeting, Council of Governors' meetings and workshops, linkages with the Council subgroups and an annual interactive forward planning session with the Board each year.

During the year we continued to focus on maintaining an effective relationship between the Board and governors through a number of ways, including the following:

- Governor attendance at public Board meetings (in the capacity of observer) is encouraged and governor attendance is recorded within the Board minutes. Attendance has decreased slightly during the second half of the year as the meetings reverted to fully face-to-face rather than virtual meetings.
- There is Non-Executive Director representation at each of the governor subgroups.

- Board members are invited to every Council of Governors' meeting and Non-Executive Directors in particular are invited to comment on the Trust's performance. Non-Executive Directors also deliver presentations to the Council on a cyclical basis outlining their involvement and providing insight into their roles and responsibilities of the Committees of the Board. Governors have the opportunity to ask them questions and seek assurances that Non-Executive Directors are holding the Executive team to account.
- As part of the Trust's forward planning process, the Board and the Council of Governors had a joint interactive workshop (in April 2023) where Board members and governors review the Trust's priorities for the year ahead and governors provide feedback from members and the wider public on such priorities.
- Information flows through a variety of events, including the Strategic Operational Group weekly feedback meeting, consultation on Trust strategic plans, and a range of working groups on patient-specific topics such as car parking and patient letters.
- Opportunities for visits to clinical areas and departments across the Trust which this year have included Finney House Community Healthcare Hub, Specialist Mobility Rehabilitation Centre, LIFE Centre, and Lancashire Eye Centre.

Board and Council engagement

The Trust Chair leads both the Board of Directors and the Council of Governors and, as such, is an important link between the two bodies. To strengthen communication and engagement further there is Non-Executive Director representation on each of the core governor subgroups. There are a range of other ways in which the two bodies work together, including joint Board and Council development sessions and written communications. In the event of any misunderstanding or disagreement, the Standing Orders for the Board set out a clear and unambiguous process for the resolution of disputes between Board and Council.

To help governors fulfil their important role of holding the Board to account, governors receive updates on progress against the Trust's Strategy and Single Improvement Plan at their quarterly Council of Governors' meetings. Non-Executive Directors routinely attend Council of Governors' meetings which provides governors with the opportunity to report their activities to Non-Executive Directors and to raise questions. Regular briefings are provided to governors on topical issues. In line with good practice, there is a policy on engagement between the Board and Council. The Chair also meets individually with the lead governor on a regular basis. The lead governor role (with a remit as set out in the Code of Governance) during 2023–24 was held by public governor Janet Miller.

The importance of joint working between the Board and the Council is acknowledged by the members of both bodies, who are committed to building on the progress that they have made in this area. The benefits of sharing good practice across NHS organisations is recognised and governors benefit from networks with colleagues in other Foundation Trusts in the Northwest as well as involvement in events arranged by organisations such as NHS Providers and MIAA.

In 2023 the Trust commissioned a review of Council. The review provided a series of recommendations for how the joint working between Council and Board could be improved further and how Council could re-align its oversight priorities to discharge its key responsibilities of holding Non-Executive Directors to account and to represent the interest of the Trust membership and public at large. A joint task and finish group was established to translate the recommendations into actions for implementation in 2024.

Declaration of interests

All governors have a responsibility to declare relevant interests as defined in our Constitution. These declarations are made to the Company Secretary and are subsequently reported to the Council and entered into a register. The register is published on our website or is available on request from the Company Secretary.

Attendance summary

There were four formal Council meetings during 2023–24, which were quarterly meetings scheduled for April, July and November 2023 and January 2024.

The table below shows governors' attendance at Council meetings in 2023–24:

Name of governor	Term of office	Type of governor	A	B	Percentage of meetings attended (%)
Will Adams	01/04/23 – 31/03/24	Appointed	4	4	100%
Pav Akhtar	01/04/18 – 31/03/24	Public	4	4	100%
Takhsin Akhtar	01/04/19 – 31/03/25	Public	4	4	100%
Peter Askew**	01/04/19 – 02/10/23	Public	2	2	100%
Sean Barnes	01/04/21 – 31/03/24	Public	4	3	75%
David Blanchflower	01/04/23 – 31/03/26	Public	4	4	100%
Alistair Bradley	01/04/23 – 31/03/24	Appointed	4	4	100%
Sheila Brennan	01/04/22 – 31/03/25	Public	4	3	75%
Kristinna Counsell**	01/04/22 – 02/06/23	Public	1	0	0%
Steven Doran	01/04/23 – 31/03/26	Staff: nurses and midwives	4	3	75%
Margaret France	01/04/17 – 31/03/26	Public	4	3	75%
Graham Fullarton	01/04/23 – 31/03/26	Public	4	3	75%
Steve Heywood	01/04/16 – 31/03/25	Public	4	4	100%
Lynne Lynch	01/04/15 – 31/03/24	Public	4	4	100%
Janet Miller	01/04/17 – 31/03/26	Public	4	4	100%
Eddie Pope	01/04/23 – 31/03/24	Appointed	4	4	100%
Frank Robinson	01/03/19 – 31/03/26	Public	4	4	100%
Suleman Sarwar	01/04/23 – 31/03/24	Appointed	4	4	100%
Michael Simpson	01/04/18 – 31/03/25	Public	4	3	75%
Piotr Spadlo	01/04/21 – 31/03/24	Staff: non-clinical	4	4	100%
Paul Wharton-Hardman**	01/04/22 – 12/03/24	Public	4	1	25%
Feixia Yu	01/04/23 – 31/03/26	Public	4	1	25%

A = Maximum number of meetings the governor could have attended | B = Meetings attended
*** Term of office ended due to resignation in 2023–24*

Director attendance at Council of Governors' meetings

The following Directors attended Council meetings during 2023–24:

Non-Executive Directors:

- Peter White, Chair
- Tim Ballard, Non-Executive Director
- Victoria Crorken, Non-Executive Director
- Paul O'Neill, Non-Executive Director
- Kate Smyth, Non-Executive Director
- Tim Watkinson, Non-Executive Director
- Jim Whitaker, Non-Executive Director
- Tricia Whiteside, Non-Executive Director

Associate Non-Executive Directors:

- Uzair Patel, Associate Non-Executive Director
- Michael Wearden, Associate Non-Executive Director

Executive Directors:

- Faith Button, Chief Operating Officer
- Sarah Cullen, Chief Nursing Officer
- Imran Devji, Interim Chief Operating Officer
- Nicki Latham, Interim Chief People Officer
- Kevin McGee, Chief Executive
- Silas Nicholls, Chief Executive
- Neil Pease, Chief People Officer
- Jonathan Wood, Chief Finance Officer/Deputy Chief Executive

Governor training and development

The importance of providing effective training and development opportunities for our governors is understood and is achieved in a number of ways.

On appointment, governors receive formal induction training to enable them to understand the context in which they are carrying out their role, including information on their statutory duties, as well as practical information such as the various subgroups available to them. The induction covers areas such as the local and national context, the role of regulatory bodies, the Foundation Trust provider licence, as well as practical details such as the calendar of meetings and the ways in which they will be expected to contribute in formal and subgroup meetings. Emphasis is placed on the respective roles of the Board and the Council of Governors. Induction is a continuous, tailored process, with skills and knowledge being identified and developed at an early stage.

A number of governor training sessions or workshops are held each year that form a key part of the governor development process, the topics of which are largely governor-led. The opportunity is also taken at workshops for updates on operational performance, communications with the regulator and topical issues affecting the Trust.

During 2023–24, our governors have participated in joint Board and Council sessions and governor workshops which included the following topics:

- A joint session between Board and Council to discuss the financial position of the Trust.
- A joint session on the planning framework and a discussion on the forward-looking strategy.
- Improvement work being undertaken within urgent and emergency care.
- A joint Board and Council session on the structure and function of the ICB delivered by the Chief Operating Officer from Lancashire and South Cumbria ICB.
- An overview of the Patient Safety Incident Response Framework (PSIRF).
- Engagement work being undertaken in the community by the Widening Partnership team.
- An overview of the Equality, Diversity and Inclusion Strategy and what had been delivered.
- A presentation by the Continuous Improvement team outlining the work of NHSE IMPACT.
- An overview of Lancashire Place and the work being undertaken across the system which was presented by the Integrated Place Leader for Lancashire.
- An introductory session with the new Chief People Officer.

Expenses claimed by Governors

Whilst governors do not receive payment for their work with us, we have a policy of reimbursing any necessary expenditure. During 2023–24 £611 of expenses were claimed by our governors.

	2022–23	2023–24
Total number of governors in office (as at 31 March)	23	22
Total number claiming expenses:	0	4
Aggregate sum of expenses (£00s):	£0	£611

Contacting your Governors

If you wish to contact a governor then please email: **governor@lthtr.nhs.uk** or alternatively contact the Company Secretary email: **company.secretary@lthtr.nhs.uk.**

MEMBERSHIP REPORT

Membership is free and aims to give local people and staff a greater influence on the provision and development of our services.

Public membership is open to members of the public aged 16 or over who live in our membership area which comprises all of the component electoral wards in the following Local Authority areas:

Blackburn with Darwen	Blackpool	Bolton
Bury	Cheshire East	Cheshire West
Cumberland	Halton	Knowsley
Liverpool	Lancashire	Manchester
Oldham	Rochdale	Salford
Sefton	St Helens	Stockport
Tameside	Trafford	Warrington
Wigan	Wirral	Westmorland and Furness

Eligible staff members automatically become Foundation Trust members unless they choose to opt out. Staff eligible for Foundation Trust membership are those who either:

- hold a permanent contract of employment with us;
- are contracted to work for a period of 12 months or longer or have held a series of temporary contracts adding up to more than 12 months; or
- are employed by the private sector or other partners (for example local Government or other NHS Trusts) and work at the Trust on a permanent basis or fixed-term contract of 12 months or more.

Our membership

The membership constituency for Lancashire Teaching Hospitals NHS Foundation Trust encompasses a wide and diverse geographical area, including the metropolitan areas of Liverpool and Manchester and the rural areas of north Lancashire and Cumbria.

Constituency	Members as at 31.03.23	Members as at 31.03.24	Difference	% Difference
Public	9,366	9,147	- 219	- 2.5%
Staff	9,314	10,252	+ 938	+ 9.6%
Total Membership	**18,680**	**19,399**	**+ 719**	**+ 3.8%**

Source: Civica Membership Database

During 2023–24 regular data cleansing was carried out to ensure that records continue to be as accurate as possible.

The membership database has continued to be updated with many members confirming their preference for receiving information from the Trust by email. This helps with more effective and efficient engagement with members as well as reducing expenditure on printing and postage costs.

The Health and Care Act 2022 recognised that NHS Foundation Trusts now operate within the new system way of working. The Council of Governors is assessing how it will discharge its wider duty to consider the Board's performance in part of the Trust's contribution to system-wide plans and their delivery, and its openness to collaboration with other partners, including with other providers through Provider Collaboratives. In holding Non-Executive Directors to account for the performance of the Board, the Council of Governors now considers whether the interests of the public at large have been factored into Board decision-making and be assured of the Board's performance in the context of the system as a whole, and as part of the wider provision of health and social care.

Review of 2023–24

Trust Matters, our members' magazine, is produced twice a year providing up-to-date information to members regarding the Trust's service developments and delivery against strategic priorities. The magazine also includes a dedicated section in which governors are able to inform members of the various ways in which they represent them and report back to members on how they have helped influence decision-making and service development from their views and feedback.

The Trust hosted its Annual Members' Meeting on 11 October 2023. The event provided an opportunity for patients, staff members and the public to find out about what had been happening at Royal Preston Hospital and Chorley and South Ribble Hospital and gave a detailed update on the progress and innovations the Trust had made during the last year. At the meeting, Chief Officers shared a review of the organisation's 2022–23 annual report and accounts and an outline of the plans for 2023–24 and beyond. This was followed by two presentations relating to the New Hospitals Programme, delivered by the Medical Lead for Lancashire and South Cumbria New Hospitals Programme; and a Research and Innovation update by the Deputy Director of Research and Innovation (Operations).

The Annual Members' Meeting was streamed on MS Teams Live from the Education Centre at Royal Preston Hospital and a link to watch the recording was published on the Trust's website following the meeting. The arrangements provided choice for people on whether they attended in person, joined remotely, or viewed the meeting at a time convenient to them or if they were unavailable on the evening. The number of people attending in person was low when compared to those joining remotely or accessing the recording on the website.

In partnership with the Communications and Engagement Team, social media has continued to prove a useful tool throughout the year to promote Trust events, elections to the Council of Governors and to provide information to the public, members, and staff.

Assessment of the membership and ensuring representativeness

As a Foundation Trust, we are required to have a membership strategy in place, together with a clear work plan for its implementation. The three-year Membership Management and Engagement Strategy (2022–25) was approved in January 2022 by the Council of Governors and the Trust Board.

Our vision for our membership is to have an informed, engaged and involved membership who are able to fully represent the needs and experiences of our community by actively participating in influencing and shaping how our services are provided both now and in the future.

We aim to have a Council of Governors elected from and by the membership which is effective in representing the membership and supporting the Board in formulating strategy, shaping culture and ensuring accountability.

Further details and a copy of our three-year Membership Management and Engagement Strategy can be found on the Trust website.

Members can contact the Corporate Affairs Office via:
Website: https://www.lancsteachinghospitals.nhs.uk/get-involved
Email: **corporateaffairs@lthtr.nhs.uk**
Members can contact governors direct via:
Email: **governor@lthtr.nhs.uk**

Also available on our website:

Further information on our membership scheme
Information on our annual members' meetings

AUDIT COMMITTEE REPORT

I am pleased to present the Audit Committee report for 2023–24. The Committee's role is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities.

Introduction

In essence the Audit Committee's remit is to assure the Board that the systems and processes that the Trust relies upon that inform its financial statements, its operational decision making and its compliance with healthcare and governance standards are accurate, robust and can be relied upon. The Committee's work is focused on providing the Trust Board with these assurances, which allow the Board to discharge its own responsibilities with regard to the outputs of our systems and processes with confidence.

The Audit Committee comprises four independent Non-Executive Directors (who are also the Chairs of the main assurance committees): Kate Smyth, Jim Whitaker, Tricia Whiteside and myself, providing a broad range of experience to provide effective challenge on behalf of the Board.

The Audit Committee has met four times between 1 April 2023 and 31 March 2024 and is assisted in its work through the routine attendance at meetings of our internal and external auditors and our counter-fraud specialist. If required, the Committee can also access independent legal or other professional advice to help in its work.

It is the responsibility of the Chief Executive, as the Accountable Officer of the Trust, to establish and maintain processes for governance and he is supported in this by a number of Executive Directors. The regular attendance of the Chief Finance Officer, Chief Nursing Officer, the Company Secretary and the Associate Director of Risk and Assurance, as a result of their lead roles in matters to be addressed by the Committee, is of further assistance to us.

The Trust's overriding priority continues to be the establishment of a safe and financially sustainable delivery model in order to deliver the quadruple aims of the NHS.

In 2022–23 the Committee increased its role in respect of oversight of strategic risks and the risk frameworks and that work continued throughout 2023–24.

The Trust has sought to maintain strong oversight and governance during the year with all Board and Council of Governors meetings, and all meetings of Committees of the Board continuing to take place through the medium of Microsoft Teams. The Audit Committee has met (virtually) in accordance with the agreed schedule throughout the year.

Financial Reporting

The Audit Committee has reviewed the 2023–24 annual financial statements. In discharging its responsibilities, the Committee has particular focused on:

- compliance with financial reporting standards;
- areas requiring significant judgements in applying accounting policies;
- the accounting policies; and
- whether the accounts and annual report are a fair reflection of the Trust's performance.

The Committee considered the financial statements audit risks including the areas where the Trust has applied judgement in the treatment of revenues and costs to ensure that annual accounts represented a true and fair position of the Trust's finances.

The external audit plan for 2023–24 highlighted as significant audit opinion risks:

(i) valuation of land and buildings

(ii) fraud risk from expenditure recognition

(iii) management override of controls

The Committee was assured that these identified risks were common across NHS bodies of our size and nature and are included in recognition of the inherent risk to an organisation of our size and complexity within the NHS.

The Committee routinely reviews management reports on losses and special payments, single tender waivers and off payroll arrangements to consider their appropriateness and correct implementation of management controls.

The Committee has considered the appropriateness of the accounts being prepared on a going concern basis and drawn on the views of management and the external auditors to support the conclusion that it is appropriate for the accounts to be prepared on this basis.

Overall assurances on integrated governance, risk management and internal control

With respect to the internal audit reports issued this year, the table below confirms the assurance levels provided and the Committee has reviewed and discussed the work carried out by the internal auditors:

No	Audit	Assurance Level
(i)	Risk Management Deep Dive	High
(ii)	Radiology Infrastructure	Substantial
(iii)	RTT – Data Quality	Substantial
(iv)	Equality, Diversity and Inclusion	Substantial
(v)	Contract Monitoring	Substantial
(vi)	Transformation Projects	Substantial
(vii)	Safer Staffing	Substantial
(viii)	Medical Devices	Substantial
(ix)	Apprenticeship Funding	Substantial
(x)	IT Business Continuity and Disaster Recovery	Substantial
(xi)	Mental Capacity Assessments and Rapid Tranquilisation	Substantial
(xii)	Mortality	Substantial
(xiii)	Safeguarding/PiPoT	Substantial/Moderate
(xiv)	Data Quality Review - Patient Initiated Follow Up	Moderate

The Committee receives all internal audit reports and pays particular attention to any 'Limited Assurance' or 'No Assurance' internal audit reports. Any significant issues arising out of such reports are escalated by the Committee to the Board. In addition, Limited Assurance reports are referred to responsible Committees of the Board with Executive leads invited to attend the Audit Committee to provide assurance on the delivery of the audit recommendations. There were no reports during the year providing Limited or No Assurance.

The Director of Internal Audit has provided an overall opinion of Substantial Assurance based on the work of internal audit during 2023–24.

The Committee draws heavily on the conclusions from the work of internal audit but also on the Committee members' own knowledge of the Trust, as members of the Trust Board. The overall source of assurance comes from the work of the Audit Committee but the other Committees of the Board also have a role in providing assurance to the Board and work collaboratively to provide this assurance with frequent cross referrals between the Committees of the Board.

In addition, a number of reports on systems and processes reviewed by internal audit received High or Substantial Assurance. However, the Trust has continued to experience some difficulty in meeting its operational targets and the Trust's underlying financial position is unsustainable. The Committee will continue to seek assurance on the steps being taken to ensure improvements can be made in 2024–25 and beyond, recognising the critical importance of addressing the underlying financial deficit whilst ensuring services continue to be delivered safely and effectively. The Committee recognises that many of the solutions are dependent on the Trust being able to work collaboratively with partners in the Lancashire and South Cumbria ICS. As the Committee's chair I am working with my fellow chairs of Audit Committees across the ICS to encourage this collaborative approach.

Compliance

Under the revised NHS Oversight Framework, the Trust continues to be placed in segment 3. NHSE undertook a review of enforcement actions pertaining to breaches of the Health and Social Care Act 2012, as prevailing undertakings do not reflect the current financial position. A draft set of undertakings (relating to financial planning, and funding conditions and spending approvals) were shared with the Trust in a letter dated 12 November 2021 and remain in place.

Our external auditors

One of the Committee's roles is to provide oversight of the performance of our external auditors. We judge KPMG through the quality of their audit findings, management's response and stakeholder feedback. This qualitative assessment, in conjunction with the use of key performance indicators within the contract for services, allows the Committee to be confident that the Trust is receiving high quality services. No decisions are taken by KPMG over the design of internal controls, and they do not perform the role of management as part of any work they undertake. In addition, after each formal meeting, the Committee holds a private discussion with the internal and external auditors on an alternating basis. This is recognised best practice and allows for a frank exchange of views, without any management presence.

In addition to attending the Audit Committee, KPMG attend and report to the Council of Governors their findings for the year. Our auditors have also provided valuable support to the Trust by sharing their thoughts and guidance from across the sector and from the wider financial regulatory frameworks.

Our internal auditors

The Committee has considered the various procurement options bearing in mind discussions amongst Trusts within the Lancashire and South Cumbria ICS region regarding the possibility of creating a region-wide internal audit service, however, at year end no firm plans had materialised. In order to provide the Trust with continuity of services whilst discussions conclude and allow flexibility to participate in any regional arrangements that may emerge, it was decided to re-appoint MIAA for the provision of this service for a further two years (with an option to extend) as allowed for within current procurement rules.

It is the role of the Committee to provide oversight of MIAA's performance. Our team at MIAA is led by an Engagement Lead along with a dedicated Audit Manager. The internal audit programme is risk-based and is aligned to our strategic risk assessment. The internal audit plans are developed in compliance with national standards and guidance. In addition, MIAA has supported the Committee and the Trust by sharing best practice from across the sector and delivering valuable sector-wide training to members of the Committee along with other Audit Committee members across the North West.

Counter fraud

We have a policy in respect of countering fraud and corruption which includes contact details of the national helpline and a local independent counter fraud officer. The Trust has an accredited anti-fraud specialist provided by MIAA and they deliver the service in line with NHS Counter Fraud Authority's standards. In 2024–25 the anti-fraud specialist has completed the work programme in accordance with the agreed plan.

Audit Committee attendance summary from 1 April 2023 to 31 March 2024

Name of Committee member	A	B	Percentage of meetings attended (%)
Tim Watkinson (Committee Chair)	4	4	100%
Ann Pennell	1	0	0%
Kate Smyth	3	3	100%
Jim Whitaker	4	2	50%
Tricia Whiteside	4	2	50%

A = Maximum number of meetings the member could have attended | B = Meetings attended

Audit Committee effectiveness

The Committee undertakes a self-assessment on an annual basis. In July 2023, Committee members participated in a survey of its effectiveness, the results of which were considered by the Committee prior to submission to the Board. I am confident that the Committee has discharged its functions and responsibilities in accordance with its terms of reference, recognising the important role of this Committee to provide assurance to the Board.

Tim Watkinson
Audit Committee Chair
25 June 2024

This Accountability Report is signed on behalf of the Board of Directors by

Professor Silas Nicholls
Chief Executive
25 June 2024

Lancashire Teaching Hospitals NHS Foundation Trust

FINANCIAL REVIEW 2023–24

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Lancashire Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2024 which comprise the Consolidated Statement of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2024 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2024 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and the Trust's services or dissolve the Group and the Trust without the transfer of their services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for [at least a year] from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Group by NHS England
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Group's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Group during the year. We therefore assessed that there was limited opportunity for the Group and the Trust to manipulate the income that was reported**.**

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to completeness of year-end accruals.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included entries made to unrelated accounts linked to the recognition of expenditure, self-approved journals and other unusual journal characteristics.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Group is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the Group's and the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2023/24. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2023/24.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 77, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 77, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2024 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Timothy Cutler

for and on behalf of KPMG LLP

Chartered Accountants

1 St Peter's Square

Manchester

M2 3AE

27 June 2024

Foreword to the accounts

Lancashire Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2024, have been prepared by Lancashire Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed …….

Name **Silas Nicholls**
Job title **Chief Executive**
Date **25 June 2024**

Consolidated Statement of Comprehensive Income

		Group	
		2023/24	2022/23
	Note	£000	£000
Operating income from patient care activities	2	731,222	688,858
Other operating income	3	78,722	79,086
Operating expenses	6, 8	(868,082)	(778,824)
Operating surplus/(deficit) from continuing operations		**(58,138)**	**(10,880)**
Finance income	10	1,707	973
Finance expenses	11	(653)	(551)
PDC dividends payable		(10,805)	(8,443)
Net finance costs		**(9,751)**	**(8,021)**
Other gains / (losses)	12	(35)	(102)
Gains / (losses) arising from transfers by absorption	31	-	-
Deficit for the year		**(67,924)**	**(19,003)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(3,000)	3,584
Revaluations		4,118	4,954
Total comprehensive income / (expense) for the period		**(66,806)**	**(10,465)**
Deficit for the period attributable to:			
Non-controlling interest, and		-	-
Lancashire Teaching Hospitals NHS Foundation Trust		(67,924)	(19,003)
TOTAL		**(67,924)**	**(19,003)**
Total comprehensive expense for the period attributable to:			
Non-controlling interest, and		-	-
Lancashire Teaching Hospitals NHS Foundation Trust		(66,806)	(10,465)
TOTAL		**(66,806)**	**(10,465)**

Statements of Financial Position

		Group		Trust	
		31 March 2024	31 March 2023	31 March 2024	31 March 2023
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14	9,256	11,416	9,256	11,416
Property, plant and equipment	15	345,836	339,088	345,832	339,082
Right of use assets	18	29,606	39,075	29,606	39,075
Receivables	20	7,032	6,379	8,532	7,879
Total non-current assets		**391,730**	**395,958**	**393,226**	**397,452**
Current assets					
Inventories	19	16,803	14,719	15,851	13,669
Receivables	20	39,678	47,844	39,541	48,004
Cash and cash equivalents	21	36,033	14,502	34,813	14,129
Total current assets		**92,514**	**77,065**	**90,205**	**75,802**
Current liabilities					
Trade and other payables	22	(99,490)	(105,123)	(98,677)	(105,354)
Borrowings	24	(8,158)	(13,727)	(8,158)	(13,727)
Provisions	25	(327)	(505)	(327)	(505)
Other liabilities	23	(5,587)	(5,224)	(5,587)	(5,224)
Total current liabilities		**(113,562)**	**(124,579)**	**(112,749)**	**(124,810)**
Total assets less current liabilities		**370,682**	**348,444**	**370,682**	**348,444**
Non-current liabilities					
Borrowings	24	(25,021)	(30,449)	(25,021)	(30,449)
Provisions	25	(3,128)	(3,379)	(3,128)	(3,379)
Other liabilities	23	(1,247)	(197)	(1,247)	(197)
Total non-current liabilities		**(29,396)**	**(34,025)**	**(29,396)**	**(34,025)**
Total assets employed		**341,286**	**314,419**	**341,286**	**314,419**
Financed by					
Public dividend capital		635,625	541,952	635,625	541,952
Revaluation reserve		40,979	41,019	40,979	41,019
Income and expenditure reserve		(335,318)	(268,552)	(335,318)	(268,552)
Total taxpayers' equity		**341,286**	**314,419**	**341,286**	**314,419**

The notes on pages 120 to 132 form part of these accounts

Name **Silas Nicholls**
Position **Chief Executive**
Date **25 June 2024**

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**541,952**	**41,019**	**(268,552)**	**314,419**
Surplus/(deficit) for the year	-	-	(67,924)	**(67,924)**
Other transfers between reserves	-	(1,158)	1,158	**-**
Impairments	-	(3,000)	-	**(3,000)**
Revaluations	-	4,118	-	**4,118**
Public dividend capital received	108,295	-	-	**108,295**
Public dividend capital repaid	(14,622)	-	-	**(14,622)**
Taxpayers' and others' equity at 31 March 2024	**635,625**	**40,979**	**(335,318)**	**341,286**

Consolidated Statement of Changes in Equity for the year ended 31 March 2023

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**516,713**	**33,443**	**(250,511)**	**299,645**
Surplus/(deficit) for the year	-	-	(19,003)	**(19,003)**
Other transfers between reserves	-	(962)	962	**-**
Impairments	-	3,584	-	**3,584**
Revaluations	-	4,954	-	**4,954**
Public dividend capital received	25,239	-	-	**25,239**
Taxpayers' and others' equity at 31 March 2023	**541,952**	**41,019**	**(268,552)**	**314,419**

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**541,952**	**41,019**	**(268,552)**	**314,419**
Surplus/(deficit) for the year	-	-	(67,924)	**(67,924)**
Other transfers between reserves	-	(1,158)	1,158	**-**
Impairments	-	(3,000)	-	**(3,000)**
Revaluations	-	4,118	-	**4,118**
Public dividend capital received	108,295	-	-	**108,295**
Public dividend capital repaid	**(14,622)**	**-**	**-**	**(14,622)**
Taxpayers' and others' equity at 31 March 2024	**635,625**	**40,979**	**(335,318)**	**341,286**

Consolidated Statement of Changes in Equity for the year ended 31 March 2023

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**516,713**	**33,443**	**(250,511)**	**299,645**
Surplus/(deficit) for the year	-	-	(19,003)	**(19,003)**
Other transfers between reserves	-	(962)	962	**-**
Impairments	-	3,584	-	**3,584**
Revaluations	-	4,954	-	**4,954**
Public dividend capital received	25,239	-	-	**25,239**
Taxpayers' and others' equity at 31 March 2023	**541,952**	**41,019**	**(268,552)**	**314,419**

Statements of Cash Flows

	Note	Group 2023/24 £000	Group 2022/23 £000	Trust 2023/24 £000	Trust 2022/23 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(58,138)	(10,880)	(58,138)	(10,880)
Non-cash income and expense:					
Depreciation and amortisation	6.1	34,607	32,215	34,605	32,213
Net impairments	7	31,889	(1,426)	31,889	(1,426)
Income recognised in respect of capital donations	3	(457)	(1,471)	(457)	(1,471)
(Increase) / decrease in receivables and other assets		9,575	(12,708)	9,872	(13,087)
(Increase) / decrease in inventories		(2,084)	(843)	(2,182)	(765)
Increase / (decrease) in payables and other liabilities		(17,045)	(14,853)	(18,089)	(14,377)
Increase / (decrease) in provisions		(456)	(1,750)	(456)	(1,750)
Net cash flows from / (used in) operating activities		**(2,109)**	**(11,716)**	**(2,956)**	**(11,543)**
Cash flows from investing activities					
Interest received		1,707	973	1,707	973
Purchase of intangible assets		(3,386)	(5,999)	(3,386)	(5,999)
Purchase of PPE and investment property		(44,048)	(35,435)	(44,048)	(35,434)
Sales of PPE and investment property		90	40	90	40
Receipt of cash donations to purchase assets		457	1,471	457	1,471
Net cash flows from / (used in) investing activities		**(45,180)**	**(38,950)**	**(45,180)**	**(38,949)**
Cash flows from financing activities					
Public dividend capital received		108,295	25,239	108,295	25,239
Public dividend capital repaid		(14,622)	-	(14,622)	-
Movement on loans from DHSC		(1,575)	(2,167)	(1,575)	(2,167)
Movement on other loans		(75)	(76)	(75)	(76)
Capital element of lease liability repayments		(12,306)	(11,203)	(12,306)	(11,203)
Interest on loans		(92)	(124)	(92)	(124)
Other interest		(3)	(1)	(3)	(1)
Interest paid on lease liability repayments		(533)	(408)	(533)	(408)
PDC dividend (paid) / refunded		(10,269)	(7,979)	(10,269)	(7,979)
Net cash flows from / (used in) financing activities		**68,820**	**3,281**	**68,820**	**3,281**
Increase / (decrease) in cash and cash equivalents		**21,531**	**(47,385)**	**20,684**	**(47,211)**
Cash and cash equivalents at 1 April - brought forward		**14,502**	**61,887**	**14,129**	**61,340**
Cash and cash equivalents transferred under absorption accounting	31	-	-	-	-
Cash and cash equivalents at 31 March	21	**36,033**	**14,502**	**34,813**	**14,129**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Guidance from the Department of Health and Social Care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. The Trust has not been informed by NHS England that there is any prospect of its dissolution within the next twelve months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

It is clear that the Trust remains in a deficit position and will need to work with its partners across the local healthcare system to achieve efficiencies, maximise the use of its assets and sustainable financial balance. The Trust will work with NHS England and its stakeholders to achieve this objective.

In addition to the matters referred to above, the Trust has not been informed by NHS England and NHS Improvement that there is any prospect of its dissolution within the next twelve months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis.

Note 1.3 Consolidation

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The Trust is corporate trustee of the Lancashire Teaching Hospitals NHS Foundation Trust Charity and the Rosemere Cancer Foundation Charity. The Trust has assessed its relationship to the charitable funds and determined them to be subsidiaries because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable funds and the ability to affect those returns and other benefits through its power over the funds. However the combined charitable funds are not material to the Trust and therefore consolidation is not required.

The Trust is sole owner of Lancashire Hospitals Services Limited, a company dispensing prescription drugs to Trust patients. The company has traded throughout the 2023/24 financial year. As sole owner the company therefore constitutes a subsidiary of the Trust and the financial results of the company through the financial year have been consolidated with the Trust to form the Group. The Trust is also the sole owner of Edovation Limited which has not been consolidated due to it being a dormant company.

Note 1.4 Segmental Reporting

An operating segment is a component of the Trust that engages in activities from which it may earn revenues and incur expenses, including revenues and expenses that relate to transactions with any of the Trust's other components.

The chief operating decision maker for the Trust is the Board of Directors. The Board receives the monthly financial reports for the whole Trust and subsidiary information relating to income and divisional expenses. The board makes decisions based on the effect on the monthly financial statements.

The single segment of Healthcare has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

Note 1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. In 2023/24 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

In 2023/24 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for CQUIN and BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.6 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Other income includes income from car parking and catering which is recognised at the point of receipt of cash consideration.

Note 1.7 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

Pension costs (continued)

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.8 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

In 2023/2024 the Trust introduced a new accounting policy for expenditure accruals. The policy is that individual items valued at less than £5,000 and/or relating to period more than 6 months in the past are not accrued. There are limited exceptions to this policy which can be approved by management. The policy applies to manual entries and does not apply to accruals generated by the E-Procurement systems.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.9 Property, plant and equipment (continued)
Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. The modern equivalent may be smaller than the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Note 1.9 Property, plant and equipment (continued)

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	80
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	15
Furniture & fittings	7	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Note 1.10 Intangible assets (continued)

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS40 or IFRS 5..

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	10
Software licences	2	10
Licences & trademarks	2	2

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Leases (continued)

Initial application of IFRS 16 in 2022/23

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced IAS 17 Leases, IFRIC 4 *Determining whether an arrangement contains a lease* and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust was an intermediate lessor, classification of all continuing sublease arrangements was been reassessed with reference to the right of use asset.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
	Exceeding 40 years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2023:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.70%).

Note 1.15 Provisions (continued)

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 25.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

The Trust is a health service body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (S519A(3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare.

Note 1.20 Climate change levy
Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange
The functional and presentational currency of the trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Any resulting exchange gains or losses are recognised in income or expense in the period in which they arise.

Note 1.22 Third party assets
Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.23 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Transfers of functions to/from other NHS bodies/local government bodies
For functions that have been transferred to the trust from another NHS / local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets / liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.25 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted
IFRS17 Insurance Contracts has been issued must be adopted for accounting periods starting on or after 1st January 2023. It will be effective from 2024/25. It is anticipated that the new standard will have no impact upon the Trusts Financial Statements.

Note 1.27 Critical judgements in applying accounting policies
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.28 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The revaluations of hospitals have been carried out by Cushman & Wakefield, who have applied the modern equivalent asset (MEA) valuation. This approach assumes that the asset would have been replaced with a modern equivalent, not a building of identical design, with the same operational value as the existing asset. The modern equivalent may well be smaller that the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. The application and assessment of the valuation has been informed by Trust management in respect of the estimated requirements of a modern equivalent hospital. Estimation uncertainty within the revaluation is primarily driven by the following key assumptions:

- Selection of individual Building Cost Information Services (BCIS) values for each individual building component fror within a published range, reflecting the condition and specifications of the actual component.
- The application of a 'location factor' adjustment to the overall BCIS index movement to reflect specific local factor relating to the cost of construction.
- The application of physical obsolescence adjustments to the valuation of individual buildings to reflect the building's ag and condition, and application of functional obsolescence adjustments to reflect the extent to which a modern equivalent asset would be configured in a more efficient manner and over a reduced gross internal area.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. Outcomes within the next financialyear that are different from the assumption around the valuation of our land or PPE could require a material adjustment to the carrying amount of the asset recorded in note 15

Note 2 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5

Note 2.1 Income from patient care activities (by nature)	2023/24 £000	2022/23 £000
Acute services		
Income from commissioners under API contracts - variable element *	154,515	-
Income from commissioners under API contracts - fixed element *	489,290	569,982
High cost drugs and devices income from commissioners	59,730	60,346
Other NHS clinical income	1,717	266
All services		
Private patient income	1,122	812
Elective recovery fund *		19,376
National pay award central funding **	371	16,911
Additional pension contribution central funding ***	20,392	18,163
Other clinical income	4,085	3,002
Total income from activities	**731,222**	**688,858**

* Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. Elective Recovery Fund income for 2023/24 amounted to £20.4m and is now included within income from commissioners under API contracts - fixed element.
More information can be found in the 2023/25 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

** Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

*** The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2023/24 £000	2022/23 £000
NHS England	244,183	245,792
Clinical commissioning groups		105,889
Integrated care boards	481,319	332,847
Department of Health and Social Care	18	2
Other NHS providers	235	266
NHS other	86	-
Local authorities	745	250
Non-NHS: private patients	968	672
Non-NHS: overseas patients (chargeable to patient)	69	50
Injury cost recovery scheme	3,340	3,002
Non NHS: other	259	88
Total income from activities	**731,222**	**688,858**
Of which:		
Related to continuing operations	731,222	688,858
Related to discontinued operations	-	-

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	2023/24	2022/23
	£000	£000
Income recognised this year	69	50
Cash payments received in-year	39	50
Amounts added to provision for impairment of receivables	204	9
Amounts written off in-year	257	120

The above note relates to the treatment of overseas visitors charges directly by the Trust in accordance with Guidance on implementing the overseas regulations 2015 issued by the Department of Health and Social Care.

Amounts written off in-year 2023/24: 73 customers (2022/23 32 customers)

Note 3 Other operating income (Group)

	2023/24			2022/23		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	3,652	-	**3,652**	3,179	-	**3,179**
Education and training	29,796	1,996	**31,792**	34,488	1,953	**36,441**
Non-patient care services to other bodies	20,619		**20,619**	12,426		**12,426**
Reimbursement and top up funding				3,176		**3,176**
Receipt of capital grants and donations and peppercorn leases		457	**457**		1,471	**1,471**
Other contributions to expenditure		141	**141**		999	**999**
Revenue from operating leases		1,944	**1,944**		1,766	**1,766**
Other income (see note 3.1)	20,117	-	**20,117**	19,628	-	**19,628**
Total other operating income	**74,184**	**4,538**	**78,722**	**72,897**	**6,189**	**79,086**
Of which:						
Related to continuing operations			78,722			79,086
Related to discontinued operations			-			-

Note 3.1 Breakdown of Other income recognised in 'Other Operating Income' (Group)

	2023/24	2022/23
	£000	£000
Car Parking income	2,977	2,435
Catering	1,974	1,263
Pharmacy sales	2,765	2,419
Staff accommodation rental	409	411
Non-clinical services recharged to other bodies	130	372
Clinical excellence awards	476	152
Other income generation schemes (recognised under IFRS 15)*	11,386	12,576
Total Other Income	**20,117**	**19,628**

*Charges for discretionary services and sales of goods.

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2023/24	2022/23
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	5,013	16,439
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	634	10,637

Note 4.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	2023/24	2022/23
	£000	£000
within one year	5,587	5,224
after one year, not later than five years	1,247	197
after five years		
Total revenue allocated to remaining performance obligations	**6,834**	**5,421**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure.
Revenue from
(i) contracts with an expected duration of one year or less and
(ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Fees and charges (Group)

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2023/24	2022/23
	£000	£000
Income	15,519	3,698
Full cost	(14,095)	(4,007)
Surplus / (deficit)	**1,424**	**(309)**

Note 4.4 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2023/24	2022/23
	£000	£000
Income from services designated as commissioner requested services	725,502	684,528
Income from services not designated as commissioner requested services	-	-
Total	**725,502**	**684,528**

Note 5 Operating leases - Lancashire Teaching Hospitals NHS Foundation Trust as lessor

This note discloses income generated in operating lease agreements where Lancashire Teaching Hospitals NHS Foundation Trust is the lessor. These leases relate to parts of the Trust buildings which are occupied by third parties to (for example) use as retail outlets.

Note 5.1 Operating leases income (Group)

	2023/24	2022/23
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	1,829	1,620
Variable lease receipts / contingent rents	115	146
Total in-year operating lease income	**1,944**	**1,766**

Note 5.2 Future lease receipts (Group)

	31 March 2024	31 March 2023
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	1,575	1,124
- later than one year and not later than two years	972	711
- later than two years and not later than three years	972	702
- later than three years and not later than four years	972	702
- later than four years and not later than five years	972	702
- later than five years	1,454	607
Total	**6,917**	**4,548**

Note 6.1 Operating expenses

	Group		Trust	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
Staff and executive directors costs	557,350	521,562	556,278	520,623
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	75,060	67,343	75,032	67,273
Supplies and services - clinical (excluding drugs costs)	59,449	56,177	59,449	56,177
Premises	43,305	35,373	44,554	36,473
Depreciation on property, plant and equipment	32,243	30,068	32,241	30,066
Net impairments	31,889	(1,426)	31,889	(1,426)
Clinical negligence	18,927	20,186	18,927	20,186
Purchase of healthcare from non-NHS and non-DHSC bodies	16,115	18,335	16,115	18,335
Supplies and services - general	13,431	11,236	13,414	11,221
Establishment	5,030	4,641	5,030	4,641
Education and training	4,382	4,611	4,382	4,611
Transport (including patient travel)	3,111	3,235	3,099	3,223
Amortisation on intangible assets	2,364	2,147	2,364	2,147
Expenditure on short term leases	1,293	1,357	1,293	1,357
Insurance	862	775	852	763
Expenditure on low value leases	800	800	800	800
Other	702	505	662	498
Legal fees	444	758	431	758
Internal audit costs	243	114	243	114
Audit services *	232	155	215	141
Inventories written down	218	250	180	221
Remuneration of non-executive directors	173	180	173	180
Purchase of healthcare from NHS and DHSC bodies	149	601	149	601
Research and development	141	214	141	214
Increase/(decrease) in other provisions	105	201	105	201
Movement in credit loss allowance: contract receivables / contract assets	90	(501)	90	(501)
Redundancy	29	84	29	84
Losses, ex gratia & special payments	11	55	11	55
Change in provisions discount rate(s)	(66)	(217)	(66)	(217)
Consultancy costs	-	5	-	5
Total	**868,082**	**778,824**	**868,082**	**778,824**
Of which:				
Related to continuing operations	868,082	778,824	868,082	778,824
Related to discontinued operations	-	-		

* Total audit services for 2023/24 are £196k (excluding VAT) which relate solely to statutory external audit. No additional work has been undertaken.

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2 million (2022/23: £2 million).

Note 7 Impairment of assets (Group)

	2023/24	2022/23
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	31,889	(1,426)
Total net impairments charged to operating surplus / deficit	**31,889**	**(1,426)**
Impairments charged to the revaluation reserve	3,000	(3,584)
Total net impairments	**34,889**	**(5,010)**

Note 8 Employee benefits (Group)

	2023/24 Total £000	2022/23 Total £000
Salaries and wages	424,448	398,945
Social security costs	45,945	42,277
Apprenticeship levy	2,140	1,989
Employer's contributions to NHS pensions	66,944	59,653
Pension cost - other	154	233
Temporary staff (including agency)	20,642	22,210
Total gross staff costs	**560,273**	**525,307**
Recoveries in respect of seconded staff	-	-
Total staff costs	**560,273**	**525,307**
Of which		
Costs capitalised as part of assets	2,894	3,661

Note 8.1 Retirements due to ill-health (Group)

During 2023/24 there were 14 early retirements from the trust agreed on the grounds of ill-health (15 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £2,063k (£632k in 2022/23).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2023/24	2022/23
	£000	£000
Interest on bank accounts	1,707	973
Total finance income	**1,707**	**973**

Note 11.1 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	72	102
Interest on other loans	18	18
Interest on lease obligations	532	409
Interest on late payment of commercial debt	4	1
Total interest expense	**626**	**530**
Unwinding of discount on provisions	27	21
Total finance costs	**653**	**551**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2023/24	2022/23
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	1
Amounts included within interest payable arising from claims made under this legislati	4	1
Compensation paid to cover debt recovery costs under this legislation	3	-

Note 12 Other gains / (losses) (Group)

	2023/24	2022/23
	£000	£000
Gains on disposal of assets	-	12
Losses on disposal of assets	(35)	(114)
Total gains / (losses) on disposal of assets	**(35)**	**(102)**

Note 13 Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's deficit for the period was £67.9 million (2022/23: £19.0 million). The trust's total comprehensive expense for the period was £66.8 million (2022/23: £10.5 million).

Note 14.1 Intangible assets - 2023/24

Group	Software licences £000	Licences & trademarks £000	IT (internally generated and 3rd party) £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2023 - brought forward	**13,366**	**13**	**1,815**	**3,910**	**19,104**
Additions	1,992	-	813	581	**3,386**
Impairments	-	-	(250)	(2,943)	**(3,193)**
Reclassifications	-	-	-	-	**-**
Valuation / gross cost at 31 March 2024	**15,358**	**13**	**2,378**	**1,548**	**19,297**
Amortisation at 1 April 2023 - brought forward	**7,432**	**13**	**243**	**-**	**7,688**
Provided during the year	2,088	-	276	-	**2,364**
Impairments	-	-	(11)	-	**(11)**
Reclassifications	1	-	(1)	-	**-**
Amortisation at 31 March 2024	**9,521**	**13**	**507**	**-**	**10,041**
Net book value at 31 March 2024	**5,837**	**-**	**1,871**	**1,548**	**9,256**
Net book value at 1 April 2023	**5,934**	**-**	**1,572**	**3,910**	**11,416**

Note 14.2 Intangible assets - 2022/23

Group	Software licences £000	Licences & trademarks £000	IT (internally generated and 3rd party) £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2022 - as previously stated	**21,354**	**13**	**1,381**	**-**	**22,748**
Additions	1,655	-	434	3,910	**5,999**
Reclassifications	180	-	-	-	**180**
Disposals / derecognition	(9,823)	-	-	-	**(9,823)**
Valuation / gross cost at 31 March 2023	**13,366**	**13**	**1,815**	**3,910**	**19,104**
Amortisation at 1 April 2022 - as previously stated	**15,310**	**6**	**44**	**-**	**15,360**
Provided during the year	1,941	7	199	-	**2,147**
Reclassifications	4	-	-	-	**4**
Disposals / derecognition	(9,823)	-	-	-	**(9,823)**
Amortisation at 31 March 2023	**7,432**	**13**	**243**	**-**	**7,688**
Net book value at 31 March 2023	**5,934**	**-**	**1,572**	**3,910**	**11,416**
Net book value at 1 April 2022	**6,044**	**7**	**1,337**	**-**	**7,388**

Note 15.1 Property, plant and equipment - 2023/24

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 - brought forward	**16,952**	**245,284**	**12,786**	**88,047**	**88**	**26,669**	**252**	**390,078**
Additions	-	26,020	3,219	21,008	24	3,868	119	**54,258**
Impairments	-	(1,084)	(4,883)	-	-	-	-	**(5,967)**
Reversals of impairments	198	2,771	-	-	-	-	-	**2,969**
Revaluations	-	(25,785)	-	-	-	(1,100)	-	**(26,885)**
Reclassifications	-	7,003	(7,036)	34	-	(1)	-	**-**
Disposals / derecognition	-	-	-	(1,112)	-	-	-	**(1,112)**
Valuation/gross cost at 31 March 2024	**17,150**	**254,209**	**4,086**	**107,977**	**112**	**29,436**	**371**	**413,341**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**1,234**	**-**	**37,251**	**73**	**12,372**	**60**	**50,990**
Provided during the year	-	6,622	-	8,785	12	4,344	32	**19,795**
Impairments	-	36,349	(14)	-	-	512	-	**36,847**
Reversals of impairments	-	(8,138)	-	-	-	-	-	**(8,138)**
Revaluations	-	(29,903)	-	-	-	(1,100)	-	**(31,003)**
Reclassifications	-	(12)	14	(2)	-	-	-	**-**
Disposals / derecognition	-	-	-	(986)	-	-	-	**(986)**
Accumulated depreciation at 31 March 2024	**-**	**6,152**	**-**	**45,048**	**85**	**16,128**	**92**	**67,505**
Net book value at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**279**	**345,836**
Net book value at 1 April 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**192**	**339,088**

Note 15.2 Property, plant and equipment - 2022/23

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	**16,475**	**219,195**	**11,558**	**135,645**	**214**	**52,798**	**1,772**	**437,657**
IFRS 16 implementation - reclassification to right of use assets	-	(100)	-	-	-	-	-	**(100)**
Additions	3	22,998	1,228	14,506	-	5,095	33	**43,863**
Impairments	-	(17)	-	-	-	-	-	**(17)**
Reversals of impairments	462	3,347	-	-	-	-	-	**3,809**
Revaluations	12	(140)	-	-	-	(1,385)	-	**(1,513)**
Reclassifications	-	1	-	(182)	-	1	-	**(180)**
Disposals / derecognition	-	-	-	(61,922)	(126)	(29,840)	(1,553)	**(93,441)**
Valuation/gross cost at 31 March 2023	**16,952**	**245,284**	**12,786**	**88,047**	**88**	**26,669**	**252**	**390,078**
Accumulated depreciation at 1 April 2022 - as previously stated	**-**	**1,189**	**-**	**91,489**	**188**	**38,808**	**1,589**	**133,263**
IFRS 16 implementation - reclassification to right of use assets	-	-	-	-	-	-	-	**-**
Provided during the year	-	7,083	-	7,534	11	4,051	24	**18,703**
Impairments	-	5,307	-	-	-	738	-	**6,045**
Reversals of impairments	-	(7,263)	-	-	-	-	-	**(7,263)**
Revaluations	-	(5,082)	-	-	-	(1,385)	-	**(6,467)**
Reclassifications	-	-	-	(4)	-	-	-	**(4)**
Disposals / derecognition	-	-	-	(61,768)	(126)	(29,840)	(1,553)	**(93,287)**
Accumulated depreciation at 31 March 2023	**-**	**1,234**	**-**	**37,251**	**73**	**12,372**	**60**	**50,990**
Net book value at 31 March 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**192**	**339,088**
Net book value at 1 April 2022	**16,475**	**218,006**	**11,558**	**44,156**	**26**	**13,990**	**183**	**304,394**

Note 15.3 Property, plant and equipment financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	17,150	246,179	4,086	59,570	27	13,202	271	**340,485**
Owned - donated/granted	-	1,878	-	3,359	-	106	8	**5,351**
NBV total at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**279**	**345,836**

Note 15.4 Property, plant and equipment financing - 31 March 2023

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	16,952	241,811	12,786	47,172	15	14,050	183	**332,969**
Owned - donated/granted	-	2,239	-	3,624	-	247	9	**6,119**
NBV total at 31 March 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**192**	**339,088**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	88	4,004	-	-	-	-	-	**4,092**
Not subject to an operating lease	17,062	244,053	4,086	62,929	27	13,308	279	**341,744**
NBV total at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**279**	**345,836**

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	3,831	-	-	-	-	-	**3,831**
Not subject to an operating lease	16,952	240,219	12,786	50,796	15	14,297	192	**335,257**
NBV total at 31 March 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**192**	**339,088**

Note 16.1 Property, plant and equipment - 2023/24

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2023 - brought forward	**16,952**	**245,284**	**12,786**	**88,047**	**88**	**26,669**	**244**	**390,070**
Additions	-	26,020	3,219	21,008	24	3,868	119	**54,258**
Impairments	-	(1,084)	(4,883)	-	-	-	-	**(5,967)**
Reversals of impairments	198	2,771	-	-	-	-	-	**2,969**
Revaluations	-	(25,785)	-	-	-	(1,100)	-	**(26,885)**
Reclassifications	-	7,003	(7,036)	34	-	(1)	-	**-**
Disposals / derecognition	-	-	-	(1,112)	-	-	-	**(1,112)**
Valuation/gross cost at 31 March 2024	**17,150**	**254,209**	**4,086**	**107,977**	**112**	**29,436**	**363**	**413,333**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**1,234**	**-**	**37,251**	**73**	**12,372**	**58**	**50,988**
Provided during the year	-	6,622	-	8,785	12	4,344	30	**19,793**
Impairments	-	36,349	(14)	-	-	512	-	**36,847**
Reversals of impairments	-	(8,138)	-	-	-	-	-	**(8,138)**
Revaluations	-	(29,903)	-	-	-	(1,100)	-	**(31,003)**
Reclassifications	-	(12)	14	(2)	-	-	-	**-**
Disposals / derecognition	-	-	-	(986)	-	-	-	**(986)**
Accumulated depreciation at 31 March 2024	**-**	**6,152**	**-**	**45,048**	**85**	**16,128**	**88**	**67,501**
Net book value at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**275**	**345,832**
Net book value at 1 April 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**186**	**339,082**

Note 16.2 Property, plant and equipment - 2022/23

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - as previously stated	**16,475**	**219,195**	**11,558**	**135,645**	**214**	**52,798**	**1,765**	**437,650**
IFRS 16 implementation - reclassification of existing leased assets to right of use assets	-	(100)	-	-	-	-	-	**(100)**
Additions	3	22,998	1,228	14,506	-	5,095	32	**43,862**
Impairments	-	(17)	-	-	-	-	-	**(17)**
Reversals of impairments	462	3,347	-	-	-	-	-	**3,809**
Revaluations	12	(140)	-	-	-	(1,385)	-	**(1,513)**
Reclassifications	-	1	-	(182)	-	1	-	**(180)**
Disposals / derecognition	-	-	-	(61,922)	(126)	(29,840)	(1,553)	**(93,441)**
Valuation/gross cost at 31 March 2023	**16,952**	**245,284**	**12,786**	**88,047**	**88**	**26,669**	**244**	**390,070**
Accumulated depreciation at 1 April 2022 - as previously stated	**-**	**1,189**	**-**	**91,489**	**188**	**38,808**	**1,589**	**133,263**
Provided during the year	-	7,083	-	7,534	11	4,051	22	**18,701**
Impairments	-	5,307	-	-	-	738	-	**6,045**
Reversals of impairments	-	(7,263)	-	-	-	-	-	**(7,263)**
Revaluations	-	(5,082)	-	-	-	(1,385)	-	**(6,467)**
Reclassifications	-	-	-	(4)	-	-	-	**(4)**
Disposals / derecognition	-	-	-	(61,768)	(126)	(29,840)	(1,553)	**(93,287)**
Accumulated depreciation at 31 March 2023	**-**	**1,234**	**-**	**37,251**	**73**	**12,372**	**58**	**50,988**
Net book value at 31 March 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**186**	**339,082**
Net book value at 1 April 2022	**16,475**	**218,006**	**11,558**	**44,156**	**26**	**13,990**	**176**	**304,387**

Note 16.3 Property, plant and equipment financing - 31 March 2024

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	17,150	246,179	4,086	59,570	27	13,202	267	**340,481**
Owned - donated / granted	-	1,878	-	3,359	-	106	8	**5,351**
Total net book value at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**275**	**345,832**

Note 16.4 Property, plant and equipment financing - 31 March 2023

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	16,952	241,811	12,786	47,172	15	14,050	177	**332,963**
Owned - donated / granted	-	2,239	-	3,624	-	247	9	**6,119**
Total net book value at 31 March 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**186**	**339,082**

Note 16.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	88	4,004	-	-	-	-	-	**4,092**
Not subject to an operating lease	17,062	244,053	4,086	62,929	27	13,308	275	**341,740**
Total net book value at 31 March 2024	**17,150**	**248,057**	**4,086**	**62,929**	**27**	**13,308**	**275**	**345,832**

Note 16.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	3,831	-	-	-	-	-	**3,831**
Not subject to an operating lease	16,952	240,219	12,786	50,796	15	14,297	186	**335,251**
Total net book value at 31 March 2023	**16,952**	**244,050**	**12,786**	**50,796**	**15**	**14,297**	**186**	**339,082**

Note 17 Donations of property, plant and equipment

In 2023/24, the Trust received medical equipment donations totalling £457k from the non-consolidated charity.

Note 18 Leases - Lancashire Teaching Hospitals NHS Foundation Trust as a lessee

The Trust leases many assets including land and buildings, vehicles, machinery, equipment, and IT. This note details information about leases for which the Trust is a lessee.

Land & Buildings leases

The Trust leases clinical space within other NHS sites which are owned by NHS Property Services or other NHS Foundation Trusts. These leases run for 5 to 12 years and amounts payable under the leases are revised annually using inflation factors as set out in NHS Planning guidance issued by NHSE.

The Trust also has two leases with commercial landlords; one for Preston Business Centre and one for Finney House. The lease for Preston Business Centre is for 10 years and commenced on 1st December 2021. The amount payable under this lease is revised at five yearly intervals as per the clauses in the lease. The lease for Finney House commenced on the 15th November 2023 for a 5 year term. The lease terms provide for an annual rental review each April using the consumer price index from the preceding February.

The Trust leases some of it's premises under operating leases (see note 5.1)

Some leases contain extension options exercisable by the Trust in accordance with the lease terms. The Trust seeks to include extension options in new leases to provide operational flexibility. The extension options are exercisable only by the Trust and not by the lessors. The Trust assesses at lease commencement whether it is reasonably certain to exercise the extension options. It reassesses whether it is reasonably certain to exercise options if there is a significant event or significant change in circumstances within it's control.

Other leases

The Trust leases vehicles and equipment, with terms between 1 to 8 years. In some cases the Trust has options to purchase the assets at the end of the contract term; in other cases the Trust is obliged to return the items to the lessor or negotiate a secondary lease. Neither are considered to be obligations and therefore the Trust is not estimating liabilities beyond the original lease terms.

Note 18.1 Right of use assets - 2023/24

Group	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**30,161**	**19,516**	**260**	**6**	**21**	**49,964**	**8,570**
Transfers by absorption	458	-	-	-	-	**458**	-
Additions	800	1,160	65	-	-	**2,025**	800
Remeasurements of the lease liability	647	-	-	-	-	**647**	(6,827)
Reclassifications	(2,346)	2,346	-	-	-	**-**	(1,667)
Disposals / derecognition	(178)	(11,290)	(75)	-	(21)	**(11,564)**	(60)
Valuation/gross cost at 31 March 2024	**29,542**	**11,732**	**250**	**6**	**-**	**41,530**	**816**
Accumulated depreciation at 1 April 2023 - brought forward	**3,808**	**6,999**	**70**	**2**	**10**	**10,889**	**1,733**
Transfers by absorption	-	-	-	-	-	**-**	-
Provided during the year	5,071	7,294	70	2	11	**12,448**	34
Reclassifications	-	-	-	-	-	**-**	(1,699)
Disposals / derecognition	(178)	(11,174)	(40)	-	(21)	**(11,413)**	(60)
Accumulated depreciation at 31 March 2024	**8,701**	**3,119**	**100**	**4**	**-**	**11,924**	**8**
Net book value at 31 March 2024	**20,841**	**8,613**	**150**	**2**	**-**	**29,606**	**808**
Net book value at 1 April 2023	**26,353**	**12,517**	**190**	**4**	**11**	**39,075**	**6,837**

Net book value of right of use assets leased from other NHS providers	-
Net book value of right of use assets leased from other DHSC group bodies	808

Note 18.2 Right of use assets - 2022/23

Group	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2022 - brought forward	**-**	**-**	**-**	**-**	**-**	**-**	**-**
IFRS 16 implementation - reclassification of existing leased assets from PPE or intangible assets	100	-	-	-	-	**100**	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	24,488	18,393	260	6	21	**43,168**	11,581
Additions	8,684	1,123	-	-	-	**9,807**	-
Disposals / derecognition	(3,111)	-	-	-	-	**(3,111)**	(3,011)
Valuation/gross cost at 31 March 2023	**30,161**	**19,516**	**260**	**6**	**21**	**49,964**	**8,570**
Accumulated depreciation at 1 April 2022 - brought forward	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	4,284	6,999	70	2	10	**11,365**	2,109
Disposals / derecognition	(476)	-	-	-	-	**(476)**	(376)
Accumulated depreciation at 31 March 2023	**3,808**	**6,999**	**70**	**2**	**10**	**10,889**	**1,733**
Net book value at 31 March 2023	**26,353**	**12,517**	**190**	**4**	**11**	**39,075**	**6,837**
Net book value at 1 April 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Net book value of right of use assets leased from other NHS providers	6,795
Net book value of right of use assets leased from other DHSC group bodies	42

Note 18.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 24.

	Group		Trust	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
Carrying value at 1 April	**39,225**	**99**	**39,225**	99
IFRS 16 implementation - adjustments for existing operating leases	-	43,168	-	43,168
Transfers by absorption	441	-	441	-
Lease additions	2,025	9,807	2,025	9,807
Lease liability remeasurements	647	-	647	-
Interest charge arising in year	532	409	532	409
Early terminations	(151)	(2,647)	(151)	(2,647)
Lease payments (cash outflows)	(12,839)	(11,611)	(12,839)	(11,611)
Carrying value at 31 March	**29,880**	**39,225**	**29,880**	**39,225**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

The Trust does not sub lease any right of use assets so the value included within revenue from operating leases in note 3 all relates to Trust owned property that is leased.

Note 18.4 Maturity analysis of future lease payments at 31 March 2024

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	7,426	78	7,426	78
- later than one year and not later than five years;	17,914	302	17,914	302
- later than five years.	6,017	743	6,017	743
Total gross future lease payments	**31,357**	**1,123**	**31,357**	**1,123**
Finance charges allocated to future periods	(1,477)	(315)	- 1,477	- 315
Net lease liabilities at 31 March 2024	**29,880**	**808**	**29,880**	**808**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		808		808

Note 18.5 Maturity analysis of future lease payments at 31 March 2023

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2023	31 March 2023	31 March 2023	31 March 2023
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	12,386	1,774	12,386	1,774
- later than one year and not later than five years;	21,378	5,229	21,378	5,229
- later than five years.	6,527	-	6,527	-
Total gross future lease payments	**40,291**	**7,003**	**40,291**	**7,003**
Finance charges allocated to future periods	(1,066)	(133)	(1,066)	(133)
Net finance lease liabilities at 31 March 2023	**39,225**	**6,870**	**39,225**	**6,870**
Of which:				
Leased from other NHS providers		6,827		6,827
Leased from other DHSC group bodies		43		43

Note 19 Inventories

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Drugs	5,692	5,093	4,740	4,043
Consumables	10,935	9,457	10,935	9,457
Energy	162	143	162	143
Other	14	26	14	26
Total inventories	**16,803**	**14,719**	**15,851**	**13,669**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £82,557k (2022/23: £92,406k). Write-down of inventories recognised as expenses for the year were £218k (2022/23: £250k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £141k of items purchased by DHSC (2022/23: £999k).

In 2022/23 these inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above for 2022/23.

In 2023/24 the Trust has, on the grounds of materiality, excluded donated PPE from inventories. Instead the deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 20 Receivables

	Group		Trust	
	31 March 2024	31 March 2023	31 March 2024	31 March 2023
	£000	£000	£000	£000
Current				
Contract receivables	28,962	41,818	29,007	42,201
Allowance for impaired contract receivables / assets	(1,532)	(1,764)	(1,532)	(1,764)
Prepayments (non-PFI)	5,521	4,234	5,511	4,226
Operating lease receivables	126	169	126	169
PDC dividend receivable	-	224	-	224
VAT receivable	2,669	1,308	2,448	1,093
Corporation and other taxes receivable	28	25	28	25
Other receivables	3,904	1,830	3,953	1,830
Total current receivables	**39,678**	**47,844**	**39,541**	**48,004**
Non-current				
Contract receivables	6,879	5,916	6,879	5,916
Allowance for impaired contract receivables / assets	(716)	(619)	(716)	(619)
Other receivables	869	1,082	2,369	2,582
Total non-current receivables	**7,032**	**6,379**	**8,532**	**7,879**
Of which receivable from NHS and DHSC group bodies:				
Current	20,893	33,436	20,678	33,221
Non-current	869	1,082	869	1,082

Note 20.1 Allowances for credit losses

	Group		Trust	
	31 March 2024	31 March 2023	31 March 2024	31 March 2023
	£000	£000	£000	£000
Allowances as at 1 Apr	2,383	3,519	2,383	3,519
New allowances arising	933	575	933	575
Changes in existing allowances	(5)	(838)	(5)	(838)
Reversals of allowances	(838)	(238)	(838)	(238)
Utilisation of allowances (write offs)	(225)	(635)	(225)	(635)
Allowances as at 31 Mar	**2,248**	**2,383**	**2,248**	**2,383**

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2023/24	2022/23	2023/24	2022/23
	£000	£000	£000	£000
At 1 April	**14,502**	**61,887**	**14,129**	**61,340**
Net change in year	21,531	(47,385)	20,684	(47,211)
At 31 March	**36,033**	**14,502**	**34,813**	**14,129**
Broken down into:				
Cash at commercial banks and in hand	1,241	392	21	19
Cash with the Government Banking Service	34,792	14,110	34,792	14,110
Total cash and cash equivalents as in SoFP	**36,033**	**14,502**	**34,813**	**14,129**
Total cash and cash equivalents as in SoCF	**36,033**	**14,502**	**34,813**	**14,129**

Note 21.1 Third party assets held by the trust

Lancashire Teaching Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	2024	2023
	£000	£000
Bank balances	7	6
Total third party assets	**7**	**6**

Note 22 Trade and other payables

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Current				
Trade payables	19,367	15,029	18,325	15,139
Capital payables	36,923	26,713	36,923	26,713
Accruals	23,309	46,810	23,558	46,947
Social security costs	5,604	5,459	5,595	5,451
Other taxes payable	6,489	5,048	6,481	5,042
PDC dividend payable	312	-	312	-
Pension contributions payable	6,380	5,662	6,380	5,662
Other payables	1,106	402	1,103	400
Total current trade and other payables	**99,490**	**105,123**	**98,677**	**105,354**
Of which payables from NHS and DHSC group bodies:				
Current	10,847	9,682	10,034	9,913
Non-current	-	-	-	-

Note 23 Other liabilities

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Current				
Deferred income: contract liabilities	5,587	5,224	5,587	5,224
Total other current liabilities	**5,587**	**5,224**	**5,587**	**5,224**
Non-current				
Deferred income: contract liabilities	1,247	197	1,247	197
Total other non-current liabilities	**1,247**	**197**	**1,247**	**197**

Cancer Alliance funding has been received by the Trust to support staff posts over a 2 year period. A proportion that represents funding for the second year is deferred as non-current and the remainder is included in the current balance.

Note 24 Borrowings

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Current				
Loans from DHSC	1,116	1,586	1,116	1,586
Other loans	79	79	79	79
Lease liabilities	6,963	12,062	6,963	12,062
Total current borrowings	**8,158**	**13,727**	**8,158**	**13,727**
Non-current				
Loans from DHSC	1,763	2,870	1,763	2,870
Other loans	341	416	341	416
Lease liabilities	22,917	27,163	22,917	27,163
Total non-current borrowings	**25,021**	**30,449**	**25,021**	**30,449**

Note 24.1 Reconciliation of liabilities arising from financing activities

Group - 2023/24	Loans from DHSC	Other loans	Lease liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2023	**4,456**	**495**	**39,225**	**44,176**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,575)	(75)	(12,306)	**(13,956)**
Financing cash flows - payments of interest	(74)	(18)	(533)	**(625)**
Non-cash movements:				
Transfers by absorption	-	-	441	**441**
Additions	-	-	2,025	**2,025**
Lease liability remeasurements	-	-	647	**647**
Application of effective interest rate	72	18	532	**622**
Early terminations	-	-	(151)	**(151)**
Carrying value at 31 March 2024	**2,879**	**420**	**29,880**	**33,179**

Group - 2022/23	Loans from DHSC	Other loans	Lease liabilities	Total
	£000	£000	£000	£000
Carrying value at 1 April 2022	**6,627**	**571**	**99**	**7,297**
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,167)	(76)	(11,203)	**(13,446)**
Financing cash flows - payments of interest	(106)	(18)	(408)	**(532)**
Non-cash movements:				
IFRS 16 implementation - adjustments for existing operating leases / subleases			43,168	**43,168**
Additions	-	-	9,807	**9,807**
Application of effective interest rate	102	18	409	**529**
Early terminations	-	-	(2,647)	**(2,647)**
Carrying value at 31 March 2023	**4,456**	**495**	**39,225**	**44,176**

Note 25 Provisions for liabilities and charges analysis

Group	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2023	**1,294**	**276**	**2,314**	**3,884**
Change in the discount rate	(66)	-	(193)	**(259)**
Arising during the year	118	72	(51)	**139**
Utilised during the year	(108)	(72)	(24)	**(204)**
Reversed unused	-	(83)	(107)	**(190)**
Unwinding of discount	27	-	58	**85**
At 31 March 2024	**1,265**	**193**	**1,997**	**3,455**
Expected timing of cash flows:				
- not later than one year;	106	193	28	**327**
- later than one year and not later than five years;	399	-	1,171	**1,570**
- later than five years.	760	-	798	**1,558**
Total	**1,265**	**193**	**1,997**	**3,455**

Permanent injury benefits
Payments are made on a quarterly basis to the NHS Pension Scheme and NHS Injury Benefit Scheme respectively.

Note 25 Provisions for liabilities and charges analysis (continued)

Clincians pension tax

Clinicians who were members of the NHS Pensions Scheme and who as a result of work undertaken in the tax year (2019/20) face a tax charge in respect of growth of their NHS pension benefits above their pensions savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme.

Dilapidation provisions

The Trust has created a provision for the reinstatement of leased properties (dilapidations). Payments will be made as and when leases expire and agreements are reached with Landlords.

Note 25.1 Clinical negligence liabilities

At 31 March 2024, £301,867k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lancashire Teaching Hospitals NHS Foundation Trust (31 March 2023: £324,548k).

Note 26 Contingent assets and liabilities

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Value of contingent liabilities				
NHS Resolution legal claims	(109)	(113)	(109)	(113)
Gross value of contingent liabilities	**(109)**	**(113)**	**(109)**	**(113)**
Amounts recoverable against liabilities	-	-		
Net value of contingent liabilities	**(109)**	**(113)**	**(109)**	**(113)**

The Trust has no contingent assets to disclose.

Note 27 Contractual capital commitments

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
Property, plant and equipment	5,832	3,159	5,832	3,159
Total	**5,832**	**3,159**	**5,832**	**3,159**

The contractual capital commitments represent the value of works committed to on projects that were work in progress at the 31st March 2023.

Note 28 Financial instruments

Note 28.1 Financial risk management

International Financial Reporting Standard 9 requires disclosure of the role which Financial Instruments have had during the period in creating or changing the risks which a body faces in undertaking its activities. Because of the continuing service provider relationship which the Trust has with its Commissioners, and the way in which those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, Financial Instruments play a much more limited role in creating or changing risk for the Trust than would be typical of listed companies, to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and Financial Assets and Liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions, and policies agreed by the Board of Directors. The Trust's treasury activities are also subject to review by Internal Audit.

Liquidity Risk

Net operating costs of the Trust are funded under annual Service Agreements with NHS Commissioners, which are financed from resources voted annually by Parliament. While the Trust is in deficit it is accessing working capital support by means of PDC through DHSC. The Trust largely finances its capital expenditure from internally generated cash, and funds made available by the DHSC. Additional funding by way of loans has been arranged with the Foundation Trust Financing Facility to support major capital developments. The Trust is, therefore, exposed to liquidity risks from the loan funding - however these risks are approved, and comply with Monitor's Risk Assessment Framework.

Currency Risk

The Trust is a domestic organisation with the overwhelming majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations, and therefore has low exposure to currency rate fluctuations..

Interest Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest rate risk.

Credit Risk

The majority of the Trust's Income comes from contracts with other public sector bodies, and therefore the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2023 is within Receivables from customers, as disclosed in the Trade and Other Receivables note to these Accounts.

Note 28.2 Carrying values of financial assets

	Group		Trust	
Carrying values of financial assets as at 31 March 2024	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	38,520	**38,520**	40,115	**40,115**
Cash and cash equivalents	36,033	**36,033**	34,813	**34,813**
Total at 31 March 2024	**74,553**	**74,553**	**74,928**	**74,928**

	Group		Trust	
Carrying values of financial assets as at 31 March 2023	**Held at amortised cost**	**Total book value**	**Held at amortised cost**	**Total book value**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	48,457	**48,457**	50,340	**50,340**
Cash and cash equivalents	14,502	**14,502**	14,129	**14,129**
Total at 31 March 2023	**62,959**	**62,959**	**64,469**	**64,469**

Note 28.3 Carrying values of financial liabilities

	Group		Trust	
	Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2024				
Loans from the Department of Health and Social Care	2,879	**2,879**	2,879	**2,879**
Obligations under leases	29,880	**29,880**	29,880	**29,880**
Other borrowings	420	**420**	420	**420**
Trade and other payables excluding non financial liabilities	79,586	**79,586**	78,793	**78,793**
Total at 31 March 2024	**112,765**	**112,765**	**111,972**	**111,972**

	Held at amortised cost £000	Total book value £000	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2023				
Loans from the Department of Health and Social Care	4,456	**4,456**	4,456	**4,456**
Obligations under leases	39,225	**39,225**	39,225	**39,225**
Other borrowings	495	**495**	495	**495**
Trade and other payables excluding non financial liabilities	89,358	**89,358**	89,603	**89,603**
Total at 31 March 2023	**133,534**	**133,534**	**133,779**	**133,779**

Note 28.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2024 £000	31 March 2023 £000	31 March 2024 £000	31 March 2023 £000
In one year or less	88,258	103,290	87,465	103,535
In more than one year but not more than five years	19,061	23,750	19,061	23,750
In more than five years	114,637	8,021	114,637	8,021
Total	**221,956**	**135,061**	**221,163**	**135,306**

Note 29 Losses and special payments (Group)

	2023/24		2022/23	
Group and trust	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	4	-	1	-
Fruitless payments and constructive losses	1	17	-	-
Bad debts and claims abandoned	918	403	753	162
Stores losses and damage to property	3	218	3	216
Total losses	**926**	**638**	**757**	**378**
Special payments				
Compensation under court order or legally binding arbitration award	1	-	2	15
Ex-gratia payments	49	149	80	548
Total special payments	**50**	**149**	**82**	**563**
Total losses and special payments	**976**	**787**	**839**	**941**

Note 30 Related parties

Lancashire Teaching Hospitals NHS Foundation Trust is a public interest body, a Department of Health and Social Care (parent of the group) Group body, authorised by NHS Improvement, the Independent Regulator for NHS Foundation Trusts. During the year none of the Board members or members of key management staff or parties related to them has undertaken any material transactions with Lancashire Teaching Hospitals NHS Foundation Trust.

Council of Governors

The roles and responsibilities of the Council of Governors of the Foundation Trust are carried out in accordance with the Trust's Provider Licence:

The Council has specific powers including:

- appointment and, if appropriate, removal of the Chair and other non-executive Directors
- approval of the appointment of the Chief Executive
- to decide the remuneration and allowances and the other terms and conditions of office of the Chair and other non-executive Directors
- to appoint and, if appropriate, remove the Trust's external auditors
- to appoint or remove any other external auditor
- to receive the annual accounts, annual report and any report on them by the auditor
- to provide their views to the board of directors when the board of directors is preparing the Trust's forward plan
- to hold the non-executive directors individually and collectively to account for the performance of the board of directors
- to represent the interests of the members of the Trust as a whole and of the public
- to approve 'significant transactions' as defined within the constitution
- to approve an application by the Trust to enter into a merger, acquisition, seperation or dissolution
- to decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose
- to approve any proposed increase in private patient income of 5% of total income or more in any financial year
- to approve, along with the Board of Directors, any changes to the Trust's consititution
- to require the attendance of one or more directors at a Council of Governors meeting, for the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or directors' performance).

The Foundation Trust maintains a register of interests for the Board and for members of the Council of Governors. Of the total of 28 members of the Council of Governors, 5 represent the interests of other organisations who the Trust has identified as key partners in the delivery of healthcare to the population of Preston Chorley and South Ribble.

Members of the Council of Governors, Executive Directors and Non-Executive Directors, or close family members of the same, who have interests in or hold positions with organisations with which the trust has had transactions during the year, are listed below:

	Income	Expenditure	Receivable	Payable	Relationship
	£000	£000	£000	£000	
NHS England	252,422	1,095	2,675	3,773	Corporate Director
East Lancashire Hospitals NHS Trust	4,040	3,238	1,754	1,752	Council of Governors Non-Executive Director
Lancashire County Council	721	71	34	4	Council of Governors
University of Manchester	429	353	16	-	Non-Executive Director Corporate Director
University of Central Lancashire	360	270	35	82	Council of Governors Executive Director Corporate Director
North West Ambulance Service NHS Trust	309	260	51	57	Chair Non-Executive Director Executive Director
Mersey & West Lancashire NHS Foundation Trust	303	159	106	357	Council of Governors
University of Bolton	156	34	42	-	Executive Director
St Catherine's Hospice	115	4	18	-	Executive Director
West Lancashire Borough Council	29	-	3	-	Council of Governors
South Ribble Borough Council	8	-	1	-	Council of Governors
Unison	6	187	3	-	Council of Governors
NHS Blood and Transplant	3	2,146	-	140	Council of Governors
Preston City Council	-	1	-	-	Council of Governors
Care Quality Commission	-	507	-	-	Non-Executive Director
Weightmans Solicitors LLP	-	176	-	-	Executive Director
Calderdale and Huddersfield NHS Foundation Trust	-	38	-	4	Non-Executive Director

The Trust previously established a wholly owned subsidiary, Lancashire Hospitals Services Ltd. Lancashire Hospitals Services Ltd took over the outpatient pharmacies accross the Trust on 1 October 2018. Being wholly owned, the Trust has prepared its financial statements on a Group basis, consolidating the results of Lancashire Hospitals Services Ltd.

The Trust is Corporate Trustee of two charities which means that the Trust has control over the charities. Both Charities are registered with the Charity Commission and produce a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) These documents will be available in December 2024, on request from the Finance Department of the Trust. Details of the charities and of material transactions between them and the Trust are detailed below.

Note 30 Related parties (continued)

Charity	Registered Number	Donations received £000	Receivable £000	Payable £000
Lancashire Teaching Hospitals Charity	1051194	86	105	0
The Rosemere Cancer Foundation	1131583	372	176	0

Note 31 Transfers by absorption (Group)

During 2022/23 the Boards of Lancashire Teaching Hospitals NHS Foundation Trust (LTH) and Northern Care Alliance NHS Foundation Trust (NCA) agreed that with effect from the 1st June 2023 the East Lancashire Financial Services (ELFS) Business Services will be transferred to LTH. This transfer has been transacted as a transfer by absorption by the two Trusts; LTH as the receiving entity and NCA as the divesting entity. The total assets transferred were equal to the liabilities transferred giving a nil impact upon the SOCI. There were no such transfers during 2022/23.

	2023/24 £000	2022/23 £000
Inward transfers Northern Care Alliance NHS Foundation Trust		
Right of Use Assets	458	-
Receivables	2,286	-
Payables	(1,003)	-
Other Liabilities	(1,300)	-
Borrowings (Right of Use Assets lease liability)	(441)	-
Net transfers - recognised in the SOCI as a loss due to transfers by absorption	**-**	**-**

If you have any queries regarding this report, or wish to make contact with any of the Directors or Governors, please contact:

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Auditor's Annual Report 2023/24

Lancashire Teaching Hospitals NHS Foundation Trust

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27 June 2024

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This report is addressed to Lancashire Teaching Hospitals NHS Foundation Trust (the Trust). We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

01 Executive Summary

Executive Summary

Purpose of the Auditor's Annual Report

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2023-24 audit of Lancashire Teaching Hospitals NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

Accounts - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).

Annual report - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.

Value for money - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.

Other reporting - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities

Accounts	We issued an unqualified opinion on the Trust's accounts on 27th June 2024.This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust We have provided further details of the key risks we identified and our response on page 7-9.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the Governance Statement had been prepared in line with the Department of Health and Social Care requirements.
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. We have nothing to report in this regard.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

02
Audit of the Financial Statements

Audit of the financial statements

KPMG provides an independent opinion on whether the Trust's financial statements:

- Give a true and fair view of the state of the Trust's affairs as at 31 March 2024 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2023/24; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Audit opinion on the financial statements

We have issued an unqualified opinion on the Trust's financial statements before 28 June 2024.

The full opinion is included in the Trust's Annual Report and Accounts for 2023/24 which can be obtained from the Trust's website.

Further information on our audit of the financial statements is set out overleaf.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Fraud risk from expenditure recognition: Liabilities and related expenses for purchases of goods or services are not completely recorded As the Trust and system is set a financial performance target by NHS England there is a risk that non-pay expenditure, excluding depreciation, may be manipulated in order to report that the control total has been met. The setting of a financial performance target can create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred. Management agreed a revised forecast of £51.5m deficit in December 2023 (£15.3m deficit agreed in original approved plan in May 2023). This was further reduced to £35.6m following additional funding from the ICB. Internal forecasting had assumed a worst case of £62m deficit. The pressure to meet a more favourable deficit means the Trust is incentivised to understate expenditure accordingly. We consider this would be most likely to occur through omitting accruals in order to mitigate financial pressures in the current year.	We have performed the following procedures in order to respond to the significant risk identified: - We assessed the design and implementation of controls for ensuring the completeness of accruals, including those controls for ensuring the cut-off of non-NHS expenditure is correct, to ensure it was captured in the correct financial year. - We inspected a sample of invoices of expenditure and payments made, in the period after 31 March 2024, to determine whether expenditure has been recognised in the correct accounting period; - We inspected a sample of cash expenditure recorded in the bank statement in the post balance sheet and reviewed associated evidence including invoices where applicable to test for unrecorded liabilities. - We inspected journals posted as part of the year end close procedures that decrease the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value could be agreed to supporting evidence - We performed a year on year comparison of the accruals made in the prior year and current year and challenged management where the movement is not in line with our understanding of the entity	- Through our testing of invoices posted and expenditure posted after year end in April and May, we did not identify any expenditure that should have been recognised in 2023-24. - We have identified accruals that have been omitted from the position at 31 March 2024. The trust has introduced new accounting policies in year whereby they no longer accrue for items less than £5k or greater than 6 months old. They have also adopted the position to not accrue for specific manual accruals they deem to be immaterial, for example holiday pay accrual - Whilst not responding to the significant risk we also carried out substantive testing over the existence and accuracy of accruals posted as at 31 March 2024. Our testing is ongoing, however to date, we have found no evidence of understatement of those transactions. - Management established a process during 2022/23 to review aged accruals on a monthly basis and ensure that old accruals (more than 6 months old) that are unlikely to be invoiced are removed from the accruals balance. This process enhances the control environment around accrued expenditure at each month end, but having documented this under ISA315 we consider that this is not formally documented in a way that represents a formal Management Review Control on which we can place reliance in line with International Standards on Auditing

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Management override of controls: Fraud risk related to unpredictable way management override of controls may occur Professional standards require us to communicate the fraud risk from management override of controls as significant. Management is in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.	We performed the following procedures: - In line with our methodology, evaluated the design and implementation of controls over journal entries and post closing adjustments. - Assessed accounting estimates for bias by evaluating whether judgements and decisions in making accounting estimates, even if individually reasonable, indicate a possible bias; - Assessed the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates. - Assessed the business rationale and the appropriateness of the accounting for significant transactions that were outside the component's normal course of business, or were otherwise unusual. - We analysed all journals through the year to identify journals displaying high risk characteristics. We performed testing over each of these journals in order to assess the appropriateness and accuracy of the transactions posted; and - We tested the completeness of the related parties identified and assess whether relevant transactions had been appropriately disclosed within the financial statements.	- Under the requirements of ISA315r, we conduct a detailed evaluation of the design and implementation of controls around journal entries. This identified that the ledger system permits reviewers / approvers of journal entries to make any amendments they wish to the journal entry before approval/posting. We are therefore unable to rely on controls around segregation of duties in journal entry processing. - We identified 27 journal entries and other adjustments meeting our high-risk criteria – our testing has not identified any inappropriate entries - We evaluated accounting estimates, including the consideration of the valuation of land and buildings and did not identify any indicators of management bias - We have not identified any significant unusual transactions. - Our evaluation over the design and implementation of related party controls identified there is no formal, documented control in place to authorise or approve significant related party transactions before they are entered into. Many of the related party transactions are through the normal course of business, however audited entities are required to have an identified control in place to formally authorise significant related party transactions

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Procedures undertaken	Findings
Valuation of Land and Buildings: The carrying amount of revalued Land & Buildings differs materially from the fair value Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'. The value of the Trust's land and buildings at 31 March 2023 was £261m, of which £244m are valued as specialised assets at depreciated replacement cost. Judgemental assumptions are made by management with regards to identifying and applying impairment indicators to the property, plant & equipment. The Trust carried out a full revaluation of its land and buildings in year. The last full revaluation took place on 31 March 2019.	We have performed the following procedures designed to specifically address the significant risk associated with the valuation: - We critically assessed the independence, objectivity and expertise of Cushman and Wakefield, the valuers used in developing the valuation of the Trust's properties at 31 March 2024; - We inspected the instructions issued to the valuers for the valuation of land and buildings to verify they are appropriate to produce a valuation consistent with the requirements of the Group Accounting Manual; - We compared the accuracy of the data provided to the valuers for the development of the valuation to underlying information, such as floor plans, and to previous valuations, challenging management where variances are identified; - We evaluated the design and implementation of controls in place for management to review the valuation and the appropriateness of assumptions used; - We challenged the appropriateness of the valuation of land and buildings; including any material movements from the previous revaluations. We challenged key assumptions within the valuation, including the use of relevant indices and assumptions of how a modern equivalent asset would be developed, as part of our judgement.; - We performed inquiries of the valuers in order to verify the methodology that was used in preparing the valuation and whether it was consistent with the requirements of the RICS Red Book and the GAM - We agreed the calculations performed of the movements in value of land and buildings and verify that these have been accurately accounted for in line with the requirements of the GAM; and - Disclosures: We considered the adequacy of the disclosures concerning the key judgements and degree of estimation involved in arriving at the valuation	We confirmed the independence, objectivity and expertise of Cushman and Wakefield, the Trust's valuation advisors; We confirmed that the valuation approach taken by the Trust was consistent with the requirements of the RICS Red Book and the GAM; We have not identified any misstatements from our work on this significant risk, and we have determined that the assumptions made by your valuers and adopted by you are balanced overall We noted increased documentation of scrutiny by management around the draft valuation presented by Cushman and Wakefield. While this management review was not documented in a way that represents a formal Management Review Control on which we can place reliance in line with International Standards on Auditing, this represents continuing the strengthening of the Trust's control environment around the year-end valuation of land and buildings. We confirmed the Trust's disclosures around the valuation of land and buildings were satisfactory.

03 Value for Money

Value for Money

Introduction

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources or 'value for money'. We consider whether there are sufficient arrangements in place for the Trust for the following criteria, as defined by the National Audit Office (NAO) in their Code of Audit Practice:

- Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance: How the Trust ensures that it makes informed decisions and properly manages its risks.
- Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Approach

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

We are required to report a summary of the work undertaken and the conclusions reached against each of the aforementioned reporting criteria in this Auditor's Annual Report. We do this as part of our commentary on VFM arrangements over the following pages.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust.

Summary of findings

	Financial sustainability	Governance	Improving economy, efficiency and effectiveness
Commentary page reference	13-17	18-19	20
Identified risks of significant weakness?	Yes	No	No
Actual significant weakness identified?	No	No	No
2022-23 Findings	No significant weakness identified	No significant weakness identified	No significant weakness identified
Direction of travel	⇧	⇔	⇔

Value for Money

NATIONAL CONTEXT

Financial performance

The 2023-24 financial year saw a significant increase in the level of financial pressures facing the NHS sector. This followed the end of Covid-19 related financing arrangements. The sector has faced cost pressures from a range of factors, most significantly the impacts of inflation felt during the year and the costs of industrial action.

At the end of January 2024 NHS England forecast that the NHS would record an overspend of £1.1bn against its agreed budgets. This came after additional funding had been made available earlier in the year to support with the costs of industrial action.

Operational performance

In January 2023 the Government announced five pledges for 2023, including reducing NHS waiting lists and the time people wait for procedures. Waiting lists had grown significantly during the Covid-19 pandemic as elective activity was postponed in order to prioritise the treatment of Covid patients and ensure safe working.

According to the Health Foundation the NHS waiting list had grown from 6.2 million patients at the beginning of 2022 to 7.2 million in January 2023. There had also been a significant increase in the number of patients with long waits. At the end of 2023 there remained 355,000 patients that had been waiting over a year for treatment. Income arrangements for the acute sector were revised in year to reimburse providers for elective activity based on the actual number of patients treated.

System working

The Health and Care Act 2022 formally established integrated care systems (ICSs), 42 partnerships within local geographies to promote closer working between the organisations responsible for healthcare delivery. Integrated Care Boards were formed on 1 July 2022, taking over commissioning responsibility from Clinical Commissioning Groups.

In their first full year of operation ICSs have continued to work to develop and embed governance arrangements both within the ICBs themselves and as systems.

LOCAL CONTEXT

Lancashire Teaching Hospitals NHS Foundation Trust is a large acute Trust providing district general hospital services to over 395,000 people in Chorley, Preston and South Ribble and specialist care to 1.8m people across Lancashire and South Cumbria. The Trust provides care across four facilities in Preston and Chorley

The Trust is part of the Lancashire and South Cumbria Integrated Care System (ICS).

In April 2023, the ICB confirmed a system-wide deficit target of £95m which required the Trust to develop a £24.3m deficit plan. Following approval by the Board in May and submission to NHSE, the Trust received £9.0m of non-recurrent support funding bringing the deficit plan down to £15.3m. This was subsequently revised to £0.4m following additional non-recurrent support in December 2023.

The Trust continued to face increasing pressure from unfunded emergency beds, driven by the number of patients not meeting the criteria to reside remaining high throughout the year. The Community Healthcare Hub at Finney House continues to provide additional out of hospital bed capacity and the introduction of virtual wards have helped to ease some of capacity pressures but further system work is still needed.

At the year end, the Trust achieved a revised deficit target of £35.6m as agreed with the ICB in December 2023. Despite the level of risk in the underlying CIP plans the Trust delivered cost improvement plans totalling £38.8m; 80% of the £48.5m target; the recurrent full year delivery being £36.9m (76% of full year target).

Whilst the outturn was £35.2m ‘off-plan’ the exit run rate deficit position at the end of FY2023/24 was £68.5m, a £28.8m reduction in the underlying deficit.

The Trust’s financial plans for 2024-25 have been based on the 2024-25 national planning guidance. As part of the Lancashire and South Cumbria ICS, the trust’s focus is driving towards financial sustainability over a three-year period. It is recognised system-wide transformation is needed to deliver these longer-term savings.

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Financial Plan 2023-24

The financial plan for 23/24 was created in accordance with NHS planning guidelines, in addition to ICS-wide principles. We saw appropriate review and approval by budget holders as well as at the Trust level by the Board of Directors. The final plan for 2023/24 was approved on 9 May 2023, with the Board receiving a presentation on the key facets of the plan and how it linked with national priorities and the priority workstreams set out by the ICS (now ICB).

The deficit plan presented at the March 2023 Board meeting was £65.2m. This was rejected by the ICB. LTH on the advice of the ICB then increased its cost improvement target to 5.5% resulting in a forecast deficit of £53.8m. At this point the ICB submitted a plan update to NHS England with a combined deficit of £167m. This was also rejected by NHS England.

Following further negotiations with the ICB and NHSE, the trust set a final plan for 2023/24 at a deficit of £24.3m which was a significant improvement on the initial submission of £65.2m deficit. This did however assume cost savings of £67m, comprising a £48.5m financial improvement target and a 'system stretch' target totalling £18.5m. In turn, risks associated with the financial plan increased from £47.8m to £75.2m. Following initial submission to NHSE, LTH received £9.0m of non-recurrent support funding bringing the deficit plan down to £15.3m.

There was clear reporting to both Board and Finance and Performance Committee (FPC), at that time and in the period leading up to finalisation of the plan. The CQC did however note in its recent report (November 2023) 'the board signed off a cost saving target of £67m without a plan detailing how this would be achieved. Together with the local health economy, the Trust Board accepted a stretch target from the ICS and at the time of the inspection there was little assurance of schemes that supported this. This represents a significant risk to the trust delivery of its financial plan'. The Board acknowledged itself that the system gap, which was driven by a balance of the remaining unfunded infrastructure and shortfalls, had few robustly identified solutions. Equally, the Board voiced concern that it would be challenging to sign up to these plans without some form of mitigation articulated and in place.

However, it was evident in the Financial Plan that mitigations were presented for the remaining £48.5m of the cost savings target which were within the trust's control, alongside the proposed CIP schemes. We are satisfied that whilst the Trust accepted a stretch target of £18.5m, the risks over achievability were appropriately considered and ultimately, it was adopted at the request of the wider system.

Financial performance 2023-24

At the year end, the Trust achieved a revised deficit target of £35.6m as agreed with the ICB in December 2023. The trust had received additional support funding during the financial year which meant the plan deficit had been revised to £0.4m. Whilst the outturn was £35.2m 'off-plan' the exit run rate deficit position at the end of FY2023/24 was £68.5m, a £28.8m underlying deficit reduction and broadly in line with the £65.2m deficit plan originally presented in March 2023.

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Financial performance 2023-24 (cont.)

Equally, we were satisfied that throughout 23/24 the budget monitoring process and associated committee scrutiny was sufficient to identify and analyse pressures that could present risks to the Trust in achieving the financial plan. Through our review of relevant Board and FPC sub-committee meeting minutes we found that financial and operational performance was appropriately challenged.

Divisional progress is monitored through the Divisional Improvement Forums and the progress of the transformational programmes is monitored through the Transformation and Recovery Board and reported to Board through FPC. We have reviewed the terms of reference for the FPC, the Transformation and Recovery Board and Divisional Improvement Forums, as well as minutes throughout the year and note that there is adequate reporting of the actual and forecast financial impact of the efficiency schemes in place, along with detail of the relevant financial RAG ratings. We are therefore satisfied that the scope of reporting is sufficient to enable management to monitor cost performance and identify areas for efficiency savings.

We have reviewed the terms of reference for the FPC, the Transformation and Recovery Board and Divisional Improvement Forums, as well as minutes throughout the year and note that there is adequate reporting of the actual and forecast financial impact of the efficiency schemes in place, along with detail of the relevant financial RAG ratings. We are therefore satisfied that the scope of reporting is sufficient to enable management to monitor cost performance and identify areas for efficiency savings.

Cost Improvement Programme (CIP) monitoring

In the month one finance report presented at FPC on 23 May 2023, a total of £22.3m improvement schemes had been identified as delivered or low risk, £5m medium risk and £17.3m deemed high risk or unidentified. Despite the level of risk in the underlying CIP plans the Trust delivered cost improvement plans totalling £38.8m; 80% of the £48.5m target; the recurrent full year delivery being £36.9m (76% of full year target). When benchmarked against other trusts – see efficiency benchmarking on page 15 – the trust's recurrent delivery has been very positive. The benchmarking does however show overall delivery against plan was at the lower end of the benchmark population

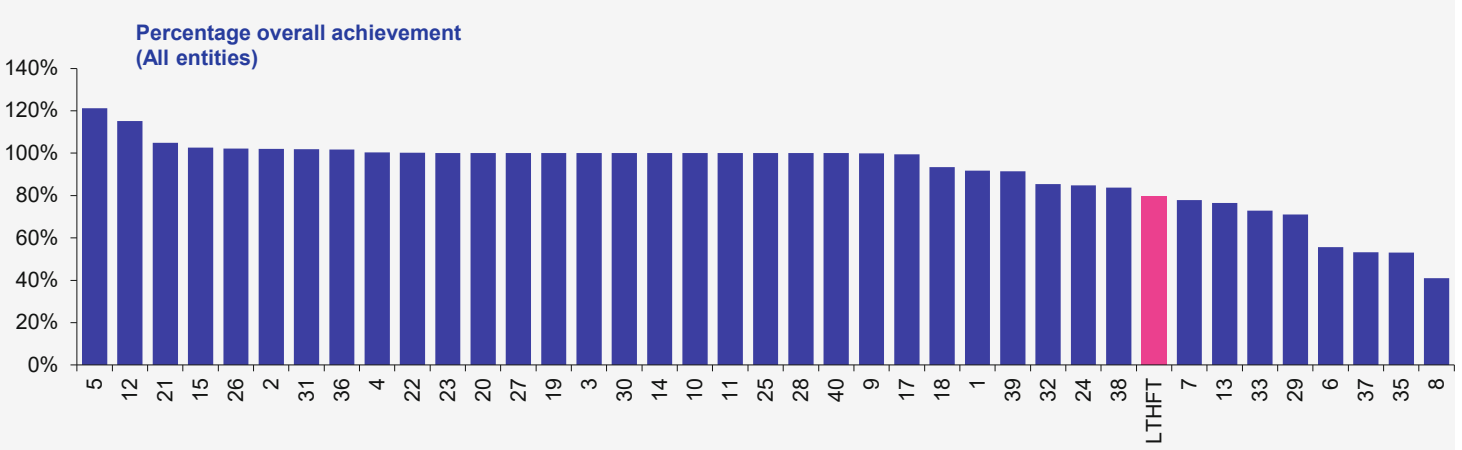
In 2023/24 we have seen regular monthly monitoring of CIP performance against targets at an individual scheme level and Trust level through FPC and to the Board, with more detailed monitoring taking place via Divisional Improvement Forums and at the Budget Holder level through monthly meetings. There is evidence that Quality Impact Assessments are completed for approved efficiency schemes.

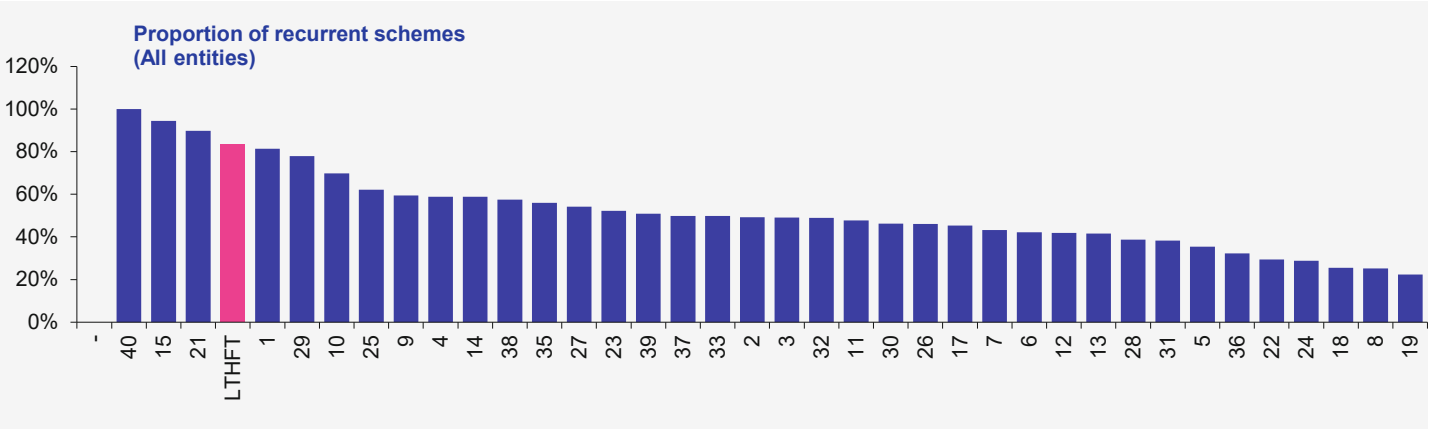
Financial Sustainability

Efficiency schemes benchmarking

We have benchmarked the Trust's efficiency schemes performance in 2023/24 against KPMG's other NHS provider audited entities.

- Most of the Trusts in our sample achieved or exceeded their scheme in full, noting this was using a combination of recurrent and non-recurrent schemes.
- The second graph demonstrates, however, that the Trust was in the upper quartile of the provider comparator group in terms of the percentage of savings delivered recurrently.





Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Financial planning 24-25 and beyond

As at the end of March, the current exit run rate for 2023-24 reported by providers in Lancashire and South Cumbria was a deficit of £276m against an initial deficit plan of £80m. NHS England clarified that they would reject any plan that is higher than 2023-24 headline outturn and as such the Integrated Care Board were aiming for organisations to plan on a combined deficit of c£190m.

We have reviewed the 2024/25 Financial Planning Update which was presented to the 26 March 2024 FPC (and subsequently to Board of Directors' meeting on 4 April), which summarised the initial financial plan for the Trust for 2024/25, the drivers of the gap and the measures necessary to address the position. The report presented details of the underlying deficit being brought forward from 2023/24, as well as additional in-year pressures that are impacting on the expected £24.3m deficit for 2024/25.

It was acknowledged taking costs out of the system requires a coordinated system-wide response, and through the Emergency, Elective and Outpatients Transformation Boards significant pieces of long-term work are underway to redesign services to reduce the recurrent costs of delivery across the system. In view of the long-term nature of many of the identified solutions, achievement of an in-year FIP target of this magnitude is subject to considerable risk

Financial Recovery Plan (FRP)

The deficit target of £24.3m included a financial improvement plan of £58.0m comprising core cost improvement of £41.4m, income/productivity of £8.3m and place based optimisation/risk management of £8.3m. Similar to 23-24, the plan contains an element of system-wide stretch, the trust is therefore reliant again on system-wide transformation. We are satisfied however that the Board is sighted on the underlying risks.

Management have demonstrated responses to the two external reviews which carried out at the start of the 23-24 financial year and have presented an update on progress against the recommendations that are either closed or completed. Alongside the Financial Recovery Plan, the Trust has committed to the development of a Single Improvement Plan which bring together the Trust's priorities for the next three years into one comprehensive delivery plan. Financial Sustainability forms one of the key strands of this plan.

To assist with the delivery of the FRP, a Turnaround Director joined on the 1st April 2024 and is working at pace with the Executive and Trust colleagues to assess the current position, deep dive into short, medium and long term opportunities, and re-set the programme with robust structure and governance.

To have a credible plan, it is proposed the Trust should have around 20% more than FRP programme identified to enable mitigation for slippage, which means the Trust should be aiming to identify a further c£12m this year bringing a total identified savings value to £70.8m. This means the current gap is realistically c.£58m.

Financial Sustainability

Financial Recovery Plan (FRP)

As at 13th May, the trust had identified £49.2m of schemes for 24/25 but with only £12.5m of schemes green or amber with any confidence of delivery. £20m (41%) were considered high risk and £16.6m (34%) described as 'hopper' (outline plan).

Conclusion

Despite a deterioration in the outturn position from the Plan agreed in May 2023 and the underlying risk associated with the Plan, we concluded that the arrangements in place were appropriate and did not indicate a significant weakness in arrangements over financial sustainability.

Similarly, whilst acknowledging the significant level of risk in the 2024-25 financial plan, and the challenge in drawing up cost improvement schemes that will deliver recurrent savings, our assessment is the trust has appropriate arrangements in place to address these challenges.

Key financial and performance metrics:	2023-24	2022-23
Planned surplus/(deficit)	(£0.4m)	(£20.7m)
Actual surplus/(deficit)	(£35.6m)	(£20.4m)
Planned CIP as a % of spend	5.5%	3.8%
- Recurrent	48.5m	£15.8m
- Non-recurrent	-	£10.5m
Actual CIP as a % of spend	4.5%	3.3%
- Recurrent	£32.3m	£9.9m
- Non-recurrent	£6.4m	£16.4m
Year-end cash position	£36m	£14.5m

Governance

How the Trust ensures that it makes informed decisions and properly manages its risks.

We have considered the following in our work:

- how the Trust monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the Trust approaches and carries out its annual budget setting process;
- how the Trust ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships;
- how the Trust ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of management or Board members' behaviour

Risk Management

The key element of the risk management process at the Trust is embodied in the Board Assurance Framework (BAF). We have reviewed the BAF at various stages throughout the year to ensure that strategic risks are appropriately included and we are satisfied that these risks are regularly discussed and challenged at Trust board meetings. The Trust's risk assessment criteria, outlined in the Risk Management policy, are used to assess all risks to ensure a consistent methodology is used.

We have inspected the Corporate Risk Register and note that this gives strong coverages of ongoing risks, showing that the Trust has appropriate processes for monitoring the implementation and effectiveness of actions to address identified risks.

The CQC were complementary about the risk processes in place at the trust, noting the trust had processes to escalate relevant risks and they observed sufficient challenge of the key areas of risk at the Board meeting they observed. However, they did note 'risks in the management of mental health patients were not always dealt with appropriately or quicky enough. There were other examples where we saw a breakdown in processes which led us to question the robustness of existing systems and wider organisational learning'.

Financial planning and monitoring

Our commentary on the review and approval of the 2023-24 financial plan is included on page 13. In respect of the process for monitoring against budgets, financial forecasts are based on the run rate plus known impacts as discussed in budget holder meetings.

We have reviewed FPC and Board minutes as well as the attached papers throughout the financial year. We are satisfied that there is sufficient ability for committee and Board members to take informed decisions based upon the detail provided in the attached papers. These papers also demonstrate that with respect to financial risks reported and recommendations made, there are detailed discussions occurring to challenge and analyse the information presented.

Compliance with laws and regulations

Through our review of the Standing Financial Instructions (SFIs) we are satisfied that these detail the roles, responsibilities and delegation of the various committees, and that this gives an appropriate escalation framework for making key decisions.

The Trust has a Local Counter Fraud Specialist who undertakes anti-fraud activities throughout the year and reports into the Audit Committee. Other key arrangements designed to detect fraud such as Whistleblowing Policy, Freedom to Speak Up and associated governance features are well embedded within the organisation.

Governance

Reviews for compliance with the staff code of conduct, laws & regulations and the Trust's constitution is completed via the Audit Committee, Board meetings and other governance structures as identified through our testing. We have made one low-priority recommendation on Page 19 regarding the fact that the Standards of Business Conduct and Recruitment & Selection Policies are now beyond their target review dates and should be refreshed.

CQC

The CQC published their latest report on 24 November 2023. The overall rating for LTH was again Requires Improvement. Safe, effective and responsive were again rated requires improvement. Caring was re-rated as good, but well-led has declined from good to requires improvement.

We note from our review of the Board and Safety and Quality Committee papers throughout the year that there has been sufficient reporting and delivery against the Quality Improvement Plan which is the Trust's document for collating and monitoring delivery of the 'Must Do' and 'Should Do' recommendations raised by CQC in previous reports. Actions are RAG-rated and an update provided bi-annually to both the Safety and Quality Committee and Trust Board to provide assurance on the work being undertaken to address the risks identified.

Management presented the CQC Action Plan for 23-24. In total, the Trust received 54 recommendations in the form of Must Do's or Should Do's (18 Must Do's and 36 Should Do's). Some recommendations are duplicated across the different core services. Upon streamlining, there are 44 recommendations in total (13 Must Do's and 31 Should Do's). This must-do actions are central to the Single Improvement Plan across multiple domains including Well-Led, Safety and Quality and People & Culture. The latest version of the action plan confirmed all Must-Do actions were either complete or on-track to deliver within timescale.

Conclusion

We have not identified any significant weaknesses in the trust's governance arrangements.

	2024	2023
Control deficiencies reported in the Annual Governance Statement	None	None
Head of Internal Audit Opinion	Substantial	Substantial
Oversight Framework segmentation	3	3
Care Quality Commission rating	Requires Improvement	Requires Improvement

Improving economy, efficiency and effectiveness

How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

We have considered the following in our work:

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the Trust evaluates the services it provides to assess performance and identify areas for improvement;
- how the Trust ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the Trust commissions or procures services, how it assesses whether it is realising the expected benefits.

Non-financial performance is scrutinised regularly by the Executive Team with specific follow up of non-compliant metrics and associated recovery plans. Non-financial performance is formally reported and scrutinised via the Integrated Performance Report to the Board on a monthly basis, as well as detailed reports on Finance, Workforce, Safety & Quality being presented to each meeting of the respective Board sub-Committees. We have reviewed examples and evidence of this in action and consider it to be appropriate.

In terms of developing and assessing plans relating to major decisions, we have reviewed the activity of the Finance function regarding the preparation of business cases, and satisfied that there is a standard business case template and guidance being utilised. The Trust has the required number of staff trained to NHS Better Business Cases training standards, and business case guidance and templates include the need to have strategic, management, economic and financial relevance. Quality / Equality Impact Assessment is required for all business cases.

Specifically we inquired over the approval of East Lancashire Financial Services (ELFS) transfer which took place in July 2023. ELFS operate as an NHS hosted service and employ c240 staff with a turnover of c£10m. The Board of Directors received an initial report on the arrangements for transferring ELFS from the Northern Care Alliance (NCA) to the Trust, in November 2022, which enable an agreement in principle decision subject to due diligence and completion of a satisfactory Business Transfer Agreement (BTA). This was approved by the Board in April 2023 and we were satisfied there was appropriate scrutiny and challenge over the decision making process.

There is an appropriate framework for monitoring of the performance of subcontractors depending on the scale of the contract (e.g. a whole clinical service versus a single specialty). We reviewed contract / performance review documentation pertaining to three different contracts of differing size and scope, and consider that the monitoring systems and processes in place are designed and implemented appropriately.

The Trust works closely with the other providers within the Lancashire and South Cumbria (L&SC) system through a prominent role on the Provider Collaborative Board, with the Trust's Chief Executive (CE) being the lead CE for the Provider Collaborative among numerous other Board-level links with both the providers in L&SC and the ICB. The Trust interfaces with the ICB on a regular basis both in terms of providing accountability for in-year performance but also with respect to strategic planning for 2024/25 and beyond. The Trust is taking a lead role on numerous projects aimed at increasing collaboration and therefore removing costs from the L&SC system, for example as the Lead Provider for the Pathology Collaborative.

The Trust has undertaken a number of initiatives during the year to redesign services and ease pressure on the urgent and emergency care system locally. During the Covid-19 pandemic the Trust's capacity expanded, with the support of non-recurrent resource. However the challenge is now to remove that additional capacity given that the funding for it is no longer available.

Conclusion

We have not identified a significant weaknesses associated with Improving economy, efficiency and effectiveness

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Board of Directors

Lancashire Teaching Hospitals NHS Foundation (LTHTR) Trust Quality Account 2023-24			
Report to:	Board of Directors	**Date:**	1st August 2024
Report of:	Chief Nursing Officer	**Prepared by:**	C. Morris
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this paper is to present the Lancashire Teaching Hospitals NHS Foundation (LTHTR) Trust Quality Account 2023-24. The Quality Account is mandated by NHS England in order to provide detail on the quality of services offered by providers.

In line with the Trust's commitment to engage and consult with the Council of Governors at a meeting of 16th April 2024, governors were invited to consider and input into the two Quality Indicators for inclusion in the 2024-25 Quality Account. These were agreed as:

Indicator 1 Insight: The Trust improves its understanding of the patient experience by listening and gaining real insight by using multiple sources of information, including patient stories, impact statements and patient surveys. This will ensure the patient and family voice is truly "heard," especially of those hear less often.

Indicator 2. The involvement of patients, families, carers when they have experienced an incident is meaningful, individualised and they are treated with respect and compassion leading to genuine and compassionate learning from incidents, especially of those involved less in the process.

The quality account has been submitted in line with Department of Health and Social Care requirements and has been uploaded onto the Trust's intranet site and can be accessed via the following link https://www.lancsteachinghospitals.nhs.uk/regulatory-information.

It is recommended that the Board of Directors:

I. Receive the quality account.

.

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,		Deliver Value for Money	☒

teaching and research	☒	Fit For The Future	☒

Previous consideration
Safety and Quality Committee May 2024.

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Excellent care with compassion

Always Safety First

@LancsHospitals

Quality Account 2023-24

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Measuring success

Throughout the Quality Account 2023-24 the following key symbols will be used as an easy reference tool.

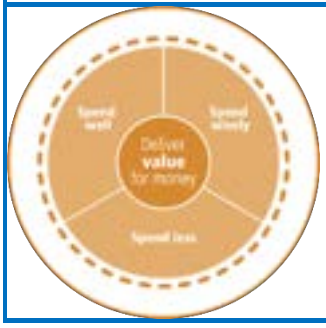
Symbol	Meaning
	The Trust continues to perform well and/or has improved
	The Trust is achieving well in some areas, but further areas require development
	The Trust is not achieving our target however are aware and have improvement projects in place

Key - Our Ambitions

Our Big Plan is our Strategy which aligns to our mission to provide "excellent care with compassion" and is founded on our four ambitions which are:

1. To 'Consistently deliver excellent care'
2. To 'Deliver value for money'
3. Be 'Fit for the future'
4. Be 'A great place to work'

Each ambition has a symbol which is presented in the key below. These are highlighted throughout our Quality Account to demonstrate how the content relates to *Our Big Plan* and Mission Statement.

Consistently deliver excellent care		**Fit for the future**	
	Improve outcomes and reduce harm Get it right first time Positive patient experience delivered in partnership Ensure a safe, caring environment		System working Place Based Partnership Strategy & Transformation
Deliver value for money		**A great place to work**	
	Spend well Spend wisely Spend less		Promote health and wellbeing Inform, listen, and involve Develop people Value each other

PART 1

Chief Executive's Statement

I am pleased to present the 2023-24 Quality Account for Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR). This report provides an overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period 1st April 2023 to 31st March 2024.

We are hugely proud to provide healthcare services to both the people of Preston, Chorley and the surrounding Central Lancashire footprint and the wider population of Lancashire and South Cumbria and we aim to deliver high quality compassionate care to patients and their families through the services we offer.

Quality is key to everything we do at LTHTR, the clinical outcomes and experiences of our patients underpins every decision we make. We intend to build on the excellent work already underway by our clinical teams and strengthen the quality of services we provide; we know that this is a primary motivator of our teams and by remaining focused on this we are more likely to attract and retain the high quality colleagues that provide our services.

The Trust has operated under the 'Our Big Plan Strategy 2021–24' during 2023-24, this has ensured a balanced approach to safety, quality, experience, workforce, operational effectiveness, finance and strategy in local and specialist services.

Our teams have worked hard to deliver the best care possible during incredibly pressured times and I would like to take this opportunity to place on record my thanks to all staff, both clinical and non-clinical, who work tirelessly to provide excellent care to our patients. It does not go unnoticed.

The operational performance of the organisation has improved in the way we deliver elective care, less patients are waiting longer this year compared to the year before. Urgent Care pathways continue to present some of the most significant challenges to the organisation and we know that this, alongside our finances are areas that requires improvement in this next year. We know how important it is to carefully balance this and our attention to the safety and quality of services remains our single largest priority.

We also recognise that things do not always go to plan, this year we launched the national Patient Safety Incident Response Framework (PSIRF) and are focusing on building a culture that encourages learning and transparency, so, on the occasions when things do not go to plan, we can recognise this and respond in ways that means the people affected have their experiences really heard and we take

measures to prevent recurrence.

The Board of Directors are committed to ensuring the capability and capacity within the organisation to deliver high quality services, our Continuous Improvement Strategy has equipped colleagues with the skills required to lead improvement at each level of the organisation.

The Trust continues to work in partnership with local partners, to develop collaborative leadership at Place level within Central Lancashire and with the Integrated Care Board, Lancashire and South Cumbria NHS Foundation Trust, Lancashire County Council, Health Scrutiny Committee and third sector partners including our local hospices; Derian House and St. Catherine's Hospice. We firmly believe that working with other organisations who are as committed to the quality agenda as we are can only be beneficial for all concerned and we work hard to make sure that organisational boundaries do not prevent the improvement of services for the benefit of our patients.

This report sets out our performance in detail and together with the support of the Trust's Executive Directors, I am pleased to confirm that, to the best of my knowledge, the following Quality Account 2023-24 complies with the necessary national requirements, the information it contains is an accurate and fair reflection of our performance and that the information in this document is accurate.

Silas Nicholls

Chief Executive Officer

PART 2

2.1 Priorities for Improvement

Our Big Plan was developed in partnership with our divisions and aligns the organisation's mission to provide 'excellent care with compassion' with our ambitions.

Our values underpin everything we do and support the delivery of our ambitions.

The plan also sets the priorities for improvement and annual performance standards aligned to each of the four ambitions below:

Our values

- Being caring and compassionate
- Recognising individuality
- Seeking to involve
- Building team spirit
- Taking personal responsibility

Figure 1- Our Ambitions

<table>
<tr><th colspan="2">Consistently Deliver Excellent Care</th><th colspan="2">Fit for the Future</th></tr>
<tr><td> 
</td><td>Improve outcomes and reduce harm

Get it right first time

Positive patient experience delivered in partnership

Ensure a safe, caring environment</td><td> 
</td><td>System working

Place Based Partnership

Strategy & Transformation</td></tr>
<tr><th colspan="2">Deliver Value for Money</th><th colspan="2">Great Place to Work</th></tr>
<tr><td> 
</td><td>Spend well

Spend wisely

Spend less</td><td> 
</td><td>Promote health and wellbeing

Inform, listen and involve

Develop people

Value each other</td></tr>
</table>

Our Big Plan is enabled through the commitments in our Clinical Strategy as well as those in our Patient Experience and Involvement Strategy using the methodology and approach outlined in the Continuous Improvement Strategy.

Clinical Strategy commitments

- Continuously strive to improve.
- Lead with care and compassion.
- Work as a team to improve as much as possible.
- Look for diversity and be inclusive.
- Nurture a workforce able to meet our local population demands.

The Patient Experience and Involvement Strategy commitments

- Deliver a positive experience.
- Improve outcomes and reduce harm.
- Create a good care environment.
- Improve capacity and patient flow.

Patient Experience

Our Big Plan and other strategies can be found on our Trust website.

Big Plan key priorities achieved:

During 2023-24 there has been positive delivery of a number of *Our Big Plan metrics as follows:

*Data source for Our Big Plan metrics from Business Intelligence.

Table 1 Big Plan Achievements

Improve outcomes and prevent harm	
*Achieve 62-day cancer target (target as per NHS England (NHSE) recovery plans)	
Mortality within the expected range for adults, children, and paediatrics	
90% patients rating services as good or very good	
75% clinical areas with Silver 'Safety Triangulation and Accreditation Review' (STAR) rating. Compliance was at 82%	
Reduction in 104-week waiters (target as per NHSE recovery plans)	
Reduce falls by 5%	
Reduction in complaints	
Ensure a safe caring environment	
Maintain staff engagement.	
Maintain 90% for appraisals	

Table 2 Big Plan indicators not achieved

Improve outcomes and prevent harm	
Reduce pressure ulcers by 5%.	
Deliver the *C. difficile* measure within nationally set trajectory.	
Reduce sickness absence to 4%.	

Reduce vacancies by a further 5%.	
Achieve 90% mandatory training.	
Core skills training	

Continuous Improvement

The Trust's Continuous Improvement (CI) Strategy been delivered throughout the year and has supported a number of key programmes as outlined below. A new CI strategy will be developed and launched through 2024.

The Lancashire and South Cumbria Flow Coaching Academy is now well established, delivering three cohorts and a fourth is currently in progress. 77 Flow Coaches have been trained and have applied the methodology in the following Big Rooms: Brain Tumour, Breast Reconstruction, Cauda Equina Syndrome, Chemotherapy, Colorectal, Deconditioning, Deteriorating Patients, Do Not Attempt Cardiopulmonary Resuscitation, Eating Disorders, Emergency Mental Health, Enhanced Care, End of Life, Endoscopy, Ears Nose and Throat, Entry to Emergency and Urgent Care Frailty, Falls Prevention, Gynaecology, Inflammatory Bowel Disease, Inpatient Avoidance, Inpatient Pre-operative Pain Management Lung Cancer, Kidney Care, Major Trauma, Neurology (Headache), Neonatal, Nutrition, Pain Management (Spine), Pneumonia, Pre-operative and Prehabilitation, Radiotherapy, Respiratory, Sepsis, Stroke, and Vascular Surgery.

The Lancashire Microsystem Coaching Academy programme has now delivered six cohorts and a seventh cohort is currently in training. With 65 areas trained in the Microsystem Coaching Academy methodology and 121 Coaches.

Over the last 12 months we have worked collaboratively with our Integrated Care System (ICS) and health care partners to test a new approach to deliver system-level improvement across our Lancashire and South Cumbria footprint. Working in partnership with the Engineering Design Centre at Cambridge University we have delivered a programme as an ICS system with a focus on Frailty. We used the Engineering Better Care model to develop and test new ways to deliver healthcare for this population group. More locally across central Lancashire the team participating in the programme have focusing their efforts on reducing conveyance from care homes to the Emergency Department by working with place and system partners to develop more joined-up support services and pathways to mitigate the need for Emergency Department attendance and support patients to live well and age well. The learning and outputs from this programme have been developed and integrated into the 2024 GP Quality Contract, supporting standardised identification, assessment, and care planning for our over 65 population living with Frailty.

There has been a continued focus throughout the year on building CI capability across the organisation through the delivery of the CI Building Capability Strategy in line with the NHSE report and dosing formula for provider organisations for year one of the strategy.

Improvement projects have included:

- Hands First Two (National Quality Improvement Collaborative with the Royal College of Surgeons).
- The Lancashire & South Cumbria Neck of Femurs (#NOF) Quality Improvement Collaborative.
- The Hospital Handover Collaborative (Regional Collaborative with North West Ambulance Service and the Advancing Quality Alliance).

- Core20Plus5 Reducing Health Inequalities (National collaborative with NHS and the Institute for Health Care Improvement).
- The Race & Health Observatory & Institute for Healthcare Improvement Learning Action Network (National collaborative with NHS and the Institute for Health Care Improvement).
- Patient experience, including participating in the Imperial College and Health Foundation Scale, Spread and Embed Research Project.
- Always Safety First Strategy delivery and improvement programmes aimed at reducing avoidable harm through the development of highly reliable systems and processes.
- Improved compliance to prescribing oxygen and development of a prioritisation process.
- Waste reduction programme within a number of divisions.
- Organisational flow through the following initiatives utilising the Theory of Constraints.
- Co-ordinating the Lancashire and South Cumbria Together Improvement Weeks in response to operational pressures.
- Maternity triage assessment unit.
- Patient flow improvement programme.

Always Safety First

The Trust's 3 year plan and organisational response to the national Patient Safety Strategy is entitled Always Safety First and was launched on World Patient Safety Day, 17th September 2022.

Key actions achieved in this reporting period are:

- Implementation of the Patients Safety Incident Response Framework (PSIRF), a comprehensive training plan, identification of local priorities and oversight of learning. PSIRF incorporates health inequalities into the terms of reference of learning responses.
- 3 Patient Safety Partners (PSP) have been recruited and commenced in post in Nov 2023 and patient safety volunteers are being recruited to. The PSPs are having a positive impact, and their role will be formally evaluated in terms of outcome measures.
- A new maternity neonatal voices partnership chair has been appointed to for maternity and neonatal services ensuring the voice of women and families is heard through the services.
- Successful delivery of the year 5, ten Clinical Negligence Scheme for Trusts (CNST) safety actions.
- Themed analysis to determine improvement priority workstreams in year 3 includes deteriorating patients, reducing violence and aggression, ED exit block and patient flow, rapid tranquilisation, Mental Health, *Clostridioides.difficile (C.difficile)* infection reduction and pressure ulcer reduction.
- The Emergency Department (ED) safety surveillance system has been completed and rolled out in Year 2 which enables the identification of real time organisational safety risks. This is being embedded in year 3.
- Safety surveillance systems are embedded within all adult inpatient acute and general wards.
- The national staff survey has demonstrated an improvement in safety scores.
- Circa 1500 colleagues across the Trust have undertaken some form of continuous improvement training.
- 41 clinical areas have been part of the Microsystem Coaching Academy focussing on safety improvement programmes and cohort 7 is in progress. This amounts to 121 individuals in total.
- Safety II toolkit with measurable outcomes is being rolled out across the organisation.

- The Learning Disability plan has been launched alongside mandatory level 1 Oliver McGowan training.
- There is a plan in place and a working group has commenced to establish the Trust approach to implementing Safety II. This is being led by the Continuous Improvement clinical fellows.
- Venous thromboembolism (VTE) risk assessment compliance has improved and sustains to above 90%. (Recent performance has dipped due to collecting the community health care hub data in the overall total however, this will be resolved).
- In year 3, the medicines safety improvement work has focussed on missed doses. As at end of March 2024, the data demonstrates consistent performance of 2% for missed doses of critical medicines. Pharmacy and nursing teams remain engaged with the continuous improvement work
- Safety metrics for medicines safety have been incorporated into the single improvement plan.
- The Deteriorating Patient Dashboard has been created which gives the Critical Care outreach team the ability to undertake proactive reviews of patients at risk of deterioration.
- Level 1 and Board and senior leaders' safety training remains compliant, level 2 safety training has been introduced and organisational compliance continues to improve.
- The Do Not Attempt Cardio Pulmonary Resuscitation Big Room (DNACPR) has led to a reduction of incidents from 10 in 2022 to 2 in 2023 for inappropriate resuscitation attempts where a valid DNACPR decision was in place.
- Development of a critical care delivery group focused on improving outcomes for patients in critical and enhanced care environments. The group is overseeing working towards compliance of the perioperative care standards in enhanced care settings.
- In year 3, the emphasis on reporting compliments and good practice is being developed so that learning from what goes well is incorporated into practice. The promotion of reporting compliments has resulted in a 45% increase during 2023-24 from the previous year.

Areas not yet progressing in line with improvement plans

- Pressure ulcer reduction
- Falls reduction
- C.difficile rate reduction

All have been subject to improvement plans this year and whilst pressure ulcers and falls have seen a reduction this has not achieved the target reduction.

Risk Management and Risk Maturity  

The Board Assurance Framework and Risk Register have been regularly scrutinised and reviewed through the Trust's governance structure and have been subject to internal and external reviews. The Trust's strategic intentions, policies, procedures, and supporting documentation are openly accessible via the intranet for all staff to reference. The existing organisational management structure and Risk Management Policy illustrates the Trust's commitment to effective governance and quality governance, including risk management processes. There is a central risk management team and a

centralised health and safety team, supported by divisional governance and risk teams, led by a Lead Clinical Governance and Risk Manager in each division.

Our Trust has adopted a strategic approach to the management of risk by integrating risk into 'Our Aims' and 'Our Ambitions' so that they link to the strategic objectives of Our Big Plan and support the well-led aspect of the Care Quality Commission (CQC) requirements.

Risk Management Strategy

In pursuit of excellence in its risk management arrangements, the Trust developed a new Risk Management Strategy 2024-27. The strategy sets out the approach to further enhancing Risk Management at Lancashire Teaching Hospitals over the next three years after consultation with key stakeholders.

Each division has governance arrangements in place including a systematic process for assessing and identifying risk in line with the policy. The Trust has in place a Board Assurance Framework (BAF), which is designed to provide a structure and process to enable the Trust to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives and is made up of two parts: the Strategic Risk Register, those risks that threaten the delivery of the strategic objectives and are not likely to change over time, and the Operational Risk Register, those risks that sit on the divisional and corporate risk registers and may affect and relate to the day-to-day running of the organisation.

Responsibility for reviewing and updating the strategic risk and providing assurance to the Board on the controls and mitigations in place is retained by the relevant Executive Director. The BAF is also presented in full to the Audit Committee at each meeting once approved by the Board.

All operational risks are categorised in line with the Trust aims or ambitions that they predominantly impact upon. Any higher scoring operational 15+ risks are also presented to Committees of the Board to which the strategic aims or ambitions are aligned.

At the end of 2023-24, the risk profile of the Trust remains similar to that at the end of 2023 with 489 overall risks in March 2024 compared to 488 in March 2023 and 85 high risks in March 2023 compared to 92 in March 2023. High risk themes continue to be reflective of the following:

- Financial challenges.
- Increasing demand.
- Use of escalation areas.
- Suboptimal capacity to meet targets/manage backlog following Covid-19.
- Staffing challenges.
- Physical environment/estate being suboptimal.
- Mental health care provision.

There is a continued focus on risk maturity, and this is being achieved through the continued embedding of risk management within the Trust.

Risk Appetite

The Trust's Risk Appetite Statement was reviewed and approved by the Board of Directors in June 2023.

The Risk Appetite Statement set by the Board is as follows:

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

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

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

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

Risk Tolerance

In addition, the Trust's risk tolerance levels were also updated to outline the boundaries within which the Board is willing to allow the true day-to-day risk profile of the Trust to fluctuate while executing strategic objectives.

Table 3 The Risk Tolerance levels as agreed by the Trust Board

Strategic Risks		Risk Tolerance	Rationale
Risks to delivery of Strategic Aim of providing outstanding and sustainable healthcare to our local communities	Risk to delivery of Strategic Ambition: Consistently Deliver Excellent Care	1-6	We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the fullest range of safety measures being put in place.
	Risk to delivery of Strategic Ambition: A Great Place to Work	4-8	Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority, and we are guided by our shared values.
	Risk to delivery of Strategic Ambition: Deliver Value for Money	8-12	Acute Trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk.
	Risk to delivery of Strategic Ambition: Fit for the Future	8-12	To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk.
Risk to delivery of Strategic Aim to drive health innovation through world class Education, Training & Research		9-12	We recognise that investments in education, training and research can take time to generate the expected benefits for the Trust, and that new ways of working have a higher inherent risk than established methods.
Risk to delivery of Strategic Aim to offer a range of high-quality specialist services to patients in Lancashire and South Cumbria		6-9	We are willing to take risks where there are clear opportunities to streamline and modernise services whilst maintaining and strengthening our position as the leading tertiary care provider in the local system.

Our principal risks and issues

The Trust continues to identify potential risks to achieving its strategic aims and ambitions as part of established organisational governance processes. The BAF is used to identify the strategic risks to the Trust alongside actions being taken to mitigate them. During 2023-24, there were six principal risks presented in figure 2 below:

Figure 2 – Principal 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.

All principal risks were reported to the Board of Directors and to the relevant aligned Committees of the Board. Principal risks are reviewed to consider the effectiveness of controls, assurances and mitigation plans to support the achievement of the target risk score, as determined by the Trust's risk appetite statement which was set and approved by the Board. In addition to the principal risks identified, during 2023-24, there have been three operational high risks escalated to the Board within the BAF.

These are:

- Impact of exit block on patient safety
- Elective restoration following the Covid-19 pandemic
- The impact of strikes on patient safety following announcement of the national pay award and the probability of ongoing strikes

These are overseen by Board of Directors whilst additional input is required to address the risk and controls.

2.2 Statements of Assurance from the Board

This section of the Quality Account is presented with the narrative which is mandated in the Quality Account regulations which refers to Lancashire Teaching Hospitals NHS Foundation Trust or the Trust.

During 2023-24 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted 46 relevant health services.

The Lancashire Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 46 relevant health services.

The income generated by the relevant health services reviewed in 2023-24 represents 100% of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2023-24.

Participation in Clinical Audits 

During 2023-24, 56 national clinical audits including three national confidential enquiries covered relevant health services that Lancashire Teaching Hospitals NHS Foundation Trust provides.

During that period Lancashire Teaching Hospitals NHS Foundation Trust participated in 95% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. The Trust did not participate in 3 national audits: Improving Quality in Crohn's and Colitis (IQCC) and National Diabetes Footcare Audit due to pressures in the services and inability to find the relevant staff to support the audit and in the National Ophthalmology Database (NOD) Audit due to system requirements. The Trust will continue to review capacity and capability to participate in these three national audits.

The applicable national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2023-24 are listed below in Table 4.

Table 4 National Audit and Confidential Enquiries – Eligible for Participation[1]

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
National Programme Name	**Audit Title**	**Trust Participation**
Adult Respiratory Support Audit	As per the national audit name	Yes
BAUS Urology Audits	BAUS Nephrostomy Audit	Yes
Breast and Cosmetic Implant Registry	As per the national audit name	Yes
Case Mix Programme (CMP)	Intensive Care National Audit a Research Centre (ICNARC)	Yes
Elective Surgery (National Patient Reported Outcome Measures (PROMs) Programme)	As per the national audit name	Yes

National Programme Name	Audit Title	Trust Participation
Emergency Medicine Quality Improvement Programmes (QIPs)	Mental Health Self Harm	Yes
Emergency Medicine QIPs	Care of Older People in Emergency Department	Yes
Emergency Medicine QIPs	Time Critical Medications	Yes
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People (CYP)	Epilepsy 12 – Cohort 5	Yes
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	Yes
Falls and Fragility Fracture Audit Programme (FFFAP)	National Hip Fracture Database	Yes
Improving Quality in Crohn's and Colitis (IQICC)	As per the national audit name	No
Learning Disability Mortality Review Programme (LeDeR)	As per the national audit name	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE UK Saving Lives, Improving Mothers' Care Surveillance & Morbidity	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK: Perinatal Mortality Births	Yes
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	End of Life Care Study	Yes
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Juvenile Idiopathic Arthritis	Yes
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Rehabilitation following Critical Illness	Yes
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit	No
National Adult Diabetes Audit (NDA)	National Diabetes Inpatient Safety Audit (NDISA)	Yes
National Adult Diabetes Audit (NDA)	National Core Diabetes Audit	Yes
National Adult Diabetes Audit (NDA)	National Pregnancy in Diabetes	Yes
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	Yes
National Asthma and COPD Audit Programme (NACAP)	Chronic Obstructive Pulmonary Disease (COPD) Secondary Ca	Yes
National Asthma and COPD Audit Programme (NACAP)	Paediatric Asthma Secondary Care	Yes
National Audit of Cardiac Rehabilitation	As per the national audit name	Yes
National Audit of Care at the End of Life (NACEL)	As per the national audit name	Yes

National Programme Name	Audit Title	Trust Participation
National Audit of Dementia	Care in General hospitals (Rou 6)	Yes
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	NAoMe- National Audit of Metastatic Breast Cancer	Yes
National Cancer Audit Collaborating Centre National Audit of Primary Breast Cancer	NAoPri - National Audit of Primary Breast Cancer	Yes
National Cardiac Arrest Audit (NCAA)	As per the national audit name	Yes
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	Yes
National Cardiac Audit Programme (NCAP)	National Heart Failure Audit	Yes
National Child Mortality Database (NCMD)	As per the national audit name	Yes
National Comparative Audit of Blood Transfusion	National Comparative Audit of Bedside Transfusion Practice	Yes
National Comparative Audit of Blood Transfusion	Audit of Blood Transfusion against NICE Quality Standard 138	Yes
National Emergency Laparotomy Audit (NELA)	As per the national audit name	Yes
Gastro-intestinal Cancer Audit Programme (GICAP)	National Bowel Cancer Audit	Yes
Gastro-intestinal Cancer Audit Programme (GICAP)	National Oesophago-Gastric Cancer Audit (NOGCA)	Yes
National Joint Registry	As per the national audit name	Yes
National Lung Cancer Audit (NLCA)	As per the national audit name	Yes
National Maternity and Perinatal Audit (NMPA)	As per the national audit name	Yes
National Neonatal Audit Programme (NNAP)	As per the national audit name	Yes
National Ophthalmology Database (NOD) Audit	National Cataract Audit	No
National Paediatric Diabetes Audit (NPDA)	As per the national audit name	Yes
National Perinatal Mortality Review Too (PMRT)	As per the national audit name	Yes
National Prostate Cancer Audit (NPCA)	As per the national audit name	Yes
National Vascular Registry (NVR)	As per the national audit name	Yes
Perioperative Quality Improvement Programme (PQIP)	As per the national audit name	Yes

National Programme Name	Audit Title	Trust Participation
Sentinel Stroke National Audit Programme (SSNAP)	As per the national audit name	Yes
Serious Hazards of Transfusion (SHOT UK National haemovigilance scheme	As per the national audit name	Yes
Society for Acute Medicine Benchmarki Audit (SAMBA)	As per the national audit name	Yes
Trauma Audit & Research Network (TARN)	As per the national audit name	Yes
UK Cystic Fibrosis Registry	As per the national audit name	Yes
UK Renal Registry Chronic Kidney Disease Audit	As per the national audit name	Yes
UK Renal Registry National Acute Kidn Injury Audit	As per the national audit name	Yes

[1] List of national clinical audits as per specification provided by the DH cited on the HQIP website https://www.hqip.org.uk/wp-content/uploads/2023/02/NHSE-QA-List-2023-24-Version-2_February-23.pdf

There were 20 reports published for the national clinical audits in 2023-24. The reports were reviewed and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Table 5 National Audits and Confidential Enquiries – Intended Actions

All Actions are monitored in the Trust's Audit Management and Tracking (AMaT) system:

Title of Audit	Actions
MBRRACE-UK: Perinatal Mortality Surveillance (2021) Births	• MBRRACE real time monitoring tool to be added to the maternity and neonatal monthly clinical governance report to the respective safety and quality committees. • Complete the annual MBRRACE quality assurance check when available on the MBBRACE platform.
National Audit of Inpatient Falls NAIF (2023)	• Falls Big Room meets regularly and is an ongoing improvement forum for the Trust. • Post fall checklist to be updated to include the national recommendations.
National Bowel Cancer Audit (NBOCA) 2023	• The Trust's case ascertainment rate was slightly below the national average and only ranked as "fair". • This was discussed with the Corporate Cancer Team and changes to the dataflow have been made to enable the teams to see data in real time for any potential issues.
National Pregnancy in Diabetes 2022	• Offer continuous glucose monitoring and other technologies such as insulin pumps and closed loop systems. • Offer HbA1c at booking. Monitor women with type 2 diabetes or a HbA1c of 41 or above. Regular clinics reviews and access to a dietician. • Offer a pre-conception clinic. Provide rapid referral to lead midwife and consultant within one week. Offer monthly checks.

National Neonatal Audit Programme 2022 (NNAP)	• Real-time monitoring of NNAP measures and data quality with internal performance dashboard reviewed at monthly Neonatal Operational Directorate meetings. • To undertake a quality improvement project focusing on early colostrum showing improvements in latest data from real-time monitoring.
National Paediatric Diabetes Audit 2022 (NPDA)	• Monthly review of patients with HbA1c >69mmol/mmol using NPDA Result online. • Multi-Disciplinary Team (MDT) meetings to assess patients who have high HbA1c and tailor management accordingly. • More intense psychology support for patients and embedding into their care from diagnosis. To offer either face to face or online appointments to all the patients. “Attend Anywhere” as a virtual clinic was provided throughout the pandemic and this continues to be provided for all the diabetes referrals. • Blood Glucose Targets: new targets agreed to drive continued improvement in HbA1c. Robust Insulin Dose Adjustments with emphasis on self- management and increase use of technology and pumps based on NICE and patient need.
Perioperative Quality Improvement Programme (PQIP)	• Digital solution to collect data/compliance with Drinking, Eating, Mobilising (DrEAMing): • Discussion with surgical team and IT regarding a DrEAMing bundle/order set requested by surgical team requiring mandatory completion by ward staff as an alternative to the above • DrEAMing is a CQUIN target.
SAMBA 2023 (Society for Acute Medicine Benchmarking Audit)	• To ensure that the clerking team is fully staffed daily. • To set up an audit to look at the reasons for readmission to hospital within 30 days.
Serious Hazards of Transfusion (SHOT)	• Every SHOT case is investigated, reviewed and presented at senior staff meetings, haematology managers' meeting, Hospital Transfusion Committee and divisional Datix meeting
The National Hip Fracture Database (NHFD)	• To improve time to surgery to meet the Key Performance Indicators: to introduce a Standard Operating Procedure for trauma theatres. • To improve physiotherapy weekend cover: to use a Band 6 physio to cover the weekends. • To improve the time from admission from Emergency Department to ward to be within 4 hours: to assess the feasibility of ring fenced beds for fractured femur patients

The reports of 401 local clinical audits were reviewed by the provider in 2023-24 and some examples of the Lancashire Teaching Hospitals NHS Foundation Trust actions to improve the quality of healthcare provided are referenced in Table 6.

Table 6 Local Clinical Audits and Resulting Actions

Audit title	Actions intended/completed
Audit	Evaluation of investigative modalities for postmenopausal bleeding at the generic outpatient department.
Actions – all complete	• Update and finalise changes to local guideline and standard operating procedure on investigation of post-menopausal bleeding. • Design and carry out a patient satisfaction survey within the post-menopausal bleeding service.

	• Set up and establish patient initiated follow up for 6mths.
Audit	Audit of ultrasound scan outcomes on Gynae assessment unit
Action – in progress Action – in progress Action – in progress Action – in progress Action – in progress	• Make changes to current gynaecology & early pregnancy assessment unit criteria: Offer face to face assessment to anyone with concerning symptoms. • Introduce M6 model for evaluation of pregnancies of unknown location. • Standardised the ultrasound reporting. • Use of systematised medical nomenclature for medicine–clinical terminology codes. Creation of gynaecology and early pregnancy assessment unit dashboard • Develop gynaecology and early pregnancy assessment unit forms on Harris Flex.
Audit	Caesarean - Section Rates at Lancashire Teaching Hospitals
Actions – all complete	• Ensure vaginal birth after caesarean clinics are running and counselling addresses patients concerns and ensure provision of updated leaflets. • Provide cardiotocography reviews/teaching to staff. • Conduct induction of labour audit to see the gestation of babies at induction.
Audit	Appropriateness of referrals of dizziness to the Ear, Nose & Throat department
Action – complete	• Design dizziness referral pathway.
Audit	Use of cell salvage in obstetric cases
Action – in progress Action – in progress	• Discuss if an electronic elective caesarean section booking form on Flex and a logbook on Flex is feasible/attainable. • Review and update if indicated, the integrated care systems guideline.
Audit	Delayed Computed Tomography Scan (CT) Reports: Cancer Care Consequences
Actions – all complete	• Share the results of the audit with Radiology and Safety and Quality Committee. • Add CT reporting to the risk register for Oncology.
Audit	Emergency Re-admissions to General Surgery
Action – complete	• Introduction of a telephone consultation follow up service for recently discharged patients to assess any ongoing symptoms.
Audit	Frailty scoring for Oncology Out-patients
Actions – all complete	• Contact Frailty team to assess which services are currently available to patients that could be used within Oncology. • Feed figures from audit into existing business case between Radiotherapy and Dietetics to increase support for on-treatment patients and look into possibility of expanding to include all patients receiving active therapy, not just radiotherapy. • Clarify what programmes the Cancer Alliance have planned around frailty in Oncology. • Ensure frailty score is captured on system for all new patients attending Oncology outpatients. • Educate outpatient staff on how to complete full frailty

	assessment, emphasising the importance of completion of all domains.
Audit	Parental education in children with asthma
Actions – all complete	• Incorporate a discharge checklist within our electronic patient records to ensure personal asthma action plans are completed. • Identify "champions" to help raise awareness of the importance of asthma care & personal asthma action plans. • Consider and discuss the possibility of combing two leaflets into one personal asthma action plans and weaning.
Audit	Systemic steroid use in children aged 1 to 5yrs admitted with wheeze to Paediatric assessment unit & general paediatrics at Royal Preston
Actions – all complete	• Create a local guideline or standard operating procedure on the subject for education and continuity and cascade to emergency department staff and trainees.
Audit	An evaluation of the experiences of diagnosis and support for individuals with functional neurological disorder.
Action – in progress	• Group psychoeducation sessions to be rolled out to reduce waiting times and improve patient care.
Audit	Intra-Oral Radiographic Audit
Actions – all complete	• Step wedge to be carried out weekly to monitor image quality. • Cassette to be fully opened and checked prior to dispensing exposed image receptor into cassette for processing. • Aiming aid to be utilised when taking x-rays. • Arrange a remedial training session on how to position the image receptor and x-ray head to produce a diagnostic x-ray. • Introduce periodic competency checks of staff taking x-rays.
Audit	Investigating “did not attend” rates in hand therapy
Action – complete	• Create a new information booklet specific to fingertip injuries to help improve patient information and attendance rates.
Audit	Neonatal sepsis audit (Jan 2022 – Dec 2022)
Actions – all complete	• Input into the national Infection in critical care quality improvement programme website for external monitoring. • Monitor antenatal/intrapartum antibiotics if the infant is less than 34 weeks. • Maintain eLearning competency assessments for peripherally inserted central catheter inserting staff. • Introduce measures to reduce colonisation of incubator environment such as: Environmental scrubbing and hand hygiene.
Audit	Re-audit Neonatal jaundice audit 2023 data
Action – in progress Action – in progress Action – in progress Action – in progress	• Education and dissemination regarding Jaundice, treatments. • Provide Badgernet training for relevant staff groups. • Create new pro forma once Badgernet established. • Improve rates in regard to when total serum or plasma bilirubin samples are to be taken, chasing blood samples & communicating results & potential treatment required. • Utilise total serum or plasma bilirubin monitoring of patients on neonatal unit over 35 weeks.

Action – in progress	
Audit	Management of Achalasia: Enhancing treatment outcomes and improving quality of life
Action – in progress	• Design and introduce a pre-op quality of life assessment and follow up questionnaire to assess longer term outcomes.
Audit	Re-audit of retrospective review of blood transfusion occurring in urgent/emergency cholecystectomy operations
Action - complete	• To improve compliance with the group and save policy by creating awareness posters/flyers and circulating them to junior doctors, senior house officers, registrars and consultants.
Audit	Syringe Driver Destination Audit
Action – complete Action - complete	• The District Nurse referral form on HarrisFlex has been amended to include a question relating to whether the patient was being discharged on a syringe driver, and if the answer is yes, there will be a prompt to remind the District Nurses to return the syringe driver. • Copy of return instructions are now included in the syringe driver envelope so that community teams know how to return the syringe driver.
Audit	Reasons for failed osteosynthesis in mandible fractures
Action – in progress Action – complete Action - complete	• Suggested 14-day course of antibiotics coverage to prevent the infection of the surgical site and consequently failure of the Open Reduction and Internal Fixation (ORIF). • Highlight to colleagues the importance throughout the consenting process of a clear explanation to patients that infection is a high-risk complication that is most linked to failure. • Highlight to colleagues the importance of a strict aseptic approach pre, intra, and post operatively.
Audit	Re-audit: Investigating the Did Not Attend (DNA) rates in Special Care Dentistry across Lancashire Teaching Hospitals
Action – in progress	• Continue department conversations with regards to recruitment of a Band 4 staff member to call patients and manage appointment reminders.
Audit	Re-audit: Assessment of Pre-Operative Instructions Compliance for Anaesthetist-led Intravenous Sedation Clinic within Special Care Dentistry Department
Action – in progress Action – in progress	• Ensure all staff are using the same pre-operative instructions. • Remind staff to continue going over pre-operative instruction with patients at pre-sedation appointment.
Audit	Referrals for paraproteinemia to haematology service
Actions – all complete	• Share the results at Lancashire Teaching Hospitals/Blackpool Teaching Hospitals Haematology job plan meeting and agree Trust guidance on choose & book Haematology referrals. • Add the Trust guidance to the induction of new locum staff.
Audit	Compliance with Stop Before You Block (SBYB)
Action – complete Action – in progress	• The simulation based training was delivered and teaching on SBYB was done at the audit meeting. • To incorporate the Prep-Stop-Block into the new theatre checklist based on the National Safety Standards for Invasive Procedures (NatSSIPs): to be done across the theatres and to be added to the new team brief whiteboards and also in the theatre system (awaiting change board approval).

Action – complete	• To extend the “8 step for safer surgery” with the Prep-Stop-Block: This will be a part of mandatory training for all theatre staff.
Audit	DrEaMing (Drinking, Eating, Mobilising) - Post Procedural Review
Action – in progress	• To set up a form which will highlight the patients to be reviewed 24hrs post-op which would help to pick up any deteriorations or complications and adjustments needed.
Audit	Adherence to British Orthopaedic Association Standards (BOAST) guidelines for medical photography of open fractures and availability of means to take, store and view photos.
Action – in progress Action – in progress	• To introduce the Clinical Uploader app on the relevant wards and areas to take pictures of the open fractures. • To introduce a Standard Operating Procedure (SOP) on managing/photographing of the open fractures. The SOP will be drafted after the Case Uploaded app is live in order to test how the process works and how reliable it is to work. ED and Plastics to be involved in this SOP development.
Audit	Lipid Profile Management in Acute Coronary Syndrome
Action – complete Action - complete	• Create a poster for the cardiology team to remind them to request lipid profile for acute coronary syndrome patients and to consider Ezetimibe/PSCK9i for those already on large, tolerated dose of statin but still have high low-density lipoproteins (LDL). • General Practitioner action request added to the discharge summary of all acute coronary syndrome patients to check lipid profile 3-4 weeks after discharge with consideration of either Ezetimibe/PSCK9i according to the LDL-C level.
Audit	Delirium - attaining the new equilibrium
Action – complete Action - complete	• Introduction of a delirium working group - involving more staff at the shop floor, educational activities and awareness - e-learning to be updated. • To update and agree delirium policy focussing on Intensive Care management of delirium.
Audit	Pre-Treatment Screening for Long-Term Steroid Therapy in Neuro-Muscular Disorders
Action - complete	• Create a checklist for pre-treatment tests and screening to remind doctors what pre-treatment screening is recommended for patients starting long-term steroid therapy for neuro-muscular disorders.
Audit	Adherence to Department of Vehicle Licensing Agency Guidelines in Acute Stroke Patients
Action - complete	• A field has been added to HarrisFlex, the Trust’s electronic patient record to prompt and improve the documentation of the driving advice that is given to stroke patients. The information is then also automatically included in the discharge summary for the patient.
Audit	Ward Round Documentation
Action – in progress	• The Neurosurgical Medical Handbook to be updated with the clear expectations of the clinical team with regards to documentation of the ward round/handover, VTE prophylaxis, referrals and communication with the patient or family.

Audit	Documentation of antiplatelets or anticoagulants on neurosurgical wards
Action - complete	• The handover sheet has been updated to include the information on antiplatelets/anticoagulants.
Audit	Re-audit of lens exclusion in routine CT head examinations
Action - complete	• Flyers/posters disseminated within the radiology department to ensure radiographers are aware of lens exclusion measure and are reminded to use gantry tilt wherever possible to reduce lens radiation exposure in patients scanned.

Clinical Research

Participation in Clinical Research

2023-24 has been a record year for the number of patients recruited during the period to participate in research, approved by a research ethics committee and completed at Lancashire Teaching Hospitals NHS Foundation Trust. The team in the Centre for Health Research & Innovation recruited 3,421 patients to National Institute for Health Research (NIHR) portfolio adopted studies in this period. The Trust recruited a further 483 participants to non-portfolio studies. In total, there are currently 190 open research studies recruiting patients at the Trust. The return to a more balanced, pre-pandemic style portfolio has stabilised with commercial trials at 13% of the case mix up from 9% at the end of the pandemic.

Research Governance

The research department granted local confirmation of capacity and capability for and opened 51 new studies during the period April 2023 to March 2024.

Trust Achievements in Research

Infrastructure

- Ongoing funding for the NIHR Lancashire Clinical Research Facility (LCRF) with further NIHR Clinical Research Network strategic award for commercial trials.
- Implementation of the new NIHR Manchester Biomedical Research Centre. There are 6 embedded studies at the Trust and progression into year 2 of a joint PhD colorectal fellow working with The University of Manchester.
- Research and Innovation in the Trust has received the Gold STAR award for safety and quality four times running.
- All research projects have a ‘green’ rating in the NIHR Clinical Research Facilities (CRF) annual report feedback.

Workforce

- The Senior Research Midwife has been accepted on to the NIHR Senior Leadership Programme which commenced in April 2024.

- The neurosciences clinical research practitioner was nominated for the 'Living the Values' Our People Award and was commended, also receiving a special recognition award at the end of the ceremony.
- Neurosciences Senior Research Nurse was part of the winning Menopause Advocates Team that won Our People Award for Colleague Health & Wellbeing.
- Consultant Oncologist has been awarded an honorary clinical chair at the University of Central Lancashire (UCLan) for his contribution in the development of the NIHR Clinical Research Facility (CRF) into a functioning centre for early phase studies as Medical Director for the CRF.
- Head of Data Science and Colorectal Surgeon has been awarded an Honorary Clinical Chair at Lancaster University, in recognition of his work on the Trust's Trusted Research Environment (TRE).
- Two successful candidates for the NIHR Early Career Researcher Development Pathway the Paediatric Research Physiotherapist and a Specialist Therapeutic Radiographer.
- In Neurosurgery three registrars are currently involved in the NIHR Associate Principal Investigator (PI) scheme.
- The Royal Preston Paediatric Neuromuscular Service received a prestigious Centre of Excellence award from leading national charity Muscular Dystrophy UK.

Studies/Trials/Research

- Refurbish of the clinical trial aseptic suite.
- A successful Research Council Impact Acceleration Account award further strengthens partnership working between Lancaster University and the Trust to further develop neurology data science work.
- Recruited the first UK patient to the HeredERA clinical trial, sponsored by F. Hoffmann-La Roche Ltd in advanced or metastatic breast cancer.
- Our motor neurone disease (MND) service is participating in the National MND studies group and TRICALS, the largest European research initiative to find a cure for MND.
- HARMONIE trial in children/neonates trialled Nirsevimab which was proven to protect infants against hospitalization for Respiratory Syncytial Virus (RSV)-associated lower respiratory tract infection and against very severe RSV-associated lower respiratory tract infection in conditions that approximated real-world settings. (Funded by Sanofi and AstraZeneca.
- A Phase 2, Multicentre, Open-Label, Umbrella Study of SCIB1 and iSCIB1+ in Patients with Advanced Unresectable Melanoma Receiving Either Nivolumab with Ipilimumab or SCIB1 with Pembrolizumab (The SCOPE Study). The Cancer Research Team and Lancashire Clinical Research Facility have recruited randomised and treated the first global patient into the Scope study. This is a first in human (FiH) treatment study.

Registration with the Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust is required to register with the CQC, and it is currently registered and licensed to provide the following services:

- Diagnostic and/or screening services.
- Maternity and midwifery services.
- Surgical procedures.

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Termination of pregnancies.
- Treatment of disease, disorder, or injury.
- Management of supply of blood and blood derived products.

CQC Finney House

The Trust is also registered to provide services from Finney House Community Healthcare Hub. Finney House provides out-of-hospital community-based care through community services, clinics and support patients medically at satellite dialysis units and is registered with the CQC and licensed to provide:

- Accommodation for persons who require nursing or personal care.
- Treatment of disease, disorder or injury.

The Chief Nursing Officer is the Registered Manager with CQC for Lancashire Teaching Hospitals NHS Foundation Trust and Finney House Community Healthcare Hub. Both the Foundation Trust and Finney House Community Healthcare Hub are fully compliant with the registration requirements of the CQC.

Trust Inspections

The CQC undertook an unannounced inspection over the period May, June and July 2023 as part of its continual checks on the safety and quality of healthcare services at the Trust. The areas inspected were urgent and emergency care at Royal Preston Hospital and Chorley and South Ribble Hospital, and medicine, and surgery at Royal Preston Hospital. A focussed inspection of maternity services was also undertaken as part of the CQC national maternity inspection programme which looked at the safe and well led questions and they also inspected the well-led key questions for the Trust overall. The report was published on the 24th November 2023 and the CQC ratings of our services stayed the same as "requires improvement". The CQC rated safe, effective, responsive and well led overall as requires improvement and caring as good. Surgery at Preston and urgent and emergency care and maternity at Chorley was rated good. With urgent and emergency care, medicine and maternity at Preston as requires improvement.

Please refer to figure 3 for the CQC Trust wide ratings for each of the domains inspected.

Figure 3 CQC Trust wide ratings

The CQC noted there was progress with performance but also highlighted areas where further work was needed to address bed pressures and flow and delivery of the financial plan. During the inspection of urgent and emergency care the Trust received a letter of concern regarding the management of mental health patients. The Trust responded to the concerns raised and since the inspection the CQC has been assured with the information provided and this area is no longer under active monitoring by the CQC. The Trust is responding to the must and should do's issued as part of the inspection through its quality improvement plan. this will be overseen through the new single improvement plan in 2024/25 and continue to be reported to the Board of Directors. At the end of March 2024, of the 54 'Must Do's' and 'Should Do's' included in the 2023-2024 CQC Quality Improvement Plan (QIP), there are 28 (52%) recommendations assessed as 'Green' i.e., delivered, 24 (44%) as 'Amber-Green' i.e. ongoing and progress made and 2 (4%) as 'Amber-Red' i.e. not currently delivered and risks with delivery. There are nil currently assessed as 'Red' i.e. not expected to deliver at any point in time.

The report highlighted several areas of good practice recognising improvements and positive changes the Trust has made to drive its safety and improvement culture as follows.

- The Trust had processes to escalate relevant risks and identified actions to reduce their impact.
- The Trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- Most staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The Trust supported staff to develop their skills and take on more senior roles.
- Leaders operated effective governance processes, throughout the services and with partner organisations. Staff were clear about their roles and accountabilities. External assurance continued to develop governance processes throughout the Trust and with partner organisations.
- The service collected reliable data and analysed it.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- The Trust had a good understanding of quality improvement methods and the skills to use them.

Quality of Data

Information Governance

The Trust has a clear focus on data quality. Performance information is triangulated with other known information to identify any areas of weakness and where data requires further exploration, specific reviews are undertaken. A data quality management review was undertaken in 2022–23 and recommendations provided. In response, the Trust is taking forward a refreshed data quality group in relation to high priority performance metrics and a data quality audit was undertaken in 2023–24.

The Digital and Health Informatics Directorate continue to secure the Trust's data and services with monitoring through the NHSE Data Security and Protection Toolkit (DSPT) Regional Health Information and Management Systems Society Infrastructure Adoption Model assessments have also

been undertaken, with recommendations assessed and added to the Cyber Security action plan and monitored through the Cyber Security Committee.

The Trust has a high risk (scoring 15) related to the potential for a cyber-attack. The risk is reviewed and updated monthly as controls are continuously improved. All eligible Windows servers and workstations have been onboarded to enhanced national threat detection and monitoring systems Cyber recovery solutions have been procured to protect critical server backups and over 11,000 staff members have been onboarded to multi-factor authentication, thus protecting Trust email and applications.

Data Quality 

It is generally accepted that good quality data is at the heart of identifying the need to improve. It also provides the evidence that there has been improvement in the quality of care delivered as a result of changes that the Trust has made.

Lancashire Teaching Hospitals NHS Foundation Trust reports on data quality through submission of a bi-annual Data Quality Assurance Report to the Trust Board providing a summary of Data Quality Team activities and an update in relation to Data Quality Risks and compliance in relation to the National Data Quality Assurance Dashboard and Maturity Index.

Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2023-24 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the latest published data, which included the patient's valid NHS number, was:

- 99.9% for admitted patient care.
- 99.9% for outpatient care.
- 99.3% for accident and emergency care.

The percentage of records in the published data, which included the patient's valid General Medical Practice code, was:

- 99.6% for admitted patient care.
- 99.6% for outpatient care.
- 99.4% for accident and emergency care.

All data set types are either consistent with or show an improvement compared to 2022-23, and all are above the national average for 2023-24.

As part of the Lancashire Teaching Hospitals NHS Foundation Trust annual assessment, the Data Security and Protection Toolkit (DSPT) is reviewed annually and updated to ensure Trust standards are aligned with current best practice. The status for the 2022-23 DSPT is 'standards met'. The Toolkit Audit for 2022-23 provided substantial assurance for the self-assessment and National Data Guardian standards. The 2023-24 submission is not due to be made until June 2024.

The Trust was subject to an internal Information Governance clinical coding quality assurance audit during 2023-24. Results indicate a high level of coding quality and completeness as follows with improvement across secondary diagnosis and procedures:

- Primary Diagnosis 92.5%.
- Secondary Diagnosis 92.65%.
- Primary Procedure 93.04%.
- Secondary Procedure 93.22%.

In terms of the NHS Digital Data Quality Maturity Index the Trust scored the following for the latest position available, above the national average in all datasets and overall showing an improvement compared to the 2022-23 position. Please see table below for NHS Digital Data Quality.

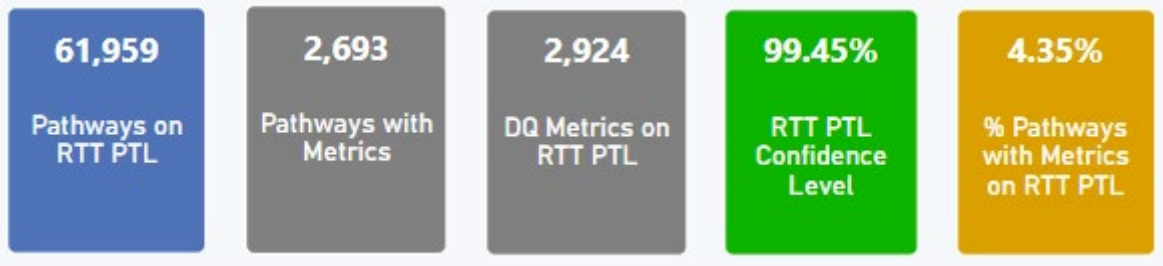
Table 7 - NHS Digital Data Quality

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

Data source NHS Data Quality Maturity Index

The National Waiting List Minimum dataset data quality confidence level of 99.45% for the Trust is above the national threshold of 95%. Compliance is detailed below and shows a 2% improvement in the number of records with a data quality query:

Figure 4 National Waiting List Data



LUNA National Data Quality Solution

Whilst the figures for data quality are above the national average the Trust remains committed to continued improvements and supporting actions are referenced below.

- Extended suite of validation reports to increase validation and assurance of the quality of data on the main Patient Administration System (PAS).

- Interactive workshops to ensure engagement with clinical and support staff regarding the importance of good data quality and individual responsibility.
- Established a Data Quality Forum to support improvements to data quality in core systems.
- Engaged with external audit partners to improve the quality and depth of clinically coded data and overall data completeness.

Information Governance 

The confidentiality and security of information regarding patients, staff and the Trust is maintained through governance and control policies, all of which support current legislation and are reviewed on a regular basis. Personal information is increasingly held electronically within secure Information Technology (IT) systems. It is inevitable that in a complex NHS organisation a small number of data security incidents occur. The Trust is diligent in its reporting and investigation of such incidents, in line with statutory, regulatory, and best practice obligations. Any incident involving a breach of personal data is handled under the Trust's risk and control framework, graded and the more serious incidents are reported to the Department of Health and the Information Commissioner's Office (ICO) where appropriate.

The Trust experienced two externally reportable serious incidents in the 2023-24 period, one of these incidents reached the reporting criteria and was sent to the ICO. For all incidents full internal processes were followed and both incidents were reported using the Data Security and Protection Toolkit (DSPT).

As part of our annual assessment, the DSPT is reviewed annually and updated to ensure Trust standards are aligned with statutory obligations. The status for the 2022-23 DSPT was 'standards met'. The Trust has submitted the baseline assessment for 2023-24 and is working towards the final submission which is due on 30th June 2024.

The Trust has established a dedicated information risk framework with Information Asset Owners throughout the organisation. This is well embedded and identifies information asset owner responsibilities for ensuring information assets are handled and managed appropriately. There are robust and effective systems, procedures, and practices to identify, manage and control information risks. Alongside training and awareness, incident management is part of the risk management framework and is a mechanism for the immediate reporting and investigation of actual or suspected information security breaches and potential vulnerabilities or weaknesses within the organisation. This ensures compliance in line with the UK General Data Protection Regulations (UKGDPR) and the Data Protection Act 2018 (DPA18).

Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance Records Committee which is accountable to the Finance and Performance Committee. The Information Governance Committee is chaired by the Chief Medical Officer who is also the Caldicott Guardian. The Board appointed Senior Information Risk Owner (SIRO) is the Finance Director.

The Information Governance Management Framework brings together all the statutory requirements, standards, and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development

of the Information Governance Management Framework is informed by the results from DSPT assessment and by participation in the Information Governance Assurance Framework.

Adult Mortality Reviews

The Trust has robust governance arrangements in place to monitor, review, report and learn from patient deaths and implemented the nationally recommended approach to Mortality Review (MR) during 2017-18 which was based on the Royal College of Physicians Structure Judgement Review (SJR) model. This has been embedded in practice for the past six years. The SJR mortality model was developed for the review of adult deaths, the outcomes of which are presented below.

Neonatal and child deaths are managed through different nationally defined review and reporting processes which are presented separately in the Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths section in this quality account. The deaths listed this section include inpatient and Emergency Department (ED) deaths which are reviewed using SJR methodology.

Structured Judgement Reviews

The Trust completed SJRs (Structured Judgement Reviews) for 52% of deaths.

During 2023-24, 1,908 of Lancashire Teaching Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 484 in the first quarter.
- 419 in the second quarter.
- 466 in the third quarter.
- 539 in the fourth quarter.

Data source: Trust data warehouse

By 31 March 2024, 964 case record reviews and 16* Serious Incident Investigations (either StEIS under Serious Incident Framework (SIF) or Patient Safety Incident Investigation (PSII) under Patient Safety Incident Response Framework (PSIRF) have been carried out or are ongoing in relation to the 1,908 of the deaths noted above. This is excluding any incident involving a child or neonate and only specifically relates to deaths.

** 12 StEIS investigations have been completed, of which 2 remain awaiting Coroner ruling, and 4 are ongoing investigations (ether StEIS or PSII under PSIRF).*

The number of deaths in each quarter for which a case record review of StEIS investigation was carried out was:

- 216 in the first quarter (plus 7 StEIS investigations).
- 267 in the second quarter (plus 4 StEIS investigation).
- 300 in the third quarter (plus 4 StEIS/PSII investigations).
- 233 in the fourth quarter (plus 1 StEIS/PSII Investigations).

Data source: Trust MR Database & Datix

3* representing 0.16 of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient in relation to each quarter, this consisted of:

- 2 representing 0.10% for the first quarter.
- 1 representing 0.05%for the second quarter.
- 0 representing 0% for the third quarter.
- 0 representing 0% for fourth quarter.

Data source: Trust MR Database & Datix

These numbers have been calculated using the SJR Mortality Review process, the StEIS/PSII process and the Coroner's Inquest process. There are 4 investigations ongoing and 2 StEIS investigations completed in 2023-24, which remain awaiting Coroner's Inquest hearing and so it is not possible to determine for all cases if deaths were on balance likely due to problems in care. It is noted that the new Patient Safety Incident Response Framework, which the Trust implemented from 6th November 2023, advises that avoidability of death should not form part of the terms of reference for PSII investigations, with that being the remit of HM Coroner.

Learning from Structured Judgement Reviews

During 2022-2023, the mortality review pro forma was updated to capture both positive and negative learning and learning from deaths is regularly shared in the divisional Safety and Quality meetings and speciality governance meetings. The learning outcomes from the SJR reviews are extracted from the electronic SJR tool in our clinical audit system; AMaT. This is collated and key themes are reported into our Divisional and Trust Safety and Quality Committees. Themes for learning are also reported into our Mortality and End of Life Care Committee which highlight excellent practice as well as areas for consideration and action.

Key positive themes arising from the outcomes of SJR Mortality Reviews 2023-24:

- Appropriate escalation of patients.
- Good Communication with the family and patient.
- Prompt investigations.
- Good documentation.
- Multi-disciplinary approach.
- Involvement of the Palliative Care Team.

Key negative themes arising from the outcomes of SJR 2023-24. These themes are being addressed through the continuous improvement and risk management process:

- Resuscitation decision making and delays in initiating a do not attempt cardio-pulmonary resuscitation (DNACPR).
- Missed escalation of patients.
- Emergency Department (ED) delays

2.3 Reporting Core Indicators

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified in the NHS Improvement compliance framework and the acute services contract.

The NHS continued to face significant challenges and like all other NHS Trusts across the country Lancashire Teaching Hospitals NHS Foundation Trust has continued to experience pressures as a result of the COVID-19 pandemic. Performance across the board, both emergency and elective has been impacted with operational pressures and infection, prevention control measures experienced through the year resulting in non-compliance in relation to a number of key standards.

Whole health economy system pressures in response to increased demand resulted in high bed

occupancy throughout the year with the need to focus both on non-elective activity and elective recovery as mandated nationally. The number of patients not meeting the criteria to reside remained high throughout the year. This, together with both Influenza demand resulted in significant capacity and demand pressures. Workforce capacity to undertake elective activity was also impacted by sickness absence and industrial action throughout the latter part of the year.

A health economy system-wide action plan is in place to address the urgent care system and pressures; with identified primary, community and social care initiatives/schemes delivering a level of sustainability across the health economy. In 2023-24 the Trust continued to take a lead role in bringing together operational delivery of the system-wide urgent and emergency care programme, including key transformational work streams identified and prioritised by all system partners: a Community Healthcare Hub at Finney House continues to provide health-led community bed capacity; the continued development of Virtual Wards; additional Home First capacity and crisis hours to support people to stay safe at home; and to expedite timely discharge from hospital.

The Trust has worked hard to deliver against the Core Indicator Performance and for the 2023-24 period a number of indicators are showing an improved position against the 2022-2023 submission. The indicator for Methicillin-resistant Staphylococcus aureus (MRSA) has been maintained with one case reported consistent with last year and there remain three indicators which have shown a deteriorating position.

- The C-difficile trajectory has not been achieved. Please refer to the Control of Infection section of this report for all actions in relation to reducing the incidence of c-difficile infections.
- The Trust 4-hour standard for Accident & Emergency (A&E) has deteriorated and a number of operational workstreams are directed towards achieving this target.
- Cancer - 31 Day Target - Subsequent treatment – Surgery – performance against the standard was not met in 2023-24 with actual performance showing a deteriorating position compared to the previous year.

Core Indicators: Summary position detailing performance for 2023-24 is shown in table 8 below.

Table 8 Core Indicator Performance 2022-23 and 2023-24

Indicator	2022-23	2023-24	Current Period	Comparison
A&E - 4 hour standard	75.3	70.4	% - Cumulative to end Mar 2024	Deteriorated
Cancer - 2 week rule (All Referrals) - New method	58.6	83.5	% - Cumulative to end Mar 2024	Improved
Cancer - 2 week rule - Referrals with breast symptoms	82.2	91.0	% - Cumulative to end Mar 2024	Improved
Cancer - 31 day target	83.3	84.4	% - Cumulative to end Mar 2024	Improved
Cancer - 31 Day Target - Subsequent treatment – Surgery	59.3	58.2	% - Cumulative to end Mar 2024	Deteriorated

Indicator	2022-23	2023-24	Current Period	Comparison
Cancer - 31 Day Target - Subsequent treatment – Drug	96.8	98.4	% - Cumulative to end Mar 2024	Improved
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	82.3	87.1	% - Cumulative to end Mar 2024	Improved
Cancer - 62 day Target	43.2	56.0	% - Cumulative to end Mar 2024	Improved
Cancer - 62 Day Target - Referrals from NSS (Summary)	29.2	29.9	% - Cumulative to end Mar 2024	Improved
28 day faster diagnosis standard – compliance	57.5	71.5	% - Cumulative to end Mar 2024	Improved
MRSA	0	0	% - Cumulative to end Mar 2024	Maintained
C.difficile Infections	196	203	% - Cumulative to end Mar 2024	Deteriorated
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	50.5	55.0	% - Cumulative to end Mar 2024	Improved
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 104 Weeks	5	0.0	End March 2024 census position	Improved
18 weeks - Referral to Treatment -Number of Incomplete Pathways > 78 Weeks	130	11.0	End March 2024 census position	Improved
% of patients waiting over 6 weeks for a diagnostic test	50.44	45.6	% - Cumulative to end Mar 2024	Improved

Data source: NHS Digital/LTHTR Data Warehouse

Summary of Performance against Core Indicators

The source of all the data presented in the following tables is from NHS Digital as is the requirement for the Quality Account and is the most current data available for each Performance Indicator presented. All benchmarking data presented is related to Acute (non-specialist) NHS Trusts.

NHS Digital Data availability

All data reflects the latest data period available on the NHS Digital Data platform.

- Summary Hospital-Level Mortality Indicator (SMHI) - Table 9 relates to 2022-23.
- Readmissions within 30 days of Discharge - Table 10 relates to 2022-23.
- Venous Thromboembolism – Table 11 relates to 2020-21 (remains paused since COVID-19).
- Clostridioides Difficile Infection - Table 12 relates to 2022-23.
- Patient Safety Incidents - Table 13 relates to 2023-24.

Table 9 Summary Hospital-Level Mortality Indicator (SMHI) * most current data					
Summary Hospital-Level Mortality Indicator (SMHI)	**December 2018- Nov-19**	**December 2019- Nov-20**	**December 2020- Nov-21**	**December 2021- Nov-22**	**December 2022- Nov-23 ***
	Trust = 0.9702	**Trust = 0.9671**	**Trust = 0.9593**	**Trust = 0.9641**	**Trust = 0.9169**
(a) the value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period	England average = 1.0	England average = 1.0	England average = 1.0	England average = 1.0	England average = 1.0
	Low = 0.69	Low = 0.69	Low = 0.71	Low = 0.71	Low = 0.71
	High = 1.19	High = 1.18	High = 1.19	High = 1.22	High = 1.25
	Banding = 2	Banding = 2	Banding = 2	Banding = 2	Banding = 2
(b) the percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period	**Trust = 53%**	**Trust = 52%**	**Trust = 51%**	**Trust = 55%**	**Trust = 55%**
	England = 36%	England = 36%	England = 39%	England = 40%	England = 42%
	High = 59%	High = 59%	High = 64%	High = 66%	High = 66%
	Low = 11%	Low = 8%	Low = 11%	Low = 13%	Low = 16%

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- NHS Digital categorises NHS Trusts into bands 'higher than expected' (banding=1), 'as expected' (banding=2) or 'lower than expected' (banding=3). The Trust remains in band 2 which is within the expected range. The SHMI for the most current data available (Dec 2021 – Nov 2022) is 0.91 which is lower than the previous 12-month period but still below the 1.0 average.
- The SHMI data does not include COVID-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were to be included it would affect the accuracy.

Table 10 Readmissions within 30 days of Discharge * most current data						
The percentage of patients aged: 0 to 15 and 16 or over Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from the Trust during the reporting period	**April 2017-Mar 18**	**April 2018-Mar-19**	**April 2019-Mar-20**	**April 2020-Mar-21**	**April 2021-Mar-22**	**April 2022- Mar-23***
0-15 years	**Trust = 15.2 (A1)**	**Trust = 15.8 (A1)**	**Trust = 13.5 (A5)**	**Trust = 12.0 (W)**	**Trust = 12.5 (W)**	**Trust = 13.7 (A5)**
	England = 11.9	England = 12.5	England = 12.5	England = 11.9	England = 12.5	England = 12.8
	High = 17.0	High = 19.3	High = 18.5	High = 12.1	High = 12.6	High = 12.9
	Low = 1.7	Low = 2.0	Low = 2.4	Low = 11.9	Low = 12.5	Low = 12.8
16 years – 74 years	**Trust = 10.9 (B1)**	**Trust = 12.0 (B1)**	**Trust = 11.8 (B1)**	**Trust = 12.4 (B1)**	**Trust = 10.4 (B1)**	**Trust = 12.7 (B1)**
	England = 12.4	England = 13.0	England = 13.1	England = 14.5	England = 13.4	England = 13.3
	High = 21.0	High = 21.8	High = 19.5	High = 14.5	High = 13.4	High = 13.3
	Low = 2.2	Low = 1.2	Low = 3.2	Low = 14.4	Low = 13.4	Low = 13.3
75 years +	**Trust = 16.9 (B1)**	**Trust = 17.8 (W)**	**Trust = 17.6 (B5)**	**Trust = 19.5 (W)**	**Trust = 16.6 (B1)**	**Trust = 17.0 (W)**
	England = 18.4	England = 18.7	England = 18.6	England = 19.6	England = 18.0	England = 17.2
	High = 22.5	High = 29.4	High = 31.9	High = 19.7	High = 18.0	High = 17.3
	Low = 6.7	Low = 6.1	Low = 8.6	Low = 19.4	Low = 17.9	Low = 17.1

2022 -2023 not yet released by NHS Digital. As such data is presented 12 months in arrears.

Banding key:

B1 = Significantly lower than the national average at the 99.8% level

B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level

W = National average lies within expected variation (95% confidence interval)

A5 = Significantly higher than the national average at the 95% level but not at the 99.8% level

A1 = Significantly higher than the national average at the 99.8% level.

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The NHS Digital readmissions data is now categorised into 0-15 years, 16- 74 years, and 75+ years.
- The banding has been presented to indicate the Trust performance.
- The 0-15 year's readmissions are higher than the England average and shows a deterioration from the last reported figure.
- The Trust re-admissions rate for patients 16-74 & 75+ is either as expected or lower than the average.

Table 11 Venous Thromboembolism (VTE) Risk Assessment * most current data			
	Q4 2018 -2019	**Q3 2019 -2020 ***	**Q4 2020-2021**
Percentage of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period	**Trust = 95.7%**	**Trust = 97.0%**	NHS Digital VTE data collection and publication paused in March 2020.
	England = 95.7% High = 100% Low = 74%	England = 95.3% High = 100% Low = 71%	**No data for 2021-22 & 2022-23**

NHS Digital VTE data collection and publication was paused to release NHS capacity to support the response to COVID-19. The Trust's VTE risk assessment compliance data continues in 2023 -24 to be collated and reported to Safety and Quality Committee in an assurance report.

Table 12 Clostridioides *Difficile (C. difficile)* Infection * most current data available nationally			
	2020-21	**2021-22***	**2022-23**
The rate per 100000 bed days of cases of *C. Difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period.	**Trust = 74.5**	**Trust = 71.4**	**Trust 68.7**
	High = 140.5	High = 138.4	High=76
	Low = 0	Low = 0	Low=0

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2023-24, the national objective set by NHSE for the Trust was to have no more than 122 hospital associated cases. The Trust exceeded the national objective with an increase in hospital associated cases during 2023-24 in comparison to previous years with a total of 203 cases. This was a 3.6% increase from 2022/2023 which had a total of 196 hospital associated cases.

Please refer to the Infection prevention and control section of this Quality Account for comprehensive data on Clostridioides Difficile (C. difficile) Infection.

Table 13 Patient Safety Incidents * most current data

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death. * Comparative data for England all Trusts has not been available nationally since April 2021 to date.

	Oct 2017-Mar 2018	Oct 2018-Mar 2019	Oct 2019-Mar 2020	April 2020 - Mar 2021	April 2021 - Mar 2022	April 2022 – Mar 2023*	April 2023 – Mar 2024
(i) Rate of Patient Safety Incidents per 1000 Bed days	**Trust Number = 6506 Trust Rate = 43.6**	**Trust Number = 7250 Trust Rate = 52.4**	**Trust Number = 7766 Trust Rate = 51.8**	**Trust Number = 14428 Trust Rate = 68.9**	**Trust Number = 19773 Trust Rate = 67.8**	**Trust Number = 20626 Trust Rate = 66.1**	**Trust Number = 26920 Trust Rate = 81.3**
	England – 42.1 All * Trusts Rate High = 69.0 All * Trusts Rate Low = 23.1	England – 45.2 All *Trusts Rate High= 95.9 All *Trust Rate Low = 16.9	England – 49.6 All *Trusts Rate High = 110.2 All *Trusts Low = 15.7	England – 57.3 All *Trusts Rate High = 118.7 All *Trusts Low = 27.2	No longer produced in the same way to compare.		

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death. * Comparative data for England all Trusts has not been available nationally since April 2021 to date.

	Severe harm or death	Severe harm or death	Severe harm or death	Severe harm or death	Severe harm or death	Severe harm or death	Severe harm or death
(ii) % of Above Patient Safety Incidents = Severe/Death	**Trust Number = 62 Trust Rate = 0.42 % of all incidents = 0.95%**	**Trust Number = 60 Trust Rate = 0.43 % of all incidents = 0.83%**	**Trust Number = 49 Trust Rate = 0.33 % of all incidents = 0.63%**	**Trust Number = 88 Trust Rate = 0.42 % of all incidents = 0.61%**	**Trust Number = 80 Trust Rate = 0.27 % of all incidents = 0.40%**	**Trust Number = 110 Trust Rate = 0.35 % of all incidents = 0.53%**	**Trust Number = 107 Trust Rate = 0.32 % of all incidents = 0.39%**
Rate = per 1000 Bed Days	England – 0.35% All *Trusts Highest % = 1.54% All *Trusts Lowest % = 0%	England – 0.32% All *Trusts Highest % = 1.82% All *Trusts Lowest % = 0%	England – 0.30% All *Trusts Highest % = 1.29% All *Trusts Lowest % = 0%	England – 0.44% All *Trusts Highest % = 2.80% All *Trusts Lowest % = 0.03%	No longer produced in the same way to compare.		

The Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The Trust continues to improve education regarding the reporting of incidents and near misses,

the importance of doing so and the outcome of the learning gleaned from incident reporting. The Trust has also seen a rise in incident reporting with regards to service delivery and the management of waiting times for example, reporting of incidents where a patient is placed into a non-designated or boarded bed space, there has also been an increase in incidents linked to gaps in Thrombectomy service provision, treatment target breaches and prolonged waiting times. Trust staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients. Incident dashboards and an automated interactive Governance Dashboard are now in use across the Trust for embedded incident analysis. The Trust continues to use the Always Safety First Learning and Improvement forum to respond to learning from incidents.

Patient experience performance indicator

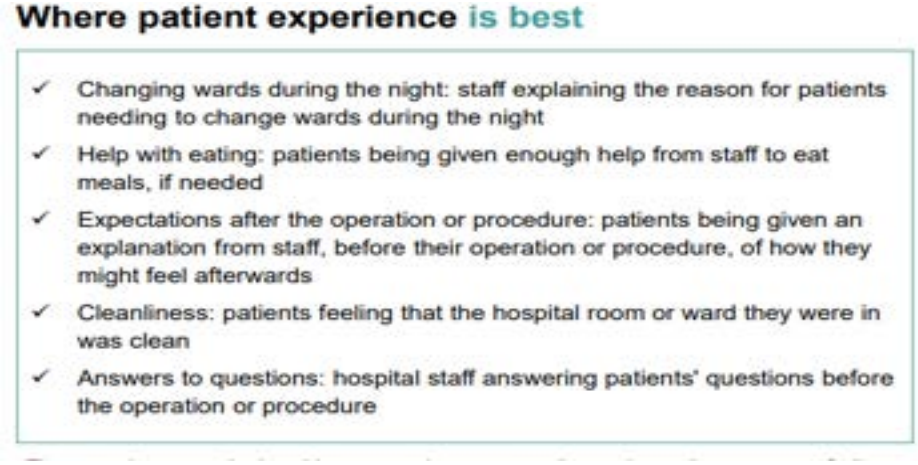
Table 14 Responsiveness to Personal Needs

Q 48. The Trust's overall experience of patient's personal needs during the reporting period	**2019-2020**	**2020-21***	**2021-22**
	Trust = 66.8	**Trust = 8**	**Trust = 6.6**
	England = 67.1 High = 84.2 Low = 59.5	England = 8.1 High = 9.4 Low = 7.4	Please refer to narrative at **

This indicator value is based on the average score from the National Inpatient Survey, which measure the experiences of people admitted to NHS Hospitals. Please note that the data methodology changed in 2020 and the scores are presented as those in the latest published report 2021/22.

* Due to methodology changes in 2020, we do not do historical comparisons any earlier than 2020. The historical comparisons include the England average for 2020-21. The national average for 2021-22 is calculated from the average score for all Trusts that exist in the data set for that year. (Source CQC: https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey)

**Following the merger of NHS Digital and NHS England on 1st February 2023 the presentation of the NHS Outcomes Framework indicators is being reviewed. As part of this review, the annual publication which was due to be released in March 2023 was delayed. Further announcements about this dataset will be made on in due course.



Where patient experience could improve

- Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital
- Enough nurses: patients feeling there were enough nurses on duty to care for them in hospital
- Privacy for discussions: patients being able to discuss their condition or treatment with hospital staff without being overheard
- Quality of food: patients describing the hospital food as good
- Taking medication: patients being able to take medication they brought to hospital when needed

The Trust is continually aiming to improve being responsive to the personal needs of patients and undertakes the following actions to improve the quality of its services, by

- Continuing to implement all of our patient experience and professional strategies in pursuit of 'consistently deliver excellent care'.
- By responding to feedback from patients and families through the Friends & Family test as well as national and local surveys.
- The Safety Triangulation Accreditation Review (STAR) accreditation system drives continuous improvement in our services being responsive to the personal needs of patients.
- Strengthening the connection between patient experience plans and equality, inclusion and diversity to support responding to patients' individual needs.

Staff experience performance indicator 

Table 15 Staff Recommendation as a Provider of Care

	2021	2022	2023
Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. (%) **NHS Digital Data** **21/22 NHS Staff Survey Data**	**Trust = 62**	**Trust = 60**	**Trust = 58.3**
	Best = 89.5 Average = 67 Worst = 43.5	Best = 86.4 Average = 61.8 Worst = 39.3	Best = 88.8 Average = 63.3 Worst = 44.3

Data is presented from the National Staff Survey with the latest survey for 2023. The Trust figure for Q25d referenced above is 58.3 which is a decrease of 1.7% from the 2022 figure. There is work to be done to improve how colleagues feel in regard to recommending the organisation if a friend or relative needing treatment, as our results are 5% below the national average for this question and this is coupled with a downward trend from 2021 to 2023.

Lancashire Teaching Hospitals NHS Foundation Trust is taking the following actions to improve this score, and so the quality of its services, by

1. Launching the new Workforce and Organisational Development People Strategy
2. Implementing continuous improvement programmes
3. Sustaining and improving our listening channels
4. Driving awareness to support Advocacy

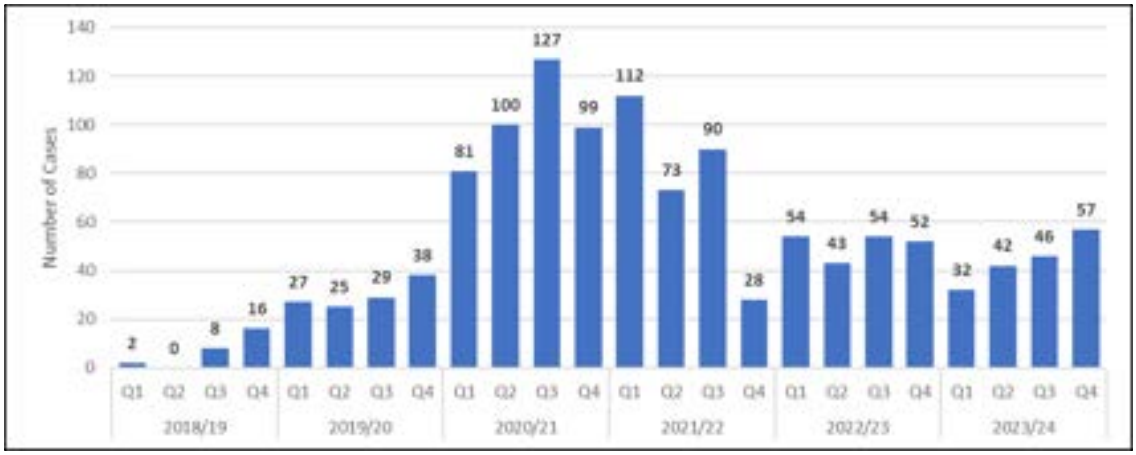
Freedom to Speak Up

In response to the principles and actions described in the review into Mid-Staffordshire Hospitals[1] (2013) and the later review of whistleblowing in the NHS[2] (2015), undertaken by Sir Robert Francis Queens Counsel (QC), the Trust reviewed its processes and systems for inviting, listening, and responding to concerns raised by staff. The Board of Directors oversaw implementation of a range of measures to strengthen systems and processes to enable staff across the Trust to raise concerns and speak up with confidence. These included:

- The appointment of a Freedom to Speak Up (FTSU) Guardian.
- Establishment of Board level representation (Executive and Non-Executive Directors) for staff raising concerns.
- Establishment of Trust policy.
- Quarterly reporting of concerns and learning that comes from them.
- Inclusion of importance of raising concerns in new staff induction for all staff including Board members and inclusion in mandatory training.

The ability to raise concerns in a safe way is essential as a contribution to the delivery of safe, effective care. The Trust recognises that this ability is also a key element towards a positive staff experience, affecting our ability to retain our staff. Trust staff are encouraged to raise any concerns, including those about: patient safety and quality of care; bullying and harassment; or financial impropriety, to immediate line managers or their line manager's superior as they feel able. Where there are immediate safety concerns, staff are encouraged to report to their line manager and to record this as a patient safety incident in Datix. Where staff feel that their concern has not been addressed, they can raise their concern with our FTSU Guardian, either directly or via the Datix Freedom to Speak Up function; a FTSU Champion; or their union representative.

Figure 5 Quarterly FTSU activity since 2018



Source: FTSU activity data/Datix

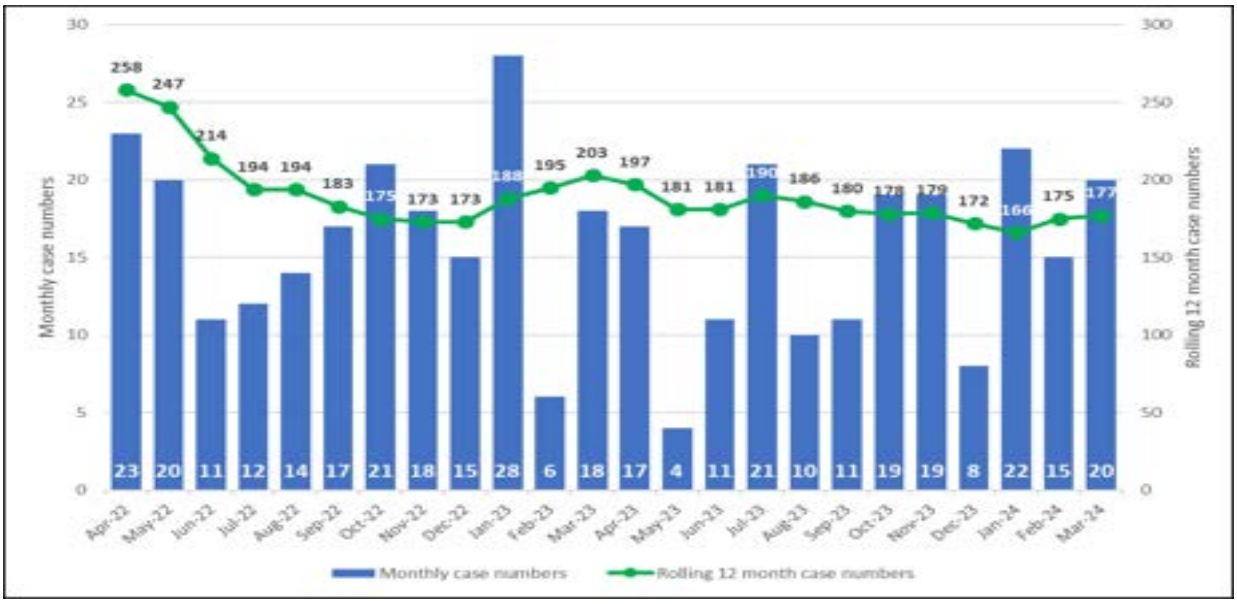
During 2023-24 there were 177 contacts with the FTSU service compared with 204 in 2022-23 and 303 in 2021-22, representing a 13% reduction in activity in the previous year and a 42% reduction against 2020-21 activity. It should be noted that the Freedom to Speak Up service passed the enquiries function on the Trust intranet, held since 2020, to the Communications team during Q3 in

[1] Francis Enquiry 2013
[2] Freedom to Speak Up Report 2015

2022. This undoubtedly impacted on the level of activity during this period and the comparability of year-on-year performance. Since 2022-23 data suggested a more consistent level of activity.

Of the concerns raised during 2023-24, 36 (33.5%) involved concerns about patient and/or worker safety. However, this figure rises to 121 (68%) when including staff who reported an adverse impact on their health and wellbeing. 24% of staff raising concerns reported that they had experienced bullying and/or harassment (an increase of 2% compared to last year) with 14% reportedly by managers (down 1%) and 10% (up 3%) by peers. The latest staff survey results demonstrated that a higher proportion of staff experienced bullying and harassment from colleagues than managers with over 50% of staff who experienced bullying from any source, reported it.

Figure 6 Monthly and Rolling 12-month FTSU case numbers.



Source: FTSU activity data/Datix

Whilst activity is again reduced compared to last year, the rate of reduction has levelled off during 2023-24 as forecast in the previous Quality Account for 2022-23. No member of staff should suffer detriment as a direct result of raising concerns with the FTSU service. Trust policy reinforces a commitment to protect staff who raise concerns from unacceptable behaviour, detriment, or harm. The Freedom to Speak Up Guardian and the Deputy Director of Workforce are identified as sources of support if such harm is suspected. The Guardian records and reports all instances of perceived/actual detriment.

During 2023-24 one staff member reported detriment that they believed to be because of raising a concern/complaint formally (though not necessarily through involvement of the Guardian). Seven others expressed a fear of detriment for speaking up, but no evidence was forthcoming that this was the case but nevertheless their anonymity was protected.

In the 2022-23 Quality Account key priorities were identified to strengthen and embed Speak Up Listen Up Follow Up across the Trust. These included:

- A review of Trust Freedom to Speak Up policies and procedures will be undertaken to ensure that Trust guidance is consistent with national guidance. This review was completed but work continues to ensure that procedures and systems to provide effective support and identify important learning are further strengthened.

- Access to support is sustained through the recruitment of Freedom to Speak Up Champions.

- A network of champions is in place with representation from a range of services and staff groups. However, there is a further identified need to include staff from under-represented groups and service areas where evidence of raising concerns is weak. This work will continue as a priority in 2024-25.

- The importance of speaking up, listening, and responding to concerns continues to be promoted across the Trust and informs the provision of safe, high-quality care and treatment along with a positive staff experience. Our FTSU Guardian provides assurance to the Board that the Trust is responsive to concerns and meets with our Chief Executive and Chair to share any concerns, emerging themes, and trends. The Trust values the benefits of rich data and intelligence in accurately identifying and responding to concerns raised by staff. The Trust's Raising Concerns Group now meets more frequently, at least six times a year and reviews data and intelligence from sources including workforce and organisational development data, safety incidents, complaints, staff surveys, and safeguarding information. Areas of concern and good practice, along with themes, trends, and actions taken are reported to the Workforce Committee and to the Board of Directors.

- During 2023-24, the group has strengthened its contribution to the Divisional Improvement Forums where areas of concern can be explored, and assurance of learning and improvement can be obtained. The Executive Freedom to Speak Up Lead and other group members are active participants in this process. Divisional management teams are now in receipt of monthly dashboards and reports providing valuable information about any area of concern within their respective teams. This information has made a valuable contribution to awareness at a more local level and improved opportunity to learn and improve.

- The Freedom to Speak Up Guardian attended the National Guardian's Office Freedom to Speak Up annual conference in 2024 and has actively attended and participated in regional network meetings.

- All new staff receive information about speaking up as part of their Trust induction and information about speaking up is available in the dedicated webpages on the Trust intranet. The Guardian has met with teams and individuals on occasions both virtually and in person to raise awareness of the importance of speaking up and to managers and others in supervisory positions on the importance of listening and responding. Allowing staff the option of anonymity is a means of creating a safe environment for colleagues. Anyone raising concerns through the Datix Freedom to Speak Module has the choice of remaining anonymous or not. During 2023-24, 18 colleagues (10%) chose to remain anonymous, a reduction of 2% compared to 2022-23.

During 2024-25, the Trust will build on previous successes and ensure that:

- The visibility of the Guardian is increased through attendance in team meeting and the availability of revised publicity resources, ensuring that staff have ready access to information on how to contact the service.

- Further developing relationships between the Guardian and the Board and Divisional management teams though the flow of information about concerns and learning and improvement arising in response to those concerns.

- Increased contribution of the Guardian to training resources, particularly those relating to leadership development, influencing the development of safe environments in which to raise concerns and encouraging a culture of business as usual for speaking up, listening, and responding.

PART 3

Review of Quality Performance – Patient Safety

The Trust considers the safety of patients to be our principal priority. To ensure the organisation is a safe place to receive care and treatment, the Trust monitors performance against certain factors and continually aims to reduce and eliminate patient harm where possible. In 2023-24 the Trust responded to the NHS National Patient Safety Strategy with Lancashire Teaching Hospitals' Always Safety First programme. During 2023-24 this has continued to be led by the Chief Nursing Officer and Chief Medical Officer and supported by the Governance, Nursing and Continuous Improvement teams. The programme promotes staff to always consider safety across the organisation and has involved lay representatives from the community to support the programme to provide opportunities to share their ideas. This section of the Quality Account presents indicators relating to patient safety, clinical effectiveness and patient experience as outlined below.

Patient Safety

- The Patient Safety Incident Response Framework.
- The Trust STAR programme.
- Falls Prevention.
- Safeguarding Adults.
- Safeguarding Children.
- Maternity Safeguarding & Safety.
- Incidents and Never Events.
- Duty of Candour.
- A Learning Organisation

Clinical Effectiveness

- The Getting it Right First Time (GIRFT) programme.
- Tissue Viability – Pressure Ulcer Incidence and Prevention.
- Nutrition for Effective Patient Care.
- Medication Incident Monitoring.
- Infection Prevention and Control.
- C Difficile
- Methicillin-resistant Staphylococcus Aureus (MRSA).
- Influenza and SARS coronavirus-2 (SARS-CoV-2) – COVID-19.
- Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths
- Medical Examiner Service.

Patient Experience

- Complaints and Concerns & Compliments.
- The Parliamentary Health Service Ombudsman (PHSO)
- Friends and Family Test (FFT) & Care Opinion
- National Survey Results

The Patient Safety Incident Response Framework (PSIRF)

The PSIRF sets out significant changes to the approach taken by the NHS in response to patient safety incidents. PSIRF provides guidance for organisations on how to respond to patient safety incidents, defined as *"unintended or unexpected incidents which could have or did lead to harm for one or more patients receiving healthcare."* The opportunity for learning is a key area of focus in the new approach advocated by PSIRF and some incidents will qualify for a Patient Safety Incident Investigation (PSII) based on national and local priorities (more information on these included below), but it is recognised that there may be other alternative proportionate responses (e.g., 'being open' conversations; after action review; and audit) as well as some incidents where 'local management will be appropriate. The selection of incidents to be investigated as PSIIs will be based on the opportunity for system-based learning. However, there are incident categories for which a PSII is nationally mandated, known as National Priorities (such as Never Events).

In line with the requirements of the National Patient Safety Strategy, the Trust commenced the transition from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) on 6th November 2023. In advance of the transition to PSIRF, the Trust sought to identify local priorities as part of the development of a patient safety incident response plan (PSIRP). The Trust reviewed a range of information held within the organisation including:

The Trust also engaged with a range of stakeholders including staff, governors, patient representatives and the Integrated Care Board (ICB). As a result of the analysis and engagement undertaken, the Trust identified and agreed five local PSIRF priorities:

1. Delayed recognition of a deteriorating patient, due to gaps in monitoring (including all pregnant women).
2. Delayed, missed or incorrect cancer diagnosis.
3. Prescribing or administration error or near miss of anticoagulation medication.
4. Adverse Discharge due to gaps in communication or misinformation.
5. Delay in responding to a critical pathology finding.

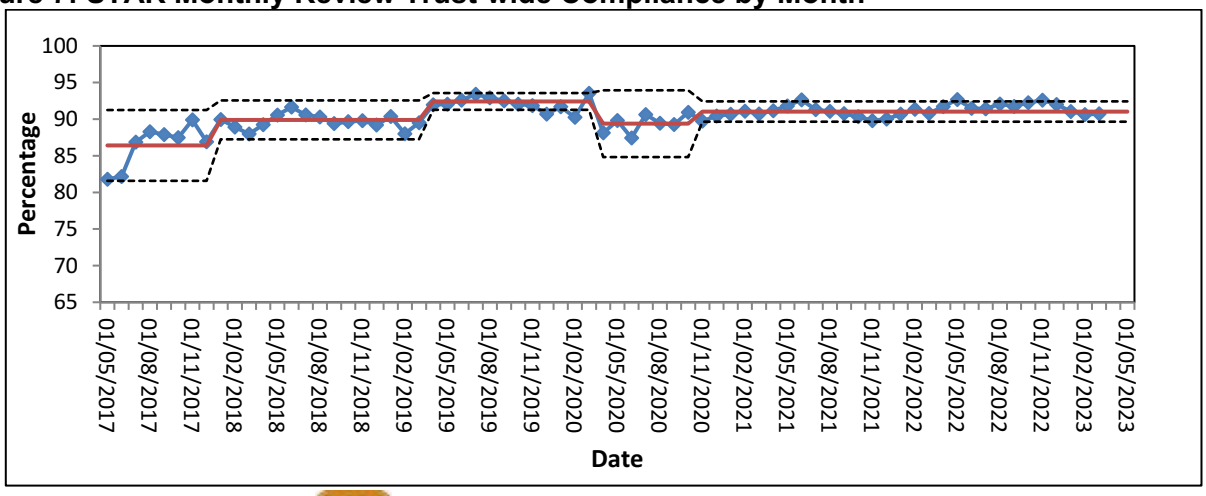
A PSIRF policy and the Trust's Patient Safety Incident Response plan was developed and approved at the Board of Directors meeting in October 2023. The Trust plans and polices were also endorsed by the ICB Quality Committee on 18th October 2023. Implementation of PSIRF was undertaken in two phases:

- Phase 1 was implemented on 6th November 2023 and included implementation of patient safety incident investigations (PSIIs) for any patient safety events that met National and Local priorities.
- Phase 2 was implemented on 25th March 2024, which included implementation of all learning responses.

Safety Triangulation Accreditation Review (STAR)

The STAR Quality Assurance Framework is the audit, assurance and accreditation system for the organisation. STAR is reported as part of the accountability framework into Divisional Improvement Forums, in Safety and Quality Committee and as part of the Big Plan to Board. Of the 126 clinical areas registered, there has been an increase in silver ratings from 76% to 82% in the reporting period, which has exceeded the Big Plan aim of 75%. Despite the challenges of the past two years of the COVID-19 pandemic, a further 25 areas have achieved gold awards, 54 in total, which demonstrates consistency in standards and evidence the clinical teams have shared learning with peers. The monthly audit of fundamentals of safety provides insight into activity at department level on a monthly basis. The focus moving into the next year is on raising standards within the inpatient and Emergency department settings.

Figure 7: STAR Monthly Review Trust-wide Compliance by Month

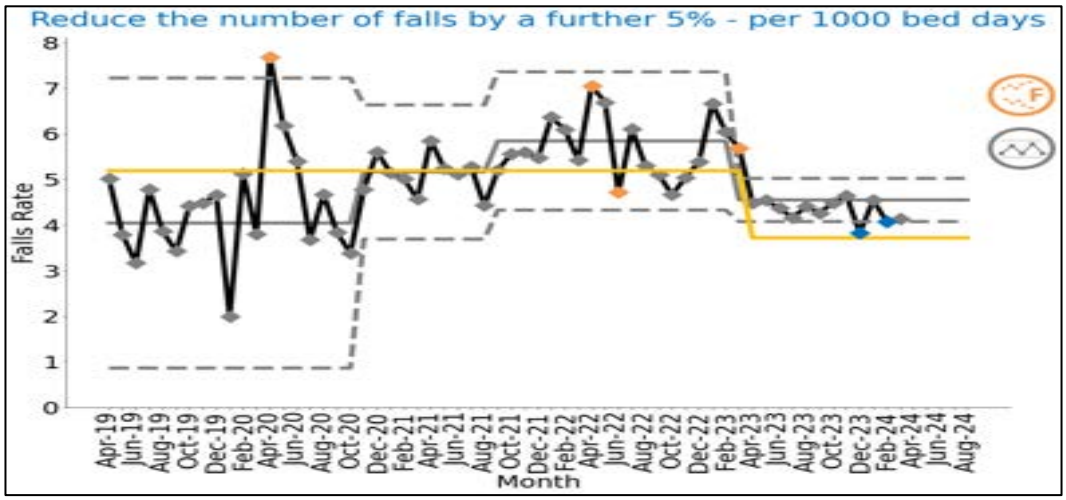


Falls Prevention

Falls prevention continues to be one of our key priorities for improvement and Our Big Plan target is to achieve a year on year 5% reduction in falls. Falls prevention will be included within the Single Improvement Plan from 2024 onwards. In this reporting period improvements have included commencement of a Falls Prevention Big Room using continuous improvement methodology, developed through the Flow Coaching Academy and Falls Prevention Champion role for teams to drive improvements in falls prevention within the Divisions.

The end of year falls data demonstrates a reduction in the overall number of inpatient falls; there were 1443 inpatient falls (Inpatients, not including Community Healthcare Hub or Finney House Residential, assisted/faints/collapses/seizures removed) during 2023-24, in comparison to 1590 inpatient falls the previous year, which is a 9.26% reduction. The total number of falls with major and above harm (severe, death) was increased; there were 17 inpatient falls resulting in major or above harm, compared to 12 the previous year. It is noteworthy that there has been an increase in the number of patients using our services and overall occupancy levels in the hospital, therefore the approach to measurement is to assess this per 1000 bed days. The falls per 1000 bed days is demonstrated below in figure 8 and demonstrates a more stable position than crude numbers only.

Figure 8 - Total Inpatient Falls/1,000 bed days – April 2019 to March 2024 (excluding Finney House Community Healthcare Hub and Finney House Residential)



Source: LTHTR data

The Trust's Our Big Plan falls prevention target for 2023-24 was to achieve a year on year 5% reduction in inpatient falls. This was achieved during 2023-24.

There were 177 falls reported within the Community Healthcare Hub and Finney House residential for 2023-34 (assisted falls/faints/collapses/seizures removed), of which 3 resulted in severe or above harm.
These were reported as:

- Buttercup - 72 falls (includes 1 with severe harm)
- Meadow - 71 falls (includes 1 with severe harm)
- Orchard (residential) - 34 falls (includes 1 with severe harm)

The Community Healthcare Hub has a relatively high proportion of patients with frailty who medically optimised but need further support and assessment or rehabilitation prior to discharge. It is expected that the rehabilitation process involves a balance of risks for the patients preparing for independence following discharge. A thematic review has been undertaken and a falls prevention action plan has been developed for Finney House.

We continue to prioritise falls prevention as part of our Always Safety First Strategy.

Safeguarding

Lancashire Safeguarding Adult Board and Children's Safeguarding Assurance Partnership

As per statutory requirements the Trust holds positions for a Head of Safeguarding, Named Doctor for Safeguarding Adults, Named Doctor for Safeguarding Children, Named Nurses for both adults and children and a Named Midwife. The Trust employs a Matron for Mental Health, Learning Disabilities, Autism and Dementia within the safeguarding team, ensuring the safeguarding/vulnerable people agenda has nursing/midwifery senior leadership and strategic direction across all portfolio areas.

Maternity Annual Safeguarding Activity

During the past 12 months there has been a significant increase in the overall safeguarding activity within Maternity in comparison to the previous year. There has been a 10% increase in the number of referrals to the Enhanced Support Midwifery Team (ESMT) with the number of out of area referrals being consistent with the previous year. There has been a 54% increase in the number of cases referred to Children Social Care (CSC) from 106 in 2022-23 to 194 in 2023-24. The number of Female Genital Mutilation (FGM) referrals have increased by 45% in comparison to the previous year. The referrals to the Specialist Perinatal Mental Health team have increased by 39% from 154 to 252 in comparison to the previous year. The team have completed 69 mental health and wellbeing plans over the past 12 months which is consistent with the previous year.

The ESMT have made 29 referrals to the Reproductive Trauma service over the past 12 months in comparison to 19 from the previous year. The ESMT have had 207 domestic abuse notifications over the past 12 months in comparison to 176 from the previous year, 99 of these cases were heard at the Multi-Agency Risk Assessment Conference (MARAC). The Trust have now appointed a hospital independent domestic violence advisors (IDVA) and a hospital Independent Sexual Violence Advisor (ISVA) who have supported the ESMT in caring for these women to ensure their safety and ensure they receive the support they require at the right time.

Safer Sleep

A safer sleep risk assessment tool has also been introduced within Maternity, Neonatal Intensive Care Unit (NICU) and NICU outreach, paediatrics, urgent care, and the Emergency Department. Safer sleep guidelines have been developed to support staff to undertake safer sleep discussions with parents/carers and ensure consistent advice is being provided by professionals across Pan-Lancashire. Audits have been completed in Maternity and NICU which have provided significant assurance of compliance and the quality of assessments being undertaken. A briefing and Standard Operating Procedure (SOP) has been produced regarding mothers being admitted to adult wards for treatment accompanied by their babies following several women being admitted for treatment with their well-baby. These mothers are usually breast feeding or have no one else to care for their baby. The briefing outlines what actions should be taken to support these women and provide safe care including advice regarding safer sleep. The ESMT and the wider Trust promoted Safer Sleep week on the 11th – 17th March 2024 across all social media channels and displays were created in each relevant area across the Trust. The Safer Sleep Project team were selected in the final three for the Best Safety Initiative award from the Trust's Our People Awards.

ICON Programme

The ICON programme (Babies Cry, You Can Cope) is a Child Death Overview Panel (CDOP) campaign which aims to help parents and carers to cope with a crying baby. The recommendation for resources came from several infant deaths and serious case reviews where a baby has died or been seriously injured because of Abusive Head Trauma (AHT). The Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership, and the Pan-Lancashire CDOP have raised awareness of key messages and resources to let parents and carers know that infant crying is normal and there are methods which can be taken to cope.

Messages were shared as part of ICON week 25th – 29th September 2023 across the Trust and Pan-Lancashire, which included lighting up the Maternity Unit, Preston Market, the Trust's Emergency Department, and Blackpool Tower in the ICON colour to raise awareness. The Trust engaged North West Ambulance Service, Enterprise, Midwifery, the wider Trust, footballers from Preston North End, Burnley, Blackburn Rovers, and University of Central Lancashire (UCLAN) to record videos and messages to raise the ICON message on all social media channels.

Articles were also published in the local press to raise awareness of ICON. The Named Midwife was also interviewed on 'That's TV' to raise the importance of the ICON messages. The Named Midwife for Safeguarding has worked in conjunction with UCLAN to ensure that the ICON learning package is now part of the Midwifery core training.

Safeguarding Audit Activity

Adults

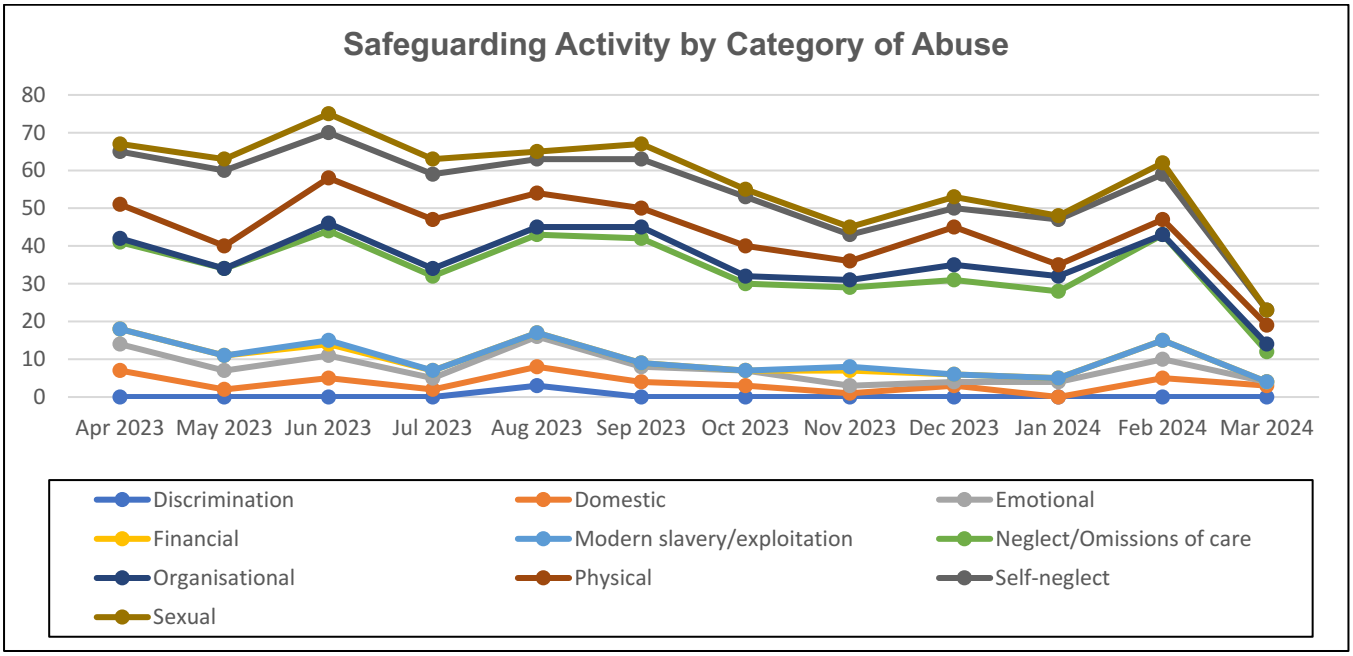
The adult pathway of the Trust Safeguarding Team has expanded over the last year due to specialist commissioning from the Police and Crime Commissioner and the Violence Reduction Network. As a

result, three new posts have been commissioned through the Police crime Commissioner: a Health Independent Domestic Violence Advisor (HIDVA), a Health Independent Sexual Violence Advisor (HISVA), and an Emergency Department (ED) Navigator. The team work as part of the Lancashire Violence Reduction Network whose aim is to facilitate a system-wide trauma-informed approach to making Lancashire a safer place to live, work and visit.

Safeguarding Activity

The Figure 9 below shows a summary of the safeguarding activity reported via Datix in the last 12 months, broken down by categories of abuse.

Figure 9 Annual Total Adult Safeguarding Activity



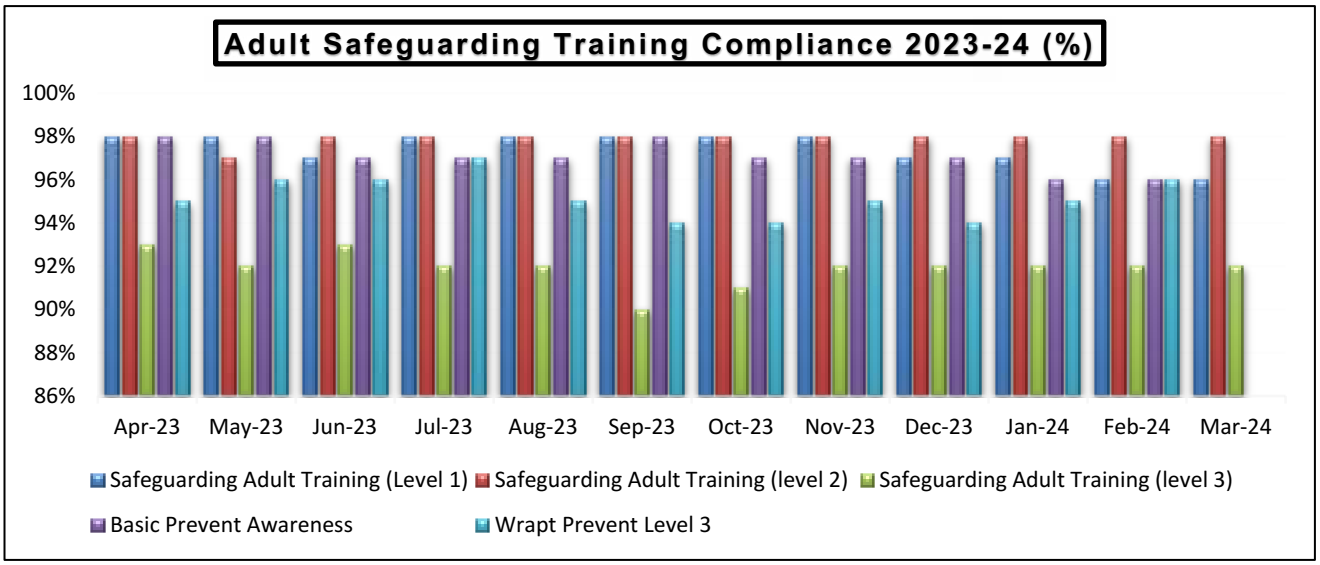
Managing Allegations Persons in Position of Trust (PiPoT)

The Deputy Chief Nursing officer is the named PiPOT for the organisation. The Safeguarding Team support workforce and the Divisional Teams in managing allegations against staff when there is a risk of harm to patients, staff, or organisational reputation.

Safeguarding Adults and PREVENT Training

Figure 10 below shows the figures for safeguarding adults and PREVENT training compliance over the previous 12 months.

Figure 10 Adult Safeguarding Training



Safeguarding Supervision

Twenty members of staff across the Trust attended the Bond Solon Bespoke safeguarding supervision training and are now supporting safeguarding supervision across the Trust.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

Trust wide MCA and DoLS Activity

The MCA/DoLS - Always Safety First project has successfully achieved an electronic MCA/DoLS pathway throughout the patient's journey during admission/attendance as per the requirements of the Mental Capacity Act (2005). The system design implemented captures cognitive assessment, best interest decision making, least restrictive practice and deprivation of liberty.

Figure 11 RPH Number of DoLS Applications

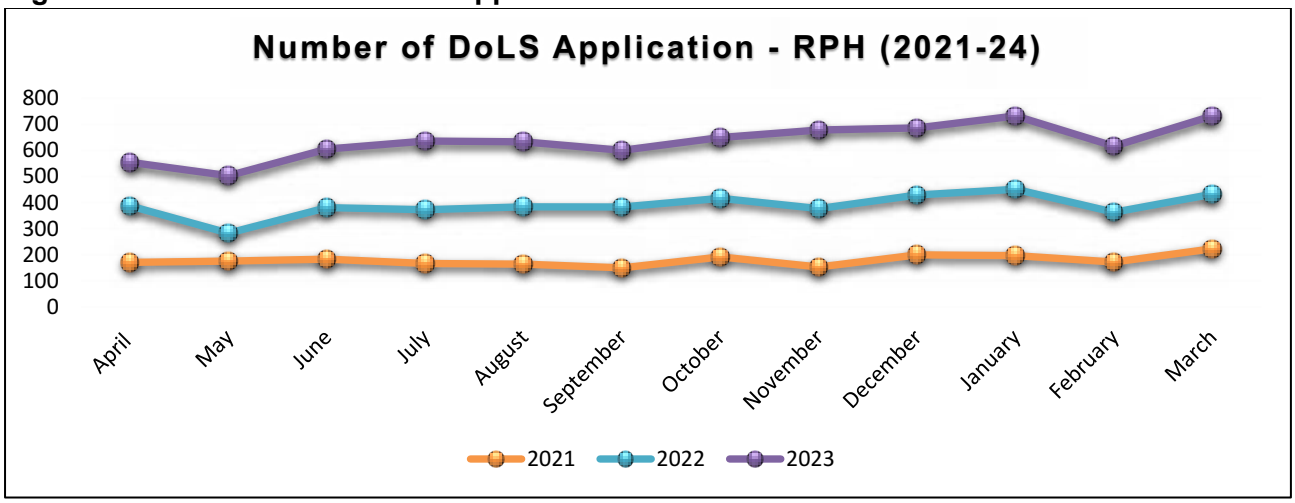
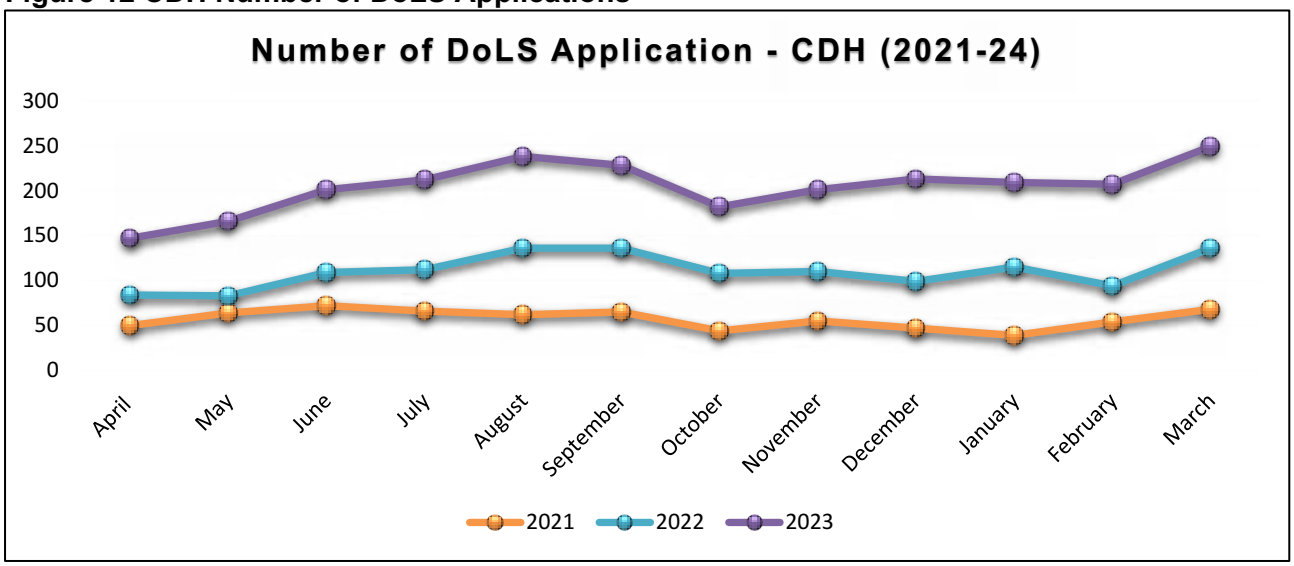


Figure 12 CDH Number of DoLS Applications



The data in Figures 11 and 12 demonstrate a year-on-year improved position in relation to the Trust upholding the principles of the Mental Capacity Act (2005). Both graphs demonstrate a continued increase in DoLS applications over a 3-year period. The 49.5% increase in activity is a positive reflection in the growth of the staff's ability to recognise additional vulnerabilities and act in accordance with the principles determined through the legislation.

Mental Health, Learning Disabilities, Autism and Dementia

The mental health, learning disability, autism, and dementia team works with some of our most vulnerable patients accessing healthcare within the Trust. The team drives continuous improvement initiatives, works to increase staff knowledge and skills, ensures compliance with the Mental Health Act (MHA) and the triangulation of other statutory requirements (such as the Mental Capacity Act and Children's Act), sits within the safeguarding team, and drives positive patient experience. The team has a High Intensity User Lead within the service and holds the role of Special Education Needs and Disabilities (SEND) champion within the Trust.
The team have focused on the following areas as part of their work this year.

- Special Education Needs and Disabilities (SEND)
- Learning Disability and Autism
- Learning Disability and Neurodiversity Training
- The Learning Disability Plan was launched June 2023
- The Autism plan has been completed and is due to be launched
- Mental Health Risk Tool (MHRT) Audit compliance
- Dementia assessment and treatment
- Delivery of the dementia strategy
- Development and pilot of a Dementia Toolkit for acute hospitals
- The High Intensity User service
- Trauma Informed development
- Rapid Tranquilisation policy and assurance
- Review of Tier 2 face to face Dementia training

Children and Young People

Summary of Safeguarding Activities

- Safeguarding supervision has continued to be embedded across paediatric areas with a focus on priority topics this year.
- Monthly audits continue of the safeguarding checklist across ED (0-15 years old, and 16-17 years old) and paediatric and adult assessment units.
- A new guideline, 'Safeguarding Guidance for assessing the risks to patients (adult and child) from dogs and dog bites' was compiled in recognition of the number of patients attending with bites, particularly to the Surgical Assessment Unit (SAU).
- A new guideline was completed, 'Admission of babies or children to adult wards when a parent or carer is admitted'.
- Focus on the 'Was Not Brought' Pathway.
- The Paediatric Liaison Form has been updated to include the voice of the child, additional demographics, and information important for the 0-19 team to follow-up the child adequately.
- 7 Minute Briefings formulated by the Children's Safeguarding team include 'Bruising in Non-Mobile Babies/Children', 'Professional Curiosity' and 'Risks to Children from Drowning at Home – Water Safety'. These have been formulated in relation to serious incidents that have occurred.
- Leaflets for bathtime safety are now available as push notifications on BadgerNet when a child is discharged from post-natal ward.
- Work has commenced in relation to obtaining demographics and awareness of the 'Hidden Male' with the Children's Community Nursing Team updating their assessment documentation to reflect all those present in the child's home when visiting.
- A bespoke training session has been facilitated by the Children's Safeguarding Team with the Local Authority Designated Officer (LADO) for all staff across the Trust, including Workforce, Security, and all Divisions. There is an upcoming session planned for May 2024.

Figure 13 Child Safeguarding Training Data (Trust wide)

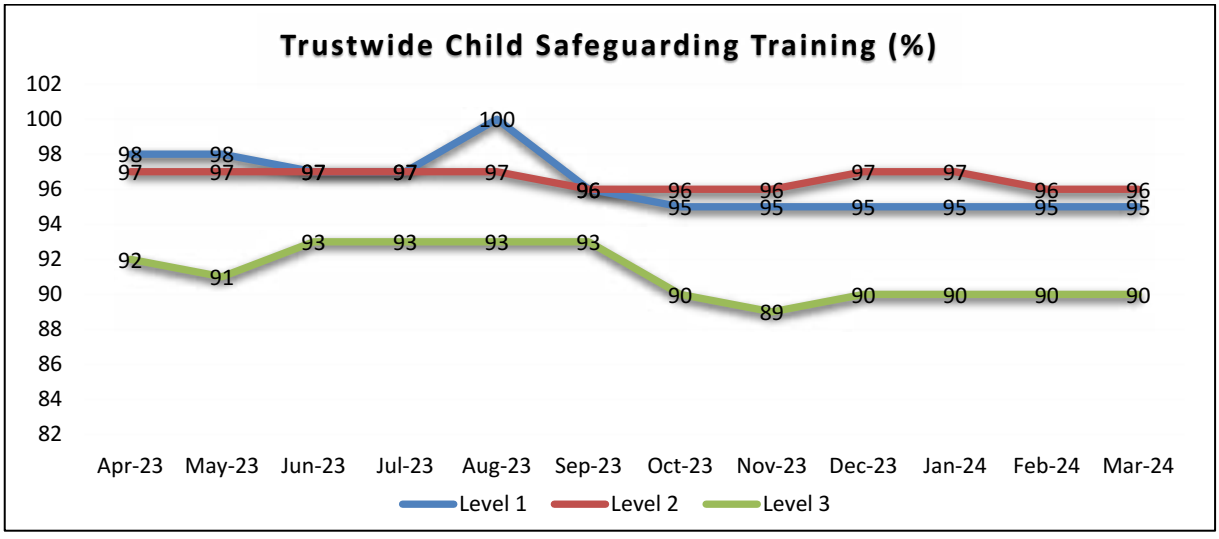


Figure 13 above shows Trust wide annual child safeguarding training levels 1 to 3. The training packages and training needs analysis are in accordance with the requirements of the Royal College

of Nursing (RCN) *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (2019). Child safeguarding training across Levels 1 and 2 has remained 95% and above, with Level 3 remaining compliant at above 90% overall.

Children's Social Care Referrals

Referrals to Children's Social Care have increased in comparison to the previous year, with a third of the year showing over 20 referrals per month as opposed to less than 20 the previous year. In comparison to the previous year (183 referrals in 2022-23 and 242 in 2023-24) there has been a 32% (n=59) increase in referrals to Children's Social Care. This increase potentially reflects staff awareness and professional curiosity when a child may be at risk or in need of support.

Child Deaths

There has been a total of 28 deaths between April 2023 and April 2024, and 61% (n=17) of these deaths were unexpected and 39 % (n=11) were expected, of these expected deaths, 64% (n=7) were neonatal deaths and the additional deaths were in other departments. There has been a 26% (n=6) decrease in unexpected deaths in comparison to the previous year, with expected deaths remaining the same as the previous year. Unexpected deaths have included Sudden Unexplained Death in Childhood (SUDC) and sadly, several children who have completed suicide or been the victim of significant trauma (accidental and non-accidental). A Trust '7 Minute Briefing' was shared in response to the National Child Mortality Database (NCMD) Report (2023) into traumatic deaths of children and young people.

Incidents

Trust staff are proactively encouraged to report all incidents including near misses and no harm to enable increased opportunity to identify themes and trends before harm occurs to patients. Our incident data with associated levels of harm from incidents in 2023-24 are presented in table 16 below. Whilst the percentage of incidents with a harm level of moderate and above is 3% of all incidents reported the Trust continues to respond with actions and learning in order to reduce incidents across all levels of harm.

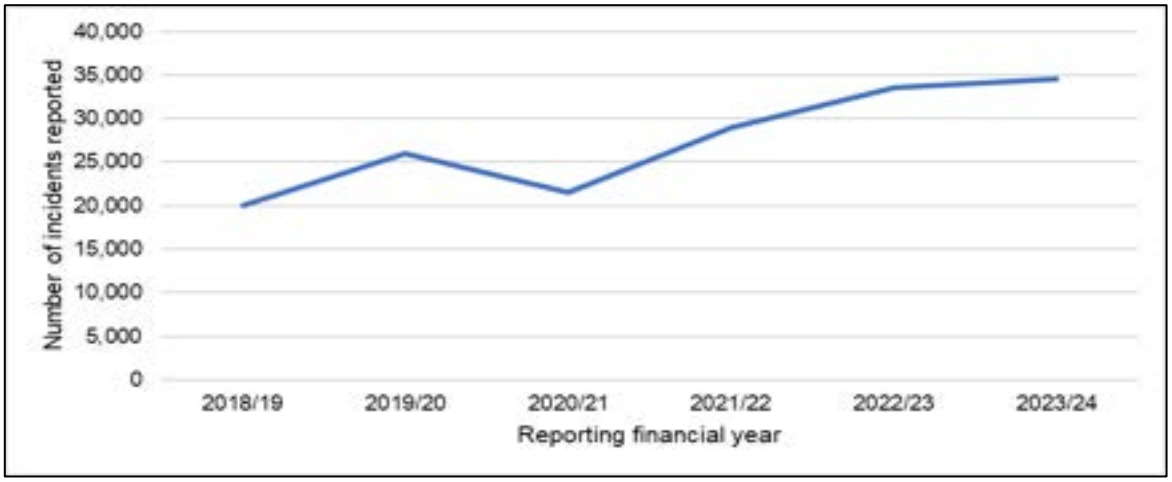
Table 16 Level of Harm Related to Incidents 2023-24

Level of Harm	Number of Incidents Reported
No Harm	24,406
Low Harm	9,072
Moderate Harm	929
Severe Harm	78
Death	33
Total	34,518

Source: LTHTR Datix data

The Trust's incident reporting has over successive years continued to improve which is demonstrated in figure 14 below.

Figure 14 Incidents Reported 2018-19 to 2023-2024



Source: LTHTR Datix data

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They can lead to serious adverse outcomes and can damage patients' confidence and Trust. All Never Events are subject to either a serious incident review (under the previous Serious Incident Framework) or considered for a Patient Safety Incident Investigation (under the new PSIRF framework that was implemented within the Trust from 6th November 2023) and reported to the local ICB as well as nationally to incident reporting systems where learning can be shared across the country. Of the three never events in the reporting period April 2023 to March 2024, two of the incident investigations have been completed and the third has a patient safety incident investigation (PSII) in progress.

The Trust has an Always Safety First work stream to review actions from all Never Events both for compliance with initial target completion dates and for quality of evidence. Never Events have been added to our 'Learning to Improve' programme to ensure that actions and learning are embedded over time and participation in a regional learning event has taken place to share learning across organisations.

Table 17 Never events incidence April 2023 to March 2024

StEIS ref	Datix ID	Incident Date	Division	Category	Level of Harm	Status
2023/11484	123788	07/06/2023	Surgery	Wrong site surgery	Moderate	Investigation completed
2024/2222	149449	31/01/2024	Surgery	Wrong site surgery	Low	PSII ongoing
2024/2223	149503	01/02/2024	Surgery	Incorrect Naso-gastro tube placement	No Harm	After Action Review completed

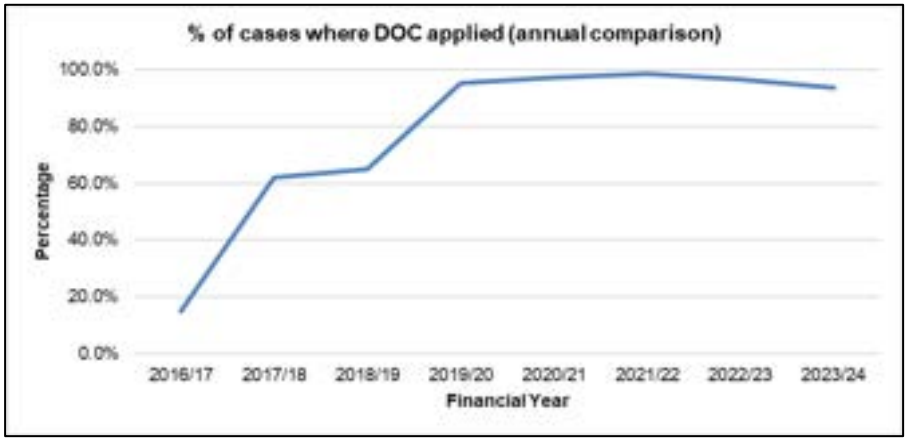
Duty of Candour

Duty of Candour is a regulation that has been applicable to health service organisations since November 2014 in response to the Francis report (2013) which stated that *"any patient harmed by the provision of health care service is informed of the fact and an appropriate remedy offered regardless of whether a complaint has been made or a question asked"* (Francis 2013).

In the year 2023-24 the Trust identified 937 cases where Duty of Candour was applicable. This is a decrease (23.1%) in cases since the previous financial year. The financial year of 2022-23 was much higher than historic financial years due to hospital-acquired COVID-19 cases which have required Duty of Candour.

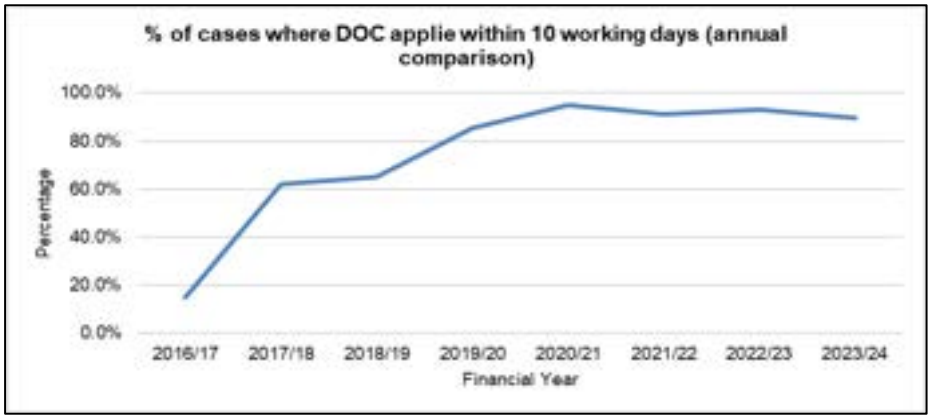
Of those 937 cases, Duty of Candour has been applied to the patient or next of kin either verbally and/or in writing on 877 occasions (93.6%). Of the remaining 60 (6.4%) all have documented validated reasons as to why Duty of Candour has not been carried out.

Figure 15 Percentage of Cases with Duty of Candour Applied (Annual Comparison)



Source: LTHTR Datix data

Figure 16 Percentage of Cases with Duty of Candour Applied in 10 Working Days



Source: LTHTR Datix data

Whilst Figure 16 demonstrates a trend of improvement between 2016/17 and 2020/21 regarding timely application of Duty of Candour, there was a slight decrease in compliance with application of Duty of Candour within 10 working days.

In 2023-24 there has been a further decrease in compliance with application of Duty of Candour within 10 working days and work is underway to improve this through enhanced education, improvements in documentation facilities and enhanced monitoring in line with the implementation of PSIRF.

Review of Quality Performance - Effective Care

The Trust aims to continually provide effective care and treatment by ensuring clinical practice is evidence-based against national standards and clinical research. Being involved with national quality and benchmarking programmes including GIRFT gives us opportunities to benchmark our services and improve our outcomes. Tissue viability and pressure ulcer prevention, nutritional support, management of medications and infection prevention and control are critical to the effective care and treatment of our patients.

We monitor our mortality benchmarking data to ensure there are no emerging risks and we also learn from the deaths of patients to inform change and improve practice where required. The Medical Examiner service provides an independent review of the care and treatment of patients who have died in our Trust. Requests from the Medical Examiner to undertake a SJR Mortality Review or Serious Incident Investigation (or consider for a PSII under the PSIRF model) are responded to and learning shared.

The following sections provide details on a number of areas that support the Review of Quality Performance.

Getting it Right First Time

The GIRFT programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

The Trust recognises the opportunities that the national GIRFT programme provides and the benefits it will bring to the services provided. This quality improvement programme encompasses a wide range of clinical pathways, and it enables us to benchmark with other similar hospital services and share the learning.

The GIRFT visits to the Trust commenced in 2016, completing 48 visits across 32 specialties, 12 of which were revisits. Learning from the pandemic, GIRFT has now transitioned to a Regional Gateway Review, to facilitate a systems approach to improving patient care and experience, providing opportunities to develop pathways. To enhance this approach, in January 2023, a Lancashire and South Cumbria GIRFT Oversight Group was set up to enable access to a wider network of support and shared learning.

Tissue Viability – Pressure Ulcer Incidence and Prevention

Pressure ulcer incidence is recognised worldwide as an indicator of safety and quality and reducing pressure ulcers has been and continues to be a priority for improvement in the care of our patients.

Pressure Ulcers

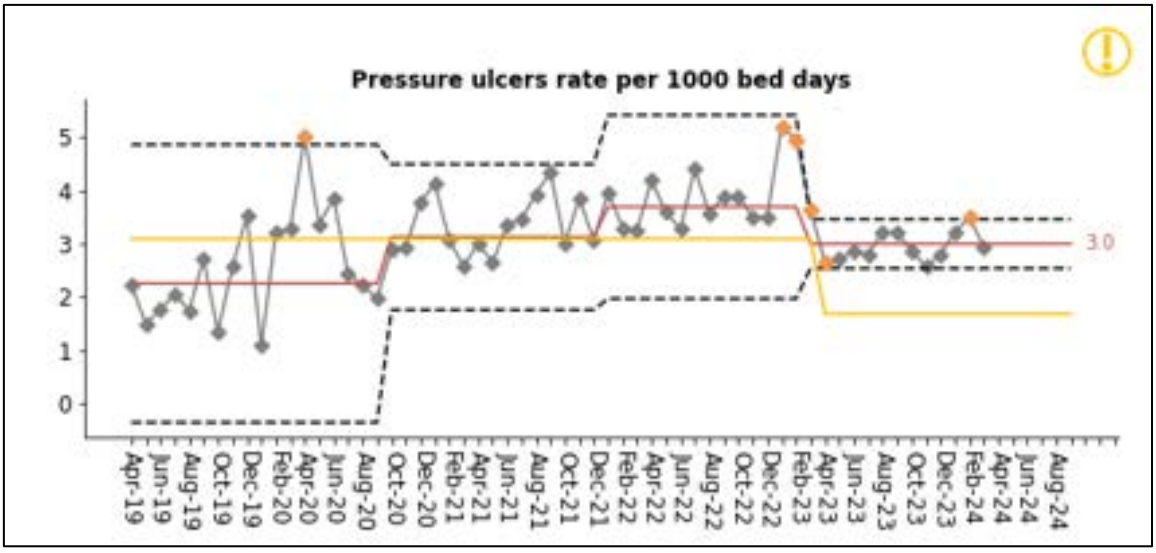
The Trust acknowledges that there has been an increase in the overall number of patients with pressure ulcers since 2018. The reason for this is multifaceted which includes the complexity and frailty of patients admitted to the Trust, increased number of patients admitted to hospital, increase in length of stay within the Emergency Department (ED) and increased bed capacity of the Trust. Consequently, pressure ulcer incidence is an area of improvement incorporating the new national wound care strategy programme recommendations. The improvement programme is focused on the delivery of:

Pressure ulcer improvement strategies also include:

- E-learning will now be completed once every 2 years to keep staff up to date on pressure ulcers, assessment and prevention. There will be two e-learning packages – one for staff who complete a risk assessment, and one for staff who do not.
- Continuous improvement program around the testing of a repositioning application on a smart device.
- The Datix system is inclusive of patients in the pressure ulcer review process to improve patient involvement in the review and learning process.
- Tissue Viability Nurse (TVN) attendance at nutritional and decondition Big Rooms, looking at malnutrition universal screening tool (MUST) and weight compliance to identify patients requiring additional nutritional support.
- Working with the ED reviewing equipment, training for staff, developing professional links within the department.
- Review of any incident that raise concerns with divisional governance and senior leadership team.
- Weekly in-depth divisional review of all Trust acquired pressure ulcers.
- Monthly Divisional Always Safety-First meetings focusing on shared learning.
- TVN link practitioner days (twice yearly).
- Pressure ulcer prevention training for healthcare assistance on induction.
- Pressure ulcer prevention champions training each.
- Student spoke days with the TVN's once a week.
- Student training sessions for each year of their training, 1st, 2nd and 3rd year on pressure ulcer prevention and complex wound management.
- Introduction of teaching in the preceptorship programme.
- Ward specific training and attending ward away days.
- Work around PSIRF and the pressure ulcer review process.
- The continue use of clinical areas taking photographs of pressure ulcers at the time identified.

When monitoring pressure ulcers within the Trust it is important to correlate the numbers of incidents that have occurred with the Trust activity in bed days. This is done by analysing pressure ulcer incidents per 1,000 bed days allowing for that comparison of incidents and Trust activity. Please see Figure 17 for Pressure ulcer rate per 1,000 bed days.

Figure 17



Nutrition for Effective Patient Care

The provision of high-quality nutritional support is complemented by our 7-day Integrated Nutrition and Communication Service (INCS) who have led and supported a number of key initiatives in previous years, many of which are now well embedded in daily practice. INCS comprises of the Nutrition Nursing Team, Dietetics, Speech and Language Therapy, Central Venous Access team and the Tobacco and Alcohol Care team, previously known as the Hospital Alcohol Liaison Service.

One of our aims continues to be to ensure that patients admitted to the Trust who remain for more than 48 hours (excluding maternity and day-case patients) have a nutritional screening assessment on admission. The assessment is carried out using the Malnutrition Universal Screening Tool (MUST) developed by the British Association for Parenteral and Enteral Nutrition. The screening tool highlights patients who are already malnourished or at risk of malnourishment and determines the need for referral for a more detailed nutrition assessment by a dietician or an alternative nutritional care plan. This is monitored as part of the STAR quality assurance system.

Medication and Incident Monitoring

Medicines Safety

Medication errors are a major concern for patient safety in the UK healthcare system, with a report from the Care Quality Commission (CQC) indicating that medication safety incidents are the most commonly reported safety incidents in healthcare settings. In 2019-20, medication errors were a factor in 29% of patient safety incidents reported to the CQC. To address this issue, the Medicines and Healthcare Products Regulatory Agency (MHRA) launched a campaign to raise awareness of medication safety risks.

At Lancashire Teaching Hospitals Pharmacy Department, medication safety is a major focus, with ongoing efforts to enhance systems and processes to minimise the occurrence of medication errors and their impact on patient safety. The Pharmacy Medication Safety team is actively involved in fostering a culture that encourages incident reporting, in line with the principles of the Patient Safety

Incident Response Framework. The Trust's incident reporting system enables prompt reporting, thorough investigation and recording of medication errors and learning actions which have been taken.

From April 2023 to March 2024, medication incidents represented an average of 8.83% of all reported Trust incidents, with an average of 258 incidents reported per month. This reflects an 8.4% increase compared to the previous year's monthly average of 238 incidents, which demonstrates a positive reporting culture.

Data from the Model Hospital dashboard reveals that the national average for reported medication incidents causing harm stands at 11%. However, throughout the 2023-24 period, the Trust has consistently achieved a considerably lower rate, with reported medicine incidents causing harm at just 4.37%.

Figure 18 Number of Medication Incidents Reported

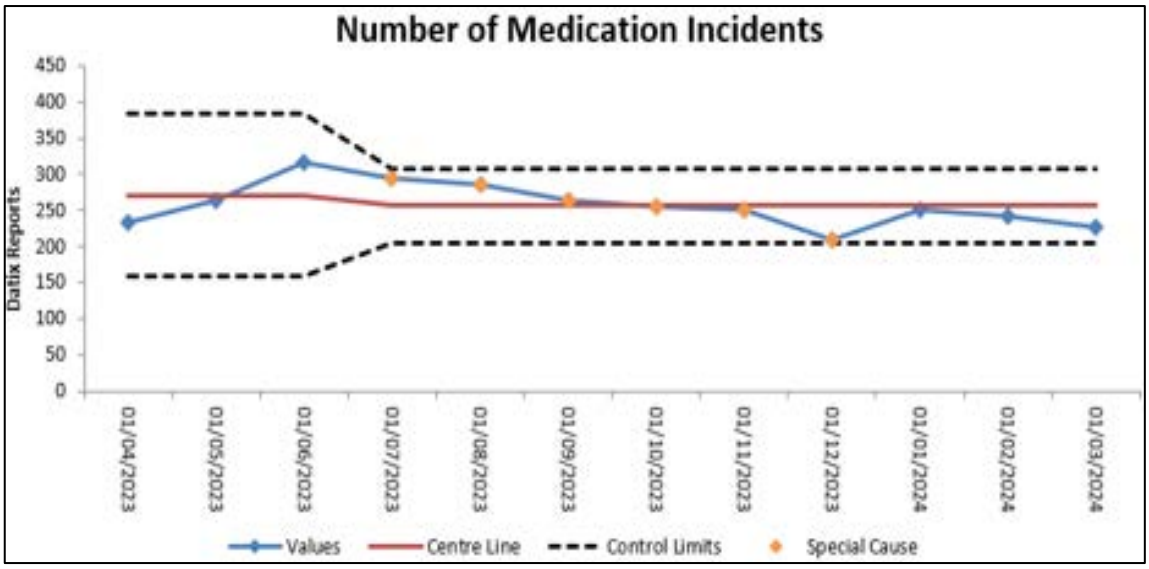
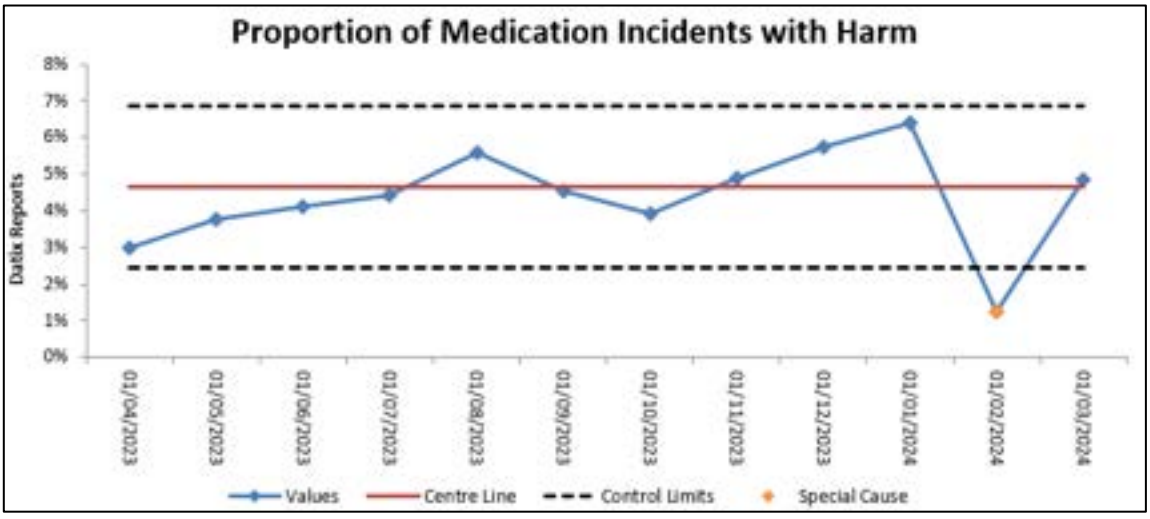


Figure 19 Proportion of Medication Incidents Leading to Harm



Source: LTHTR data

We have implemented a robust system for swiftly reviewing incidents of moderate harm or higher. This process is led by our Corporate Governance team through weekly meetings, with assistance from our Medication Safety Team and Divisional Governance Leads. We prioritise early interventions to make an immediate impact, identifying and disseminating important information even before formal investigations are concluded.

To proactively address medication safety, we actively share incident themes with relevant divisions, present Medication Safety reports during Always Safety First meetings, and maintain a network of Medication Safety Champions who convene monthly to exchange knowledge and serve as an educational platform. Our Medication Safety Team provides support to these champions.

On a monthly basis, we monitor our performance and report on harm and near miss patterns and trends to the Medicines Governance Committee. This committee follows a risk assurance reporting cycle aligned with our Trust's Risk agenda. This proactive approach to monitoring and sharing medication safety information enables us to continuously enhance our processes, mitigate harm, and ensure optimal outcomes for our patients.

Medicines Reconciliation

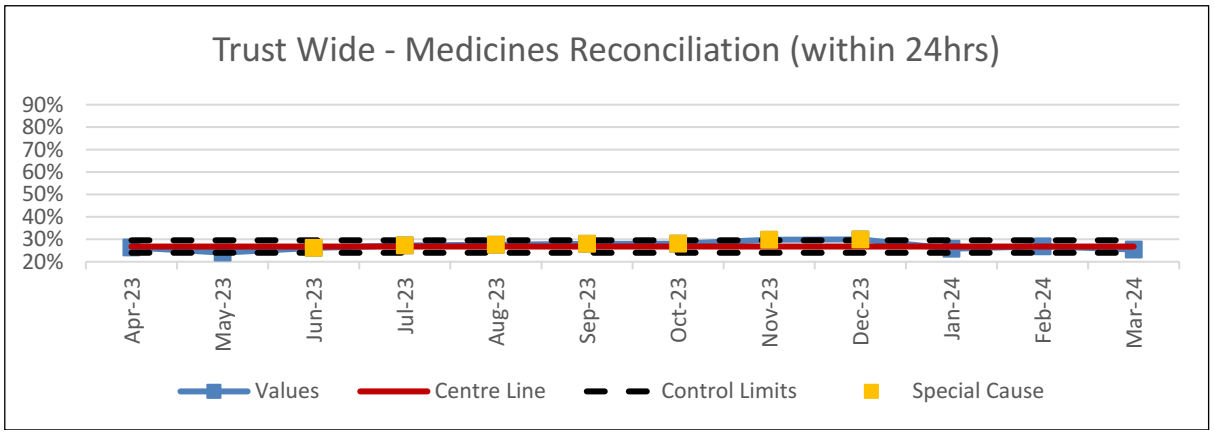
Medicines reconciliation is a critical process for ensuring patient safety during hospital admissions. It involves collecting and verifying information on a patient's medication history, including any changes made to their medication during on admission. The National Patient Safety Agency (NPSA) and National Institute for Health and Care Excellence (NICE) recommend that medicines reconciliation should be completed within 24 hours of admission.

Following the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system across the Trust, a pharmacy dashboard was developed within the Trust's Business Intelligence (BI) portal application. The dashboard uses data from the live EPMA system, which is updated every 15 minutes, to provide real-time information on medication-related processes.

In 2023-24, medicines reconciliation was completed within 24 hours of admission for 27% of patients, the significant decrease from 52% in 2022-23 is as described above due to the timestamp used. Factors impacting on performance relating to medicines reconciliation include pharmacy staffing challenges, such as vacancies (20% at junior pharmacist level), as well as additional unfunded beds due to patient flow issues across the system.

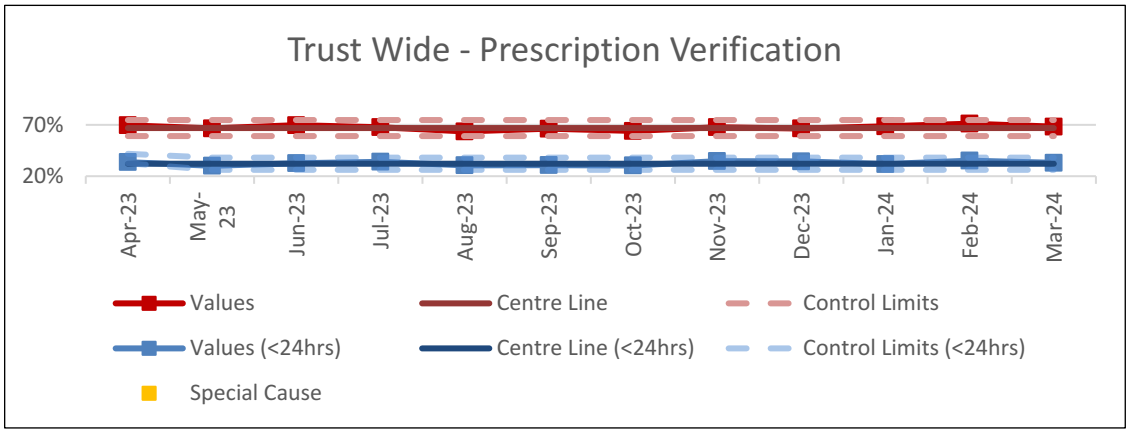
The variation in the 2023-24 data has led to a benchmarking survey within the ICB to check what other organisations use as the time point medicines reconciliation is completed. Three Trusts use the drug history documented and discrepancies communicated and one Trust the drug history documented. The former of these completion points aligns with the Royal Pharmaceutical Society hospital expert advisory group definition. Going forward into 2024-25, this definition will be adopted by the Trust. This is particularly important as we look to the best way to utilise staff. The medicines management technicians undertake a significant proportion of drug history documentation, enabling them to record the factual discrepancies will enable medicines reconciliation to be completed by this staff group and improve performance. To support patient safety a prioritisation whiteboard identifies patients prescribed any of the four high risk categories of medicines (antibiotics, anticoagulants, insulin and antiepileptics). Patients prescribed these medicines are prioritised for medicines reconciliation.

Figure 20 Medicines Reconciliation (within 24 hrs)



Source: LTHTR data

Figure 21 Prescription Verification



Source: LTHTR data

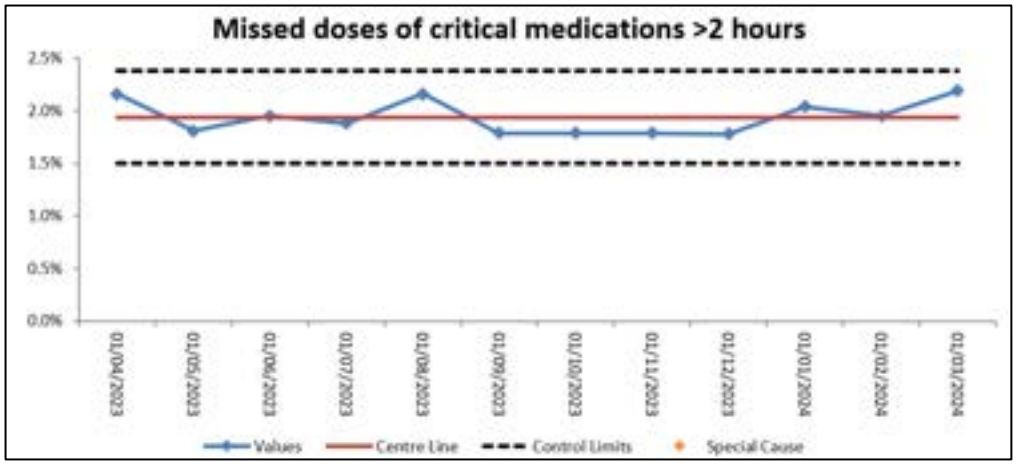
Our pharmacists play a vital role in assessing prescriptions for dose, legibility, interactions, appropriateness of therapy, formulary compliance, and legal requirements. However, we recognise that compliance with prescription verification within 24 hours has been a challenge, with the average compliance rate currently standing at 32%, down from 38% in 2022-23. On average, 67% of all live prescriptions are verified, down from 75% in 2022-23. Contributing factors include the ongoing increase of live prescriptions up by over 200 from the average in 2022-23. To mitigate patient risk the pharmacy teams, target high risk medicines with anti-epileptics and anticoagulants having verification sooner than the average medicine. Due to the frequent change of doses or formulation the other two high risk groups of insulin and antimicrobials remain a challenge.

Administering medicines

Ensuring the proper administration of prescribed medications is a crucial aspect of patient care within hospitals. However, we acknowledge that instances of missed doses have occurred in the UK, with some organisations reporting a rate exceeding 20%. Such occurrences can lead to suboptimal treatment outcomes and potential harm to patients. To address this, our Trust utilises data from an electronic prescribing and medication administration (EPMA) system to identify any missed doses. This information is then utilised by our pharmacy and nursing teams to take necessary action,

including administering the missed doses or documenting valid clinical reasons for their omission. Our Trust remains dedicated to continuously improving our medication administration procedures. Over a 28-month period since the start of the continuous improvement project we have seen a considerable reduction in missed doses with further reduction from 4% to 1.94% in the last year. This ongoing improvement project has resulted in better management of patient's medication and increased confidence in the safety and effectiveness of our medication administration processes.

Figure 22 Critical Missed Doses



Source: LTHTR data

Antimicrobial Stewardship

Our Antimicrobial Stewardship team conducts audits across all in-patient areas, with an automated data collection process facilitated by EPMA. All patients prescribed antimicrobials in every inpatient ward are included. The audit assesses compliance with documentation of antibiotic indications, compliance with the Trust's antimicrobial guidelines or Microbiology recommendations, and documented reviews within 72 hours.

Table 18: Antimicrobial Stewardship Point Prevalence Audit Results

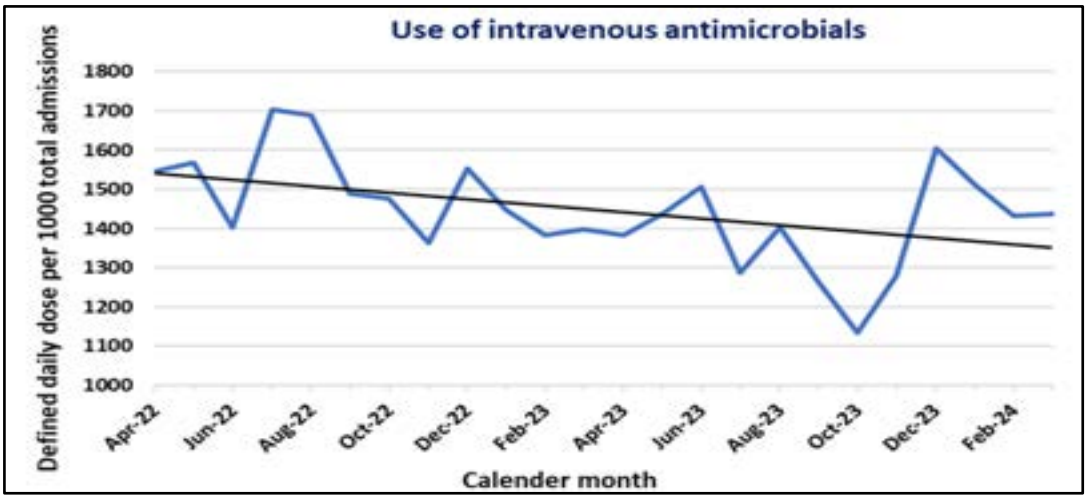
	Nº of patients on antibiotics	Nº of antibiotic prescriptions audited	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with guidelines or Recommended by Microbiology	% Compliance with documented review within 72hrs
Trust Wide Q4 2023-24	396	512	96%↑	89%↑	91%↑	97%↑
Trust Wide Q3 2023-24	341	437	95%↓	88%↓	90%↓	96%↑
Trust Wide Q2 2023-24	311	425	98%↑	91%↑	93%↑	86%↓
Trust Wide Q1 2023-24	351	465	95%↔	85%↓	88%↓	91%↑

Source: LTHTR data

Antimicrobial audit results are reported Trust-wide quarterly and specialities that achieve a red result in any of the three compliance areas are required to complete an action plan. The Antimicrobial Stewardship team offers support in the form of education/teaching or highlighting areas where good practice is not being followed.

A national focus for the past year has been timely intravenous to oral switch (IVOS) of antimicrobials. Our Trust has exceeded the IVOS Commissioning for Quality and Innovation (CQUIN) target of less than 40% of patients remaining on intravenous (IV) antimicrobials after meeting switch criteria, with results of 17%, 9%, 9% and 14% respectively for each consecutive quarter. We have seen a downward trend in use of IV antimicrobials as illustrated by the graph in figure 23 below and the focus on timely IVOS will continue.

Figure 23 Use of intravenous antimicrobials



Source: LTHTR data

Infection Prevention and Control (IPC)

Infection Prevention and Control (IPC) remains a key priority for Lancashire Teaching Hospitals. The IPC team continues to work closely with other providers across the health economy. a Consultant Microbiologist, currently holds the Director of Infection Prevention and Control (DIPC) role and the Matron for Infection Prevention and Control, is the senior nursing lead. The DIPC is supported by the Deputy Chief Nursing Officer, the IPC specialist nurses, and Microbiologists.

Overview of positive IPC outcomes

In 2023-24 the Infection Prevention and Control speciality has delivered a number of positive improvements including a stable leadership and a full complement of IPC nurses providing a 7-day service.

There has been one case of hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteraemia case.

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care. The Trust has met the national CQUIN target prompting a switch of intravenous to oral antibiotics for 2023-24 seeing a reduction in the 12-month trend for proportion of intravenous (IV) antibiotic use versus oral. The significant benefits of this have been shared widely across the Trust including reduction in patient length of stay and financial savings. The antimicrobial stewardship team work closely with the sepsis lead and a change in Trust guidance for first line antimicrobial options for sepsis of unknown source has supported a

reduction in cefuroxime usage which is linked to Clostridioides difficile infection (CDI) incidence. There is increased assurance of IPC and cleaning processes via the STAR accreditation process.

Figure 24 STAR accreditation compliance for Infection Prevention and Control

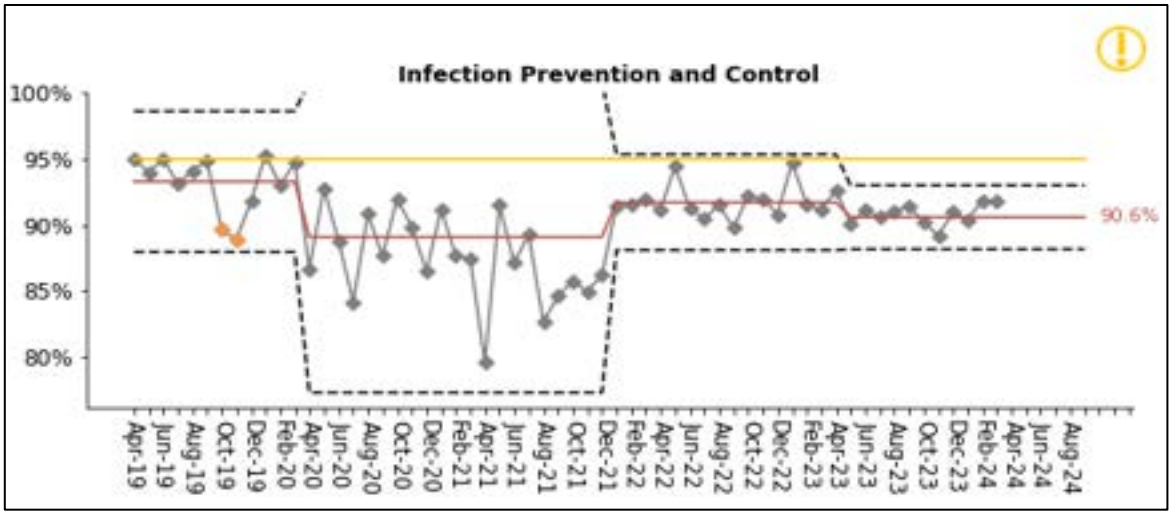
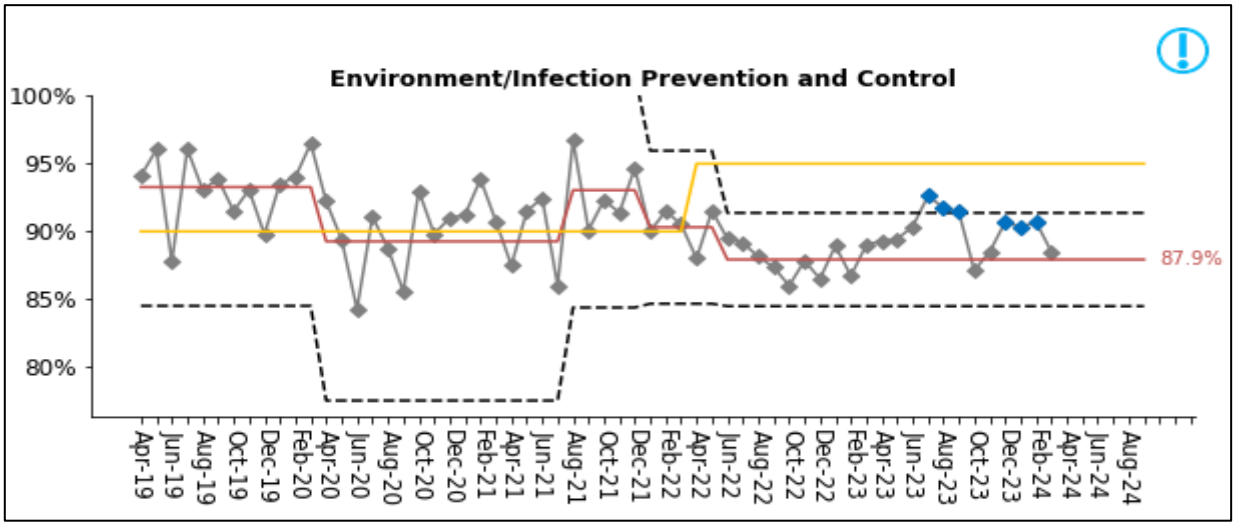


Figure 25 STAR accreditation compliance for Environment/Infection Prevention and Control



The infection prevention and control leads have ensured there are plans in place in response to the national measles outbreak with a measles policy formulated, Trust wide communications and scenario simulations to support staff with the actions required. The Trust target for IPC mandatory training is compliant and the Trust remains compliant with decontamination standards for decontamination of medical devices.

Overview of negative IPC outcomes

Challenges remain and during the year 2023-24 there has been an increase in Norovirus, Measles, extensively Drug Resistant Pseudomonas, and Influenza with the Trust and wider NHS operating under significant pressure as a result of the recovery following the COVID-19 pandemic.

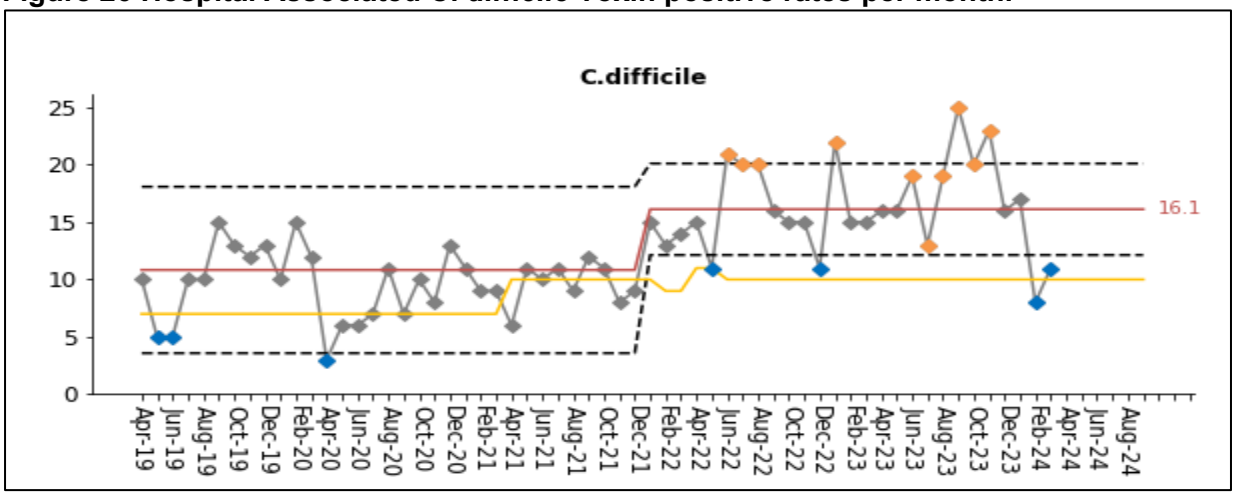
Clostridium *difficile*

The prevention of C. *difficile* infection remains a key priority for our organisation. In the year 2023-24, the national objective set by NHS England for the Trust was to have no more than 122 hospital associated cases. The Trust exceeded the national objective with an increase in hospital associated cases during 2023-24 in comparison to previous years with a total of 203 cases. This was a 3.6% increase from 2022-23 which had a total of 196 hospital associated cases.

Although the year 2023-24 saw an overall higher number of hospital associated cases, the number of Hospital Onset Hospital Acquired cases decreased compared to 2022-23 with a reduction of 12 cases. Improvement work remains focused on faecal testing, mitigating the risk associated with the low percentage of side rooms within the hospital through accurate and early identification and isolation of C. *difficile* in the patient's journey.

There has been a national increase in C. *difficile* infection and a significant proportion of Trusts nationally are above trajectory. In the North West 12/24 Trusts (50%) were over their objectives. However, it is to disappointing to report that the Trust ranks highest of major Trusts in terms of C. difficile rate per 100,000 bed days.

Figure 26 Hospital Associated C. *difficile* Toxin positive rates per month.



The improvement work to address the increase in cases includes;

1) Removal of cefuroxime for treatment of unexplained sepsis since July 2023 as this is a high-risk antibiotic.
2) Introduction of Tristel jet (sporicidal) for general cleaning on wards since September 2023
3) Introduction of ward staff cleaning checklist for items that require daily and weekly cleaning by ward staff since August 2023. Assurance of this is built into the STAR process.
4) Gradual roll out of national cleaning standards by domestic services (15 wards currently) with a proposal to continue with all inpatient wards, subject to investment.
5) Improvement in fogging compliance where *C. difficile* cases were detected. This is now tracked via the daily bed capacity meetings and escalation actions recorded where fogging has not been completed within timescale.
6) Alternative ultraviolet (UV) light option being explored to mitigate delay in fogging.
7) Reduction in patient transfers on beds to enable beds to remain the property of wards, hence greater assurance of cleaning and mattress checks.
8) Trust wide mattress audit and replacement programme
9) Improved assurance of IPC/cleaning standards through the "STAR" assurance framework where wards get inspected and given a STAR rating.

10) New flag for estates remedial work requests from wards, if they have an IPC impact, so that they can be managed quickly from August 2023
11) Weekly communication of IPC-flagged estates requests and the time-period to resolution from August 2023
12) Improvements in electronic "Side-room audit" which lists everyone in hospital who is in a side-room and why they were placed in the side-room. To allow more efficient use of side-room capacity. Improvements sustained since July 2023
13) Expansion in the definition of diarrhoea to include type 5 stools (June 2022) – this resulted in a 50% increase in testing and earlier diagnosis of cases in 2022/23.
14) Introduction of rapid test for *C. difficile* (and 21 other gastro-intestinal (GI) pathogens) for use if side-room capacity is limited. If the test is negative, the patient with diarrhoea can remain in a bay.
15) Introduction of a ward "Whiteboard," which is checked 1-2 times per day by ward co-ordinators and flags patients who have diarrhoea from their electronic stool charts.
16) Introduction of a new electronic nursing Kardex which alerts nurses to recent diarrhoea and prompts them to perform a risk assessment for testing and isolation.
17) A dashboard that is available to IPC nurses which compiles a list of everyone in hospital with diarrhoea and includes details including – laxative use, recent CDI testing and whether or not they are in a side-room.
18) Implementation of a *C. difficile* Qlikview page which displays all the *C. difficile* cases in hospital, where they were detected and the wards that they passed through in graphical form to allow for pro-active fogging.

However, the following issues continue to impact on the delivery of IPC standards:

- Lack of capacity in domestic services to fully implement 2021 national cleaning standards in most areas.
- High reports of blockages, in the sewage system – estate survey commissioned to understand further action options.
- Insufficient decant facilities for more timely decontamination of the environment ("Fogging") in response to cases of infection.
- Sub-standard estate due to reduced funding for repairs and insufficient decant to perform repairs.
- Surfaces that are difficult to clean due to their deterioration.
- Insufficient side-room capacity leading to delays in isolation of *C. difficile* diagnosed patients.
- Understaffing within the Domestic Services and Estates, maintenance and service team and its impact on IPC practice.
- Overcrowding of patients on hospital sites because of increased demand.

Other organisms of concern

MRSA Bacteraemia

Staphylococcus aureus (S. aureus) is a bacterium that commonly colonises human skin and mucosa. Most strains of S. *aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. However, some S. *aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant S. *aureus* (MRSA). Bacteraemia occurs when bacteria get into the bloodstream.

Infection Prevention and Control continues to be a key priority for the Trust, and the incidence of MRSA is outlined below:

- In 2021-22 there has been 1 incident of hospital onset MRSA bacteraemia and 2 cases of community onset MRSA.
- In 2022-23 there has been 1 incident of hospital onset MRSA bacteraemia and 5 cases of community onset MRSA.
- In 2023-24 there has been 1 incident of hospital onset MRSA bacteraemia and 7 cases of community onset MRSA.

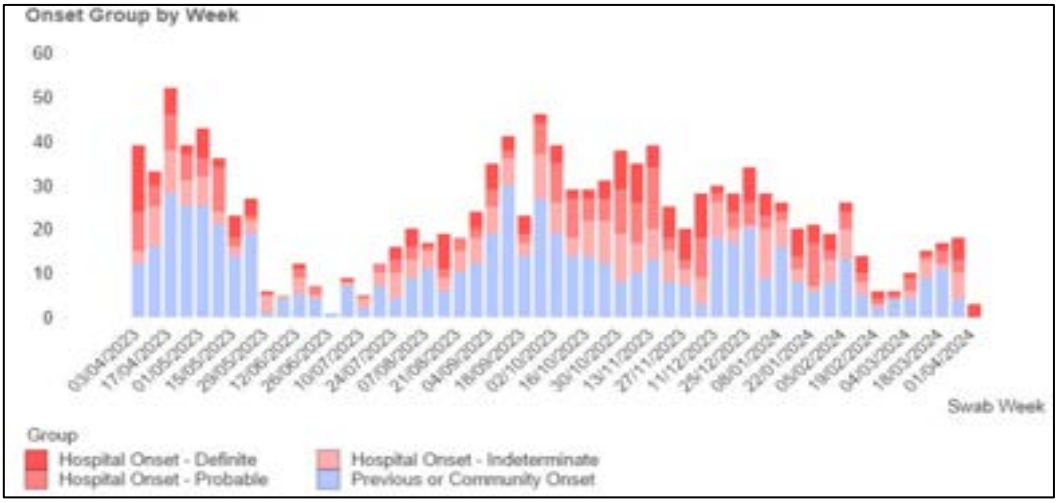
Despite an increase in MRSA bacteraemia cases in the community over the past year, the numbers reported as hospital onset have remained consistent with 1 case per annum.

Cases are investigated by a multi-disciplinary team using the national post infection review tool and discussed with the Director of Infection Prevention & Control to identify causes and actions for future prevention. The Hospital associated case identified in September 2023 was reviewed and was determined to be a contaminant. The key contributory factors were a lack of re-screening and further decolonisation after treatment.

Covid-19

On 31 December 2019, World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified. The virus is mainly transmitted by respiratory droplets and aerosols, and by direct or indirect contact with infected secretions. Infection control, which, in large part, relies on segregation of infected from non-infected individuals, is incredibly difficult as one third of infected individuals have no symptoms but are still able to transmit the infection to others. Changes in policy in 2023-24 mirrored changes in national guidance. The impact of the operating environment during 2023-24 decreased however, there remained a significant impact as a result of Covid-19.

Figure 27 Hospital Onset versus Community Onset COVID-19 infections



Source: LTHTR data

Gram-negative bacteraemia

NHS England published objectives for Trusts to reduce Escherichia coli (E. coli), Klebsiella species, and Pseudomonas aeruginosa in 2022-23.

E. coli bloodstream hospital associated infections

The 2023-24 objective for E. coli bloodstream hospital associated infections was 95. The Trust ended the year with a total of 101 hospital associated with E. coli cases which was 6 cases above objective. However, this was a reduction of 7 cases from the previous financial year 2022-23.

Pseudomonas aeruginosa bacteraemia

The 2023-24 objective for *Pseudomonas aeruginosa* bacteraemia bloodstream hospital associated infections was 12. The Trust ended the year with a total of 17 hospital associated *Pseudomonas aeruginosa* bacteraemia bloodstream cases for 2023-24, this was 5 cases above objective.

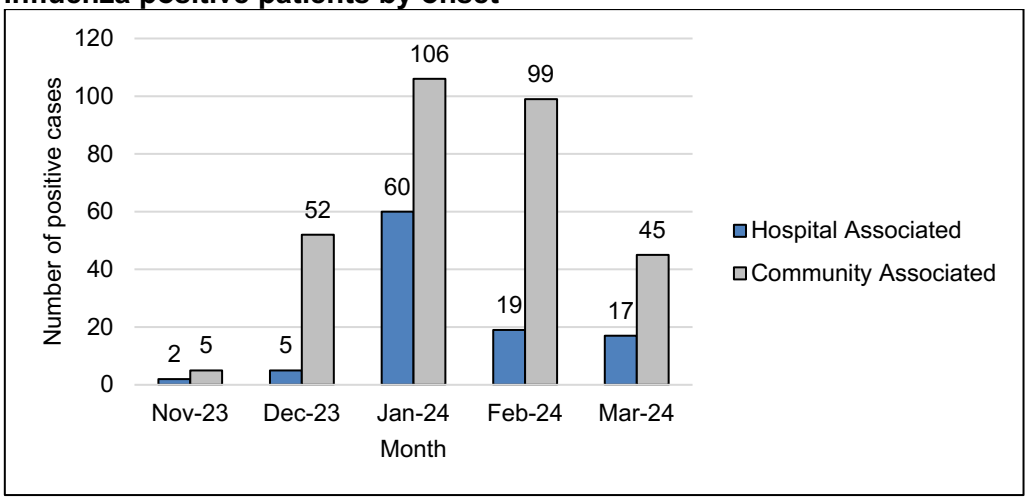
Klebsiella species infections

The 2023-24 objective for *Klebsiella* species bloodstream hospital associated infections was 25. The Trust ended the year with a total of 30 hospital associated Klebsiella species cases for the year 2023-24, this is 5 cases above objective.

Influenza season 2023-24

The Influenza season in the Trust for 2023-24 started in December 2023 in line with the national pattern and peaked in January and February 2024. The year 2022-23 saw a noticeable high-volume peak in December 2022. This year, 2023-24 did not have this significant peak however the Trust saw a sustained increase in cases across a 4-month period which reflected the national pattern. The sustained nature of this Influenza season posed significant challenges for Infection Prevention and Control, and there were a larger proportion of Nosocomial cases. Influenza A was the most predominant strain with a small number of cases of Influenza B.

Figure 28 Influenza positive patients by onset



Source: LTHTR data

Mortality Surveillance and Learning from Adult, Child & Neonatal Deaths

Our ambition to Consistently Deliver Excellent Care is also supported through monitoring our mortality rates and importantly what we learn from the deaths of patients. This section presents how we monitor and improve through learning from Neonatal, child and adult deaths.

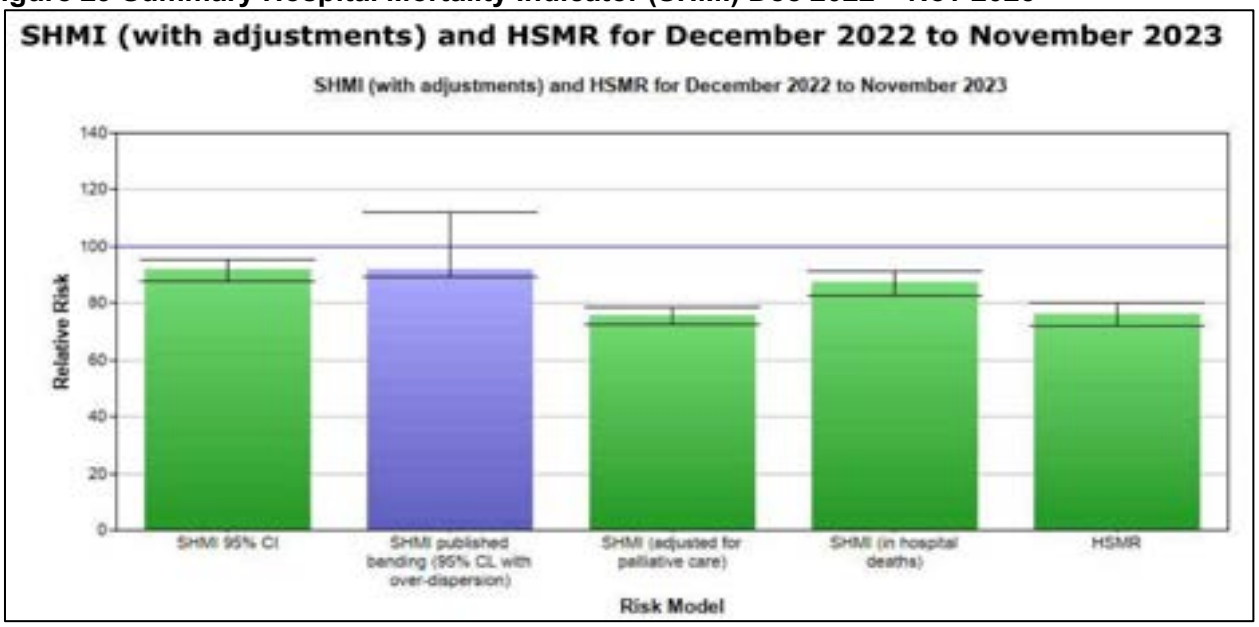
Mortality Surveillance

The Trust recognises the importance of mortality rates as a key indicator in promoting confidence in the quality of the care and treatment provided through our services. The mortality data used relates to both the Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR).

The SHMI measures mortality in patients who die in hospital or within 30 days of discharge from hospital. The SHMI does not take account of palliative care coding, social deprivation, but includes zero length of stay emergency patients and maternal and baby deaths. The SHMI data does not include COVID-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were included it would affect the accuracy.

The SHMI for the most current period available at the time of report writing is for the 12-month period from December 2022 to November 2023, is 91.69 and is statistically significantly lower than expected. When the SHMI is adjusted for palliative care, it is 75.66 and for in hospital deaths 87.03, both of which are lower than expected.

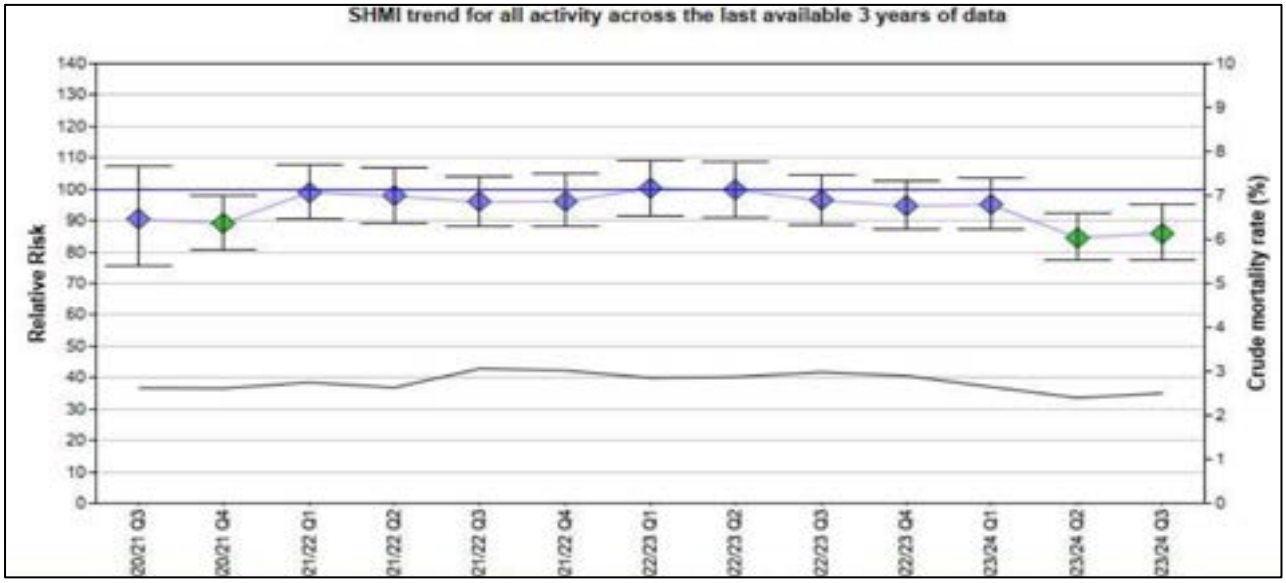
Figure 29 Summary Hospital Mortality Indicator (SHMI) Dec 2022 – Nov 2023



Source|: Telstra Health

The SHMI trend for the last 3 years is presented below, it demonstrates a within expected position for most quarters, however the 2 most recent quarters (23/24 Q2 and 23/24 Q3) report as statistically significantly lower than expected.

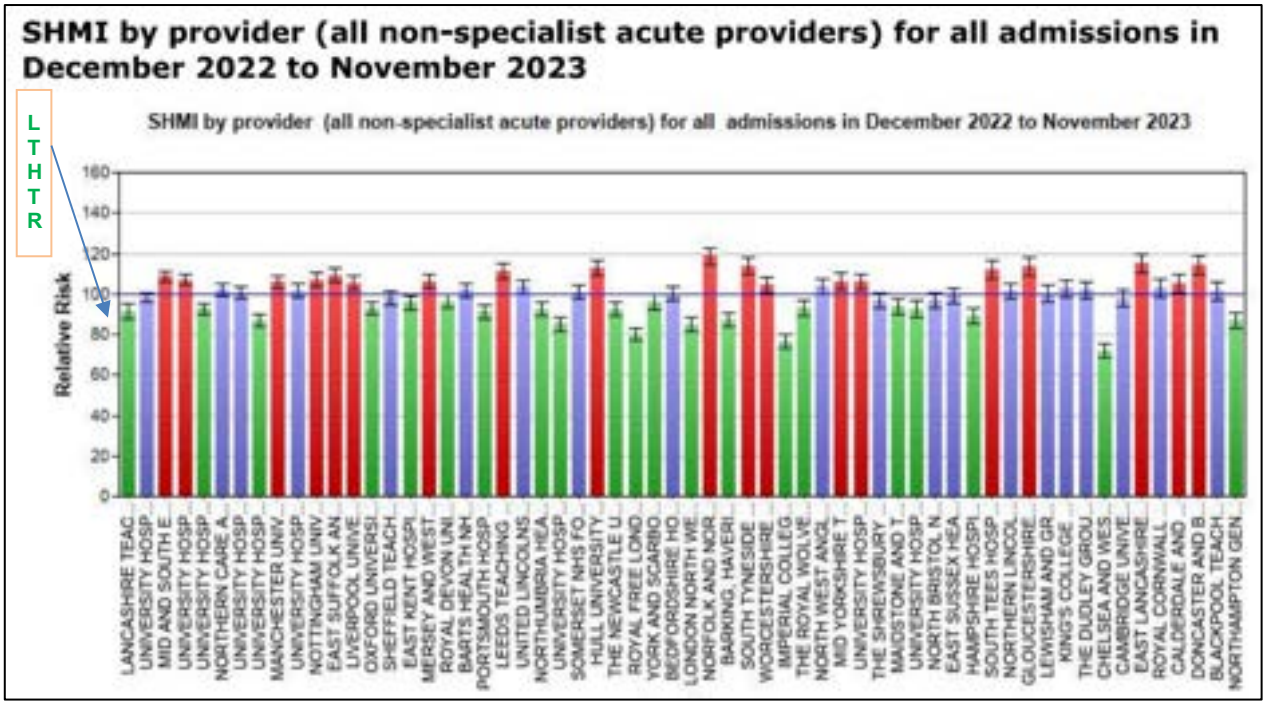
Figure 30 Summary Hospital Mortality Indicator 3 Year Trend



Source|: Telstra Health

The Trust can compare our SHMI with national peers and this is presented in Figure 31 below, the Trust is the first organisation in the bar chart. Trust's featuring in blue are those within the expected range, green bars are lower than expected and those in red are higher than expected.

Figure 31 Summary Hospital Mortality Indicator Peer Comparison



Source|: Telstra Health

Hospital Standardised Mortality Rate (HSMR)

In addition to the SHMI the Trust monitors mortality rates using the HSMR which is derived from data based on 56 diagnostic groups, which account for approximately 80% of all hospital deaths. The data is adjusted to include a range of factors that can affect survival rates but that may be outside of our

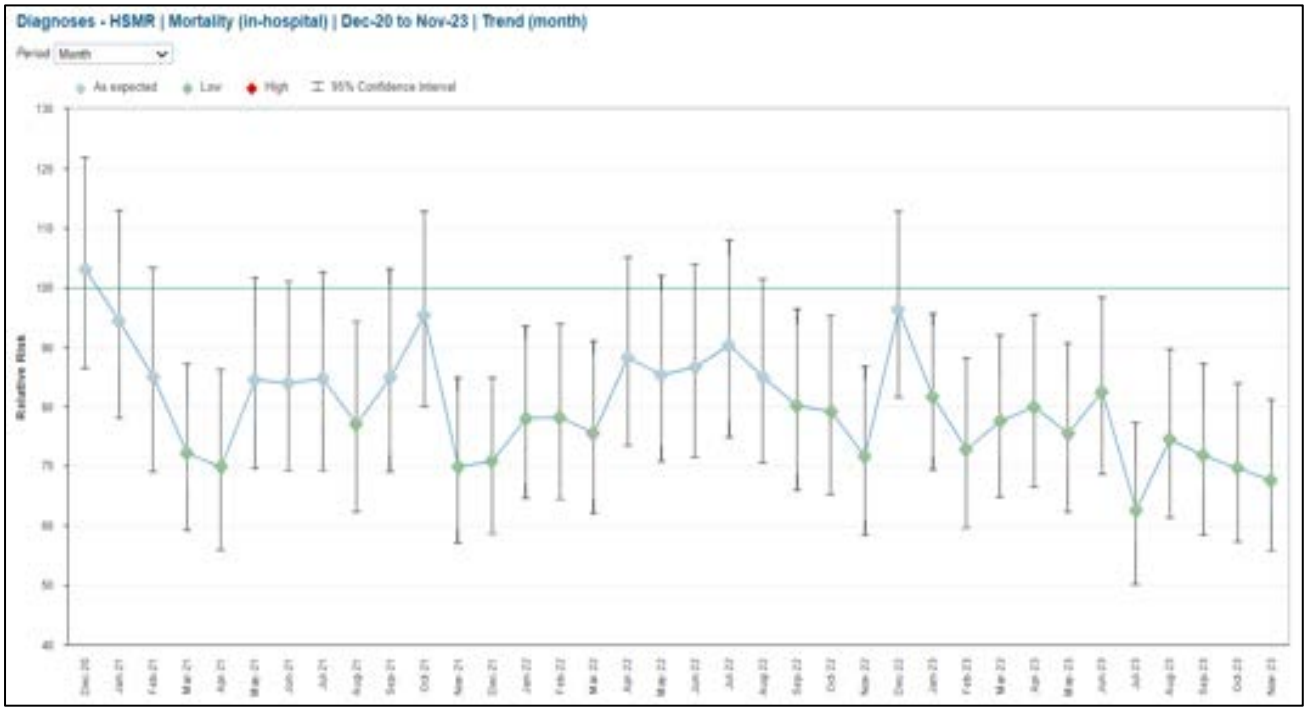
direct control such as age, gender, associated medical conditions and social deprivation. The HSMR is defined as the ratio of observed deaths to expected deaths (based on the sum of the estimated risks of death) multiplied by 100. A rate greater than 100 indicates a higher-than-expected mortality rate, whilst a rate less than 100 indicates either as expected or lower than expected.

The HSMR does not include patients who presented with a primary diagnosis of COVID-19; these are mapped to the viral infections group and included in the Standardised Mortality Ratio, which includes all diagnoses. However, any patients who present with one of the 56 diagnoses within the HSMR basket, who subsequently develop COVID-19, are included in the HSMR figure.

The most current 12-month HSMR data relates to the period from December 2022 to November 2023, the figure is 76.2 and remains lower than expected. The HSMR for the same period between February 2022 and January 2023 was 82.0 and significantly lower than expected.

Our HSMR trend over the past three years is presented in Figure 32 below and demonstrates the continued HSMR trend of mortality being either within expected or lower than expected range. Most notably, 11 of the 12 most recent months report as statistically lower than expected.

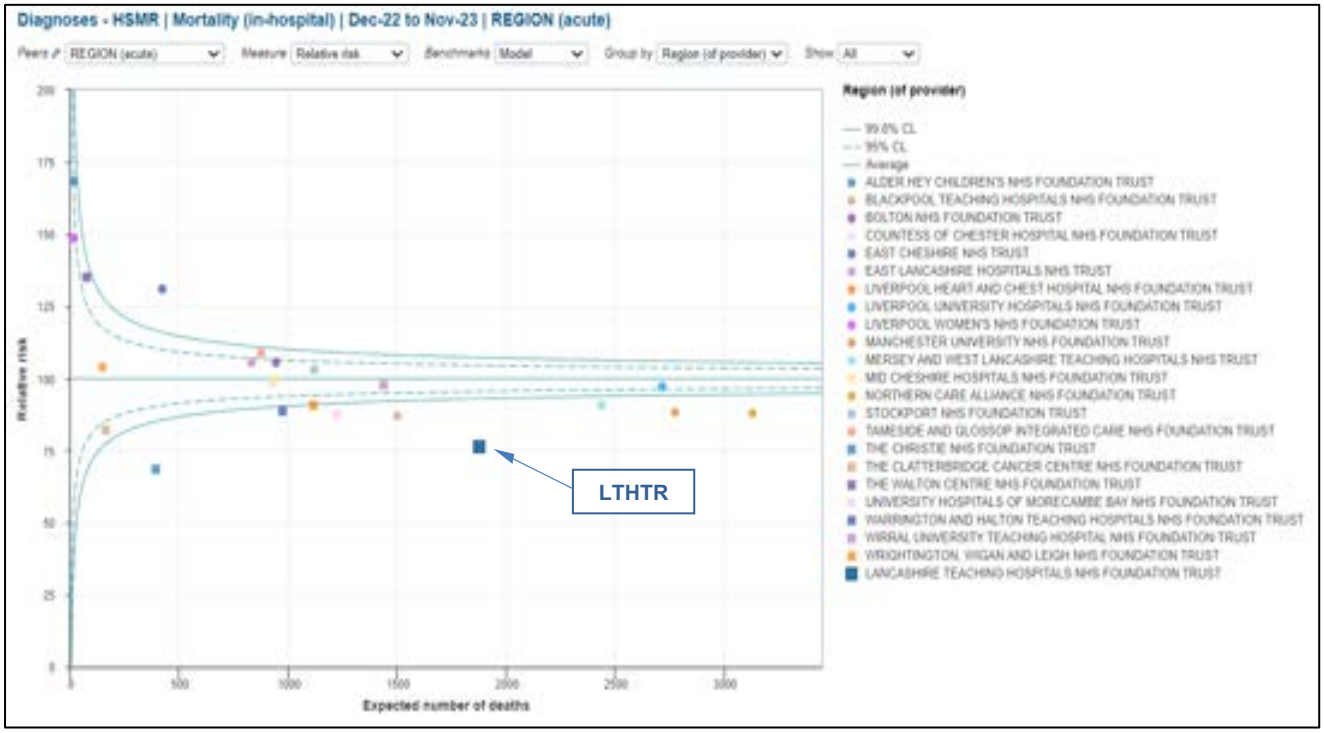
Figure 32 Hospital Standardised Mortality Rate Dec 2020 – Nov 2023



Source|: Telstra Health

A comparison with other regional acute peers is also presented below in the funnel plot in Figure 33 which shows the Trust has one of the lowest HSMRs in relation to our regional acute peers for the most recent data available.

Figure 33 HSMR Regional Acute Peers Benchmark Dec 2022 – Nov 2023

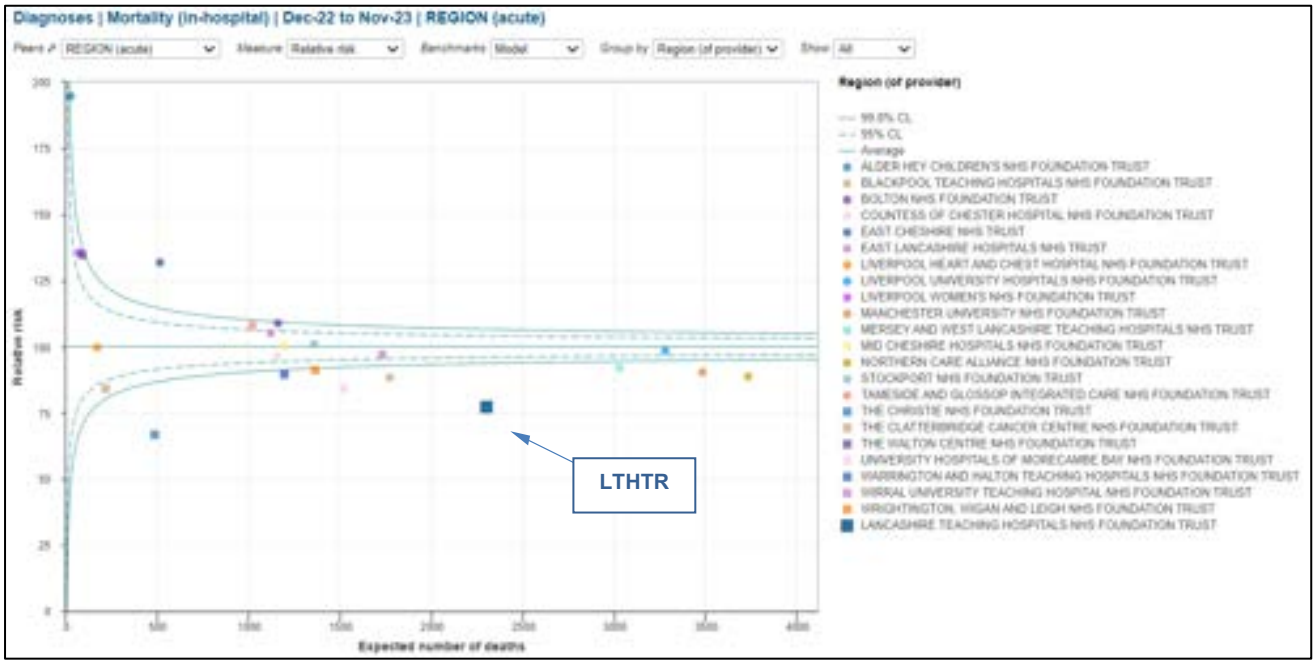


Source|: Telstra Health

Standardised Mortality Ratio – Relative Risk for All Diagnoses

The Trust also monitors the Standardised Mortality Ratio (SMR) 'Relative Risk' for 'All Diagnoses' and for the period December 2022 to November 2023 this was 77.4, which is lower than expected. The funnel plot in figure 34 below, demonstrates that again the Trust has one of the lowest relative risks compared to our regional acute peers.

Figure 34 SMR Regional Acute Trust Benchmark Dec 2022 – November 2023



Source|: Telstra Health

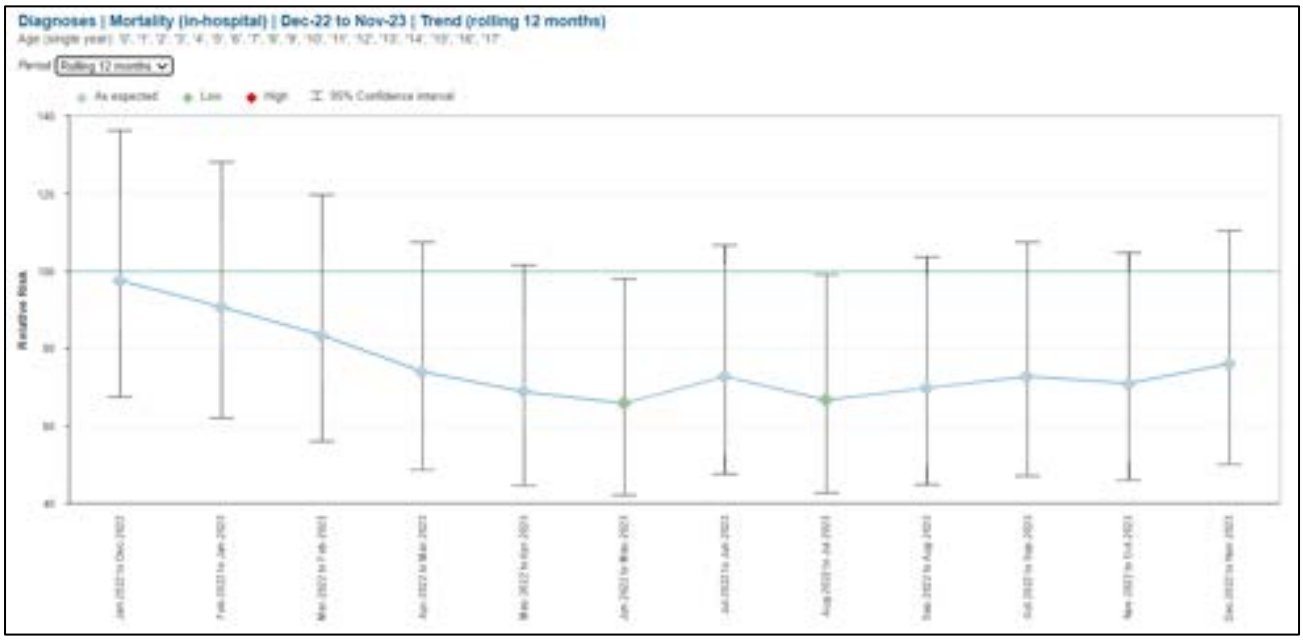
Learning from Mortality Reviews is shared at speciality level Morbidity and Mortality, and Safety and Quality meetings. The learning outcomes from the SJR reviews are extracted from the electronic SJR tool in our clinical audit system; AMaT. This is collated and key themes are reported into our Divisional, and Trust Safety and Quality Committees. Themes for learning are also reported into our Mortality and End of Life Care Committee which highlight excellent practice as well as areas for consideration and action.

Child Deaths

Reporting of child deaths is managed in line with local and national guidance. The Trust offers immediate support to parents and families and the Trust has a bereavement midwife available to support the parents of newborn infants.

All child deaths are reported to HM Coroner unless the death is expected, and this has previously been agreed with HM Coroner. The statutory requirements for reporting child deaths to the child death overview panel (CDOP) are followed with this panel providing an independent multi-disciplinary review with the purpose of identifying lessons and preventing future deaths. In addition to reviewing children who have died in the Trust, a case review is undertaken for any children known to the children's services at the Trust for example those transferred to Paediatric Critical Care or children who have died unexpectedly at home.
The SMR for children for the 12-month period December 2022 to November 2023 (the most recent period available) is 76.0, which is within expected range as demonstrated in figure 35 below.

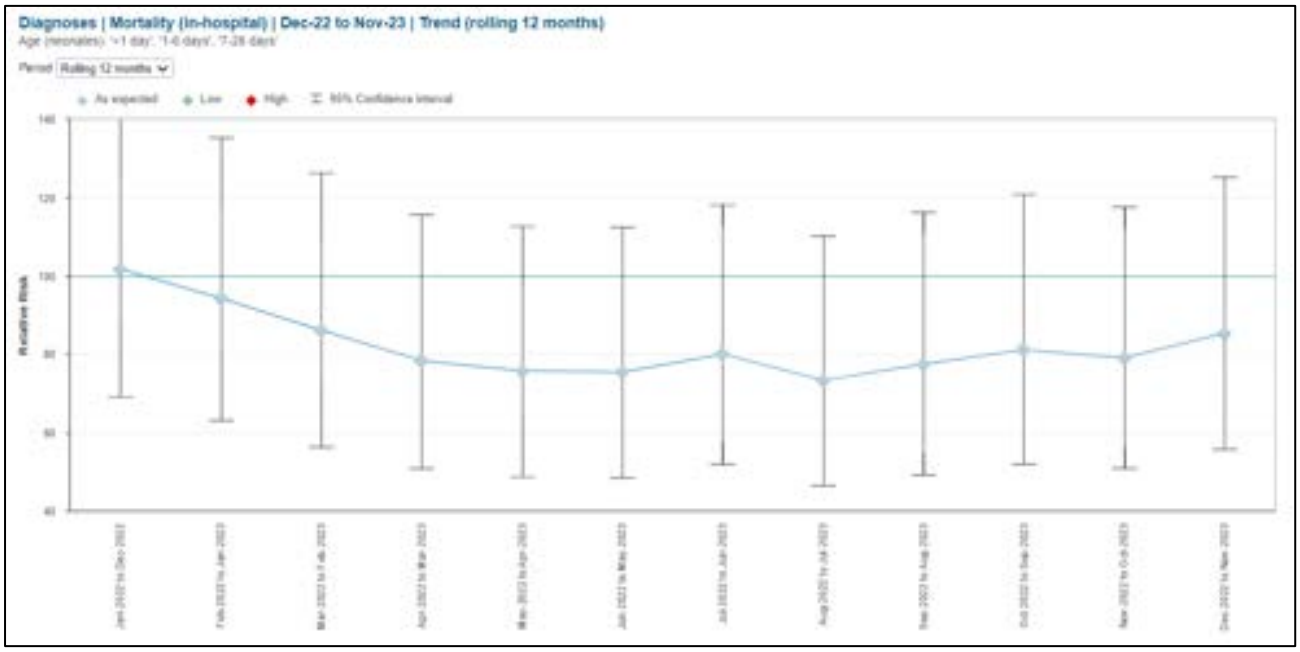
Figure 35 SMR for Children (<1 - 17 years)



Neonatal Deaths

The SMR for Neonatal deaths for the 12-month period December 2022 to November 2023 (the most recent period available) is 85.3 which is within expected range and is demonstrated in figure 36 below.

Figure 36 SMR for Neonatal Deaths (<1 - 28 days)



All neonatal deaths under 28 days are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). MBRRACE-UK is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths, and infant deaths, including the Confidential Enquiry in Maternal Deaths (CEMD).

In addition, local reviews are undertaken by the neonatal lead Consultant for neonatal death or the Named Doctor for Safeguarding Children. All reviews are shared locally at departmental level and neonatal reviews have been shared at the Lancashire and South Cumbria Neonatal Operational Delivery Network Clinical Effectiveness Group. A summary is also presented to the Trust Mortality and End of Life Committee on a quarterly basis.

Perinatal Mortality & Perinatal Mortality Review Tool

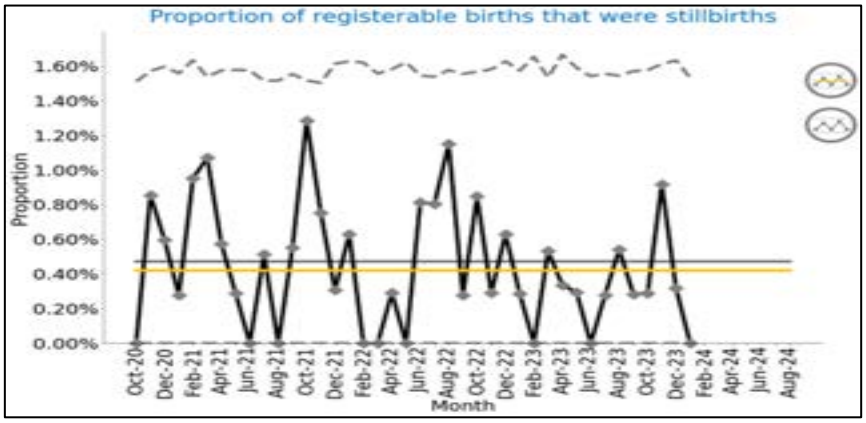
The Trust uses the Perinatal Mortality Review Tool (PMRT) to review deaths of babies within defined eligibility criteria. This includes a comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth, excluding termination of pregnancy and those with a birth weight less than 200g. The tool is used to review the care collaboratively with a multi-disciplinary panel and includes an opportunity to consider the views and any concerns parents have about the care they received. The review results in a written report which is shared with the family within 6 months. When learning is identified from the reviews, action plans are formulated and tracked through Safety and Quality Committee for oversight and assurance.

The Trust also shares a summary report of all cases at the Maternity Safety Champions meetings held bi-monthly. Formal reporting is provided to the Trust Board bi monthly as part of the Maternity Service Update Report. Between March 2023 and April 2024, we reported 22 cases to MBBRACE that met the criteria for PMRT review, there were 11 cases of stillbirth and 11 cases of neonatal death.

Stillbirths

The stillbirth rate is monitored monthly by maternity Safety and Quality Committee. The SPC analysis, as shown in figure 37 shows variation of the stillbirth rate that is within the expected range with no cause for concern identified. Currently the mean stillbirth rate is below the national average of 4.9 per 1000 births.

Figure 37 Maternity SPC analysis - Incidence of Stillbirths (per 1000 births)



Medical Examiner Service

The Medical Examiner (ME) service was introduced nationally to establish a system which provides independent scrutiny of deaths, improved accuracy of death certification, more consistent and appropriate referrals to HM Coroner, reduced rejections of medical certificates by the Registrar and improved focus on the bereaved by responding to and reducing concerns. The MEs are supported by Medical Examiner Officers (MEOs).

The MEO under delegated authority scrutinises every death that occurs at the Trust, discusses any areas of concern the bereaved may raise and ensures that the correct medical certificate of cause of death (MCCD) is issued. Any concerns that require additional support are raised to either the attending doctor or the ME.

Table 19 Medical Examiner Service Performance 2023-24 data

	Number	Percentage
Inpatient & ED Deaths	2032	
ME Reviews of all Deaths	1422	70%
MEO Reviews of all Deaths	2032	100%
ME/MEO Reviews of all Deaths	2032	100%
ME/MEO Conversations with Bereaved	1900	94%
Referrals to Coroner	419	21%

Source: LTHTR Data

The Coroner's Officers hold conversations with the bereaved when the death is referred to HM Coroner and out-of-hours the families are supported by the General Office team and bereavement service. The Registration Service has reported a reduction in the number of certificates rejected due to inaccurate or inappropriate causes of death, improving the experience of families.

Review of Quality Performance – Experience of Care

Patient Experience Performance Report 2022-23

Patient care

Improving patient experience is a key ambition for the Trust underpinned by the mission to provide 'Excellent care with compassion'. Acquiring and acting upon the feedback provided by our patients, families and carers on their experience is an important component to achieving that ambition.

The strategy is divided into 3 sections.

- **Insight –** improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information.
- **Involvement –** to equip our patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.
- **Improvement -** to design and support improvement programmes that deliver effective and sustainable change.

Insight

- Patient Experience is a key part of the MCA (Microsystem Coaching Academy) with projects using the voice of the patient to help develop changes.
- Expanded participation in the patient experience research led by Imperial College Healthcare NHS Foundation Trust.
- Quarterly deep dive reports allowing for emerging themes to be identified.
- Friends and family feedback increased by 22.19%.
- Complaints reduced by 27.1%.
- National surveys demonstrate sustained positive performance in Maternity Services and cancer surveys, improvement in the Emergency Departments and a maintained position that requires improvement in adult inpatients.
- Governors and Integrated Care Board teams involved with STAR visits with an increase in compliance on patient feedback.
- Established links with under-represented group the '*Sahara Centre'.*

Involvement

- The recruitment of 3 Patient Safety Partners and a new maternity neonatal voices partnership chair.
- Over 170 patient champions established across wards and areas.
- Volunteers supporting patient experience and hospital guide roles.
- 16 forums or groups for patients, advocacy services, charities, 3rd Sector and staff working collaboratively.
- All wards with 2 ward managers have demonstrated an improved STAR position.
- The development of an eLearning training package regarding Patient Advice and Liaison Service (PALS) concerns and local resolution.
- Increased number of Flow Coach Academy (FCA) big rooms and MCA projects.
- Increased training for staff in basic British sign language (BSL).

- Development of the Trust proud awards using MAGNET principles.
- Personalised Stratified Follow-Up (PSFU) and health and wellbeing workshops and initiatives have started across various specialities.

Improvement

- Person-Led Assessment of the Care Environment (PLACE) visits recommenced.
- Digitised food ordered with increased diverse options i.e. Vegan.
- Redesigned Gynae and women's assessment unit.
- Recruitment to a full time bereavement lead for Gynaecology services.
- Emergency department redesign and creation of Acute Assessment Unit.
- Day case surgery for children on CDH site.
- Multi-disciplinary CARING rounds focused on end of life.
- 7-day bereavement services.
- Refurbishment of ward 8 parent room.
- New Garden of Remembrance to honour organ donors and those who lost their life during pandemic.
- Increased satisfaction of patients attending radiotherapy.

Complaints and Concerns

During 2023-24 the Trust received 355 formal complaints, a decrease of 132 from 2022-2023 and during this period the backlog of complaints from the COVID-19 pandemic was addressed with all now closed. The complaint performance has been monitored through the year and patients receiving response with 35 or 60 days has risen from 50% in April through to 79% in March and an average for the year at 75% compliance. It is the intention of the team to return and maintain the Trust target of 90% in 2024-25.

Figure 38

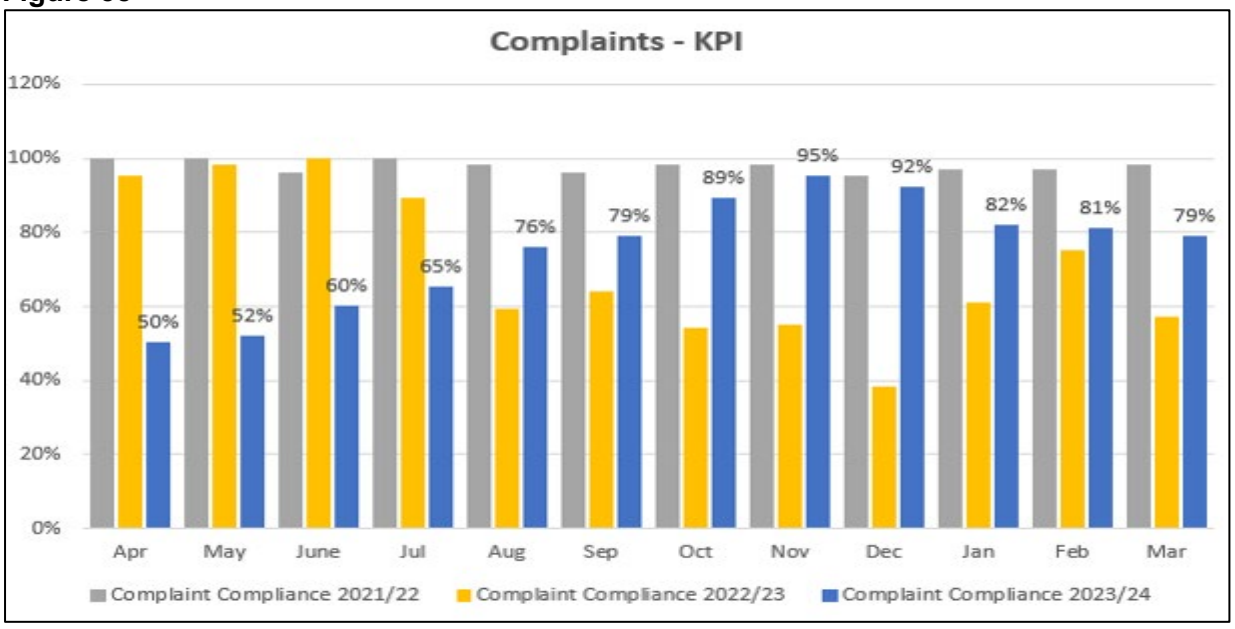


Table 20 Comparator data for Complaints 2021/22 to 2023/4 inclusive

Year	Complaints received	Increase/reduction
2021-22	580	+219
2022-23	487	-93
2023-24	355	-132

Source: LTHTR Datix

During 2023-24 the Trust received 355 formal complaints, a decrease of 132 from 2022-2023. The decrease represents a percentage of 27.1%. This continues to follow the trend from the previous year where there was also a reduction. The trend in the ratio of complaints to patient contacts over the past three years is detailed in the table below:

Table 21 Trend of ratio of complaints per patient contact 2021/22 to 2023-24 inclusive

Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints topatient contacts
2021-22	580	821,526	1:1,416
2022-23	487	849,328	1:1,744
2023-24	355	871,231	1:2,454

Source: LTHTR Datix

Of the 355 complaints received between April 2023 to March 2024, 285 (80%) related to care or services provided at the Royal Preston Hospital (RPH), 65 (18%) to care or services provided at Chorley and South Ribble Hospital (CDH), 1 (0.2%) to care or services provided by Preston Business Centre, and 4 (1.8%) to care and services provided at Finney House Community Healthcare Hub. There were no cases which were outside of the 12 months' timescale set out under the NHS Complaints Procedure.

Table 22 Number of Complaints by Division – April 2023 to March 2024

Division	Number (%)	Division	Number (%)
Medicine	150 (42%)	Women and Children's Services	43 (12%)
Surgery	129 (36%)	Diagnostics and Clinical Support	27 (8%)
Estates and Facilities	1 (0.5%)	Corporate Services	5 (1.5%)

Source: LTHTR Datix

During this financial year there were 334 cases due to be closed. The outcome of these can be broken down into the following outcomes 17 (5.9%) of the complaints had been upheld. 180 (53.89%) were partly upheld and 127 (38.02%) were not upheld. 10 cases currently remain open at the end of the year.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 87% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team. Whilst 100% of patients receive an acknowledgement via email or verbally on the telephone.

Second letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2023 and March 2024

we received 19 second letters.

During the period 1st April 2023 to 31st March 2024 249 complaints were closed. 75% of complaints received in 2023-24 were closed within the 35-day or 60-day timescale. Of note the organisation is not mandated to respond within 35 days, however the standard set is to ensure that complainants receive timely responses to provide a better patient experience. The Patient Experience and PALS Team have dealt with a total of 2,325 concerns and 2,741 enquiries.

Top Themes Complaints and Concerns by Division

The following table provides detail of the top three themes based on the number of complaints made in each area for each division for the period April 2023 to March 2024.

Table 23 Top Themes of Complaints and Concerns by Division

Division	Themes
Diagnostic and Clinical Support	1. Confidentiality or communication 2. Treatment/Procedure 3. Nursing care
Women's and Children's	1. Confidentiality or communication 2. Treatment/procedure 3. Staff Behavior or Attitude
Medicine	1. Confidentiality or communication 2. Treatment/procedure 3. Nursing care
Surgery	1. Treatment/Procedure 2. Confidentiality or communication 3. Nursing care

The patient experience and involvement strategy will continue to focus on strategic plans to reduce the number of patient complaints through listening and taking action on the issues raised by patients.

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2023-24 a total of 3,871 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. There has been a 45% increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Datix system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and divisions. A new Trust campaign has been implemented to encourage recording of compliments recognising value our teams place on the recognition they receive from patients and families. From April 2024 league tables will be published to enable teams to benchmark against one another.

The Parliamentary Health Service Ombudsman

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1st April 2023 to 31st March 2024 there were 10 cases referred to the PHSO; 3 were partly upheld and 7 are ongoing. During this period, the PHSO sent final reports for 3 cases which were opened prior to April 2023 and the outcome of these were that 2 were not upheld and 1 was partly upheld. There is one further case referred to the PHSO prior to April

2022, which is still under investigation by the PHSO, and a final decision is yet to be reached.

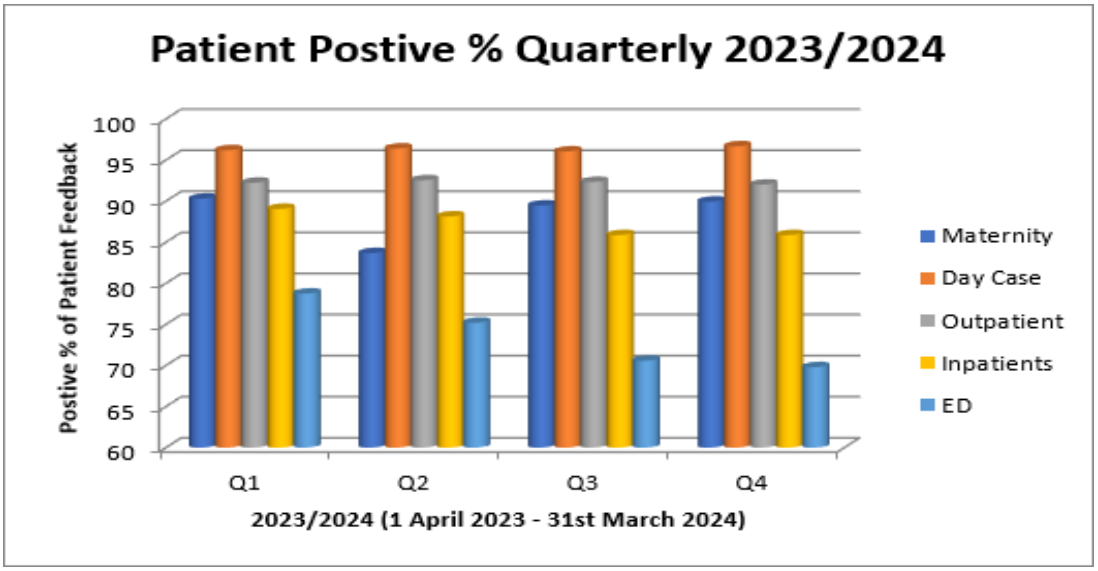
Patient experience feedback

Friends and Family Feedback

The Friends and Family Test (FFT) is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

Figure 39 Quarterly percentage of positive responses Friends and Family by Division



Source: FFT data CIVICA

A target of 90% is set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department. Maternity has achieved this in Q1 and Q4, Day Case and Outpatients have consistently achieved more than 90% in all four quarters, Inpatients and the Emergency Department are under the target percentage in all four quarters.

The Trust undertakes surveys in Children and Young People's Services to ensure an equitable approach to measurement of experience. Children and Young People using the Urgent and Emergency pathways are reporting less favourable experiences. The day case and outpatient departments are demonstrating positive performance. The neonatal service has maintained a sustained performance of 100%.

Figure 40 Children and Young People (CYP) Quarterly percentage of positive responses

Source: FFT data CIVICA

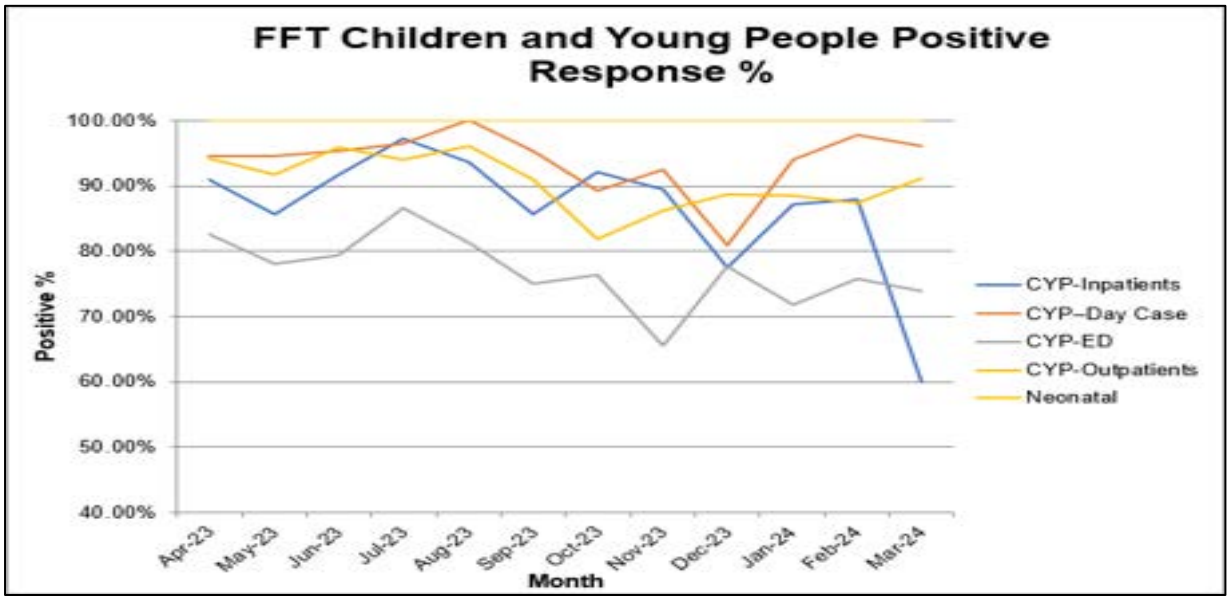
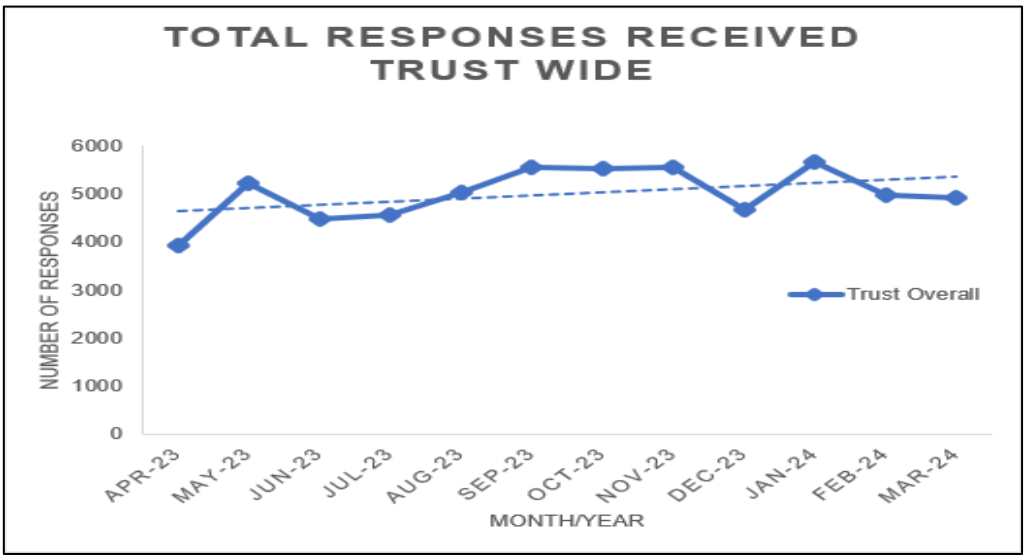


Figure 41 Friends and Family % Response



Source: FFT data CIVICA

The data above demonstrates an overall increase in responses and an increase in usage of the various methods of collection.

Friends and Family response rate

Expanding the methods used to collect feedback is important if the Trust is to understand what matters to patients. The response rate is an area we set out to improve and the data below demonstrates this has been achieved with a total of 11,359 more valuable pieces of feedback than what was collected in 2022-23.

It is not yet possible to view this feedback through the lens of protected characteristics and deprivation, however work is underway to capture this.

Table 24 Friends and Family response rate

Year	QR codes/online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2021-2022	1,468	2,829	3,684	36,128	44,109
2022-2023	2,905	6,788	4,421	37,070	51,184
2023-2024	3,016	10,944	2,112	46,471	62,543

In the year 2023-2024 there has been a positive increase in the response rates overall of 22.19% on the previous year. Increases have been realised due to the use of Quick Response (QR) codes, online surveys, paper surveys and Short Message Service (SMS) test surveys. There has been a reduction in the telephone surveys which in part may be due to an increase in online and mobile preferences for service users.

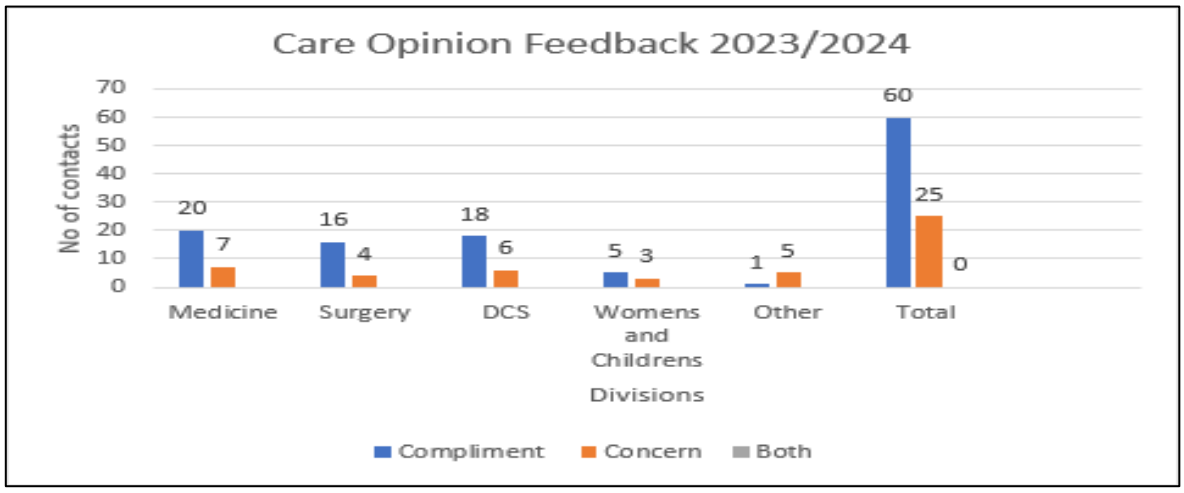
The Trust is continually training staff to use the system and ensure the patient experience boards are kept updated with the "You said, we did" posters and various reports that can be downloaded.

Managers and Leaders are actively seeking to make improvements with the Friends and Family test and this is measured through the Safety and Quality Committee.

Care Opinion Website

During the past financial year there have been a total of 85 reviews posted on the Care Opinion website relating to care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust. These have consisted of 60 compliments and 25 concerns.

Figure 42 Care Opinion feedback



National Survey Results

National Maternity Survey

The National Maternity survey is based on a sample of maternity service users who had a live birth between 1st March 2023 and 31st March 2023. In the 2023 survey the Trust was ranked 18th out of the 61 participating Trusts. Compared to the 2022 survey results, the Trust ranked 19th out of 65 Trusts surveyed by Picker. The response rate for the 2023 survey was 39% compared to the 2022 survey response rate of 44%.

Analysis identified two areas where the Trust scored significantly better when compared to the 2022

survey. There were no areas identified where the Trust score was significantly worse than the 2022 survey.

Overall, women reported that they were treated with kindness and compassion during labour and birth (98%), they had confidence and trust in staff during labour and birth (97%) and felt midwives and doctors were aware of their medical history during labour and birth (84%).

Within the bottom five scores, issues were identified in relation to information regarding infant feeding choices, review of health records by midwives and doctors, and induction of labour. The survey results triangulate with safety intelligence and patient feedback data already known to the maternity service. Action plans are in place to respond to this feedback with the aim of improving experience for women, birthing people and families.

National Inpatient Survey

Compared to the National Inpatient Survey in 2021, Lancashire Teaching Hospitals remains in the same position, with no areas identified as significantly better or significantly worse for 2022. Lancashire Teaching Hospitals is now ranked 50th out of the 70 Trusts surveyed by Picker. This compared to the 2021 survey where the Trust was ranked 55th out of 73 Trusts surveyed. This shows a slightly improved position in the overall positive score of 2 points, however, does not represent the improvement ambition the organisation is aspiring to. Adult inpatient experience is a priority area of action for the Patient Experience and Involvement strategy and progress against the strategies deployment will continue to be overseen by the Safety and Quality committee.

Emergency And Urgent Care Survey

The National Picker Adult and Urgent & Emergency Care Survey 2022 for patients attending the Royal Preston Hospital Emergency Department and Chorley District General Hospital. The Urgent and Emergency Care Survey is carried out every 2 years. The previous survey was undertaken in 2020. The purpose of the survey is to understand what patients think of the care they have received within a Type 1 Emergency department. The results demonstrated an improved position for the Emergency Department compared to the last National Picker survey in 2022. The Trust is ranked 18th out of 62 Trusts nationally. This is compared to the 2020 survey, where the Trust was ranked 34th out of 66 Trusts surveyed.

Children's and Young Peoples Survey

There have not been any Picker survey results in this reporting period for Children and Young People. The survey will be undertaken between March and May 2024.

Cancer Survey

The survey results were published in July 2023. The overall score for care at our Trust was 9 out of 10, which is higher than previous years. There were 61 questions in total and 14 questions were in the higher-than-expected range with no responses in the lower-than-expected range which is a significant improvement on the previous years.

Common themes that require improvement across the range of cancer services include:

- Hospital care confidence in staff particularly within Head & Neck (H&N) Gynae and Upper gastro-intestinal (GI).
- Discussions with patients about research.
- Support and communication from primary care and cancer care reviews in primary care.
- Emotional support from voluntary services in the community.
- Information regarding immunotherapy.

Areas where the Trust has scored positively are:

- Head and Neck team scored highest with an overall rating of 9.5.
- Teams scoring above an overall rating of 9 were Lung 9.4, Prostate 9.3, Sarcoma 9.3, Upper GI 9.2, Colorectal 9.2.
- All teams scored highly for privacy when receiving results. H&N, lung, prostate and sarcoma all scored 100%.
- All teams scored highly regarding support from main contact, UGI, Skin and Colorectal teams scored 100%.
- All teams scored highly for review of care plans with patients, Upper GI, skin, colorectal and H&N scored 100%.
- All teams scored highly in the Treatment section.

Major Service Developments and Improvements

Despite significant challenges across the Lancashire and South Cumbria healthcare system due to winter pressures, sustained demand for our services and the effects of industrial action, we continued to implement a number of major service developments during 2023–24. The developments have benefitted both patients and colleagues, helping to alleviate pressure on our emergency care pathways, reduce elective waits and improve flow across our sites.

These developments are testament to the resilience of our hard-working and dedicated colleagues and key partners who have remained committed to improving our services for the communities we serve. The major service developments during the past year are outlined below:

Sir Lindsay Hoyle officially launches expansion of Clinical Health Psychology Services

The expansion of the Clinical Health Psychology Service was launched in May 2023 with a ribbon-cutting event attended by Sir Lindsay Hoyle, Member of Parliament for Chorley and Speaker of the House of Commons.

Sir Lindsay was invited to formally launch the expansion, with the Clinical Health Psychology Service (CHPS) opening a new department at Royal Preston Hospital, making psychological services more accessible to patients across Lancashire, when they need it most.

The aim of the service is to offer help and support to adult patients with psychological distress that they may experience as a result of chronic and life-changing physical health conditions or injuries, such as cancer or severe spinal injury.

UK-first for cutting-edge LungVision Bronchoscopic Navigation System

In June 2023, Lancashire Teaching Hospitals NHS Foundation Trust became the first Trust in the UK to implement Lung Vision - the latest navigation bronchoscopy technology to locate and diagnose challenging peripheral lung tumours in a minimally invasive, safe fashion through an advanced tracking and navigation system.

Lung Vision enables doctors using a bronchoscope to examine inside a patient's lungs in real time, penetrating deeper and reaching areas they were previously unable to reach to take

biopsy samples. This procedure represents an incredible advancement which will identify lung cancer more quickly and enable patients to receive personalised treatment and enhanced care.

Lung cancer is responsible for 1.6 million deaths worldwide and 75% of patients have advanced disease at the time of diagnosis. Identification of patients with lung cancer at the earliest stage is vital if outcomes are to be improved. Patients often need to undergo multiple biopsies due the limited diagnostic yield ranges of existing equipment, which can lead to more than double the length of time a patient waits for their diagnosis. This creates additional stress for patients and even a few days or weeks delay can affect lung cancer outcome rates.

This system uses artificial intelligence to create 3D intraoperative images, improving accurate navigation and increasing biopsy success rates from 60% to above 85%. This helps to give timely and accurate diagnosis and therefore shortening the pathway for patients. It also helps in reducing the number of procedures to get to diagnosis thereby benefitting patients and healthcare systems.

The Trust engaged widely with partners, colleagues and the Rosemere Cancer Foundation Charity, who funded the equipment, to manage the process of bringing the system to the UK.

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

A new Regional Hyper-Acute Stroke Unit (HASU) was opened in June 2023, bringing experts and equipment under one roof to help reduce death rates in stroke patients.

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

This project began planning in 2017, and the Trust is now the comprehensive stroke centre in the area. Patients will be monitored in a high care area, which will enable the staff to identify any deterioration and manage or escalate appropriately to prevent further deterioration.

Waiting lists for children on the decrease thanks to new surgery offer

July 2023 saw the opening of a new low complexity day surgery service for children based at Chorley and South Ribble Hospital.

The pop-up service, which operates once every two weeks from Rawcliffe Ward, was created to improve efficiency, experience and the number of children waiting for elective treatment.

The service brings together paediatric, anaesthetic and surgical teams to perform a range of procedures including dental, maxillofacial, ophthalmology, plastic surgery and ear, nose and throat (ENT)

Finney House celebrates its first anniversary

Finney House celebrated its first birthday in November 2023, marking one year since the Trust took over the facility to run a Community Healthcare Hub designed to accommodate patients who no longer need specialist hospital care.

In its first year the Community Healthcare Hub saw over 1,500 admissions and helped 70% of patients return home with support – in turn helping the local healthcare system to support discharge, patient flow and ease pressure on ambulance crews.

The site was formally opened on 14 November 2022, when the Trust took on the lease of the building and became the CQC-registered provider of services. Since opening, all 64 Hub beds within the facility are in use with a further 32 beds providing care for Local Authority and private residents.

Since opening, additional equipment has been purchased to enhance the therapy provision and outcomes at the Hub, which includes five specialist chairs, enabling all patients to spend time out of bed, various moving and handling adjuncts, gym equipment and functional assessment aids.

New breast pain clinic launches in Central Lancashire

The NHS in Lancashire and South Cumbria launched a new breast pain clinic to support people in Central Lancashire in November 2023.

The clinic provides examinations and advice to patients suffering from breast pain in Preston, Chorley and other parts of Central Lancashire and aims to reduce anxiety and worry for many patients who might otherwise have been unnecessarily referred for hospital tests on a cancer pathway.

Most women will experience breast pain at some stage in their life and there are different ways in which women describe the sensations in their breasts including pain, discomfort, a bruised sensation, tingling/itching behind the nipple, and tenderness.

There are many causes of breast pain, including pregnancy, breastfeeding and other hormone-related issues, muscle-related pain or nerve problems and back pain. There are no mammograms or scans in the breast pain clinic. Instead, it focuses on finding the cause of the pain and identifying ways to help manage it.

Trust upgrade robotic system to speed up prescription processing

A replacement robotic system has been installed in the Trust Pharmacy departments, to help both Royal Preston Hospital and Chorley and South Ribble Hospital speed up prescription processing to get medication to patients, faster.

The update to the Royal Preston Hospital's Pharmacy department comes on the back of upgrading the system at Chorley and South Ribble Hospital, and now complete, it will save valuable time for the Pharmacy team and bring greater efficiency to pharmacy processes.

The previous system was 16 years old, and is replaced by a more modern, more efficient robot. Once Pharmacy staff process the label for the medicine or input an order for stock, the robot selects the box from the shelves, scans it to ensure it is the right medication and transports it along a conveyer belt to a collection point.

The robot at Chorley will hold 12,000 packs of medicines, and 30,000 at Preston, and can supply the same number of packs in an hour that can be manually picked in a day.

There are other benefits such as accuracy, with the robot using barcode technology to identify the correct medicine, form, strength required and improved stock management.

Trust unveils newly refurbished Gynaecology and Early Pregnancy Assessment Unit (GEPAU)

In January 2024, the Trust opened its newly refurbished Gynaecology and Early Pregnancy Assessment Unit at Royal Preston Hospital, helping to enhance and improve care for women and families experiencing early pregnancy or complications.

The £90,000 scheme to redesign the Gynaecology Assessment Unit (GAU), received significant support from Baby Beat – part of Lancashire Teaching Hospitals Charity – who contributed £30,000.

This initiative is part of the broader women's health improvement programme to enhance the care for women and families experiencing early pregnancy or acute gynaecological complications including miscarriage and baby loss. Thanks to charitable funding, the refurbishment has relocated and rebuilt the scanning facility, provided a dedicated ambulatory care suite for women who experience hyperemesis gravidarum and created a welcoming space for women and families attending the department. The redesign has been co-produced with feedback from service users, ensuring women's voices were heard and asking families to share deeply personal accounts of their experiences has ensured that the new design is reflective of the needs of the people using our service.

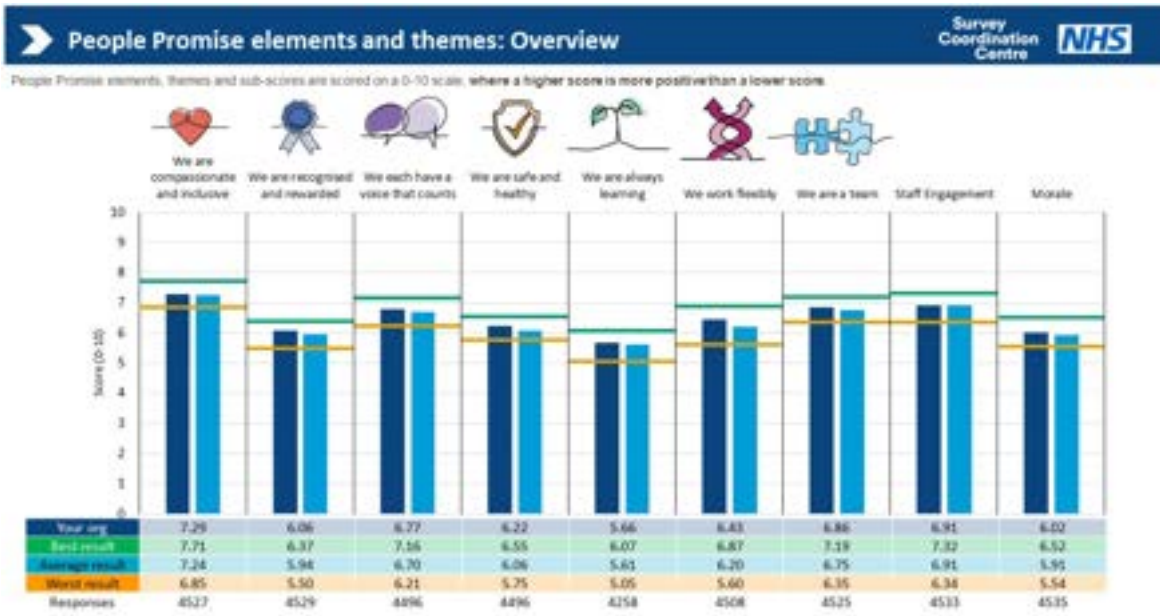
Staff Survey and Recommendation of Our Care

Annual National Staff Survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The Trust's response rate to the 2023 survey was 45%. This is 2% lower than the 2022 survey (47%) however we have met the national average (45%) in our benchmarking group (Acute and Acute and Community Trusts).

Scores for each indicator together with that of the survey benchmarking group are presented in figure 43 below.

Figure 43 Annual National Staff Survey



Source: National Staff Survey

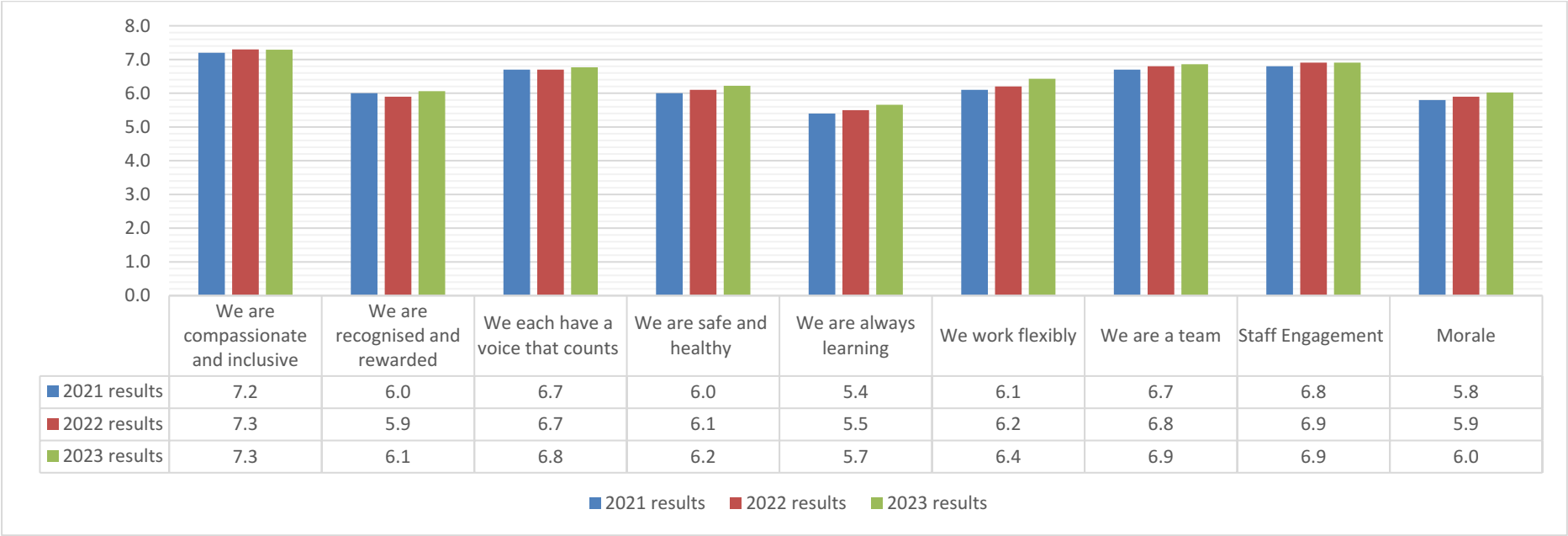
As indicated in figure 43 above, the benchmarking against the People Promise elements displays our position (navy blue bar) shows that we are **above** the national average for **all elements** except one (Staff Engagement measure) for which we have met the national average.

Within the context of pressure facing the organisation, teams and managers, these results are very positive. We have been able to sustain our levels of engagement whilst demonstrating improvements across the majority of the People Promise measures. Whilst the results still show us where are areas for improvement are, we can see we are continuing to make progress towards our aspiration of being the 'best' in the NHS.

Table 25 People Promise Results Comparison 2022 – 2023

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

Figure 44 People Promise Measure Results - 2021-2023



In table 25 above it shows that across four of the national measures we have seen an increase of 0.1 points, ('We each have a voice that counts', 'We are safe and healthy', 'We are a team' and 'Morale'). Across 3 of the elements, we have seen an increase of 0.2 points ('We are rewarded and recognised', 'We are always learning' and 'We work flexibly') and we have remained the same for the measures 'We are compassionate and inclusive' and overall Staff Engagement.

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

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

Looking at the data over the last three years (since the People Promise was launched) figure 44 demonstrates that we are showing a positive trend across all the People Promise measures, Staff Engagement and Morale.

Figure 44 indicates that 'We are always learning', and 'We work flexibly' are the areas we are showing the most overall progress (+0.3 points) followed by 'We are safe and healthy', 'We are a team' and over Morale which have all improved by 0.2 points.

Staff Engagement

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

Table 26 below details the overall staff engagement score for 2023 and the breakdown of scores for questions which measure the 3 facets of team engagement, namely motivation, involvement and advocacy. The results compare our scores against our 2022, identifies the changes and compares to the benchmark average for this year.

Table 26 below shows that for staff engagement we have seen improvements in all except two questions which have slightly deteriorated and both are linked to colleagues perceptions of the quality of care across the Trust. This was further seen through the free text comments analysis were colleagues felt patient care and services was being impacted by lack of staffing and resources.

Table 26 2023 Staff Engagement Results and Comparisons

	Organisational Results and comparison (2022 to 2023)			Picker Average 2023 Comparison	
Question	**Organisation 2023**	**Organisation 2022**	**Changes**	**Picker Average 2023**	**LTH comparison to Picker average**
Motivation					
Often/always look forward to going to work	**57.00%**	55.19%	1.81%	55.00%	2.00%
Often/always enthusiastic about my job	**71.25%**	70.20%	1.05%	69.39%	1.86%
Time often/always passes quickly when I am working	**75.55%**	74.50%	1.05%	72.33%	3.22%
Involvement					
Opportunities to show initiative frequently in my role	**76.49%**	75.73%	0.76%	73.66%	2.83%
Able to make suggestions to improve the work of my team/dept	**74.96%**	74.68%	0.28%	71.43%	3.53%
Able to make improvements happen in my area of work	**57.16%**	56.54%	0.62%	56.35%	0.81%
Advocacy					
Care of patients/service users is organisation's top priority	**72.52%**	72.84%	-0.32%	74.83%	-2.31%
Would recommend organisation as place to work	**59.44%**	57.18%	2.26%	60.52%	-1.08%
If friend/relative needed treatment would be happy with standard of care provided by organisation	**58.33%**	59.89%	-1.56%	63.32%	-4.99%

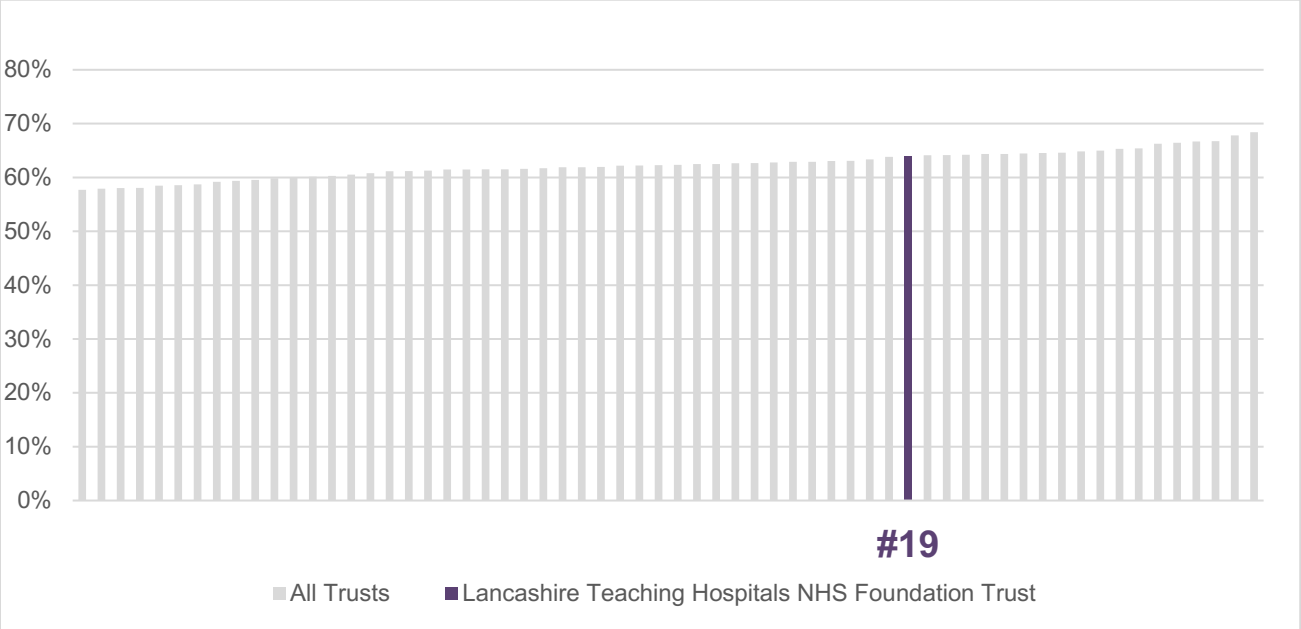
To summarise the staff engagement findings:

- In table 26 we can see our 2023 results are broadly in line with the benchmark average and we can see yearly improvements in our motivation and involvement sub-score which are both above the national average and shows all the questions in these themes have increased and are all scoring more positively than our comparative Trusts.
- Our overall staff engagement score has remained largely stable and whilst we are yet to see improvements in our advocacy score, we have not seen a decline either. When we look at the national picture, the average advocacy score has declined every year since 2020.
- Whilst our overall advocacy score has remained the same, when we look at the question breakdown, it shows an increase in colleagues agreeing they would recommend the organisation as a place to work. This is the first increase since 2020 and is a positive improvement towards our Big Plan goal to 'to be a great place to work'.
- However, it appears the score continues to be driven by a deteriorating perception in our colleagues with regards to if the care of patients/service users is organisation's top priority and if a friend or relative needed treatment they would be happy with the standard of care.

Figure 45 below shows our position in the league table when compared against 62 other Acute and Acute

Community Trusts who used Picker as their annual staff survey provider, this indicates, we ranked positively at position 19, which is a decline from last year's position of 13 but it is important to remember that each year the number of Trusts using Picker changes so this is not a direct comparison to previous years.

Figure 45 NHS Staff Survey 2023: Overall Positive Score



Future priorities and targets

The 2023 results show us where we are making progress to improve our overall staff experience and they help us to understand our priorities and key areas we need to pay attention to over the next 12 months. Many actions will continue to be delivered by the Workforce and Organisational Development team as outlined in Our People Plan 2023-26 which identifies our key strategic aims and deliverables.

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

- **Health, Safety & Wellbeing**
    - Address the different perceptions of the quality of care and find ways to increase feelings of advocacy across teams for provision of high-quality care.
    - Address the level of burn out and wellbeing concerns reported and explore how our corporate offer can further support improvements for colleagues experiencing this.
- **Staff Engagement/Morale/Hygiene Factors**
    - Continue to embed our new recognition offers at a corporate level and increase local level recognition to support all colleagues to feel rewarded, recognised and valued despite internal resourcing/financial challenges.
    - Explore and scope options there may be to improve key hygiene factors such as access to kitchen, break areas, car parking solutions, catering, dilapidated estate etc.

- **Culture/Leadership/Inclusion**

    - Support key manager practices such as 1:1s, appraisals and involving teams in decision making and continue to invest in leadership and management development.
    - Continue work to support more positive team cultures, calling out behaviours and incivility that does not support this and further embed 'Our Best Version of Us' to help address behavioural challenges.
    - Address experiences of personal safety i.e. discrimination, bullying, harassment, aggression by further embedding our Zero Tolerance approach to support colleagues to feel safe at work.
    - Implement the NHS' Sexual Safety Charter which will support addressing experiences seen through the new question set which focus on unwanted sexual behaviour.

- **Teamworking**

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

We know we can do better to improve our overall colleague experience and our corporate level action plan will detail the actions we will be taking to make improvements to these areas. Progress against our priorities and measurement of impact will be reported to the Workforce Committee through the regular cycle of business.

Medical and Dental Workforce Rota Gaps

Our Workforce Department monitor vacant posts and as part of the 'Guardian of Safe Working' requirements are required to provide a quarterly vacancy gap analysis as required in relation to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Schedule 6 paragraph 11b. The Trust is required to include a plan for improvement to reduce the gaps for NHS Doctors and Dentists only in the Trust's Quality Account. There is no such requirement for Registered Nurses or Allied Health Professionals (AHP's).

An overview of Trust wide vacancies per grade are presented in Table 27 below.

Table 27 Medical and Dental Vacancies

Data is for each post as a whole time equivalent. It does not reflect gaps as a result of long-term sickness, maternity/adoption leave and working part time.

Grade	Vacant	Filled	Total	Vacancy Rate
Deanery				
FY1	1	56	57	1.75 %
FY2	2	54	56	3.57 %
ST1-2	3	113	116	2.59 %
ST3+	11	144	155	7.10 %
Trust				
Junior Clinical Fellow	25	60	85	29.41 %
Senior Clinical Fellow	33	92	125	26.40 %
SAS	16	82	98	16.33 %
Consultant	73	456	529	13.80 %

Source: LTHTR data

Our Workforce Business Partners provide monthly reports to the Divisional Workforce Committees which includes the detailed status of each vacant post. The team use this information to work closely with Clinical Directors and departmental managers to source vacancies and agree recruitment strategies for new and hard to fill posts at speciality. This year this will feature as part of the single improvement plan under the medical workforce project.

Core Skills Training

Core skills training is an area of focus identified by the CQC that requires improvement. Focused improvement work is underway to address the areas where compliance is not being achieved and maintained at professional group level. This analysis is monitored and managed through the Trust's Education, Training and Research (ETR) Report which is presented to the ETR Committee.

Please see table 28 below for detail of the Trust's Core Skill straining metrics.

Table 28 Core Skills training metrics

Staff Group	Mar-24
Conflict Resolution	98.59%
Equality, Diversity and Human Rights	94.82%
Fire Safety	95.16%
Health, Safety and Welfare	94.79%
Infection Prevention and Control - Level 1	93.88%
Infection Prevention and Control - Level 2	93.14%
Info Gov: All Staff	94.02%
Moving & Handling L1 (Non-Clinical)	83.52%
Moving & Handling L2 (Clinical)	84.50%
Preventing Radicalisation - Awareness	94.92%
Preventing Radicalisation - Basic Awareness	95.55%
Resus - Level 1, Non-Clinical	91.62%
Resus - Level 2, ABLS&PBLS	83.75%
Resus - Level 3, ILS	56.33%
Resus - Level 3, NILS	83.94%
Resus - Level 3, PILS	49.52%
Safeguarding Adults (Level 1)	95.93%
Safeguarding Adults (Level 2)	97.88%
Safeguarding Adults (Level 3)	92.37%
Safeguarding Children (Level 1)	94.67%
Safeguarding Children (Level 2)	96.00%
Safeguarding Children (Level 3)	90.08%

Quality Assurance

Our Quality Account has presented the data, information and assurance required by NHS England. The Trust has provided information related to the statutory core performance indicators and assurance on our data quality. The Trust has presented progress with our key priorities for 2023-24 which were stated

in the 2022-23 Quality Account and highlighted new priorities for 2023-24 which align to Our Big Plan. The Trust has presented a review of activity in relation to safety, effective care and patient experience which are aligned to the ambitions and risk appetite of the Trust.

Our Safety and Quality Committee promote a safety and quality culture in which staff are supported and empowered to improve services and care. The Committee provides the Board of Directors with assurance on the patient experience and outcomes of care 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 and ensuring appropriate and effective responses occur when indicated.
- Ensuring compliance with NHS England and relevant CQC standards.

Trust governors continue to be actively supportive of the Trust's quality improvement activities and continue to play a major part in providing assurance by participating in STAR and other quality assessments as well as attending our Patient Experience Improvement group.

Our Governor involvement in the New Hospitals Programme has been hugely valued and much appreciated by the Trust. Our governors also continue to offer valuable insights and challenge contributing to continuously improving the services we offer patients and our wider communities. Our Quality Account for 2023-24 has provided assurance of the performance and ongoing activity which promotes patient safety, effective care, and excellent experience.

Annex 1:

Statements from External Stakeholders

Statement from the Lancashire County Council Health Scrutiny Committee in response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account for 2023-24

This year the Lancashire County Council Health Scrutiny Committee have provided a comprehensive response to four of the eight Quality Accounts received (Blackpool, Lancashire and South Cumbria NHS Foundation Trust, NWAS and University Hospitals Morecambe Bay) due to the priorities in the Health Scrutiny work plan and this will be reviewed again next year.

The statement from is as follows: -

“Although we are unable to comment on this year’s Quality Account we are keen to engage and maintain an ongoing dialogue throughout 2024/25.”

Statement from Healthwatch Lancashire In response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2023-24

From: Jodie Carney
Manager
Healthwatch Lancashire,
Leyland House, Lancashire Business Park
Centurion Way, Leyland
PR26 6TY

Healthwatch Lancashire
Response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts Report for 23-24

Introduction

We are pleased to be able to submit the following considered response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts for 2023-24.

It was pleasing to see the reference tool at the beginning of the document used to measure success throughout.

Chief Executive's Statement

A comprehensive statement delivered from the Chief Executive Officer detailing challenges presented in Urgent Care pathways and the launch of the Patient Safety Incident Response Framework. Partnership working is highlighted and celebrated as being beneficial to the Trust, which we welcome any opportunities to support as a Healthwatch.

Registration with the Care Quality Commission

Trust Inspections

Urgent and emergency care, medicine and maternity at Preston requires improvement following an inspection in 2023. Although it is pleasing to learn that the Trust is no longer being monitored by the CQC regarding the management of mental health patients, we would be interested to learn about this concern and how it has since been resolved.

Review of Quality Performance- Experience of Care

Patient Care

Please note that the new role for the Maternity and Neonatal Voices Partnership is referred to as a lead now and not a chair.

It is pleasing to see ways in which there are opportunities for patient involvement, in terms of patient champions and the 16 forums, would it be possible to include how peoplecan become involved with these?

Patient experience feedbackFriends and

Family feedback

Patient experience of care is a key part of the role as Healthwatch and we are particularlyinterested in patients feedback which has been obtained by the Trust.

It is positive to learn that there has been a positive increase in response rates to feedbackand an increase of 11,359 pieces of feedback collect compared to last year. We look forward to learning of work that is underway to ensure that feedback is reflected frompeople of diverse communities.

Major Service Developments and Improvements

There is lots to celebrate here and this section highlights that although there are challenges, the Trust are continuing to implement developments and services that overallwill improve patient experience and care.

Summary

In accordance with the current NHS reporting requirements, mandatory quality indicatorsrequiring inclusion in the Quality Account, we believe that the Trust has fulfilled this requirement. The quality indicators, results and supporting narrative are clear and welllaid out.

Overall, this is a fair and well-balanced document which acknowledges areas for improvements and actions being taken to further improve patient treatment, care andsafety.

We welcome these and as a Healthwatch we are committed to supporting the Trust toachieve them.

Jodie Carney

Manager- Healthwatch Lancashire

Statement from NHS Lancashire and South Cumbria Integrated Care Board in response to the Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2023-24

Our ref: Quality account/2023-24

Please contact: Sarah O'Brien

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24 May 2024

Silas Nicholls
Chief Executive Officer
Lancashire Teaching Hospitals NHS Foundation Trust

Dear Silas

Re: ICB Response to Lancashire Teaching Hospitals NHS Trust Quality Account 2023/24

The Lancashire and South Cumbria Integrated Care Board (ICB) would like to take this opportunity to comment on the annual Quality Account from Lancashire Teaching Hospitals NHS Foundation Trust.

The ICB would also like to recognise all the challenging work that has been undertaken during 2023/24.

- Compliance with the year 5, 10 safety actions for maternity services demonstrating continued progress on the Trust's maternity improvement journey.
- Successful reduction in 104-week waiters in line with NHSE recovery plans
- Participation in 95% of national clinical audit (the Trust did not participate in Improving Quality in Crohn's and Colitis (IQCC), national diabetes footcare audit and national ophthalmology database (NOD) audit), the ICB acknowledge non-participation due to service pressures, appropriate staff to undertake and system requirements to undertake these but look forward to seeing participation in future years. It is also noted that the Trust participated in 100% of national confidential enquiries.
- Ensuring services were able to be safely operated whilst supporting staff during a period of continued industrial action, which impacted on services.

The CQC have undertaken inspections throughout 2023. The CQC ratings of services remain the same, "requires improvement" (rating remained since November 2019) The CQC rated safe, effective, responsive, and well led overall as requires improvement and caring as good. Surgery at Preston and urgent and emergency care and maternity at Chorley was rated good. With urgent and emergency care, medicine and maternity at Preston as requires improvement. The ICB notes CQC's acknowledgement of progress with performance, but echo the further work needed to address bed pressures, flow, and delivery of the financial plan. The ICB continues to support the Trust through engagement work with the One Plan.

The ICB acknowledges that Infection Prevention and Control (IPC), and most notably Clostridioides difficile (C. difficile) was a key priority for the ICB and Trust last year. It is recognised that in 2023-24 the Trust had a 3.6% increase (203 compared to 196 in 2022/23) in cases. However, the ICB is aware

that there has been a national increase in C. difficile infections across a significant proportion of Trusts nationally. The ICB is also aware that there are wider IPC issues linked to E. coli, Pseudomonas and Klebsiella species infections all being above the target objective figures. The ICB is assured of the risk management approach and the mitigating action plans in place, and also appreciate the constraints of success due to the estate.

In 2023/24, Trust performance in relation to NHS Constitutional targets was again adversely impacted by the residual effects from the pandemic as well as industrial action, the ICB value the progress that the Trust has made in attaining the NHSE recovery trajectories for 104 week waits and will continue to support the Trust in its plans for achievement over the coming year.

It is disappointing to note that the readmission rate for 0–15-year-olds is higher than the England's average, and showing a deteriorating position, the ICB looks forward to collaborating on the Trust's plans to improve and sustain this position.

The ICB acknowledges the increasing reporting rate for patient safety incidents, demonstrating a positive reporting culture, and recognises the driving themes for these relating to boarded patients, Thrombectomy service provision, treatment target breaches and prolonged waiting times. The ICB appreciates the work ongoing to improve these areas and commends the continued use of the Always Safety First Learning and Improvement forums to respond to learning from incidents.

The ICB recognises the Trust's commitment to improving the care it delivers to patients and the experience they received, despite the challenges that the last few years have brought. It is important to acknowledge increased service provision, including:

- A number of schemes undertaken through the Continuous Improvement Strategy, including "Flow Coaches" and "Big Rooms" for areas under pressure. These schemes provide multi-disciplinary staff with an opportunity for discussion, review and focused approaches for shared learning and identifying improvements for patient care and outcomes.
- PSIRF has been implemented and embedded into practice (phase 1 Nov 23, phase 2 Mar 24). With the culmination of five local PSIRF priorities – delayed recognition of a deteriorating patient, due to gaps in monitoring (including pregnant women), delayed, missed or incorrect cancer diagnosis, prescribing or administration error or near miss of anticoagulation medication, adverse discharge due to gaps in communication or misinformation and delay in responding to a critical pathology finding. The ICB will continue to work closely with the Trust and wider system to develop shared learning platforms and inform service improvements.
- The ICB acknowledge the 3 Never Events relating to wrong site surgery and mis-placed nasogastric tube. The ICB has seen the action plans and is assured that learning has been implemented and systems put in place to mitigate the risks identified. The ICB appreciate the regular engagement with the patient safety team and the open and transparent approach to the work around these Never Events.
- Safety Triangulation Accreditation Review (STAR) visits. Out of 126 clinical areas registered for these visits, 82% have achieved silver ratings and an increase of 25 areas (total of 52) have achieved gold awards. The ICB has been invited to participate in the STAR visits during 2024-25

The Trust acquired Finney House in November 2022 to enable the Trust to improve patient flow by providing 64 out-of-hospital health-led community bed capacity, reducing medicine bed capacity in hospital as a result. The ICB recognises the actions being taken to improve overall patient flow and support collaborative system working across the health economy. The ICB acknowledges the higher level of falls that have occurred within Finney house and appreciate that a thematic review and bespoke action plan has been put in place for the unit.

The Trust co-produced a new three-year Patient Experienced Involvement Strategy for 2022 to 2025 in collaboration with patients, families, carers, governors, and staff. It is positive to note that this

strategy links closely to a number of existing Trust strategies including Equality, Diversity, and Inclusion; Mental Health; Learning Disability and Autism; Dementia; and the Always Safety-First strategy. Actions will be monitored through the Patient Experience and Involvement Group, which in turn provides assurance to the Trust Safety and Quality Committee.

The ICB also notes that there have been some key achievements to support improved patient safety and experience including:

- Establishing links with underrepresented group the 'Sahara Centre'
- Creating an open and accountable reporting culture where staff are encouraged to identify and report issues.
- An increase in completed FFT surveys has been seen through 2023/24. Most services were over 90% for some or all quarters, except for ED which was consistently under the target. A re-design of ED is taking place to address the number of patients in the department and the number of patients waiting extended periods of time.
- Digitising food ordering systems with increased diverse options
- Redesigned gynaecology and women's assessment unit, and emergency department redesign and creation of an acute assessment unit
- 7-day bereavement services and recruitment to a full-time bereavement lead for women's services
- Development of day case surgery on the Chorley site
- Increased satisfaction of patients attending radiotherapy

The ICB appreciates that the Trust Quality Account for 2023/24 acknowledges that there are a number of areas where the Big Plan metrics were not met but some have been carried forward into 2024/25. It is positive to note the continued focus on these areas:

- Reduce pressure ulcers by 5%.
- Deliver the C. difficile measure within nationally set trajectory.
- Reduce sickness absence to 4%.
- Reduce vacancies by a further 5%.

To conclude, 2023/24 was a challenging year for the Trust in terms of the operational and workforce challenges, including through industrial action, financial pressures within the NHS and restoration recovery plans to reduce waiting lists. The ICB notes that these will continue into 2024/25 in terms of restoring services to full capacity and addressing the backlog of patients still waiting for treatment.

We look forward to working closely with the Trust with the 2024/2025 priorities and further developing our collaborative partnerships to continue to improve the quality of care to our patients.

Yours sincerely

Professor Sarah O'Brien
Chief Nurse

Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust
Quality Account: Feedback from Council of Governors Meeting on 16th April 2024

In line with the Trust's commitment to engage and consult with the Council of Governors at a meeting of 16th April 2024, governors were invited to consider and input into the two Quality Indicators for inclusion in the 2024-25 Quality Account.

The agreed topics which support putting patients are at the heart of what we do support delivery of The Patient Experience and Involvement Strategy 2022–2025 and the Patient Safety Incident Response Framework and are as follows: -

Indicator 1 Insight: The Trust improves its understanding of the patient experience by listening and gaining real insight by using multiple sources of information, including patient stories, impact statements and patient surveys. This will ensure the patient and family voice is truly "heard," especially of those hear less often.

Indicator 2. The involvement of patients, families, carers when they have experienced an incident is meaningful, individualized and they are treated with respect and compassion ensuring leading to genuine and compassionate learning from incidents, especially of those involved less

Annex 2:

Statement of directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2023-24 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2023 to March 2024.
- Papers relating to quality reported to the Board over the period April 2023 to March 2023.
- Feedback from Integrated Care Board 24th May 2024
- Feedback from Healthwatch 29th May 2024
- Feedback from Overview and Scrutiny Committee 31st May 2024
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 is incorporated in the Annual Patient Experience Report 2023-24.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review by MIAA to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHSI's Quality Account manual and supporting guidance as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Peter White
Chair Date: 18th June 2024

Silas Nicholls
Chief Executive Date: 18th June 2024

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Glossary of Abbreviations

A&E	Accident & Emergency
AHP	Allied Health Professionals
AMaT	Audit Management and Tracking System
AMG	Antimicrobial Management Group
AQuA	Advancing Quality Alliance
BAF	Board Assurance Framework
BAUS	British Association of Urological Surgeons
BI	Business Intelligence
BRC	Biomedical Research Centre
CAHPR	Council for Allied Health Professions Research
CBG	Capillary Blood Gas
CDH	Chorley District Hospital
C.Difficile	Clostridioides Difficile
CDOP	Child Death Overview Panel
CEMD	Confidential Enquiry in Maternal Deaths
CI	Continuous Improvement
CIWA	Clinical Institute Withdrawal Assessment for Alcohol
CMP	Case Mix Programme
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
CP-IS	Child Protection Information Sharing System
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CrCu	Critical Care Unit
CSAP	Child Safeguarding Assurance Partnership
CSC	Children's Social Care
CTG	Cardiotocograph
CYP	Children & Young People
DIPC	Director of Infection Prevention & Control
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DNAR	Do Not Attempt Resuscitation

DoLs	Deprivation of Liberty Safeguards
DSPT	Data Security and Protection Tool
E.coli	Escherichia coli
ED	Emergency Department
EDI	Equality Diversity Inclusion
EOS	Early Onset of Sepsis
EPMA	Electronic Prescribing and Medicines Administration
EWS	Early Warning Score
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FTSU	Freedom to Speak Up (FTSU) guardian
FY1	Foundation Year 1
FY2	Foundation Year 2
FY3	Foundation Year 3
GAS	Group A streptococcus
GDPR	General Data Protection Regulations
GGI	Good Governance Institute
GICAP	Gastro-intestinal Cancer Audit
GIRFT	Getting It Right First Time
GMC	General Medical Council
GP	General Practitioners
GSK	GalaxoSmithKline
H&N	Head and Neck
HCG	Human chorionic gonadotropin
HOHA	Healthcare Onset/Healthcare Associated
HSSIB	Health Services Safety Investigation Body
HSMR	Hospital Standardised Mortality Ratio
HQIP	Healthcare Quality Improvement Partnership
HVLC	High Volume, Low Complexity
IARC	International Agency for Research on Cancer
IBD	Inflammatory Bowel Disease (Programme)

ICB	Integrated Care Board
ICNARC	Intensive Care National Audit & Research Centre
ICO	Information Commissioner's Office
ICS	Integrated Care System
IDA	Iron Deficiency Anaemia
iGAS	Invasive group A Streptococcus
INCS	Integrated Nutrition and Communication Service
IPC	Infection Prevention and Control
IPL	Inter-professional learners
IT	Information Technology
LCRF	Lancashire Clinical Research Facility
LeDeR	Learning Disability Mortality Review Programme
LFPSE	Learn from patient safety events
LMNS	Local Maternity Neonatal Systems
LSAB	Lancashire Safeguarding Adults Board
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust
MASH	Multi Agency Safeguarding Hubs
MAU	Medical Assessment Unit
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MCA	Mental Capacity Act
MCCDs	Medical Certificate of Cause of Death
MDT	Multidisciplinary Team
ME/MEs	Medical Examiner/s
MEO/MEOs	Medical Examiner Officer/s
MHRA	Healthcare Products Regulatory Agency
MIAA	Mersey Internal Audit Agency
MINAP	Myocardial Ischaemia National Audit Project
MITRE	Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit
MRSA	Methicillin Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MUST	Malnutrition Universal Screening Tool

NABCOP	National Audit of Breast Cancer in Older Patients
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
NACEL	National Audit of Care at the End of Life
NAIF	National Audit of Inpatient Falls
NCAA	National Cardiac Arrest Audit
NCAP	National Cardiac Audit Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCMD	National Child Mortality Database
NCPRES	National Cancer Patient Experience Survey
NDA	National Adult Diabetes Audit
NELA	National Emergency Laparotomy Audit
NGT	Nasogastric tube
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIH	National Institute of Health (USA)
NIHR	National Institute for Health and Care Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NMAHP	Nursing Midwifery Allied Health Professionals
NMPA	National Maternity and Perinatal Audit
NMPs	Non-Medical Prescribers
NNAP	National Neonatal Audit Programme
NOGCA	National Oesophago-gastric Cancer Audit
NPCA	National Prostate Cancer Audit
NPDA	National Paediatric Diabetes Audit
NPSA	National Patent Safety Agency
NRLS	National Reporting and Learning System
NVR	National Vascular Registry

OGD	Oesophago Gastro Duodenoscopy
ORDER	Overseas Registrar Development and Recruitment
PALS	Patient Advice and Liaison Service
PAU	Paediatric Assessment Unit
PCR	Polymerase Chain Reaction
PEWS	Paediatric Early Warning Score
PHSO	Parliamentary and Health Service Ombudsman
PIRs	Post Infection Reviews
PMRT	Perinatal Mortality Review Tool
POP	Plaster of Paris
PPE	Personal protective equipment
PQIP	Perioperative Quality Improvement Programme
PROMs	Patient Reported Outcome Measures
PROMPT	Practical Obstetric Multi-Professional Training
PSCF	Procedure-Specific Consent Form
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PUL	Pregnancy of unknown location
QIPs	Quality Improvement Programmes
RAG	Red, Amber and Green
RALP	Robot-Assisted Laparoscopic Radical Prostatectomy
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
REJOIN	Emergency ureteric injury management
RPH	Royal Preston Hospital
SAMBA	Society for Acute Medicine Benchmarking Audit
SAS	Speciality and Specialist grade
SAU	Surgical Assessment Unit
S. aureus	Staphylococcus aureus
SBAR	Situation-Background-Assessment-Recommendation
SDEC	Same Day Emergency Care

SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusions
SIRO	Senior Information Risk Owner
SJR	Structured Judgement Review
SLT	Speech and Language Therapy
SMR	Standardised Mortality Ratio
SMRC	Specialist Mobility Rehabilitation Centre
SPC	Statistical Process Control
SPCMHT	Specialist Perinatal Community Mental Health Team
SSNAP	Sentinel Stroke National Audit Programme
ST 1-2	Speciality Trainee 1-2
ST 3+	Speciality Trainee 3+
STAR	Safety Triangulation Accreditation Review
StEIS	Strategic Executive Information System
SUDC	Sudden Unexpected Death in Childhood
SUS	Secondary User Service
TACT	Tobacco and Alcohol Care Team
TARN	Trauma Audit and Research Network
TED	Team Engagement and Development Tool
TVNs	Tissue Viability Nurses
UGI	Upper Gastro-Intestinal
UKCRF	UK Clinical Research Facility
UKHSA	UK Health Security Agency
VTE	Venous Thromboembolism
WHO	World Health Organisation

Board of Directors Report

Safeguarding Annual Report 2023/24

Report to:	Board of Directors	**Date:**	1st August
Report of:	Chief Nursing Officer	**Prepared by:**	Head of Safeguarding
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary

The purpose of this report is to provide an annual account of safeguarding activity and assurances to the Board of Directors following scrutiny at the Safety and Quality Committee demonstrating the organisation's commitment to safeguarding.

The report demonstrates that demand and activity across the safeguarding agenda has continued to increase and that safeguarding team partnership and system working and shared learning across Lancashire and South Cumbria is in place. The Trust is compliant with the requirements of the NHS England and NHS Improvement Safeguarding Accountability and Assurance Framework (2019) and the local Children's Safeguarding Assurance Partnership (CSAP) and Lancashire Safeguarding Adults Board (LSAB).

Continuous improvement methodology drives the approach and delivery of the safeguarding agenda and evidence of sustainability is obtained by robust audit activity, demonstrating lessons learnt, and ensuring improvements are embedded in practice.

Overall, the report demonstrates a sustained improved safeguarding adult and child position. The Trust is compliant with all elements of safeguarding training and has delivered improvements across the safeguarding agenda during 2023/24, some of which are detailed below:

- Consistent compliance with safeguarding training for children and adults.
- Section 42 process has been refined to ensure robust governance and opportunities for shared learning.
- Maintained Trust wide assurance in the improved compliance for MCA/DoLS.
- Continued implementation of regular safeguarding supervision and recording of compliance via the annual appraisal system.
- Robust audit activity across multiple areas to gain assurance in staff knowledge and compliance of processes in place.
- Publication of the Learning Disability Plan and Autism Strategy.
- Implementation of the Dementia and Mental Health strategies.

- Recruitment to key positions including Head of Safeguarding, Independent Health Independent Domestic Violence Advisor (HIDVA) and Health Independent Sexual Violence Advisor (HISVA).
- Established Cycle of Business into the Safeguarding Board with divisional reports and learning bulletins.
- Joint Targeted Area Inspection (JTAI) - Serious Youth Violence inspection held in February 2024, highlighted positive practice and highlighted the need to increase professional curiosity and the voice of the child, the action plan to respond to this is underway.
- Proactive safe sleep improvement work has lead to national recognition and inclusion in Student Midwife training.
- Launch of the new sexual safety policy April 2024
- The High Intensity User service has demonstrated all patients have reached the 20% KPI reduction for 12-month post discharge from the HIU Service
- The MIAA PiPOT audit provided a moderate assurance outcome, the actions in response to recommendations have commenced.
- The MIAA Safeguarding Supervision audit provided a substantial assurance outcome.

Service risks include:

- Access to mental health beds for children/young people and adults.
- Management of mental health risk behaviours in the hospital setting particularly when awaiting a mental health bed, and the continued drive to implement the mental health risk assessment tool.
- Time spent in acute hospitals for children who require ongoing mental health input and/or local authority placements.
- Knowledge and understanding of the MCA/DoLS process and Local Authority Authorisations processes remain outside of agreed parameters.
- Increasing complexity and volume of safeguarding activity.
- Increased focus on children and young people (outside of specific children services).
- Staffing gaps due to the inability to recruit suitably trained staff has impacted on the team.

The Board of Directors are asked to receive the content of the Safeguarding Annual Report for information.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Safeguarding Annual Report 2023/24

1.1. Purpose

1.1.1 The purpose of this report is to provide an annual account of safeguarding activity and assurances to the Board of Directors following scrunty at the Safety and Quality Committee demonstrating the organisation's commitment to safeguarding. The report will provide an overview of the increasing safeguarding activity and developments across the safeguarding agenda. The report demonstrates compliance with statutory standards and evidence of how lessons learnt from serious incidents are embedded in practice, resulting in better outcomes, improved safety and quality in the care delivered to the most vulnerable patients and families. The safeguarding team cover the safeguarding and vulnerable people agenda from "cradle to the grave". This includes:

- Children and Young People
- Adults
- Maternity services
- Mental Health, Learning Disabilities, Autism and Dementia

1.2. Governance and Accountability Arrangements

1.2.1. As per statutory requirements the Trust holds positions for a Head of Safeguarding, Named Doctor for Safeguarding Adults, Named Doctor for Safeguarding Children, Named Nurses for both adults and children and a Named Midwife. The Trust employs a Matron for Mental Health, Learning Disabilities, Autism and Dementia within the safeguarding team, ensuring the safeguarding/vulnerable people agenda has nursing/midwifery senior leadership and strategic direction across the portfolio. The team operationally report to the Head of Safeguarding with accountability and overall strategic leadership to the Deputy Chief Nursing Officer and ultimately to the Chief Nursing Officer who holds the Executive responsibility for safeguarding. The Chief Nursing Officer is also the Health Executive lead for provider Organisations at the Lancashire and South Cumbria Safeguarding Health Executive Group, which feeds into the Local Safeguarding Adult Board (LSAB) and Child Safeguarding Assurance Partnership (CSAP).

1.2.2. The Trust is well represented across the local safeguarding partnership arrangements including executive and senior operational level via the Chief Nursing Officer and Head of Safeguarding. As a large provider organisation, the Trust is fully sighted and actively involved in the safeguarding agenda and board priorities for Lancashire and South Cumbria. The board priorities are linked to the activities undertaken within the safeguarding team annual work plan. In addition, the named professionals and safeguarding team are active members on several sub-groups to the LSAB, CSAP, and Mental Health Transformation work. During the reporting year the safeguarding partnership for Pan-Lancashire has moved to place based board arrangements and the first Lancashire safeguarding board was held in September 2023. This has provided an opportunity to review the effectiveness of the safeguarding partnership arrangements with a plan to strengthen the audit activity and improve connectivity with the relevant strategic boards.

2. Annual Safeguarding Activities Highlights (2023/24)

2.1. Patient Safety Incident Response Framework (PSIRF)

2.1.1. The safeguarding team have been an integral part of the Trust PSIRF implementation and operationalisation process sitting on both the PSIRF Triage and Oversight Panels to support with safeguarding incidents, particularly, those that meet the Care Act (2014) Section 42 inquiry threshold. The safeguarding team in collaboration with the governance team, have developed a PSIRF Section 42 safeguarding incidents triage process (see appendix 1) to ensure that relevant and appropriate safeguarding incidents are escalated to the PSIRF Triage and Oversight Panels and that improvement actions are prioritised, and learning is shared. This triage process compliments the new Pan-Lancashire Section 42 safeguarding incidents inquiry and management process (see appendix 2). All safeguarding incidents from the local authority are now classified as Section 42 inquiries which means an increase in the workload due to the statutory demands of addressing Section 42 safeguarding incidents. Therefore, the Pan-Lancashire Section 42 safeguarding incidents management process was co-developed with the contribution of Lancashire Teaching Hospitals NHS Trust (LTH) safeguarding team with the aim to reduce the statutory workload demands and focus resource where it is needed.

2.2. New Working Together to Safeguard Children (2023)

2.2.1. In December 2023 the New Working Together to Safeguard Children (2023) came into effect and replaced Working Together to Safeguard Children (2018). Working Together to Safeguard Children (2023) focuses on strengthening multi-agency working across the whole system of help, support and protection for children and their families, keeping a child-centred approach while bringing a whole-family focus, and embedding strong, effective, and consistent multi-agency child protection practice. The update and changes include:

- Principles for working with parents and carers that centre the importance of building positive, trusting, and co-operative relationships to deliver tailored support to families.
- Expectations for multi-agency working that apply to all individuals, agencies and organisations working with children and their families, across a range of roles and activities.
- New national multi-agency child protection standards that set out actions, considerations and behaviours for improved child protection practice and better outcomes for children.
- Improving Practice with Children, Young People and Families Guidance – this provides advice for local areas on embedding working together to safeguard children and the children's social care national framework.
- Statutory framework - the updated statutory framework sets out the legislation relevant to safeguarding and should be read alongside the statutory guidance.

2.2.2. The Head of Safeguarding is currently working with system partners through the Pan-Lancashire Children's Safeguarding Assurance Partnership (CSAP) Board to ensure there is consistency in the implementation of the new framework and improved multi-agency working between system partners. The Head of Safeguarding is also working together with the Trust Named Nurse for Children and Young People, and Named Midwife to ascertain how these updates and changes can be embedded in Trust processes to strengthen safeguards for children, young people, and their families.

2.3. Thirlwall Inquiry (Lucy Letby Response)

2.3.1. The government has now agreed the terms of reference for the Thirlwall Public Inquiry to examine events in the neonatal unit at The Countess of Chester Hospital where Registered nurse Lucy Letby murdered seven babies and attempted to murder six others.

2.3.2. Although the inquiry is expected to start in autumn 2024, the Trust is already engaged with system partners through Pan-Lancashire CSAP and Child Death Overview Panel meetings as an immediate response to the identified concerns from the Letby case and in anticipation of the learning/recommendations from the inquiry. Furthermore, as part of the response, there is a renewed focus on the Trust to ensure that it has robust systems in place to support whistleblowing and that Freedom to Speak Up (FTSU) is embedded across all services within the Trust. The Trust has an established formal FTSU offer of support which is connected both locally and nationally to this agenda. The Trust has developed strong connectivity between FTSU initiative, our Persons in Position of Trust (PiPoT) process, Local Area Designated Officer (LADO), and safeguarding responsibilities to ensure that all members of staff have access to safe spaces to raise any concerns that may bring harm to children and vulnerable adults. Additionally, learning from the incidents at the Countess of Chester has been embedded into the revised Trust Managing Allegations (PiPoT) policy.

2.4. Child Protection Information Sharing (CP-IS) Service

2.4.1. The Child Protection Information Sharing (CP-IS) system is a process that enables Local Authorities to flag children that are subject to child protection or looked after children plans on the Summary Care Record (SCR). A check on SCR alerts health staff that the child has a plan and sends an automated message to the social work team that the child has accessed a health care setting. At LTH this is now successfully embedded into the Emergency Departments, and the Trust is currently working with NHS Digital to have the system implemented in community paediatrics at the Broadoak site.

2.5. Joint Targeted Area Inspection (JTAI) - Serious Youth Violence

2.5.1. A JTAI was held Lancashire and South Cumbria-wide led by an inspection team of 16, inclusive of Care Quality Commission (CQC), Office for Standards in Education (Ofsted), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), and His Majesty's Inspectorate of Probation (HMIP) which commenced at the beginning of February 2024. LTH was required to return an audit of relevant cases prior to the inspection and to discuss cases brought by the Inspectors on the inspection day. The Inspectors attended Emergency Department (ED) and looked through several cases held by the Trust's ED Navigator and cases prior to this post commencing. Good practice was identified by the inspectors in relation to the ED Navigator and focus of the role, which is based on quality interactions and support for the attending child and the whole family, namely 'Think Family'. It was also acknowledged that the Social Care referrals that were reviewed were of good quality and copies were uploaded to Evolve.

2.5.2.The Inspectors noted that throughout all the records reviewed, there was no 'victim blaming' language used by colleagues. All documentation was professional, and trauma informed. The Inspectors also positively commented on the use of direct quotes from a child, highlighting that their voice was heard and listened to by staff.

2.5.3 Gaps that were identified during the inspection included a lack of evidence of the voice of the child within ED records, lack of documentation regarding who held parental responsibility (PR) for a child and lack of documentation regarding whether a child was subject to a legal order. Since the inspection actions have been taken in response to the findings which have included an update to the paediatric liaison form to include the voice of the child and legal orders. A seven-minute briefing has also been compiled and shared in relation to Professional Curiosity.

2.6. Liberty Protection Safeguards (LPS)

2.6.1. In response to concerns around Deprivation of Liberty Safeguards (DoLS), the government intended to introduce LPS to replace DoLS at the beginning of 2023 following a postponement of the proposed introduction in 2020 due to COVID-19, however, these plans have now been deferred indefinitely.

2.6.2. The current DoLS system continues to struggle to cope with demand for assessments and problems with the process, including delays in processing and authorising applications and the inconsistent staff knowledge about the safeguards.

2.6.3. The safeguarding team and its leadership are continuing to raise awareness regarding the DoLs process and what that this means for vulnerable people who are potentially going to be deprived of their liberty and identifies patients at risk. The Local authority (LA) is responsible for authorisation of the applications and this poses delays. Disabled people and older people are more likely to require the safeguards offered by DoLS when in health and social care services and will therefore be disproportionately affected by the decision to delay LPS. The Safeguarding team, through various forums, is committed to work with system partners to continue to raise the profile of this issue and lobbying for a better system that protects our vulnerable children/young people and adults. LTH is currently working on improving staff knowledge of MCA/DoLS and the Trust MCA/DoLS Lead is working with system partner to review the MCA/DoLS process to ensure consistency across Lancashire place. The Trust remains compliant with the notification process and the processing of DoLS application by external partners remains an issue (see Section 6 for further details).

2.7. New PREVENT and CHANNEL Counter Terrorism Guidance

2.7.1. New PREVENT and CHANNEL guidance was published in December 2023. The updates are the repositioning of focus for the two statutory guidance which is reflected in the change in terminology from ‘Protecting people vulnerable to being drawn into terrorism’ to ‘Protecting people susceptible to radicalisation’ in the new guidance. The notion behind the change in terminology is to capture a wider risk group by recognising that not only vulnerable people can be drawn into terrorism activities but also other members of the public who may be deemed not to necessarily meet the threshold for the ‘vulnerable person’ definition. The Head of Safeguarding is the Trust PREVENT Lead and is currently working with system partners and the Lancashire and South Cumbria ICB Head of Safeguarding to ensure consistency in the adoption of the guidance into policies and procedures across the system.

2.8. Sexual Safety Policy

2.8.1. The Sexual Safety policy was developed in response to His Majesty Westminster/House of Commons parliamentary debate, May 2023 around Investigations of Abuse and Sexual Assaults in the NHS and the need for NHS leaders to have oversight of the scale and types of problems that are being seen within the NHS. This position was further strengthened by NHS England Sexual Safety Charter (2023) which commits signatories to take and enforce a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace and adhere to the charter’s ten core principles and actions to achieve this. Consequently, the safeguarding team developed a new standalone Sexual Safety policy for both patients and staff in consultation with Workforce and divisional colleagues in response to NHS England Sexual Safety Charter (2023) launch. The policy has now been completed and is in effect as of April 2024. This is a positive step forward to support the managing allegations processes where sexual safety is implicated.

2.9. Mersey Internal Audit Agency (MIAA) Report - Action Plan

2.9.1. The MIAA audit for Safeguarding Supervision and Persons in a Position of Trust (PiPoT) September 2023 gave moderate assurance for Persons in a Position of Trust (PiPoT), and found that the Trust had

a comprehensive framework for the management of allegations made against PiPoT. Roles and responsibilities were defined as was the governance reporting arrangements. A review of randomly selected managing allegation incidents within Datix found areas for improvement relating to the completeness of the Datix records, and there was no quality assurance process identified to check the Datix records for completeness.

2.9.2. In relation to Safeguarding Supervision element, the audit gave substantial assurance and found that the Trust had a formal framework which aligned to national guidance. Roles and responsibilities for supervisors and supervisees were defined including the requirement to record safeguarding supervision sessions. The recommendations have actions assigned to these and are monitored via audit committee.

2.10. Violence Risk Alerts

2.10.1. The Head of Safeguarding is now the Senior Responsible Officer (SRO), accountable to the Chief Nurse, for patient violence/aggression risk against staff on the Trust Single Improvement Plan. The plan will incorporate Multi-Disciplinary Team training, restraint, least restrictive practices, enhanced levels of care to minimise and deescalate violence. Reporting of progress against the plan will be completed via the Single Improvement Plan reports.

3. Maternity

3.1. System Partnership Working Assurance

3.1.1. The Trust maternity and children's safeguarding teams continues to contribute to various Pan-Lancashire safeguarding children and young people agendas and workstreams through multi-agency working, attendance, and participation in several Pan-Lancashire children and young people safeguarding groups and subgroups (see appendix 3). The Trust Named Midwife is a representative of the Lancashire Pre-birth task and finish group which reviews the pre-birth pathways, pre-birth assessments, and good practice guidance with children's' social care to ensure that they are linked to the strength-based model of practice and learning from current research and best practice guidance undertaken by Nuffield Family Justice Observatory.

3.2.2 Fig.2 shows that during the past 12 months there has been a significant increase in the overall safeguarding activity within Maternity in comparison to the previous year. There has been a 10% increase in the number of referrals to the Enhanced Support Midwifery Team (ESMT) with the number of out of area referrals being consistent with the previous year. There has been a 54 % increase in the number of cases referred to Children Social Care (CSC). The number of Female Genital Mutilation (FGM) referrals have increased by 45% in comparison to the previous year. The referrals to the Specialist Perinatal mental health team have increased by 39% .

3.2.3. The ESMT have made 29 referrals to the Reproductive Trauma service over the past 12 months in comparison to 19 from the previous year. The ESMT have had 207 domestic abuse notifications over the past 12 months in comparison to 176 from the previous year, 99 of these cases were heard at the Multi-Agency Risk Assessment Conference (MARAC). LTH has now appointed a Health Independent Domestic Violence Advisor (HIDVA), a Health Independent Sexual Violence Advisor (HISVA) who have supported the ESMT in caring for these women to ensure their safety and ensure they receive the support they require at the right time. Safeguarding Supervision is embedded within maternity and across the Trust. The ESMT have delivered 105 safeguarding supervision sessions to 277 members of staff over the past 12 months across maternity and the corporate team. In addition, the Enhanced Support Midwifery Team attend the safety huddle daily where case discussions are held. It has been identified that 3636 case discussions have been held throughout the past 12 months as part of the

huddle process. This ensures that any safeguarding concerns are dealt with in a timely manner and that staff are fully supported. There have been 16 care orders granted in court over the past 12 months and 11 sets of 'Hold On Pain Eases' (HOPE) boxes given out to the 11 women who have had babies removed from their care. The HOPE boxes were well accepted and appreciated by the women and will help to reduce the trauma when a decision is made in court to remove a baby from a woman's care.

3.3. Safer Sleep

3.3.1. A safer sleep risk assessment tool has also been introduced within maternity, Neonatal Intensive Care Unit (NICU) and NICU outreach, paediatrics, urgent care, and the emergency department. Safer sleep guidelines have been developed to support staff to undertake safer sleep discussions with parents/carers and ensure consistent advice is being provided by professionals across Pan-Lancashire. The ESMT and safeguarding children's team have provided safer sleep training to staff who will be completing the assessments to increase their knowledge and skills and ensure consistent advice is being given to parents and carers. The risk assessment tool and guideline aim to reduce the number of child deaths because of unsafe sleep practices including bed-sharing and co-sleeping. Audits have been completed in maternity and NICU which have provided significant assurance of compliance and the quality of assessments being undertaken. The safer sleep guidance has recently been updated in line with National Institute for Health and Care Excellence (NICE) Recommendations, National Guidance and the Lullaby Trust Guidance and will be launched in Lancashire in May 2024.This new guidance includes sections on older children, and older children with complex medical needs and babies who are on NICU. Following this, the safer sleep guidance was updated and safeguarded through training.

3.3.2.A briefing and Standard Operating Procedures (SOP) has been produced regarding mothers being admitted to adult wards for treatment accompanied by their babies following several women being admitted for treatment with their well-baby. The ESMT and the wider Trust promoted Safer Sleep week on the 11th – 17th March 2024 across all social media channels and displays were created in each relevant area across the Trust. Pictures of the displays were shared with Child Death Overview Panel (CDOP), Sudden Unexplained Death in Childhood (SUDC), the Safer Sleep Task and Finish group and with the Lullaby Trust. The Trust Named Midwife and SUDC chair also promoted safer sleep when they were interviewed by Rock FM and Radio Lancashire. The SUDC group also delivered a webinar on the 14th of March 2024 to promote safer sleep. The Safer Sleep Project team were selected in the final three for the Best Safety Initiative award from the LTH Our People Awards.

3.4. ICON Programme

I Infant crying is normal and it will stop

C Comforting can sometimes soothe the baby – is the baby hungry, tired, or in need of a nappy change?

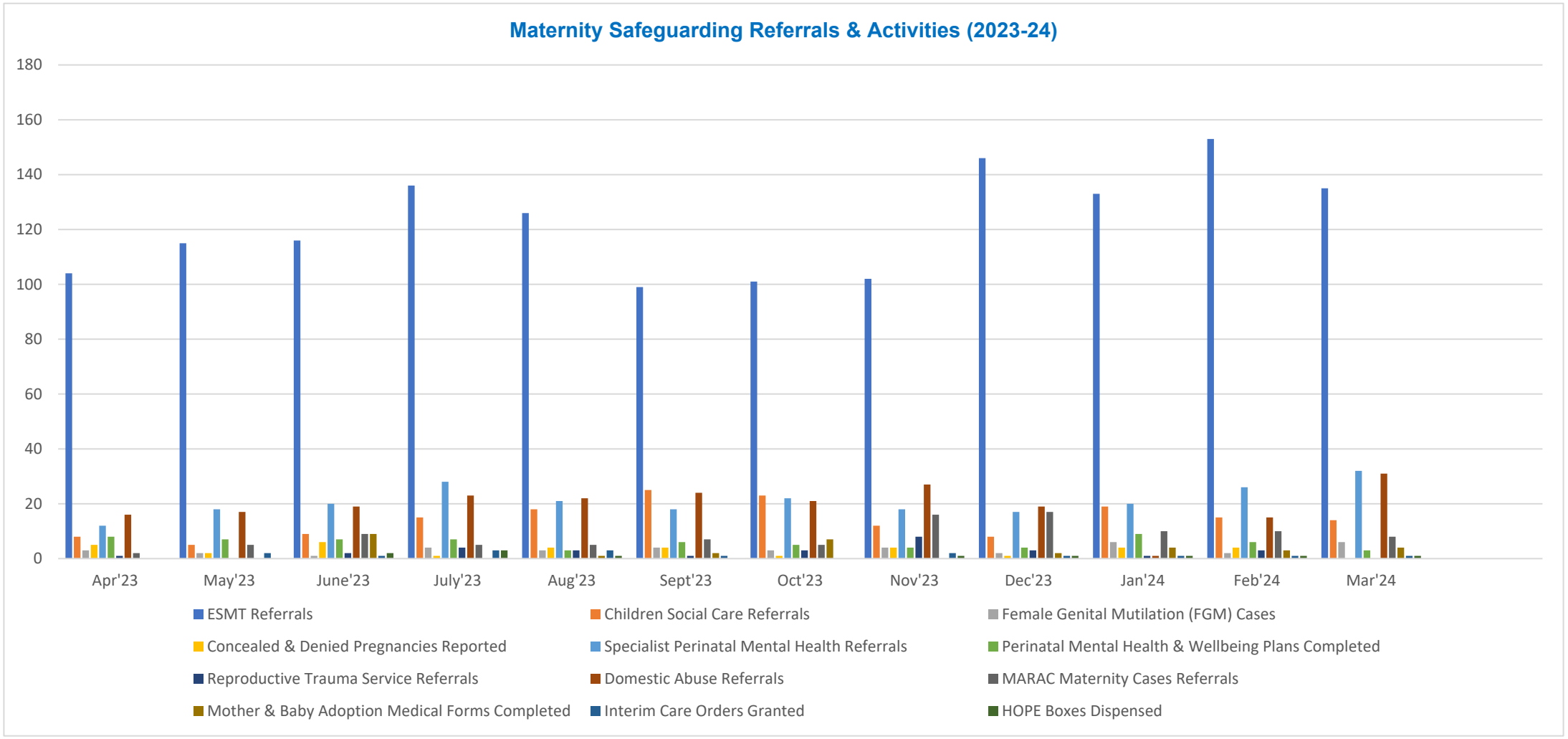
It's **O**kay to walk away if you have checked the baby is safe and the crying is getting to you. After a few minutes, when you're feeling calm, go back and check on the baby;

N Never shake or harm a baby; it can cause lasting damage or death

If you need support, speak to someone such as:
your family, friends, Midwife, Health Visitor or GP

3.2. Maternity Annual Safeguarding Activity

Fig.2. Maternity Safeguarding Referrals & Activity Data



3.4.1. The ICON programme (Babies Cry, You Can Cope) is a CDOP campaign which aims to help parents and carers to cope with a crying baby. The recommendation for resources came from several infant deaths and serious case reviews where a baby has died or been seriously injured because of Abusive Head Trauma (AHT). The Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership, and the Pan-Lancashire CDOP have raised awareness of key messages and resources to let parents and carers know that infant crying is normal and there are methods which can be taken to cope. Messages were shared as part of ICON week 25th – 29th September 2023 across the Trust and Pan Lancashire, which included lighting up the Maternity Unit, Preston Market, LTH Emergency Department, and Blackpool Tower in the ICON colour to raise awareness. LTH engaged Northwest Ambulance Service, Enterprise, Midwifery, the wider Trust, footballers from Preston North End, Burnley, Blackburn Rovers, University of Central Lancashire (UCLAN) to record videos and messages to raise the ICON message on all social media channels. Articles were also published in the local press to raise awareness of ICON. The Named Midwife was also interviewed on 'That's TV' to raise the importance of the ICON messages.

3.4.2. The ESMT and Trust Communication team received a thank you from the CDOP Chair for their hard work in raising awareness regarding ICON during ICON week. The work that LTH had completed to raise the ICON messages were also featured in the national newsletter. The Named Midwife for Safeguarding has worked in conjunction with UCLAN to ensure that the ICON learning package is now part of the Midwifery core training. The ESMT in collaboration with UCLAN have also provided two-days safeguarding simulation training session followed by a debrief session to Midwifery students. These sessions received positive feedback from the students and further sessions have been planned for May and June 2024.

3.5. Reproductive Trauma Service and Perinatal Mental Health

3.5.1. Lancashire and South Cumbria Reproductive Trauma Service celebrated its second anniversary, and over the last two years they have triaged more than 900 referrals therefore ensuring that those women and their families receive the most appropriate support from the most appropriate service for them and their needs. They have been shortlisted for several awards including one with the Royal College of Midwifery Award and were awarded the NHS Parliamentary Award for Excellence in Mental Health. The integrated maternity and mental health team works with all six Trusts, service users, key partners and stakeholders across Lancashire and South Cumbria, offering assessment and intervention for women with severe/complex mental health difficulties and those with symptoms of Post Traumatic Stress Disorder (PTSD) following birth trauma, fear of childbirth or perinatal loss.

3.5.2. The peer support coordinator carefully matches up mothers/fathers/partners and co-parents with an appropriate peer support volunteer based on experiences, demographics, and the need to provide additional pastoral support. ESMT have promoted Perinatal Mental Health awareness week in May.

3.6. Rapid Reviews (External) and Child Safeguarding Practice Reviews

3.6.1. In the previous 12 months, the Maternity and Children's Safeguarding Teams have been part of five external Rapid Reviews for children who have suffered significant harm or have died. The Rapid Review is important for deciding if the case should go forward to a Local Child Safeguarding Practice Review, however, the Rapid Review itself can provide immediate learning for dissemination.

3.6.2. The lessons learned included that the teams involved in the mother's care ensured that all information was provided to the mother, an increased focus on consent and provisions of one to one care on the inpatient wards. The paediatric cases lessons learned focused on the process regarding bruising on

non-mobile babies leading to a Trust 7 Minute Briefing in relation to bruising in non-mobile babies being developed. Work is still on-going in relation to the collection of demographics of family members and those living with the child, in view of recent reports relating to the 'Hidden Male' such as 'The myth of invisible men' (Child Safeguarding Practice Review Panel [CSPRP], 2021). An outcome of this has been a change in the documentation used by the Children's Community Nursing Team to include a section for demographics for those living with the child or who have significant involvement in their lives.

3.7. Maternity Audit Activity

3.7.1. The annual safeguarding audit activity is directed by the local safeguarding board priorities, previous CQC "must do's and should do's" and learning from local and national safeguarding practice reviews. Audit activity for 2023/2024 includes:

- Annual Maternity Alcohol consumption screening audit at the initial booking appointment
- Annual Maternity Mental Health audit of the Whooley screening questions at the initial booking appointment
- Annual Maternity domestic abuse audit regarding routine enquiry and compliance with NICE Guidance
- Annual Maternity Safer Sleep audit regarding the compliance of the safer sleep assessment tool
- Annual FGM audit regarding the compliance of following the correct pathway when FGM is identified

3.8. Audit Activity

The audit activity within safeguarding is summarised below:

- Excellent compliance regarding maternal mental health risk assessments (Whooley questions) being completed at maternity booking appointments. 50 case notes were audited retrospectively between January 2023 to September 2023 and showed 100% compliance. Out of the 4 women/birthing person who gave a positive response to the Whooley questions there was 100% compliance in completing the Patient Health Questionnaire 9 (PHQ9) and General Anxiety Disorder 7 (GAD7) screening tool and following the correct pathway.
- Assurance that women are being seen alone as part of their booking appointment and that routine enquiry into domestic abuse during pregnancy is being undertaken. 50 case notes were audited retrospectively between January 2023 to September 2023 in which 88% of women/birthing person were seen alone during their booking appointment and if not seen alone 100% of women/birthing person electronic BadgerNet records were flagged to ask routine enquiry at the next appointment.Of the 50 case notes audited 100% were asked routine enquiry at their Community Midwife antenatal appointments during pregnancy. This shows full compliance for asking routine enquiry at any point during pregnancy. The audit also showed 100% compliance in ensuring that each woman/birthing person was given a safe opportunity to be asked routine enquiry into domestic abuse on at least 2 occasions.
- Assurance that the safer sleep assessment tool is being completed. Out of the 50 sets of case notes audited between June 2023 to September 2023 the safer sleep assessment tool was completed in the following ways: 98% prior to discharge from hospital/ home birth which was an increase of 10% from the previous audit, 86% on the primary visit which showed an increase of 4% since the previous audit, 94% at discharge to the Health Visitor which showed an increase of 8% since the previous audit. It also showed that 80% of the women/families had had a safe sleep assessment completed on all 3

occasions which shows a 10% improvement from the previous audit. It also showed that the safer sleep assessment tool had been completed at least once in 100% of the notes.

- Assurance that pregnant women are being screened regarding alcohol consumption at the initial booking appointment. 50 case notes reviewed between January 2023 to October 2023 in which 100% of women/birthing person were asked routine enquiry in relation to alcohol consumption at the initial booking appointment. The audit also showed 100% in asking routine enquiry regarding partner's alcohol consumption.
- The Female Genital Mutilation (FGM) audit provided assurance regarding staff knowledge around FGM and the FGM policy and guideline. This audit focused on several areas of the Trust including maternity, gynaecology, safeguarding, and the neonatal unit. FGM is incorporated into maternity training and is now incorporated into the Safeguarding children and adults training which may be attributable to staff awareness of FGM.
- Bi-monthly audits to assess the quality of the BadgerNet referrals to the ESMT have shown significant assurance regarding the identified fields being completed.

4. Children and Young People

4.1. Summary of Safeguarding Activities

4.1.1. Over the past 12 months, there have been many changes and improvements in relation to processes and guidance. Closer working arrangements have been forged across Divisions. Over the year, there has been increased joint working with Gynaecology Services in relation to the increased number of children under 16 attending and the complexity of these cases. It is envisaged over the next 12 months that increased liaison will develop between Safeguarding, Paediatrics and Safe Centre as work has already commenced in this area.

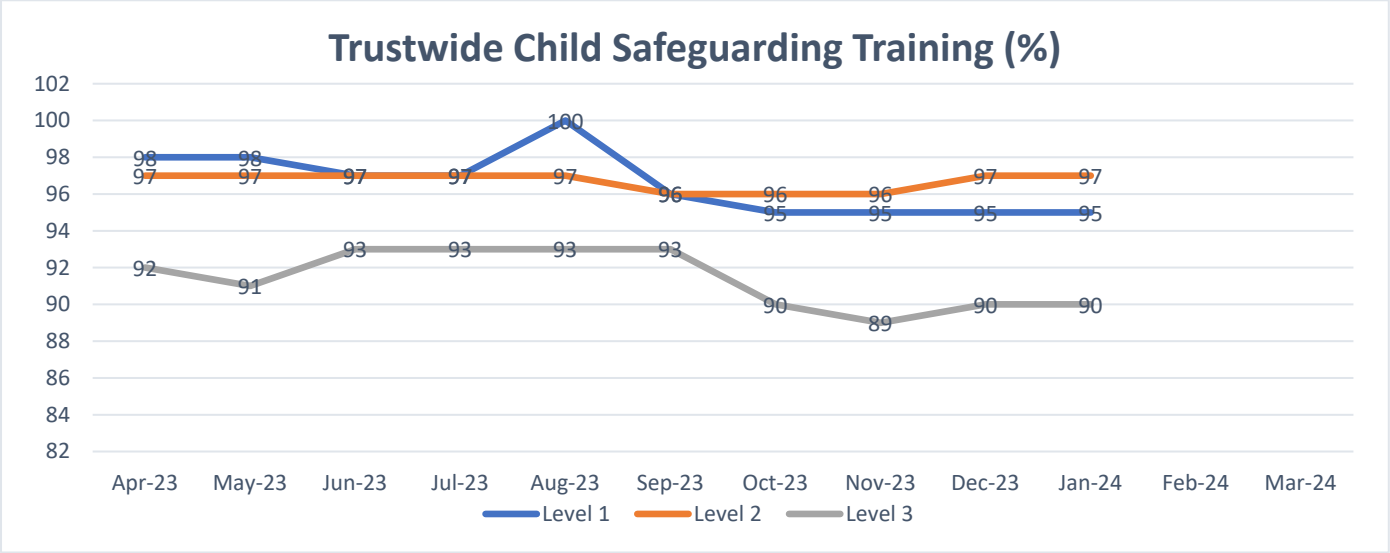
4.2. Annual Achievements (Positive Changes and Progress 2023-24)

- The Medical Assessment Unit (MAU) and Surgical Assessment Unit (SAU) audits have continued monthly to monitor the standard of care offered to 16 and 17 year olds who attend adult assessment areas. There is ownership and increased input from the matrons and managers of these areas overseen by the safeguarding team. These audits show that SAU have increased compliance since September 2023 with a compliance of 60-80%. MAU at Royal Preston Hospital (RPH) has very few patients aged 16-17 and often has none over the month. They however showed significant improvement in compliance in November 2023 and March 2024 with 100% compliance. MAU at Chorley District Hospital (CDH) has shown variable compliance from 50% to 100% over the year but with 4 of the 12-month achieving 100% which is very positive.
- Safeguarding supervision has continued to be embedded across paediatric areas with a focus on priority topics this year, including the 'Hidden Male'.
- Monthly audits continue of the safeguarding checklist across ED (0-15 years old, and 16-17 years old) and Paediatric Assessment Unit (PAU). ED 16-17 years safeguarding checklist audit shows compliance of 86-100% over the year with ED 0-15 at 100% every month except for February which was 96%. The compliance for PAU was 85-100% over the last year.
- A new guideline, 'Safeguarding Guidance for assessing the risks to patients (adult and child) from dogs and dog bites' was compiled in recognition of the number of patients attending with bites, particularly to SAU.
- A new guideline was completed, 'Admission of babies or children to adult wards when a parent or carer is admitted'. This was the result of almost 12 months of joint working across Children's, Maternity and Adult divisions.

- The Named Nurse for Child Safeguarding and Named Midwife have started to attend the CSAP Neglect Sub-group. We are working on a current priority within the partnership neglect action plan – 'Was Not Brought Pathways', which is led by LSCFT.
- The Paediatric ED meeting which was stood down during the COVID-19 pandemic has re-started. Attendance so far has included, Adult and Child ED, Safeguarding, Urgent Care, Paediatric Liaison, and the ED Navigator. It is hoped 'We Are With You' will provide attendance as the year progresses.
- The Paediatric Liaison Form has been updated to include the voice of the child, additional demographics, and information important for the 0-19 team to follow-up the child adequately.
- The 16–17-year-old Bi-Portal now includes all children admitted to all adult wards who are 17 years and under. This is in relation to work completed with Gynaecology where there are some children admitted or seen under the age of 16.
- Work is underway with the Sexual Assault Forensic Examination (SAFE) Centre to facilitate closer relationships and appropriate sharing of information.
- 7 Minute Briefings formulated by the Children's Safeguarding team include 'Bruising in Non-Mobile Babies/Children', 'Professional Curiosity' and 'Risks to Children from Drowning at Home – Water Safety'. These have been formulated in relation to serious incidents that have occurred, and in relation to the feedback from the JTAI – Serious Youth Violence (Professional Curiosity).
- Leaflets for bathtime safety are now available as push notifications on BadgerNet when a child is discharged from post-natal ward.
- Work has commenced in relation to obtaining demographics and awareness of the 'Hidden Male' with the Children's Community Nursing Team updating their assessment documentation to reflect all those present in the child's home when visiting.
- Liaison and closer working relationships with Lancashire Local Area Designated Officers (LADOs) has been underway this year and is on-going. This has fed into the wider work in terms of Managing Allegations across the Trust. A bespoke training session has been facilitated by the Children's Safeguarding Team with the LADO Manager for all staff across the Trust, including Workforce, Security, and all Divisions. There is an upcoming session planned for May 2024.
- There has been on-going work with Gynaecology in the latter part of this year in recognition of the increasing numbers of children under 16 years (and 16-17 years) accessing their services. An audit was completed to ascertain the numbers of children attending and the reason for this. The audit suggested that the process for informing the Children' Safeguarding team, the use of Paediatric Liaison forms to share information and the consideration of Children's Social Care referrals is variable, however there were no safeguarding issues missed. A Safeguarding checklist for both adults and children have been formulated and will be in place imminently to assist staff with identifying any safeguarding issues. Additionally, the biportal has been changed to include all children under 17 admitted to adult wards to provide an additional layer of assurance (this is checked daily by Safeguarding Duty). Work is on-going in relation to updating the Paediatric-Gynaecology SOP and additionally a 'Was Not Brought/Did Not Attend' flowchart for termination of pregnancy. This is a joint piece of work between Maternity Safeguarding, Gynaecology and Child Safeguarding.

4.3. Child Safeguarding Training Compliance

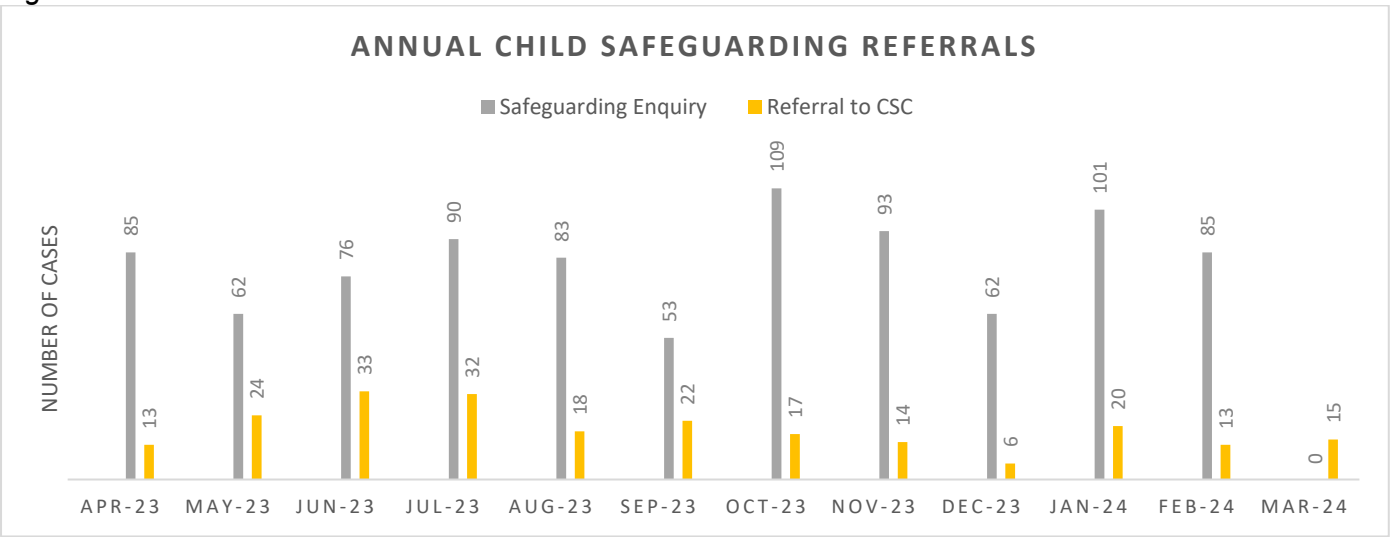
Fig.3. Child Safeguarding Training Data (Trustwide)



4.3.1. Fig.3 shows Trust wide annual child safeguarding training levels 1 to 3. The training packages and training needs analysis are in accordance with the requirements of the Royal College of Nursing (RCN) *Safeguarding Children and Young People: Roles and Competencies for Health Care Staff* (2019). Child safeguarding training across Levels 1 and 2 has remained 95% and above, with Level 3 remaining compliant at above 90% except for a reduction to 89% in November 2023. The issue of foundation doctors training has been on-going; however, a plan is in place for all foundation doctors to complete face-to-face level 3 safeguarding training during their induction with the Trust, and this will commence with the next foundation doctor's intake in August 2024.

4.4. Children's Social Care Referrals

Fig.4. Referrals to Children's Social Care



4.4.1. Referrals to Children's Social Care have increased in comparison to the previous year, with a third of the year showing over 20 referrals per month as opposed to less than 20 the previous year. In comparison to the previous year (183 referrals in 2022-23 and 242 in 2023-24) there has been a 32% (n=59) increase in referrals to Children's Social Care. This increase potentially reflects staff awareness and professional curiosity when a child may be at risk or in need of support.

4.4.3. For the coming year, there will be increased focus looking at the referral process and thresholds, particularly for the Emergency Departments (ED) as although referrals have increased overall, they have decreased in Paediatric ED from 65 in 2022-23 to 41 in 2023-24. Referrals from Adult ED have however increased from 53 to 73 in the last 12-months. There has been a significant increase in referrals made by the Safeguarding Children's team from 39 to 84 this year. This highlights the continued and increasing workload of the team. Most of these referrals are complex cases such as fabricated and induced illness, complex care needs and sexual abuse.

4.5. Child Deaths

4.5.1. There has been a total of 28 deaths between April 2023 and April 2024, and 61% (n=17) of these deaths were unexpected and 39 % (n=11) were expected, of these expected deaths, 64% (n=7) were neonatal deaths and the additional deaths were in other departments. There has been a 26% (n=6) decrease in unexpected deaths in comparison to the previous year, with expected deaths remaining the same as the previous year. Unexpected deaths have included SUDC and sadly, several children who have completed suicide or been the victim of significant trauma (accidental and non-accidental). A Trust '7 Minute Briefing' was shared in response to the National Child Mortality Database (NCMD) Report (2023) into traumatic deaths of children and young people which highlighted deaths by drowning. The child mortality meetings continue to be chaired by the Named Doctor for Children Safeguarding and the meetings are now being formally recorded and actions monitored by Womens and Children's Governance. This has resulted in a more robust meeting which is vital for the child death process to run smoothly.

4.5.2. Rapid Incident Reviews continue to be undertaken for child deaths. Datix incidents for deaths are reviewed for the Named Doctor prior to a decision regarding if a Rapid Review is required. The Children's Safeguarding Team continue to attend Joint Agency Response (JAR) meetings after a child has died unexpectedly and participate into the child death process fully, in addition to the child's Paediatric Consultant. The Named Nurse for Safeguarding Children and the Named Midwife are part of the Child Death Overview Panel Continuous Learning & Improvement Group (CDOP CLIG). They have both recently attended and participated in a development session working with system partners in ensuring the CDOP process is as robust as possible and developing an audit plan to provide assurance that the child death reporting process is fit for purpose.

5. Adults

5.1. Summary of Adult Safeguarding Activities

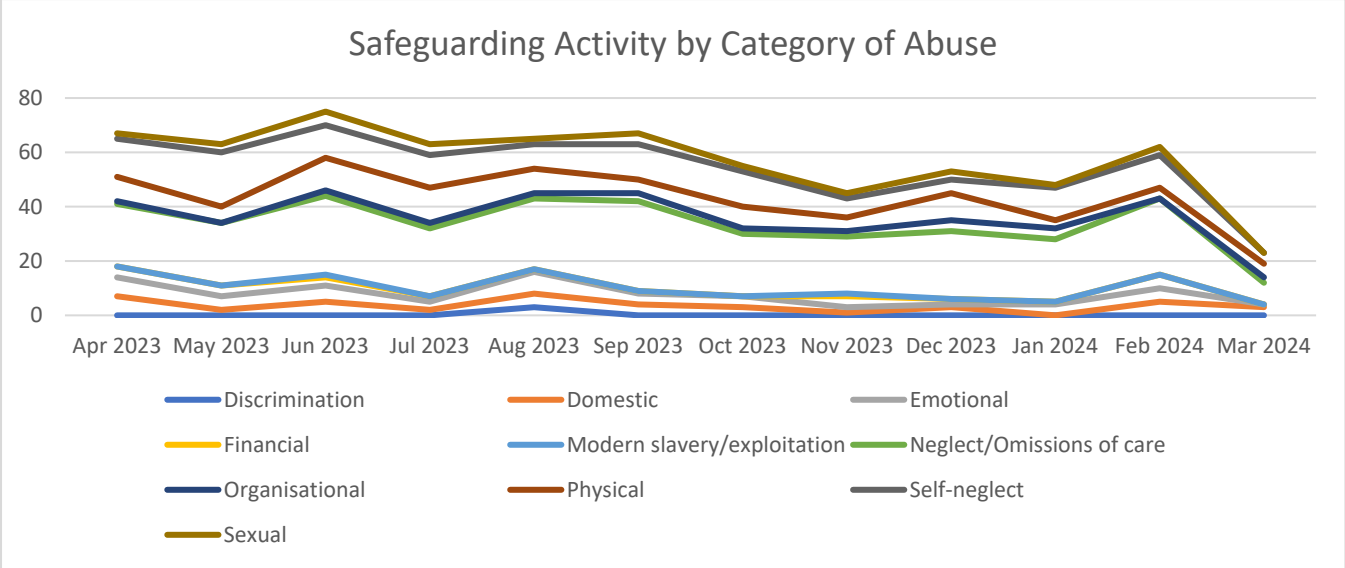
5.1.1. The adult pathway of the Trust Safeguarding Team has expanded over the last year due to specialist commissioning from the Police and Crime Commissioner and the Violence Reduction Network. As a result, the adult safeguarding pathway now consists of the Named Nurse for Safeguarding Adults, Named Professional for MCA/ DoLS, a Specialist Safeguarding Practitioner, a Safeguarding Practitioner, a Health Independent Domestic Violence Advisor (HIDVA), a Health Independent Sexual Violence Advisor (HISVA), and an Emergency Department (ED) Navigator. The commissioning arrangements for the three posts come from two different funding streams. The HISVA role, commissioned until March 2027 and the HIDVA role, commissioned until March 2025 are funded through the Police Crime Commissioner. The ED Navigator role is commissioned until March 2025 through the Lancashire Violence Reduction Network. The Lancashire Violence Reduction Network is made up of several partners from across public services and the third sector. Representatives include those from youth offending teams, schools and colleges, public health, police, Children's Social Care, Probation, Community Safety Partnerships, Lancashire PCC, Lancashire County Council, and the NHS. Through this network, the aim is to facilitate a system-wide trauma-informed approach to making

Lancashire a safer place to live, work and visit. All three roles are designed to deliver care in a trauma informed manner.

5.2. Safeguarding Activity

5.2.1. The Fig.6 below shows a summary of the safeguarding activity reported via Datix in the last 12 months, broken down by categories of abuse.

Fig.6. Annual Total Adult Safeguarding Activity

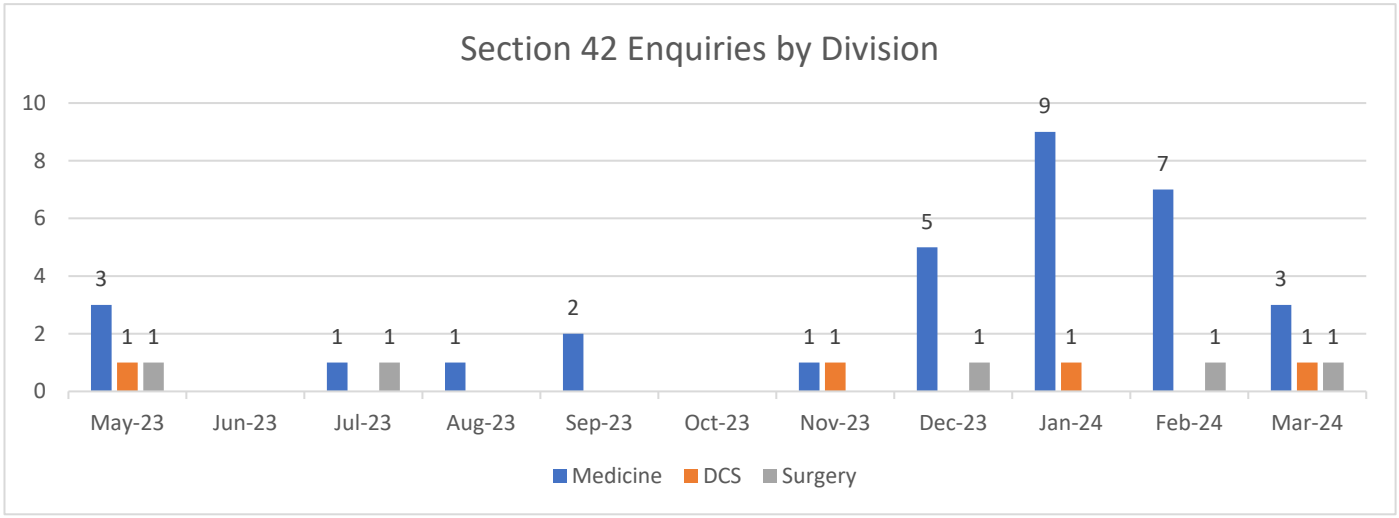


5.3.2. The most frequently reported incidents are in relation to neglect or omissions of care, followed closely by self-neglect, this is reflective of activity on a local and national level.

5.4. Section 42 Enquiries

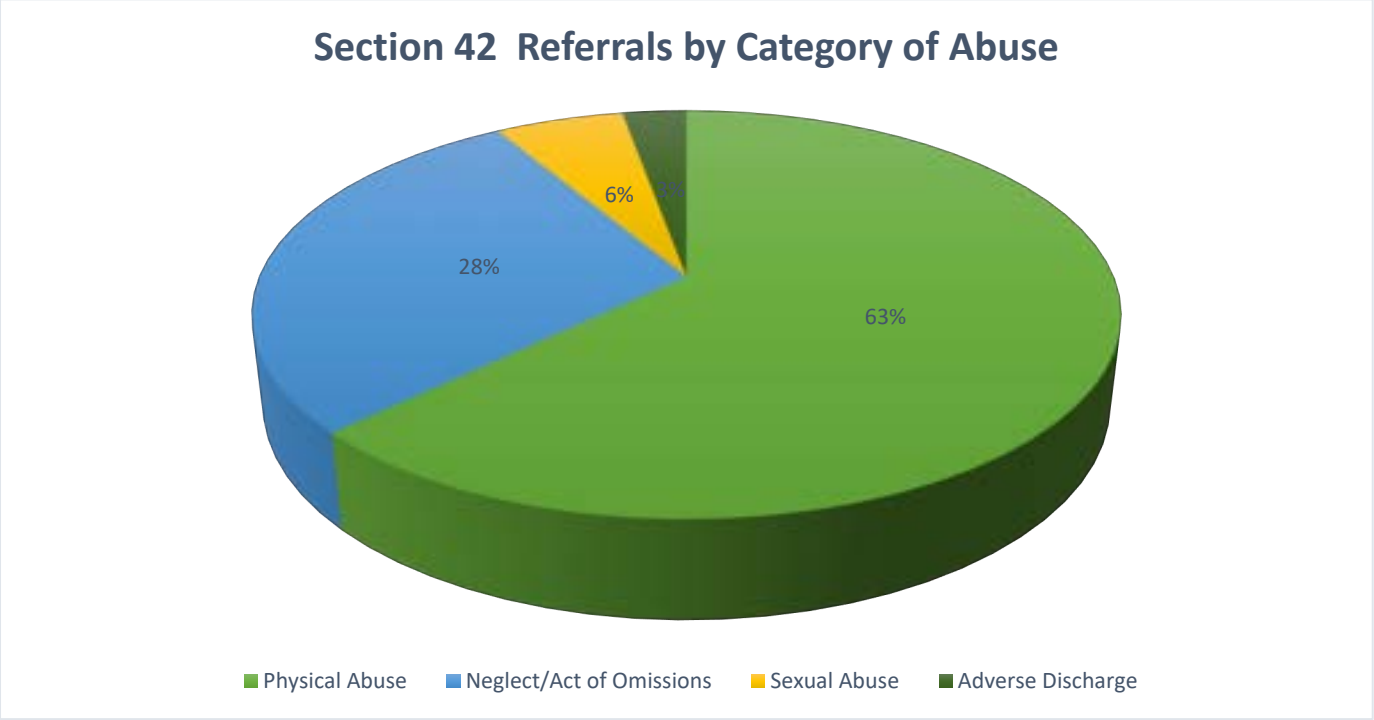
5.4.1. The Safeguarding Team have worked closely with Lancashire County Council (LCC) over the last year to ensure that a tight governance process is in place for the reporting of, and investigation of Section 42 enquiries (Care Act 2014). All incidents received from the local authority that are to be investigated by the Trust now come under the umbrella of a Section 42 enquiry. Fig.7 below shows the number of Section 42 enquiries raised against the Trust in the last 12 months. The spike in numbers of enquiries received reflects the embedding of the new processes with the Local Authority.

Fig.7. Divisional Section 42 Enquiries



5.4.2. The Fig.8 below shows Section 42 referrals against the Trust by category of abuse. The data shown is from November 2023 – March 2024 when LCC introduced the new safeguarding Section 42 process. To address adverse discharges from our hospitals, the adverse discharge improvement plan was developed and completed in April 2024. The improvement plan brought together several pieces of improvement work into one single improvement plan. This is designed to demonstrate how through collaboration, continuous improvement, and progression the Trust is supporting patients to receive early supported discharge in a safe and consistent way. The improvement plan includes evidence-based monitoring to ensure ongoing safety and quality expectations are met and this is overseen at Safeguarding Board through the Trust Clinical Discharge Lead reports.

Fig.8. Section 42 Referrals



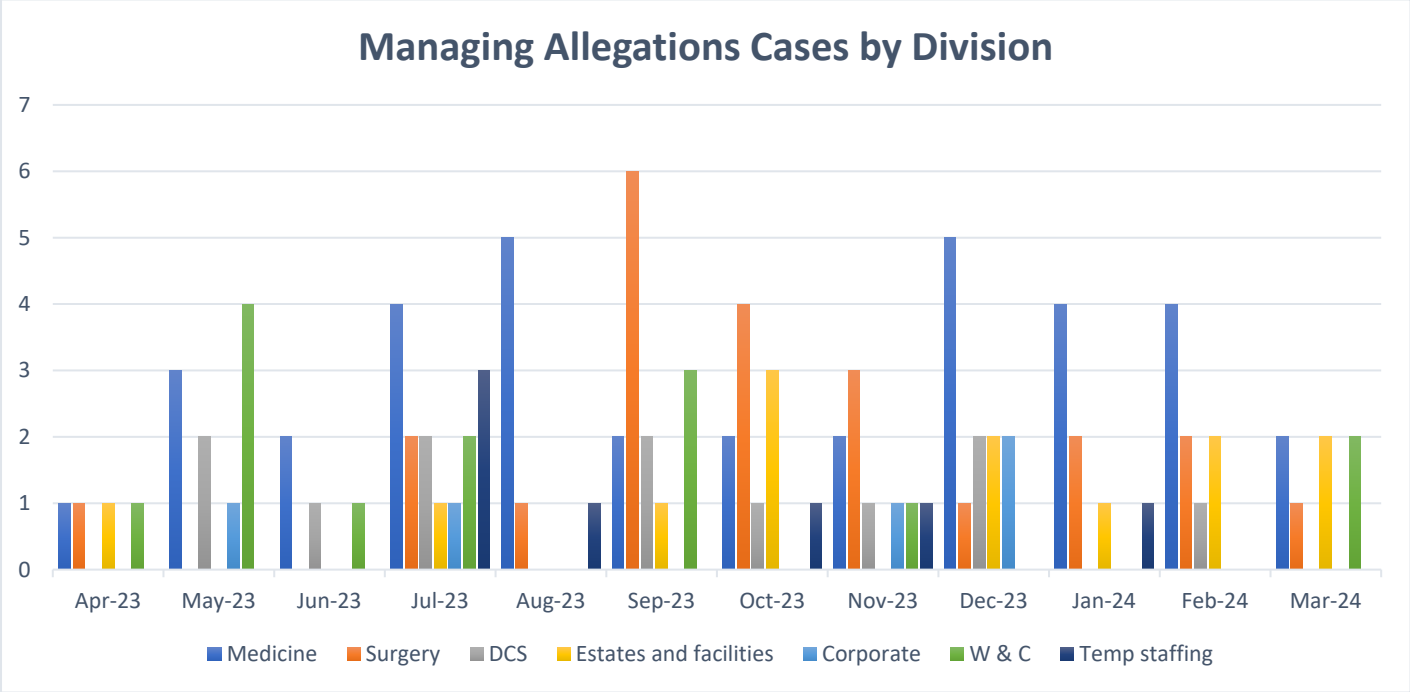
5.5. Managing Allegations Persons in Position of Trust (PiPoT)

5.5.1. The Safeguarding Team support workforce and the Divisional Teams in managing allegations against staff when there is a risk of harm to patients, staff, or organisational reputation. The managing allegations policy has been revised incorporating learning from Lucy Letby and feedback from the MIAA report to ensure that processes are robust and consistent across the Trust.

5.5.2. The Safeguarding Team's role is to ensure that all internal and external processes are followed and to liaise with external agencies such as the Police and Adult Social Care. Fig.9 below shows the number of managing allegations cases the Safeguarding Team have been involved with over the past year by Division.

5.5.3. An annual thematic review of PiPoT managing allegation cases are reported to Safeguarding Board.

Fig.9. Managing Allegations Cases



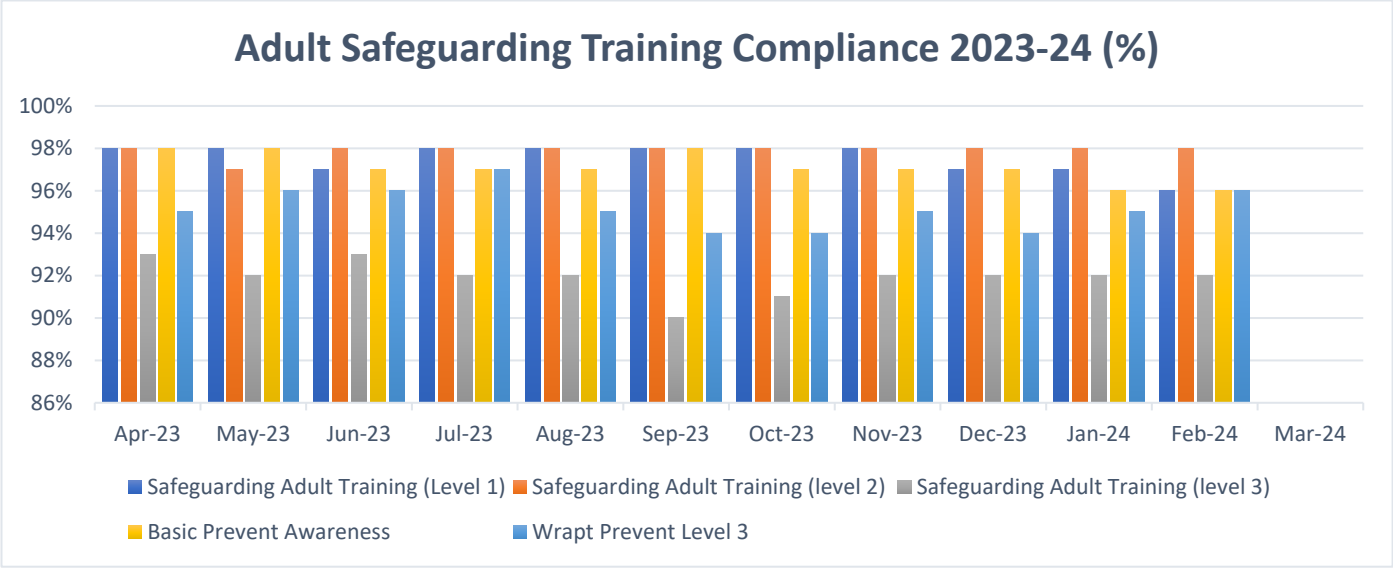
5.6. Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)

5.6.1. Over the last year LTH have been asked to contribute towards three SARs considerations and four potential DHRs. The Safeguarding Team have been asked to participate in the panel meetings of three of the DHRs and contribute to the final report through the completion of an IMR. Any learning found whilst undertaking the investigation into LTH provision of care to the subject of the reviews is disseminated through monthly divisional safeguarding meetings and bulletins.

5.7. Safeguarding Adults and PREVENT Training

5.7.1. The Fig. 10 below shows the figures for safeguarding adults and PREVENT training compliance over the previous 12 months. The PREVENT training compliance has consistently been above 90% throughout the year.

F*ig.10. Adult Safeguarding Training*



5.8. Safeguarding Supervision

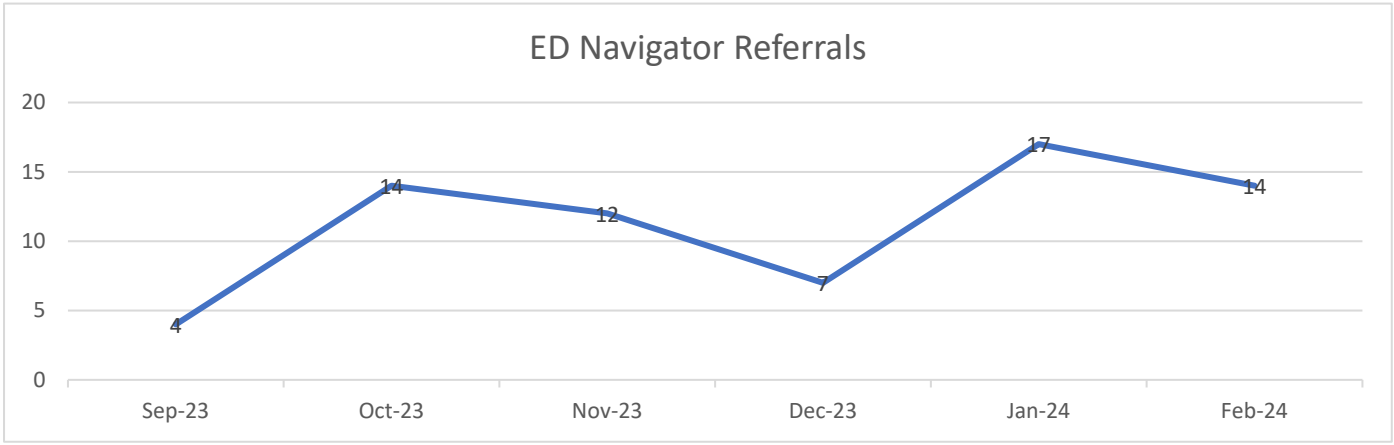
5.8.1. Twenty members of staff across the Trust attended the Bond Solon Bespoke safeguarding supervision training and are able to support with safeguarding supervision across the Trust. This was arranged by the Safeguarding Named Midwife and Named Nurses for Children and Adults to assist in the facilitation of supervision during team meetings and at other opportunities to support staff well-being and reflective practice. Both the Trust Safeguarding Children's Team and ESMT continue to offer group and responsive/ad hoc supervision as per policy in relation to specific cases and incidents or in relation to Children Social Care referrals. The MIAA audit outcome provided a substantial assurance opinion in relation to this topic.

5.9. Emergency Department (ED) Navigator

5.9.1. The Trust has an ED Navigator in post who commenced their role in September 2023. The role of ED Navigator includes connecting with patients who come into the ED and work with them in the community following discharge from hospital. The Navigator aims include connecting patients with services that can support them to make positive changes in their lives.

5.9.2. Fig.12 below shows the number of referrals made to the ED Navigator since commencing in post in September 2023.

Fig.12. ED Navigator Referrals

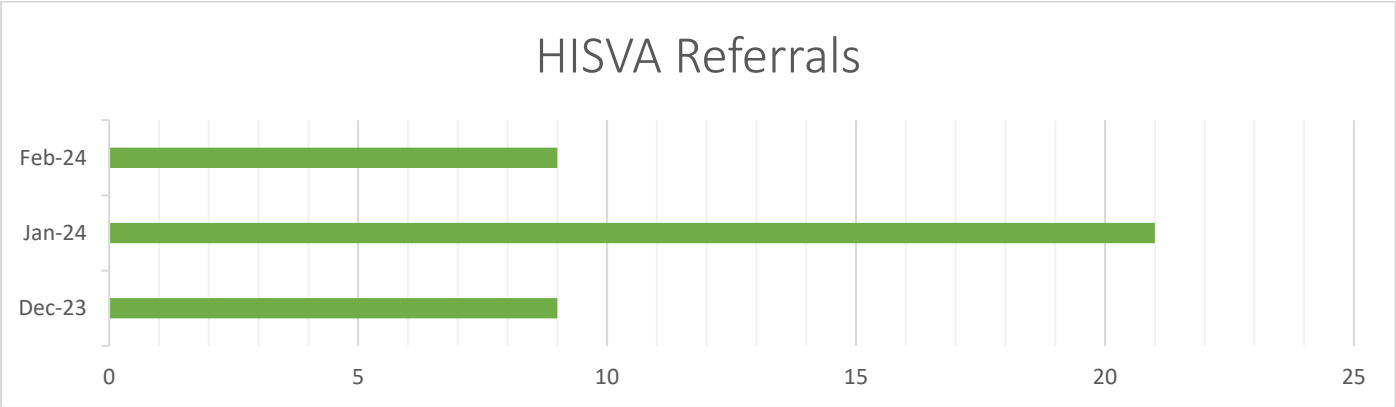


5.9.3. The Trust ED Navigator received a letter of commendation from the Deputy Chief Constable of Lancashire Police, recognising the positive impact their work was having. The ED Navigator also provides assurance reports to the Violence Reduction Network (VRN) on a quarterly basis to enable the VRN to collate intelligence regarding hotspots for violent crime throughout Lancashire and identify interventions to mitigate the risks.

5.10. Health Independent Sexual Violence Advisor (HISVA)

5.10.1. The Trust has now recruited a HISVA who provides support and safety planning to victims of sexual violence including staff and patients within Lancashire Teaching hospitals.

Fig.11. HISVA Referrals



5.10.2. There has been a total of 39 referrals to the HISVA service since the end of November 2023 when the HISVA commenced their role (see fig.11 above), 49% (n=19) of theses referrals have been to support staff at LTH and 51% (n=20) has been for patients support. The high numbers in January 2024 are because of duplication in reporting by a cluster of staff raising concerns of the same incident. 19 survivors reported the crime to the Police either during or after engagement with the service and 21 survivors were signposted or directing referred to other agencies or services for long term support.

5.11. Health Independent Domestic Violence Advisor (HIDVA)

5.11.1. The Trust has also been able to recruit for the HIDVA post which the HIDVA began in post in January 2024. The HIDVA is providing support for victims/ survivors of domestic abuse.

5.11.2. Since commencing in post, the HIDVA has received 41 referrals either through the Safeguarding Duty team or from Maternity services. The HIDVA has also supported eight members of staff, and the role is vital to some staff who view work to be their “safe space or place of safety.” The HIDVA works with these staff members over a longer period as work is viewed as a safe environment for them.

5.11.3. The HIDVA has also begun to deliver training within the Trust and offers to attends wards/departmental meetings to raise the profile of this workstream as appropriate.

6. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

6.1. Trust-wide MCA and DoLS Activity

6.1.1. The MCA/DoLS - Always Safety First project has successfully achieved an electronic MCA/DoLS pathway throughout the patient’s journey during admission/attendance as per the requirements of the Mental Capacity Act (2005). The system design implemented captures cognitive assessment, best interest decision making, least restrictive practice and deprivation of liberty. Below Fig.13 and 14 show the number of DoLS applications completed at both Royal Preston Hospital (RPH) and Chorley District Hospital (CDH) over a 3-year period from 2021-24.

Fig.13. RPH Number of DoLS Applications

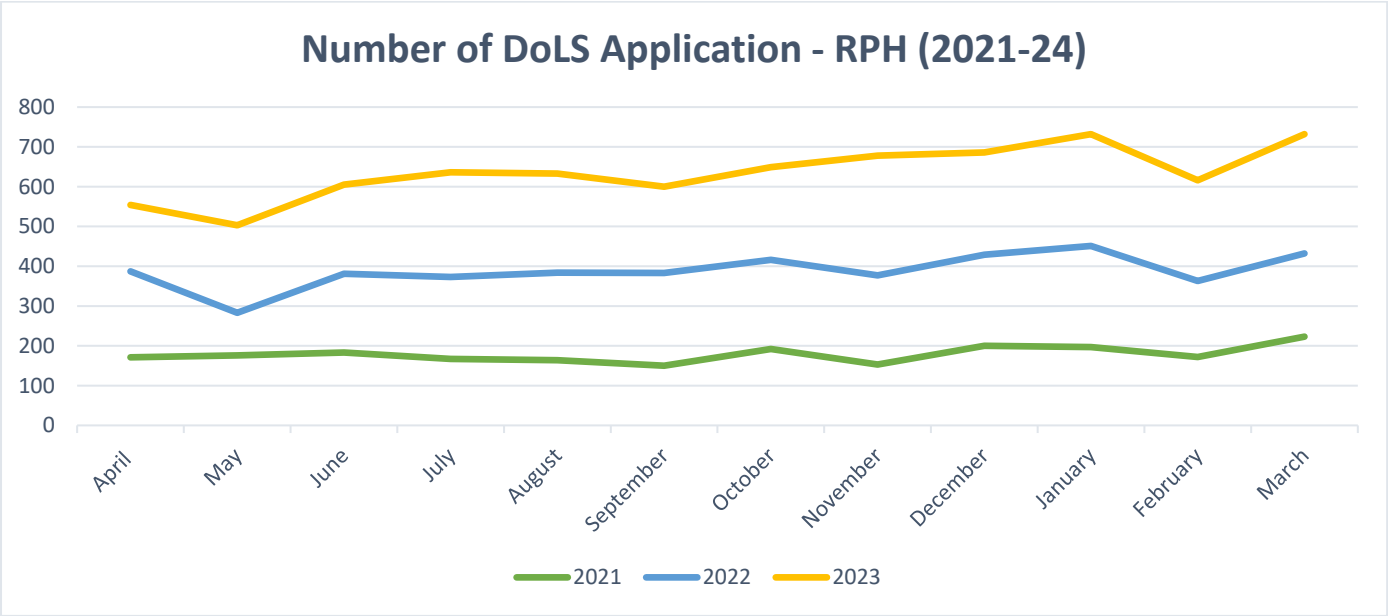
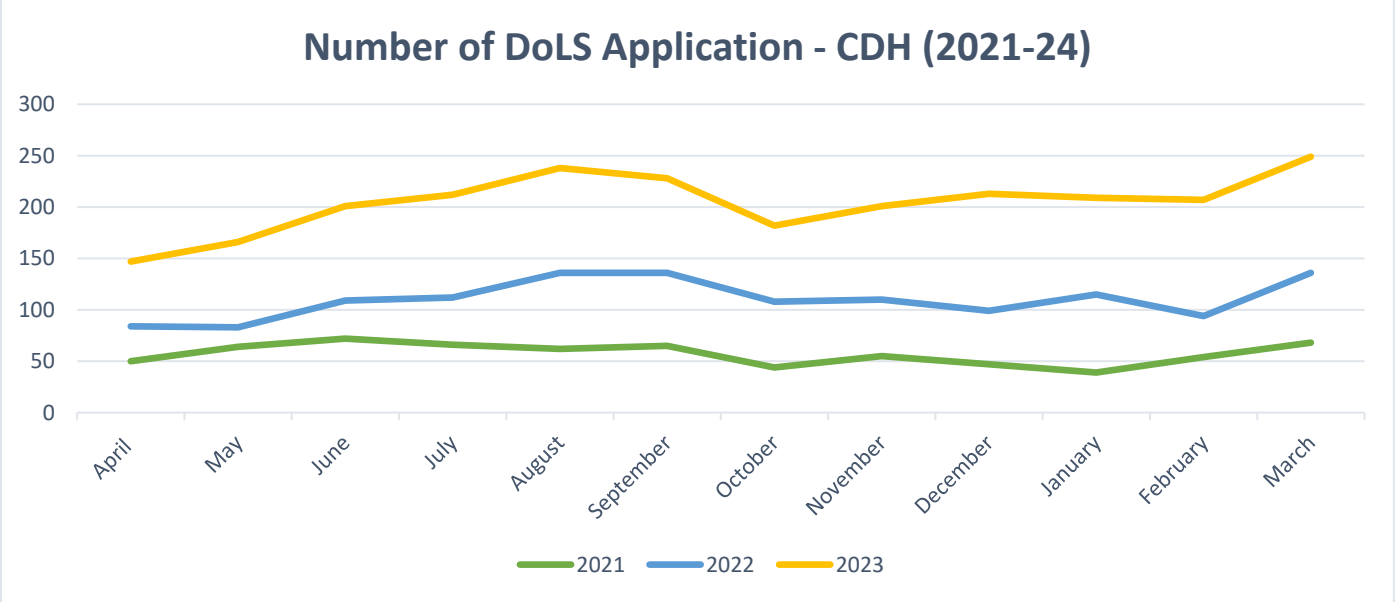


Fig.14. CDH Number of DoLS Applications



6.1.2. The data in Fig.13 and 14 above demonstrate a year-on-year improved position in relation to the Trust upholding the principles of the Mental Capacity Act (2005). Both graphs demonstrate a continued increase in DoLS applications over a 3-year period. The 49.5% increase in activity is a positive reflection in the growth of the staff's ability to recognise additional vulnerabilities and act in accordance with the principles determined through the legislation. The safeguarding team continue to notify the Local Authority on a weekly basis of any unauthorised DoLS applications, including those that have exceeded the initial 14-day urgent authorisation and/or any patients who have regained capacity, been discharged, or have passed away.

6.1.3. A clear process is in place to notify CQC of outcomes for patients who have been subject to DoLS whilst at LTH. However, due to the increased volume of DoLS applications, this has caused a backlog of CQC notifications with a recorded number of 1,220 notifications being made during 2023-24, whilst 4,238 DoLS applications have been made with 142 of these applications from Finney House. This backlog

has been identified as a risk and will be added to the risk register. The risk of supervisory bodies not assessing and authorising DoLS remains on the risk register (this is a national risk), the Trust has several control measures in place to mitigate, including quality assurance of applications and clear referral processes to the Local Authority. The Local Authority have now agreed a triage system for DoLS applications and will action and prioritise those with higher than standard restrictions or those of patients, or their families, who demonstrate a challenge to the application. Restrictions that are attached to a patient who has an unauthorised DoLS application are reviewed every 72 hrs through the least restrictive best interest assessment. This provides staff with a prompt to notify the safeguarding team if those restrictions have increased.

6.1.4. In turn, the Safeguarding Team will then escalate these increased restrictions to the local authority. Although the implementation of Liberty Protection Safeguards (LPS) was stood down in April 2023, ICS workstreams are still ongoing in relation to LPS. This workstream has identified the gaps in learning and inadequate processes relating to DoLS. With the further delay of LPS or overhaul of Deprivation of Liberty Safeguards, this affords the trust time to strengthen the MCA / DoLS processes and knowledge inhouse. Work within this area is underway and will be ongoing throughout the 2024-2025 workplan.

6.1.5. Training figures in relation to MCA/DoLS remains compliant across the Trust and is evident within the Adult Safeguarding training compliance provided in the Adult Safeguarding section (see fig.10). However, staff feedback has indicated that the practical step of completing the documentation remains confusing and therefore staff have been offered bespoke training sessions for the completion of paperwork. Immediate bespoke training for MCA has been provided to all areas where weaknesses have been identified following internal investigations/StEIS reports and more recently PSIRF. A standalone training package is on the 2023-2024 safeguarding workplan, and this will see the separation of MCA, DoLS and best interest process from the Safeguarding adult level 3 training package and will incorporate the completion of documentation and court applications. The safeguarding team actively support staff in best interest decision making meetings and the Trust MCA Lead attends all meetings and works collaboratively with legal colleagues both internal and external to support any best interest decisions that are likely to require oversight and authorisation from the Court of Protection.

7. Mental Health, Learning Disabilities, Autism and Dementia

7.1. Mental Health, Learning Disabilities, Autism and Dementia Activity

7.1.1. The mental health, learning disability, autism, and dementia team works with some of our most vulnerable patients accessing healthcare within the trust. The team drives continuous improvement initiatives, works to increase staff knowledge and skills, ensures compliance with the Mental Health Act (MHA) and the triangulation of other statutory requirements (such as the Mental Capacity Act and Children's Act), sits within the safeguarding team, and drives positive patient experience. The team has a High Intensity User Lead within the service and holds the role of Special Education Needs and Disabilities (SEND) champion within the Trust. The work streams continue to work on a qualitative rather than quantitative basis and have a higher number of complex cases requiring clinical input, for example: attending best interest meetings, supporting wards/specialist teams or calls with patients, families, and carers rather than face to face.

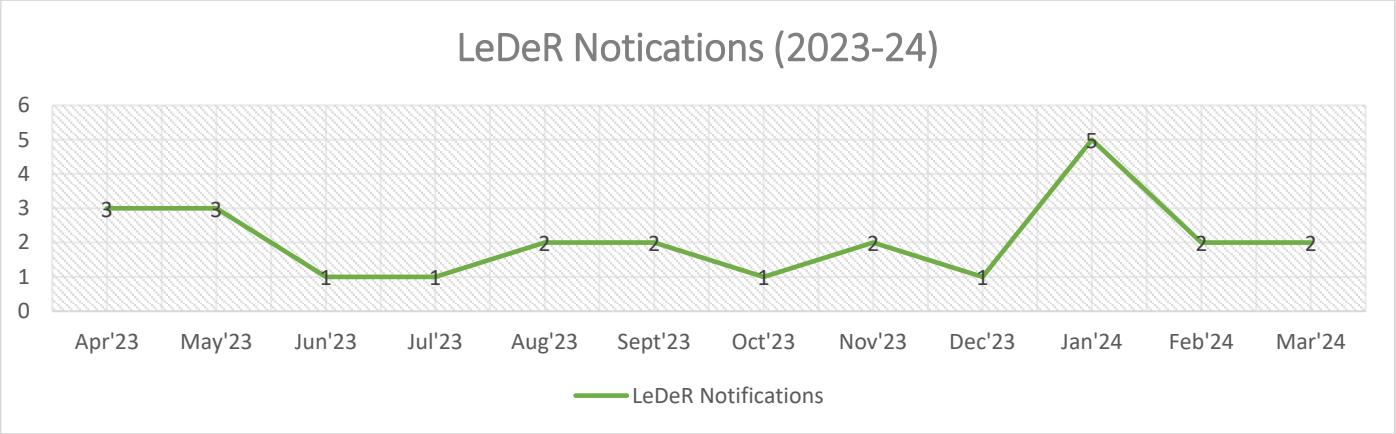
7.2. SEND Annual Activity

7.2.1. The safeguarding team have continued to drive the agenda of Special Education Needs and Disabilities (SEND) with the Matron for mental health, learning disabilities and autism being the identified SEND Champion and working closely with the SEND Doctor/Clinical Lead in Community Paediatrics. The annual activity has been focused on:

- The continued implementation of the monthly SEND improvement group with Trust divisional representation given the 0-25 years inclusion. Now with full divisional representation and the SEND Champion feeding into the Chairs reports for the monthly Divisional Safeguarding Operational Meetings (to consider wider Trust actions i.e. Voice of children/parents – Youth Forum feedback, and Transition)
- SEND Champion involvement into the development of the SEND Data dashboard – developed using initial data requests from the ICB and expanded upon by LTH, for example, inclusion of Education, Health Care Plans (EHCP)
- Attendance at ICB SEND Champion meetings
- Close working with the SEND Doctor/Clinical Lead who attend the quarterly ICB SEND Provider Forum
- Working with Designated Clinical Officers (DCO's) and receiving returns for EHCP audit – dissemination of audit and considering statutory requirements in relation to response timescales.
- Progressing work for the Reasonable Adjustment Needs flag on patient electronic records, and improvements for these to be on ward whiteboards and outpatient whiteboards
- The SEND agenda has been included into both the Learning Disability Plan 2023-2026 and Autism Strategy 2024-2027

7.3. Learning Disability and Autism

Fig.15. Annual LeDeR Notifications



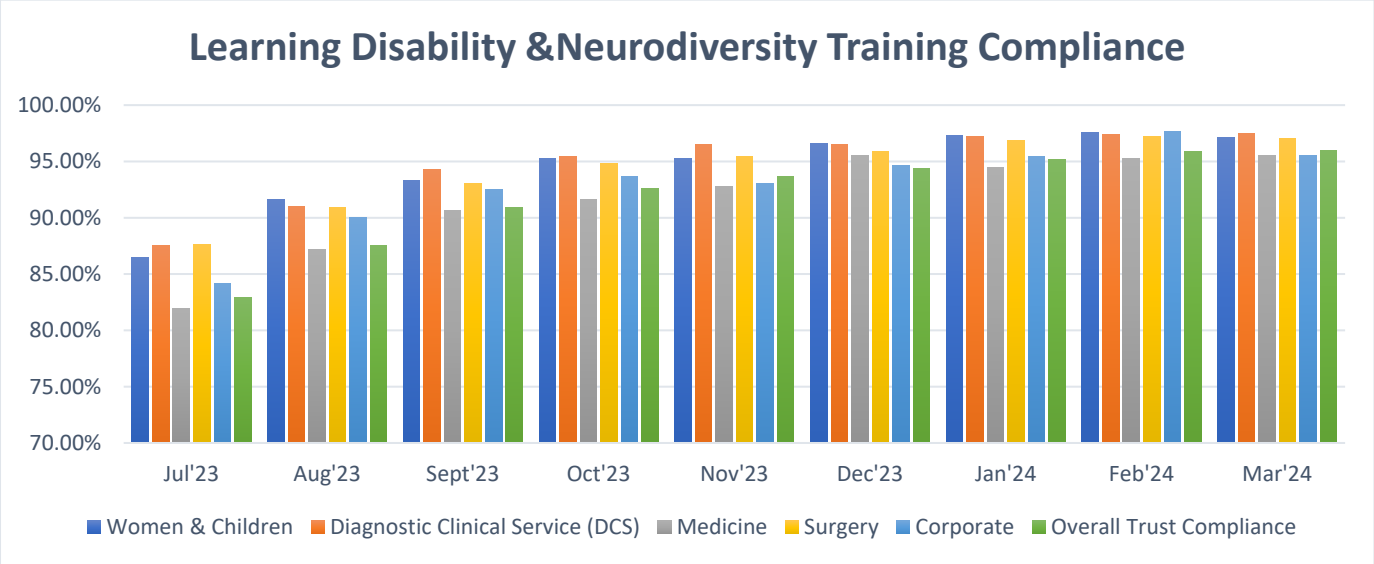
7.3.1. Fig.15 above shows the number of LeDeR notifications completed over the past year, and the following was also observed over the same period:

- There were no notifications submitted in the 2 working day timescale as now required for ICB contracting purposes.
    - Work is ongoing around Patient Death Notifications (PDN) to ensure that the Trust can meet its ICB contractual obligations of completing LeDeR Notifications with 2 working days.
    - There was no 'national data opt out' notification recorded over the past year.
    - There has been 1 child death in November 2023 which will be led by CDOP process, therefore LeDeR notification not submitted.
    - No patients have opted out in the national data opt out process.
    - There have been no LeDeR reviews for 2023-2024.
    - There have been no individual redacted LeDeR reviews received for LTH up to the financial year however, six have been received mid-April 2024 and these will be reviewed to consider Trust

learning and actions. The redacted reviews are a new process commenced by the ICB to allow for sharing.

7.4. Learning Disability and Neurodiversity Training

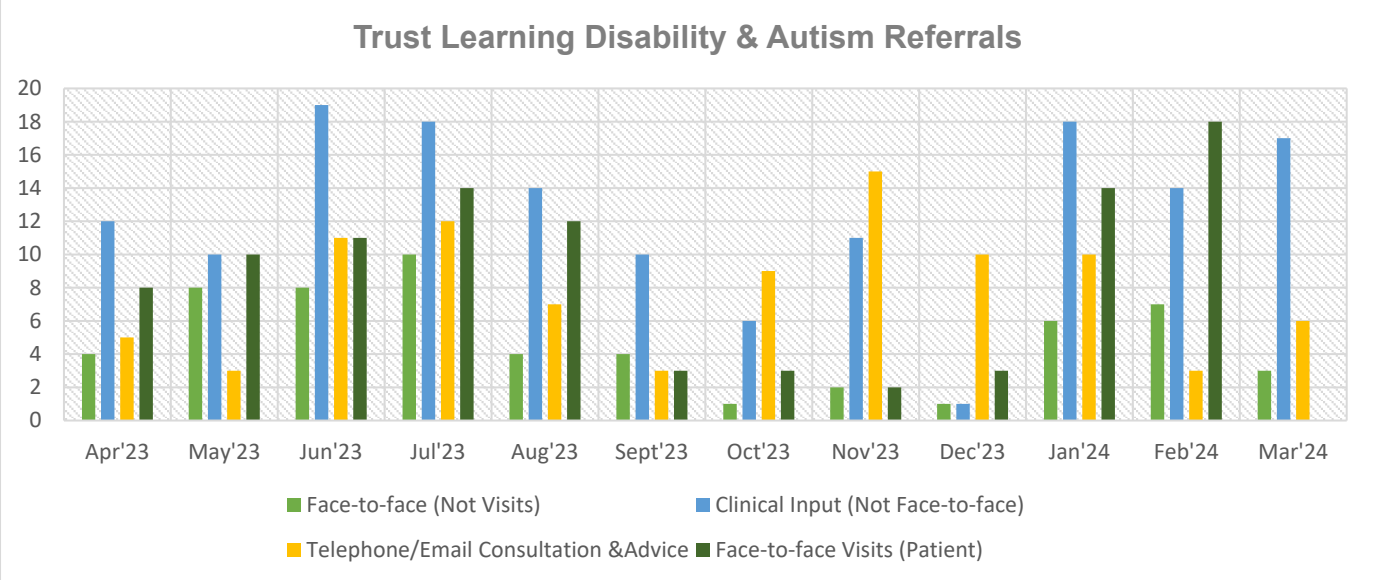
Fig.16. Learning Disability and Neurodiversity Training Compliance



7.4.1. Fig.16 above shows the Learning Disability and Neurodiversity training compliance by Division and the overall Trust compliance since it was mandated in May 2023. The Divisions and the Trust continues to be compliant (above 90%) with Tier 1 Learning Disability and Neurodiversity Core e-learning module.

7.5. Learning Disability and Autism Referrals

Fig.17. Referrals Into Learning Disability and Autism Pathway



7.5.1. Fig.17 above shows the referrals activity into the learning disability and autism pathway which continued to be managed despite carrying a vacancy from September 2023 to January 2024. Activity increased in January 2024 with the appointment of a new mental health practitioner. The focus has been to support reasonable adjustments, best interest meetings, multi-agency working and sharing of hospital passports.

7.6. Learning Disability and Autism Matters for Positive Escalation

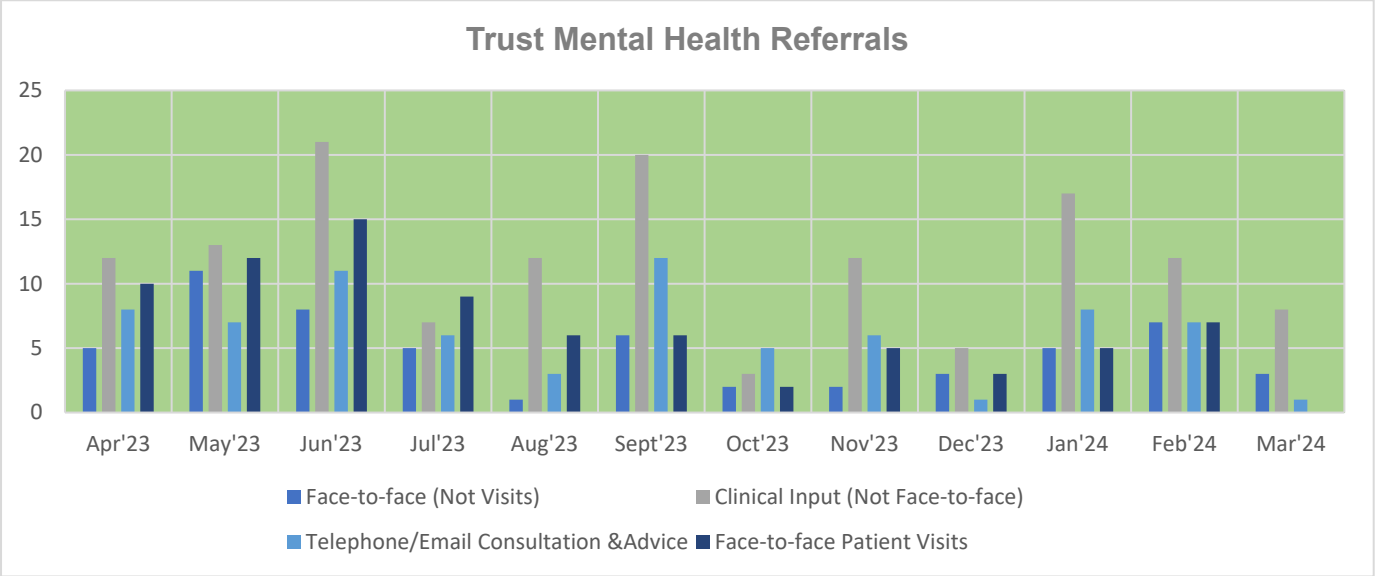
- The Learning Disability Plan was launched June 2023, and an accessible version in Easy Read format is being drafted.
- The Autism Strategy has been completed and currently going through the ratification process. The strategy shares several commitments with the Learning Disability Plan – for example: Reasonable Adjustments, use of Hospital Passports and the SEND agenda; and the Trust Neurodevelopmental Assessment Pathways are also included.
- The recruitment of the Learning Disability and Autism Specialist Practitioner in January 2023 enabled meaningful support for our patients. For example, development of social stories, easy read information, and de-sensitisation for example to ensure health access and a positive journey at the Trust.
- The Learning Disability team have worked closely with the Enhanced Support Midwifery Team to improve BadgerNet – including noting of hospital passports, reasonable adjustments, and have completed bulletins in relation to Learning Disability and Autism for sharing with midwifes.
- Monthly training is now delivered to midwifes about caring for our patients with a learning disability and/or autism. This work compliments findings from a serious case review in relation to a mother with a learning disability and mental health difficulties, and findings from LeDeR in relation to use of hospital passports and reasonable adjustments.
- There continues to be significant developments with the SEND Data dashboard in relation to capturing data i.e.: the waiting times for children in the Neurodevelopmental Assessment Pathways, therapy teams and work will continue to be able to capture more data including EHCP returns and reasonable adjustment flags.
- Multiagency working has been ensured with the Matron/team attending the Autism Partnership Board Health and Social Care Group and Learning Disability Board Health Inequality group. There is a current focus on the development of a new Autism Passport with autistic people, community groups and the ICB developing with LTH, and a future pilot is planned.
- In June 2023 the first annual Health Day post COVID-19 was completed. The aim of the event being to reduce health inequalities and reduce anxiety in attending the hospital. The day highlighted patient journeys, introduced specialist teams, and had several stalls from community colleagues who support our patients with a learning disability and / or autism.
- The Reasonable Adjustment Needs flag is now pulled through from Harris/patient notes onto the ward whiteboard and outpatient whiteboards. Some outpatient departments are using this to inform future appointments. This is an ongoing project for 2024-2025.

7.7. Learning Disability and Autism risks

- The vacancy of the Learning Disability Practitioner has impacted on patient experience with complaints about the lack of hospital passports and reasonable adjustments.
- Inability to report LeDeR notifications within 2 working days – plans are in place to make changes to the Patient Death Notifications electronic system to address this issue.

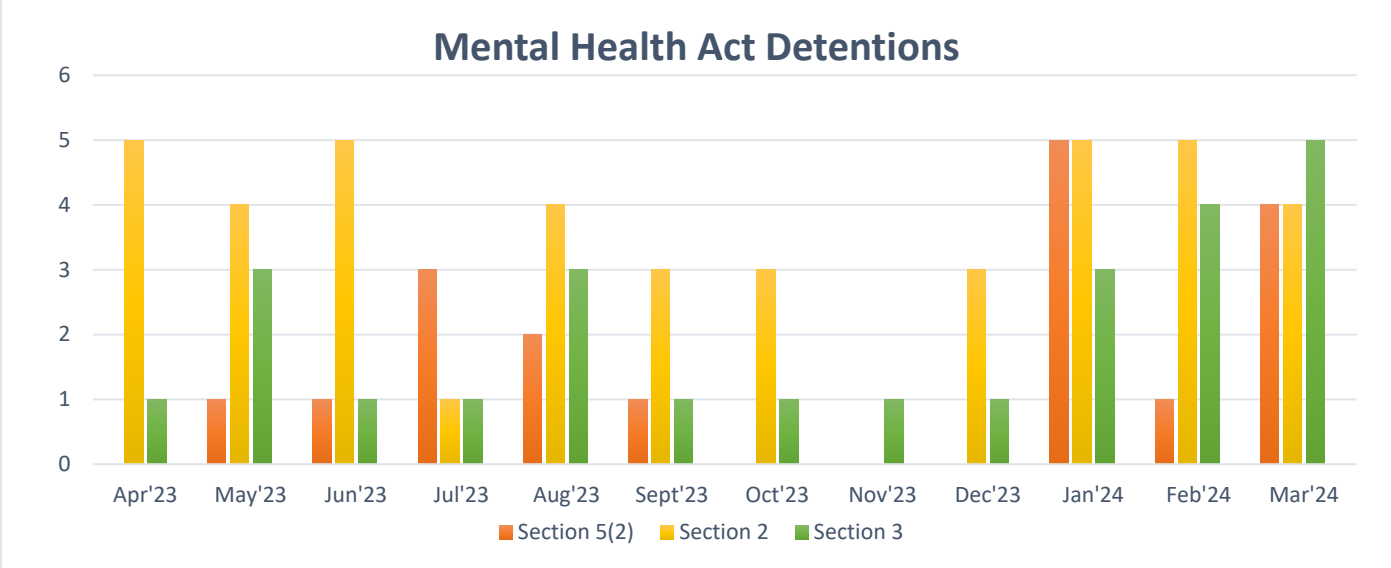
7.8. Mental Health

Fig.18. Mental Health Referrals



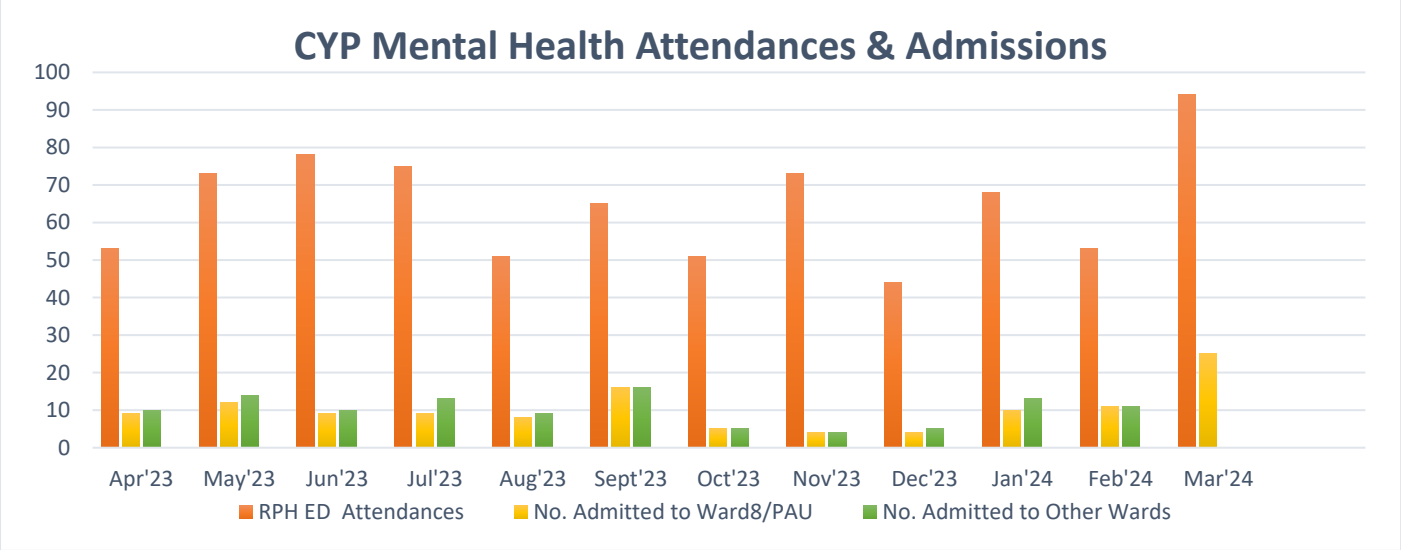
- Fig.18 above shows the referrals activity into the mental health pathway.
- Following the vacancy of the Mental Health Practitioner the referral activity has fluctuated depending on the Matrons leave and ability to meet demand. An increase in referrals in September, November 2023 and January 2024 has been experienced. Referrals are generally linked to acute crisis presentation and high risk, social care / complex cases and patients with MHA detentions and more prolonged admission.

Fig.19. Mental Health Act (MHA) Detentions by Section



7.8.1. Fig.19 above highlights an increase in all MHA detentions between December 2023 and February 2024, with some patients being detained under Section 2 MHA for assessment and waiting for a bed but requiring further detention on Section 3 MHA and still having to wait for a bed. Mental Health Liaison Team (MHLT) have escalated this issue within LSCFT. Patients have required detention for several clinical presentations including – eating disorders, self-neglect, severe depression, and acute psychosis. No children have been detained to LTH in the reporting period.

Fig.20. Children and Young People (CYP) Mental Health Attendances & Admissions



7.8.2. There have been ongoing and significant challenges with obtaining mental health beds. This continues to be escalated through the bed Gold Calls, to LSCFT Bed and Central Directors. Bed allocation has been needed for patients with long waits in ED and those with high risk (to self and others). The LTH Mental Health, Learning Disabilities, Autism and Dementia Matron has attempted to remain involved to ensure least restrictive practice, and support for patients and staff. Some patients have been in LTH for the whole of their Section 2 MHA and months into their Section 3 MHA with acute psychosis or complex mental health needs. This issue remains on the Risk Register as a high risk score of 16.

7.9. Mental Health Risk Tool (MHRT) Audit

7.9.1 The MHRT Audit is completed by the LTH Mental Health team to assess compliance and standards in the completion of the MHRT for patients who attend the Emergency Department (ED), and who are then either admitted into LTH inpatient areas, or who develop a mental health difficulty and associated risk behaviour whilst an inpatient. The MHRT is designed to enable staff to consider risks associated with mental health needs and then to develop a risk management plan until mental health services assess, resulting in increased patient safety and positive patient experience. The audit also considers completion and quality of the MHRT including compliance with the Trust policy. Actions are managed locally and focused on improving compliance wit the use of the risk assessment tool.

7.9.2. Audit Results

Fig.21. below indicates breakdown of cases audited and whether a Mental Health Risk Tool was completed as clinically required.

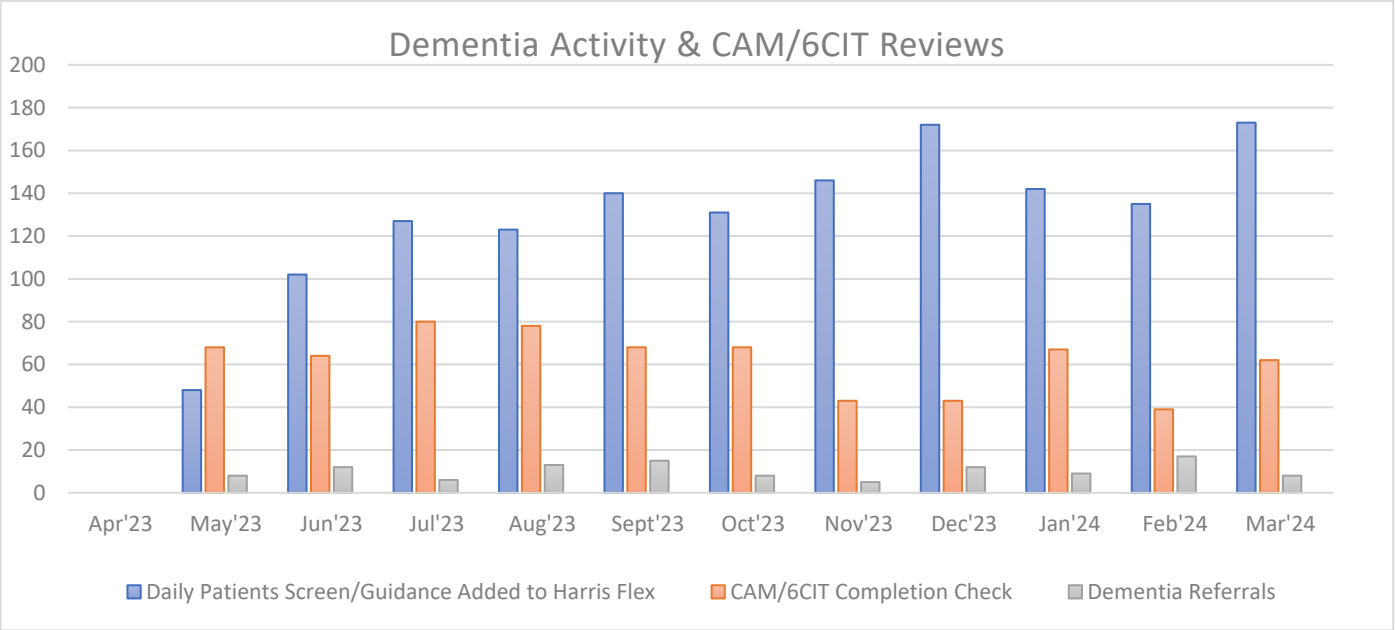
Fig.21. Annual MHRT Completion Compliance

Mental Health Risk Tool audit	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Total
Total number of patients audited	50	53	50	50	50	50	50	50	50	50	50	50	603
Compliance Percentage 2023-2024	74%	84%	76%	73%	80%	84%	76%	81%	73%	83%	77%	75%	78%
2022-2023 Audit Comparison	56%	68%	65%	61%	73%	62%	62%	59%	63%	51%	61%	74%	62%

7.9.3. Overall, there has been significant progress with staff's awareness to consider risk behaviours when a patient either attends or is admitted with a mental health difficulty. Mental Health face-to-face training has been significantly reduced due to a vacancy for 9 months until March 2024, and therefore there has been little opportunity to widely increase staff confidence and has either been delivered through bespoke sessions or following referral to LTH. This will be a focus in 2023-2024. Training compliance for the Trust has dropped, however this is due to Divisions widening their mandate/training needs analysis. An action plan has been developed to address the annual MHRT audit findings.

7.10. Dementia

Fig.25. Dementia Pathway Activity and Confusion Assessment Method (CAM)/6 Cognitive Impairment Test (6CIT) Reviews



7.10.1. Fig.25 shows the annual dementia pathway activities, CAM assessments, and 6CIT reviews completed. There is no data for April 2023 because the pathway was carrying a Dementia Practitioner vacancy, and activity commenced in May 2023 following a successful recruitment process for the post. The Dementia referral activity has remained stable from September 2024. There has been significant activity to complete daily business intelligence screens to add guidance i.e. reasonable adjustments, to prompt the 'Forget me Not' and consider care/helpful strategies. The CAM assessment and the 6CIT are tools used for early identification and referral need to Memory Assessment Service (MAS). The CAM and 6CIT are also reviewed to ensure discharge letter inclusion.

7.11. Mental Health and Dementia Matters for Positive Escalation

- The Trust Dementia Strategy has reported into the ICB and supported the development of ICB Dementia Strategy. The Dementia Practitioner attends the ICB meetings.
- The Trust/Dementia Practitioner has piloted a Dementia Toolkit for acute hospitals – reporting back to the ICB for further review.
- The team continue to be involved in Big Rooms with the focus on Continuous Improvement including continued attendance of the Mental Health Emergency Department Big Room, Frailty Big Room, Nutrition Big Room, and Eating Disorder Big Room. Two training sessions have been co-delivered with LSCFT Eating Disorder Service for Ward 24 (64 staff) as part of the Eating Disorder Big Room. LTH focus was on self-harm, Mental Health Risk Tool, Enhanced Levels of Care, and MHA.

- The High Intensity User Lead is a Trauma Informed Champion / Train the Trainer and has adapted care plans to always consider the patient's story and ensuring language reflects this. Positive patient experience has been reported and multi-agency partners have reported reflection on language and noted positives in the HIU Leads ability to engage.

- NHS England (NHSE) have reported expecting Acute Hospitals to have a HIU Lead/service. LTH is the only hospital in Lancashire and South Cumbria/and wider to have the role embedded into the hospital, and the role will be out of existing budgets for other hospitals.
- The Mental Health Practitioner role was vacant from August 2023. This has now been filled in March 2024 which will impact on the support for the Trust going forward.
- The Matron has jointly worked on Trust or departmental policies for example: - the Trust Rapid Tranquilisation policy, AMAT audit build and the Emergency Department self-harm policy with Divisional Nurse Director (DND) introduction of a SWARM review on Datix for self-harm incidents.
- The Dementia Practitioner has fully reviewed Tier 2 face to face Dementia training and dates will be offered in 2024-25.

7.12. Mental Health and Dementia Matters risk

- There have also been challenges in relation to mental health assessment of children, and 16–17-year-olds in the Emergency Department and inpatient areas as Rapid Assessment Intensive Support Team (RAIST) provision stops at 20:00 hours therefore the latest mental health assessment can be offered at 18:00 hours. The MHLT no longer assess children through the night resulting in admission to the Paediatric Assessment Unit.
- There have been reported challenges in RAIST with an inability to attend and assess in 48 hours.
- Young people aged 16- 17 years are experiencing delays in the Emergency Department due to MHLT referring to Child and Adolescent Mental Health Services (CAMHS) or RAIST if known / open to their services. A meeting (May 2024) with the ICB has been arranged to review the mental health provision for children and young people.
- An increase of admissions for children's ward/PAU has been experienced in January and February 2024 due to the lack of CAMHS/RAIST services.

8. High Intensity User (Admission Avoidance)

8.1 High Intensity User (HIU) Background

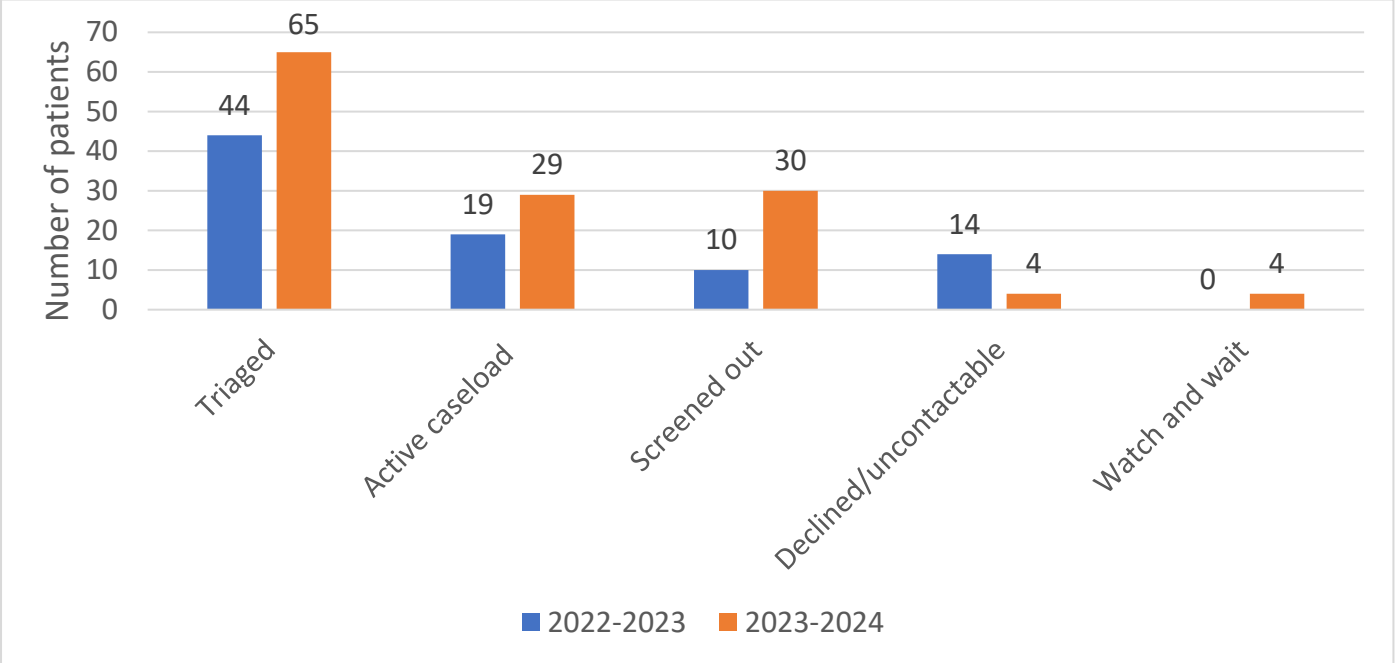
8.1.1. The HIU model uses a health coaching non medicalised approach, targeting individuals who are relying heavily on unscheduled services to meet their needs. The five core principles of the HIU service are to identify, personalise, de-escalate, discharge, and manage relapse. The HIU Lead works to safely manage and co-ordinate a rolling cohort of individuals who have been identified as being high intensity users of unscheduled services. The service aims to support these individuals to flourish whilst reducing the impact on front line resources through for example, sustaining job opportunities, improving support networks, supporting holistic needs (housing and financial issues), improving physical and emotional wellbeing by using a person-centred coaching approach. Through use of multiagency support, the service aims to reduce the activity of these individuals within unscheduled services such as the Emergency Department and avoidable non elective admissions.

8.1.3. The service is for adults aged 18 and over who attend the Emergency Department (ED) 10 times or more in 12 months, 5 times or more within 3 months or 3 times in 1 month and have an unmet need identified.

8.2. HIU Annual Activity

8.2.1. The HIU Lead triaged 65 new referrals to ensure that the inclusion criteria was met. This is a 48% (n=21) increase compared to last year in which 44 referrals were received. Of the 65 new referrals, 24 were accepted, 5 remained open from the previous year (2023-24) which translates to 29 active patients on the HIU caseload. This is a 53% (n=10) increase in the HIU caseload compared to last year's caseload of 19 patients. The number of patients reviewed on Qlikview top 100 attendances has not routinely been captured. 4 patients are on a 'watch and wait' monitoring with ED attendances being monitored, 30 patients met the exclusion criteria, 3 patients declined support/did not engage with the HIU Lead, and 1 patient was uncontactable.

Fig.26. Triage and Caseload 2023-24

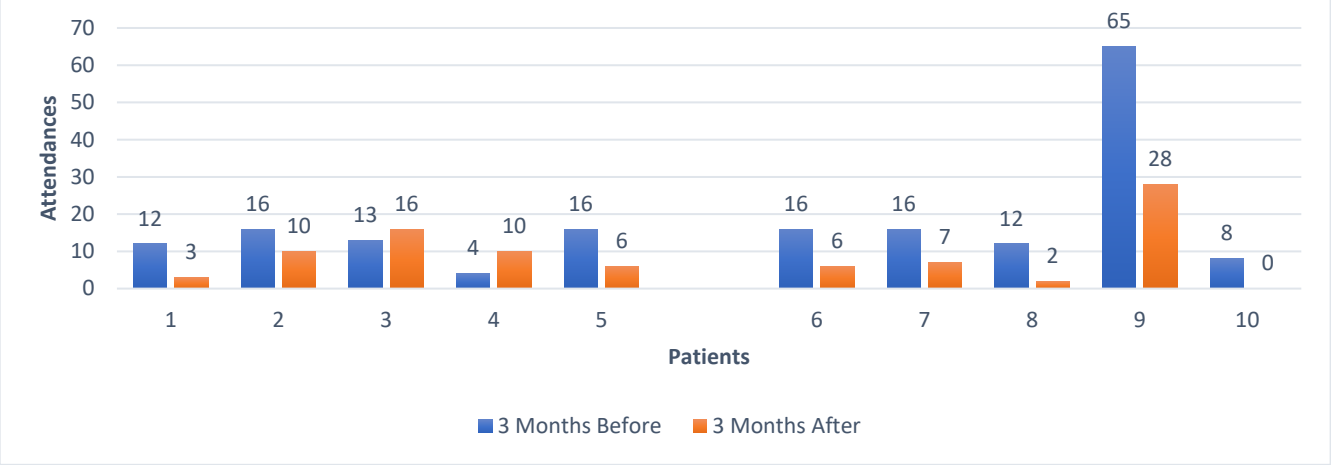


8.2.2. Outcomes

- The KPI in relation to ED attendances is a 20% reduction for the cohort of patients, compared to the previous 12 or 3 months.
- There are 10 patients who have ED attendance data for 12 months after discharge from the HIU service. This data was not available in the previous year annual report.
    - There are 4 patients who have ED attendance data for 12 months after 1st contact of the HIU Lead.
    - 10 additional patients have data for 3 months after the 1st contact with the HIU Lead (Fig.27).
    - New patients under the 3-month period have not been counted in this report.

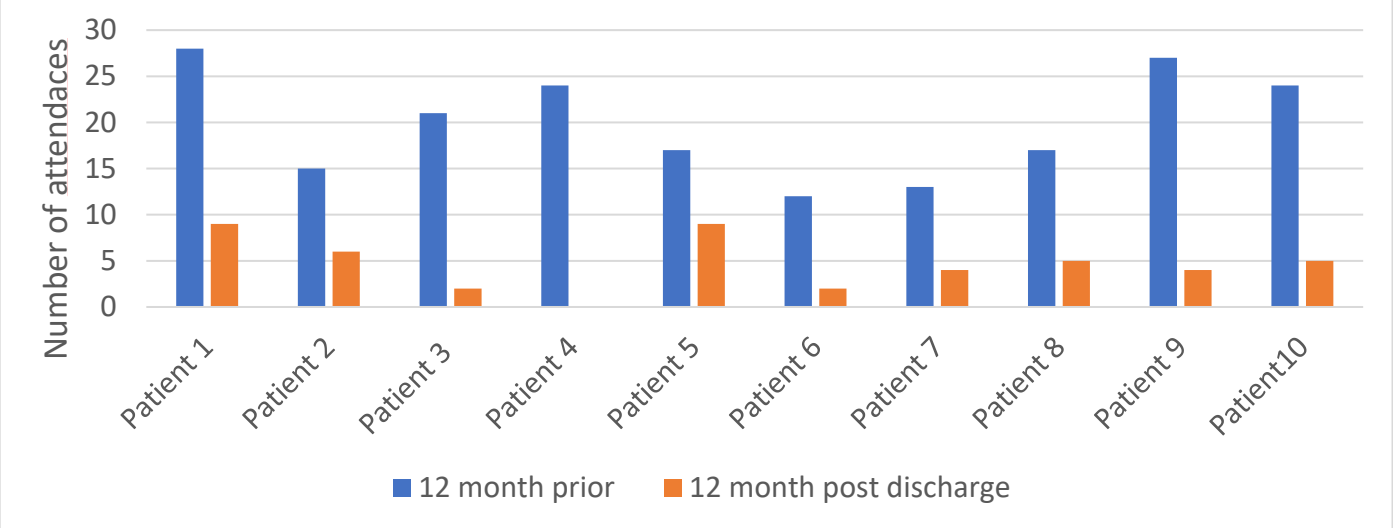
Other patients on the HIU cohort have not yet reached the KPI timeframe.

Fig.28. Emergency Department Attendances (3-Month Post HIU Contact)



- 7 out of the 10 patients had a reduction in attendances in the first 3 months of contact. This reduction ranged from between 25%-100%. Therefore 7 patients reached or went above the 20% KPI at the 3-month HIU contact stage.
- 1 individuals' attendance reduced by 100% whilst receiving input from the HIU Lead.
- 2 patients increased their attendance at the 3-month point (Patient 4 and 5), however Patient 4 had experienced significant events resulting in the increase, and both patients have significantly decreased their attendance in the following months. There is evidence that some of the HIU cohort may increase at the 3 month point but significantly decrease by 6 months. Patient 4 decreased his attendance to 1 in the last 6 months and has had zero attendances since discharge in February 2024 (therefore 6 months post HIU contact). Patient 5 likewise has had zero attendances in the last 3 months (6 months post HIU contact).
- Patient 8 who had reached 17% decrease at 3 months has decreased further at 6 months with zero attendances in the last 6 months (6 months post discharge).

Fig.29. ED Attendance 12 Months Post Discharge from HIU Service



8.2.3. Fig.29. above shows that all patients have reached the 20% KPI reduction for 12-month post discharge from the HIU Service. One patient has a minimum of 52%, Patient 4 has reached 100% reduction post discharge.

8.2.4.Non-Elective Admissions (NEA)

The KPI for non- elective admission is for a 20% reduction compared to the previous 3 or 12 month position (see fig.30. below). Non-elective admissions for all the cohort of patients in the last 12 months has not been a significant challenge for our patients. With only 2 patients having had NEA's linked to inability to access routine appointments prior to HIU service input.

The KPI's for Emergency Department admission have been met for 70% of the patients at month 3. Three patients met the KPI at month 6 and continued resilience is noted at month 12 post discharge when a reduction of at least 50% is evident. Patient satisfaction has also been reached at 100% for the 9 feedback forms returned, which is above the 90% KPI.

8.2.4.Next Steps and Future Plans

Given the success of the HIU role at LTH, the ICB have approached the LTH HIU Lead to understand the model to consider widening this out across Lancashire and South Cumbria. NHSE have indicated their desire to have HIU leads embedded in acute hospitals. Although the HIU Lead will aim to support over a 12-week rolling period it has been recognised that engagement and success requires far more time for some patients. Focus is being given to the use of virtual platforms to widen the scope of contact, allowing individuals to 'meet' the HIU Lead at times when trying to sustain daily routine or accessing work. This mode of contact will compliment face to face, telephone, and text communication in accordance with patient need.

9. Safeguarding Annual Plan (2024-25)

9.1. Key Priorities Moving Forward

9.1.1.The Head of Safeguarding and the Safeguarding Team will focus on delivering the below for the next 12 months to ensure safe and effective safeguarding service delivery to protect our vulnerable patients:

- Maintain strong oversight of managing allegations (PiPoT) cases and provide leadership.
- Oversee the implementation process for safeguarding referrals through Harris Flex.
- Strengthen the delivery of safeguarding supervision and provide an audit, monitoring, and assurance process in line with updated policy.
- Develop a Trust standalone MCA, DoLS and best interest process training package, and the team will continue to work with all wards and departments to ensure that MCA remains business as usual.
- Oversee the development of a Trust process for LeDeR notifications with 2 working days to meet contractual obligations.
- Continue to work with the Divisions to achieve the required safeguarding training compliance with increased team visibility throughout the Trust to support staff in meeting their safeguarding responsibilities.
- Relaunch safeguarding champions network for Trust staff.
- Introduce of an adult safeguarding refresher training programme to maintain training compliance levels whilst providing staff with interactive workshops covering a variety of safeguarding topics.

10. Recommendations

The Board of Directors are asked to receive the content of the Safeguarding Annual Report for information.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Annual Mortality Report 2023 -2024						
Report to:	Board of Directors			**Date:**	1st August 2024	
Report of:	Chief Medical Officer			**Prepared by:**	K Flinn G Clarke A Gale	
Purpose of Report						
For assurance	☐	**For decision**	☐	**For information**		☒

Executive Summary:

The purpose of this annual mortality report is to provide an update and assurance to the Board of Directors that the Trust has robust governance arrangements in place to review, report and learn from patient deaths. The report has been considered by the Mortality and End of life Committee at its meeting in June 2024.
This report presents a range of information and benchmarking data to provide assurance to the Committee in the following areas:

- Mortality benchmarking – Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Indicator (SHMI)
- Adult Structured Judgement Reviews (SJR) Mortality Reviews & Learning
- Learning from Inquests
- Mersey Internal Audit Agency (MIAA) Mortality and Learning from Deaths report.
- Changes to TELSTRA (Dr Foster) methodology
- Learning Disabilities Deaths, Reviews & Learning (LeDeR)
- Strategic Executive Information System (StEIS) /Patient Safety Incident Response Framework (PSIRF) and Maternity and Newborn Safety Investigations (MNSI) Deaths & Learning
- Perinatal, Neonatal & Child Deaths
- Medical Examiner Service Activity
- Mortality Improvement Projects

- This annual mortality report presents mortality benchmarking, demonstrating that the Trust **HSMR** of **76.2** and SMR of **77.4** are significantly lower than expected for the 12-month period of December 2022 / November 2023.
- The Trust **SHMI** for the data period of December 2022 – November 2023 is **91.69** and within expected range.

- The **SMR for children** is 76.0 and lower than expected**.** The latest 12-month SMR for neonatal deaths including stillbirths is 85.3 and within expected range. The latest 12-month SMR for neonatal deaths excluding still births is 50.2 and below the expected range. The trend analysis reveals that overall, the relative risk has decreased significantly.

- The Trust completed SJRs (Structured Judgement Reviews) for 51% of deaths during 2023 -2024.
  Key themes of learning from SJRs have been presented, as well as the learning from LeDeR reviews, StEIS /PSIRF reported deaths and Inquests.

- Learning from incident investigations, mortality reviews and inquests has been collated and reported.

- MIAA Audit has concluded with a rating of “Substantial Assurance”.

It is recommended that the Board of Directors

i. Note the content of the report for information and confirm it is assured of the robust arrangements in place relating to the management of patient deaths.

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	☒

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		Fit For The Future	☒

Previous consideration
N/A

1.0 Introduction

The purpose of this report is to provide an update and assurance to the Board of Directors that the Trust has robust governance arrangements in place to monitor, review, report and learn from patient deaths. This report presents a range of mortality information and benchmarking data to provide assurance to the Committee in the following areas;

- Mortality benchmarking – HSMR and SHMI
- Adult SJR Mortality Reviews & Learning
- Learning from Inquests
- MIAA Mortality and Learning from Deaths
- TELSTRA methodology changes
- LeDeR Deaths, Reviews & Learning
- StEIS Deaths & Learning
- Perinatal, Neonatal & Child Deaths
- Medical Examiner Service Activity
- Mortality improvement projects

The reporting period for TELSTRA (formerly Dr Foster) Mortality data is December 2022 – November 2023 which is the most recent data set available There is a one-month delay in the expected data period due to an anomaly with recent data which TELSTRA and NHS England are working to resolve.

The reporting period for the remaining data is April 1st 2023 – March 31st 2024.

2.0 Mortality Benchmarking

HSMR Regional Acute Peers Benchmark December 2022 – November 2023

Mortality benchmarking demonstrates that the Trust **HSMR** of **76.2** and Standardised Mortality Ratio (SMR) of **77.4** are significantly lower than expected for the 12-month period of December 2022 – November 2023.

The Trust had during the 12-month period one of the lowest HSMRs and SMRs in relation to regional acute peers as demonstrated in the funnel plots in Appendix 1 page 16.

SMR Regional Acute trust Benchmark Child Mortality

The 12-month rolling SMR for children is **76.0** and within expected range. There were 27 deaths during the twelve-month period, compared to an expected figure of 35.

The funnel plots and graph showing rolling 12-month peer comparison are at Appendix 1 pages 17,18,

SMR Stillbirth and neonatal mortality data (<1 day – 28 days)

The latest 12-month SMR for neonatal deaths including stillbirths is 85.3 and is within the expected range . The SMR value has seen some fluctuation over the last year – notably the Trust has seen an increase in SMR since August 22 – July 2023 where peers have seen a steady and stable decrease. This matter has been investigated and separately reported to the Safety and Quality Committee.

SMR Neonatal mortality (<1-28days) excluding still births

The latest 12-month SMR for neonatal deaths excluding still births is 50.2 and " lower than expected ".

Still birth mortality

There were 11 still births reported to TELSTRA during the reporting period. Analysis highlights that all have been recorded as having a 0-day Length Of Stay (LOS) Previously errors in LOS for stillbirth have been

identified in previous reports – however the Trust has since identified how the reporting error was made and has corrected the data on the Trust clinical information system.

Funnel plots and rolling 12-month peer comparison graphs highlighting stillbirth and neonatal mortality are at Appendix 1 pages 18-21.

Detailed reporting of perinatal mortality data and reviews is presented separately to the Safety and Quality committee.

Summary Hospital-level Mortality Indicator

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged. Deaths related to COVID-19 are excluded from the SHMI.

The Trust **SHMI** for the data period of July 2022 – June 2023 is **91.69** and within expected range.

3.0 TELSTRA methodology review

TELSTRA has recently completed a 2-year review of the methodology used for mortality benchmarking. A number of changes will be implemented over the next six to eight months.

An engagement event and presentation has already been provided to the Trust Mortality Teams with an extended invitation to Business Intelligence/Continuous Improvement Teams. Support will continue to be provided through the transition period.

The aim is to provide more robust benchmarking and to incorporate updates to key features of risk adjustment, which will allow greater assurance regarding key outcome measures in mortality, length of stay and readmissions.

The changes related to both the cohort groups and the models used to calculate risk adjustments.

Changes are summarised in the table below.

Table 1: Changes to TELSTRA methodology

	Old methodology	**New methodology**
Cohort	Still births included	Still births removed
	57 diagnosis groups	41 diagnosis groups including viral infections
Risk Adjustment	Palliative care included	Palliative care removed to reduce bias factors
	Frailty not included	Frailty added
	Deprivation index used Carstairs model	Deprivation index uses IMD index (Index of Multiple Deprivation) which is more up to date, considers more factors, and is widely used in research
	Comorbidity index uses Charlston index. Includes 17 conditions. Not subject to review	Co morbidity index used Elixhauser-Bottle index which has 32 conditions including dementia and will be subject to 3 yearly review.

4.0 Adult Mortality Structured Judgement Reviews (SJRs) & Learning

4.1 Primary Structured Judgement Reviews

The Trust overall reviewed 51% of all death cases that occurred at the Trust, with the divisional performance presented in Table 2 below.

Although the aspiration is that all Trust deaths are reviewed, there is pragmatically a minimum target set of 20% in each directorate. There is work ongoing to support those specialties who have historically returned low review figures with continued improvement noted over the past twelve months across each of the specialities requiring support.

Table 2: Primary Structured Judgement Review Annual Performance

Division	April – June 2023			July - September 2023			October - December 2023			January – March 2024			Annual Totals		
	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%	Deaths	Reviews	%
Medicine	352	152	43%	290	132	46%	342	144	42%	407	153	38%	1391	581	42%
Surgery	87	87	100%	81	81	100%	72	66	92%	79	66	83%	319	300	94%
DCS	45	25	56%	47	23	49%	51	16	31%	53	25	47%	196	89	45%
WAC	0	0	N/A	1	1	100%	1	1	100%	0	0	N/A	2	2	100%
Total	**484**	**264**	**55%**	**419**	**237**	**57%**	**466**	**227**	**49%**	**539**	**244**	**45%**	**1908**	**972**	**51%**

The avoidability of death score at Primary SJR is used to determine cases which require escalation for a Secondary SJR, which are those cases with scores 1-3. Some cases may be directly referred for a Datix incident review where there is already a concern that a clinical incident has occurred. Where relevant, those cases will be reviewed at the Patient Safety Incident Response Framework (PSIRF) Level 2 Triage meeting where the level of investigation will be determined. In cases requiring further investigation the avoidability of death is only finally determined after an incident investigation has been completed or after a coroner's inquest where applicable.

Table 3: Avoidability Scores at Primary Review 2023-2024

Avoidability Scores	Medicine	Surgery	DCS	WAC	TOTAL
Score 1 Definitely avoidable					**1**
Score 2 Strong evidence of avoidability					
Score 3 Probably avoidable (more than 50:50)	1				**1**
Score 4 Possibly avoidable but not very likely (less than 50:50)	20	15	3		**38**
Score 5 Slight evidence of avoidability	82	25	11		**118**
Score 6 Definitely not avoidable	428	260	75	2	**765**

4.2 Secondary Reviews 2023-2024

For the deaths which occurred during 2023-2024, 38 were referred for a secondary review which is a decrease from 53 cases in the last year's annual report. It should be noted that a request for a secondary review is not always due to the avoidability of death score or poor care. Some specialities trigger a secondary review if a second opinion/specialist opinion is required, or a need to highlight an issue to another speciality involved in patient's care.

Out of the 38 cases two patients were given an avoidability of death score of 1 or 3 at the primary review. One case has been referred for a level 3 SEIS investigation and the other case is awaiting a secondary review. See the breakdown of all the outcomes in Table 4.

Table 4: Avoidability Scores at Secondary Review

Primary SJR Avoidability Scores	Cases escalated for Secondary SJR	Post Secondary Review Avoidability
Score 1 Definitely avoidable	1	Level 3
Score 2 Strong evidence of avoidability	0	
Score 3 Probably avoidable (more than 50:50)	1	1= Awaiting a review
Score 4 Possibly avoidable but not very likely (less than 50:50)*	8	1= Score 4 1= Score 5 2 = Level 3 3= Awaiting a review 1= Score not available
Score 5 Slight evidence of avoidability*	10	1= Score 5 4= Score 6 2= Awaiting a review 2= further review not required (DATIX recorded) 1= RIR (low harm)
Score 6 Definitely not avoidable*	18	1-Score 5 9= Score 6 2= RIR/Level 2 5= Awaiting a review 1= Review not required

* Please note that cases scoring 4-6 do not require escalation for Secondary Review. A secondary review is also triggered by a poor care score.

4.3 Learning from Structured Judgement Reviews

The mortality review proforma has been designed to capture both positive and negative learning.
Learning from deaths is shared in the divisional Safety and Quality meetings and speciality governance meetings.

Key positive themes arising from the outcomes of SJR Mortality Reviews during 2023-2024:

- Appropriate escalation of patients.
- Good communication with the family and patient.
- Prompt investigations.
- Good documentation.
- Multi-disciplinary approach.
- Involvement of the Palliative Care Team.

Key negative themes arising from the outcomes of SJR Mortality Reviews during 2023-2024:

- DNACPR decision making and delays in initiating a DNACPR.
- Missed escalation of patients.
- Lack of /delayed Involvement of the palliative care team

5.0 Learning Disabilities (LeDeR) Deaths, Reviews & Learning

There were 20 deaths of patients with Learning Disabilities and 3 deaths of patients with Autism in 2023-2024, all of these have had a Structured Judgement Review completed.

Table 5: LeDeR and Autism Deaths Reviews 2023-2024

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Totals
LeDeR	2	2	2	1	1	1	0	2*	2	3	2	2	20
Autism	1	0	0	0	0	1	0	0	0	0	1	0	3
Total	3	2	2	1	1	2	0	2	2	3	3	2	23

*this includes patients who died in ED (1 in total)

Good care was reported in 23 cases. In 22 cases death was 'Definitely not avoidable' and in one case the death had a "slight evidence of avoidability'. This patient was referred for a secondary review to the parent speciality to obtain more information on the management of the patient. Feedback is awaited.

6.0 Deaths subject to StEIS /PSIRF Investigation

During the reporting period 17 incidents with an outcome of death have been reported onto the Datix system. Full details of these cases have been separately reported to Safety and Quality Committee in the quarterly Serious Case Review Reports

As of 30th May 2024, 11 of the 17 StEIS/PSIRF/MNSI investigations have been concluded. Of the 11 completed cases nine were subject to inquest with seven having concluded and two ongoing (cases 7 and 9).

The learning from the 11 StEIS /MNSI cases where investigation has been completed includes:

Case 1: Patient with high output stoma developed critically low Potassium levels post discharge and died from a cardiac event.

- Ward based training for the management of high output stomas.
- The development of a directory of dedicated telephone numbers for GP practices for Pathology to report urgent blood results.

Case 2: Mental Health patient left the ward and jumped / fell from the motorway bridge.

- ED Mental Health Policy to be drafted and Self harm policy to be published.
- Mental Health Risk Assessment Tool – training to be provided and compliance audited.
- Daily identification of high-risk mental health patients from Matrons to Security Staff.

Case 3: Patient developed necrotising fasciitis.

- Explore the current process related to the management of Urgent Care Centre/GP referrals to medicine via the MAU at CDH.
- Review approach to transfer risks balancing stabilisation needs versus definitive treatment options and time to request category 1 ambulances.
- Education on red flags for Necrotising Fasciitis.
- A clinically led debrief with GTD(Go to Doc) Healthcare clinical lead regarding the findings of this investigation and areas for learning and improvement.

- Include a “scoop and run” process where clinically indicated to the Stabilisation and Transfer of a critically ill patient from CDH Standard Operating Procedure (SOP) that recognises surgery as lifesaving intervention that can only be provided at the RPH site.
- Simulation training related to the Stabilisation and Transfer of a critically ill patient from CDH SOP.

Case 4: Patient suffered sub dural haematoma following an in-patient fall with bed rails in place when they should not have been.

- Enhanced care risk assessment competencies to be undertaken within one month for new starters.
- Importance of accurate completion of all risk assessments to be addressed at Ward meetings.
- Explore the linking of physiotherapy mobility assessments to Nursing Kardex.

Case 5: Blood glucose not monitored in line with hyperkalaemia guideline.

- Prompt within EPMA to monitor blood glucose for patients with hyperkalaemia
- Relevant training workbook to include questions regarding blood glucose monitoring for patients with hyperkalaemia

Case 6: Patient presented at the weekend with a stroke that would have been amenable to treatment with thrombectomy but thrombectomy service not available.

Learning relates to the Thrombectomy Service Expansion Plan, which is separately reported to the Safety and Quality Committee.

Case 7: Incomplete information on discharge letter resulted in GP not referring patient to specialist eating disorder service.

- Safety net process in relation to Immediate Hospital Discharge Information (IHDI) to be established.
- Addition to Risk Register with reference to unwritten/incomplete IHDI.

Addition to discharge checklist to include IHDI prompt.

Case 8: Patient became agitated prior to cardiac arrest. Security staff in attendance.

- Review of leadership and co-ordination of cardiac arrest
- Training on use of the appropriate pads for the defibrillator
- Supportive interaction from security and nursing staff when dealing with distressed patient (positive learning)

Case 9: In patient fall of independently mobile patient.

- Need to make patients more aware of increased falls risk when in hospital
- Completion of lying and standing blood pressure recordings

Case 10: In patient fall of young neurosurgery patient (head injury leading to death)

- Use of “Call Don’t Fall“ posters
- Low threshold for imaging of post fall patients on anticoagulation
- Completion of lying/standing blood pressure recordings
- Timely monitoring of patients on heparin infusions
- Trust wide focus of bathroom related falls

Case 11: Neonatal death due to catastrophic haemorrhage with condition of vasa praevia (torn blood vessels)

- No safety recommendations made as findings from analysis did not contribute to the outcome.

Of the outstanding six cases, two are subject to Patient Safety Incident Investigations under the PSIRF framework, one is subject to StEIS investigation, one subject to MNSI investigation and two are part of a thematic review into missed follow up of neurovascular patients (also StEIS reported). The committee will be updated of the findings in the quarterly Serious Case Review Report.

The action plans from the completed StEIS /PSIRF investigations are recorded and monitored through the Trust's Datix system and for complex inquest cases through the Trust's PSIRF Oversight Panel.

7.0 Inquests

7.1 Coroner concerns (Regulation 28, Neglect Conclusion, and formal concerns)

7.1.1 Regulation 28

The Trust has received one Regulation 28 in the reporting period. This was issued by HM Coroner for South Manchester in January 2024 following the inquest of a 20-year-old patient with a mental health condition and autism who died from a pulmonary embolus shortly after having been discharged from the Neurosurgery Unit having undergone spinal surgery.

The Trust last received a Regulation 28 in 2019.

An action plan was developed in response which was shared with the Coroner, the ICB and the CQC.

This is subject to ongoing monitoring for completion and evidence of embedding of actions.

A paper providing full details of the Regulation 28 has been previously shared with the Safety and Quality Committee.

The Trust also reported this case to LeDeR – the outcome is awaited and will be included in the bi-annual mortality report in January 2025.

7.1.2 Neglect Conclusions

A conclusion of Neglect was received in September 2023 in relation to deficiencies in nutrition and pressure ulcer care. This matter has also been reported separately to the committee.

This prompted a review of neglect conclusions received by the Trust. The report is attached at Appendix 2 page 22. The Trust has not received any Neglect conclusions since September 2023.

7.1.3 Letters /expressions of concern

The Trust has received two Coroner letters of concern in 2023 -2024 and in two further cases a formal response was required following verbal concerns raised by the Coroner during the inquests; responses have been provided and accepted in all but one case where the inquest was recently held (30.04.24)

Matters relate to:

- GP access to urgent/soon specialist advice (formal response to verbal concerns)
- Communication with Blackpool Victoria Hospital with regard to Neurosurgery advice (recent case formal letter expected)
- Discharge and communication with community colleagues for patient with complex nutritional needs (formal letter)
- Environmental issues regarding toilet doors (in relation to a case involving a patient fall)

7.2 Learning from Inquests

In the majority of cases learning from inquests will be evidenced in the trust investigation reports shared with the Coroner and bereaved families ahead of the inquest. However, in some cases the Coroner and families provide further challenge and feedback during the course of the inquest which provide valuable opportunities for further learning.

In the case of family feedback this is often softer learning in relation to their own experiences and views on care.

Themes include difficulty in speaking to senior clinicians, poor communication, being unaware of the severity/deterioration of the patient's condition, concerns not being listened to and difficulties in understanding their role in the DNACPR process. Families not understanding their role in decision making and sharing of information where patients have capacity and confidentiality needs to be considered has also been noted as a theme at inquests.

These matters are fed back into the divisions for consideration at Safety and Quality meetings and are formally reported through the Mortality and Learning from Deaths Annual and Bi-Annual reports.

Families have also provided very positive feedback on care delivered – notably in cases involving Respiratory Medicine at CDH, Critical Care, Emergency Department and Neurosurgery.

Going forwards Inquest feedback will also be shared via an Inquest Learning Bulletin which will be included in future Mortality Reports to the committee.

8.0 Perinatal, Neonatal and Child Deaths

The report on perinatal, neonatal and child deaths and the learning from these deaths is presented in separate reports to this meeting of the Committee on a quarterly basis as per the cycle of business.

A deep dive investigation into neonatal death/stillbirth data has been completed in 2023 -2024 and the ensuing report presented to this committee. As noted in section 2.0 this has resulted in accurate data on stillbirth numbers now being provided and reflected in TELSTRA reporting.

The Northwest Neonatal Operational Delivery Mortality Response is attached at Appendix 3 page 26.

The Standard Operating Procedure (SOP) following a neonatal death has been reviewed and updated to provide an increased level of assurance as a result of the Lucy Letby Enquiry. The SOP has been previously shared with the committee as part of the bi-annual mortality report and is attached at Appendix 4 page 32

for ease of reference.

The expansion of the Medical Examiner role to include neonatal deaths will provide further assurance on this matter with the start date for this process now being pushed back from April 2024 to September 2024 to align with new national Medical Examiner legislation.

9.0 Medical Examiner (ME) Service

9.1 Medical Examiner data

The tables below show ME review data for both in hospital/ ED deaths (Table 6) and Community deaths (Table 7).

100 % of in-patient/ED cases were reviewed by the Medical Examiner Officer (MEO) and 100% of deaths not directly referred to the Coroner were reviewed by a Medical Examiner (cases referred directly to the Coroner do not require a review by the ME).

The ME service currently has around 75% of community deaths referred - 100% of those were reviewed by a medical examiner.

By September 2024- 100% of community deaths will be referred and reviewed by the medical examiner service.

Table 6: Hospital Medical Examiners Data 2023-24

Hospital 2023-2024	Number	Percentage
Inpatient & ED Deaths	1960	
MEO Reviews of all Deaths	1960/1960	100%
Direct Coroner Referrals	182 / 1960	9%
ME Reviews of all Deaths (Non - coronial)	1775/1775	100%
ME/MEO Conversations with Bereaved	1606 / 1960	82%
Referral to coroner post ME review	333 / 1775	19%
Total Referrals to Coroner	515/1960	26%

Table 7: Community Medical Examiners data 2023 - 24

Community 2023-2024	Number	Percentage
Total Community Deaths	639	
MEO Reviews of all Deaths	639/639	100%
Direct Coroner Referrals	8 / 639	1%
ME Reviews of all Deaths (Non - coronial)	631/631	100%
ME/MEO Conversations with Bereaved	633 / 639	99%
Referral to coroner post ME review	14 / 631	2%
Referrals to Coroner	22/639	3%

In addition, the ME office was asked, by other ME offices, to scrutinise the case records of two patients who had died in other acute hospitals – Lancaster Royal Infirmary and Royal Bolton Hospital showing increasing maturity of the ME service.

Identified Themes:

The medical examiners continue to identify themes and trends during scrutiny. Themes identified in cases referred to the coroner and/or for further review include:

• Delayed recognition of the last days of life and delayed referral for palliative care input.

• Over-investigation of frail, elderly patients

• Delays in cancer diagnostic pathways

• Delays in responding to critical pathology findings

• Delays in responding to a deteriorating patient.

The reporting and learning from these issues are managed through either the Datix incident management or SJR processes depending on which pathway these concerns are raised through.

9.2 Medical Examiner Updates 2023-24

9.2.1 Staffing

The medical examiner service is currently fully staffed with 13 Medical Examiners providing 1.5 Whole Time Equivalent cover in line with NHS England recommendations based on 4,500 community and hospital deaths per annum.

9.2.2 Training and Education

The medical examiner team has continued to deliver training and updates to stakeholders with the lead ME and MEO have delivered sessions in the community and at the regional registration services update day.

Within the Trust The ME team continue to provide regular teaching to medical students and doctors in postgraduate training. The team also offer bespoke placements to trust staff to further education and training at ward level. These are educational opportunities provided to students, nursing and AHP colleagues to enable them to spend time in the ME office to gain a better understanding of the work. Excellent feedback has been received. The ME team has also helped to deliver the trust bereavement study day.

As part of professional development of the MEs themselves “Away Days “ have been held covering Coronial services, Death Registration service and the management of Paediatric deaths.

9.2.3 Future Developments

The legislation to make the Medical Examiner system statutory has now gone through parliament and September the 9th 2024 has been announced as the date on which this will commence. Three new pieces of legislation have been released:

• The Medical Examiners (England) Regulations 2024

• The Medical Certificate of Cause of Death Regulations 2024

• The National Medical Examiner (additional functions) Regulations 2024

As well as giving legal standing to the Medical Examiner Service this legislation describes changes to the completion of Medical Certificate of Cause of Death (MCCD) and the registration of a death. All deaths, where an MCCD is issued, will have to have scrutiny performed by a medical examiner before the death can be registered. In the period between now and the statutory start date the ME team are continuing to engage with stakeholders to ensure they are aware of the coming changes, as well as making sure that trust processes are in place, in order to have as smooth a transition as possible.

10. Ongoing Maturity of Governance arrangements in relation to Mortality

10.1 Engineering Better Care Project – Unexpected Death investigations

With the aim of offering bereaved families a clearer and more responsive service, and to support clinicians and governance teams involved in all types of death investigation in September 2022 the Inquest and

Mortality Team, supported by the Continuous Improvement Team, launched the Engineering Better Care (EBC) Project.

The implementation of Patient Safety Incident Response Framework (PSIRF) has significantly affected the capacity to engage in the programme; because of this issue, and in order to ensure that the project will be aligned with PSIRF principles for investigating complex deaths, a pause on the project took place until January 2024.

Whilst the PSIRF process is now progressing it is still affecting corporate and divisional governance teams capacity to consistently engage with the EBC project. Additionally, there is now limited capacity in the Continuous Improvement Team to lead the project due to competing priorities.

Priorities for continuing work have been established at the January 2024 meeting with a review of the project's position planned for July 2024.

Priorities for continued work:

- Staff support and feedback
- Bereaved Family feedback
- Development of shared portal for emerging information for multiple investigations.

10.2 Medical Examiner Review / Structured Judgement Review Audit

In Q2 2023 -2024 the Medical Examiner Service and the Inquest and Mortality Team initiated an audit process to cross check the Medical Examiner Reviews with the Structured Judgement Reviews of a selection of cases. This provides a quality check for both processes and is a recommendation from the national Medical Examiner Programme.

The audits, which take place quarterly, focus primarily on the quality of care provided and the avoidability of death.

To date the findings of the SJR and ME cases examined are broadly consistent with 30 cases having been reviewed.

Attendance at the meetings will be widened going forwards to include more Medical Examiners to ensure a range of clinical speciality opinions and robust attendance numbers.

10.3 TELSTRA data validation – Summary Mortality Indicators

Due to consistently low HSMR values reported and published for the trust by TELSTRA a deep dive, data driven analysis was performed by the Mortality Team supported by the Continuous Improvement Team and has now concluded in relation to Adult data.

This work has been presented in a separate paper to the Safety and Quality Committee.

A deep dive investigation into neonatal death/stillbirth data has also been completed and presented to the committee.

11.0 MIAA audit

The MIAA Audit into the Trust mortality management. has been completed with a rating of "Substantial Assurance" given.

The overall objective was to review the effectiveness of frontline to Board governance arrangements for identifying, investigating, and reporting on mortality.

Three key findings /recommendations were made:

Key finding 1.
Mortality and Learning from Deaths Policy required more clarity with regard to:

- Inclusion of autism in LEDER considerations
- Identification and prioritisation of patients with significant mental illness for Structured Judgement Reviews
- Governance structure with regard to mortality reporting

Key finding 2.
Obtaining regular and formal feedback from Bereaved families should be obtained - with particular reference to the reinstating of bereavement questionnaires.

Key finding 3.
Process for sign off of actions from the Mortality and End of Life Committee Action tracker needs to be strengthened.

An Action Plan has been developed to address the above concerns – this has been appended to the MIAA report which has been presented to the Audit Committee in April 2024.

12. Summary

- This mortality report presents mortality benchmarking demonstrating that the Trust **HSMR** of **76.2** and **SMR** of **77.4** are significantly lower than expected for the 12-month period of December 2022 / November 2023.
- The **SMR for children** is **76.0** and lower than expected The latest 12-month **SMR** for neonatal deaths (excluding still births*) is **50.2** and reported as lower than expected.*
- The **SHMI** is **91.69** and within expected range.
- 11 Stillbirths have been reported with accurate data confirmed.
- The Trust completed SJRs (Structured Judgement Reviews) for 51% of deaths during the year. Key themes of learning from SJRs have been presented as well as the learning from LeDeR reviews, ME reviews, StEIS reported deaths and Inquests.
- A MIAA Audit has been completed with a rating of "Substantial Assurance "
- The trust has commenced /continued the following maturity and improvement projects in 2023:
    - Continued then paused an Engineering Better Care Project to improve the management of complex investigations into a death.
    - Completed a data validation project in respect of summary dataset submissions to TELSTRA.
    - Commenced an Audit programme in relation to Medical Examiner and Structured Judgement Reviews

- Reviewed and updated the SOP in relation to neonatal deaths to provide increased levels of assurance.

13. Financial implications

None identified

14. Legal implications

The death related cases identified at section 6.0 may be subject to litigation.

15. Risks

The Regulation 28 issued in January 2024 represents a reputational risk to the Trust. This has been managed by a comprehensive action plan which has been shared with the Coroner, the ICB,CQC and the patient's family.

16. Impact on stakeholders

It is expected that the Engineering Better Care work and MIAA actions relating to family feedback to the Bereavement Team will have a positive impact on bereaved families.

17. Recommendations

It is recommended that the Board:

i. Note the content of the report for information and confirm it is assured of the robust arrangements in place relating to the management of patient deaths.

Appendix 1.

Mortality Benchmarking

Figure 1: HSMR Regional Acute Peers Benchmark, December 2022- November 2023

The HSMR for LTHTR is 76.2 and significantly 'lower than expected' for the most recent 12-month period.

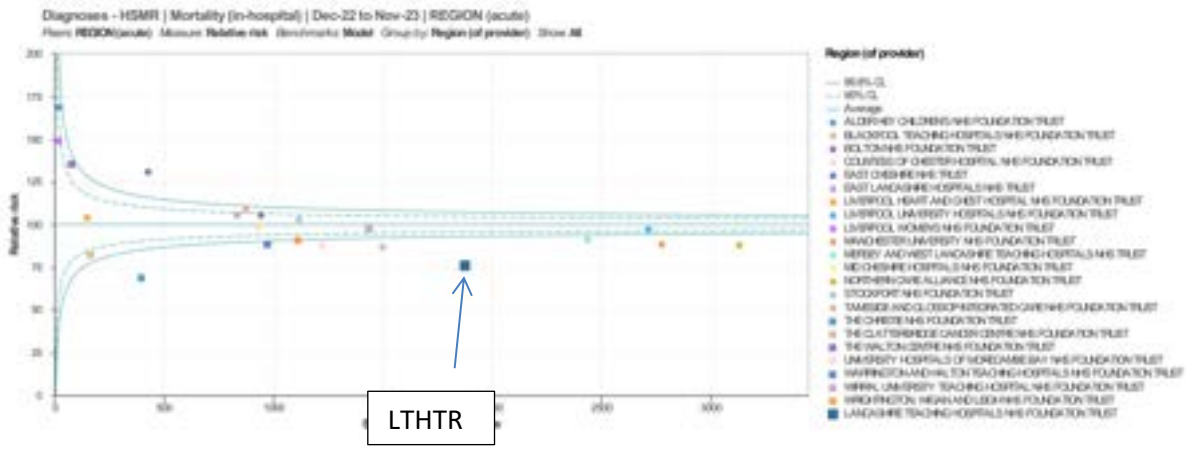
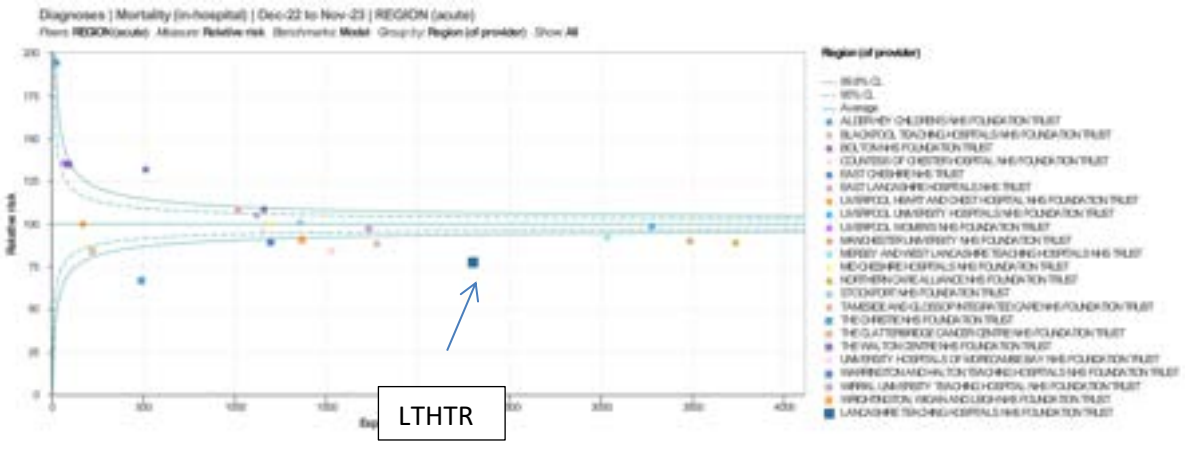


Figure 2: SMR Regional Acute Trust Benchmark, December 2022- November 2023

The SMR for LTHTR is 77.4 and significantly 'lower than expected' for the most recent 12-month period.



Trust HSMR Trend

Figure 3: HSMR by month trend December 2022- November 2023

This shows that the Trusts monthly HSMR for the last 11 months (Jan-23 – Nov-23) reported as 'lower than expected' (green diamonds).

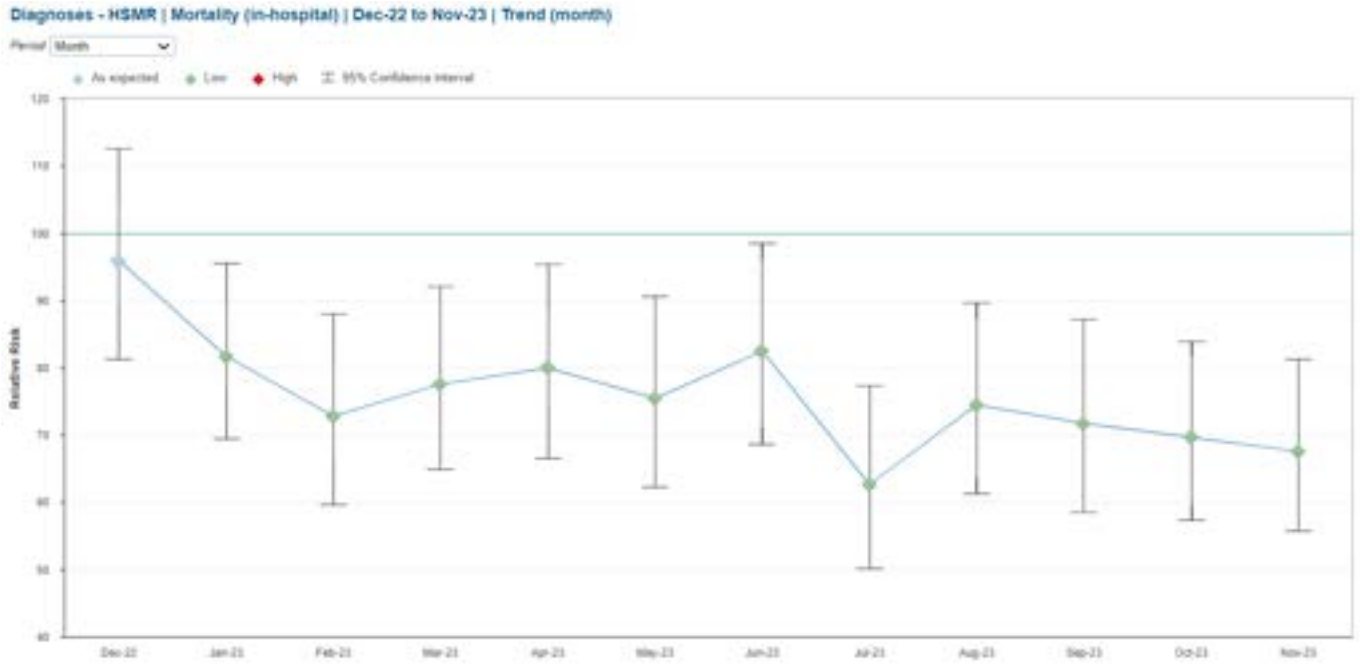
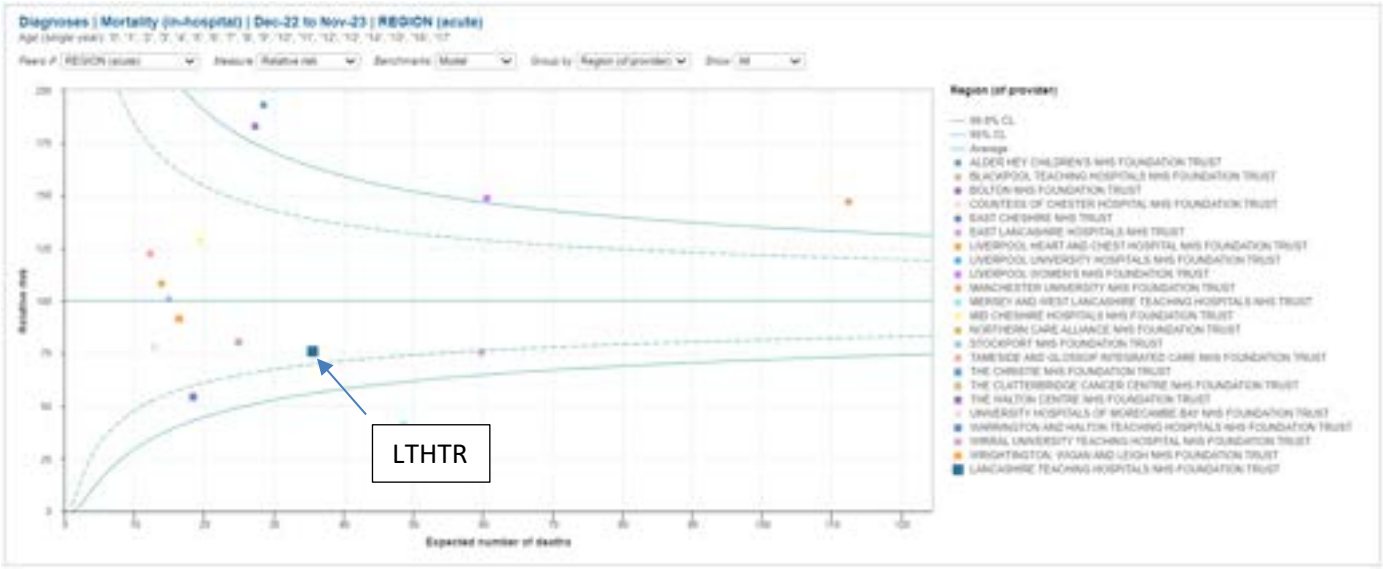


Figure 4 - SMR Regional Acute Trust Benchmark Child mortality, December 2022- November 2023



The twelve-month rolling SMR for children is 76.0 and within the expected range. There were 27 deaths during the twelve-month period, compared to an expected figure of 35.5. The trend analysis reveals that overall, the relative risk has decreased significantly, however there has been a slight uptick in the last 4 data periods.

Figure 4a SMR child mortality – rolling twelve-month peer comparison

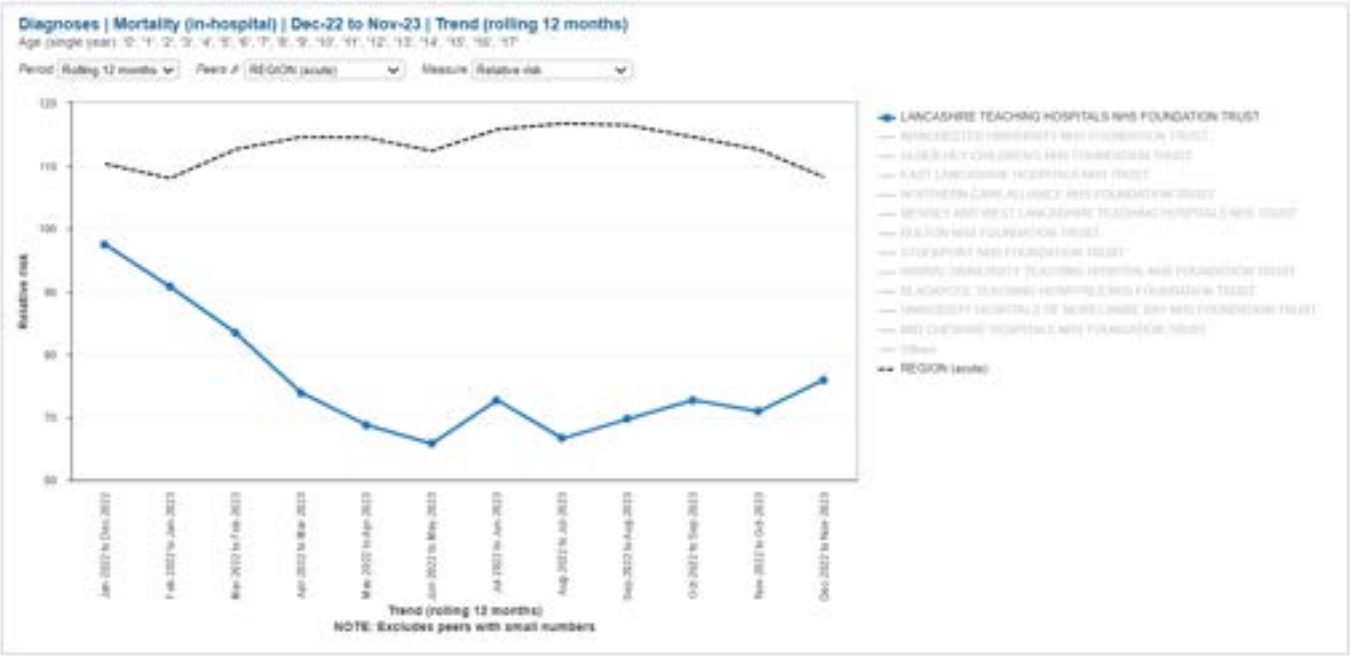
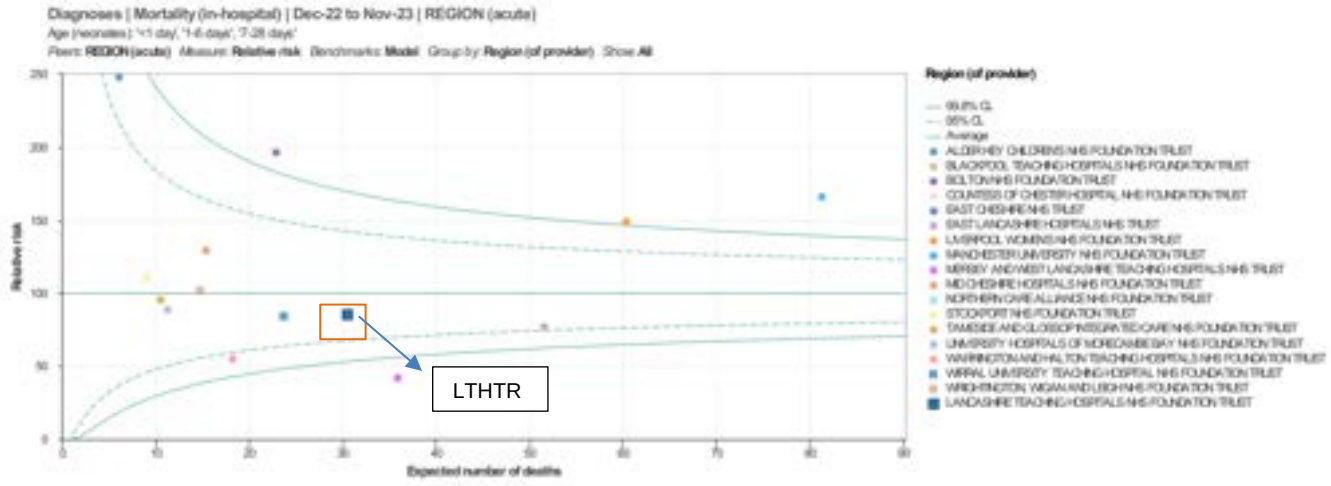


Figure 4b SMR child mortality – monthly observed mortality

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp. rate (%)	Obs-Exp	Relative risk	Low CI	High CI
All	17917	100	17941	27	0.15	35.54	0.20	-8.54	75.97	50.05	110.54
Dec-22	1540	8.60	1542	3	0.19	2.83	0.18	0.17	106.05	21.31	309.86
Jan-23	1454	8.12	1454	2	0.14	2.80	0.19	-0.80	71.38	8.02	257.72
Feb-23	1383	7.72	1384	1	0.07	2.84	0.21	-1.84	35.26	0.46	196.21
Mar-23	1686	9.41	1687	2	0.12	4.15	0.25	-2.15	48.20	5.41	174.02
Apr-23	1388	7.75	1390	1	0.07	2.81	0.20	-1.81	35.58	0.46	197.94
May-23	1383	7.72	1383	1	0.07	3.20	0.23	-2.20	31.20	0.41	173.61
Jun-23	1389	7.75	1391	4	0.29	2.59	0.19	1.41	154.68	41.61	396.01
Jul-23	1416	7.90	1417	1	0.07	2.87	0.20	-1.87	34.88	0.46	194.09
Aug-23	1342	7.49	1346	3	0.22	2.04	0.15	0.96	146.94	29.53	429.34
Sep-23	1521	8.49	1527	2	0.13	2.41	0.16	-0.41	82.96	9.32	299.53
Oct-23	1722	9.61	1723	3	0.17	3.43	0.20	-0.43	87.41	17.57	255.39
Nov-23	1693	9.45	1697	4	0.24	3.57	0.21	0.43	112.01	30.13	286.76

Figure 5: SMR Stillbirth and neonatal mortality data (<1 day – 28 Days), December 2022-November 2023



The latest 12-month SMR for neonates aged between zero and twenty-eight days is 85.3 and is within the expected range. The SMR value has seen some fluctuation over the last year. Most notably, the Trust has

seen an increase in SMR since Aug-22 – Jul-23, where peers have seen a steady and stable decrease. See figure 6a for further details.

Figure 5a SMR Stillbirth and neonatal mortality data (<1 day – 28 Days) -rolling twelve-month peer comparison.

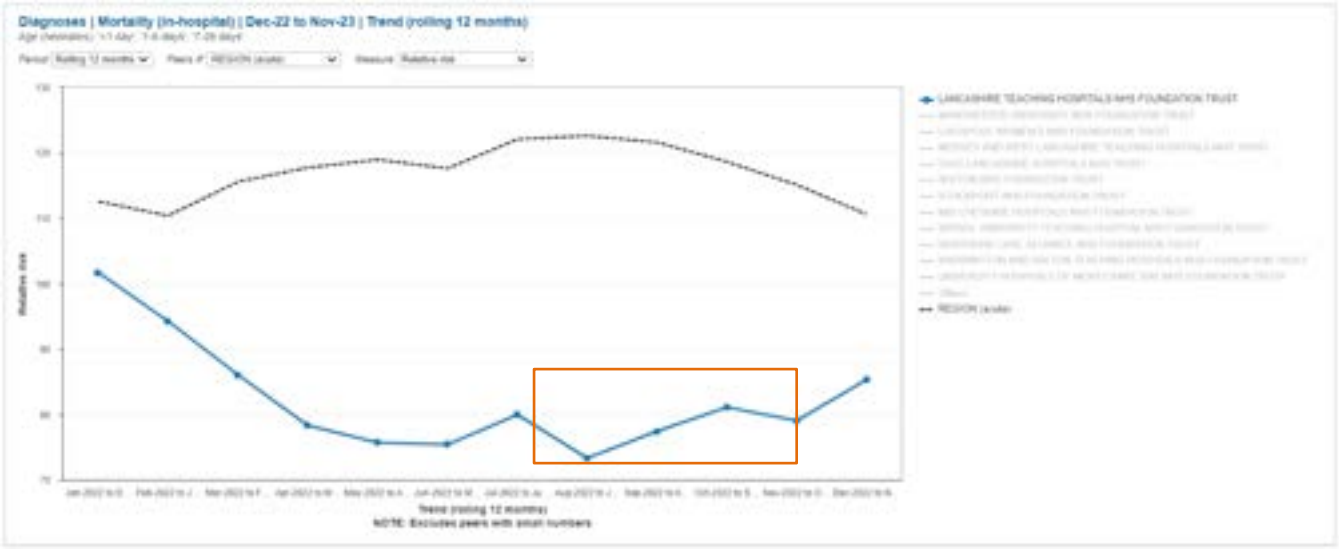


Figure 5b SMR Stillbirth and neonatal mortality data (<1 day – 28 Days) – monthly observed mortality for the period from December 2022- November 2023

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp. rate (%)	Obs-Exp	Relative risk	Low CI	High CI
All	4999	100	5008	26	0.52	30.47	0.61	-4.47	85.33	55.73	125.04
Dec-22	407	8.14	408	3	0.74	2.17	0.53	0.83	138.11	27.76	403.54
Jan-23	438	8.76	438	2	0.46	2.42	0.55	-0.42	82.56	9.27	298.07
Feb-23	376	7.52	377	1	0.27	2.44	0.65	-1.44	41.03	0.54	228.26
Mar-23	445	8.90	446	2	0.45	3.76	0.84	-1.76	53.20	5.97	192.07
Apr-23	382	7.64	382	1	0.26	2.51	0.66	-1.51	39.90	0.52	221.99
May-23	413	8.26	413	1	0.24	2.95	0.71	-1.95	33.95	0.44	188.91
Jun-23	414	8.28	415	3	0.72	2.30	0.55	0.70	130.70	26.27	381.88
Jul-23	436	8.72	436	1	0.23	2.33	0.53	-1.33	42.92	0.56	238.78
Aug-23	440	8.80	442	3	0.68	1.71	0.39	1.29	175.37	35.25	512.39
Sep-23	411	8.22	414	2	0.49	2.08	0.51	-0.08	95.94	10.78	346.4
Oct-23	440	8.80	440	3	0.68	2.90	0.66	0.10	103.30	20.76	301.81
Nov-23	397	7.94	397	4	1.01	2.90	0.73	1.10	137.88	37.1	353.01

No months are considered statistically significant. The latest monthly data for November 23 reveals a slightly increased relative risk figure of 137.88, however this remains within the expected range.

Figure 6 Still birth mortality – December 2022- November 2023

The analysis provides a mortality trend, for neonates recorded under the ICD 3 code for fetal death of unspecified cause (ICD code P95). There were 11 still births reported to TELSTRA during the period from December 2022- November 2023. The table of data in below includes very low volumes of activity.

Trend (month)	Superspells	% of All	Spells	Observed
All	12	100	12	11
Dec-22	2	16.67	2	2
Jan-23	1	8.33	1	0
Feb-23	0	0	0	0
Mar-23	2	16.67	2	2
Apr-23	1	8.33	1	1
May-23	1	8.33	1	1
Jun-23	0	0	0	0
Jul-23	1	8.33	1	1
Aug-23	2	16.67	2	2
Sep-23	1	8.33	1	1
Oct-23	0	0	0	0
Nov-23	1	8.33	1	1

Figure 6a still birth mortality – age analysis – December 2022- November 2022

The analysis highlights that all still births have been recorded as having a 0-day LOS (see table below). Previously, errors in LOS for stillbirth deaths had been identified in the previous report. The Trust, however, have since identified how the reporting error was made and has corrected the data on Harris Flex. All still birth records for the current data period are correct.

Length of stay	Superspell	% of All	Spells	Observed	Crude rate (%)
All	12	100	12	11	91.67
'0'	12	100	12	11	91.67

Figure 7 SMR Neonatal mortality (<1 day – 28 Days) – excluding still births – December 2022- November 2023

The latest 12-month SMR for neonatal deaths (excluding still births) is 50.2 and 'lower-than-expected'. In comparison to regional peers, the latest data reveals that the Trust are below control limits. Dec-22 – Nov-23 records an increase since the previous data period but remains statistically 'lower-than- expected'. Please see the time-series analysis in figure 8a.

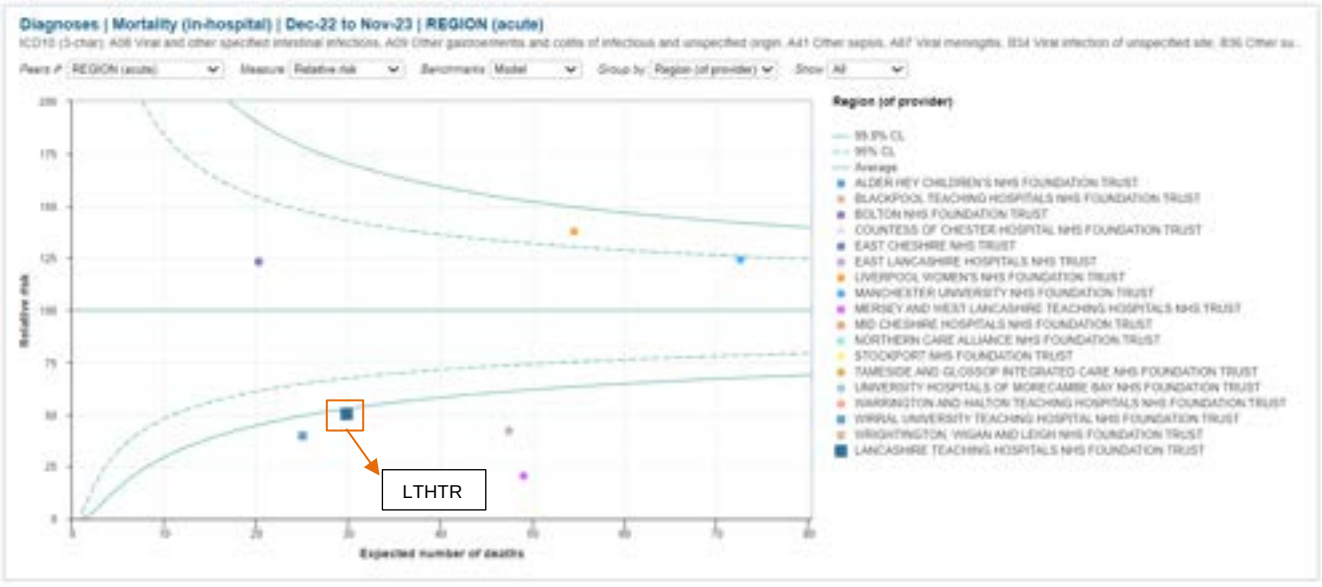


Figure 7a SMR Neonatal mortality data (<1 day – 28 Days) – excluding still births -rolling twelve-month peer comparison.

The rolling twelve-month relative risk shows a decrease across all NICU's during 4 data periods. The data has been suppressed due to small numbers in accordance with the NHS Digital HES Analysis Guide December 2019.

Figure 7b SMR Neonatal mortality data (<1 day – 28 Days) – Excluding still births - monthly observed mortality for the period from December 2022- November 2023

Trend (month)	Superspells	% of All	Spells	Observed	Crude rate (%)	Expected	Exp. rate (%)	Obs-Exp	Relative risk	Low CI	High CI
All	4987	100	4996	15	0.30	29.85	0.60	-14.85	50.24	28.1	82.87
Dec-22	405	8.12	406	1	0.25	2.03	0.50	-1.03	49.36	0.65	274.61
Jan-23	437	8.76	437	2	0.46	2.36	0.54	-0.36	84.75	9.52	306.01
Feb-23	376	7.54	377	1	0.27	2.44	0.65	-1.44	41.03	0.54	228.26
Mar-23	443	8.88	444	0	0	3.62	0.82	-3.62	0	0	101.23
Apr-23	381	7.64	381	0	0	2.46	0.65	-2.46	0	0	148.85
May-23	412	8.26	412	0	0	2.91	0.71	-2.91	0	0	126.09
Jun-23	414	8.30	415	3	0.72	2.30	0.55	0.70	130.70	26.27	381.88
Jul-23	435	8.72	435	0	0	2.29	0.53	-2.29	0	0	160.31
Aug-23	438	8.78	440	1	0.23	1.63	0.37	-0.63	61.25	0.8	340.78
Sep-23	410	8.22	413	1	0.24	2.05	0.50	-1.05	48.81	0.64	271.6
Oct-23	440	8.82	440	3	0.68	2.90	0.66	0.10	103.30	20.76	301.81
Nov-23	396	7.94	396	3	0.76	2.86	0.72	0.14	104.71	21.05	305.95

None of the months in the trend above are considered statistically higher than expected. The relative risk was at its highest during June 2023 at 130.70. The overall volume of deaths in the most recent twelve-month period is 15, compared to an expected figure of 29.85. The last month's figures for November 2023, reveals a relative risk of 104.71, with three deaths reported.

Appendix 2. Inquest "Neglect " conclusions 01.04.22 – 30.09.23

Inquest "Neglect "conclusions 01.04.22 – 30.09.23

During the period 01.04.22. to 30.09.23 the Trust has received 4 inquest conclusions which included a rider[1] of Neglect. The purpose of this report is to provide the Senior Team with details of each case and to explore any commonalities.

Table 1. below outlines the dates, specialties involved and incidents by type.

Table 1.

Reference	Jurisdiction and Coroner	Date	Specialty	Incident type
1	PBWD Dr JA	07.12.22	Neurology	Clinical care
2	PBWD Mr CL	10.12.22	Maternity	Perinatal death
3	PBWD Mr RT	30.01.23	Maternity	Maternal death
4	PBWD Mr CL	07.09.23	Rehabilitation	Nutrition/ hydration, Pressure ulcer care

Case 1

Formal record of inquest

XXX died on 2 June 2020 at [redacted] *following a twenty-month period during which time he was investigated for five collapses with loss of consciousness. A neurological assessment of all the information available and discussion of the risk and benefits of commencing appropriate treatment had not been completed at the time of* [redacted] *death.*

Key Safety topics

- Risks of not taking medication to manage epilepsy were not explained to the patient.
- Inconsistent sharing of clinical information between specialties /other local trusts where there is diagnostic doubt.

[1] In Inquest terms a rider is an addition to an existing Conclusion.

Actions

Case reviewed at Neurology Mortality and Morbidity meeting in January 2023 with an Action Plan and subsequent audit agreed.

The Action Plan covers the sharing of clinical information across specialties and across different trusts within the Neurology service, plus a directive that Neurology Doctors will need to be explicit with regards to the discussion of the documentation about the risk of harm and death through uncontrolled seizures.

Case 2

Formal record of Inquest

XX died on 7/11/20 at RPH. She was born on 5/11/20 showing no signs of life. Following extensive resuscitation, she showed signs of severe encephalopathy and was commenced on hypothermia therapy and showed little signs of recovery and did not survive. Prior to birth, she was identified to be lying in breech position, which she remained in. Clinicians did not agree a clear plan. Her death was contributed to by not intervening sooner to expedite birth by CS, which amounted to neglect.

Key Safety topics

- Poor communication between Consultant and SpR regarding the management of the labour and plan for breech birth
- Sub optimal interpersonal relationships within the clinical team
- Lack of experience by SpR in managing breech births

Actions

Comprehensive action plan including HSIB recommendations developed and audited by WACS. No additional actions identified at Inquest.

Case 3

Formal Record of Inquest

XX died at Royal Preston Hospital from sepsis to which neglect was a contributing factor. Diagnosed with a urinary tract infection on 21st August 2021 there was a delay in the administration of essential antibiotics, and she presented at hospital on 23rd August with a severe sepsis which was not promptly treated. Following a miscarriage, she suffered two cardiac arrests and died on 17th August 2021
The definition of neglect is made out on 21 August 2021, that led to sepsis for which there was a gross failure to provide basic medical treatment. It was possible but not probable [redacted] *would have survived on 23*

August if treated, but the damage was already done. If antibiotics were maintained on 21 August, on balance [redacted] *would have survived.*

Key safety topics

- Delayed administration of antibiotics
- Sub optimal handover from NWAS /triage on admission
- Loss of focus on the developing clinical condition of the Mother during the miscarriage

Actions

Comprehensive action plan developed and audited by WACS. No additional actions identified at Inquest.

Case 4

Record of Inquest

XX died on 9 September 2021 at Royal Preston Hospital, Preston in Lancashire. [redacted] *required life changing bladder removal surgery to control bleeding from a fragile bladder due to previous radiotherapy for prostate cancer. He developed an infective intra-abdominal collection as a result of the bladder removal procedure. His condition resulted in a long stay in hospital where* [redacted] *condition deteriorated including the development of pressure sores and loss of significant weight meaning he became frailer. He did not recover. His death was contributed by neglect by not providing adequate pressure area management, not adequately treating pressure sores, not providing medication in a timely fashion, and not responding adequately to* [redacted] *condition in relation to his weight loss, malnutrition, and dehydration.*

Key Safety Topics

- Pressure Area management
- Nutrition/hydration (lack of weighing)
- Nursing care provided within the Avondale Rehabilitation Unit
- Delayed medication (treatment of oral thrush)

Action Plan

Level 3/StEIS Action plan and evidence of completed actions approved by SLG.
Actions relate to the decommissioned Avondale Rehabilitation Service. Additional assurance on current comparable service (Finney House) was provided to the Coroner in respect of Nutrition/ Hydration/ PU Care and Governance arrangements.

Conclusion

Whilst it appears that there are no clear commonalities in the key safety factors outlined above, it is noted that the sharing of documentation across external agencies and neighbouring trusts was a factor in Cases 1 and 3.

Cases 2 and 3 (both involving maternity services) involved a senior Specialist Registrar shortly to become a Consultant (case 2) and a junior Consultant (case 3) which may prompt discussion as to what support is provided at this particular stage of an obstetric career and whether there is any learning in respect of this.

Appendix 3. North - West Neonatal Operational Delivery Network Mortality Response.

1. Purpose

The purpose of this document it to support the local provider in responding to a flag raised around mortality by providing a standardised proforma for reporting back through locality Neonatal Steering Group (NSG) findings of the requested local review.

2. Background

Mortality is reviewed in the Northwest Neonatal Operational Delivery Network (NWNODN) via the Neonatal Dashboard and through the Locality Clinical Effectiveness Groups (CEG).

The Dashboard Flags document https://www.neonatalnetwork.co.uk/nwnodn//wp-content/uploads/2021/08/Flags-Support-Document-2122-Revised-July-21.pdf sets out when a flag will be identified. The NWNODN Mortality reporting process sets out process for monitoring flags and actions required **PD-ODN-07-Mortality-reporting-updated-22.7.22.docx (live.com)**.

3. Expectations

When a unit has been identified for increased mortality, there is a requirement for a local review of all mortalities to be undertaken.

This review must ensure that a robust local review with external neonatal input and MDT representation has been undertaken in line with PMRT standards.

Any themes identified within the learning from each case should be summarised in section 6.

Any areas of concern identified from this local review should be set out clearly within section 7.

If following local review, there is a need identified for further external/independent review to be supported by the NWNODN this should be set out clearly within section 8.

There is an expectation that the detail of this review is signed off at directorate level.

Once this report is completed it should be returned to the NWNODN and a meeting set up to discuss the findings with the NWNODN Director, Locality Clinical Lead and Locality lead nurse. This meeting will set out actions for reporting back through NSG.

4. Data

Preston Neonatal unit has been highlighted within the NWNODN dashboard data as having signalled for 2 consecutive quarters, Q4 and Q1 for mortality.

Measure	Location	202223_Q2	202223_Q3	202223_Q4	202324_Q1	Mean
MORTALITY GESTATION 24-31 WEEKS	NWNODN	5.4%	8.0%	9.0%	4.7%	6.8%
	Lancashire and South Cumbria	13.0%	5.7%	6.7%	6.7%	8.4%
	Burnley	12.5%	11.1%	5.3%	10.5%	10.0%
	Furness General	-	-	-	0.0%	0.0%
	Royal Lancaster Infirmary	12.5%	0.0%	0.0%	0.0%	6.7%
	Royal Preston	0.0%	0.0%	6.7%	7.7%	4.0%
	Victoria Blackpool	33.3%	0.0%	12.5%	0.0%	13.3%

Cases for review and feedback.

Month of death	Location of death	ODN Ref	Badger ID
January	**Neonatal Unit**	**LSC-RPH- 23-01**	**AZYJIE**
February	**Neonatal Unit**	**LSC-RPH- 23-02**	**A822LE**
February	**Neonatal Unit**	**LSC-RPH- 23-03**	**AYLOJE (BVH-AIYNJE)**
June	**Neonatal Unit**	**LSC-RPH- 23-04**	**A7MVSE**
June	**Neonatal Unit**	**LSC-RPH- 23-05**	**AYWASE**
June	**Neonatal Unit**	**LSC-RPH- 23-06**	**AT5OEE**

5. Local Review Findings

Badger ID	Gestation	Birth Weight	Cause of Death	Age at Death	Local review complete	Grade assigned following PMRT	External neonatal representation at local review	Learning identified
AZYJIE	24+4	620g	a. Extreme prematurity at 24+4w gestation b. Significant IVH and Pulmonary haemorrhage c. Significant RDS of prematurity	38h	YES	A (Both RPH care and referring Unit)	NO (Joint PMRT Review with referring Level2 Neonatal Unit)	This was an out of network transfer and there was difficulty in getting parents to Preston when withdrawal of care was being considered
A822LE	24+2	290g	a. Extreme prematurity b. Severe IUGR c. Placental Insufficiency d. Maternal smoking	7h	YES	B	NO	Temperature on admission was unrecordable despite adequate efforts at thermoregulation – attributed to extreme low birthweight. Review also suggested a quicker transfer time from Delivery suite to NICU after birth would help to maintain optimum temperature.
AYLOJE (BVH-AIYNJE)	41+1	3760g	Severe Hypoxic Ischaemic Encephalopathy	13 days	YES	B (draft PMRT grading done for care at RPH)	NO HSIB report and Post-Mortem awaited	The baby had a line infection, but this had no bearing on the final outcome. There was also a Medication error which was appropriately managed and also had no bearing on final outcome.
A7MVSE	24+5	480g	a. Extreme prematurity at 24w b. Twin to Twin Transfusion syndrome (Donor) c. Maternal antepartum haemorrhage	8 days	YES	B (draft PMRT grading after local review)	NO	The baby had an accidental ETT dislodgement a few hours before care was withdrawn. The ETT was immediately replaced and the procedure for taking babies out for a cuddle was

			d. Pulmonary Hypoplasia with Oligohydramnios					discussed at the Mortality Review.
AYWASE	33+1	2550g	a. E.Coli septicaemia b. Foetal hydrops with bilateral pleural effusions c. Genetic abnormality – Kabuki Syndrome	11 days	YES	B	NO (Joint PMRT Review with referring Level2 Neonatal Unit)	Cause of death was Neonatal Sepsis with E.Coli grown from blood cultures 72h after birth (on day 8). The organism was not cultured from any of the line tips nor surface swabs. Local review felt that there were no recorded lapses in general infection control measures.
AT5OEE	25+1	820g	a. Severe Hypoxic Respiratory Failure with Covid19 bronchiolitis and secondary pneumonia b. Chronic lung disease of prematurity c. Extreme prematurity 25w gestation	233 days	YES	Beyond age range for PMRT	NO	Medication errors noted at local review – all Datixed appropriately and were no harm incidents. Incident during ETT change by anaesthetist – correct equipment was not immediately available. This was then rectified. During the Mortality review the key discussion point was that this baby was still managed on NICU despite being well over Term corrected age. However, this was because there were no other options (PICU refused because they felt baby would not survive).

Mortality Review Findings:

The Local Mortality review has been completed for all the above Neonatal deaths. All deaths were reviewed using a standard excel spreadsheet template and this review was done by a neonatal consultant

who was not directly involved with the care of the baby at the time of death. A separate template was also used for the review of nursing care.

All deaths have been reported to CDOP and MBRRACE within the required time frames. The PMRT process has been completed for 3 babies. The PMRT process is not indicated for AT5OEE. The reason for draft PMRT grading for AYLOJE is because the HSIB report and Postmortem report is still awaited. Local review for A7MVSE has only recently been completed and PMRT is ongoing.

Where needed (in 2 cases) there was a joint review with the referring trust for the PMRT when the baby/mother had care in a different hospital before transfer to Preston. We did not have an external neonatologist at the local Mortality Reviews. Attendees at the Local Mortality review includes representation from the Neonatal medical team, Neonatal Nursing team, Neonatal Matron, Neonatal Clinical Educator, Clinical Governance, and the Specialist bereavement Midwife. All the above deaths (except AT5OEE) have also been presented and discussed at the local monthly Perinatal Meeting.

Post-Mortem was requested for AYLOJE as there appeared to be no preceding antenatal/intrapartum events leading to HIE. This baby was an ex-utero transfer to Preston for cooling. The department has recently received a complaint regarding care received from the parents of AT5OEE and this is currently being addressed by the directorate clinical governance team. Due to this, it is likely that there will be an independent external review of this case.

We acknowledge that our local mortality reviews do not include an external neonatologist currently. All cases are presented and discussed at the quarterly CEG meetings when local reviews and PMRT is completed. Where indicated (when the baby is born at Preston), joint Rapid Incident Reviews are conducted with the maternity team and clinical governance team as soon as possible. The specialist bereavement midwife remains in contact with the family till the PMRT reviews are complete and bereavement meetings (usually joint with Obstetric and Neonatal) are completed.

Summary

In summary, the LTHTR Standard Operating Procedure after a Neonatal death[1] has been followed for all the above Neonatal deaths. The causes for the mortality have been variable and there have been obvious reasons for demise. Learning identified from our Mortality Review process is discussed at the appropriate forums and disseminated further where indicated. Areas of good practice included the appropriate use of the local Bereavement support team, and where needed the LTHTR Pastoral Care team and Hospice services.

6. Themes Identified through Local Review

There were 3 deaths of extreme preterm babies who had deaths expected in the circumstances due to Neonatal Morbidity associated with preterm birth. All the inborn deaths were 'expected ' given the clinical situations, with care re-orientated with parental involvement.

7. Concerns Identified

Our current review process does not *mandatorily* require an external neonatologist to be present at the PMRT review meetings.

8. Next Steps

We will work with the NWODN Clinical Effectiveness Group to identify a suitable process to have an external neonatologist present at either the local Mortality reviews or at the PMRT reviews.

REFERENCES:

1. Standard Operating Procedure following a neonatal death. Version3. http://lthtr-trust-documents.nhslibraries.com/Scripts/Hapi.dll/retrieve2?SetID=3D97C8B2-72FB-4D5D-B4BC-29005E5EC158&searchterm=dharmaraj%20&Fields=%40&Media=%23&Bool=AND&SearchPrecision=40&SortOrder=T1&Offset=18&Direction=%2E&Dispfmt=F&Dispfmt_b=B00&Dispfmt_f=F00&DataSetName=TRUSTDATA

Appendix 4. Standard Operating Procedure following a Neonatal Death

DOCUMENT TYPE: Standard Operating Procedure		**UNIQUE IDENTIFIER:** SOP-30	
DOCUMENT TITLE: Standard Operating Procedure following a Neonatal Death		**VERSION NUMBER:** 3	
		STATUS: Ratified	
SCOPE: Neonatal		**CLASSIFICATION:** Departmental	
AUTHOR: Dr Sandeep Dharmaraj	**JOB TITLE:** Consultant Neonatologist	**DIVISION:** Women's & Children's Health	**DEPARTMENT:** Neonatal
REPLACES: Standard Operating Procedure following a Neonatal Death v2		**HEAD OF DEPARTMENT:** Dr Raju Narasimhan	
VALIDATED BY: Neonatal Guideline Group		**DATE:** **13 October 2020**	
RATIFIED BY: Procedural Documents Ratification Group		**DATE:** 27 October 2020	
(NOTE: Review dates may alter if any significant changes are made).		**REVIEW DATE:** 31 October 2023	

AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes
Document for Public Display: No
Evidence reviewed by Library Services N/a

This applies to neonates who die at Royal Preston Hospital – Delivery Suite, Birthing Centre, Postnatal ward and NICU – with the Neonatal team in attendance. Some aspects (i.e. debrief and review) may apply to babies treated at RPH and transferred elsewhere for surgical/cardiac care or to a hospice.

Neonatal Death

- Bereavement Midwife informed.
- Neonatal Bereavement checklist completed and NICU notify Harris Flex.
- PM information given to parent (by Clinician/Bereavement MW)
- Coroners Officer informed (changes to Medical Examiner from 04/2024)

Postmortem (where indicated)
Death certificate issued (by treating clinician) *
Badgernet discharge/ letter to GP (cc Obstetricians/ HV) +MBRRACE reporting – within 48h
CDOP form completed (by treating clinician)

Rapid Review with Obstetrics and Clinical Governance

Local Neonatal Debrief and Mortality review-within 2-4 weeks**

- MBRRACE-PMRT form completed for <28d Neonatal Deaths (Neonatal data input by SD and maternal data completed by Governance/Bereavement MW)
- Letter from Clinician to family for bereavement visit (in 2-3months)

- Network ODN Mortality report form completed (SD)
- Quarterly Mortality review at Network ODN

Annual Neonatal Mortality Audit (SD/Trainee)

Annual data check notification and Annual national report from MBRRACE & NDAU

* Bereavement MW to review death certificate and email it to the Registry Office
** External Neonatologist to be present (where available) at PMRT/Mortality Review

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1. SUMMARY

The SOP is to direct the Neonatal Team on the process to be followed after a Neonatal death.

2. PURPOSE

To ensure correct actions are taken following the death of a neonate.

3. SCOPE

Neonatal services.

4. STANDARD OPERATING PROCEDURE

See algorithm on page 2.

Following a neonatal death on the delivery suite, birth centre (Preston or Chorley), post-natal ward or neonatal intensive care unit a number of actions are taken in line with national standards.

4.1 Process immediately following the death

The bereavement midwife is notified so support can be offered to the parents. There is a NICU bereavement checklist which the nurse on duty will complete to ensure that the baby is appropriately prepared for the mortuary including keepsakes for the family and ensuring relevant professionals are informed.

The coroner's officers based at RPH are informed and the parents are provided with information regarding a postmortem by either the bereavement midwife or the neonatal medical team. All neonatal deaths are reported to the coroners' officers who advise if the coroner should be contacted. Where indicated the coroner may be contacted directly by the neonatal/obstetric consultant. From April 2024, the LTHTR Medical Examiners will be informed of the death rather than the Coroners Officer.

When indicated the postmortem is completed but this is not required in all deaths. It is however offered in all deaths as a marker of best practice. The death certificate is issued by the clinician and a copy is sent to the registry office by the bereavement midwife. The parents are required to register the death (and the birth if not previously registered). Baby Beat charity has pre - paid the registration fees for neonatal deaths.

4.2 Reporting to Professional/ Statutory bodies

Within 48 hours of the death a summary letter is completed on the Badger net clinical record system, and this is sent to the General Practitioner, Health Visitor and Obstetric team. As part of notifications, the death notification form (Corporate forms) is completed and NICU staff (nursing or administrative) will also complete the death notification on Harris Flex.

The statutory form for the Child Death Overview Panel (CDOP) is completed by the clinician. The CDOP is an independent multidisciplinary panel that provides a review of all deaths of children who are under 18 and was mandated in the Working Together to Safeguard Children 2018 and operates at a pan Lancashire level managed by the Children's Safeguarding

Assurance Partnership. The main purpose is to identify lessons learnt and prevent future deaths.

All neonatal deaths under 28 days are reported to Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK (MBRACE-UK). MBRRACE-UK is national collaborative programme involving the surveillance and investigation of maternal deaths, stillbirths, and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The lead neonatal consultant for mortality inputs the neonatal care and the bereavement/Clinical governance midwife inputs for maternal care into MBRRACE.

The Perinatal Mortality Reporting Tool (PMRT), generated from MBRRACE, is completed by the Neonatal Consultant and the Clinical Governance and Risk manager for Maternity and Women's Health. This is done following the local mortality review and debrief. Where indicated, if there is a joint PMRT meeting for Obstetrics and Neonatal care, we will attempt to have an external neonatologist review the care. Also, if an issue has been identified at rapid review stage an external neonatal reviewer for PMRT is requested. The parents are aware of this review and are given opportunity to highlight concerns for inclusion in the terms of reference. This report is shared with parents as well as the trust.

For Term infants where Hypoxic Ischaemic Encephalopathy is listed as the cause of death, a referral is made to Maternity and newborn Safety Investigations programme (MNSI). This was previously known as HSIB (now known as HSSIB- Health Services Safety Investigations Body).

4.3 **Local review**

A date is scheduled within 2-4 weeks (unless there is involvement from the coroner, or a post-mortem is taking place) for a local debrief and mortality review. To avoid bias the local reviewer is a consultant who has not been directly involved in the infant's care. An invite for an external neonatal reviewer is also requested where indicated, especially if a care issue has been identified at rapid review stage.

A mortality report is completed for the Lancashire and South Cumbria Neonatal Operational Delivery Network Clinical Effectiveness Group (NWODN CEG) and the network hold a quarterly mortality review. This is attended by the neonatal intensive care governance lead clinician, the matron, clinical educator, and the consultant lead for mortality. Feedback is disseminated following this meeting to the wider group, and this includes the wider network allowing feedback learning from deaths in other units.

A summary of the local neonatal review is presented at the Trust End of life and mortality committee on request if there is any variations/increase in mortality rates.

A quarterly PMRT report is provided to safety and quality and included within the bimonthly reporting to the Board of Directors as part of the CNST update. Regional comparison data is also shared at the Safety and Quality committee.

There is an annual neonatal mortality audit supervised by the neonatal lead consultant. This is reported at the local perinatal mortality meeting, it is recorded on the AMAT audit system and also reported at the Child Health Audit meeting.

MBRRACE produces annual reports with thematic reviews and learning to support improvement.

4.4 Follow up.

The family receive an invitation for them to attend a bereavement appointment with a consultant in 2-3 months' time to discuss the death of their child. This may be a joint meeting with the Obstetric and Neonatal consultant and usually facilitated by the Bereavement midwife. Information is shared following the mortality review with opportunity for questions and discussion. A letter is generated following this meeting and a record of the discussion stored on the EVOLVE record system.

5. AUDIT AND MONITORING

Aspect of compliance or effectiveness being monitored	**Monitoring method**	**Individual responsible for the monitoring**	**Frequency of the monitoring activity**	**Group / committee which will receive the findings / monitoring report and act on findings.**	**Group / committee / individual responsible for ensuring that the actions are completed**
Mortality Review process	Annual Audit	Consultant Neonatologist	Annual	Neonatal Team	Neonatal team

6. TRAINING

TRAINING Is training required to be given due to the introduction of this policy? No		
Action by	**Action required**	**Implementation Date**

7. DOCUMENT INFORMATION

ATTACHMENTS	
Appendix Number	Title
Appendix 1	Equality, Diversity & Inclusion Impact Assessment Form

OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library
	Lancashire Teaching Hospitals (2023) *Notification of patient death.* https://lancsteachinghospitals-dash.achieveservice.com/AchieveForms/?mode=fill&consentMessage=yes&form_uri=sandbox-publish://AF-Process-67cb2472-38f5-4519-ab49-1ab65f91bf4a/AF-Stage-6516dc0b-faf6-44f2-aebc-69d7cbb0dcad/definition.json&process=1&process_uri=sandbox-processes://AF-Process-67cb2472-38f5-4519-ab49-1ab65f91bf4a&process_id=AF-Process-67cb2472-38f5-4519-ab49-1ab65f91bf4a

SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full** checked by library 06/12/2023 ZM	
Number	References
1	Maternity and Newborn Safety Investigations (2023) https://www.mnsi.org.uk/
2	Health Services Safety Investigations Body (2023) https://www.hssib.org.uk/
3	CDOP-https://www.safeguardingpartnership.org.uk/cdop/
4	Mothers and Babies: Reducing risk through audits and confidential enquiries across the UK (2023) https://www.npeu.ox.ac.uk/mbrrace-uk/reports/perinatal-mortality-surveillance
Bibliography	

DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition
CDOP	Child Death Overview Panel
MBRRACE	Mothers and Babies Reducing Risks through Audit and Confidential Enquiry
MW	Midwife
NDAU	National Data Analysis Unit
ODN	Operational Delivery Network
CEG	Clinical Effectiveness Group

PM	Postmortem
SD	Dr Sandeep Dharmaraj
PMRT	Perinatal Mortality Review Tool
MNSI	Maternity and Neonatal Safety Investigations
HSSIB	Healthcare Services Safety Investigations Body

CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted
Ruth Kirby	Bereavement Midwife	Jan 2020

DISTRIBUTION PLAN	
Dissemination lead:	Sandeep Dharmaraj
Previous document already being used?	Yes
If yes, in what format and where?	Electronic, heritage library system, hard copy
Proposed action to retrieve out-of-date copies of the document:	Knowledge and library to replace with updated version. Any paper copies to be removed and placed in confidential waste.
To be disseminated to:	Trust wide
Document Library	Heritage
Proposed actions to communicate the document contents to staff:	Include in the LTHTR weekly Procedural documents communication– New documents uploaded to the Document Library

Appendix 1

Lancashire Teaching Hospitals
NHS Foundation Trust

Equality, Diversity & Inclusion Impact Assessment Form

Department/Function	Neonatal			
Lead Assessor	Sandeep Dharmaraj			
What is being assessed?	Standard Operating Procedure following a Neonatal Death			
Date of assessment	September 2020			
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Group	☐	Staff Side Colleagues	☐
	Service Users	☐	Staff Inclusion Network/s	☐
	Personal Fair Diverse Champions	☐	Other (Inc. external orgs)	☐
	Please give details:			

1) What is the impact on the following equality groups?			
Positive: ➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups		**Negative:** ➢ Unlawful discrimination, harassment, and victimisation ➢ Failure to address explicit needs of Equality target groups	**Neutral:** ➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged
Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments:** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?	
Race (All ethnic groups)	Neutral		
Disability (Including physical and mental impairments)	Neutral		
Sex	Neutral		
Gender reassignment	Neutral		
Religion or Belief (includes non-belief)	Neutral		
Sexual orientation	Neutral		
Age	Neutral		
Marriage and Civil Partnership	Neutral		

Pregnancy and maternity	Neutral	
Other (e.g., caring, human rights, social)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups.
- This should be reviewed annually.

ACTION PLAN SUMMARY

Action	**Lead**	**Timescale**

HOW THE NHS CONSTITUTION APPLIES TO THIS DOCUMENT

WHICH PRINCIPLES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Principles	Tick those which apply.	WHICH STAFF PLEDGES OF THE NHS CONSTITUTION APPLY? Click here for guidance on Pledges	Tick those which apply
1. The NHS provides a comprehensive service, available to all.	√	1. Provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.	☐
2. Access to NHS services is based on clinical need, not an individual's ability to pay.	☐	2. Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.	√
3. The NHS aspires to the highest standards of excellence and professionalism.	√	3. Provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.	√
4. The patient will be at the heart of everything the NHS does.	☐	4. Provide support and opportunities for staff to maintain their health, wellbeing, and safety.	☐
5. The NHS works across organisational boundaries.	☐	5. Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.	☐
6. The NHS is committed to providing best value for taxpayers' money.	☐	6. To have a process for staff to raise an internal grievance.	☐
7. The NHS is accountable to the public, communities, and patients that it serves.	☐	7. Encourage and support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Employment Rights Act 1996.	☐

WHICH AIMS OF THE TRUST APPLY? Click here for Aims	Tick those which apply.	WHICH AMBITIONS OF THE TRUST APPLY? Click here for Ambitions	Tick those which apply.
1. To offer excellent health care and treatment to our local communities.	√	1. Consistently deliver excellent care.	√
2. To provide a range of the highest standard of specialised services to patients in Lancashire and South Cumbria.	√	2. Great place to work.	√
3. To drive innovation through world-class education, teaching, and research.	√	3. Deliver value for money.	☐
		4. Fit for the future.	√

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Appraisal, Revalidation & Medical Governance Annual Report							
Report to:	Board			**Date:**	1st August 2024		
Report of:	Chief Medical Officer			**Prepared by:**	A Gale / L Eccles		
Part I	√			**Part II**			
Purpose of Report							
For assurance	☒	**For decision**	☐	**For information**	☐		

Executive Summary:

This report covers the period of the 1 April 2023 to the 31 March 2024.

The template format of the report has been provided by the NHS England Revalidation Team. All Trusts have been requested to use the template and submit the full report which includes the Compliance Statement to NHS England before 31 October 2024.

The purpose of this report is to provide assurance that appraisal systems are robust, support revalidation and are operating effectively, whilst acknowledging that there are further improvements to be made. The report forms part of the Chief Medical Officer's duties as Responsible Officer.

On the 31 March 2024 there were a total of 772 doctors who had a prescribed connection to Lancashire Teaching Hospitals NHS Foundation Trust.

Of the 772 doctors connected to the Trust, 688 were due an appraisal in 2023/24 appraisal cycle. A total of 670 doctors completed an appraisal between 1 April 2023 and 31 March 2024. There were 18 approved missed appraisals which were due to sickness absence, career break or parental leave. No appraisals were categorised as an unapproved missed appraisal.

A total of 142 revalidation recommendations were made between 1 April 2023 and 31 March 2024, 116 were positive recommendations and 26 deferrals (mainly due to non-completion of 360 MSF feedback).

The Board is asked to approve the recommendation of the Workforce Committee for the Chair to sign the Statement of Compliance (section 9) prior to submission of the return to NHS England.

Trust Strategic Aims and Ambitions supported by this Paper:			
Aims		**Ambitions**	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒
To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☐
		Fit For The Future	☒
Previous consideration			
Workforce Committee, 9th July 2024. Approved.			

1. **Financial implications**

   None

2. **Legal implications**

   None

3. **Risks**

   None

4. **Impact on stakeholders**

   N/A

2023-2024 Annual Submission to NHS England North West: Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Lancashire Teaching Hospitals NHS Foundation Trust
What type of services does your organisation provide?	Acute and elective NHS secondary and tertiary care services

	Name	Contact Information
Responsible Officer (RO)	Dr Geraldine Skailes	DrGeraldine.Skailes@lthtr.nhs.uk
Chief Medical Officer (CMO)	Dr Geraldine Skailes	As above
Medical Appraisal Lead (MAL)	Dr Alison Gale Dr John Anderton (from 1st July 2024)	Alison.gale@lthtr.nhs.uk John.anderton@lthtr.nhs.uk
Appraisal and Revalidation Manager (RAM)	Post vacant from March 2024. New post holder starts July 2024. Being covered by Lisa Eccles, Head of medical workforce (see below)	
Head of Medical Workforce	Lisa Eccles	Lisa.eccles@lthtr.nhs.uk

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

Organisation: St Catherines Hospice

Please describe arrangements for Responsible Officer to report to the Board:
Act as RO for doctors employed by St Catherines Hospice

Date of last RO report to the Board:
August 2023

Action for next year:
Continue with process for presentation of report to Board

Introduction

NHS England have provided the following template for this annual board report and statement of compliance. This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/Narrative
Section 2 – Metrics
Section 3 – Summary and conclusion
Section 4 – Statement of compliance

Section 1: Qualitative/narrative

1A – General

The board/executive management team of Lancashire Teaching Hospitals NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	None
Comments:	Dr Geraldine Skailes remains Responsible Officer for Lancashire Teaching Hospitals (LTH).
Action for next year:	None identified

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	None
Comments:	A Peer Review in 2023 identified the Appraisal and Revalidation team was very small at LTH given the number of doctors. This review also identified the funded time allocated for appraisals was very short (0.025 PAs per appraisal) compared with peers.
Action for next year:	Review resource associated with appraisal and revalidation. Consider whether further resource could be allocated, however this is challenging due to Trust financial position.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	None
Comments:	The revalidation & appraisal manager monitors new starters, leavers, and all GMC connections in line with agreed processes.
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	None
Comments:	The scheduled 3-yearly review of the Medical Appraisal Policy implemented in 2021 is in progress.
Action for next year:	Complete policy review and re-publish

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	"The appraisal team will review the Trust peer review report (July 2023) for actions and any process changes recommended. The appraisal team will also review good practice highlighted in the peer review final meeting. Any actions will be provided in the next board report with process changes."
Comments:	The trust peer review was undertaken by the revalidation team at University Hospitals Morecambe Bay (UHMB). The final report can be found in appendix 1. In conclusion the team from UHMB were satisfied that the appraisal and revalidation function at LTH is fit for purpose. Concerns identified and the trust comments regarding these: 1. *"The Appraisal and Revalidation Team is very small for so many doctors and it is a credit to them how well the appraisal process is managed at LTH."* This has been an on-going issue however there is no scope to increase resource at this point in time due to Trust financial position 2. *"The MAL role was vacant for 2 years, putting the new MAL under pressure without a Deputy and the RAM feeling isolated and pressured."* This role has been filled by Dr Alison Gale in April 2022 and a new Trust appraisal lead has been appointed and starts in post 1st July 2024. 3. *"The RAM is a lone worker and has indicated she will be retiring in March 2024. There is no clear succession plan for such a specialised and important role which is of concern*." Due to the size of the team and funding this remains unchanged. The appraisal and revalidation manager post has been recruited to from July 2024. The head of medical workforce has filled this post in the interim period. 4. *"Due to the number of doctors and appraisal window, there are always high appraisal numbers to be reviewed."* The workload is dependent on the number of medical staff. 5. *"How does the MAL ensure the quality of Appraisers if the training is done by the Organisational Development team?"* Significant work has taken place in the last 12 months to improve

	training and the MAL plays an active role in training new appraisers and appraiser update sessions. 6. *"The time allocated for Appraisers is very short at 0.025PA. Our Clinical Appraisal Lead (CAL) raises some concern that this is not enough for the task, considering the time also taken to prepare for each appraisal meeting, and asks if the Trust might review this."* There is no scope to increase this currently due to the Trust financial position. 7. *"Although locum doctors with LTH as their designated body do not have appraisals if they are employed less than 6 months, and receive an "exit" report, our CAL questions if they still receive support from the A&R team to ensure they meet the requirements of revalidation."* Further work to take place on this when the new RAM starts in July 2024. 8. *"Having at least one Deputy MAL would give the team more opportunity for training and developing their roles to enhance the dedicated support to their doctors, which also aids the reputation of the department."* There is no scope to increase this currently due to the Trust financial position.
Action for next year:	As detailed in the section above. A copy of the peer review can be found in appendix 1.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	None

Comments:	The trust has an established medical bank. Doctors engaged through the bank work ad-hoc hours, some more than others. Some bank doctors require the trust to act as their designated body when they undertake most of their work at Lancashire Teaching Hospitals whereas others may be employed elsewhere, and this employer acts as the designated body. For those with a prescribed connection to LTH as their designated body, the doctors will undertake an annual appraisal and be supported through revalidation by the Trust. For those doctors without a prescribed connection, support for revalidation is provided on a case-to-case basis (eg. completed exit report). All new doctors, including bank doctors, who have a prescribed connection are invited to meet the RAM for training on appraisals and content.
Action for next year	Ensure all bank doctors receive adequate support from the A&R team to ensure they meet the requirements of GMC revalidation.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	N/A
Comments:	Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) license to practice. Each doctor is allocated an appraisal month and should complete their appraisal in that specified month. This appraisal is completed using an online system and includes all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.
Action for next year:	Embed Good Medical Practice 2024 into medical appraisal.

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	N/A
Comments:	The Trust issue a series of reminders to doctors when appraisals are not completed and these escalate if action is not taken by the individual doctor to complete the appraisal. The reminders sent are as follows: L2P – Notification that appraisal is due (pre appraisal month) 1st reminder – sent the month following appraisal due 2nd reminder – sent the 2nd month following appraisal being due 3rd reminder – Non engagement notification, at this stage the MAL will ask to meet the doctor to understand the reasons for the appraisal not being completed and set a target completion date. The Trust also enables doctors to submit a postponement form where they have identified a delay these are considered by the appraisal team and then if agreed completion is monitored according to the postponement date agreed. Doctors with a prolonged period of absence eg. parental leave and long-term sick leave may be classified as 'approved-missed appraisal' depending on the circumstances. This would require approval of the MAL.
Action for next year:	Review reminders issued to ensure timely. Review reporting of late appraisal completed using L2P as currently no option to report completed late on the system.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	N/A
Comments:	The medical appraisal policy is compliant with national policy and has received the Board's approval.
Action for next year:	This policy is currently under review. To incorporate the new GMC good medical practice domains.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	N/A
Comments:	During 2023-24 the trust had 165 trained appraisers for 772 doctors with a designated connection. This averages just under 5 appraisals per appraiser. The trust is aware that this is at the lower end of the working benchmark range. Appraiser allocation is usually within specialty, however this may extend to the wider division if necessary.
Action for next year:	Review appraiser: appraisee ratio to ensure proficiency and quality assurance.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	N/A
Comments:	Regular update events are delivered locally to inform appraisers of national updates and L2P system changes. A larger half day event with GMC input was delivered within the 2023-24 year. Appraisers can link evidence of attendance/learning into their own appraisal. Performance review (quality assurance) should be completed by the RAM for 20% of appraisals, with feedback being provided to individual appraisers. Due to resource issues this has not happened within 2023-24 and will be a focus for the new Revalidation and Appraisal manager. The feedback from appraisees is collated by L2P and is available for appraiser development.

Action for next year:	Further development of training and network events, this is something the new MAL will be leading upon. Review of quality assurance/performance review process.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	None
Comments:	The quality assurance (QA) of 20% of appraisal summaries should be undertaken each year. Due to resource issues this has not happened within 2023-24 year and will be a focus for the new Revalidation and Appraisal manager. Although full QA has not been completed the RAM does assess each appraisal when signed off to ensure quality. Post appraisal questionnaire (PAQ) summary reports are being provided from the L2P system for those appraisers who have received 3 or more completed feedback questionnaires from appraisees. The RAM collates all feedback obtained through the annual quality assurance process and themes identified from this feedback are incorporated into the annual update sessions.
Action for next year:	Review QA processes

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practice of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	None
Comments:	142 recommendations were made to the GMC between 1 April 2023 and 30 March 2024. These were as follows: • 116 Positive Recommendations • 26 Deferrals (a decrease from 34 deferrals in 2022-23) • 0 non-engagers.

	Out of the 26 deferred: 25 were due to 360 multi-source feedback not being completed. 1 due to parental leave.
Action for next year:	Continue to work towards further reduction of deferrals due to non-completion of 360 multi-source feedback. Allocation of 360 2 years before revalidation has already been implemented but further chasers to be developed by the new RAM starting July 2022.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	None
Comments:	All doctors receive confirmation of their revalidation recommendation promptly. Action plan completed and sent to all doctors who are deferred. Completion of the actions identified is monitored by the RAM.
Action for next year:	No further actions

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	Repeat GMC 'Effective Clinical governance for Medical Profession' self-assessment and complete a full benchmarking exercise to inform future improvements.
Comments:	Repeated November 2023 and improvements identified were as follows: *To consider identification of a non-executive director role specifically for doctors' revalidation and management of concerns:* ➢ Non-executive director lead appointed for these areas. *Greater focus on clinical and medical engagement with the governance agenda:*

	➢ A governance review at divisional and specialty level is planned for 2024/25. *Development of Governance handbooks to include a medical governance section:* ➢ This is still under development, *Better use of audit as a test of change:* ➢ An improvement plan for audit is in development as part of the organisation's Single Improvement Plan (SIP). This will include clinical audit linking with the Always Safety First, Patient Safety Incident Response Framework (PSIRF) and risk agenda to ensure clinical audit supports the assessment of recommendations and actions implemented leading to changes that deliver improved outcomes. *Corporate risk team testing robustness and efficacy of feedback from incidents and utilizing results from 2023 survey to make improvements where indicated:* ➢ Steps have been taken to improve feedback and shared learning – further work will be undertaken as part of PSIRF and the evolving learning framework. *Run risk management workshops to ensure continued learning:* ➢ Training on risk management has been agreed at Risk Management Group and this will be rolled out in Quarter 2, 2024/25. *To further explore ways the Trust uses lay representation to support and improve clinical governance for doctors:* ➢ this is still under consideration as the Trust is adapting to new processes following the implementation of PSIRF. *Test of change, regarding outcome data, re-audit reduction in incidents is incorporated into the measure of improvement. But needs more focused attention as this is not systematic across all improvement projects:* ➢ this is still under development as the Trust is adapting to new processes following the implementation of PSIRF. *Explore specifically processes underpinning clinical governance for disabled doctors:* ➢ A governance review at divisional and specialty level is planned in 2024/25 and this will be considered as part of this review.

	Ensuring 20% Quality Assurance across all appraisals and link this to appraiser training: ➢ This has been identified as a priority for the new Revalidation and Appraisal manager coming into post July 2024. *Concerns regarding doctors in training remains a gap as there is not an automatic link to LTH governance systems:* ➢ A governance review at divisional and specialty level is planned in 2024/25 and this will be considered as part of this review.
Action for next year:	Repeat of benchmarking exercise by November 2025 to review progress against the above improvements and actions identified above.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Review of the appropriate membership to the Responsible Officer Advisory Group (ROAG) to be undertaken.
Comments:	Membership of the ROAG group has been reviewed and this meeting takes place on a monthly basis. Membership of this group includes: • Chief People Officer • Chief Medical Officer/Responsible Officer • Deputy Chief Medical Officer (Professional Standards Lead) • Head of Workforce Advice • Head of Medical Workforce • Revalidation and Appraisal Manager In addition to the above the Chief Medical Officer /RO has regular meetings with the GMC and when required meetings are held with the Practitioner Professional Advice Service (which is part of NHS Resolution) to discuss individual cases. The L2P appraisal system has an RO note function which allows a flag to be placed on the appraisal record of any doctor for whom there are conduct or performance concerns. The Trust case management system is used to monitor and track all Maintaining High Professional Standards (MHPS) cases to ensure these are being processed in a timely manner Clinical Directors and Divisional Medical Directors have a role in

	supporting colleagues at a local level and will escalate to the ROAG as required.
Action for next year:	N/A

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	N/A
Comments:	Doctors request a report from governance by completing the template in L2P resources which lists clinical incidents and complaints. This can be uploaded into the appraisal on L2P and doctors are asked to reflect on these and document this reflection.
Action for next year:	Further review to be carried out to ensure these are always uploaded into the appraisal document.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practice, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	N/A
Comments:	The Trust 'Handling Concerns about doctors & Dentists Conduct & Capability' Policy details how concerns are responded to. All ongoing Conduct and Performance concerns are reviewed monthly by the Chief Medical Officer, Deputy Chief Medical Officer, Chief People Officer, Head of Workforce Advice and the Revalidation and Appraisal Manager. Regular meetings are also held with the NHS Resolution Practitioner Performance Advice (PPA) and the GMC ELA (Employer Liaison Advisor) to review active cases. As well as these planned meetings, urgent cases are discussed by a decision-making group (membership as above) and referred where necessary for PPA/GMC ELA advice.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Annual report to be presented to Workforce Committee
Comments:	This information is presented to the Workforce Committee annually in the 'Concerns about Doctors Annual Report'. The 2023 report was prepared by the Head of Workforce Advice according to the Committee Cycle of Business.
Action for next year:	Annual report will be produced and presented to Workforce Committee in accordance with the cycle of business.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	None
Comments:	A RO-to-RO transfer of information form is completed and sent to a new organisation as requested. For a doctor with concerns, the transfer of information document is prepared by the RO or DRO and provided to the new organisation and doctor. The RO will communicate directly with the new RO to discuss any concerns if necessary or discuss with the GMC ELA if there is no current new designated body.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	None
Comments:	Trust policies followed for example MHPS, Early resolution policy, Freedom to Speak up policy. Policies are quality impact assessed and are completed in consultation with staff side and in various forums.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	N/A
Comments:	The Trust has a policy for responding to inquiries or other national reviews. This sets out the systems and processes in place to monitor learning opportunities from the wider system such as local/national reviews and the outcomes of national inquiries. Some examples of where the Trust have implemented changes in response to national/local reviews include, implementing changes in response to the Ockenden requirements and more recently the Trust have reviewed the outcomes of Phase 1 of the Fuller Inquiry at the Board of Directors meeting. The Trust are also reviewing the outcomes of the Greater Manchester Mental Health review. Where learning is identified, actions are taken to improve culture, policy, practice and process.
Action for next year:	N/A

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	N/A
Comments:	This report covers Medical and Dental staff. All ongoing conduct and performance concerns are reviewed monthly by the Chief Medical Officer, Deputy Chief Medical Officer, Chief People Officer, Head of Workforce Advice and the Revalidation and Appraisal Manager. Regular meetings are also held with the NHS Resolution Practitioner Performance Advice (PPA) and the GMC ELA (Employer Liaison Advisor) to review active cases. As well as these planned meetings, urgent cases are discussed by a decision-making group (membership as above) and referred where necessary for PPA/GMC ELA advice.
Action for next year:	Inclusion of Physician Associates

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	None
Comments:	All doctors recruited to the Trust (whether substantive, fixed term or bank) are subject to the same pre-employment checks as defined by NHS Employment Check Standards Each check when completed is recorded on the Trust recruitment system (TRAC). All documents are seen and verified in person and are scanned as evidence.
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	N/A
Comments:	The strategy ("To create a positive organisational culture") is reviewed on an annual basis to ensure that the focus and priorities of work align to the current context, needs and future direction of the organization, and the wider NHS agenda. The most recent report (June 2024) submitted to the organisational Workforce Committee noted that there have been several achievements delivered on this strategic aim, including: • the continued roll-out and utilisation of the 'Best Version of Us' cultural improvement framework • the delivery of additional training on team culture improvement • a strengthened focus on taking a zero-tolerance approach towards abuse • successful leadership engagement and bespoke support for teams with cultural issues • the reconfiguration of our organisational culture survey to utilise the National Quarterly People Pulse Survey (NQPPS) • achievement of a number of actions to strengthen processes around Freedom to Speak Up and Raising Concerns. These have contributed to the achievement of several impact measures, including the improved NHS Staff Survey and NQPPS scores. However, some scores such as the experience of civility and kindness and general feelings around the culture have declined slightly, as evidenced through TED Scores. There is acknowledgement of the need to continue to mature and redefine the cultural improvement delivery plan to ensure it continues to align with organisational priorities moving forwards. The programme of work over the next 12 months to deliver on this strategic aim therefore enhances focus on areas such as sexual safety and zero-tolerance, civility, kindness and respect, raising concerns and taking a restorative just culture approach to truly enhance the ability to learn and improve as an organisation.
Action for next year:	Annual review of strategy ("To create a positive organisational culture") to ensure that the focus and priorities of work remain aligned to the current context

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	N/A
Comments:	Please see response to 1F(iii) below which incorporates this question.
Action for next year:	N/A

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	N/A
Comments:	Focus has been maintained on outreaching and engaging with as many leaders as possible to increase understanding and capability for leading cultural improvement in teams and services. Culturally focussed topics are a consistent part of the content for the Clinical Director Development Programme, and continue to be referenced within LTH ILM, Core People Management Skills (CPMS) and Consultant Leadership courses. More recently, collaboration with the Education Department to respond to cultural themes arising through trainee and student feedback. This has included conducting additional focus groups, engagement sessions and learning sessions to encourage reflection and improvement in areas such as bullying/harassment and creating a supportive environment for learners. There is ongoing focus on supporting all colleagues to take a zero-tolerance approach towards negative behaviours and abuse. The messaging on this was originally launched through the ‘Best Version of Us’ newsletters, linked to the cultural behaviour ‘Call It Out’ and the organisational value of ‘Taking Personal Responsibility’. In the last 12 months a Zero-Tolerance Toolkit for colleagues has been designed and created which is accessible via our intranet. To date, this has been accessed by 144 colleagues, viewed 685 times, and a total of 65 colleagues have attended the live training session for this content. The aims of this training

	are to support all colleagues to understand their personal responsibilities towards upholding a zero-tolerance approach towards abuse at Lancashire Teaching Hospitals. This included reviewing the organisational approach to zero-tolerance and how all colleagues are encouraged to take this approach in their day-to-day work and exploring leadership responsibilities to support zero-tolerance within teams. The strategic focus for the culture programme of work continues to build on the foundations and achievements detailed above. There is continued focus on the individual colleague and leadership responsibilities towards taking positive action to drive forwards cultural improvement at a team, service, and organisational level. The information below details priorities around creating a positive organisational culture, as detailed in the Single Improvement Plan: • To develop and define how culture is measured, support areas to improve and evaluate impact. • To further embed 'Best Version of Us' as the method in which to transform and communicate about culture. • To achieve the expected standards as defined by the Sexual Safety Charter. • To create a Zero Tolerance culture and ethos. • To mature the FTSU, Raising Concerns Group and Confidential Risk Processes. • To further embed the 'Just Culture' approach in the management of disciplinary and resolution processes. In addition, there are several actions underway to ensure that responsibilities as an employer are upheld as signatories of the NHS Sexual Safety Charter. These include: • Enhanced approach as a learning organisation, for example through colleague stories and incident reviews. • Improving data collection methods, and processes for review, triangulation, and escalation. • Ensuring data and reporting mechanisms consider the intersectional trends that impact levels of risk and ability to speak up, raise concerns and report incidents. • Raising awareness of the appropriate approaches to support victims of abuse and the specialised services they should also be signposted to.
Action for next year:	N/A

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	N/A
Comments:	Complaints regarding the appraisal process are addressed through the Trust early resolution policy (Grievance policy). This is documented in the current policy.
Action for next year:	None Identified

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	N/A
Comments:	Please see response to 1D(v). The annual report submitted to the Workforce Committee includes the key demographics of the medical workforce who are the subject of formal disciplinary processes. This includes race and gender.
Action for next year:	An action for next year is to include details in the report relating to the country of primary medical qualification.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher- level responsible officer quality review processes, engaging with peer review programs.

Action from last year:	N/A
Comments:	The Revalidation and Appraisal team attend regional events including networking meetings. The trust participated in the 2023 peer review programme; a copy of

	the peer review report can be found in appendix 1. The trust hosted a higher-level responsible officer visit on the 14th May 2024. The outcome letter following this visit is attached in appendix 2.
Action for next year:	Ensure new RAM and MAL are invited to regional events and network meetings.

Section 2 – Metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024. All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	772

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	670
Total number of appraisals approved missed	18
Total number of unapproved missed	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	142
Total number of late recommendations	0
Total number of positive recommendations	116
Total number of deferrals made	26
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	5
Total number of trained case managers	4
Total number of new concerns registered	1 new case has progressed to formal processes in 2023/2024

Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March	142 working days

Median duration of concerns processes closed	322 working days
Total number of doctors excluded/suspended	1
Total number of doctors referred to GMC	11 complaints were recorded by the GMC relating to 11 Doctors

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	199 (Substantive)
Number of new employment checks completed before commencement of employment	100% this is requirement of NHSLA

2F – Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	1
Number of these appeals upheld	0 (1 still in progress)

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
An update on all actions identified in last years annual submission has been undertaken and is detailed in section 1 above, however it was identified that a few questions posed within the national template were new as of 2024 therefore no actions from last year had been noted against these. The Trust has participated in a peer review and higher-level RO visit (please see appendix 1 and 2 for the outcome letters), from both of these the Trust received positive feedback and the dedication and hard work of the team was recognised. The Trust policy is compliant with national policy although is now due for review (May 2024) The Trust has successfully managed to reduce the number of deferrals due to 360 MSF feedback by ensuring these are started 2 years prior to revalidation date.
Actions still outstanding
Actions identified last year have been completed and details of these can be found in section 1.
Current issues
• Gap in Revalidation and Appraisal Manager post (19/03/24 – 22/07/2024). • Quality Assurance processes need to be refreshed and undertaken in the 2024 appraisal round. • Continued focus on reducing deferrals due to 360 feedback.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Review Resource associated with appraisal and revalidation and consider whether further resource could be allocated. • Complete review of appraisal policy, embed the 2024 Good medical practice domains and re-publish. • Ensure all bank Doctors receive adequate support from the Appraisal and Revalidation team to ensure they meet the requirements of GMC revalidation. • Embed Good Medical Practice (2024) into medical appraisal. • Review timeliness of reminders being sent to doctors and review ability to report late appraisals using L2P.

- Review appraiser: appraisee ratio to ensure proficiency and quality assurance.
- Further development of training and network events
- Review of Quality assurance review process.
- Continue to reduce deferrals due to non-completion of 360 multi source feedback by increasing chasers and ensuring all doctors start this (where possible) 2 years prior to their revalidation submission date.
- Increase focus on clinical and medical engagement with the governance agenda.
- Development of governance handbooks to include a medical governance section.
- Consider the way in which the trust uses lay representation to support and improve clinical governance for doctors,
- Ensure the governance report (complaints and significant incidents) is uploaded into appraisals for all appraisees.
- Undertake annual review of strategy ('To create a positive organisational culture') to ensure that the focus and priorities of work remain aligned to the current context.
- Include details in the workforce annual report next year regarding the country of primary medical qualification of any doctors who have been involved in concern/disciplinary processes.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

We are happy with the work undertaken within the last year but recognise some gaps identified particularly with the quality assurance which has resulted from resource issues and specifically the RAM retiring earlier in the year. We look forward to a new RAM starting and the opportunity to refresh our processes and provide dedicated resource.

Appendices:

Appendix 1 - Peer Review Report (2023)

Appendix 2 – Higher Level Responsible Officer Visit – Outcome Letter (May 2024)

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of the designated body	Lancashire Teaching Hospitals NHS Foundation Trust

Name:	Mr Peter White
Role:	Trust Chair
Signed:	
Date:	

Medical Appraisal and Revalidation Peer Review of Lancashire Teaching Hospitals NHS Foundation Trust

Date of visit – Tuesday 4th July 2023

1.0 Introduction

The peer review process has been implemented across the Northwest region with the aim of supporting designated bodies and reducing inconsistencies in medical appraisal and revalidation processes.

Each designated body will undergo a peer review at least once in the revalidation cycle.

The process of peer review involves a review and sharing of good practice and making recommendations to the reviewee and the wider regional revalidation team on areas for improvement/opportunities for consistency.

This report follows UHMB's visit to LTHTR on 4th July 2023 to review their process for appraisal, revalidation and responding to concerns.

2.0 Documents provided to the review team prior to the peer review visit

The following documents were provided by LTHTR prior to the visit:

- Letter of Good Standing template
- LTHTR Trust Board Report 2020/2021
- LTHTR Trust Board Report 2021/2022
- Medical and Dental Staff Appraisal Policy
- Medical/Dental Temporary Staffing Policy
- MIAA Review Working Paper
- Private Practice Guidelines
- Peer review of LTHTR by Blackpool Teaching Hospitals NHS Trust - 2017
- Peer Review Paper prepared for this Peer Review

3.0 Attendance at the review

Trust	Name and title
Lancashire Teaching Hospitals NHS Trust	Dr Alison Gale, Medical Appraisal Lead (MAL), Deputy Chief Medical Officer for Professional Standards.
	Mrs Rhona Butters, Revalidation and Appraisal Manager (RAM)
University Hospitals of Morecambe Bay NHS Foundation Trust	Mr Peter Dyer Associate Medical Director of Appraisal & Revalidation / Fitness to Practise
	Mr Karnad Krishnaprasad Deputy Medical Director for Professional Standards
	Mrs Johanne Herman Medical Appraisal & Revalidation Co-ordinator
	Miss Sally Totton Medical Appraisal & Revalidation Administrator

3.0 **Summary of discussion**

The following areas were discussed during the visit:

Topic	Comments
Introduction and background	• Dr Gale and Rhona gave a detailed presentation of the Appraisal and Revalidation team's role at their Trust, including the recent history of not having had a Medical Appraisal Lead for two years until Dr Gale was appointed. • There are no Deputy Medical Appraisal Leads. • Appraisal sits within the Workforce function but, although the RAM reports to the Medical Workforce Manager, the A&R function is kept separate from Workforce to avoid conflict. • The appraisal window is between April to November. This has increased from a six-month window. • The Trust has switched to the L2P appraisal software in November 2019, just before the Covid pandemic hit. • They moved to the "Edgecumbe 360" for their Patient Feedback in May 2021 as they found it more useful for their specific patient feedback programme. This has been particularly useful for Anaesthetics and Radiology which are two areas which normally struggle with feedback.
Provision of governance reports for all doctors, including private practice.	• L2P contains an email template in the "Resources" section for doctors to request their own reports from "Datix" and the Complaints team, who email back with any relevant information. The doctor can then upload the email to their appraisal for reflection as necessary. • It is the doctor's own responsibility to source governance information for any private practice, including volunteering roles. There is a "good standing" template on L2P Resource for the doctor to use.

	• The Appraisers must ensure that all scope of work is declared, and that the correct documents are uploaded to the appraisal.
Appraisers : *Numbers and training *Allocations *Quality assurance	• The Trust currently has around 710 doctors with a GMC Connection and 167 Appraisers. The appraisers are trained in-house by the Organisational Development Team, outside of the Appraisal and Revalidation function. The training is in line with the GMC framework. • Appraisers are allocated within the same Division, and usually within the same speciality. The MAL feels that cross-specialty appraisals are good, but there is currently resistance from Divisions. • The Divisions pay towards the cost of the L2P software. • L2P is set to automatically reallocate the same Appraiser for the maximum of 3 years. • Appraisees do not choose their own Appraisers. • The RAM reviews the L2P reports for doctors without Appraisers and allocates. • Appraisers receive a SPA allocation of 0.025 per appraisal within their job plan for a minimum of 4 and a maximum of 10 per year. This does not include time for update events. The Team is looking into this. • Newly trained Appraisers do a maximum of 3 appraisals in their first year. • QAs are done using the modified “Galloway” form. The RAM undertakes a sample of 20% of completed appraisals for the quality assurance audit. Due to Covid and the lack of a MAL for the 2 years, no QAs were done from 2020 until it was revived for the 2022/23 revalidation cycle. • Locum doctors employed for 12 months or more will be provided with an appraisal. • Those employed for less than 6 months are not offered an appraisal but receive an “exit report” to take with them to their next employer.
Maintaining an accurate list of prescribed connections	• The RAM is based in the Medical Workforce team and has access to TRAC. She receives notifications when a new starter is generated.

	• The RAM has access to the medical locum bank also. • The RAM gets contract change details. • The RAM sends a welcome email to new doctors with details of their appraisal month and allocates a named Appraiser.
Multi-Source Feedback – training and giving feedback	• This is done in-house by the Organisational Development team who train 360 Facilitators. This sits outside of the Appraisal function. • Doctors who are not Appraisers may be encouraged to be 360 Facilitators. • Doctors can choose to download a Patient Feedback form from Edgecumbe, use electronic feedback, or use a QR code. All responses go back to the doctor's account and are reviewed by a 360 Facilitator for feedback. The doctor can then upload it to their L2P account for reflection. • The RAM gets an email when the report is ready to review it for revalidation purposes.
Process for Non-Engagers	• There is a good process in place with the L2P reminders followed by two letters to participate with the process. Doctors must then meet with the MAL to discuss the situation. • The RAM documents each stage and pulls a final report for the Medical Director / Responsible Officer for any incomplete appraisals.
Areas of Concern	• The Appraisal and Revalidation Team is very small for so many doctors and it is a credit to them how well the appraisal process is managed at LTH. • The MAL role was vacant for 2 years, putting the new MAL under pressure without a Deputy and the RAM feeling isolated and pressured. • The RAM is a lone worker and has indicated she will be retiring in March 2024. There is no clear succession plan for such a specialised and important role which is of concern.

	• Due to the number of doctors and appraisal window, there are always high appraisal numbers to be reviewed. • How does the MAL ensure the quality of Appraisers if the training is done by the Organisational Development team? • The time allocated for Appraisers is very short at 0.025PA. Our Clinical Appraisal Lead raises some concern that this is not enough for the task, considering the time also taken to prepare for each appraisal meeting, and asks if the Trust might review this. • Although locum doctors with LTH as their designated body do not have appraisals if they are employed less than 6 months, and receive an “exit” report, our CAL questions if they still receive support from the A&R team to ensure they meet the requirements of revalidation. • Having at least one Deputy MAL would give the team more opportunity for training and developing their roles to enhance the dedicated support to their doctors, which also aids the reputation of the department. • The MAL and RAM have indicated they look forward to the Peer Group follow up meeting to look at other areas of good practice

Summary

The UHMB team are grateful to LTH for the opportunity to meet and assess their service as part of our Peer Review process. It is clear from the Review that the small team at LTH are dedicated, follow their processes, and work hard to ensure doctors respect the revalidation process with appropriate support given as needed. The team from UHMB are satisfied that the appraisal and revalidation function at LTH is fit for purpose.

Higher Level Responsible Officer
NHS England and NHS Improvement
North West
Regatta Place
Brunswick Business Park
Summers Road
Liverpool
L3 4BL

Our Ref: MDNW/EH

28 May 2024

Dr Gerry Skailes
Responsible Officer
Lancashire Teaching Hospitals NHS Foundation Trust

Sent by email only to:

geraldine.skailes@lthtr.nhs.uk

Dear Gerry

Visit to Lancashire Teaching Hospitals NHS Foundation Trust

I would like to express my thanks to you and your team for meeting with me, Anne Steer, Lesley Atherton and Penny Johnson on Tuesday 14 May 2024 and for making us feel welcome.

In my role as deputy to the Regional Medical Director and Higher Level Responsible Officer, I seek assurance from the Responsible Officers (ROs) in the region that there are robust systems in place that will enable them to carry out their responsibilities under the RO Regulations. In line with the Framework of Quality Assurance for ROs and Revalidation, myself and the team conduct visits to Designated Bodies to gain assurance from ROs that all associated governance systems are in place and functioning effectively. These visits also have a primary focus of providing support and guidance where required.

In attendance at the meeting were:

Dr Gareth Wallis – Medical Director for System Improvement and Professional Standards	Dr Gerry Skailes - Responsible Officer/ Chief Medical officer
Anne Steer Deputy Head of Professional Standards	Dr Alison Gale - Deputy Chief Medical Officer
Dr Lesley Atherton – Appraisal Lead	Lisa Eccles - Head of Medical Workforce
Penny Johnson – Programme Manager	

The meeting began with introductions and the Trust provided a presentation to update on actions over the last year.

The Trust are catching up following the impact of the Covid 19 Pandemic, there is a focus on educating the workforce of the importance of engaging with appraisal. There was good traction with appraisal prior to the pandemic and the Trust feel they are getting back on track following a challenging reduction in engagement post Covid.

The reasons for deferrals are in line with other Trusts in the Region and a lack of feedback is the most common reason for deferral alongside ongoing GMC processes.

The Trust are fully engaged in peer review and in July 2023 had a visit from another Trust who provided helpful feedback. The review noted good governance in place, appraiser numbers acceptable and confirmed the process was fit for purpose.

The review also noted some areas for improvement which included the size of the appraisal and revalidation team and the high appraisal numbers within the appraisal window. The Trust has had the appraisal lead role vacant for two years and since successfully recruiting to that role has been able to make improvements around appraisal and revalidation.

The medical appraisal lead is involved in appraiser training, and has reviewed the training package to make it more focused on medical appraisal as it was previously generic appraisal training. The appraisal and revalidation manager undertakes the quality assurance review of appraisal summaries, following which the medical appraisal lead meets with any underscoring appraisers. All new appraisers have a meeting with the medical appraisal lead within the first 12 months.

The Trust is looking to recruit further medical appraisal leads within each division to try and encourage more engagement and support with appraisal and revalidation.

The Trust uses the L2P system and they have recently added an education and leadership module to allow them to make more use of the system. The Trust advised that they use Edgecumbe for the 360 feedback as they have found this to be more accessible for their workforce and they have 35 clinical facilitators trained to provide the 360 feedback.

The Trust has moved to encouraging feedback gathering in year three of the revalidation cycle in order to reduce the number of revalidations deferred because of a lack of evidence; in the past year the trust has managed to reduce revalidation deferrals by 11%. The current revalidation deferral rate is 17%.

The appraisers undertake 4 to 5 appraisals a year and while the Trust recognises that this is slightly below the recommendation of between 5 and 20 appraisals a year, the Trust acknowledges that they have some challenges with appraisers taking on more appraisals. There are a few appraisers that undertake six to seven appraisals and the general feeling is that if all appraisers were asked to do more, they would start to lose appraisers.

The trust has developed an active programme to embed the new GMC Good Medical Practice (GMP) into the appraisal process and a meeting was held in March 2024. L2P has also embedded the new GMC GMP pillars and there is a plan in place when the new appraisal and revalidation manager starts in post to pick up aligning the Quality Assurance of appraisals (QA) to GMP.

Allocations of appraisals is undertaken manually. However, the L2P system does allow for conflicts to be added and this is used. Appraisers and appraisees are also asked to flag if there is a conflict with the appraiser they are matched with. Good discussion was held around engagement with revalidation and NHSE shared their

approach to encouraging doctors to engage early with the revalidation process particularly in regards to gathering feedback and ensuring they have their appraisal in good time.

Action: NHSE to share their Revalidation Policy

A discussion was held around the Quality Assurance (QA) process used by the Trust. The Trust confirmed that there was work to complete to review and update the QA process, and provide education on summaries and outputs for appraisers.

Action: NHSE to share QA summary template and tool

The Trust is part of the pilot for NHS Resolution's Compassionate Conversations and this work is ongoing. The learning for this is fed through the clinical development programmes and the Trust is asking NHS Resolution to deliver multidisciplinary sessions. Alongside this, the clinical directors are engaged in the GMC behaviours work which has very similar themes.

These areas of work are having a mixed impact across the organisation with some clinicians being very engaged with it and others having less engagement. The Trust explained that it has landed well with the clinical directors and work is ongoing to embed this in the organisation.

The Trust confirmed their process for doctors coming into the organisation was that an MPIT request went to the RO via the appraisal and revalidation team, although they acknowledge that sometimes these are slow to return; they always request this information when doctors start in the Trust.

When a doctor leaves the organisation the Trust share information with the receiving RO.

The Trust has undertaken international recruitment and these recruits are well supported and inducted. There is a lead clinician and forums to provide information and support. The Trust is well versed with the GMC's Welcome to UK programme and elements of this are integrated into their own induction.

The Trust do feel that they are supported by the Board and they recognise that the team is fragile in terms of numbers and there is a risk around single point of failure in that they only have one appraisal and revalidation manager.

The Trust has tried to mitigate some of this risk by planning for cross cover with appraisal and revalidation and job planning. There are challenges in the medical workforce team due to sickness but they try to ring fence appraisal and revalidation and job planning to avoid these resources being overstretched. The Trust is looking into the financial viability of a further admin role to provide support to appraisal and revalidation but funding is proving challenging.

Information was shared around the RO network being held on the 16th July and the annual submission was discussed. The Trust were aware of the requirement for this to be approved by their Board and be submitted to NHSE by the 31st of October 2024.

The Trust confirmed that they have contact with their GMC ELA and we advised Practitioner Performance Advice (part of NHS Resolution) can be a helpful resource when managing concerns.

No additional support from the NHSE England HLRO was requested at this time and the team can be contacted via england.nw.hlro@nhs.net if their assistance or advice is required.

I trust that you find the information contained within this letter is an accurate reflection of our discussions. Please let me know if you would like me to address any points of accuracy. Should you have any general queries do please contact me or the Tier 2 Regional Office Team, england.nw.hlro@nhs.net

Thank you once again for your kind hospitality and for meeting with me and my team.

Yours sincerely

Dr Gareth Wallis
Medical Director for System Improvement and Professional Standards
NHSE North West

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRU…

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Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

This report reflects the data held by Practitioner Performance Advice, part of NHS Resolution. .
The report summarises the interactions of the organisation with Practitioner Performance Advice to:

- Aid reflection and learning about your cases around practitioner concerns
- Consider the report in the context of your own information held locally
- Be used as basis for conversations with your Link Adviser to understand any further support we can provide

Throughout the report your organisation is compared to organisations of a similar size in England in terms of the size of the workforce of doctors at your organisation. Duration of cases is calculated for each period a case was open and is the time in months between the open and closed date for every instance.

Doctor workforce size category
Small = less than 500
Medium = 500-1000
Large = greater than 1000

Employing/contracting organisations owe a duty of confidentiality, whether explicitly or implicitly, to practitioners and individuals who access the services of Practitioner Performance Advice. Organisational activity reports should be handled with sensitivity, and not be shared without due consideration that all necessary steps are taken to maintain confidentiality based on the information contained in these reports.
Practitioner Performance Advice also has a duty to maintain confidentiality in respect of information that has been provided in confidence and will not normally disclose the details of a case to a party other than those who are involved in it. There are some circumstances where it may be necessary for Practitioner Performance Advice to share information we hold. For example, responding to requests under the Freedom of Information Act 2000, or sharing information with other NHS bodies or regulators in the interest of patient safety and public protection. For more information about how we collect and use data, please visit our website.

Your Link Adviser at Practitioner Performance Advice is Ms Marian Martin available on 020 7811 2614 or email marian.martin1@nhs.net. If you are unable to contact your Adviser directly please call 0207 0811 2600 and a member of the Advice team will make arrangements for a call-back.

If you have any queries about the information contained in this report, please contact us at nhsr.adviceresearchandevaluation@nhs.net

Note: Only case types of Individual practitioner, Team group and General case are included. Cases with case status Open or Closed are included only.

Case Summary

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date

14 March 2024

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Doctor workforce size category

Small = less than 500

Medium = 500-1000

Large = greater than 1000

NHS Resolution

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Trust workforce profile the doctor workforce and total clinical staff data is based on workforce statistics from NHS Digital and is correct as of 31 Mar 2023

Trust size	Doctor worforce	Total clinical staff	No. of trusts of similar size
Large	1,020	4,929	44

Cases opened in reporting period in comparison to cases in trusts of a similar size

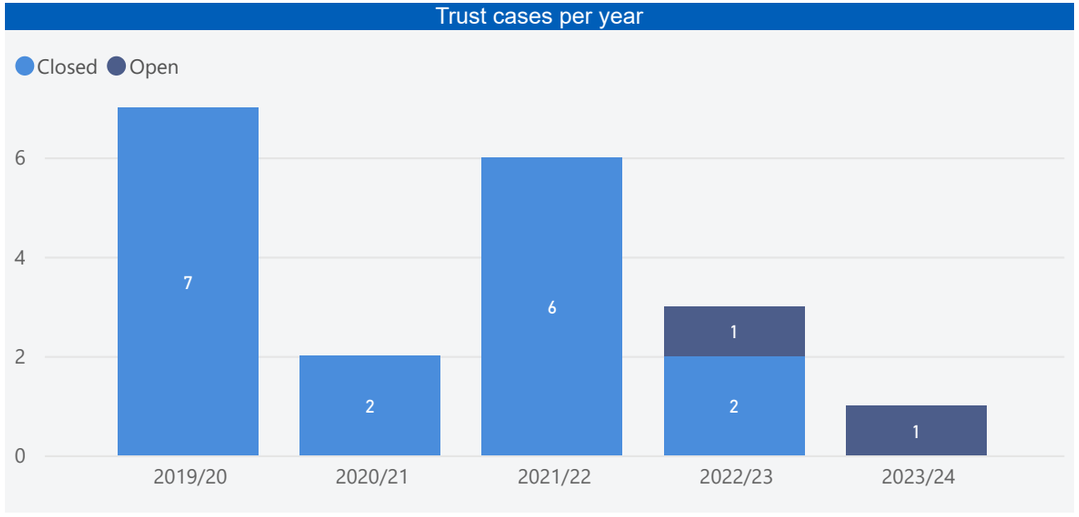
Total trust cases	Avg cases similar size trusts
19	23

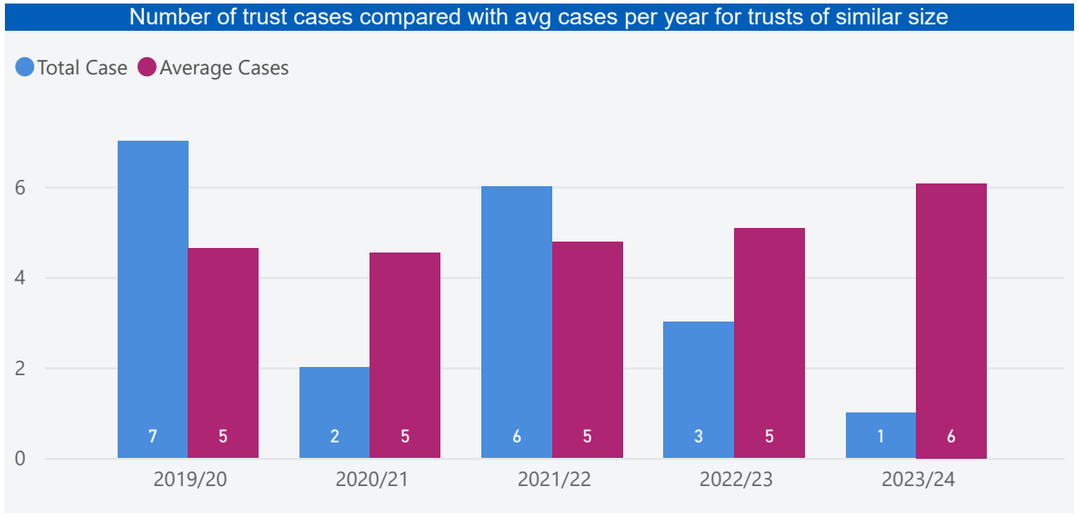
The number of trust cases open and closed at the end of the reporting period

Open cases	Closed cases
2	17

Reopened cases in the trust for cases initially opened in the reporting period

Number of cases reopened
2





Case Duration Summary

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date

14 March 2024

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Small = less than 500
Medium = 500-1000
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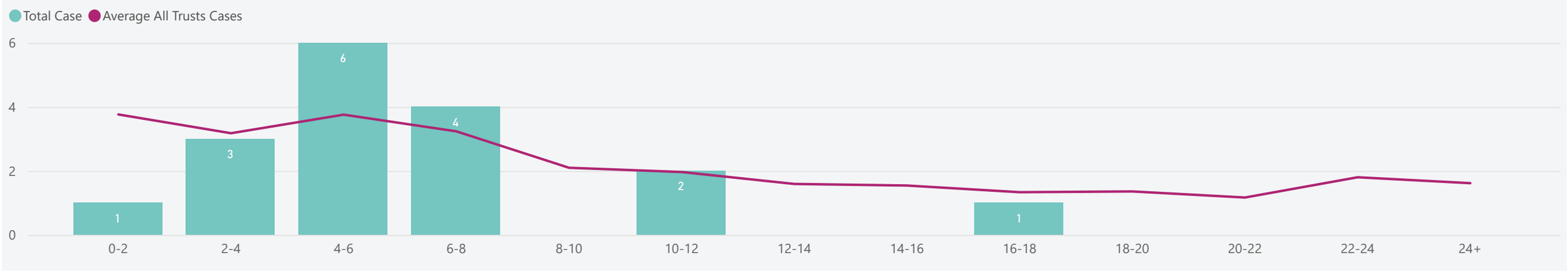
NHS Resolution

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Average duration (months) of cases with Practitioner Performance Advice for cases which are closed.
The duration of a case is the sum of all periods of the case being open.

Trust cases by duration group (months) compared with cases at trusts of similar size



Avg trust duration of cases (months)	Median trust duration of cases (months)	Max trust duration of cases (months)
5.7	5.0	16.0

Avg duration of cases (months) for trusts of similar size	Median duration of cases (months) for trusts of similar size
7.3	5.0

Concerns

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date

14 March 2024

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Doctor workforce size category
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Medium = 500-1000
Large = greater than 1000

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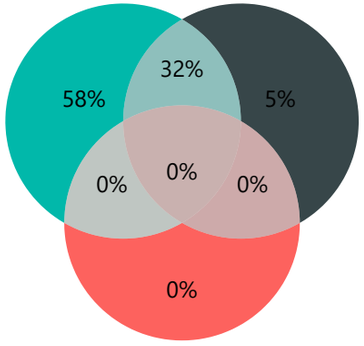
Concerns in trust cases

Behaviour/Misconduct Concerns Clinical Concerns Health Concerns

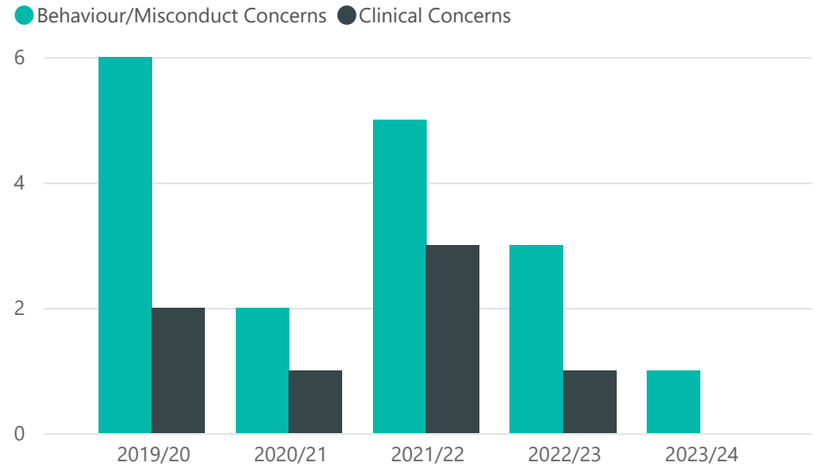


Concerns in trust cases

Concern	Total Cases	%
Behaviour/Misconduct Concerns	17	70.83%
Clinical Concerns	7	29.17%

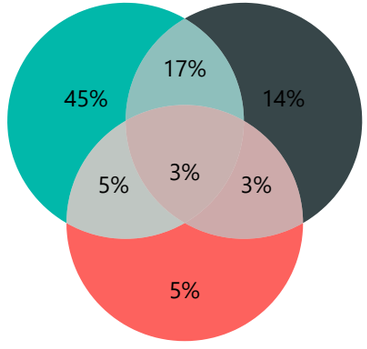
This table shows figures for the number of concerns reported. There can be multiple concerns per case and thus the column 'Total cases where concern reported' may be greater than the total cases for the trust.

Concerns in trust cases by financial year



Concerns in similar size trusts cases (%)

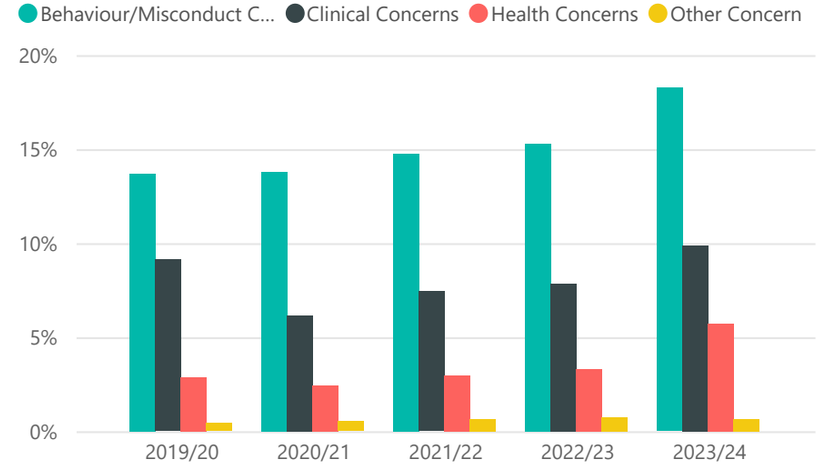
Behaviour/Misconduct Concerns Clinical Concerns Health Concerns



Concerns in similar size trust cases (%)

Concern	%GT Count of CaseId
Behaviour/Misconduct Concerns	75.80%
Clinical Concerns	40.45%
Health Concerns	17.30%
Other Concern	2.97%

Concerns in similar size trusts cases by financial year (%)



Practitioner Characteristics

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date

14 March 2024

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Doctor workforce size category

Small = less than 500

Medium = 500-1000

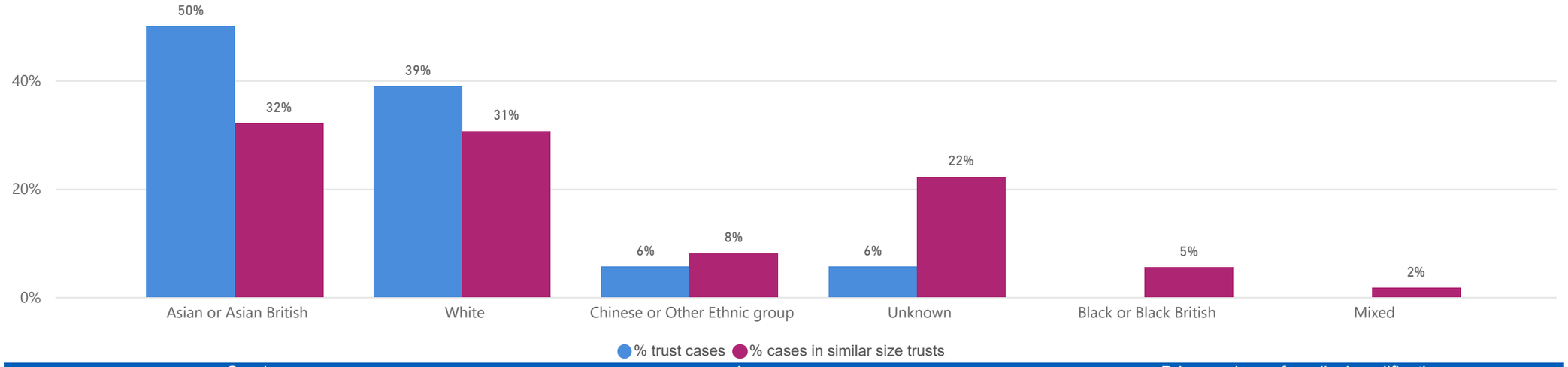
Large = greater than 1000

NHS Resolution

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

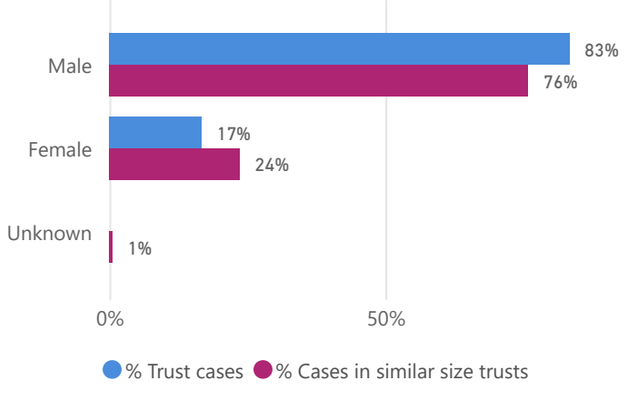
Comparison of trust cases with trusts of similar size - Please note that this page shows information for cases involving an individual practitioner. Cases involving multiple practitioners, i.e. Assisted Mediations and Team Reviews, or general cases are not included in the figures. The percentage of practitioners with a case represent a rate of cases over the five year reporting period.

Ethnicity group

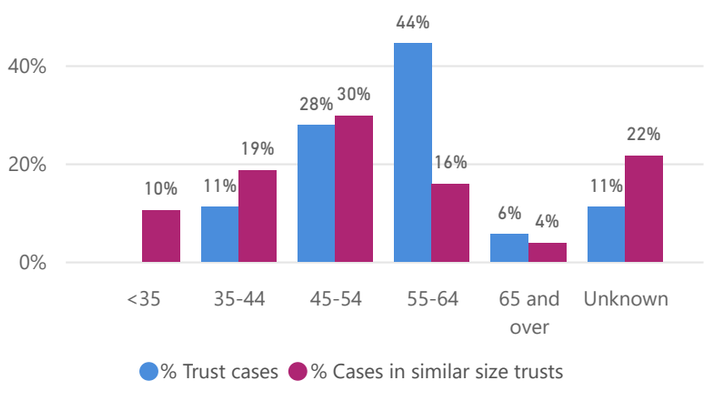


Total number of practitioners with a case	% of practitioners at the trust with a case	% of practitioners with a case in similar size trusts
18	1.8%	0.4%

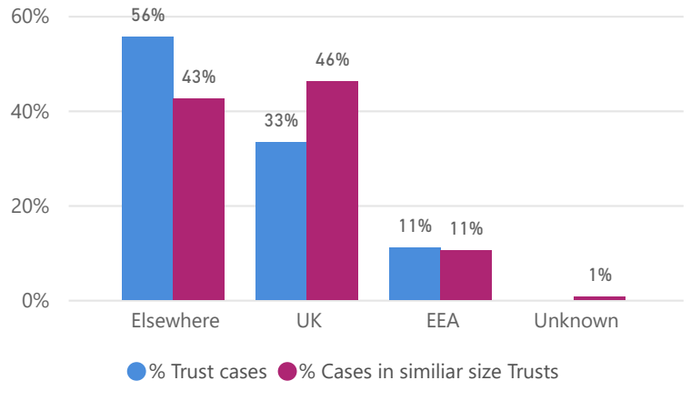
Gender



Age group



Primary place of medical qualification



Practitioner Specialty Group

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date

14 March 2024

CONFIDENTIAL

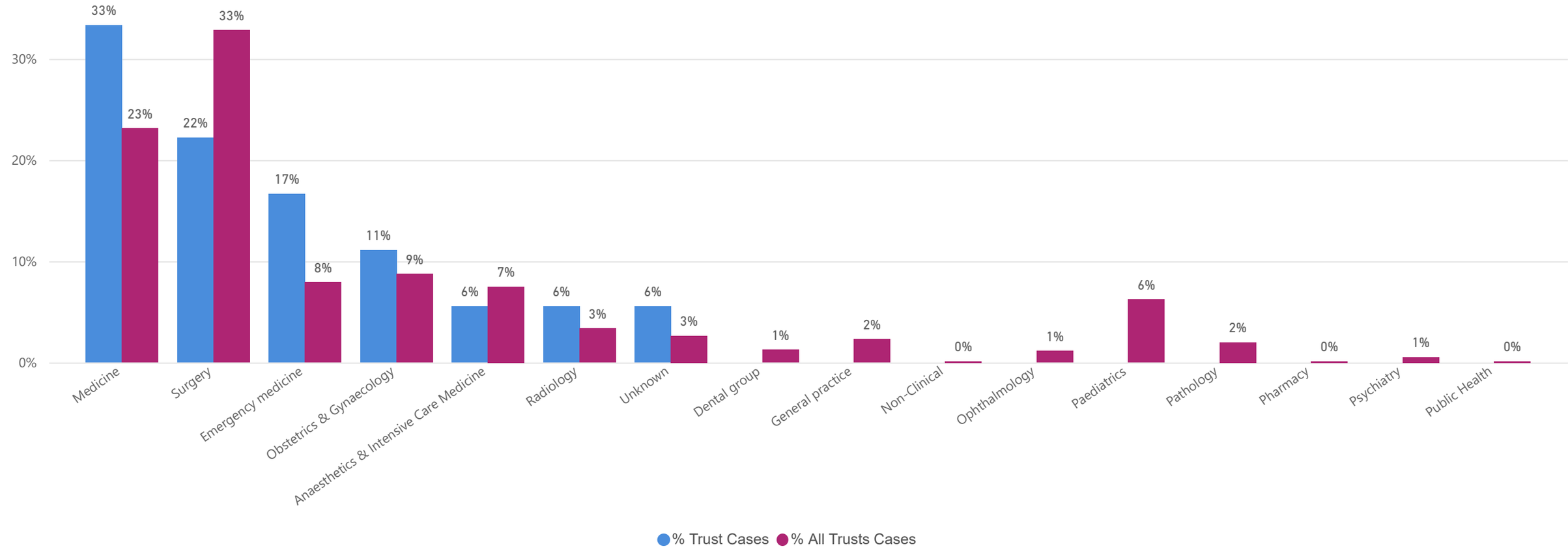
Doctor workforce size category
Small = less than 500
Medium = 500-1000
Large = greater than 1000

NHS Resolution

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Please note that this page shows information for cases involving an individual practitioner. Cases involving multiple practitioners, i.e. assisted mediations and team reviews are not included in the figures

Similar size trusts cases by specialty group



Practitioner Grade Group

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date

14 March 2024

CONFIDENTIAL

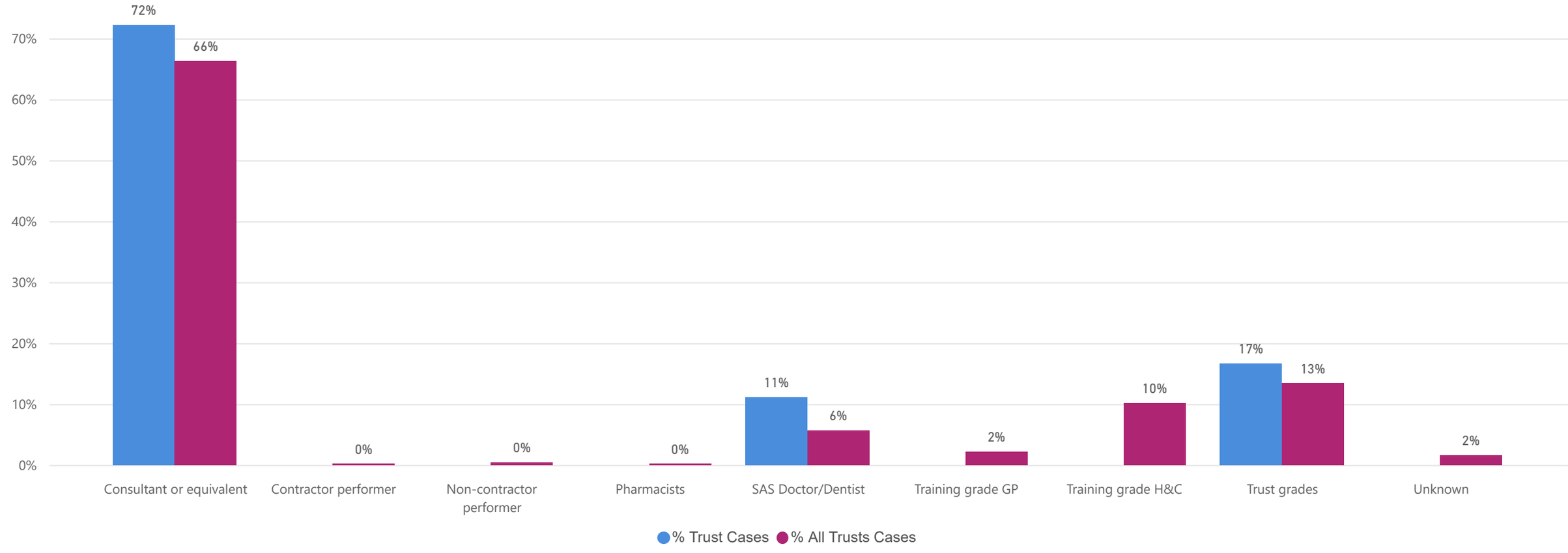
Doctor workforce size category
Small = less than 500
Medium = 500-1000
Large = greater than 1000

NHS Resolution

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Please note that this page shows information for cases involving an individual practitioner. Cases involving multiple practitioners, i.e. assisted mediations and team reviews are not included in the figures. Other grades include contractor performer, non-contractor performer and training grade GP.

Similar size trusts cases by grade group



Use of advice, assessments & remediation

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date
14 March 2024

CONFIDENTIAL

Doctor workforce size category
Small = less than 500
Medium = 500-1000
Large = greater than 1000

NHS Resolution

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Cases Involving Advice	19	We offer advice in all cases provided by an established team of expert Advisers on the application of performance management procedures, good practice in local case management and investigation, option to address and resolve concerns and signposting to other avenues of professional support. More information
Clinical Performance Assessment	0	This assessment provides an independent view on the clinical performance of the practitioner and information to assist the referring organisation in decisions about the next steps in their management of the case. More information *Note: the figure represents clinical assessments that have been offered in this format from November 2018*
Behavioural Assessment	0	This assessment provides an independent view on the behavioural characteristics of the practitioner and information to assist the referring organisation in decisions about the next steps in their management of the case. More information *Note: The figure represents behavioural assessments that have been offered in this format from November 2018*
Professional Support & Remediation	0	We draft action plans for healthcare organisations regarding doctors, dentists and pharmacists who have been identified by their healthcare organisation as needing support to deliver sustained, safe and effective practice. More information
Assisted Mediation	0	Assisted mediation is an independent, voluntary and confidential process in which two accredited mediators work with the parties concerned to create a mutual understanding of the issues and to find a way forward that enables a more effective professional working relationship. More information
Team Reviews	0	Where concerns relate to the functioning of a clinical team, we can undertake a team review to identify the issues perceived by the team, any barriers to their resolution and to suggest a plan for improving professional relationships within the team. More information
Education		Our training courses aim to provide healthcare organisations with the knowledge and skills to identify and manage performance concerns locally. Our courses are run in-house in individual organisations and can be tailored to meet your individual requirements. More information

Many of our services are free of charge to NHS organisations or have a nominal associated cost. To find out more, contact your Link Adviser. Figures relating to interventions are counted up to the end of the previous financial year. The number of cases involving advice are counted up to the reporting date

Exclusions

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date

14 March 2024

CONFIDENTIAL

Doctor workforce size category
Small = less than 500
Medium = 500-1000
Large = greater than 1000

NHS Resolution

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Formal exclusion cases where the exclusion commenced in the reporting period.

Please note that open and closed case numbers relate to individual Practitioner Performance Advice cases and not episodes of exclusion. If a case has more than one episode of exclusion this is described in the table below.

Open cases with an exclusion episode	Closed cases with an exclusion episode
1	0

Most recent episode of exclusion in trust cases where there was an exclusion

CaseId	Formal Exclusion Date	Immediate Exclusion Date	Mainconcern	Outcome
29307	08/12/2022	24/11/2022	Conduct/suitability	

Trusts of similar size average number of formal exclusion cases and the average duration (months)

Average number of cases with an exclusion epsiode for all trusts	Average duration of most recent episode of exclusion for all trusts (months)
2.3	3.4

Reporting requirements for exclusions in secondary care

NHS Resolution's Practitioner Performance Advice service should be contacted for advice where a healthcare organisation is considering excluding, suspending or restricting a practitioner's practice. Please read our reporting requirements webpage.

Resources to support good practice in the management of exclusions

Exclusion is designed as a short-term, temporary measure to remove a practitioner from their usual place of work until the nature and cause of a performance concern are understood and while an investigation is carried out. Resources to support good practice in the management of exclusions are outlined on the Resources page of this report and can also be found here.

HPANs

Cases with Practitioner Performance Advice

1 April 2019 to 14 March 2024

Reporting date

14 March 2024

CONFIDENTIAL

Doctor workforce size category
Small = less than 500
Medium = 500-1000
Large = greater than 1000

NHS Resolution

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

NHS Resolution are responsible for the management of the Healthcare Professional Alert Notices (HPANs) system. This is a system where notices are issued by us to inform NHS bodies and others about healthcare professionals who may pose a significant risk of harm to patients, staff or the public. HPANs cover all types of registered healthcare professionals or those purporting to be a registered healthcare professional.

HPANs are usually used whilst the regulator is considering the concerns and provides an additional safeguard during the pre-employment checking process.

NHS organisations and other bodies providing services to the NHS, who wish to request the issue of an HPAN should notify us at nhsr.hpan@nhs.net using the downloadable form.

Please note: the request must be made by an Executive Board member or their authorised deputy and must relate to a healthcare professional (or a person holding himself out to be a healthcare professional) who:
- poses a significant risk of harm to patients, staff or the public;
- may continue to work or seek additional or other work in the NHS as a healthcare professional;
- that there is a pressing need to issue an alert notice

Please see our website for more information.

Requested

Profession	Total
Total	**0**

Issued

Profession	Total
Total	**0**

Resources

Practitioner Performance Advice

CONFIDENTIAL

LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

Insights

Our *Insights* publications share analysis and research which draw on our in-depth experience providing expert, impartial advice and interventions to healthcare organisations to effectively manage and resolve concerns raised about the practice of individual healthcare practitioners.

Resources to support good practice in the management of exclusions

Exclusion is designed as a short-term, temporary measure to remove a practitioner from their usual place of work until the nature and cause of a performance concern are understood and while an investigation is carried out. Resources to support good practice in the management of exclusions are listed below and can also be found here.

Insights: Insights from 10 years of supporting the management of exclusions in England

Reporting requirements: Please read our reporting requirements webpage

Decisions flowchart: Download our exclusions flowchart to ensure compliance with good practice

Templates for documenting any case where exclusion is considered:

- Download our recording template for formal exclusion
- Download our template letter for exclusion

Case studies: Download our Exclusions Case Studies – Learning pack

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Freedom to Speak Up Biannual Report

Report to:	Board of Directors	**Date:**	1st August 2024
Report of:	Chief People Officer	**Prepared by:**	Estelle Hickman

Purpose of Report

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

Executive Summary:

The purpose of this report is to provide an update on Freedom to Speak up (FTSU) and whistleblowing activity during the past year and to describe priorities in response to concerns raised and learning for 2023/24.

During 2023/24 the number of concerns being raised has levelled to an average of fifteen concerns per month (not including external whistleblowing events). More than half of all those raising concerns believed that the concern or the raising of it had an adverse effect on their health and well-being. The most frequently stated reasons for contacting the Freedom to Speak Up Guardian related to behaviours and perceived lack of support and leadership. A perceived lack of fair treatment was also evident. The reporting of patient safety incidents was halved during the year compared to 2022-23. Rates of reporting of bullying and harassment is consistent with the national reporting rates and with staff survey results with almost one quarter of those raising concerns referencing bullying by managers or their peers.

The Board of Directors are asked to note the information and assurance relating to Freedom to Speak Up activity during 2023/24, described within this report, in particular:

- Strengthened reporting to Divisional leadership teams.
- Embedding of e-learning as part of the mandatory training programme
- The strengthening of governance arrangements through follows up contacts with those raising concerns with opportunity for further support if required.
- The learning and improvement resulting from speaking up including whistleblowing events.

The Board is also asked to note and support priorities for 2024/25.

Appendix 1: Activity data
Appendix 2: 2023 Staff Survey Results
Appendix 3: Freedom to Speak Up Action Plan

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒

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

1. **BACKGROUND**

In response to the principles and actions described in the review into Mid-Staffordshire Hospitals (2013) and the subsequent review of whistleblowing in the NHS (2015), undertaken by Sir Robert Francis QC; here at Lancashire Teaching Hospitals, we reviewed our processes and systems for inviting, listening, and responding to concerns raised by staff. The Board of Directors oversaw implementation of a range of measures to strengthen systems and processes to enable staff across the Trust to raise concerns and speak up with confidence. These and subsequent actions and improvements have been reported annually in previous reports to the Board of Directors.

Completion of these and other actions does not represent an end point. The NHS continues to face further scandals where difficulty in speaking up has been a factor in respect of prevention or early intervention and the Trust has reviewed its approach in response to these scandals and in response to case reviews undertaken by the National Guardian's Office. The latest of these, at the Countess of Chester Hospital is currently subject to inquiry by Lady Justice Thirlwall[1]. The Trust will undertake a benchmarking exercise against findings and recommendations once they are known.

In addition to external events, we recognise that there is more to do to ensure that raising concerns is business as usual for all our colleagues and that when colleagues do raise concerns, they are confident that those concerns will be heard and, as appropriate, acted upon.

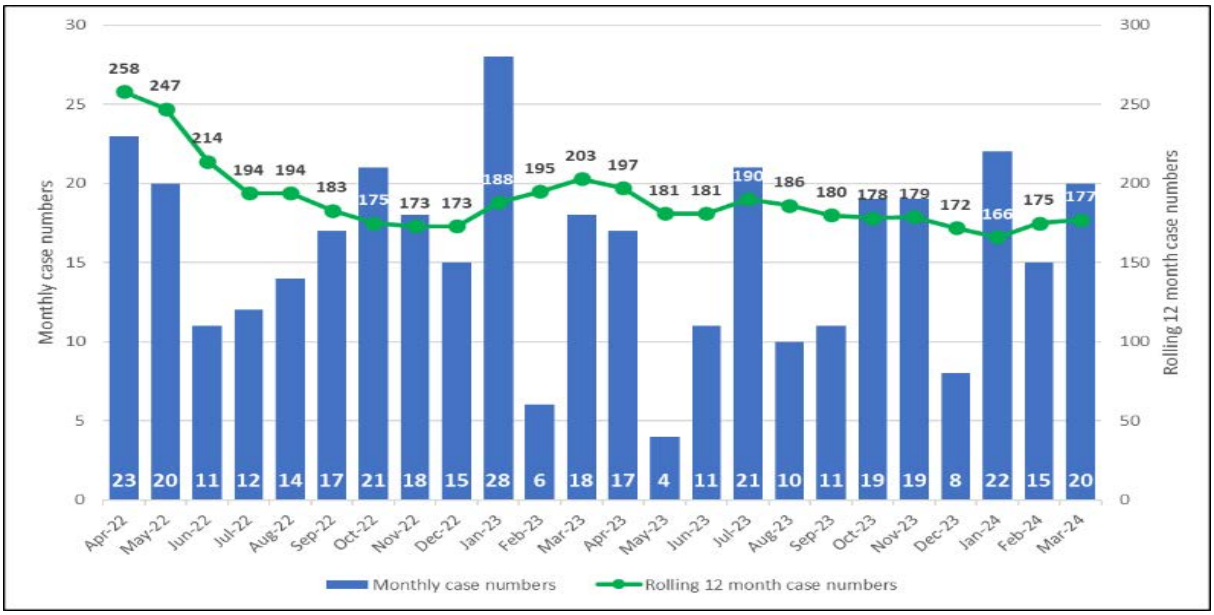
This report provides an update on our current position and activity during the year to date. The report includes a summary of actions taken in response to strategic objectives described in the 2023 report and planned actions for the coming year.

2. **DISCUSSION**

Activity

A total of 177 concerns were raised with the Freedom to Speak Up Guardian during 2023-24 compared to 204 in the previous year. The significant reduction that was evident in 2021- 22 has now equalised with little current variation in the rolling 12 monthly activity in the last 12 months as detailed in the graph below. It is hoped that in the longer-term numbers may decrease in response to improved organisational culture in respect of listening and responding and the achievement of efforts to make speaking up business as usual.

Figure 1: Rolling 12 month and Monthly Record of Concerns



The two largest Divisions (Surgery and Medicine) generated the greatest numbers of concerns Divisions are

[1] Thirlwall Inquiry 2024

provided with monthly updates on the nature and distribution of concerns to enable learning and improvement.

Figure 2: Concerns Raised by Division (where identified) During 2023-24

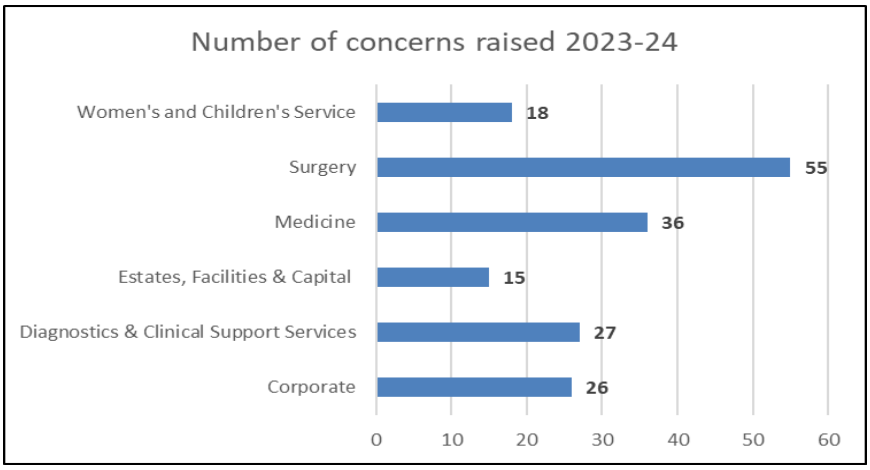


Figure 2 (Source - Datix)

National staff survey results suggest that there is still work to do, however we have seen increases in satisfaction across the 4 FTSU related questions in the last 12 months, with satisfaction levels being slightly above the national average. Specifically with 70.34% of colleagues feeling secure raising concerns about unsafe clinical practice, 55.64% of colleagues reporting feeling confident that the organisation would address their safety concern, 66.66% of colleagues feeling safe to speak up about anything that concerns me in this organisation and finally 49.69% reporting that they would be confident the organisation would take action to address these broader concerns.

National data for concerns raised in respect of the numbers and range of concerns has not yet been collated for 2023/24 but comparisons can be made with 2022-23 data as displayed below.

Table 1: Comparison between national and local FTSU activity

	Nationally 2022-23 (%)	**LTHTR 2023-24 (%)**
Concerns referencing patient safety and quality issues	19.3	20.3
Concerns referencing bullying and harassment (by manager or peer)	22	24
Concerns raised anonymously	9.3	10
Concerns referencing worker safety or wellbeing concerns	27.4	58
Concerns referencing poor attitudes or behaviours (excluding bullying and harassment)	30	22.5
Concerns where detriment occurred because of raising concern	3.9	4.5

Table 1 (Source - Datix and NGO)

Of the concerns raised in the Trust during 2023-24, performance is close to national performance in 2022-23 except for worker safety, where Trust incidence was reported as almost double. Trust scores are significantly influenced in this respect by concerns where an adverse impact on health and wellbeing is recorded, rather than an identified specific worker safety risk. That is not to suggest that failure to address a concern may not carry such a risk of adverse impact in future, but concerns raised by staff clearly have an affect. 101 staff who raised concerns during 2023-24 indicated that the concerns had such impact.

24% of staff raising concerns reported that they had experienced bullying and/or harassment (an increase of 2% compared to last year) with 14% by managers (down 1%) and 10% (up 3%) by peers. (Latest staff survey results demonstrated that a higher proportion of staff experienced bullying and harassment from colleagues than managers. Over 50% of staff who experienced bullying from any source reported it.)

The most frequently stated reasons for contacting the Freedom to Speak Up Guardian predominantly concern relationships and behaviours:

- poor attitudes or behaviours of managers or peers (76),
- unfair treatment, bias, or breach of policy (43)
- lack of response from manager (41), and
- poor leadership (34), and

Twenty-seven staff raised concerns about patient safety (a reduction of 50% on 2022-23 reporting). 10 concerns were raised about worker safety. Car parking concerns were lower again than last with only 7 compared to 10 in 2022-23.

Allowing staff the option of anonymity is a means of creating a safe environment for colleagues. Anyone raising concerns through the Datix Freedom to Speak Module has the choice of remaining anonymous or not. During 2023-24, 18 colleagues (10%) chose to remain anonymous compared to 9.3% nationally in 2022-23, and 12% locally in 2022-23.

Unsurprisingly, clinical staff raised the most concerns in 2023-24 with nurses and midwives collectively raising 45% of concerns. The proportion of maintenance and ancillary staff reporting concerns was lower in 2023-24. Reporting was also low from midwives with no students or volunteers recording concerns either. The proportion of medical and dental professionals, generally considered low responders, increased in 2023-24.

Table 2: Concerns Raised During 2023-24 by Professional Group

Professional Group	Number of concerns	Percentage	
		2023/24	2022-23
Administration and Clerical	36	24%	17%
Allied Health Professional	15	10%	13%
Corporate Services	12	8%	NR
Healthcare Assistant	19	13%	18%
Maintenance/Ancillary Staff	6	4%	8%
Medical and Dental Professional	13	9%	6%
Midwife	2	1%	NR
Registered Nurse	46	31%	27%

Table 2 (Source - Datix)

Whistleblowing

There has been a total of 15 recorded whistleblowing events during 2023-24. Of these, nine related to the same department in the Surgery Division, which was already the focus of improvement activity. Themes related to leadership, competency, culture, and the ability to raise concerns. The Guardian reinforced their availability to staff in response to this and departmental managers also stating their support for staff raising concerns to them.

In addition to these a further six concerns were raised in respect of other services, with three across three services in Women and Children's services, two in two services in Diagnostics and Clinical Support Services and a further concern in Surgery. Themes included staff training, competency and experience, leadership, lack of response, concerns about medical handover and medication errors and unfair treatment.

Raising Awareness and Creating a Positive F2SU Culture

In April 2023, three e-learning programmes were introduced into the Trust's e-learning catalogue. These include an annual update for all colleagues together with further programmes for those with managerial and supervisory responsibilities and for senior leaders.

Earlier this year a process was introduced to contact all staff who raised a concern to seek feedback on whether their concern had been resolved with a view to reopen the concern if they require extra support. Since introduction in January 139 staff were contacted and only 4 concerns have so far reopened through this process.

The Raising Concerns Group continues to meet every two months to review, triangulate and respond to intelligence relating to concerns raised across the Trust. In doing so the group identifies themes and organisational learning, reporting to the Trust's workforce committee.

Governance arrangements were strengthened during 2023 with the provision of monthly activity reports to Divisional Leadership Teams to support their awareness of concerns reported within their teams and enabling opportunities for learning and improvement.

The Trust's, Freedom to Speak Up Action plan (Appendix 1) is informed by the National Guardians Office's strategic framework[2] and identified local priorities for action, and is designed to promote speaking up, listening up ad following up as business as usual. The Raising concerns policy was reviewed in 2023 and is consistent with national policy.

All new colleagues receive information about speaking up as part of their Trust induction and information about speaking up is available in the dedicated webpages on the Trust intranet. The Guardian has met with teams and individuals on occasions both virtually and in person to raise awareness of the importance of speaking up and to managers and others in supervisory positions on the importance of listening and responding.

In support of the Trusts Organisational Sexual Safety Charter a process has been agreed for the identification, reporting and escalation of concerns relating to sexual abuse and harassment as raised with the FTSU service.

Learning and Improvement

In the 2022-23 report, key priorities were identified to strengthen and embed Speak Up Listen Up Follow Up across the Trust. These included:

- A review of Trust Freedom to Speak Up policies and procedures will be undertaken to ensure that Trust guidance is consistent with national guidance. - This review was completed but work continues to ensure that procedures and systems to provide effective support and identify important learning are further strengthened.
- Access to support is sustained through the recruitment of Freedom to Speak Up Champions - A network of champions is in place with representation from a range of services and staff groups. However, there is a further identified need to include staff from underrepresented groups and service areas where evidence of raising concerns is weak. This work will continue as a priority in 2024-25.

Aside from the improvements described in previous sections of this report, there are many examples across the organisation of learning at an individual and team level because of colleagues speaking up. Many of these relate to effective leadership, good communication and the building of stronger, more effective interpersonal relationships through meaningful, mutually respectful dialogue, and have been achieved through:

- Recognition of the impact on health and wellbeing of staff when treated disrespectfully and taking action to change behaviours.
- Recognition of need for prompt intervention and staff support in addressing colleagues' competence and behaviour that impacts on staff confidence, personal safety, workload, and wellbeing.
- Recognition of the impact of the fear of detriment (rather than evidence of actual detriment) on the confidence of staff to raise concerns through the appropriate channels persists.
- Compassionate support in sensitive situations, e.g. in situations where staff are experiencing pressures because of capacity, staffing and activity pressures.
- Early resolution and effective de-escalation.
- The importance of positive role modelling from leaders in promoting positive freedom to speak up behaviours within their team, which encourage speaking up, provide meaningful response and demonstrate action.

[2] NGO strategic framework 2021

- The unacceptability of 'banter' and offensive behaviour/language towards colleagues.

As in previous years speaking up activity has led to investment in training and support for leaders and team where concerns have been identified and in response to identification of learning and developmental need. Despite this investment and effort, whilst there is evidence of excellent engagement from some teams, challenges remain in some areas with ongoing concerns about the pace of change.

PRIORITIES FOR 2024/25

During 2024/25, the focus for future actions will be centred upon ensuring colleagues know how to speak up and by identifying and tackling barriers to speaking up. Leadership will be encouraged to promote a positive culture that takes learning from speaking up activity within their teams. The high level action plan is provided in Appendix 1, details the programmes of work and progress to date in delivery of actions.

Raising Awareness

The actions to be delivered in the next 12 months are to:

- Refresh induction materials and include an opportunity for the FTSU Guardian to attend all induction sessions.
- In addition to participation in core training through the e-learning programme leaders will be encouraged to undertake manager and senior leader FTSU training as part of their development.
- Refresh and relaunch promotional materials and resources (posters, webpages etc) to ensure that information is up to date and relevant.

Identifying and Tackling Barriers to Speaking Up

To take targeted activity in areas of the organisation and specific staff groups where speaking up activity is limited, specifically focussing in on the following areas over the next 12 months; Hotel Services teams, Security Services, Students, Volunteers and Midwives.

To understand the barriers or lack of awareness colleagues from these groups will be invited to engage with FTSU service to better understand what would support increasing awareness and removal of perceived and real barriers to raising concerns.

Further actions will include:

- The recruitment of Champions in these teams and staff groups to support colleagues in raising concerns.
- Use of surveys to measure awareness of the service and activity reviewed to evidence any improvements in engagement.
- Scope different ways for seeking feedback from colleagues using the services with specific reference to those with protected characteristics in order to have a better understanding of their experience and improve the quality of information in respect of those accessing the service.

Promoting a positive culture through leaders

The value of the relationship between the Guardian and leaders within the organisation will be strengthened through:

- The provision of timely information and intelligence on areas of concern and in working in partnership to listen and respond.
- Development of line manager workshops to provide bespoke support where the need is identified.
- Reestablishment of the network of Champions through the introduction of quarterly workshops to provide support in teams /areas where they are needed.

The FTSU action plan (Appendix 1) describes the key principles and actions required to making speaking up business as usual. Training records, colleague awareness evidenced through National Staff Survey and STAR ward accreditation processes, patient feedback and speaking up activity will demonstrate impact of the actions within the plan. The plan itself will be subject to ongoing informal review and formal annual review. Progress will be reported to the Raising Concerns Group on a bi-monthly basis and reported to the workforce committee biannually.

3. **FINANCIAL IMPLICATIONS**
   None

4. **LEGAL IMPLICATIONS**
   There are no legal implications associated with this report. However, Trust arrangements for raising and responding to concerns (included Board responsibilities) are referenced in the standard NHS contract; are subject to review by the Care Quality Commission (CQC) as part of the Well-led domain; and are monitoring by the National Guardians Office (NGO), which is sponsored by the CQC and NHS England (NHSE).

   Failure to address concerns being raised within the organisation could result in external concerns being raised including legal action such as employment tribunals or as a result of safety concerns not being appropriately resolved.

5. **RISKS**
   No new risks have been identified by the FTSUG. Risks associated with speaking up incidents are owned and managed by the relevant Divisions.

6. **IMPACT ON STAKEHOLDERS**
   Review of user feedback suggests that access to support when raising concerns remains positive, following ongoing improvements since 2018/19. Staff awareness of how to contact the Guardian is demonstrated through staff responses during STAR audit accreditation visits.

7. **RECOMMENDATIONS**
   The Committee is asked to note the information and assurance relating to Freedom to Speak Up activity during 2023/24, described within this report to note and support priorities for 2024/25 as described in section 2e. and in the attached action plan.

APPENDIX 1 - FREEDOM TO SPEAK UP –ACTION PLAN 2024

This attached plan is designed to align Trust focus with national priorities, as described by the National Guardians Office, and local priorities as identified through review of speaking up activity and local feedback. Within the plan the delivery of aims and objectives is supported by the identification of actions and evidence of achievement/status. The plan is structured around four themes:

- Workers (Colleagues)
- Leadership
- Healthcare Systems, and
- The Freedom to Speak Up Guardian

It is anticipated that focus on these themes will promote an organisational culture where speaking up is considered business as usual, where staff feel safe in raising concerns and confident that their concerns will be heard and responded to.

Workers

Regular, clear, and inspiring communication is an essential part of making a speaking-up culture a reality. However strong an organisation's speaking-up culture though, there will always be some barriers to speaking up. Finding and addressing them is an ongoing process.

Key principles – To champion and support staff to speak up by:

- Making sure that colleagues know how to speak up and feel safe and encouraged to do so.
- Identifying and tackling barriers to speaking up

Action	Lead	Review Date	Status	Progress Update
Increase visibility of the FTSU service by proactively engaging with colleagues and attending sessions/meeting to communicate on FTSU issues. Examples include: • New Starter Forums/Inductions • Student and International Nurse Forums • Bespoke Team/Service/Department requests	FTSUG	Oct-24	In progress	FTSUG is available to meet with teams on request or where a need has been identified as part of a local action plan. Video/PowerPoint presentations are made to all new starters. Face-to-face presentations are to be re-introduced during 2024-25
Have mechanisms to ensure staff who raise concerns are protected by the Trust	FTSUG	Ap-24	Complete	Trust policy reinforces a commitment to protect staff who raise concerns from unacceptable behaviour, detriment, or harm. The Freedom to Speak Up Guardian and the Deputy Director of

				Workforce are identified as sources of support if such harm is suspected. The Guardian records and reports all instances of perceived/actual detriment. In addition, policy also describes processes and organisations to which staff can safely raise concerns if they do not feel comfortable raising their concerns internally to ensure they are protected as far as possible.
Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff	FTSUG	Mar-25	In progress	A Trust action plan has been developed alongside the Trust Freedom to Speak Up strategy identifying actions and goals, progress against which is reported to the Workforce Committee and included in the annual report to the Board. Staff feedback mechanisms following contact with the Freedom to Speak Up Guardian provide opportunity for staff to disclose protected characteristics and for the Guardian to review the effectiveness of the service. During 2024-25 reporting arrangements through Datix will be revised to strengthen the reporting of protected characteristics and improve the quality of reporting. A review of all policies and procedures where raising concerns is relevant to improvement in safety and quality is underway and will reference the importance of supporting staff to raise concerns. Induction training, mandatory and leadership training also includes guidance on raising concerns and supporting staff who wish to do so
Identify staff groups and services where raising of concerns is known to be low, including among colleagues with protected characteristics who may experience additional barriers to speaking up	FTSUG	Oct-24	In progress	Some services identified through FTSU activity data, as detailed in activity reports to workforce committee. Process for the identification of staff with protected characteristics requires strengthening (See 'Healthcare systems')
Promote the value, awareness of the FTSU service and how to access it to staff in teams	FTSUG/ service managers	Mar-25	Not yet started	Some limited activity in response to known issues. Expectation that activity will increase

and roles where raising of concerns is known to be low.				
In addition to existing e-learning packages and with the cooperation and involvement of service leads; develop bespoke training support specific to identified need that is timely and relevant to the needs of staff.	FTSUG/ service managers	Mar-25	In progress	Video detailing the importance of listening and responding available on the intranet
Introduce a three month follow up after a concern has been closed to establish whether the person raising the concern feels this has been adequately addressed.	FTSUG	Apr-24	Complete	Process in place for three month follow up. Where staff do not feel concerns have been addressed consideration given to reopen concern. Reopened concerns reported to Raising Concerns Group
Develop an agreed process for reporting and escalation of concerns relating to Sexual Abuse and Harassment to support the Organisational Sexual Safety Charter.	FTSUG	Apr-24	Complete	Datix system amended to capture concerns that reference sexual abuse or harassment and included in activity reports to Raising Concerns Group.
Explore and develop alternative means for colleagues to raise concerns for staff who do not have access to Trust devices to raise concerns (e.g. QR Code/paper forms).	FTSUG	Oct-24	Not yet started	

Leadership

Leadership Role-modelling by leaders is essential to set the cultural tone of the organisation. For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

It is essential to recognise that speaking up is not easy, so when someone does speak up, they must feel appreciated, heard, and involved.

Key principles – To support and encourage leadership at all levels to foster a speak up, listen up, follow up culture by:

- Valuing speaking up,
- Role modelling speaking up and setting a healthy Freedom to Speak Up culture, and
- Ensuring that when someone speaks up, they are thanked, listened to and their concerns are followed up.

Action	Lead	Review Date	Status	Progress Update
Increase visibility of the FTSU service through engagement with colleagues and attending meetings as requested to communicate on FTSU issues: • Ward/team meetings • Divisional Workforce Committees • Divisional Improvement Forums	FTSUG	Oct-24	In progress	FTSUG available for team meetings on request. Activity reports/dashboard available to Divisional Workforce Committees via Divisional Management Team (DMT). Executive FTSUG lead monitors response to speaking up issues through Divisional Improvement Forums
Establishing trust and positive relationships across the DMTs and other senior leaders to provide assurance on the management of FTSU cases and sharing of themes.	FTSUG/ Exec FTSU lead	Oct-24	In progress	Monthly activity reports provided to DMT in advance of Divisional Improvement Forum with offer of follow up discussion if required. Corporate Division report to be developed. Exec FTSU lead in attendance at Divisional Improvement Forum. Early warning of significant concerns provided by FTSUG to DMTs as confidentiality agreements allow.
Develop FTSU training resource to be delivered Trust wide and at Team levels to explain what FTSU is, how to use, what a positive FTSU culture would look like in teams and line managers role in creating this.	FTSUG	Mar-25	Not yet started	
Create and deliver Manager workshops / Q&A forums for managers on Freedom to Speak Up to influence, help manage concerns effectively and continuous improvement.	FTSUG	Mar-25	Not yet started	

Create content for managers to be included in Core People Management Skills Programme about how to encourage raising concerns, how to respond to concerns etc.	FTSUG	Mar-25	In progress	Speaking up is referenced in some core people management training but would benefit from further detail and wider inclusion
Provide information and intelligence where there is a developing trend or significant risk detailed within concerns raised to FTSU.	FTSUG	Oct-24	In progress	Information shared to extent that confidentiality and exclusions to confidentiality allow.
Provide twice yearly reports to Board, and regular communications to all colleagues on the value of FTSU, what colleagues have spoken up about, lessons learned, and action taken to respond to these.	FTSUG	Mar-24	Not yet started	To commence as agreed in Board reporting schedule

Healthcare Systems

The aim of speaking up is to improve patient safety and the working environment for all staff. Trust information systems and processes relating to speaking up must be fit for purpose and capable of informing patient safety and quality improvement focus and activity, ensuring relevance to staff, Trust, and national priorities.

Key principles – To support health system alignment and accountability, by:

- Using speaking up as an opportunity to learn and improve, and
- Continually improving speaking up culture.

Action	Lead	Review Date	Status	Progress Update
Develop FTSU case management process, ensuring process reflect good practice and provides information that meets the needs of the Trust and the National Gurdian, updating as necessary to ensure robust and consistent service delivery.	FTSUG	May-24	Complete	Process completed
Continually review practice against described processes ensuring that data collection and reporting capabilities continue to meet any changes in need of the Trust and the National Guardian.	FTSUG	Mar-25	In progress	Review undertaken March 24. Further reviews will be undertaken as necessary in response to changing national guidance or locally identified need
Reviewing existing FTSU Service branding and resources with a view to updating materials (visual resources, e.g., posters and intranet pages. -	FTSUG	Oct-24	In progress	Intranet pages updated with new content and format
Liaise with colleagues (such as Union and Workforce Advice) to ensure that FTSU service is used appropriately to support colleagues when they have a concern they want to raise.	FTSUG/ union representatives/ workforce team	Oct-24	In progress	FTSUG works together with union officials to provide support where appropriate to staff members. FTSUG advises where support from FTSUG is appropriate. Workforce team provide valuable advice to aid and inform FTSUG support for staff
Agree the Terms of Reference and content and format of bi-monthly FTSU Report to Raising Concerns Group to support triangulation of all available intelligence (e.g. external whistleblowing events, patient	FTSUG	Mar-24	Complete	Terms of reference approved by Raising Concerns Group. Reporting format and content agreed.

safety incidents and risks, confidential culture risks, GMC trainee and other staff survey data, team dynamic issues and employee relation issues)				
Update and align the FTSU into wider policies (pressing priority is PSIRF), ensuring adequate reference and signposting.	FTSUG and policy authors	Oct-24	In progress	A review of all policies and procedures where raising concerns is relevant to improvement in safety and quality is underway and will reference the importance of supporting staff to raise concerns.
Complete necessary requirements of the IAO role including documenting, understanding, and monitoring: What information assets are held, and for what purpose, how information is created, amended, or added over time, who has access to the information and why. Understand and address the risk to the asset, providing assurance to the SIRO	FTSUG	Oct-24	Not yet started	FTSUG to clarify with National Guardians Office re ownership of data and
Update local Freedom to Speak Up policy to reflect the new national policy template	FTSUG	Jan-24	Complete	
Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff	FTSUG	Mar-24	In progress	During 2024-25 reporting arrangements through Datix will be revised to strengthen the reporting of protected characteristics and improve the quality of reporting.
Redesign the FTSU Feedback form so that additional information can be captured, and the data is accessible to the FTSU service via Trust systems	FTSUG	Oct-24	Not yet started	Feedback system in place but not yet integrated to other Trust FTSU systems

The Freedom to Speak Up Guardian

Key principle – To support the Guardian to fulfil their role in a way that meet staff needs and national requirements.

Action	Lead	Review Date	Status	Progress Update
Ensure that the Guardian delivers the requirements of the role within the scope set out by the National Guardian's Office, acting as an independent source of support for all those involved in the concern.	Ass workforce Director/ Exec FTSU lead	Mar-25	In progress	Delivery monitored via Raising Concern Group activity, Board and organisational feedback and managed through appraisal/ performance management processes. Both managers have attending National Guardians office training
Identify, recruit, and induct Champions, focussing on areas/staff groups where speaking up activity is low.	FTSUG	Mar-25	In progress	Recruitment of Champions is an ongoing process with assistance of service managers in identifying need
Develop the Freedom to Speak Up Champion network, ensuring that Champions are aware of their role and have regular access and support from the Guardian. Support will include the sharing of themes regarding speaking up activity and learning opportunities arising from them.	FTSUG	Oct-24	Not yet started	Current champions identified. Event to be organised and primary gap analysis to be undertaken.
Maintain a manageable caseload that allows for engagement with training, awareness raising, and other activities as outlined in action plan	FTSUG/ Exec FTSU lead	Mar-25	In progress	Upper limit of 25 open cases currently exceeded (28 open cases) following quarter if increased activity.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Annual Assessment of Fit and Proper Persons 2023-24

Report to:	Board of Directors	**Date:**	1 August 2024
Report of:	Company Secretary	**Prepared by:**	J Foote
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

In line with NHS England's Fit and Proper Persons Test (FPPT) Framework for Board Members, the annual FPPT assessment was undertaken covering the period 1 April 2023 up to and including 20 June 2024. The assessment involved a review of the Chair, Non-Executive, Associate Non-Executive and Executive Directors, including starters and leavers during the reporting period, to ensure that very senior Directors of the Trust were fit and proper to serve as Board members.

The annual assessment involved completion of a range of documents including declarations, self-attestations, and checks completed on central registers, such as Companies House, the Insolvency Register, professional governing bodies, and social media platforms.

A satisfactory conclusion was reached on the annual FPPT assessment with two legacy issues which were not material breaches under Regulation 5, both of which had been managed and remedial action taken as required.

The annual FPPT assessment was submitted by the Chair to NHS England in line with reporting deadlines.

The Board is asked to note the successful outcome of the Fit and Proper Persons Annual Assessment for 2023-24.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable