NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

BOARD OF DIRECTORS MEETING

6 February 2025

12:45 GMT Europe/London

Lecture Room 1, Education Centre 1, Royal Preston Hospital

AGENDA

STAFF STORY : MDT, ORTHOPAEDICS

Information Item | L Graham/A Davies | 12:45

AGENDA

REFERENCES

Only PDFs are attached

Agenda - Board (part I) - 6.02.25 .pdf

Board of Directors

6 February 2025 | 12.45pm | Lecture Room 1, Education Centre 1, Royal Preston Hospital, Sharoe Green Lane, Fulwood, Preston, Lancashire, PR2 9HT

Agenda

At 12.45pm, there will be a **Staff Story** presented by MDT, Orthopaedics

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	M Thomas
2.	Apologies for absence	1.01pm	Verbal	Information	M Thomas
3.	Declaration of interests	1.02pm	Verbal	Information	M Thomas
4.	Minutes of the meeting held on 5 December 2024	1.03pm	✓	Decision	M Thomas
5.	Matters arising and action log update	1.04pm	✓	Decision	M Thomas
6.	Chair's opening remarks and report	1.05pm (5mins: Pres)	✓	Information	M Thomas
7.	Chief Executive's report	1.10pm (10mins: Q&A)	✓	Information	S Nicholls
8.	Board Assurance Framework	1.20pm (10mins: Disc)	✓	Assurance	S Regan
9.	**FIT FOR THE FUTURE** (STRATEGY & PLANNING)				
9.1	2025/2026 Planning Guidance	1:30pm (15mins: Q&A)	Pres	Information	A Brotherton
9.2	Health Improvement Plan	1:45pm (10mins: Q&A)	✓	Decision	S Morrison
10.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
10.1	Safety and Quality Committee Chair's Report	1.55pm (10mins: Q&A)	✓	Assurance	K Smyth
10.2	Adult and Paediatric Audiology – Trust Response to CQC	2:05pm (10mins: Q&A)	✓	Decision	S Morrison
10.3	Maternity and Neonatal Services report	2.10pm (10mins: Q&A)	✓	Assurance	J Lambert
11.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
11.1	Integrated Performance Report as at 31 January 2025 including Finance update and Single Improvement Plan *(considered by appropriate Committees of the Board)*	2.20pm (20mins Q&A)	✓	Assurance	K Foster-Greenwood/ S Morrison/ N Pease/ D Stonehouse
11.2	Finance and Performance Committee Chair's Report	2.40pm (10mins: Q&A)	✓	Assurance	T Whiteside
11.3	Audit Committee Chair's Report	2.50pm (10mins: Q&A)	✓	Assurance	T Watkinson

№	Item	Time	Encl.	Purpose	Presenter
11.4	Charitable Funds Committee Chair's Report	3.00pm (10mins: Q&A)	✓	Assurance	K Smyth
12.	**GREAT PLACE TO WORK** (WORKFORCE, EDUCATION AND RESEARCH)				
12.1	Workforce Committee Chair's Report	3.10pm (10mins: Q&A)	✓	Assurance	V Crorken
12.2	**Report recommended for approval**: a. Gender Pay Report	3.20pm (10mins: Q&A)	✓	Decision	N Pease
	Report recommended for assurance: b. Equality, Diversity and Inclusion Annual Report	3.30pm (10mins: Q&A)	✓	Decision	N Pease
13.	**GOVERNANCE AND COMPLIANCE**				
13.1	Scheme of Reservation and Delegation	3.40 (5mins: Q&A)	✓	Decision	J Foote
14.	**ITEMS FOR INFORMATION**				
14.1	Register of Interests		✓		
14.2	Membership Strategy 2025-28		✓		
14.3	Date, time and venue of next meeting: *3 April 2025, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital*	3.45pm	Verbal	Information	M Thomas

1. CHAIR AND QUORUM

Information Item | M Thomas | 13:00

2. APOLOGIES FOR ABSENCE

Information Item | M Thomas | 13:01

3. DECLARATION OF INTERESTS

Information Item | M Thomas | 13:02

4. MINUTES OF THE PREVIOUS MEETING HELD ON 5 DECEMBER 2024

Decision Item | M Thomas | 13:03

REFERENCES

Only PDFs are attached

04.0 - Minutes - Board (Part I) - 5 Dec 24 - draft.pdf

Board of Directors

5 December 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
Ms S Cullen	Chief Nursing Officer
Ms K Foster-Greenwood	Chief Operating Officer
Professor S Nicholls	Chief Executive
Dr G Skailes	Chief Medical Officer
Ms K Smyth	Non-Executive Director
Mr D Stonehouse	Interim Chief Finance Officer
Mr T Watkinson	Non-Executive Director
Mrs T Whiteside	Non-Executive Director

In attendance:

Mr G Doherty	Director of Strategy and Planning
Mrs N Duggan	Director of Communications and Engagement
Dr D Kendall	Consultant Paediatrician and Guardian of Safeworking *(patient story)*
Ms J Lambert	Interim Divisional Nursing and Midwifery Director *(minute 162/24)*
Ms B Lowe	Paediatric Healthy Weight Coach *(patient story)*
Mr N Pease	Chief People Officer
Mrs J Wiseman	Corporate Affairs Officer *(minutes)*

Governors observing: Margaret France, Janet Miller, Frank Robinson, Mike Simpson, Graham Robinson, Steve Heywood

Observers: Raj Purewal, C2-Ai, Mr Mike Thomas, Chair of MBHT

Prior to the meeting the Board received the Following Presentation: Patient Story, Paediatric Complications of Excess Weight (CEW) Clinic - Children and Young People Division.

Representatives from the Division of Children and Young People presented a video of their patient, Faith, who had lived with severe obesity for many years. Before her referral to the Paediatric Complications Excess Weight Clinic, Faith had experienced feeling tired, nervous about discussing her health and described how her fears and embarrassment were alleviated once she attended the CEW Clinic. It had been a relief to know that there was no judgement from the team involved in her care and Faith had felt entirely supported. On Faith's first appointment, the CEW team had discussed her diet, exercise plan and medical history, including her mental health. This had been a welcomed opportunity to talk and be open with the team about previous test results. As time had progressed, Faith had spent time with the psychologist attached to the service and informed of the positive journey she had experienced with other members of the CEW team. Close contact with support from the dietician, had helped Faith to choose healthier options and advised that there had been no judgement. This had helped Faith to feel comfortable to speak openly about food. The care plan had felt individualised and adapted around the patient rather than a 'one size fits all' service.

Faith explained how the dietician and psychologist worked with her to achieve her goals and understand her emotions. Faith wanted other patients who were worried about their referral to know that she regarded the CEW Clinic as the best form of care and experience she had known and ended by conveying her gratitude to the CEW team for all their guidance and support to achieve her goals.

The Board asked if once patients had received interventions for their health care, if the benefits from attending the CEW Clinic were lifelong. Dr Kendall explained that there were 20 clinics of this nature across the country and the follow up data would be collated. The long term data showed that this typed of severe obesity was a chronic long-term condition but any intervention helped to delay the onset of type 2 diabetes and that improved life expectancy. A high percentage of children were known to relapse hence the need for the longer support mechanism.

The board were informed that NHSE had confirmed funding for the clinic for the next financial year and patient data that was being collated would be reviewed. This included the qualitive data for children returning to education after these health interventions.

The Paediatric Healthy Weight Coach described her career journey and how she had achieved additional qualifications to perform her role.

191/24 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. The Chair welcomed an observer of the meeting, Professor Mike Thomas, current Chair of University Hospitals of Morecambe Bay NHS Foundation Trust, who would commence in his role as Chair of Lancashire Teaching Hospitals Foundation Trust from 1 January 2025.

192/24 Apologies for absence

Apologies for absence were received from Mr U Patel, Ms A Brotherton, Mrs J Foote and Prof Paul O'Neill.

193/24 Declaration of interests

There were no conflicts of interest declared by the Board in respect of the business to be transacted during the meeting save for the following:

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

194/24 Minutes of the previous meeting

The minutes of the meeting held on 3 October 2024 were approved as a true and accurate record.

195/24 Matters arising and action log

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

196/24 Chair's report

The report provided a summary of work and activities undertaken during October and November 2024 by the Trust Chair including a resumé of the items discussed in the part II Board meeting in October.

The Chair expressed his gratitude to all who support the Trust: governors, staff and the Board for their support during his term of office. The executive team continued to work with ongoing intervention during the financial challenges; the Chair thanked governor and Non-Executive colleagues for their support whilst there was additional scrutiny and holding to account. It was explained that the Board workshop earlier in the day had reviewed the Strasys report which included an amount of detail for the Trust and system to work through. This had previously been presented to governors at an earlier training session. The report identified potential opportunities and a strategic approach for the challenges of service delivery.

197/24 Chief Executive's report

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

New Hospitals Programme - Lancashire Teaching Hospitals NHS Foundation Trust NHP scheme had been confirmed as within the scope which had recently been announced. This was a big step forward to becoming a reality. From January 2025 public engagement would commence to provide information around the function and site of the new hospital as a precursor to the formal consultation later in 2025. Part of the pre-engagement work would include a combination of channels to reach out that would consist of surveys on-line with a postal option and telephone number. There would be a series of public meetings held with different interested groups. The Trust website would also include information. The Chief Executive Officer expressed a debt of gratitude in recognition of the support from key stakeholders, MPs across the region and the tireless support of the New Hospitals Programme by Sir Lindsay Hoyle.

The Director of Strategy - Gary Doherty Director of Strategy would leave the Trust at the end of December to take up a new role as the Managing Director for the Provider Collaborative in Greater Manchester. The Board recognised that Gary would be greatly missed and congratulated him on his new role, wishing him every success for the future.

Outgoing Chair – Appreciation was conveyed to the current Chair whose term of office would end at the end of 2024. The Chair had provided stability and completed some great work in support of the executive team throughout his term of office. The Chair's long history of public service and experience had been of great value to the Trust.

Shaw Trust Disability Power 100 – The Board had recognised the National Disabled History month and were reminded of Non-Executive Director Kate Smyth, who had been listed in the prestigious Shaw Trust Disability Power 100 2024 and celebrated as one of the 100 most influential disabled individuals in the UK.

198/24 Board Assurance Framework

The report explained that the Well Led Framework by NHS England and the Care Quality Commission (CQC) required Boards of all provider organisations to ensure there was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. It extended to include a Board Assurance Framework (BAF) which provided a structure and process to enable organisations to identify those strategic and operational risks that may compromise the achievement of the Trust's objectives. The paper also proposed a change in approach in respect of the Board Assurance Framework and a draft version had been attached to consider adoption by the Board. A summary of the programme of work undertaken by the Board during the second half of the year was included. The aim was to move away from the current strategic approach in managing risks, to a principal risk approach.

The approach had been reviewed against NHS providers, other organisations and a number of training exercises had been undertaken with the Board of Directors. The change was initiated from wanting to progress to a point as a Board to own a level of risk with a greater degree of determination. Risks were being developed through the review of the corporate objectives which would drive improvement to the long standing risks.

If the Board adopted the new assurance framework there would be a requirement to reset the Trust's risk appetite and tolerances outlined in the report. Transition arrangements for the escalated 'Operational High Risks of Concern' to 'principal risks' were in place.

The Board remarked that the test would be if the actions delivered the strategic aims and ambitions for the organisation however, this appeared to be an improvement to the risk framework. The new approach of principal risks was supported. In principle the Board supported the change with further consideration given to the overarching strategic risks to ensure nothing adverse had been missed.

The Board RESOLVED that the recommendations for the new principal risk approach were agreed in principle with further consideration given to the overarching strategic risks.

199/24 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 27 Sept and 25 Oct 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Board were alerted to the continued non-compliance of national cleaning standards. The analysis now evidenced that non-compliance and frequency of cleaning had positively led to a reduction in C.difficile rates. Consideration of the business case to implement national cleaning standards within the organisation would be included as part of the budget setting for 2025/26.

The registered midwife component of the Birthrate plus recommendation that required funding would also be a consideration as part of the 2025/26 budget setting.

The Winter Planning Paper 24/25 outlined a strategy to attempt to address the anticipated bed gap during the winter period. The paper identified the risks associated

with an increased demand over the winter period which was calculated to result in a bed deficit. The Urgent and Emergency Care picker survey outlined that the Trust position had deteriorated regarding the experience of patients in the UEC pathway. A plan was presented to the committee that was dependent on the wider UEC plan delivering the aims it sets out. It was acknowledged by the committee that the position regarding the boarding of patients was having an adverse impact on patients and staff throughout the UEC pathway.

The Safety and Quality Committee advised the Board of the welcomed progress on the nationally mandated health inequalities data for 2023/24 and the data would be used to develop the Health Inequalities Plan. The Committee had confirmed it was assured of the progress report against the Always Safety First Strategy 2021-24 and had been reminded of the key successes demonstrated in the report that included the implementation of PSIRF. The Board agreed that it would be helpful to include PSIRF update as a topic for a future development workshop.

The Committee had received numerous assurance reports relating to:

- Annual maternity staffing
- Winter Planning
- Thrombectomy 7 day service would be resumed
- Maternity Picker Survey demonstrated an improved position
- Medicines governance
- Health Inequalities
- Equality Quality Impact Assessment Report

The Committee received assurance in relation to ward 8 for children outcome measures. The leadership changes were demonstrating signs of improvements in key metric compliance data and staff sickness absence.

A question was asked if the EQIA policy was robust enough to sufficiently capture the right balance that considered other pressures in the organisation when reviewing other demands similar to the gap in maternity funding. The Board noted that the organisation was becoming more familiar with the EQIA process and captured a rounded view.

200/24 Maternity and Neonatal Services Report

The report provided an update in relation to safe staffing, the safety and quality, 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 were included in the report for cross triangulation and information. The report had previously been reviewed by the Safety and Quality Committee.

The Board was asked to note that the CNST progress within the service was validated by the local Maternity and Neonatal System LMNS and signed off against 7/10 of the standards for the MIS. The remaining 3 standards were on track to meet the recommendations. On the 20 November 2024 NHS Resolution wrote to the Trust to confirm that the thematic review of cases reported by the Trust to the Early Notification (EN) scheme between 1 April 2017 and 29 February 2024 was now complete. In the letter, it was confirmed that they were satisfied with the detailed evidence of learning and completed actions provided by the service.

The Board noted the assurance from the level of scrutiny undertaken by the external reviews and surveillance outcomes. The early signs of improvement of the incidence of third and fourth degree tears was recognised. The mitigations in place around the red flags for obstetric waiting times was noted and the Board were reminded of the requirement of birthrate staffing. During a recent visit to the maternity department the Board had witnessed the dedication to the improvement work being undertaken by staff.

The Board RESOLVED to:

1. **approve the Maternity and Neonatal Service Update, noting the CNST update report and recommendations; and**
2. **confirm it was satisfied that a comprehensive level of check and challenge had been applied by the Board level Safety Champions to understand the performance and pressures affecting the maternity and neonatal service and reflect that in the minutes.**

201/24 Workforce Committee Chair's report

The Chair's report from the Workforce Committee provided an overview of items discussed at the meetings on 12 November 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Board were alerted to the impact of the firebreak on resource planning and colleague morale, with an emphasis on the need to regularly communicate updates and provide clear messaging around the temporary firebreak to address these concerns.

The Committee advised the Board of the findings from the MIAA audit on sickness absence, noting the substantial work being undertaken in response. A recommendation had been to review the governance structure, ensuring clear reporting pathways from operational oversight to the Workforce Committee. There was an ongoing programme of work to improve sickness absence with significant progress having been identified. That had included management training that involved early management of sickness absences and policy adherence.

The Committee had discussed the governance and oversight challenges related to working with One LSC on people issues, particularly around visibility and engagement in decision-making processes.

Assurance had been provided on the progress on the AHP strategy in year 2 of the 3 year strategy, which reflected a focused and positive approach to addressing workforce priorities. Twenty five of the objectives had been achieved to date. The Committee received an update on the "engage, retain, recognise" initiative, which highlighted ongoing efforts to support and value colleagues, fostering a positive and supportive work environment.

The Committee had received an assurance report on freedom to speak up and a question was asked if the process had sufficient robustness to ensure that colleagues had awareness of the available channel to raise concerns. There had been a reduction in concerns that was being monitored and could indicate that there was improved confidence or potential short-comings in the service. The Board was reminded of the sad and recent passing of the Freedom to Speak Up Guardian Steve O'Brien and

commended his dedication to the NHS. The importance of service availability was noted and thanks were extended to Kate Holt for her support.

The Board noted the early improvements around the reduction of sickness absence as a commitment to the Financial Recovery Plan. It was confirmed that there were actions in place to ensure that the sickness attendance policy was being managed effectively.

202/24 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee provided an overview of items discussed at the meeting on 8 October 2024. The Board noted that there were no 'alerts' highlighted.

The Board were advised of the reprioritisation of research studies. The Committee had noted concerns from senior consultants about prioritising commercially funded studies over academic studies, potentially affecting reputation. While the Committee acknowledged the need for financial balance, the potential for reputational impact was highlighted as a matter for ongoing monitoring and consideration.

The need for consistent quoracy across assurance committees had been noted as an issue. This would be raised with the executives to ensure reliable committee function and maintained assurance integrity. A report had been provided for the Board for discussion later in the meeting.

The Board were advised of the ongoing work in postgraduate medicine that involved the resident doctors' rotas and their experience working at Lancashire Teaching Hospitals. A working group with a broad membership were supporting the improvement work and the resident doctors.

The Committee had been assured of the Knowledge and Library Services annual report who had received commendation, highlighting the exemplary work in supporting staff development and resource accessibility. Assurance was provided of the early-stage work on University Hospital status that was underway, demonstrating strategic alignment with broader organisational goals and commitment to growth in education and research capabilities.

The importance of having the right skills and capabilities across the organisation was noted. A potential weakness around contract management had been raised as a concern and a training programme was in place to ensure that when colleagues were committing the organisation to contractual arrangements, they had the appropriate skills to do so.

203/24 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 meeting on 24 September and 22 October 2024 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

Key points of discussion had been around the Financial Recovery Plan. The financial recovery was identified as a high-risk area. The need to inform the Board of the current status, risks and the high-stakes nature of the financial forecast was agreed upon, with

attention on the risk to delivery. There were early indicators of improvement around the tightening grip and control. A shift in the financial forecast had revealed a deteriorating deficit position, prompting the need for a comprehensive reset. Some assurance had been observed in the action plans to improve by having external expertise and the additional scrutiny applied. The Committee had discussed the Trust's financial position and cash flow remained a concern, with potential cash exhaustion by early 2025 without further mitigations. Capital spending reviews were underway to seek cash support, prioritising payments in line with agreed principles.

More recently the Committee had discussed the concerns of patients with metal health conditions having long waits in the emergency department. The area was awaiting capital investment and the key pressures for the department had been noted as a concern for the Committee.

A positive update had been provided on the steps being taken to improve planning controls, strengthen levels of partner, stakeholder and colleague engagements, in the formulation of the 10-year Strategic Plan and 2025/26 Operating Plans.

There had been limited assurance on the Single Improvement Plan. The Committee identified gaps in tracking key milestones within the SIP. While some improvements in control structure and reporting were noted, visibility and risk concerns remained, especially in relation to the plan's organisation-wide rollout. Further efforts were requested to enhance transparency and clarity around key outcomes from the transformation programmes, to provide assurance on the path to achieving improvements in the NOF rating, CQC rating, and financial sustainability.

One LSC had been discussed by the Committee and it had been agreed that the Board would be alerted to the issues and risks within the One LSC system, particularly in light of ongoing collaboration challenges.

The Winter Plan had been scrutinised for the preparedness for winter, with acknowledgement of further work and level of risk exposure to close identified bed gaps.

An uplifting presentation on the Digital Strategy had been received. The significant progress was noted, particularly regarding license consolidation, automation benefits, and enhanced data capture processes that would support improved financial outcomes.

An update was requested on the status of the PMO and resources to manage the improvement programmes of work. The PMO review had been agreed and resources moved to cover those areas of work. Due to the cash position, there were likely to be additional tightening measures in January 2025.

204/24 Integrated Performance Report as of 31 October 2024

The integrated performance report as of 31 October 2024 provided an overview of key performance indicators.

(a) ***Operational Performance Summary*** – The Urgent and Emergency Care performance against the national 4-hour access standard had shown an improving trend over the summer months however the compliance position saw a deterioration in September and further deterioration in October 2024. Performance was below the improvement trajectory set. Similarly, increases had been seen against the 15-30 min and over 60-

minute ambulance handover standards, boarding on wards and overcrowding within the Emergency Department. Patients not meeting the criteria to reside remained static however, in recent weeks the data in bed days lost had increased and would remain a key focus for the Trust. From a benchmarking perspective the Trust was eight out of twenty in the NW region. Improvement measures were being implemented that included 'Doc at the Door' which had been successfully introduced in the Manchester area. Following the rapid improvement week, the continuous flow model had been tested in medicine and was now being implemented in surgery. Winter plans had been developed to further mitigate the surge demands over the forthcoming months.

From an elective recovery perspective, there was a continued reduction in long waits for elective treatment with further reductions seen in the over 52 week waits and was the seventh month of reduction. The trend of reducing over 65 week RTT waits had deteriorated with 65 month end breaches being reported due to capacity and additional funding shortfalls. Comparison to the latest NW region position indicated that the Trust was currently 11th out of all acute and specialist trusts and 4th out of acute Trusts in terms of the overall number of 65 week waiters with ongoing reductions each week.

The cancer 62 day compliance for October 24 was slightly below trajectory but remained an unvalidated position. Actual performance had improved compared to the previous month. The unvalidated Faster Diagnosis Standard (FDS) performance was 5.4% above trajectory for October.

The diagnostic access standard (DM01) had fallen below the trajectory for October, following a period exceeding the trajectory for 2 months. The Trust remained significantly below the national standard and a review of the last published data indicated that the Trust was the second worst performing NHS Trust in the NW region. The Diagnostic Improvement Group established with ICB partners was driving productivity, demand and transformation opportunities. Key actions to address poor performance related to demand management, access and reducing DNAs, improved waiting list management and detailed capacity and demand analysis with corresponding work force plans being developed. The board noted that improvement in time for diagnosis would lead to other improved metrics for healthcare treatments that would continue to be monitored.

The Board were informed that for the first time in a number of years, the latest data demonstrated that the Trust had delivered an over average target theatre utilisation and the ICB as a whole were there second highest at a national level.

(b) ***Consistently Deliver Excellent Care*** – The adult inpatient areas remained in a positive position with Registered Nurse and Health Care Assistants staff fill rates achieving around 100%. The maternity support worker fill rate had reduced to 85% due to sickness and vacancy. A plan was in place regarding recruitment.

The Star accreditation process had been refreshed to introduce the mandatory standards that mirror areas that were consistently not achieving. This was predicted to initially negatively impact the outcomes within STAR with the aim to leading to an improvement. The HSMR mortality metrics remained stable and were within the expected parameters. Pressure ulcer data now presented lower than the average number of pressure ulcers reported in the last 3 years. CNST was on target to deliver the 10 standards by the end of 2024.

The Trust was focused on delivering the outstanding 7 CQC 'should do' recommendations with a number of actions in place. The areas of focus related to training and appraisal compliance by professional group and CQC core service, medical staff training compliance in urgent and emergency care and medicine, evidence of a timely assessment by a senior decision making in surgery, medical staffing in medicine and documentation specifically in relation to fluid balance and vital signs. A delivery date had been set for each of the outstanding must do's.

(c) ***Great Place to Work*** – The vacancy rate had increased to 6.8% which was recognised as partly due to the vacancy freeze. The overall sickness absence rate remained above 6% throughout Quarter 2 and this was slightly higher than the same period last year. A new system would be implemented in 2025 to assist with effective management around sickness. Mandatory training had achieved 94% compliance and appraisals achieved 90% compliance. Improvements were underway and it had recently been identified that some appraisals had been completed but not submitted. A spike in staff turnover was expected to be reported due to the staff who had transferred to One LSC.

The staff take up rate of 20% for the influenza vaccination was noted as a concern. Actions had been put in place to promote the importance of vaccinations for staff and this had been identified as a national issue.

In relation to the commissioned trauma informed training, it was noted that staff from the Children and Young People Division and the Emergency Department had undertaken the training. Further work together with Red Rose Recovery was hoped to lead to further improvement.

(d) ***Deliver Value for Money*** At month 7 the Trust had a deficit of £15.5m, an adverse position of £8.2m against a planned deficit of £7.3m. The main variances to plan were the £5.4m variance to Financial Recovery Plan Target and £2.6m shortfall on income from urgent and emergency care capacity and investment funding to support frailty and intermediate care. The position for the formal forecast was expected to be close to £30m off plan. The continued operational pressures associated with the revenue deficit were adding to the cash burden in the plan and it was expected that the Trust would require further cash support from DHSC in Q4.

Simon Worthington from NHSE had recently visited the Trust and had made a number of recommendations as part of the I&I interventions to improve processes. An initial change to the approach on temporary pay had led to workshops which had identified new improvement ideas. The Board was advised that the temporary pay measures around overtime were more effective than the vacancy control measures. It was expected that staffing modelled on reconfigured services would be more effective.

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

205/24 Annual Health and Safety Review Report

The report provided an overview of the management of Health and Safety at Lancashire Teaching Hospitals during 2023/2024 in line with legislative requirements as overseen

by the Health and Safety Governance Group. The Safety and Quality committee had reviewed and scrutinised the report.

The Director of Estates and Facilities had recommended authorising engineers and appointed persons who provided independent expert assurance to the Trust. This would be through advice, direction, specialist training, risk assessment and audit, submitting corrective action plans to the estates departments subgroups and capital projects programme. The report demonstrated the number and type of health and safety incidents during the year and highlighted the challenges found in an ageing estate and under financial constraints. The Trust was taking the opportunity to understand how health and safety was organised across the ICS and draw from those strengths to create stronger resilience. Overall, the majority of health and safety incidents had resulted in 97.1% being no or low harm up to September 2024. There had been no incidents reported with a harm level of death however, there had been two incidents of severe harm reported in 2022 and 2023, and 3 reported in 2024. The moving and handling training had been revised in the last 12 months.

A number of audits were in place and a Staffside health and safety lead representative would be reviewing the health and safety improvement plan to ensure it was a co-designed policy. A number of elements of health and safety were tested as part of the Safety Triangulation Accreditation Review (STAR).

Overall, the organisation was in a stable position for health and safety noting the ongoing issues for an ageing estate. Focus would remain on the areas that could be improved and risk assessments would ensure that mitigations were in place where they were appropriate.

Due to the long term sickness of the Health and Safety Governance Manager, the Board asked if there was adequate oversight in place. It was advised that the Trust had 3 members of staff currently undertaking the National Examination Board in Occupational Safety and Health (NEBOSH) course enhancing their Health and Safety knowledge and understanding. The Associate Director of Safety and Learning currently had overall oversight working with support from the Director of Estates.

The Board confirmed assurance of:

1. **the actions being undertaken to mitigate Health and Safety risks, despite ongoing challenges.**
2. **the Health and Safety Single Improvement Plan and the development of a Health and Safety Dashboard as key initiatives to enhance governance arrangements across the organisation.**

206/24 Revision to Workforce and ETR Committee Terms of Reference

The report laid out proposals to revise the terms of reference of the Education, Training and Research Committee and the Workforce Committee to allow the respective non-voting Executive Directors who held the portfolio for these areas to sit as full members of the committees.

It was RESOLVED that the revised term of reference to the Workforce and ETR Committees be approved.

207/24 Items for information

The following reports were received and noted for information:

(a) Emergency Preparedness Resilience and Response (EPRR) Core Standards 2024-25. The outcome ratings were queried and it was explained that they had been accepted by the ICB and would continue to be monitored closely. The Board noted that business continuity was an area for improvement that was being tracked.

208/24 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Thursday, 6 February 2025 at 1.00pm in Lecture Room 1, Education Centre 1, Royal Preston Hospital.

Signed: _____

Chair

Date: _____

5. MATTERS ARISING AND ACTION LOG UPDATE

Decision Item | M Thomas | 13:04

REFERENCES

Only PDFs are attached

05.0 - Action log - Board (part I) - 5 Dec 24.pdf

Action log: Board of Directors (part I) – 5 December 2024

Outstanding items

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	198/24	5 Dec 2024	***Board Assurance Framework*** - that the recommendations for the new principal risk approach were agreed in principle with further consideration given to the overarching strategic risks.	Associate Director of Risk & Assurance	6 Feb 2025	**Completed** **Update for 6 Feb 2025** - The principal risks have begun to be reviewed through committee structures. Principle risks will be considered through the lens of delivery of the Corporate Objectives and where there are risks that sit outside of this, these can be escalated to Board as an operational high risk of concern. Each of the principal risks has considered the potential legal and regulatory impact of the risk materialising. Further risks may be developed as the principal risk framework embeds within the Trust.

COMPLETED ACTIONS *(for information)*

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

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | M Thomas | 13:05

REFERENCES

Only PDFs are attached

06.0 - Chairs Report - 30.01.25.pdf

Board of Directors Report

Chair's Report			
Report to:	Board Of Directors – Part 1	**Date:**	06.02.2025
Report of:	Chair	**Prepared by:**	Mike Thomas, Chair
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 January by the Trust Chair.

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Chair's Report

1. Introduction

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

2. **Summary of Board Part II Meeting - 5 December 2024**

The Board convened and confirmed a quorum. The minutes of the previous meetings were approved, and all actions from previous meetings were completed.

NHP Land Acquisition Update: The Board was updated on the site acquisition for the New Hospitals Programme (NHP). Contracts were exchanged for the Brooklands site, with completion on 28 November 2024. The Trust would manage the land, and formal consultation would follow the acquisition of additional land. Security arrangements for the site were also discussed.

One LSC Post Commencement Update: The Board received an update on the One LSC programme, which involved the transfer of colleagues from four trusts into ELHT. The transition was smooth, with ongoing support and communication for staff. A 30-day report would be developed to include business-as-usual information, and financial delivery remained a key focus.

Finance Update: The Board reviewed the Trust's financial performance for Month 7 of 2024/25. The Trust was on forecast, with some issues around non-pay and variable income. The Finance and Performance Committee had explored the Financial Recovery Plan, which was deemed sufficient but required careful execution.

Commissioning Intentions: The Board discussed the Trust's response to Commissioning Intentions for 2025/26.

Outpatient Pharmacy Dispensing Service: The board was updated on the collaborative pharmacy programme with a transfer date extended to 1 February 2025. Due diligence and financial planning were ongoing, with a special board meeting planned for January 2025 to finalise legal documents.

Maternity Serious Untoward Incident Report: The board reviewed maternity serious incident investigations from quarters one and two of 2024-2025. The importance of embedding learning into the service and adhering to standard operating procedures was emphasised.

Items for Information: The board received reports on acute service reconfiguration, staff suspensions, and minutes from various committee meetings.

3. Chair's attendance at meetings

Details below are the meetings attended and activities undertaken during January 2025.

Date	Activity
January 2025	
2nd	Nominations Committee
	Board Agenda Pre-Meet
7th	1:1 – Chief Executive
	Board Workshop
8th	1:1 – ELHT Chair

	PwC and Chair's Meeting
	IAG Meeting
9th	Chair/NEDs Monthly Meeting - UHMB
14th	1:1 – Executive
	Intro Meeting – Chaplaincy Team
	1:1 - Executive
15th	1:1 – Chief Executive
	1:1 – Lead Governor
	1:1 – PCB Managing Director
16th	1:1 – Executive
	1:1 – NHP Lead
	Provider Chairs Meeting
	Provider Collaboration Board Meeting
	Intro Meeting – Non-Executive Directors
21st	1:1 – Executive
	PCB Agenda Setting
	Council of Governors Meeting
	Special Board Part 2
	NHP Assurance Committee
23rd	NHP Meeting
	IAG Pre-Meet
28th	IAG Pre-Meet
	IAG Meeting
	Chorley Site Visit
	EY Intro Meeting

29th	RPH Site Tour – Porting and Support Services
	NHP Regional Call
	1:1 – Executive
30th	1:1 – Executive
	Intro Meeting – MP
	Intro Meeting Psychology Team Lead
	Provider Collaboration Board Meeting
	1:1 – Executive
	1:1 – Lancashire County Council – Public Health Lead
31st	Intro Meeting - MP

4. Financial implications

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

5. Legal implications

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

6. Risks

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

7. Impact on stakeholders

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

8. Recommendations

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

7. CHIEF EXECUTIVE'S REPORT

Information Item | S Nicholls | 13:10

REFERENCES

Only PDFs are attached

07.0 - Chief Executive's Report Final (002).pdf

Board of Directors Report

Chief Executive's Report			
Report to:	Board of Directors	**Date:**	6 February 2025
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

New Hospitals Programme

On 20 January, the Secretary of State for Health and Social Care, Wes Streeting, made a statement on the outcome of the Government's review into the national New Hospital Programme.

The review, which was announced in July 2024, was designed to ensure that the New Hospital Programme could be delivered in a realistic and costed manner.

The review shows an ongoing commitment to delivering two brand-new hospitals on two new sites to replace Royal Preston (RPH) and Royal Lancaster Infirmary (RLI) which will create better outcomes for patients and colleagues across Lancashire and South Cumbria.

However, it was confirmed that the timescales for delivering both hospitals are now delayed. RPH and RLI fall into wave three of the programme with construction work on a replacement RLI expected to start between 2035 and 2038 and construction work on a replacement RPH expected to start between 2037 and 2039.

The local NHS has now collectively made the decision to suspend public and colleague engagement on the proposed sites, with a planned programme of public events and independent market research cancelled until further notice.

We will continue to work closely with all our partners and stakeholders to ensure that the need for new facilities remains high on everybody's agenda so that our communities can continue to access high quality and specialist care in an environment that truly suits their needs.

New hospitals are, of course, just part of the picture for health services. The NHS in Lancashire and South Cumbria will continue to deliver improvements in health and care across the region, including how we work together with hospitals, community and primary care, and local authorities to reconfigure our services so that they deliver the best possible outcomes for our population.

Given the news, we have begun to review, at pace, our comprehensive estate strategy against a new timeline under no illusion that significant additional capital funding will be needed at the existing RPH site to ensure patient services and health outcomes are not impacted by the delay. We must also ensure our colleagues' working environment does not further deteriorate given the age and poor condition of the estate.

We also want to be very clear on our ongoing commitment to Chorley and South Ribble Hospital. This has benefited from a number of investments in recent years including the Birth Centre, Lancashire Eye Centre, additional theatre capacity, and GIRFT accredited surgical and paediatric hubs and we continue to seek appropriate investment there.

Financial pressures

Nationally, the NHS, along with much of the public sector, remain under huge financial pressure. As one of the systems in the most financial debt, and the only one with a deteriorating position, we need to appreciate that this has a significant impact on the overall NHS financial position.

Our Trust, along with the wider Lancashire and South Cumbria system, are under intense scrutiny to ensure we are doing what is needed to get our finances back on track. Whilst a huge amount of work has gone on this year, we are simply not seeing the scale of change needed quickly enough.

We are therefore working very closely with NHS England and the Integrated Care Board to put in place a series of measures to ensure that we do all that we can to reach the end of the financial year in a better position and have more effective and realistic plans for 2025/26.

The Executive team have been working closely with Divisional teams to put measures in place to ensure the delivery of a series actions during the last quarter of the year, including a focus on reducing variable pay and our overall run rate.

Achieving the levels of financial savings required will involve some difficult decisions and will need to be balanced carefully with our quality and safety agenda, however we are fully committed to getting our finances back on track.

We have and will continue to be clear with our staff, staff side colleagues and wider stakeholders about the implications of this in terms of headcount reductions and the cessation of unfunded services. Consultation will take place where appropriate.

Operational pressures

Throughout the winter period both Royal Preston and Chorley and South Ribble hospitals experienced significant operational pressures due to increased respiratory and gastro-intestinal cases in the Emergency Departments, adverse weather affecting staff availability, and high levels of sickness absence.

The NHS confirmed that 2024 was the busiest year ever for A&E and ambulance services in England. A&Es saw 2.35 million attendances in December, bringing the total number of attendances in 2024 to 27.42 million – the busiest year for A&Es ever recorded and 7.1% higher than in 2023 (25.61 million).

Within this context it is vital that staff feel empowered to raise concerns, particularly regarding patient safety, and efforts are ongoing to raise public awareness of hospital pressures via regular media briefings and social media updates, among other methods. Staff have also been encouraged to access wellbeing support if required.

We'd like to acknowledge the hard work and dedication of all staff over the winter period and thank them for all that they do for patients, their families and one another.

Ward capacity

It is normal operational practice for hospitals to flex ward capacity to account for seasonal demand and in line with both patient need and available funding. For example, last year this applied to Avondale, Fell View and Ward 5 at Royal Preston Hospital and, as you would expect, we generally have more ward capacity open during December, January and February than at other times.

At the end of January, we began a discussion with colleagues at Chorley's Cuerden Ward about deployment opportunities as we will be closing this 24-bed general medical ward by the beginning of March. The cost of staffing the ward was originally covered from covid funding, however this is no longer available.

This has resulted in some inaccurate social media coverage, and we would like to be clear that all colleagues on the ward will receive offers of suitable alternative employment in other areas with staffing gaps and where care is most needed.

At any one time we have at least two wards worth of patients within our hospitals whose needs would be better met within a different care setting or would benefit from same day emergency care or technological solutions such as virtual wards. Many of these patients end up on a general medical ward so we are working with our community partners to strengthen these alternatives.

In addition, due to pressures at Preston, all GP and urgent care referrals had been going into Chorley, and many of these patients had been admitted to the medical wards there including Cuerden Ward. However, Preston patients are now being referred through the new Acute Medical Unit at Preston which will reduce demand at Chorley. Chorley residents are still being directed to Chorley & South Ribble Hospital for their care.

New Chair takes up position

I'm delighted to now be working with Professor Mike Thomas, for whom this is his first board meeting since taking up the position as new Chair of our Trust Board on New Year's Day.

Mike is also the Chair of the Lancashire and South Cumbria Provider Collaborative Board.

Mike brings with him a wealth of experience. Prior to entering academia, Mike served in the Royal Navy, working for five years in HM Submarines before employment in the engineering sector and then qualifying as a mental health nurse and later a psychological therapist. He remains research active and a practising clinical psychotherapist. For many years he carried out clinical research to enhance mental health support for individuals who experience severe and enduring eating disorders whilst, simultaneously, over the last fifteen years he has been working with research colleagues across the UK investigating issues that impact on compassionate leadership in both the public and private sectors.

As Chair of the University Hospital of Morecambe Bay Mike was also instrumental in steering them through their financial and quality challenges, so is well placed to helping the Trust achieve the step change needed in our financial recovery journey.

Thank you – Peter White and Gary Doherty

I would like to put on record my thanks to our former Chair, Peter White and Director of Strategy, Gary Doherty - both of whom left the Trust at the end of 2024.

Peter Joined Lancashire Teaching Hospitals in August 2023 alongside his role as Chair of North West Ambulance Service (NWAS) and I very much valued Peter's knowledge and support throughout my first 12 months in the role.

Meanwhile, Gary Doherty, our former Director of Strategy, left the organisation in December to take up the role of Managing Director of the Provider Collaborative in Greater Manchester. Gary had been with the Trust since 2020, initially in an interim capacity and he was then successful in securing the permanent role of Director of Strategy and leading on several system work programmes such as Elective Recovery and Digital Conversion as well as being the lead Executive for the New Hospitals Programme.

Gary's departure was the second Board level role that we, as an executive team, gave up in 2024 having not – replaced the Director of IM&T, Stephen Dobson, when joining One LSC. Like the rest of the organisation, we continue to play our part in developing different ways of working and opportunities for cost and head count reduction when they arise.

Following Gary's move, Ailsa Brotherton, who has been leading much of the work on our new Single Improvement plan, has picked up the strategy portfolio alongside her existing Continuous Improvement work. Ailsa has also become the lead Executive for the NHP while some of the system work will now be picked up within the Lancashire and South Cumbria Provider Collaborative.

Community Diagnostic Centre officially opened

The Preston Healthport Community Diagnostic Centre (CDC) in Fulwood officially opened earlier this month. The centre will deliver thousands of extra lifesaving tests, checks and scans in the heart of the community, ensuring that patients across Lancashire and South Cumbria can get quicker diagnoses, care and treatment.

The CDC is the result of joint working between the Trust, NHS England and NHS Property Services. The facility in Fulwood was previously occupied by Lancashire and South Cumbria NHS Foundation Trust, who have relocated their services to enable the development of the new Preston Healthport CDC.

NHS England provided vital investment to develop, extend and refurbish the facility, enabling it to be converted to a CDC. This investment has enabled the existing facility to be extended and includes the purchase of new, state-of-the-art diagnostic imaging equipment.

Preston Healthport CDC is part of the Government's national investment programme, which aims to create more appointments and improve access to diagnostic tests to help people get the treatment they need more quickly, reduce the amount of time patients have to wait for diagnostic appointments and follow-on treatment, and move some diagnostic testing out of hospitals into the community, helping to protect planned care from the impact of seasonal and other service pressures.

The CDC is open 7 days a week, 8am–8pm and will provide an additional 105,000 tests per year.

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.

- **Professor Munavvar appointed as Head of Assembly for the European Respiratory Society**

Congratulations to Professor Mohammed Munavvar, Respiratory Consultant and Interventional Pulmonologist, who has been appointed as Head of Assembly 14 (Clinical techniques, Imaging and Endoscopy), by the European Respiratory Society members group.

The European Respiratory Society (ERS) is the largest scientific and clinical organisation in respiratory medicine in Europe. Its members are scientists, clinicians, allied healthcare professionals and other experts from around the world.

This appointment reflects Professor Munavvar's expertise in the field of interventional pulmonology and global recognition for his fantastic contribution in this field. It is one of the highly coveted posts in European Respiratory Society.

We would like to extent our sincere congratulations to him on his election as a head of assembly and wish him all the best for future.

- **New Year's Honours**

Congratulations to former Trust colleague Gregg Stevenson, who was appointed MBE for services to rowing in the New Year Honours List.

Gregg lost both his legs in an explosion while serving as a Royal Engineer Commando in Helmand Province, Afghanistan in 2009, and was referred to Lancashire Teaching Hospitals' Specialist Mobility Rehabilitation Centre (SMRC), before going on to work at the centre as Lead Physical Instructor and Mental Health Practitioner.

Having turned his hand to rowing, Gregg won gold in the mixed double sculls at the 2024 Paralympics in Paris with rowing partner Lauren Rowles in only his second season in the sport, at the age of 40.

He still makes regular trips to SMRC for support with his prosthetics - recently returning for the paediatric prosthetic patients' Christmas party at the centre.

Also in the New Year Honours, Trust Consultant Orthopaedic Surgeon Steve Mannion was appointed Companion of the Most Distinguished Order of St Michael and St George (CMG, founded in April 1818). The appointment is a senior but rare honour for distinguished service overseas or for those who render extraordinary or important non-military service to the United Kingdom in a foreign country.

Steve's Feet First Worldwide achievements have been a significant part of the award, having founded the charity in 2004 with the aim of raising money to fund orthopaedic education and training in the less developed world, with a focus on improved club foot treatment in children.

Each year since 2007, Steve and a dedicated team of volunteers give their time and expertise for two weeks to provide surgeries and training in some of the most under-resourced hospitals in northern Malawi. Their most recent mission, in June and July 2024, saw them treat 120 patients and perform 50 surgeries.

- **Trust Medical Photography Team Lead receives prestigious Gold Medal award**

Congratulations to Trust Medical Photography Team Lead, Lucy Tinniswood, who was the recipient of the Institute of Medical Illustrators' most prestigious award, the Norman K. Harrison Gold Medal at the Institute's recent annual awards at the Radisson Blu Hotel in Castle Donington.

Lucy was awarded the medal by Institute chair Cat Lamoon, Senior Clinical Photographer with the Trust's Blended Learning team, who also won the award in 2015.

The Norman K. Harrison Gold Medal is presented annually at the discretion of the Chair to a member considered to have made an outstanding contribution to the Institute or profession.

Chris Harpley from Medical Photography also won a bronze award for his work on the night, while there was a gold, two silver and four bronze awards for Cat Lamoon, Kelly Cassidy, Deidre Justusson and Xinlin Chen from Blended Learning.

- **Trust consultant advocates for comprehensive action on Lung Health**

Sharada Gudur, a Respiratory Medicine Consultant at Lancashire Teaching Hospitals and a respiratory champion for Lancashire and South Cumbria Integrated Care Board, recently joined representatives from Asthma and Lung UK at the Houses of Parliament to urge the Government to prioritise lung health in its NHS 10-year plan.

Respiratory diseases are the third leading cause of death in the UK, yet they remain under-prioritised by policymakers, with dire consequences for individuals and the healthcare system.

"A Mission for Lung Health," a comprehensive report by Asthma and Lung UK, outlines strategic recommendations for addressing the UK's respiratory health crisis. The report's goals include reducing health inequalities, enhancing NHS productivity, and easing winter pressures on hospitals. By tackling air pollution, supporting smoking cessation, and improving housing conditions, the initiative aims to shift the NHS's focus from treatment to prevention.

Key statistics reveal the severity of the problem - respiratory diseases are the third leading cause of death in England and a major driver of winter hospital admissions, while the UK's lung disease death rate is the highest in Europe.

As a respiratory champion, Dr. Gudur will play a pivotal role in a year-long pilot project by Asthma and Lung UK aimed at improving asthma and COPD care across Lancashire and South Cumbria Integrated Care Boards (ICB) along with five other respiratory champions from other ICBs in England. She is collaborating with local healthcare teams to enhance diagnostics and community care.

- **Trust participates in first-of-its-kind clinical trial of breakthrough antimicrobial technology**

Following a first-of-its-kind clinical trial conducted at Lancashire Teaching Hospitals, Primel announced use of its Active Hand Shield technology will improve patient safety, address the current challenges of hand hygiene compliance by healthcare workers, and reduce the cost and burden of healthcare-associated infections.

The trial of Primel Active Hand Shield (PAHS) at Royal Preston Hospital demonstrated an average of 91% higher antimicrobial efficacy after one hour, compared to the current standard of care hand sanitiser at 15 minutes. This is the world's first-hand hygiene product that has both a broad spectrum of antimicrobial activity and long lasting (residual) efficacy.

The trial results demonstrated that the application of PAHS provides users with superior protection against a broad spectrum of pathogens, including some of the most drug-resistant microbes, on immediate application and over a continuous period, as well as showing less transfer of pathogens to surfaces, compared to a traditional hand sanitiser.

After immediate application, Primel Active Hand Shield was 98% effective, and after one hour still 92% effective, therefore maintaining protection on hands better than a standard alcohol-based hand sanitiser, which dropped its efficacy considerably from 97% to 68%, respectively in 15 minutes.

In addition, Primel Active Hand Shield proved it was on average 76% more effective than traditional hand sanitisers in reducing the transmission of microbes from contaminated hands to a surface.

Dr David Orr, Director of Infection Prevention and Control with the Trust, said: “The results from this trial have been very encouraging, and the feedback from our staff was very positive.”

- **New support group launched for the ‘1 in 10’ in Lancashire with endometriosis**

The Trust has collaborated with Endometriosis UK on a new volunteer-led support group - the only platform of its type currently available nationwide - to help those with suspected or diagnosed endometriosis.

The Endometriosis UK Lancashire Support Group will offer peer-to-peer support, and a chance to share stories, information and advice, both online and at in-person meet-ups and events, while an endometriosis specialist nurse from the Trust will initially join in-person meetings, before offering support as required, including in online group meetings.

The first event took place in late November at Charters Restaurant in Royal Preston Hospital, chaired by Jasmine Watson from Endometriosis UK, in collaboration with Lancashire Teaching Hospitals NHS Trust, with Emma Fleet, Clinical Nurse Specialist in Gynaecology and Endometriosis and Alison McCrudden, Patient Experience and Involvement Lead for LTHTR

The forum was well attended, with patients and members sharing their experiences and stories and advising what a support group would mean to them while dealing with their condition.

- **UK’s first-of-its-kind radiotherapy machine improving patient outcomes in Lancashire**

State-of-the-art radiation therapy equipment at Rosemere Cancer Centre has been reducing treatment times for patients since being installed last summer.

The centre upgraded one of its radiation therapy machines, taking receipt of the UK’s first Elekta Harmony linear accelerator (also known as a Linac).

Radiotherapy is given to treat cancer and reduce the risk of it coming back in the future, and to control cancer symptoms. It works by directing X-rays at the tumour, however, normal cells within or near to the treated area will also be affected, but they are usually able to recover.

Early data shows that time patients spend in the machine has reduced by 17.6 per cent over other Linacs at the hospital, which means the oncology department can dedicate more time to individualised patient care, in turn improving outcomes.

- **Trust Consultant named as new president of Intensive Care Society**

Professor Shondipon Laha, Critical Care Consultant with Lancashire Teaching Hospitals, was named the new president of the Intensive Care Society (ICS) at the beginning of December at the society’s annual members’ meeting, beginning a two-year term.

Professor Laha feels his appointment also showcases some outstanding work done at the Trust and in the intensive care department, and how both have heavily supported multiprofessional working and diversity.

He becomes the second individual of Asian origin to hold the prestigious position.

- **Trust celebrates significant milestone for growing Functional Neurological Disorder (FND) service**

The Trust have hit a significant milestone with our growing Functional Neurological Disorder (FND) service, with the addition of a new Patient and Public Involvement Partner (PPI) who was successfully treated following his diagnosis.

Following his full recovery, Matthew Newsham, from Morecambe, has taken on the role of PPI partner, which involves current, former or potential patients participating in research and engagement for a specific service at the Trust.

FND, previously known as conversion disorder, is one of the most common but little-known Neurological conditions, with around 200,000 people suffering in the UK, and Matthew, having had a difficult five years with the condition, helped raise awareness by presenting the Trust's EPSRC-funded research at the inaugural National Rehabilitation Centre (NRC) Rehabilitation Technologies conference in Nottingham.

Dr Abhijit Das, Consultant Neurologist and Clinical Lead of the Functional Neurological Disorder Service, has built up the FND service since joining LTHTr in 2022 and has helped Matthew to a stage where he is in remission.

1. RECOMMENDATIONS

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

8. BOARD ASSURANCE FRAMEWORK

Decision Item | S Regan | 13:20

REFERENCES

Only PDFs are attached

08.0 - Board Assurance Framework Risk Paper - Feb 2025 - Final.pdf

Board of Directors Report

Board Assurance Framework (BAF) Risk Report

Report to:	Board of Directors	**Date:**	6th February 2025
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 England and the Care Quality Commission (CQC) requires 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 the Trust's objectives.

This paper provides the Board of Directors with an update on the historic strategic risks that may compromise the achievement of the Trust's high level strategic objectives prior to December 2024, along with updates on the principal risks under the new Board Assurance Framework from December 2024.

Historic Strategic and New Principal Risks

A copy of the Trust's new BAF can be found in Appendix 1, whilst Appendix 2 provides the ongoing action plans against the historic Strategic Risks. Due to scheduling of committees, the Principal risks that are detailed in Appendix 1 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. Updates since the last Board of Directors meeting:

- The current score for Principal Risk 4 (Timely access to planned and cancer care) has reduced from 20 to 16 in January 2025. This is because there has been sustained improvements in elective and cancer performance leading to the reduction in likelihood score from 5 (Almost Certain) to 4 (Likely), however recognising the risk still remains a high risk.
- Following the government announcement of the delay in the New Hospitals Programme (NHP) for Royal Preston Hospital, on 20 January 2025, the NHP Assurance Committee met as planned on 21 January 2025 and discussed Principal Risk 14 related to 'Readiness for the New Hospital Programme'. It was agreed that this risk has reduced and could be considered reasonably controlled. The delayed timescales means there is limited risk to the delivery of the Corporate Objective 'to develop and deliver our plans for the New Hospital Programme'. It is therefore recommended that the Board of Directors approve Principal Risk 14 (Readiness for the New Hospital Programme) to be controlled at this time. The risk has been reviewed and the score is now 4 based on the reduced likelihood of this particular risk materialising. There will be further consideration of the risks and next steps in response to the announcement.

Operational High Risks for Escalation/De-escalation

There are currently no operational high risks escalated to the Board within the BAF this month.

Risk Management Policy

The updated Risk Management Policy was originally planned to be submitted for Chairs approval and presented at Audit Committee and the Board of Directors meeting in February 2025. However, upon review, additional changes are required in relation to the process to monitor cultural risks. As a result, following consultation the revised policy will be submitted to Audit Committee in April 2025 for validation and at the Board of Directors meeting in June 2025 for ratification.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.
ii. Note and approve the updates to the ongoing action plans for the historic Strategic Risks
iii. Approve the recommendation to control Principal Risk 14 related to the New Hospital Programme following the government announcement of the delay in the programme for Royal Preston Hospital.
iv. Note and endorse the approach to the Risk Management Policy being reviewed at the next Audit Committee and Board of Directors' meetings.

Appendix 1 – Board Assurance Framework
Appendix 2 – Ongoing Action Plan against Historic 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 England and the Care Quality Commission (CQC) requires 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 the Trust's objectives.

1.2 This paper provides the Board of Directors with an update on the historic strategic risks that may compromise the achievement of the Trust's high level strategic objectives prior to December 2024, along with updates on the principal risks under the new Board Assurance Framework from December 2024.

2. Current Board Assurance Framework

2.1 The BAF in Appendix 1 identifies the Principal risks that threaten the delivery of the corporate objectives.

2.2 It should be noted due to scheduling of Committees, the Principal risks detailed in Appendix 1 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 The current score for Principal Risk 4 (Timely access to planned and cancer care) has reduced from 20 to 16 in January 2025. There has been sustained improvements in elective and cancer performance leading to the reduction in likelihood score from 5 (Almost Certain) to 4 (Likely), however recognising the risk still remains a high risk.

2.4 Following the government announcement of the delay in the New Hospitals Programme (NHP) for Royal Preston Hospital, on 20 January 2025, the NHP Assurance Committee met as planned on 21 January 2025 and discussed Principal Risk 14 related to 'Readiness for the New Hospital Programme'. It was agreed that this risk has reduced and could be considered reasonably controlled. The delayed timescales means there is limited risk to the delivery of the Corporate Objective 'to develop and deliver our plans for the New Hospital Programme'. It is therefore recommended that the Board of Directors approve Principal Risk 14 (Readiness for the New Hospital Programme) to be controlled at this time. The risk has been reviewed and the score is now 4 based on the reduced likelihood of this particular risk materialising. There will be further consideration of the risks and next steps in response to the announcement.

3. Ongoing Action Plans against Historic Strategic Risks

3.1 Within Appendix 2 there is the detail of the ongoing action plans which are aligned to the historic Strategic Risks, which continue to be monitored through Committees of the Board until such time as they are complete.

4. Operational High Risks for Escalation/De-escalation

4.1 There are currently no operational high risks escalated to the Board within the BAF this month.

5. Risk Management Policy

5.1 The updated Risk Management Policy was originally planned to be submitted for Chairs approval and presented at Audit Committee and the Board of Directors meeting in February 2025. However, upon review, additional changes are required in relation to the process to monitor cultural risks. As a result, following

consultation the revised policy will be submitted to Audit Committee in April 2025 for validation and at the Board of Directors meeting in June 2025 for ratification.

6. Financial implications

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

7. Legal implications

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

8. Risks

8.1 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.

9. Impact on stakeholders

9.1 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.

9.2 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.

10. Recommendations

10.1 It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.
ii. Note and approve the updates to the ongoing action plans for the historic Strategic Risks
iii. Approve the recommendation to control Principal Risk 14 related to the New Hospital Programme following the government announcement of the delay in the programme for Royal Preston Hospital.
iv. Note and endorse the approach to the Risk Management Policy being reviewed at the next Audit Committee and Board of Directors' meetings.

Lancashire Teaching Hospitals
NHS Foundation Trust

Board Assurance Framework

2024/25

Update to Board – February 2025

How the Board Assurance Framework fits in

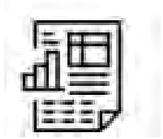
Strategy: Our strategy sets out our ambitious plans between 2025 – 2030 to enhance healthcare delivery, align with the NHS Long Term Plan, and continue our journey towards building a new hospital that meets the evolving needs of our communities that we serve both locally and across Lancashire and South Cumbria. Our new strategic framework is founded on our vision and values and organised around five strategic objectives – our '5 P's': Patients, Performance, People, Productivity and Partnership.

Corporate objectives: Each year the Board of Directors agrees corporate objectives which set out in more detail what we plan to achieve over a 12-month period. The corporate objectives are designed to focus on delivery of the priorities during the year, which will support the overall delivery of the objectives identified within the strategy.

Board Assurance Framework: The Board Assurance Framework (BAF) provides a mechanism for the Board of Directors to monitor the effect of uncertainty on the delivery of the agreed objectives by the Executive Team. The BAF contains principal risks which are the risks considered most likely to materialise and those which are likely to have the greatest adverse impact on delivery of the corporate objectives, and therefore could also affect the ability to deliver the overall objectives set out in the strategy.

Seeking assurance: To have effective oversight of the delivery of our corporate objectives, the Board of Directors uses its committee structures to seek assurance on its behalf. Whilst individual corporate objectives will cross a number of our strategic objectives, each is allocated to one specific strategic objective for the purposes of monitoring. Each principal risk is allocated to a monitoring committee who will seek assurance on behalf of, and report back to, the Board of Directors.

Accountability: Each principal risk has an allocated Director who is responsible for leading on delivery. In practice, many of the principal risks will require input from across the Executive Team and from senior leaders as part of the Trust's accountability framework. However, the lead Director is responsible for monitoring and updating the principal risks that make up the Board Assurance Framework, and has overall responsibility for the areas for improvement. Some principal risks may require external actions / improvements and where this is the case, the lead Director will be responsible for leading on behalf of the Trust and developing actions in consultation with external stakeholders.



Reporting: To make the Board Assurance Framework as easy to read as possible, we use visual scales based on a traffic light system to highlight overall assurance. Red indicates items with low assurance, amber shows items with medium assurance and green shows items with high assurance. It is recognised that elements of this document may not support accessibility standards, but this can be re-produced in an accessible form if required. Should this be required, please contact company.secretary@lthtr.nhs.uk.

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

Likelihood ↑						
	5 Almost Certain	5 Moderate	10 Significant	15 High	20 High	25 High
	4 Likely	4 Moderate	8 Significant	12 Significant	16 High	20 High
	3 Possible	3 Low	6 Moderate	9 Significant	12 Significant	15 High
	2 Unlikely	2 Low	4 Moderate	6 Moderate	8 Significant	10 Significant
	1 Rare	1 Low	2 Low	3 Low	4 Moderate	5 Moderate
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
		Consequence →				

DIRECTOR LEADS	
CEO	Chief Executive Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CNO	Chief Nursing Officer
CPO	Chief People Officer
CMO	Chief Medical Officer
DCE	Director of Communications & Engagement
DSP	Director of Strategy and Planning
DIRI	Director of Improvement, Research & Innovation
CIO	Chief Information Officer

Definitions	
5 P's	The 5 P's is an abbreviation to describe the five strategic objectives identified in the Trust strategy – Patients, Performance, People, Productivity and Partnership
Corporate Objectives	The corporate objectives are designed to focus on delivery of the priorities during the year, which will support the overall delivery of the ambitions identified within the strategy. Delivery against the corporate objectives will be monitored
Principal risks	Risks to the delivery of the corporate objectives, which are considered most likely to materialise and those which are likely to have the greatest adverse impact on delivery. There is also therefore the potential to affect the ability to deliver the overall strategic objectives. Principal risks populate the Board Assurance Framework. Potential risks to delivery are monitored through the Single Improvement Plan and the Integrated Performance Report. Principal Risks are approved by the Board and managed through Lead Committees and Directors.
Controls	The measures in place to reduce the likelihood and/or the consequence of the risk to secure a reasonable level of control.
Gaps in Controls	Areas which require action/attention to ensure that appropriate controls are in place to secure a reasonable level of control.
Assurances	A measure/methodology/source which provides confirmation that the control measures put in place are effective and sustainable to secure a reasonable level of control. These can be internal or external sources, depending on the risk and the appropriate level of assurance required.
Gaps in Assurances	Areas where there is limited or no assurance that the control measures put in place are effective and sustainable to secure a reasonable level of control.
Risk Treatment:	Actions required to mitigate the gap(s) in controls or assurance, with timescales and identified owners. Five T's - Terminate, Transfer, Tolerate, Treat, Take the Opportunity.

Our strategic approach at a glance

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

Our purpose
- To provide the best specialist and local health and care services

Strategic priorities
- Advanced Diagnostics
- Anchor Institution
- New Models of Care & Population Health
- Pioneering Specialist Services
- Stronger links with Academic Partners

Lancashire & South Cumbria New Hospitals Programme

Our values

Caring & Compassionate · Building Team Spirit · Recognising Individuality · Seeking to Involve · Taking Personal Responsibility

Strategic framework
- Patients
- People
- Partnership
- Productivity
- Performance

Enabling strategies

Always Safety First • Digital • Estates & Facilities • Finance • Workforce

Strategic Objectives

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

Performance – deliver timely, effective care
Delivering on key workstreams to achieve standards.

People – be a great place to work
Creating an inclusive environment where people can reach their potential.

Productivity – deliver value for money
Delivering on key workstreams to maximise resources.

Partnerships - be fit for the future
Transforming services and making a positive contribution to our local communities.

2024/25 Corporate Objectives

Patients
- Improve outcomes and prevent harm
- Deliver a positive patient experience
- Develop new ways of working across the system that lead to more effective patient interventions and pathways.

Performance
- To minimise the risk of harm to patients through the delivery of our cancer recovery plan
- To minimise the risk of harm to patients through the delivery of our elective recovery plan
- To improve the responsiveness of urgent and emergency care

People
- To enable better access to care by having the right people, in the right place, in the right number at the right time
- To ensure we improve experience at work by actively listening to our people, and turning understanding into positive action
- To be consciously inclusive in everything we do.

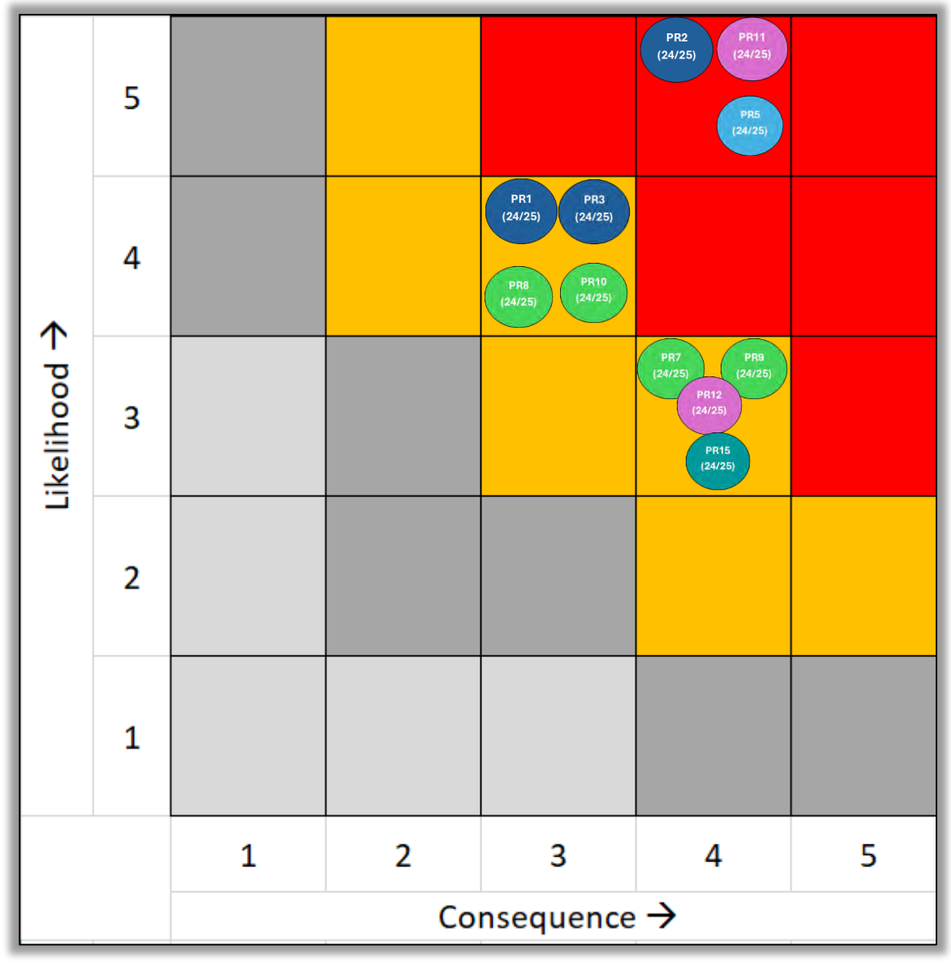
Productivity
- To provide value for money services by spending less, spending well and spending wisely
- To deliver sustained improvement evidenced through the single improvement plan
- Improve our underlying productivity and efficiency

Partnership
- To develop and deliver our plans for the New Hospitals Programme
- To develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable
- To make progress towards our ambition to be a University Teaching Hospital

Principal Risk Management

Our Risk Appetite and Tolerance position is summarised in the table and the heat map shows the distribution of the principal risks based on the current score.

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Current score	Direction of score since last report
PR1 (24/25)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	12	→
PR2 (24/25)	Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection	CNO	Patients	SQC	Cautious	1-6	20	→
PR3 (24/25)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6	12	→
PR4 (24/25)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1-6	16	↓
PR5 (24/25)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6	20	→
PR6 (24/25)	Reliance on temporary medical workforce	CMO	People	WFC	Open	4-8	16	→
PR7 (24/25)	Experience of under-represented staff groups	CPO	People	WFC	Open	4-8	12	→
PR8 (24/25)	Sub-optimal experience of Resident Doctors	CPO	People	ETR	Open	4-8	12	→
PR9 (24/25)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8	12	→
PR10 (24/25)	Compliance with Core Skills Training & Appraisals	CPO	People	ETR	Open	4-8	12	→
PR11 (24/25)	Failure to meet the financial plan 2024/25	CFO	Productivity	FPC	Open	8-12	20	→
PR12 (24/25)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Open	8-12	12	→
PR13 (24/25)	Ability to access required Capital	CFO	Productivity	FPC	Open	8-12	16	→
PR14 (24/25)	Readiness for the New Hospital Programme	CFO	Partnership	NHP	Seek	8-12	4	↓
PR15 (24/25)	Research capacity and capability to enable progress towards University Hospital status	DIRI & CMO	Partnership	ETR	Seek	8-12	12	→
PR16 (24/25)	Implementing the long term strategy for the Trust	DIRI & CMO	Partnership	FPC	Seek	8-12	12	→



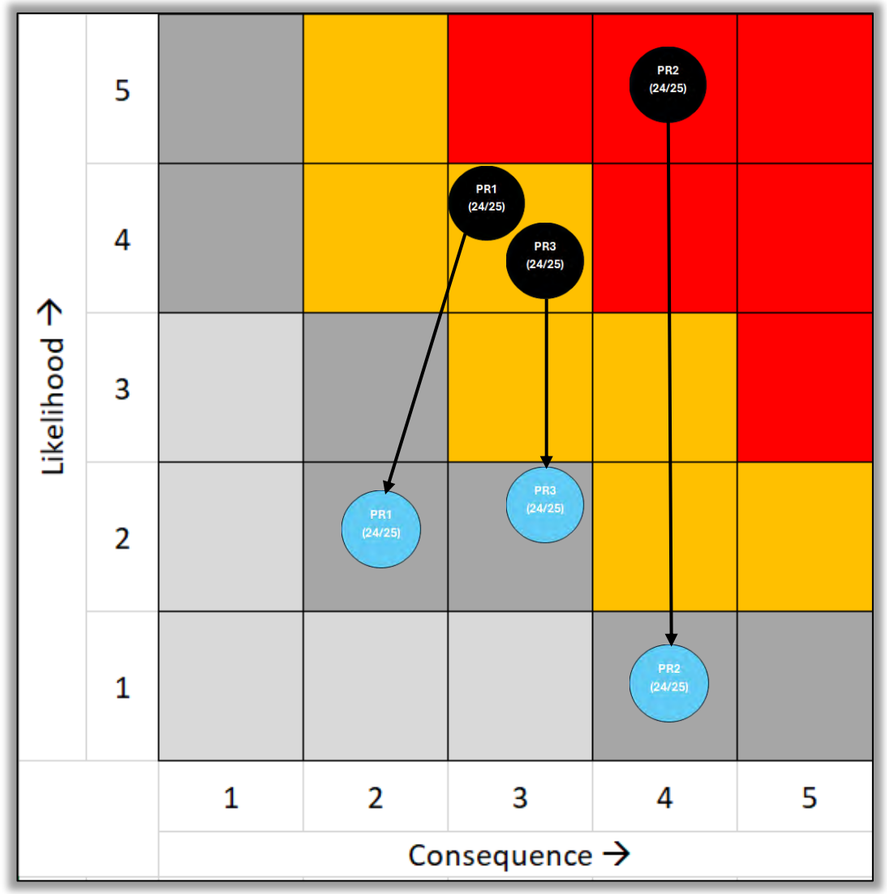
Key- Dark Blue = Patients, Light Blue = Performance, Green = People, Pink = Productivity, Turquoise - Partnership

Patients: Deliver excellent care

Monitored through Safety & Quality Committee

The following 2024/25 corporate objectives are aligned to the **Patients** strategic objective:

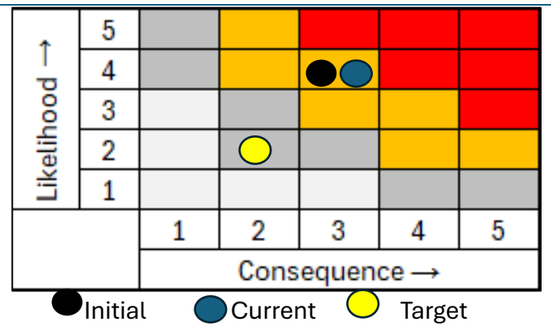
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO1	Improve outcomes and prevent harm	• Review and improve the UEC pathway medical model. • Improvement in average time to see a clinician in ED • Progress in peer review compliance for specialist services. • Develop approach to medical staffing assurance. • Deliver medicines safety and optimisation programme • Lead delivery of CQC action plan • Implement PSIRF & demonstrate maturity in the approach to learning. • Conclude year 3 of the ASF strategy, develop the new ASF and learning strategy, • Deliver agreed C.difficile profile • Deliver 10 CNST safety actions • Deliver annual safe staffing requirements	Risk identified
CO2	Deliver a positive patient experience	• Improve the experience of inpatients, maintain position in ED, cancer and maternity	Risk identified
CO3	To develop new ways of working across the system that lead to more effective patient interventions and pathways.	To deliver more services to patients outside of hospital: • Lead the approach to community transformation • Develop & deliver the community transformation plan • Change model of care at Finney House • Establish new ways of working with primary care to promote partnership approach to transformation • Clinically lead the transformation of patient pathways	Risk identified



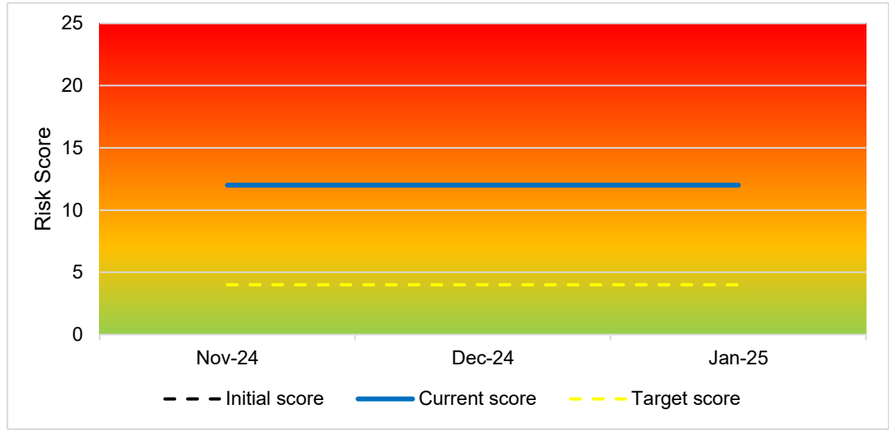
Heat map key: Black = current score, Blue = target score

Strategic Objective: Patients	**Corporate Objective:** Deliver a positive patient experience	Overall Assurance Level	Medium

Principal risk 1 (24/25) (ID 2102)	Risk Title:	Patient experience within the urgent and emergency care pathway		
	Risk Description:	There is a risk that patient experience within the urgent and emergency care pathway may be negatively impacted due to high service demand, long waiting times and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	10/01/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

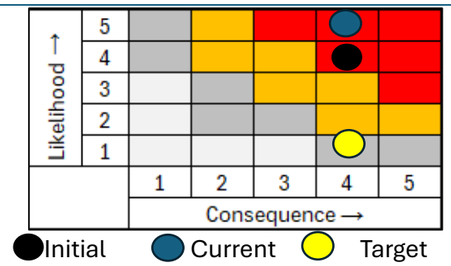
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Patient experience and Involvement Strategy. • Patient Experience & Involvement Group. • Single Improvement Plan related to patient experience. • National OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). • Urgent & Emergency Care Delivery Board. • Urgent & Emergency Care Picker Survey Action Plan. • Discharge Improvement Plan.	• Community demand for primary and UEC services. • Alternatives to Emergency Care. • Ageing estate and environment. • Sub-optimal escalation areas. • Being cared for in areas that are waiting areas / not traditional bed spaces. • Financial constraints. • Unpredictability of patient acuity. • Gap in the required number of beds. • Patients cared for outside of designated bed spaces.	• Friends & Family Test – some areas of positive assurance. • Complaints and concerns – approx. less than 1% versus attendances. • Patient Experience & Involvement Group reports to Safety & Quality Committee • STAR patient experience has some areas of positive performance. • Urgent and Emergency Care Picker Survey reported to Safety & Quality Committee. • ED dashboard provides monthly overview of safety, quality and performance metrics in ED. • Improved position at CDH in relation to time to triage, average time to see a clinician.	• Friends and Family Test – gaps related to communication, waiting times and overall experience. • Urgent and Emergency Care Picker Survey identified areas for improvement. • Time to see a clinician at RPH consistently exceeds the 60 min average target.

Risk Treatment

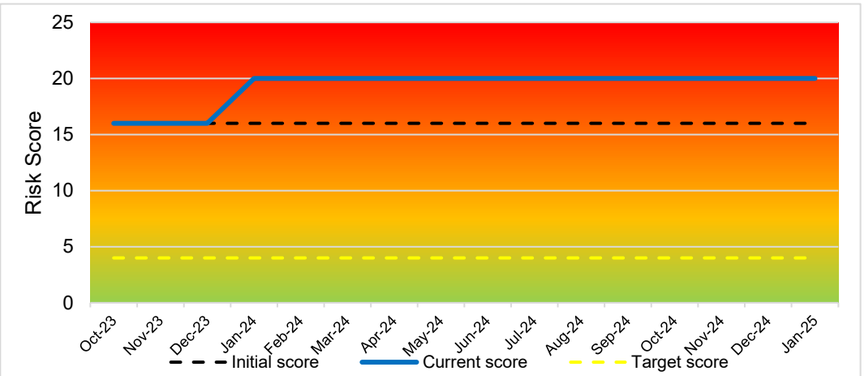
Action	Action Owner	Due Date	Done Date	Action Progress Update
Nurse staffing plan to respond to times of escalation.	S. Cullen	31.10.24	31.10.24	Complete: Presented to Board and agreed approach to escalation of staffing during escalation to maintain safety.
Develop case to minimise risk with requiring agency as a result of turnover of registered nurses in ED	S Cullen	05.01.25	05.01.25	Case to over offer to reduce risk of vacancies leasing to agency completed and agreed
Specialist review of models of care in Emergency and acute medicine requested through NHS England to ensure models in place reflect best practice.	G. Skailes	28.02.25		Dec 2024: ED specialist secured, awaiting acute medical lead to be identified and confirm date of review. Jan 2025: Yet to have confirmed what support will be received
Delivery of Urgent & Emergency Care Picker Survey Action Plan	A. Booth	~~31.01.25~~ 30.03.25		Jan 2025: Monthly meetings continue to ensure all actions being progressed; most actions complete but continue to be monitored. Due date extended.
Review the medical staffing rota requirements for next phase of Consultant and middle grade recruitment.	G. Skailes	31.03.25		Recruitment to key Consultant and middle grade colleagues in progress. Obtained support for optimising the medical rotas in emergency and acute medicine. Plans are being finalised (but not yet signed off)

Strategic Objective: Patients	**Corporate Objective:** Improve outcomes and prevent harm	Overall Assurance Level	Medium

Principal risk 2 (24/25) (ID 1157)	Risk Title:	Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection		
	Risk Description:	There is a risk that there will be higher than trajectory rates of patients contracting C.*difficile* infection. The reasons for this are multifactorial and present a risk of increased mortality and morbidity, longer length of stay, poor patient experience, regulatory action, and reputational impact.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	09/06/21	Date of last review	13/01/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

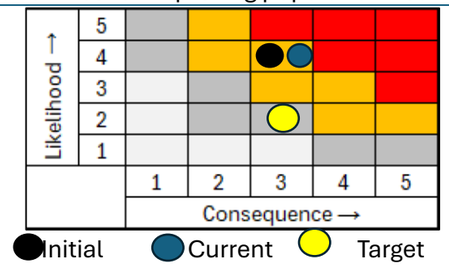
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Annual IPC Plan in place approved by IPCC and Trust Board. • IPC Policy in line with national guidance. • Director for IPC and Matron for IPC in place. • Mandatory annual IPC e-learning core skills for all staff. • Antimicrobial pharmacist in post to drive improvements in antimicrobial usage and stewardship. • National cleaning standards in place on 15 wards, with remaining wards completing IPC audits and ward daily cleaning check lists. • Enhanced cleaning/fogging in place as required. • Sporicidal cleaning product (capable of killing C. difficile spores) is in place for general ward environmental cleaning • Ward whiteboard provides visibility of patients who present an infection risk to prompt timely action. • Isolation Room Dashboard ensures visibility of infection status in single rooms, ensuring rooms are used correctly and efficiently. • A rapid gastrointestinal test is available for exclusion of infection in diarrhoeal patients to aid rapid diagnosis. • Operational IPC meetings across Divisions.	• Patient non-concordance with medical advice. • High prevalence nationally and community onset cases identified upon attendance at the hospital which creates an increased risk to others. • Non-adherence to antimicrobial guidelines in some cases. • Some staff demonstrate non-compliance with IPC advice and policy. • Isolation facilities insufficient to meet IPC needs across all infections. • Ageing estate impacting upon IPC controls. • Lack of funding to support improvements to ageing estate. • A high number of blockages in the single stack sewage system leading to backflow of infectious waste into clinical areas. • A high frequency of macerator blockages and down-time leading to higher risk disposal methods of infectious waste • Lack of decant facilities to allow for thorough environmental decontamination. • Insufficient space for appropriate separation and storage of clean and dirty items on clinical areas • Lack of funding for the implementation of the domestic services elements of the National Cleaning Standards 2021 beyond the 15 high risk areas where this has been implemented.	• Monthly IPC committee includes internal stakeholders and system partners from the ICB, UKHSA and LCC. • IPC BAF report reviewed and shared at IPCC for assurance. • IPC Dashboard triangulating process measures with outcome data. • IPC monthly revalidation audits including hand hygiene, commodes, environmental checks and mattress checks. • Monthly reporting into S&Q Committee, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. • STAR includes IPC audits and cleaning checklist compliance. compliance is mandatory to achieve a silver and above star accreditation. • ICB & NHSE IPC Collaborative meetings. • Fogging compliance data available • Hospital acquired infection are reported on Datix. Themes and trends are monitored to identify learning. • Incident oversight in PSIRF triage meetings and regular MDT reviews under PSIRF for high prevalence wards.	• Inconsistent audits on National Cleaning Standards – only 15 wards compliant. • Trust / NHS England Review of wards that do not have national cleaning standards in place show that this gap could be contributing to an increase in infection rates. • Awaiting final report from NHS England review undertaken at the Trust.

Risk Treatment

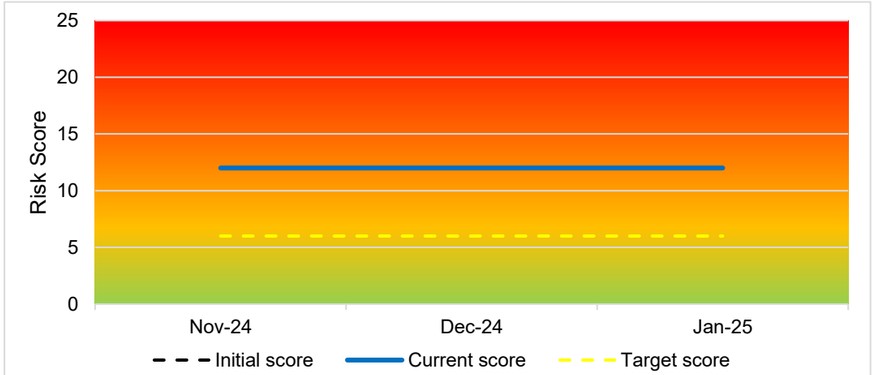
Action	Action Owner	Due Date	Done Date	Action Progress Update
Commence ward rounds to clinically review patients with C.*difficile*	D. Orr / S. Marsh	31.01.25		Jan 2025: First CDI ward round scheduled for 23rd January 2025.
Review the approach to audit for IPC ensuring approach remains efficient and effective.	S Marsh	31.03.25		Jan 2025: Drive for improvement in hand hygiene, glove awareness etc continues and monitoring of compliance continues.
Write a business case to implement the roll out of National Cleaning Standards in all ward areas.	~~S Cullen~~ C Gregory	31.03.25		Business case being written in conjunction with facilities colleagues. This will go through Trust process for approval before being considered as part of budget setting by the Trust Board.

Strategic Objective: Patients	**Corporate Objective:** Develop new ways of working across the system that lead to more effective patient interventions and pathways	Overall Assurance Level	Medium

Principal risk 3 (24/25) (ID 2103)	Risk Title:	People experiencing Health inequalities		
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	20/01/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire & South Cumbria Integrated Care Partnership Health and Wellbeing Strategy. • LTH Health Improvement Plan, developed in conjunction with L&SC system partners. • Health Inequalities Group. • Health Inequalities Patient Tracking List (PTL) Group. • Health literacy group relating to communication with patients. • Specific improvement programmes for adults and children (e.g. High intensity user service, prisoner referral to treatment and ED navigator role in partnership with Lancashire Violence Reduction Network).	• Commissioning arrangements are led by the ICB. • The Trust has no Public Health Consultant. • Anchor institute plan is under review to link to other plans. • Anchor institute group to be established.	• Annual compliance NHS statement on information on Health Inequalities – data does not suggest there are barriers for patients from areas of lower deprivation to accessing elective care services. • Quarterly Report to ICB on Health Inequalities. • Monthly chairs reporting to Safety & Quality Committee • Bi-annual update on Health inequalities to Safety & Quality Committee.	• Annual compliance NHS statement on information on Health Inequalities – challenges around the completeness and accuracy of ethnicity data captured, with around 7% of patient's ethnicity either unknown or not stated for Central Lancashire. • Inability to access primary care data that would allow improved data quality on high risk groups such as patients with a learning disability, serious mental health and/or physical disability.

Risk Treatment

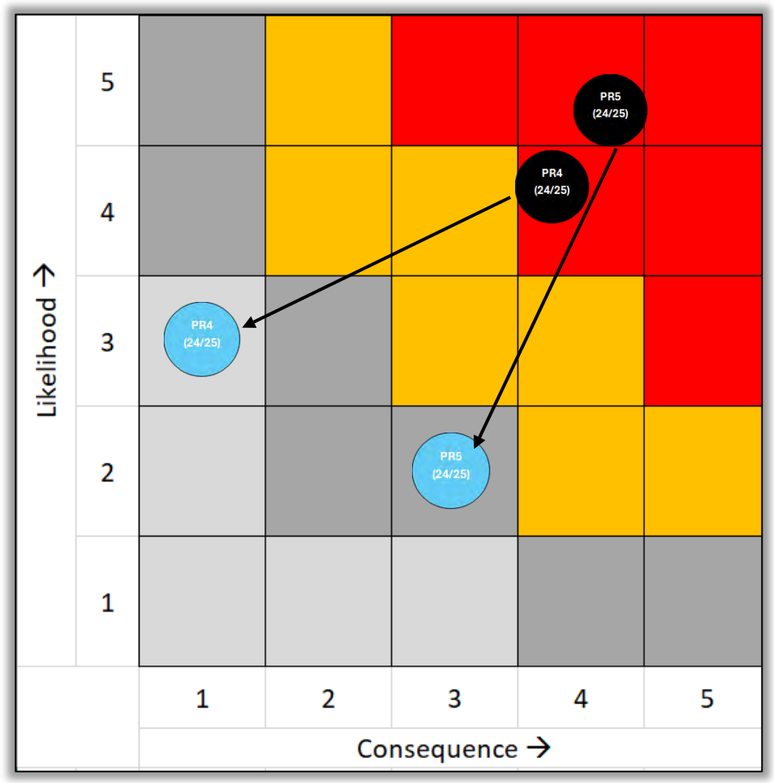
Action	Action Owner	Due Date	Done Date	Action Progress Update
Develop Health Improvement Plan	S. Cullen	30.11.24	30.11.24	Health Improvement Plan finalised. Scheduled for presentation at Board of Directors 06.02.25
Re-commence Anchor Institute Group	N. Pease	31.01.25	21.01.25	Jan 2025: The Anchor Institute Group has been re-instated and meeting dates now scheduled. Action completed
Finalise Anchor Institute Plan	N. Pease	~~28.02.25~~ 31.03.25		Jan 2025: Associate Director of Workforce & OD supporting with the drafting of a new plan, with literature searches requested. All contributors to the plan will be asked to consider their strategic actions for the next 12 months in the short term at the next Anchor Institute meeting. Deadline for the action extended, as the new Trust Strategy will be required to be approved ahead of Anchor Institute Plans being drafted and finalised.
Reviewing options for gap in Public Health Consultant	S. Cullen	31.03.25		
Support case to approve the data sharing agreements between primary and secondary care.	S. Dobson	30.06.25		
Delivery of the Trust's Health Improvement Plan	S. Cullen	31.03.26		

Performance: Deliver timely, effective care

Monitored through Finance & Performance Committee

The following 2024/25 corporate objectives are aligned to the **Performance** strategic objective:

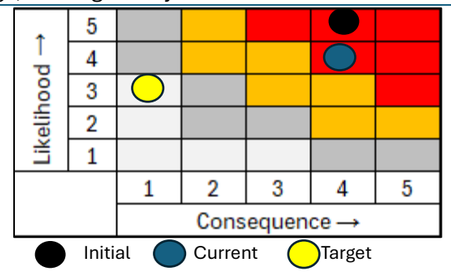
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO4	To minimise the risk of harm to patients through the delivery of our cancer recovery plan	• Delivery of additional elective activity to improve performance against cancer waiting times standards, working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access and working with locality partners to manage demand effectively.	Risk identified
CO5	To minimise the risk of harm to patients through the delivery of our elective recovery plan	• Delivery of additional elective activity to improve performance against elective waiting times standards, working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access and working with locality partners to manage demand effectively.	Risk identified
CO6	To improve the responsiveness of urgent and emergency care	• Working with our partners we will continue to transform urgent and emergency care to deliver safe, high-quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients and reducing length of stay.	Risk identified



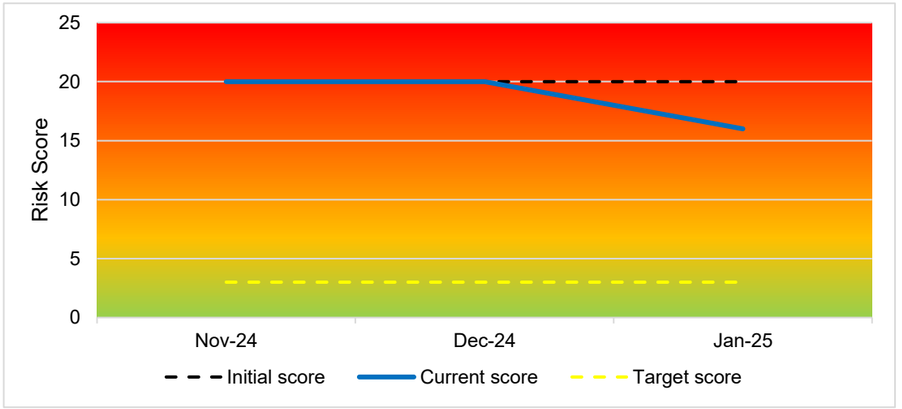
Heat map key: Black = current score, Blue = target score

Strategic Objective: Performance	**Corporate Objective:** Minimise the risk of harm to patients through the delivery of our cancer/elective recovery plan	Overall Assurance Level	Medium

Principal risk 4 (24/25) (ID 1125)	Risk Title:	Timely access to planned and cancer care	
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to planned and cancer care. This is because of backlogs that continue to be seen from the COVID period, surges in demand, shortfalls in capacity, the impact of industrial action, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely access to planned and cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	19/05/21	Date of last review	20/01/25



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

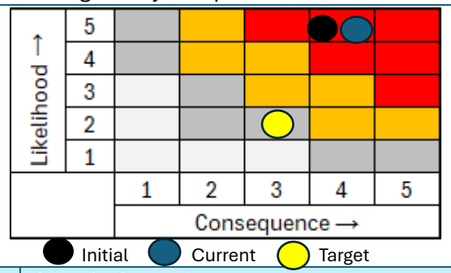
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Elective Restoration Plans seek to deliver the revised long waiting RTT targets. Plans include monthly trajectories and associated action plans. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority (P2 – P6) of those patients to support scheduling the most clinically urgent. • ChatBot to support validation of the waiting list and digital letters to support the process. The frequency of validation is monitored via Divisional and organisational performance forums. • Weekly monitoring of cancer patient tracking lists (PTLs) to reduce any delays with tumour specific action plans in place. • A report for P2 patients waiting over 5 weeks is in place for Divisions to plan their elective capacity. • Non-recurrent funding acquired for Winter plans to support and offer resilience for Medicine flow/capacity and thus elective surgery capacity is ringfenced and protected in times of winter/non-elective pressure. • 6-4-2 protocols in place to drive optimal use of theatre capacity. • Forecasting of potential breaches for Divisions to proactively focus on patients for review and listing, focusing on month-end 65 week risks as part of the performance recovery group. • Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented • Mutual aid process in place with the ICB. • Sherwood Endoscopy Unit opened and additional SGU Theatre in use.	• Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes • Inability to fully validate waiting lists regularly. • Lack of standardised SOPs for validation. • Shortfalls in funding to support the required capacity to deliver the elective restoration plan • Inability to eliminate extended waits for patients. • National medical employment & terms and conditions, restricting staff working additional hours. • Restricted admin capacity to backfill short notice procedure cancellations.	• Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Live PTL performance report and Validation reports. • Harm reviews process in place for >65 week and cancer pathway patients. • Benchmarking data analysis – model hospital, GIRFT, etc. • Performance monitoring for Cancer waiting times is delivered via the Tier 1 performance framework and meetings are held fortnightly. • DMO1 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Delays in concluding some harm reviews • Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. • Inability to assess the risk for patients on surveillance pathways.

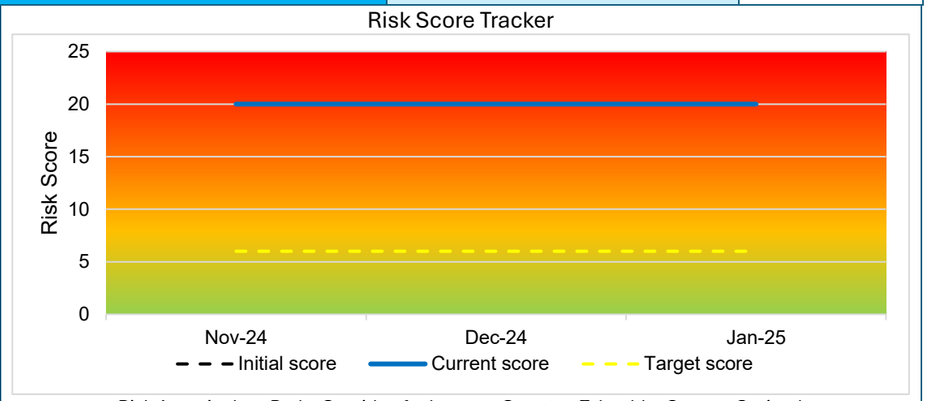
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Strengthen the data quality of opera reporting.	D Hudson	~~31.12.24~~ 28.02.25		Jan 2025 - Part of the DQ assurance work identified that when generating a pended visit via Opera, the visit was being generated on the incorrect site, necessitating a transfer from one site to the other post admission. This requires a technical fix by Harris Flex but unable to confirm a go live date so action extended whilst awaiting confirmation.
Agree process and timetable for Model Service reviews to triangulate capacity and demand (C&D), benchmarking data and job planning	~~K Foster-Greenwood~~ A Brotherton	~~31.12.24~~ 28.02.25		Jan 2025: As part of the ICB wide Financial recovery intervention, all L&SC providers will commence a Service review programme - pending finalisation of this, a revised mobilisation plan will be agreed. Director of Continuous Improvement is the lead for Model Service programme, action ownership re-aligned and due date extended
Phase 1 (Top 10 specialties) capacity mitigation plans including benchmarking analysis	K Foster-Greenwood	28.02.25		
Undertake demand management plans for top 10 specialties in relation to patient initiated follow up and advice and guidance.	K Foster-Greenwood	~~31.01.25~~ 31.03.25	20.01.25	Jan 2025: C&D modelling has been completed for 75% of the LTHTR specialties and thus action noted to be completed by Chief Operating Officer.
Did Not Attend management plan to be scoped and agreed for top 10 specialties	K Foster- Greenwood	~~31.01.25~~ 31.03.25		Dec 2024: External organisation commissioned to support LTH (and L&SC trusts) - work commencing Jan 25, therefore due date extended
Complete capacity and demand modelling for top 10 specialties	K Foster-Greenwood	~~28.02.25~~ 31.03.25	20.01.25	Jan 2025: Action is a duplication. C&D modelling has been completed for 75% of the LTHTR specialties and thus action noted to be completed by Chief Operating Officer.

Strategic Objective: Performance	**Corporate Objective:** Improve the responsiveness of urgent and emergency care	Overall Assurance Level	Low

Principal risk 5 (24/25) (ID 2104)	Risk Title:	Timely access to urgent and emergency care		
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust's reputation and regulatory compliance.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Operating Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	20/01/25	





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Clinical triage process • OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). • Winter plan. • Ambulatory and admission avoidance pathways. • Same Day Emergency Care facilities. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan. • Discharge Improvement Plan. • Bed meetings and associated action cards • Clinical discharge team management of all patients with no criteria to reside. • Community Healthcare Hub provides a facility for discharge to create capacity in the hospital. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections for social care access to prevent avoidable attendances and admissions.	• Insufficient flow within the hospital bed base to prevent ED overcrowding. • Out of hospital provision is insufficient to meet the demand. • The community healthcare hub medium to long term funding model is yet to be agreed. • The winter plan has identified an unmitigated bed gap. • The environment and estate is sub-optimal.	• Urgent & Emergency Care Board provides monthly monitoring of all improvement actions across the system. • LTH UEC Improvement Board meets monthly and tracks all actions and outcome delivery. • Emergency Department Dashboard to Safety & Quality Committee • Finance and Performance Committee. • ED Safety Surveillance dashboard monitors live metrics to assess risks of patient harm.	• High bed occupancy levels (above 92%). • Ambulance turnaround times are not meeting the Trust targets. • Time to triage and first senior review are not meeting Trust targets. • Performance for the 4 hour wait times and 12 hour total wait time in the department, are not meeting the Trust targets.

Risk Treatment

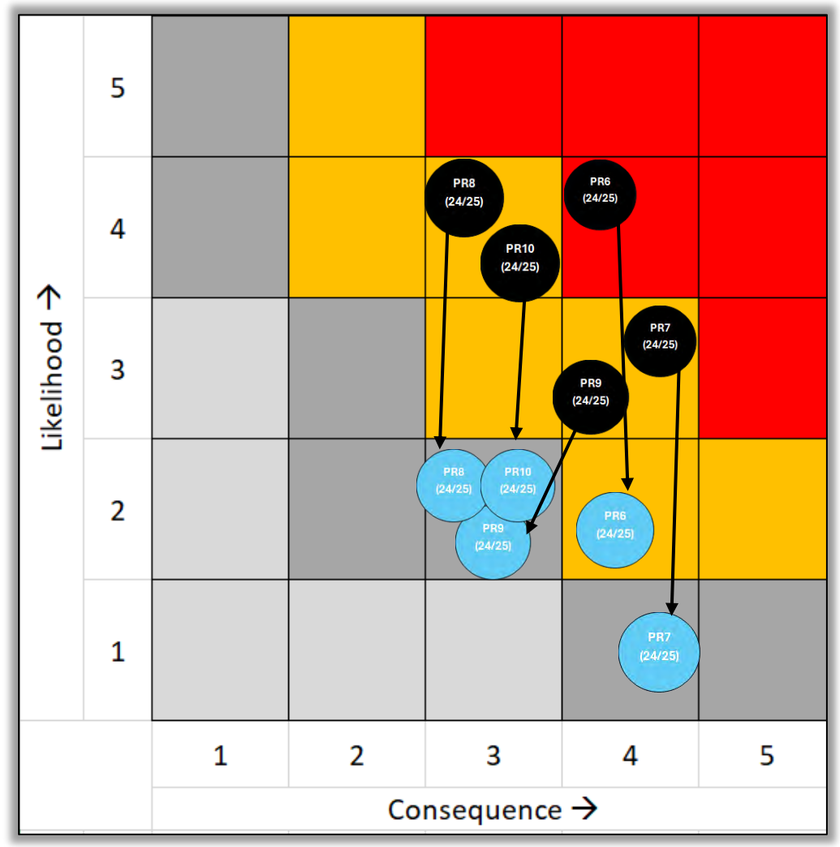
Action	Action Owner	Due Date	Done Date	Action Progress Update
Agree revised escalation protocols and action cards and implement.	K. Foster Greenwood	31.12.24	11.12.24	All escalation cards updated and tested within RPIW in Dec 24.
Agree Ward and Board round standards and pilot.	S. Cullen	31.12.24	11.12.24	Ward and board round standards drafted. Elements being tested within RIPW Dec 24.
Develop a breach allocation by Division methodology and agree improvement plans.	K Foster Greenwood	31.12.24	31.12.24	Jan 2025: This is completed and live in DIFs from January 2025.
Mobilise Winter Plans.	K. Foster Greenwood	01.01.25	01.01.25	Jan 2025: All winter schemes mobilised – some gaps where staffing shortfalls occur. Action can be closed. Plans to analyse 24/25 winter plan effectiveness by June 2025. New action identified.
Finalise funding approach to Finney House.	S. Cullen	31.01.25		Options paper has been shared with ICB – awaiting feedback.
Scope and trial the Dr@Door process.	K Challen	~~31.12.24~~ 14.02.25		Jan 2025: Visit to North Manchester General Hospital completed in Dec 2024, with information and SOPs regarding their Dr@Door processes obtained to trial implementation at LTHTR. Plan for a new test of change being compiled prior to implementation of the trial. Due date extended to allow for trial.
Completion of planned expansion of the surgical assessment unit (SAU).	K. Foster-Greenwood	31.03.25		
Expand the volume of Same Day Emergency Care (SDEC) activity.	G Skailes	31.03.25		Increases in SDEC pathways have been tested in Nov and early Dec – evidence of increases can be seen in data packs. Further clinical pathways are under development. NHSE clinical support being scoped with target commencement of Jan 25.
Implement a Continuous Flow Model.	S. Cullen	31.03.25		CFM mobilised in pilot phase on Ward 23 and AMU Nov 24. Plans to pilot on Ward 18 Dec 24.
Roll out testing of revised Board and Ward round standards	S Cullen	31.03.25		
Review and analyse 24/25 winter plan effectiveness in preparation for 25/26 plan development	K Foster-Greenwood	30.06.25		

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

The following 2024/25 corporate objectives are aligned to the **People** strategic objective:

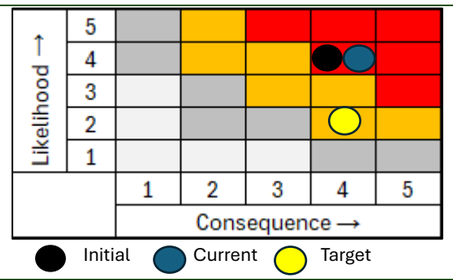
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO7	To enable better access to care by having the right people, in the right place, in the right number at the right time	• To deliver a workforce plan that meets the needs of the community	Risks identified
CO8	To ensure we improve colleagues wellbeing and experience at work by actively listening to our people, and turning understanding into positive action	• To ensure staff choose to stay and work in Lancashire Teaching Hospitals and they are healthy and happy at work	Risks identified
CO9	To be consciously inclusive in everything we do	• To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care	Risks identified



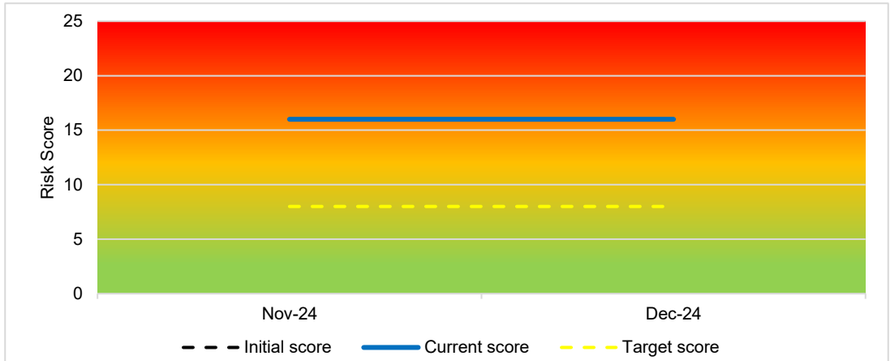
Heat map key: Black = current score, Blue = target score

Strategic Objective: People	**Corporate Objective:** To enable better access to care by having the right people, in the right place, in the right number at the right time	Overall Assurance Level	Medium

Principal risk 6 (24/25) (ID 2105)	Risk Title:	Reliance on temporary medical workforce	
	Risk Description:	There is a risk that there may be insufficient numbers of medical staff across the Trust. This is due to increasing capacity and demand, and an inability to recruit to vacancies in some specialities. This could result in a reliance on temporary medical staff, lack of continuity of care, patients not receiving treatment in a timely way, poor outcomes, patient harm, lack of detailed organisational knowledge of processes, poor patient and staff experience, staff working extra hours and an impact on wellbeing, financial impact of enhanced payment rates, regulatory enforcement, legal action and reputational impact.	
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	18/12/2024



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Medical and Dental Job Planning Policy. • Job plans in place for Consultants and Speciality Doctors. Agreed annually as a prospective plan. • Processes for changes in job plans where this occurs in-year. • Healthroster system used to manage rotas. • Medical bank in place. • On-call system in place outside of normal working hours (built into job plans). • Non-medical roles for certain specialities to reduce the need for medical input (i.e. Advanced Nurse Practitioners, Consultant AHP roles, physician associates). • Enhanced grip and control measures for the use of temporary medical and agency staff.	• Inconsistent capacity and demand modelling across specialities. • Healthroster not fully aligned to job plans and when job plans are changed. • Operational capacity and technical ability to monitor 42-week productivity against job plans. • Vacancies in hard to recruit specialities can cause long gaps. • Understanding of speciality-by-speciality minimum safe staffing levels. • Sufficient resource to deliver transformational medical staffing projects.	• Annual Job plan report to Workforce Committee. • Monthly processes in place to review opportunities based on pay activity. • Monitoring of patients seen by a clinician within 14 hours of admission. • Monitoring of patients seen by a clinician following initial assessment.	• Inability to articulate the required medical staffing model. • Inability to report on safe staffing levels in relation to medical staffing in response to CQC must do. • Delays in patients accessing senior medical reviews consistently in all specialties. • Absence of robust 42-week monitoring of activity between Healthroster and L2P job plan software. • Requirement to strengthen consistency between ledger and vacancies.

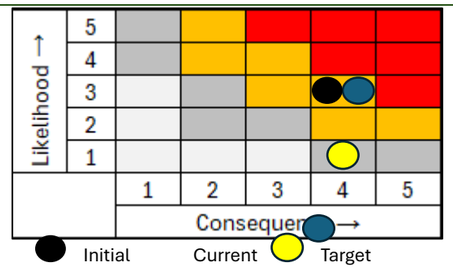
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
To determine priorities and number of service reviews that will be completed in the Model Service Programme for 25/26	K. Foster-Greenwood	31.03.25		
Agree an approach to determining minimum safe staffing levels	G. Skailes	31.03.25		
Implement actions following ICB Job Plan Programme	G. Skailes	31.03.25		
Review Job Plan Internal Audit outcome when finalised	G. Skailes	31.01.25		Audit report in draft and being reviewed
Development of 42-week productivity tool	G. Skailes	30.04.25 ~~31.01.25~~		Discussions are ongoing to look at how this can be delivered within the systems currently used and action date extended.

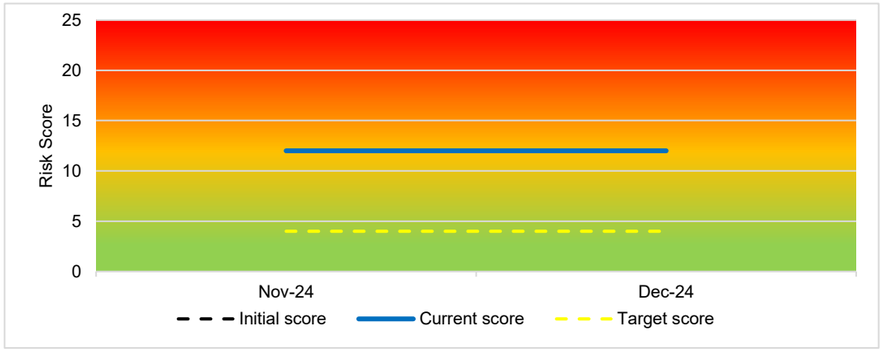
Strategic Objective: People	**Corporate Objective:** To be consciously inclusive in everything we do	Overall Assurance Level	Medium

Principal risk 7 (24/25) (ID 2110)	Risk Title:	Experience of under-represented staff groups
	Risk Description:	There is a risk that the Trust may not be considered a great place to work for colleagues, or prospective employees from under-represented groups. This could result in negative experience for staff, inability to retain a skilled & valued workforce, staff absence, regulatory intervention, and legal action.

Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	18/12/2024



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

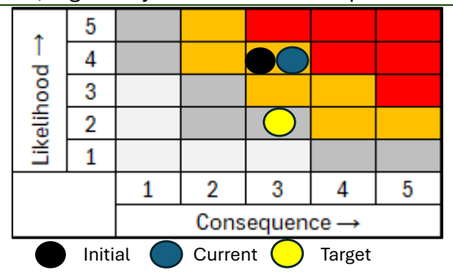
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Equality, Diversity and Inclusion Policy. • Equality, Diversity and Inclusion Strategy. • Single Improvement Plan. • Equality, Diversity and Inclusion mandatory training. • Supporting Disability in the Workplace policy and agreement. • Trans and non-binary policy. • Equality Impact Assessment policy. • NHSE 8 High Impact Actions. • NHS People Promise. • Culture programme, including Zero Tolerance campaigns. • Freedom to Speak Up Policy, Process and Champions. • Employee Relations policies and processes. • Trust Values/Best Version of Us/Leadership in Lancs frameworks. • Core People Management Skills programme. • EDI resources/education/toolkits • Leaders/All Colleague briefings • Staff ambassador forums for colleagues with protected characteristics.	• No equivalent national Workforce Equality Standard for LGBTQ+ colleagues. • ESR Declaration rates for colleagues with a long-term condition or disability. • EQIA process/lack of challenge in respect of EIA findings. • Gaps in localised application of inclusive management practices and in addressing poor behaviours which are not inclusive.	• Equality, Diversity and Inclusion Strategy Group. • L&SC ICS ED&I Group. • Equality, Diversity and Inclusion Strategy monitoring. • Internal Audit review of ED&I in 2023/24 – Substantial Assurance. • Workforce Committee. • Some positive areas identified in the Workforce Race Equality Standards (WRES). • Some positive areas identified in the Workforce Disability Equality Standards (WDES). • North West Anti-Racist Framework. • EDS2022 • North West ED&I Assurance template • Equality Diversity and Inclusion Annual Report	• Areas for improvement identified in the Workforce Race Equality Standards (WRES). • Areas for improvement identified in the Workforce Disability Equality Standards (WDES). • WRES/WDES report only completed on an annual basis • Challenges in ability to drill down into the data from a minority group/divisional basis due to low numbers and confidentiality • Ethnicity Pay Gap/Disability Pay Gap • Ability to take meaningful actions which impact the Gender Pay Gap with Agenda for Change (AfC) • EDS2022 – areas for improvement identified

Risk Treatment

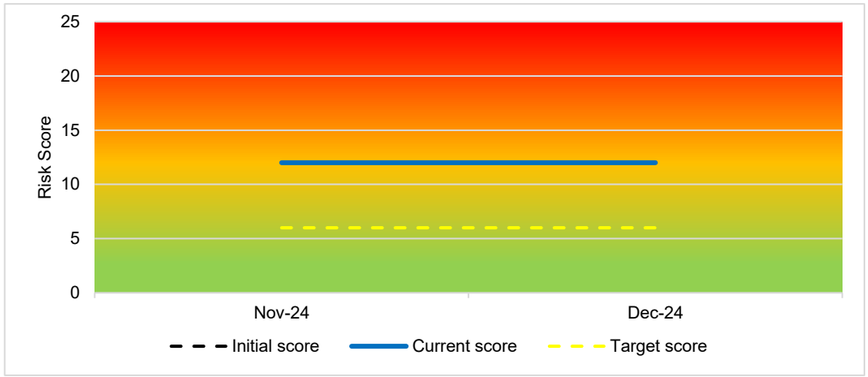
Action	Action Owner	Due Date	Done Date	Action Progress Update
Reducing the % of colleagues who have not declared disability status on ESR (annual measure)	M. Davis / R. Smith	31.03.25		
Increasing the diversity of colleagues in band 8a and above as per WRES/WDES annual report	M. Davis	31.07.25		
Increase level of satisfaction for NHS Staff Survey People Promise element “We are compassionate and inclusive”	M. Davis	31.03.25		
Reducing variation in experience around bullying and harassment for disabled vs non-disabled colleagues	M. Davis / R. Smith	31.03.25		
Reducing variation in experience around discrimination for minority ethnic vs white colleagues	M. Davis / E. Hickman	31.03.25		

Strategic Objective: People	**Corporate Objective:** To ensure we improve colleagues wellbeing and experience at work by actively listening to our people, and turning understanding into positive action	Overall Assurance Level	Medium

Principal risk 8 (24/25)	Risk Title:	Sub-optimal experience of Resident Doctors	
	Risk Description:	There is a risk that resident doctors experience of working at the Trust may not always be positive. This is because of operational pressures and working practices. This could result in poor staff experience, grievances, absence, a reduced level of medical staff, inability to recruit, patient safety incidents, regulatory intervention and reputational damage.	
Committee	Education, Training and Research Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	15/01/25



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

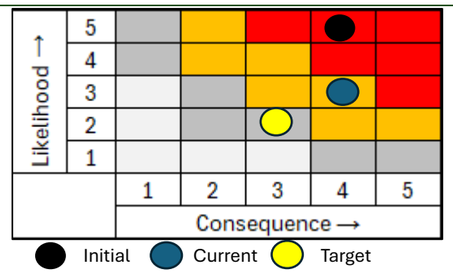
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Resident doctor Single Improvement Plan. • Workforce and OD Strategy. • Education and Training Strategy. • Divisional education contracts. • NHS Education Contract. • Medical Workforce team.	• Lack of national guidance on "Improving the working lives of doctors in training" . • National requirement to take an NHS Staff Survey approach to the GMC National Training Survey. • StatMand training currently under review for all staff groups including resident doctors. • Requirement to work with Lead Employer who holds employment responsibilities for resident doctors. • Time restriction of Lead Medical Education officer to progress the resident doctor agenda. There is a need to identify an accountable officer for responsibility of improving the working lives of doctors	• Education, Training and Research Committee. • Workforce Committee. • Divisional Workforce Committee. • Resident doctor forum. • Exception Reporting. • Raising Concerns. • NHSE Monitoring the Learning Environment quarterly meetings. • GMC National Training Survey (NTS). • National Education and Training Survey. • Annual Internal Placement Experience.	• Gap in triangulation of GMC National Training Survey into Raising Concerns, Exception Reporting and NHS Staff Survey Reporting • GMC National Training Survey 2024 results indicated that Trust performance is marginally below the national average in 14 out of 18 themes. • A number of areas of Post Graduate Medical Education are currently being monitored within the NHSE Intensive Support Framework • Lack of NHS Staff Survey level of analysis and corporate level action plan for GMC national training survey NTS and National Education and Training Survey for resident doctors, with insufficient triangulation of themes and organisational and specialty level.

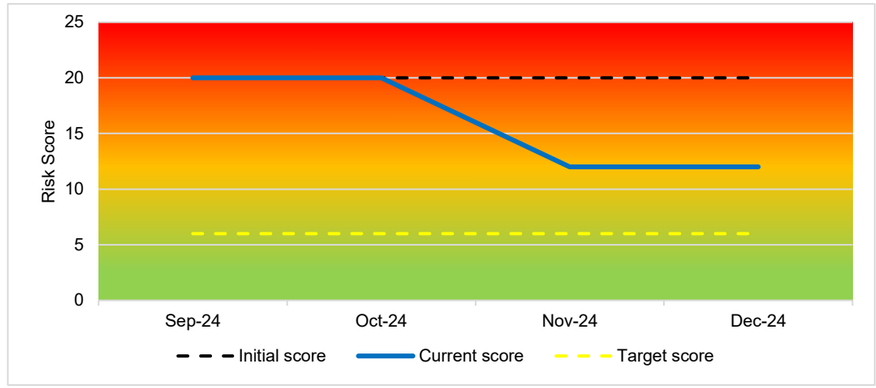
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Review current structures within Education to identify dedicated Medical Education leadership role	L. O'Brien	31.12.24	31.12.24	Jan 2025: Medical Education structures have been reviewed with next steps agreed with Workforce Business Partners. The change is expected to be enacted by the start of the new financial year.
Identify opportunity to develop resident doctor SIP group, including identification of Chair	L. O'Brien	31.12.24	31.12.24	Jan 2025: A new Group (Enhancing The Working Lives of Resident Doctors Group) has been established and the first meeting is scheduled for 24th January 2025. This group is co-chaired by N Pease and G Skailes.
Review educational governance processes to determine where resources relating to the design and delivery of corporate and specialty level interventions sit	L. O'Brien	31.01.25		Jan 2025: The action is on track to meet the given deadline and further update will be provided to ETR Committee in February 2025.
Review Education and Training Strategy	L. O'Brien	31.03.25		

Strategic Objective: People	**Corporate Objective:** To ensure we improve colleagues wellbeing and experience at work by actively listening to our people, and turning understanding into positive action	Overall Assurance Level	Medium

Principal risk 9 (24/25) (ID 499)	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates			
	Risk Description:	There is a risk that failure to effectively manage staff absence due to ineffective systems or processes, or managerial capability will compromise our ability to deliver safe staffing levels and continuity of care. It could also result in increased costs associated with temporary staffing, the Trust being unable to achieve Trust or National targets and could impact on staff morale.			
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8		
Director	Chief People Officer	5Ts status	Treat		
Date risk opened	10/02/14	Date of last review	31/12/24		





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

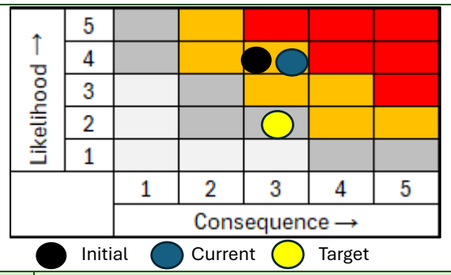
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Sickness Absence Policy in place. • Core People Management Skills training in place. • Monthly reports to Divisions - check & challenge. • Accountability Framework in place which has recently been refreshed. • Toolkits and templates for Managers. • "What Good Looks Like" for Managers. • Live data & reports in Health Roster. • Workforce Advisor Support in place (although at an insufficient level) • Health & Wellbeing Strategy in place. • Workforce & Organisational Development Strategy in place. • Operational processes in place Divisionally to look at staffing levels. • Dashboards in rosters to see safe staffing levels. • Rostering guidance and support in place.	• Gaps in localised management practices. • Lack of one complete absence record affecting ability to demonstrate policy compliance. • Insufficient capacity within the Workforce team to support absence management as proactively as possible. • Lack of localised risk assessments/stress risk assessments/moving & handling risk assessments. • Lack of triangulated data to support prediction/notice of warning signs for sickness absence. • Insufficient capacity within the psychological wellbeing service.	• Workforce Committee. • Divisional Workforce Committees. • Divisional Improvement Forums review absence levels. • Sickness absence reports are produced on a monthly basis which enables trend analysis of absence rates at cost centre level. These are reported through divisional workforce committees. • The Workforce team have undertaken local audits of absence management practice e.g. Return To Work Interview compliance.	• Inability to achieve the 4% target. • Internal audit of sickness absence management practices, (October 2024) provided limited assurance. • Currently a manual process to monitor compliance with absence management policy and processes.

Risk Treatment

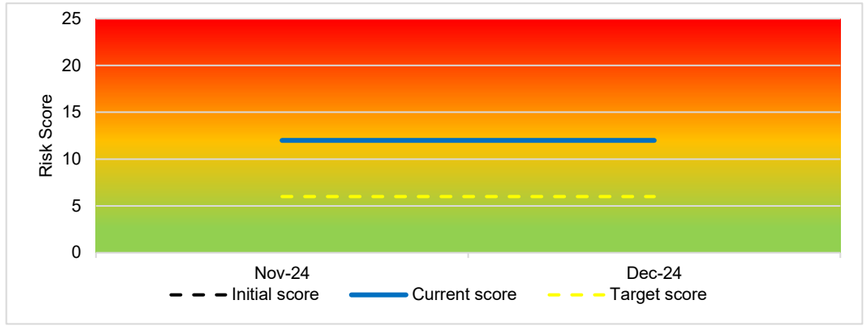
Action	Action Owner	Due Date	Done Date	Action Progress Update
Pilot Empactis as a digital absence management system	R. O'Brien	~~31.12.24~~ 28.02.25		Dec 2024 update: Deployment of Empactis has been delayed in implementing due technical requirements. Due date extended.
Continuous Improvement programme for Workforce Advice Team to support improvement of absence management across the Trust	R. O'Brien	31.12.24	31.12.24 stood down	Dec 2024: Action closed as it is now superseded by the absence reduction plan, with 4 workstreams, uploaded to Datix and overseen by the Sickness Absence Reduction FRP Group
Develop business case for additional psychologist	R. O'Brien	~~31.12.24~~ 31.01.25		Dec 2024: Data analysis to support the business case has been completed. Business case still to be written, due date extended
Review of the Sickness Absence Policy	R. O'Brien	31.01.25		Jan 2025: Updated policy in draft and awaiting JNCC review
Progress and evaluate outreach calling	R O'Brien	31.01.25		
Deliver absence reduction 'plan on a page' against 4 key workstreams	R. O'Brien	30.06.25		

Strategic Objective: People	**Corporate Objective:** To enable better access to care by having the right people, in the right place, in the right number at the right time	Overall Assurance Level	Medium

Principal risk 10 (24/25) (ID 2041)	Risk Title:	Compliance with Core Skills Training & Appraisals		
	Risk Description:	There is a risk that staff may not have received the core skills training required for their role or had an appraisal in the Trust-defined timeframes. This is due to unavailability of staff, time and capacity. This could result in staff not having up to competencies, patient safety incidents, poor patient experience, poor staff experience, regulatory action, claims and complaints.		
Committee	Education, Training & Research Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	15/01/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Core skills training framework (CSTF). • Training needs analysis. • Corporate Induction process. • Local Induction process. • Appraisal Policy. • Appraisal Policy for Medical and Dental colleagues. • Accountability Framework. • Self-service e-learning and appraisal platform. • Regular review of target audiences with Clinical Educators and Divisional leadership. • Training Compliance and Assurance Sub-Committee govern any proposed changes to Core Skills topics. • Monthly emails to staff to show compliance with training and appraisals and any areas that are due to expire. • Weekly reminder to staff who are out of date with Core Skills training. • 'Super red' tool produced to support the divisions in identifying staff who have more than 1 super red topic. • Monthly meetings take place between Training Performance and Compliance and Divisional Nursing Directors to review target audiences and complete approval for sign off of any changes.	• Gaps in localised application of appraisal policy and processes. • Nationally set Core Skills training framework. • National review of Core Skills Training Framework (CSTF), which is reviewing statutory and mandatory training across all Trusts, with a plan to produce a national StatMand framework in 2025. This could increase / change the requirements for delivery of training nationally and the governance processes.	• Training & Appraisal Compliance report - produced monthly and sent to divisional and corporate leaders. • Regular provisions and/or presentation of compliance including Core Skills training report to Divisional Workforce Committees. • Reports to Training, Compliance and Assurance sub-committee. • Training and Appraisal reports to Divisional Improvement Forums. • Bi-monthly Education Training and Research committee reports to escalate gaps and assurances in plans to rectify. • Annual Appraisal Strategic Update report to Workforce Committee. • Integrated Board Performance Report. • NHS Staff Survey Results	• The Trust is currently non-compliant with specific mandatory (core skills training framework) & essential training subjects as reported to ETR Committee. • The Trust are not meeting the target for appraisal rates. • The training reports currently provided do not map directly to CQC core services, or by professional group.

Risk Treatment

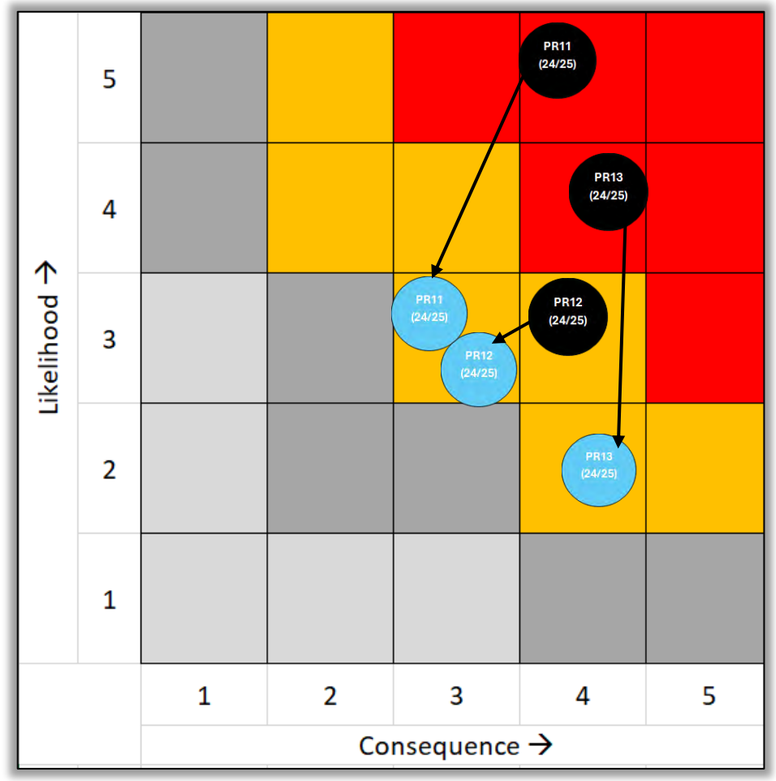
Action	Action Owner	Due Date	Done Date	Action Progress Update
Training & appraisal data being re-aligned to CQC Core Services	L. O'Brien	13.12.24	19.12.24	Dec 2024: This has now been completed
Divisional Mandatory Training compliance action plan for each division	Divisional leads	28.02.25		Jan 2025: Surgery complete and being monitored – other Divisions are awaited.
Detailed reporting to Divisional Improvement Forums for colleagues that have not attended training	L. O'Brien	~~13.12.24~~ 31.01.25		Dec 2024: DNA reports will be provided to DIFs as a regular item from January 2025. Due date extended. Jan 2025: The action is on track to meet the given deadline and further update will be provided to ETR Committee in February 2025.
Review Mandatory Training Policy	L. O'Brien	31.03.25		Jan 2025: There is currently no policy in place, however there is a plan with the national StatMand team to publish a standardised policy for all NHS Trusts which can be localised. There is no date yet confirmed for when this will be published.
Review Appraisal Policy	L. Graham	31.12.24	13.12.24	Dec 2024: Policy has been reviewed and submitted to policy group for feedback
Review Appraisal Policy for Medical & Dental colleagues	J. Anderton / D. Kellet	28.02.25	13.12.24	Dec 2024: Policy has been reviewed and being presented at the Local Negotiating Committee on 13/12/24 for sign off
Reviewing processes including guidance provided on how to complete appraisals, reviewing appraisal forms, monitoring and QA processes and developing intranet information hub.	L. Graham	31.03.25		
Reviewing and updating appraiser training	L. Graham	~~30.01.25~~ 31.03.25		Jan 2025: Content of appraisal training and the practical in-session exercises design is underway, further consultation will be needed as proposing to increase the length of the training to 1 full day. Need to consider how this will be resource and accommodated as will need to be face to face. Following this, training content will be updated and a draft version will be created in order to pilot. Within the plan when the course design is finalised, there is plans to deliver "train the trainer" package to the leadership team. Commencement of training expected to be in March 2025, driven by room bookings, time to communicate to colleague and allow for "train the trainer" to be conducted. Due date extended.

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

The following 2024/25 corporate objectives are aligned to the **Productivity** strategic objective

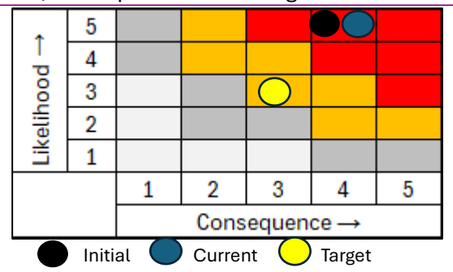
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO10	To provide value for money services by spending less, spending well and spending wisely	• To evidence improved value for money and delivery of the financial recovery programme.	Risks identified
CO11	To deliver sustained improvement evidenced through the single improvement plan	• To deliver against the plan and demonstrate this as improved outcomes for the organisation.	No risks identified
CO12	Improve our underlying productivity and efficiency	• To maximise our productivity through the delivery of our FRP, SIP and other transformation plans.	No risks identified



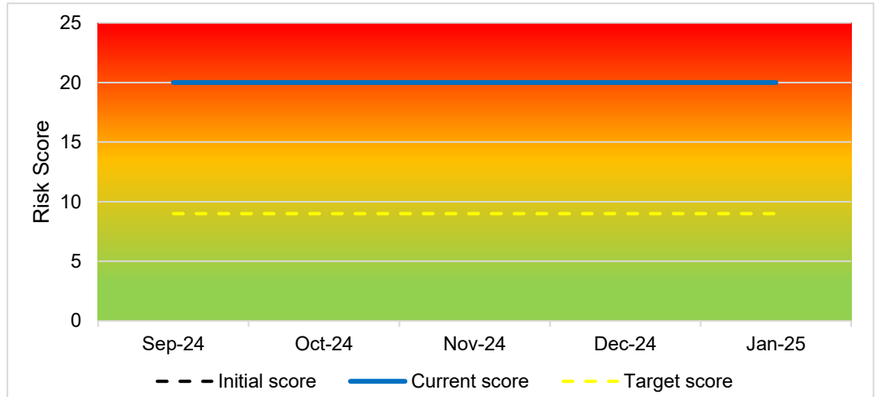
Heat map key: Black = current score, Blue = target score

Strategic Objective: Productivity	**Corporate Objective:** Provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

Principal risk 11 (24/25) (ID 1557)	Risk Title:	Failure to meet the financial plan in 2024/25		
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2024/25. This is because of factors such as under-delivery of planned efficiency savings, inability to reduce some operational costs, rising operational demand, and insufficient external funding for some services. This could result in a significant financial deficit, reduced resources for patient care, challenges in maintaining service delivery, further regulatory intervention, impact on staff experience, and reputational damage.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12	
Director	Chief Finance Officer	5Ts status	Treat	
Date risk opened	03/06/24	Date of last review	20/01/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

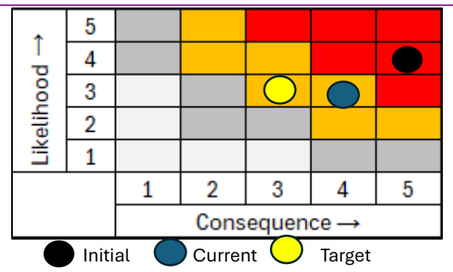
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. • Financial plan triangulated with activity and workforce plans. • The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are in place to support controlling expenditure. • Budgets set at the start of the financial year and agreed with budget holders, risks identified and rated to enable the Board of Directors to approve the budgets. • There are a suite of pay controls for filling vacancies and using agencies. • Processes are in place to ensure financial recovery plan (FRP) schemes that are delivered are transacted through the ledger. • There are a range of grip and control measures in place for managing discretionary expenditure. • There is a no PO no pay system in place for managing non pay expenditure.	• 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. • The savings programme alongside additional control measures is currently failing to deliver the required level of financial improvement. NHSE are supportive of using additional advisory support to maximise delivery in the current financial year and develop plans for 25/26. • Fully embedded PMO to support the divisions to deliver the financial recovery plan. • Operational pressures limiting management capacity.	• Financial plan monitored monthly to; budget holders, DIF, F&P committee, externally through provider finance returns (PFR) monthly returns and system improvement board assurance meetings. • Risks identified monthly to Finance and Performance committee. • Internal Audit - on the integrity of financial systems - through Audit Committee. • External Audit - on the financial accounts - through Audit Committee. • Ledger reconciliations - on the integrity of the financial data. • Variance and trend analysis - on the integrity of the financial data. • Collaborative working in ICS - integrity of financial data.	• The Trust is reporting a forecast year end variance to financial plan driven principally by under delivery of our savings programme. The deterioration of our forecast has resulted in escalated scrutiny from NHSE and the I&I improvement lead. • Development of the transformation agenda is required to support delivery of the FRP. • There is insufficient understanding of the plan to address productivity shortfalls.

Risk Treatment

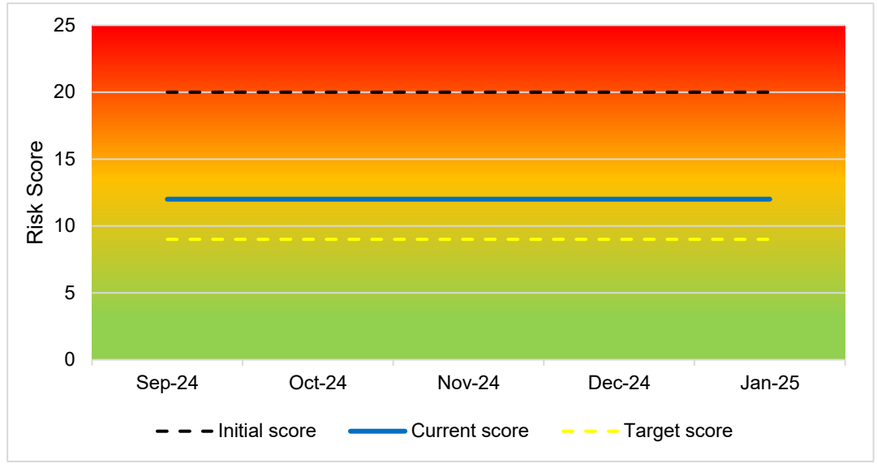
Action	Action Owner	Due Date	Done Date	Action Progress Update
Lancashire & South Cumbria system in enhanced oversight by NHS England with revised monthly reporting framework to the improvement and assurance group (IAG)	D. Stonehouse	22.01.25		New action. Revised finance forecast for the financial year 2024/25 (9+3) to be submitted having received Board of Directors sign off, along with first draft of the Trust's plan for 2025/26.
Finance Governance review to be undertaken	D. Stonehouse / J. Roberts	~~31.01.25~~ 14.02.25		Jan 2025 - Terms of reference agreed through NHSE. Review has been commissioned, the outputs may be provided in early February 2025.
Implementation of grip and control activities from Investigate and Intervene system review	D. Stonehouse / C. McGourty	~~31.01.25~~ 28.02.25		Jan 2025 - Enhanced vacancy firebreak put into place with oversight from CEO. Rapid improvement weeks rolled out to all clinical divisions with further programme to be developed Full response to I&I improvement plan included as part of finance reports with regular updates. External support being provided to enhance capacity. Further controls review to be undertaken by external party as part of the performance review intervention.
Business Case to review/finalise the recurring resources needed for Trust project management office.	A. Brotherton	~~31.01.25~~ 28.02.25		Jan 2025: The PMO Business Case was presented to the Trust Management Board on 8th January 2025. It was not supported in its current format due to the level of investment required. A revised model has been proposed and supported by the CEO which will be shared at the TMB meeting in February 2025. Due date extended.
Review benchmarking and current service line reporting (SLR) analysis to understand how to best inform future savings programme development	D. Stonehouse	28.02.25		Jan 2025: SLR update presented at December Finance and Performance Committee. Currently reviewing how to inform 25/26 budget setting as part of a consistent approach across L&SC.

Strategic Objective: Productivity	**Corporate Objective:** To provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

Principal risk 12 (24/25) (ID 802)	Risk Title:	Cash consequences of the Trust's underlying financial position	
	Risk Description:	There is a risk that the Trust may face cash flow challenges because of its underlying financial position, including recurring deficits, delayed delivery of financial recovery savings, or insufficient income to cover operational costs. This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	06/06/24	Date of last review	20/01/25



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal

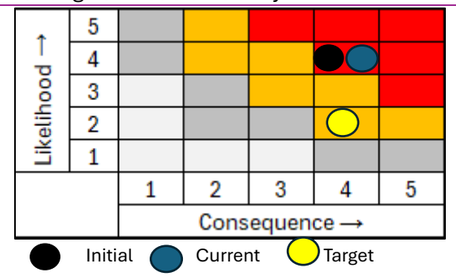
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Cash Management committee in place. • Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital programme and timing of expenditure. • Engaging with affected suppliers. • Internal escalation process for urgent cash issues. • NHSE process for requesting cash support. • Additional NHSE process to draw down emergency cash if necessary. • Regular review of cash position and forecasts. • Financial services team resourced for cash management and forecasts.	• Levels of understanding of the cash consequences of not using the established ordering processes. • Access to cash support is subject to external approval.	• Internal Audit reporting through Audit Committee. • Monthly reporting of position including KPIs to Finance & Performance Committee. • Monitoring and reporting performance against 30-day deadline for payments.	• Forecasting generally highlights potential shortfalls in cash availability. However, some invoices can be delayed in being received. • Drop in performance against 30-day deadline for payments.

Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Timely submissions to NHSE for cash support with Board of Director approval	C. McGourty	31.03.25		Jan-25 Update: Support from the Board of Directors to make a cash request based on a number of risk scenarios was requested and approved at the December Board. Cash support request made to NHS England in January 2025. Awaiting outcome.

Strategic Objective: Productivity	**Corporate Objective:** To provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Medium

Principal risk 13 (24/25) (ID 2106)	Risk Title:	Ability to access required Capital	
	Risk Description:	There is a risk that there may be insufficient internally generated capital to support all priority areas. This is because of valuation decisions which determine capital funding allocations, the Trust's underlying financial position, competing priorities across the healthcare system, and delays in approvals for capital investment projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	20/01/25



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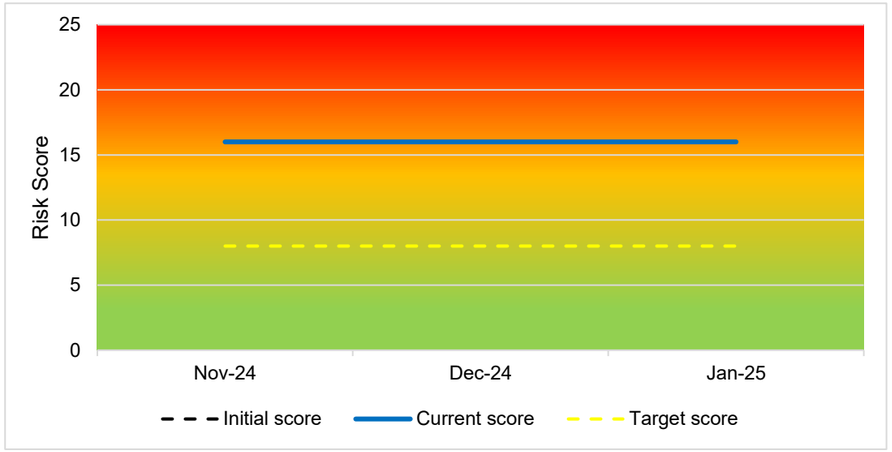


Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Trust planning framework. • Capital Planning Forum review and determine risk-based approach and recommendations. • Capital Plan agreed by Executive Team & Trust Board. • Backlog maintenance programme developed from 6 facet survey outcome, undertaken annually. • Medical Equipment Group with clinical input to support risk assessment and prioritisation. • IT provided with a budget from Capital Planning forum. • Contingency budget identified at the start of the financial year. • Emergency capital funding process for extreme situations. • Identification of national funding 'bid opportunities'. • Standing financial instructions. • Standing Orders. • Scheme of Reservation and Delegation.	• Externally set capital allocation. • External capital bid opportunities have short timeframes and ability to fully cost this is limited by operational capacity. • Impact of inflation in terms of project costs and timescales. • Ageing estate and inability to comply with latest statutory guidance. • Estates Strategy not finalised. • Approach to IT allocations requires review. • Inability to replace medical equipment as required.	• 6 facet survey and independent annual report which details the scope and level of the situation. • Estates Returns Information Collection (ERIC) returns to support benchmarking. • Asset register in place to support oversight of medical equipment. • Medical Device report to Safety & Quality Committee. • Capital update to Finance & Performance Committee.	• Significant backlog maintenance. • Data for ERIC returns is delayed in being released via Model Hospital (2 financial years behind). • Tracking of project overruns and underspend. • Governance around contract change notices. • Contingency budget is at risk of being exhausted at month 8 of the financial year indicating a potential risk should contingency be required.

Risk Treatment

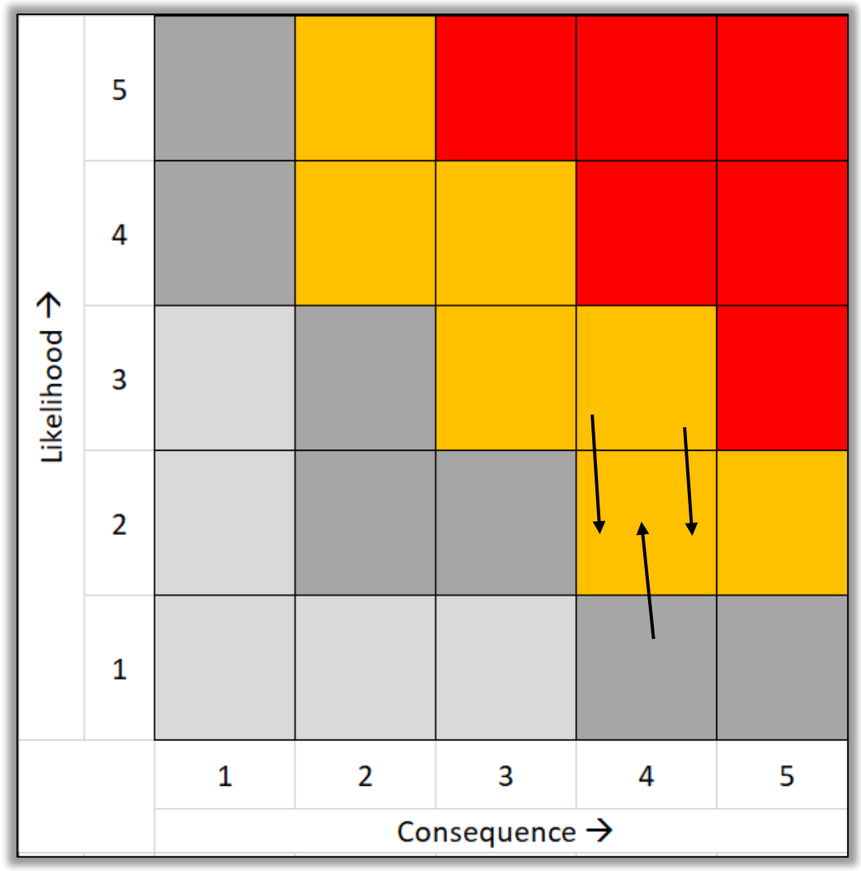
Action	Action Owner	Due Date	Done Date	Action Progress Update
Develop Estates Strategy	C. Howell	28.02.25		
Review and improve governance of contract change notices	B. Patel / C. Howell	31.03.25		
Review approach to management and reporting of project spend at Capital Planning Forum	D. Stonehouse	31.07.25		
Review and propose alternative options for capital funding allocations	B. Patel	31.03.26		Dec-24 update: Capital planning group had a robust conversation to best align available funding for 25/26 to known risks which is supporting a higher level of investment in medical equipment next year.

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

The following 2024/25 corporate objectives are aligned to the **Partnership** strategic objective:

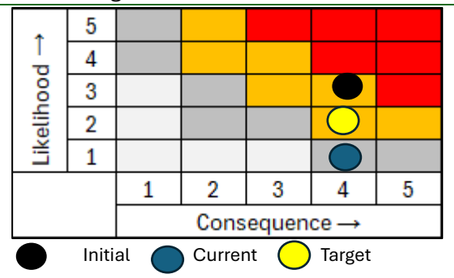
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO13	To develop and deliver our plans for the New Hospitals Programme	• Ensure the successful delivery of our once in a lifetime opportunity to deliver a New Hospital for the residents of Central Lancashire and Lancashire and South Cumbria	No risks identified
CO14	To develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable	• Deliver plans for OneLSC and develop and implement agreed clinical service strategies/plans • As an Anchor Institution, work with partners to improve population health, supporting development of a thriving local economy and reducing health inequalities.	Risk identified
CO15	To make progress towards our ambition to be a University Teaching Hospital	• Work towards achieving University Hospital status	Risk identified

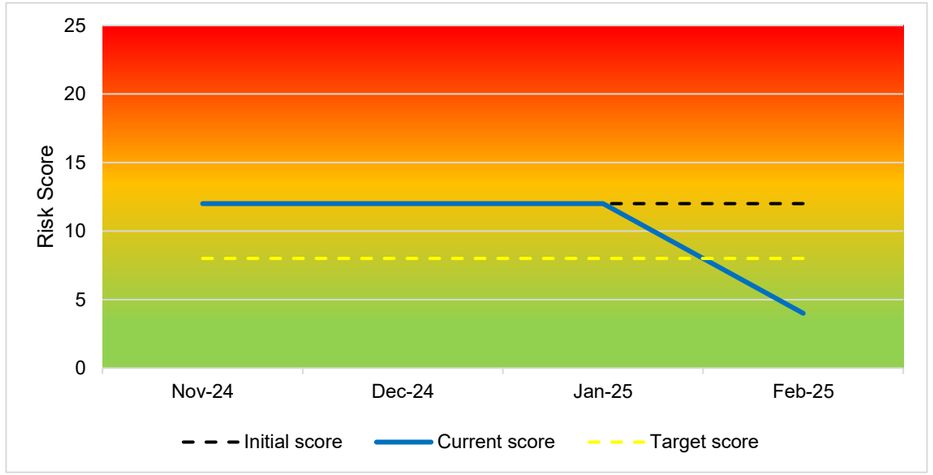


Heat map key: Black = current score, Blue = target score

Strategic Objective: Partnership	**Corporate Objective:** To develop and deliver our plans for the New Hospitals Programme	Overall Assurance Level	Medium

Principal risk 14 (24/25) (ID 2112)	Risk Title:	Readiness for the New Hospital Programme	
	Risk Description:	There is a risk that the New Hospital may be delayed because of a lack of agreement on future clinical strategies across Lancashire & South Cumbria, insufficient delivery of transformation, and the inability to secure an appropriate site. This could result in risks to the deliverability/success of the project and right sizing a new hospital, project timeline delays, increased overall costs, as well as a loss of confidence among stakeholders.	
Committee	New Hospital Programme Committee	Risk Appetite and Tolerance	Seek 9-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	30/01/25





Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

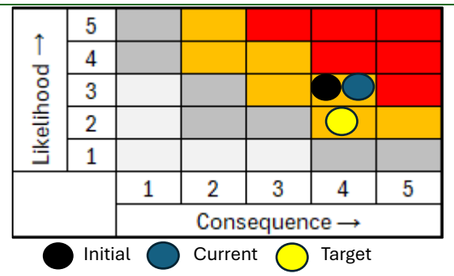
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Framework model of care for the Trust has been developed. • Established links between NHP and transforming community care programme to understand out of hospital provision. • New Hospital LTHTR master plan which identifies dependencies with transforming community care. • L&SC NHP demand and capacity modelling completed (2021). • Monitoring of demand and capacity assumptions against delivery trajectories. • Governance structure in place across the L&SC system to review products, timeline, risks and dependencies.	• Land for the new hospital is yet to be acquired. • Delivery plans for transforming community care are yet to be aligned with NHP demand and capacity assumptions. • National NHP demand and capacity exercise underway and due to conclude in Q4 2024/25 which may impact programme assumptions.	• Framework model of care signed off within Programme Governance. • Trust Board development sessions held on L&SC NHP baseline demand and capacity assumptions.	• Output of the national demand and capacity exercise is ongoing and will require review to understand the impact/actions required.

Risk Treatment

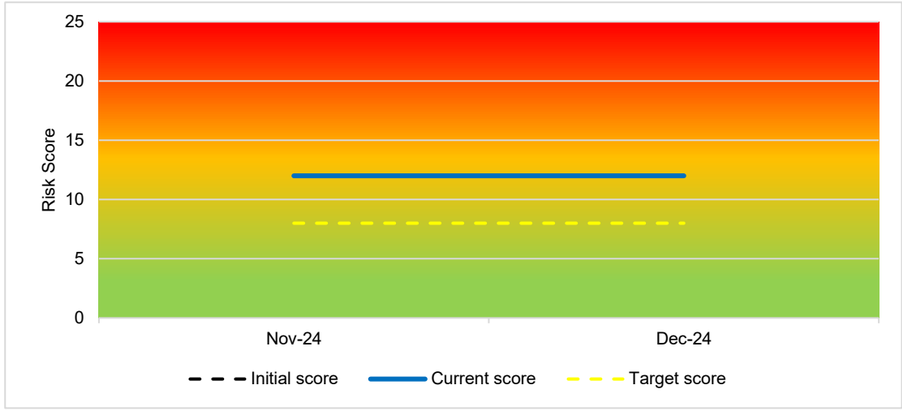
Action	Action Owner	Due Date	Done Date	Action Progress Update
Identification and acquisition of land for New Hospital	Programme Director	31.03.25	06.12.24	January 2025: Completed
Following acquisition, undertake engagement on proposed site location	Programme Director	31.03.25	Action stood down	January 2025: Following the government announcement about the delay for commencement of building the new Royal Preston Hospital, this action has been stood down.

Strategic Objective: Partnership	**Corporate Objective**: To make progress towards our ambition to be a University Hospital	Overall Assurance Level	Medium

Principal risk 15 (24/25)	Risk Title:	Research capacity and capability to enable progress towards University Hospital status		
	Risk Description:	There is a risk that the research capacity and capability of the Trust may be insufficient to support the longer-term objectives of becoming a University Teaching Hospital. This is because of limitations of the Trust and potential partners in relation to funding, workforce constraints, lack of dedicated research time for clinical staff, lack of established clinical academics in L&SC and the need for an enhanced infrastructure to support research activities. This could result in missed opportunities for innovation and improvement in patient care, difficulty attracting and retaining talented research staff, an inability to advance the Trust's reputation as a leader in research and clinical excellence and the income generation associated with University Hospital opportunities.		
Committee	Education, Training & Research	Risk Appetite and Tolerance	Seek 9-12	
Director	Director of Improvement, Research and Innovation, and Chief Medical Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	15/01/25	



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Fixed National Institute of Health & Care Research (NIHR) Income. • Research & Innovation Strategy (2022-25). • Some protected job-planned time for clinical research activity. • Quarterly Research Collaborative meetings with the 2 main LSC universities to develop research opportunities. • Some joint appointments with university partners.	• Historical and current overspend of research budget. • Funding available to increase capacity and capability. • Ability to engage medical colleagues in in different academic specialities to support advances in research in those areas. • Strategy and appetite of universities to invest in clinical or other academic roles to be based at the Trust.	• Bi-annual Research & Innovation Strategy update. • Research & Innovation Committee. • Education, Training & Research Committee. • Integral role in ICS R&I Collaborative.	• Income generation plan for financial recovery plan is behind trajectory. • Initial project plan to develop partnerships not currently agreed and therefore progress is not able to be reported to R&I Committee and ETR Committee. • Universities are experiencing similar budget constraints and so may lack ability to invest in these areas.

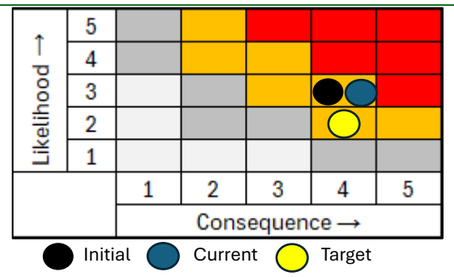
Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Formulate a clear project plan to develop partnerships with potential University partners to explore UH status. This will include plans to engage the clinical teams in the specialities to support these to come to fruition.	P. Brown	28.02.25		Jan 2025: A list of names for an internal Task & Finish Group has been present to Director of Continuous Improvement, with a view for the group to be pulled together in February 2025.
Delivery of the Income recovery plan for R&I	P. Brown	31.03.25		Jan 2025: Strategic agreement with external organisation under discussion.

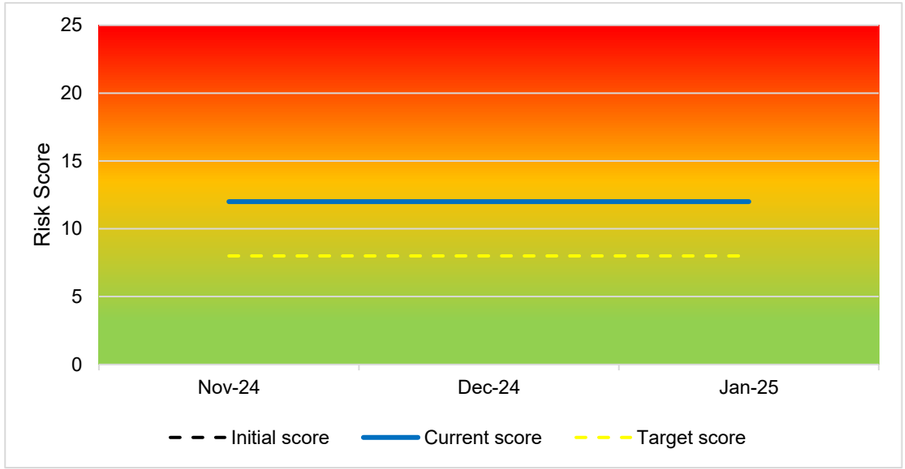
Strategic Objective: Partnership	**Corporate Objective**: To develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable	Overall Assurance Level	Medium

Principal risk 16 (24/25) (ID 2107)	Risk Title:	Implementing the long term strategy for the Trust	
	Risk Description:	There is a risk that the implementation of the long term strategy for the Trust may be hindered because of lack of alignment with system partners, clear commissioning intentions, insufficient clarity/strength within our processes for system governance/change, resource limitations, and potential resistance to change. This could result in delays in achieving the objectives, fragmented service delivery, reduced quality of patient care, increased costs and inefficiencies across the healthcare system, and failure to improve health outcomes for the population.	

Committee	Finance & Performance	Risk Appetite and Tolerance	Seek 9-12
Director	Director of Improvement, Research and Innovation/Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	20/01/25



Risk Score Tracker



Risk Appetite key: Red = Outside of tolerance, Orange = Tolerable, Green = Optimal
(Note: Initial score is same as current score and so not showing on graph)

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire and South Cumbria (L&SC) Integrated Care System (ICS) joint NHS forward plan and Clinical Blueprint • System Improvement Board • Three-year Single Improvement Plan • Trust's Annual Corporate Objectives • Provider Collaborative Board Joint Committee (PCB JC) • Place based working • Trust development/integration plans with LSCFT	• L&SC Clinical Blueprint has been developed but we are not yet at the stage where we have a detailed, agreed implementation plan. • Discussions with external partners regarding greater service/pathway integration still need further development and may be impacted by the discussions/plans with respect to the L&SC Clinical Blueprint. • Trust long term strategy not yet finalised • Draft ICB Commissioning intentions have been shared but more discussion needed to agree the implications for the Trust. • The 2024 Darzi Review has given a clear indication of the issues to be addressed in the NHS, and some indication of the likely actions needed, but the new long term NHS strategy will not be released until 2025/26. • System based working is still evolving/improving e.g. the PCB Governance reset is underway but has not been fully implemented and Place based working is still developing.	• Finance & Performance Committee system updates • Trust Board discussions/papers • Trust Board workshops/seminars	• Finalised Trust long term strategy

Risk Treatment

Action	Action Owner	Due Date	Done Date	Action Progress Update
Fully implement PCB Reset	PCB JC	28.02.25		Reset is underway
Finalise implementation plan for the LSC Clinical Blueprint	ICB / PCBJC	31.03.25		Discussions are underway across LSC e.g. Trust Board discussion is scheduled for December 2024.
Agree the implementation plan for the ICB 2025/26 Commissioning Intentions	ICFO / A. Brotherton	31.03.25		Jan 2025: Work is underway as part of the system financial enhanced oversight. Work will be implemented as developed
Agree final Trust long term strategy	A. Brotherton	~~28.02.25~~ 30.06.25		Jan 2025: This has been delayed to enable the new chair to advise on the strategy development so is anticipated to be finalised in Q1 of 2025/26. Due date extended.

Appendix 2 – Ongoing Action Plans against Historic Strategic Risks

Ongoing Action Plan supporting the historic strategic risk to Consistently Deliver Excellent Care (CDEC)

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
CDEC 014 B	Completion of planned expansion of SAU	Chief Operating Officer	31 March 2025	N/A	Stood down	Control	• The current environment within medical and surgical assessment units does not meet demand.
CDEC 018	The national cleaning standards implementation requires delivery – Priority 1.	Chief Financial Officer	Unable to determine delivery date	N/A	Stood down	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	N/A	Stood down	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 November 2024	30 November 2024	Complete	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	30 April 2025		Ongoing	Control	• The environment and facilities within the children's ward require improvement.
CDEC 028	Agree funding approach to Finney House intermediate care service to secure immediate to medium term plan.	Chief Nursing Officer	31 January 2025	N/A	Stood down	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.

Updates on Actions – January 2025

- Action CDEC 014B – Stood down as included within the action plan for Principal Risk 5, overseen at Finance & Performance Committee.
- Action CDEC 018 – Stood down as included within the action plan for Principal Risk 2, overseen at Safety & Quality Committee .
- Action CDEC 019 – Stood down as included within the action plan for Principal Risk 13, overseen at Finance & Performance Committee
- Action CDEC 028 – Stood down as included within action plan for Principal Risk 5, overseen at Finance & Performance Committee.

Ongoing Action Plan for historical Strategic Risk for Delivering Value for Money (DVFM)

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
DVFM 039	Robust delivery of the financial recovery plan and other financial risks which may arise during the course of 2024/25	Chief Financial Officer and Turnaround Director	31st March 2025	N/A	Stood down	Control & Assurance	The savings programme alongside additional control measures is currently failing to deliver the required level of financial improvement. NHSE are supportive of using additional advisory support to maximise delivery in the current financial year and develop plans for 24/25
Action Update January 2025: This action is now stepped down as per update in December 2024 that this is being monitored within the new Principal Risk framework – Principal Risk 11.							

Ongoing Action Plan for historical Strategic Risk for Fit for the Future (FFTF)

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	6th February 2025	N/A	Stood down	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 006	Establish new governance arrangements to support the development of the PCBC in conjunction with the programme office and the ICB	~~Executive Leads~~ PCB	~~31st January 2025~~ 28th February 2025		Ongoing	Control	• Integration of services and pathways
FFTF 007	Redesign our Social Value Strategy	Chief People Officer	6th February 2025		Stood down	Control	• Effective Place and system based working.
FFTF 008	Strengthen the Trusts capability and capacity for strategy formulation, planning & execution and transformational change	Director of Strategy & Planning, Director of Continuous Improvement & Transformation	~~31st December 2024~~ 31st January 2025	N/A	Stood down	Control	• Integration of services and pathways • Effective Place and system based working. • Single Improvement Plan approach still under development
Action Updates January 2025: • Action FFTF 001 – Action stood down as now being monitored through Principal Risk 16 • Action FFTF 006 – Action owner updated to be PCB. Feedback from the PCB indicates that the new arrangements are coming into effect in January. This splits the change programmes into four portfolios, clinical, clinical support, digital and centrals services. There will be four portfolio boards. The joint committee has two new sub committees, the executive committee and the assurance committee. All of the new arrangements are due to be in place in February and therefore the action has been extended. • Action FFTF 007 – Action stood down as included within Principal Risk 3 (previously named Anchor Institute Plan actions) • Action FFTF 008 – Action stood down as included within Principal Risk 11 (PMO action)							

Ongoing Action Plan for historical Strategic Risk for a Great Place to Work (GPTW)

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
GPTW002	Identify, develop and deliver transformational schemes that support long term sustainability and workforce re-modelling as part of annual planning cycle	Chief Operating Officer	Identify & develop: 31st December 2024 Deliver: TBC as schemes developed	N/A	Stood down	Control	• Identification and Development of transformation schemes to support long term sustainability and workforce re-modelling linked to service re-design.

Update December 2024

There is a comprehensive programme of work detailed in the single improvement plan which supports the financial recovery plan and replaces the action GPTW002. As part of the strategic programmes of work there is a workforce planning action, this includes delivering the NHSE requirements as part of the national planning rounds, alongside the development of a profession specific workforce plan. The Workforce Committee receives an annual workforce planning update to provide assurance, with the operational detail considered in the single improvement plan – portfolio board meeting.
As such, the action GPTW 002 aligned to the Strategic Risk for a Great Place to Work is stood down.

Ongoing Action Plan for historical Strategic Risk for a Education, Training & Research (ETR)

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~~ 31.10.24	15.01.25	Stood Down	Assurance	• Inability to meet Trust Mandatory Training targets across all disciplines across all divisions

Summary of Updates – January 2025

- Action ETR 007: Restructure and Consultation documents going through necessary processes for Research roles in Medicine and Surgery (Women's & Children's likely to be next in the plan), with plan for roll out at the start of the new financial year.
- Action ETR 008: This action is stood down as the work supporting this is encompassed within Principal Risk 10 under the new BAF.

9. FIT FOR THE FUTURE (STRATEGY & PLANNING)

9.1 2025/2026 PLANNING GUIDANCE

Information Item | A Brotherton | 13.30

Presentation

9.2 HEALTH IMPROVEMENT PLAN

Decision Item | S Morrison | 13.45

REFERENCES

Only PDFs are attached

09.2 - Health Improvement Plan.pdf

Board of Directors

Health Improvement Plan 2024 - 2026			
Report to:	Board of Directors	**Date:**	6 February 2025
Report of:	Chief Nursing Officer	**Prepared by:**	K Marshall

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

Executive Summary:

The purpose of this report is to share the finalised version of the first Lancashire Teaching Hospitals Health Improvement plan: A plan to reduce health inequalities 2024 – 2026.

This plan has been developed through an extensive consultation exercise to ensure appropriate engagement with key internal and external stakeholders including:

- Patient experience groups and forums,
- Colleagues within the organisation and Trust Board,
- Voluntary, community, faith and social enterprise partner organisations,
- Primary Care health inequality clinical leads,
- Integrated Care Board population health colleagues,
- Public health consultant colleagues from our provider collaborative network,
- Director of Public Health, Wellbeing and Communities at Lancashire County Council.

The plan reflects the shared ambition of our partners who are equally crucial to its success. The Director of Public Health, Wellbeing and Communities at Lancashire County Council has been influential in steering our approach to this work and has shared generously his expertise and knowledge, ensuring what is produced aligns to the priorities of both the Integrated Care Partnership, Integrated Care Board and Lancashire County Council.

In response to NHS England's legal statement relating to the duty of ICBs and providers to report on health inequalities under section 13SA of the National Health Service Act 2006, the 2023/24 dataset was produced, analysed and published on the Lancashire Teaching Hospitals website. This data will enable a year on year comparison to understand the impact of work undertaken across the system.

A key enabler for this work to be effective is addressing health literacy and communicating in a way that anyone can understand. Being conscious that the plan is aimed to reach a wide audience, the plan will be converted into a short summarised version which can be translated into other languages, an easy read version, a read aloud British Sign Language version, and a one page visual summary which will be installed across the organisation.

The success of the plan will rely on the organisations ability to integrate the aims within every programme of work so that it becomes part of the way we do things within the organisation. This approach will take time to develop and will be critical to the success of the plan. The Single Improvement Plan contains the health inequalities programme of work and is the vehicle for overseeing the organisations approach.

A bi-annual update report continues to be provided to the Safety and Quality committee and will report on the outcomes of the plan. This programme is operationally led through the health inequalities LTH group.

Recommendation

The Board of Directors is asked to

i. Receive the new plan, note the plan to publish and promote across the organisation and to integrate health improvement further throughout the organisation.

Appendix 1: Health improvement plan: A plan to reduce health inequalities 2024 – 2026.

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

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Health Improvement Plan

Our plan to reduce health inequalities

Content

Foreword

As the Director of Public Health for Lancashire, I am honoured to present Lancashire Teaching Hospital's Health Improvement Plan, a comprehensive strategy aimed at reducing health inequalities across our region. This is a testament to the organisation's unwavering commitment to fostering a healthier, fairer society where everyone can thrive.

Health inequalities are a persistent challenge, deeply rooted in the social, economic, and environmental conditions in which people are born, grow, live, work, and age. These disparities are not only unjust but also preventable. The Trust's mission is to address these inequalities head-on, ensuring that every individual, regardless of their background or circumstances, can lead a healthy and fulfilling life.

The foundation of this Health Improvement Plan is built upon improving the social determinants of health. By focusing on these determinants, we aim to create an environment where health equity is the norm, not the exception. This approach is holistic, encompassing a wide range of factors that influence health outcomes, from education and employment to housing and community support.

One of the key components of the plan is the Core20PLUS5 framework, which targets the most deprived 20% of our population and identifies specific groups at increased risk of poor health outcomes. This targeted approach allows us to concentrate our efforts where they are needed most, ensuring that our interventions are both effective and equitable. By addressing the unique needs of these populations, we can make significant strides in reducing health disparities and improving overall health outcomes.

This plan also highlights the importance of collaboration and partnership. Health improvement is not the sole responsibility of the healthcare sector; it requires a concerted effort from all sectors of society. We are committed to working closely with our partners in health and social care, education, housing, and the voluntary and community sectors. Together, we can create a supportive network that promotes health and well-being at every stage of life.

Our Health Improvement Plan is not just a document; it is a call to action. It is a roadmap for creating a healthier, more equitable society, and it requires the commitment and participation of everyone in our community. As we move forward, we will continue to engage with our residents, listen to their needs, and adapt our strategies to ensure that we are making a meaningful impact.

I am confident that, with the dedication and collaboration of our partners and the resilience of our community, we can achieve our vision of a safer, fairer and healthier Lancashire. Together, we can build a future where health inequalities are a thing of the past, and every individual can live a healthy, fulfilling life.

Sincerely,

Dr Sakthi Karunanithi
Director of Public Health, Wellbeing and Communities,
Lancashire County Council.

Introduction

As the CEO of Lancashire Teaching Hospitals, I am deeply committed to addressing the health inequalities that persist within our community. These inequalities are not only avoidable and unfair but also systematic differences in health that affect various groups of people. In 2010, Professor Sir Michael Marmot's strategic review[1] of health inequalities provided us with a clear roadmap for improvement through six key recommendations:

1: Give every child the best start in life

2: Promote education and life-long learning

3: Ensure fair employment and good working conditions

4: Secure the minimum income necessary for a healthy life

5: Create healthy and sustainable environments and communities

6: Adopt a social determinants approach to prevention and healthy lifestyles

To implement these recommendations effectively, it requires concerted, coordinated, and long-term action from the entire community. At Lancashire Teaching Hospitals, we are dedicated to transforming into a 'health improvement organisation' that not only treats illness but also actively promotes health and well-being.

At Lancashire Teaching Hospitals we provide a full range of general hospital services not only to our local population of 390,000 people in Preston, Chorley and South Ribble but also provide specialist care to the 1.8 million people across the region. To effectively implement a health improvement approach to not only to the local population of Central Lancashire but across the region to the patients we serve we will need to work in partnership with our wider health and social care network and the voluntary, community, faith and social enterprise partner organisations to achieve the shared goal of healthier and happier lives in Lancashire. Across the Lancashire and South Cumbria region there are high levels of deprivation and persistent poverty in coastal areas, rural communities as well as in its towns and cities, all of which contribute to unfair and wide inequalities in health and poor health.

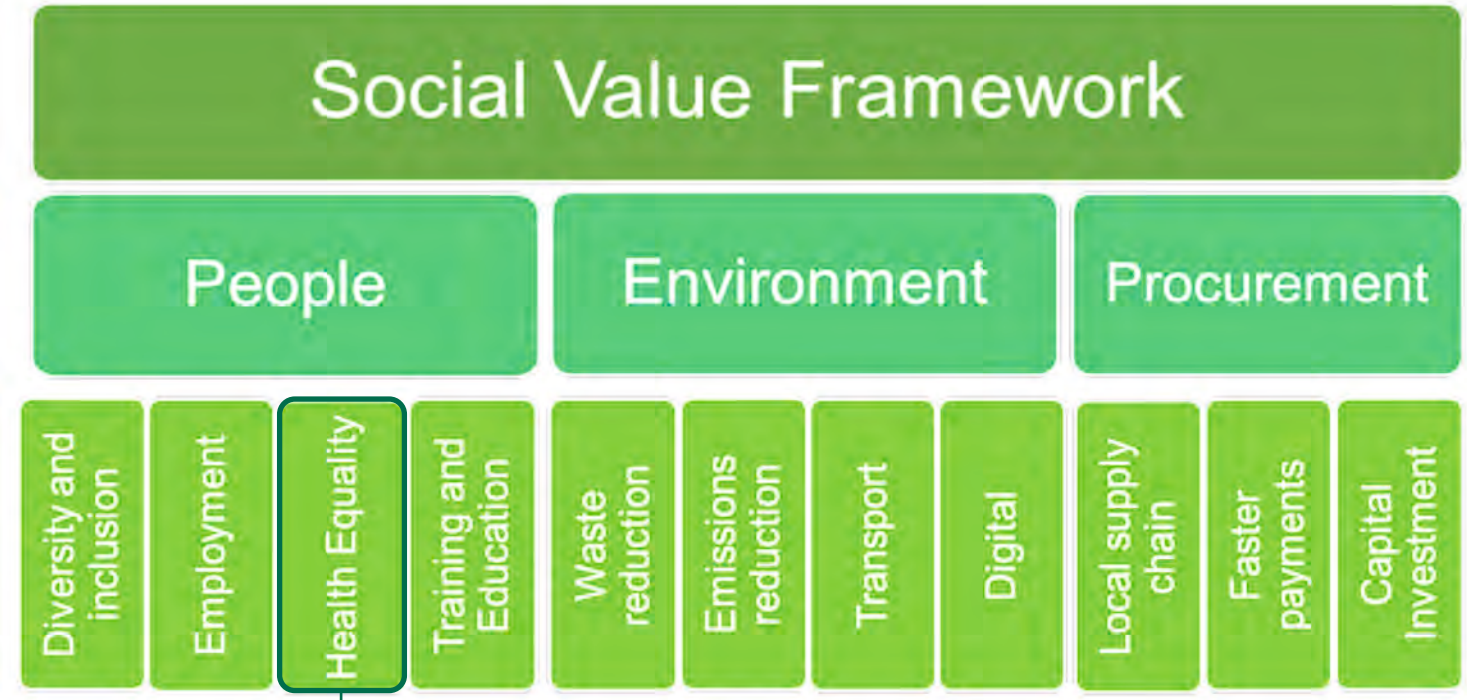
Our role is crucial, and we take it very seriously. We are committed to working collaboratively with our partners and the community to tackle the root causes of health inequalities and have aligned our work to that of the Lancashire and South Cumbria Integrated Care Partnership strategy 2023–2028 and the life course approach of Starting well, Living well, Working well, Ageing well and Dying well. By focusing collectively on prevention, education, and creating supportive environments, we aim to ensure that everyone has the opportunity to lead a healthy life. Together, we can make a significant impact on the health and well-being of our community, now and for future generations. It is our mission to lead this change and to inspire others to join us in this vital endeavour.

Prof. Silas Nicholls
Chief Executive,
Lancashire Teaching Hospitals.

1. Strategic Review of Health Inequalities in England post-2010. (2010). Fair society, healthier lives: The Marmot review

Lancashire Teaching as a Health Improvement Organisation

The LTH **Social Values Framework** supports the Trust to align associated priorities, agree improvements, mobilise change and celebrate improvement. The framework for Lancashire Teaching Hospitals has 3 main lenses: **people**, **environment** and **procurement**.



Anchor Institution Framework – to drive improvements in the wider determinants of health through our corporate functions such as recruitment, procurement, managing our estate and partnership working.

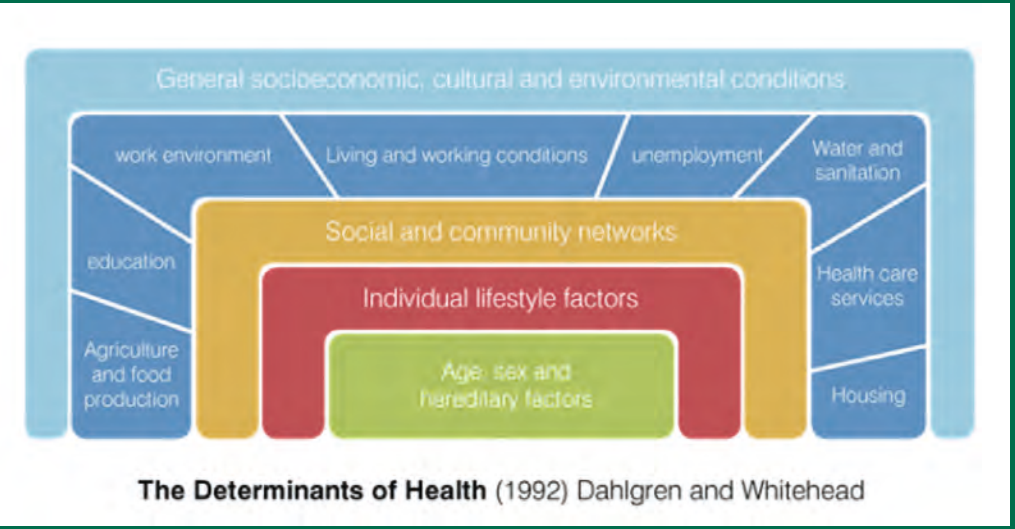
Health Improvement Plan – working with our partners aligned to the Lancashire and South Cumbria Health and Wellbeing Partnership Strategy to improve health for the population of Lancashire

Green Plan – to reduce our environmental impact and adapt our services to the changing climate

Social determinants of health

Almost every aspect of our lives impacts our health and ultimately how long we will live. This includes:

- **Our jobs**
- **Our homes**
- **Our access to education,**
- **Our access to employment opportunities**
- **Our public transport networks**
- **Our social networks**
- **Whether we experience poverty**
- **Whether we experience discrimination.**



The Determinants of Health (1992) Dahlgren and Whitehead

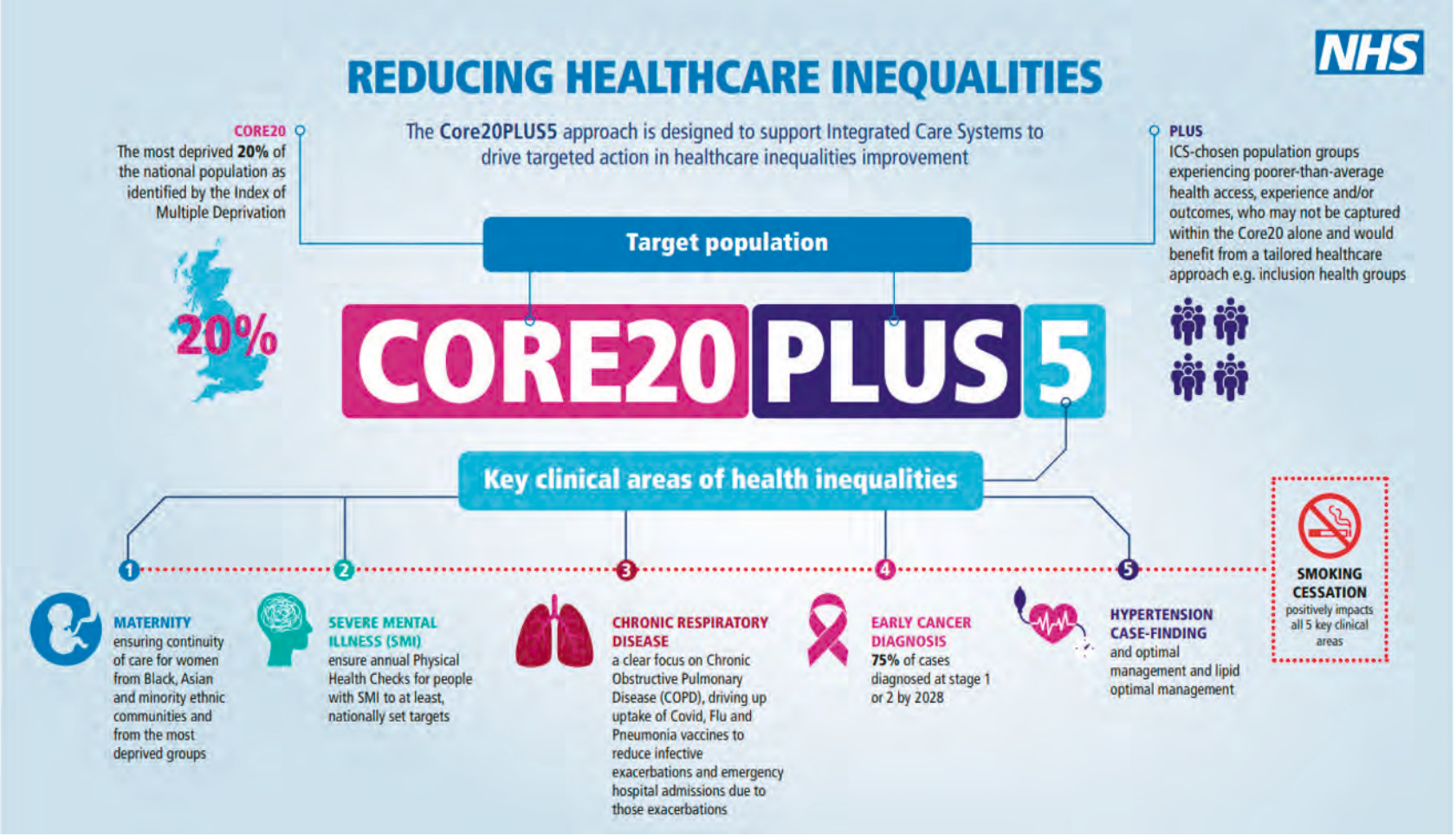
These factors are often referred to as the wider determinants of health. Where we live can dictate the extent to which it facilitates exercise, a good diet and social connections.

This is a challenge for those who want to address the widening inequalities in health across the country. When people see how jobs, homes, hardship and discrimination link to health, they are more likely to understand how they can help address the inequalities many of our population in Lancashire and South Cumbria face.

Source: The Health Foundation (2022) How to talk about the building blocks of health. Dahlgren G, Whitehead M. Policies and Strategies to Promote Social Equity in Health. Stockholm: Institute for Futures Studies.

Core20PLUS5: Adults

This is an NHS framework to inform action on reducing healthcare inequalities at a national and system level based on the theory of social determinants of health. The approach defines a target population – the '**Core20**' most deprived 20% of the population, '**PLUS**' population groups that are at increased risk within our area, and identifies '**5**' focus clinical areas requiring accelerated improvement and drive action in healthcare inequality improvement. The Core20PLUS5 framework forms the basis of our clinical interventions for adults.

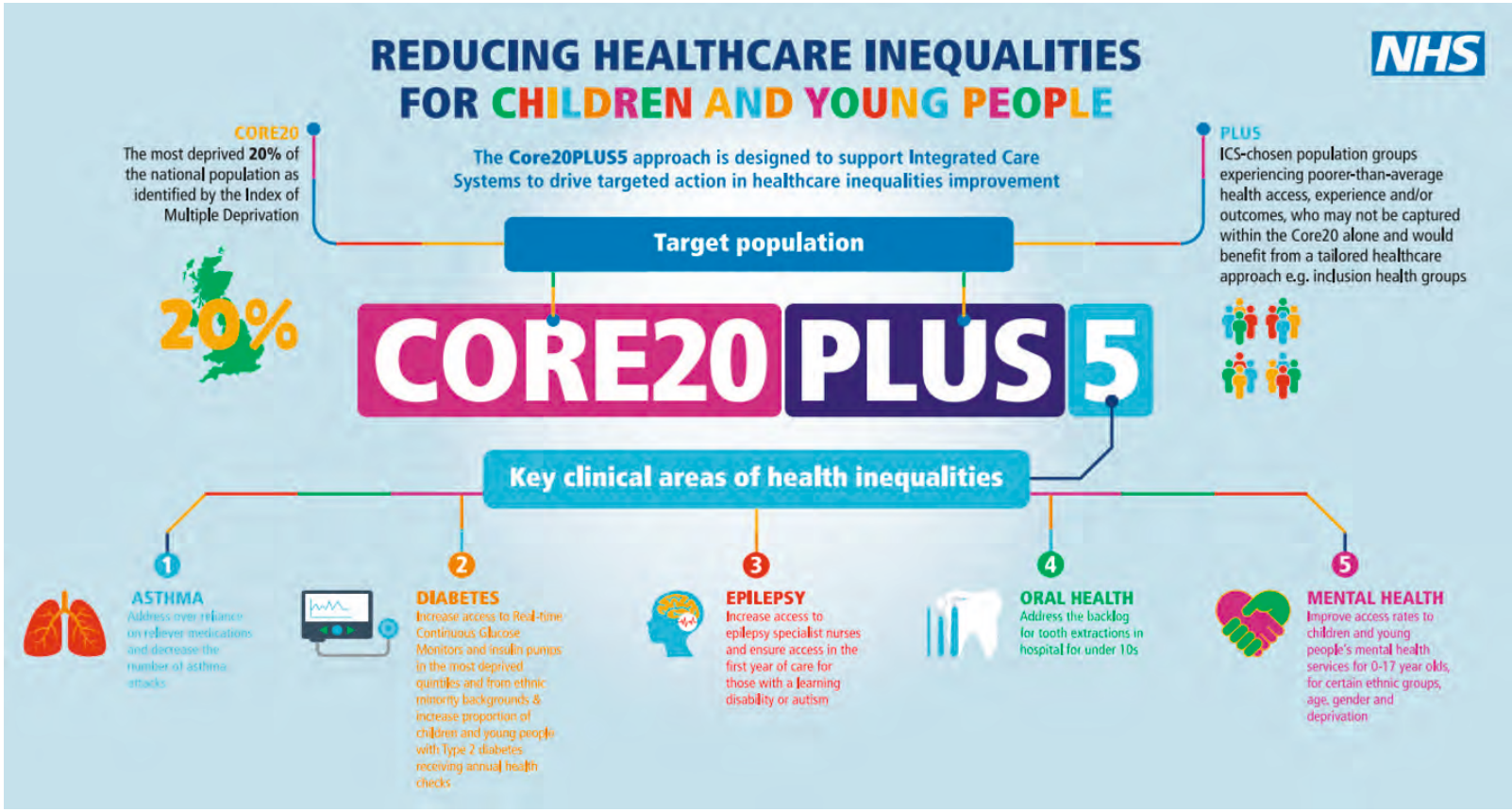


Core20PLUS5: Children and Young People

Focussing on children's health ensure they have best start in life. Children and Young people need special attention for health inequalities because:

- **Critical Development**: Early years are crucial for growth and development.
- **High Vulnerability**: Children and Young people are more affected by poor living conditions.
- **Preventable Issues**: Many health problems in children and young people can be prevented.
- **Long-term Benefits:** Healthier children and young people lead to healthier adults.
- **Educational Impact**: Poor health affects school performance and future opportunities.

The **Core20Plus5** priorities form the basis of our clinical interventions for children and young people.



Health Inequalities in Lancashire & South Cumbria

The Lancashire and South Cumbria ICS has a population of 1.8m people, as the specialist provider it is important we think about inequalities across the whole of Lancashire and south Cumbria as well as the local Central Lancashire footprint.

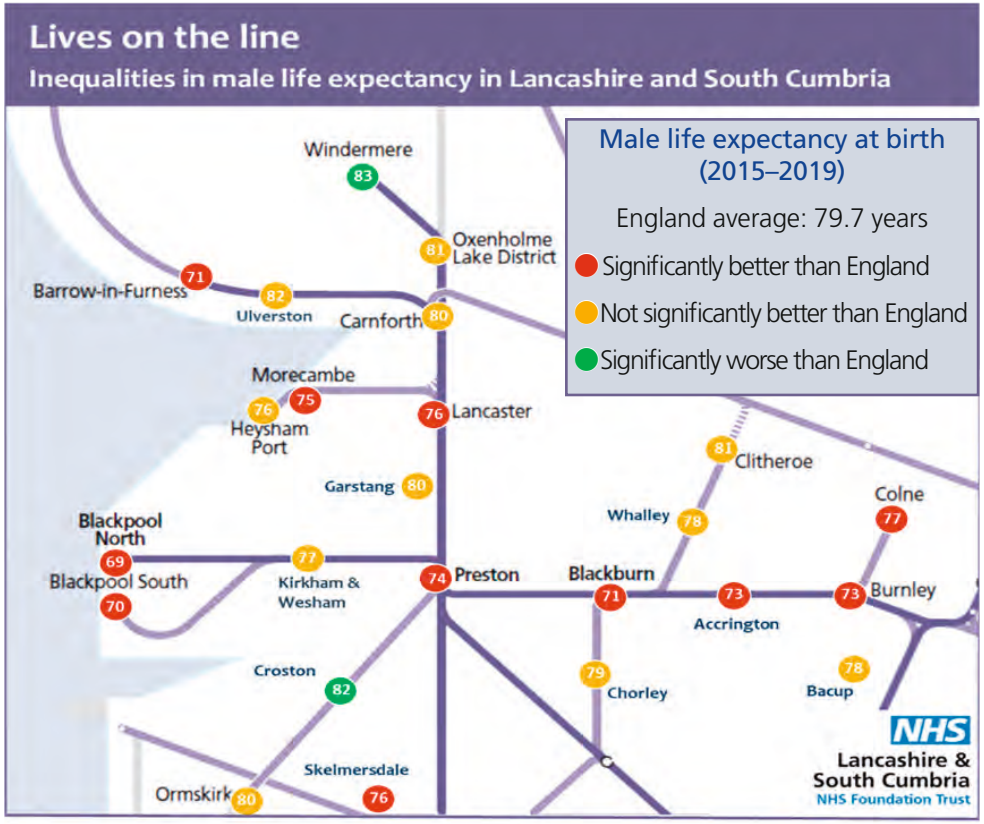
This summary table shows our key population demographics and prevalence across Lancashire and South Cumbria in line with the priorities in the Core20PLUS5 framework

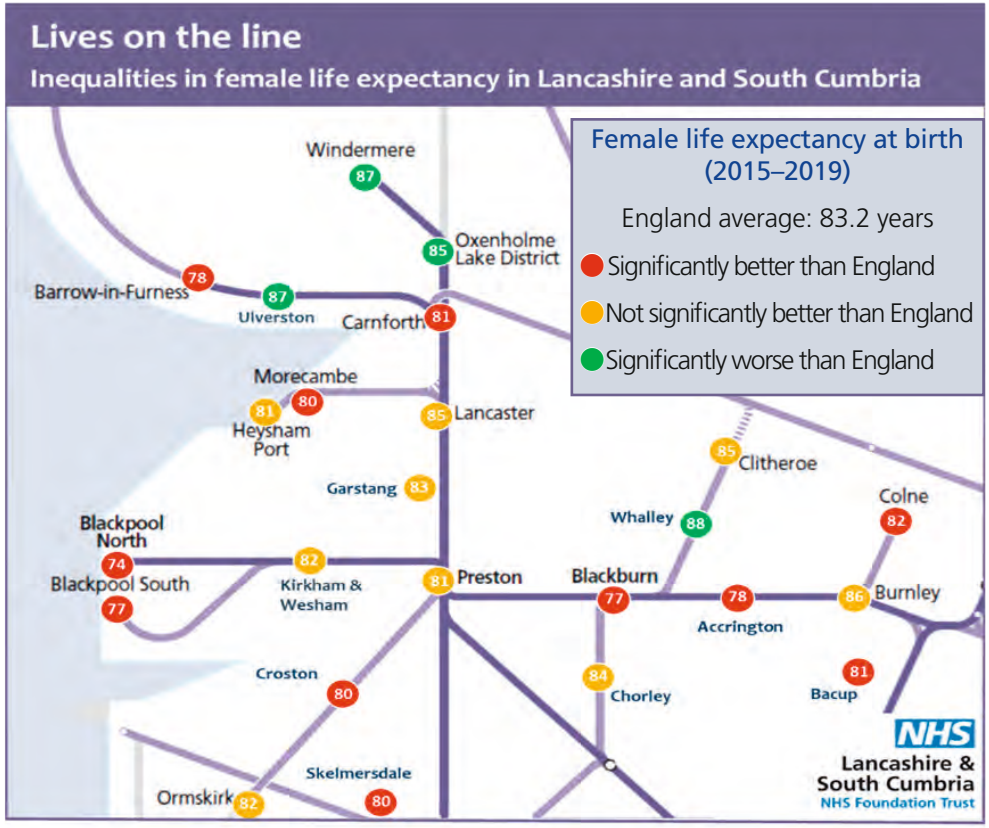
Core20	PLUS		5	
Deprivation	**Diverse**	**Aging population**	**Long Term Conditions**	**Core Determinants**
The 'Core20' accounts for **31% of our population**. In some of our places it is a much higher proportion. **In Blackpool 70% of the population are within the 20% most deprived areas**. Up to **25% of children** are **living in poverty and 20% of over 65s are living in poverty**.	17% of people in Pennine Lancashire are in minority ethnic groups. Population in **rural communities is 20.4%** vs national average for England is 17%. Locally determined groups include: • LGBTQ+ and transgender, • BAME, • Sex workers • People in contact with justice system • Victims of modern slavery • Gypsy Romany travellers • Asylum seekers and refugees • Veterans • Homeless.	Over **75s will double by 2035**. Population over 65 is 19.9% vs national average for England is 18.2%. **One person households with people aged 65** or over is 14% vs national average for England is 12.4%.	High levels of mental health conditions including depression. High levels of other long term health conditions including: • Cardiovascular disease, • Heart failure • Hypertension • Asthma • Dementia.	High rates of: • Alcohol and smoking/ respiratory related admissions,Obesity and digestive related conditions • Late-stage cancer diagnosis.

Life expectancy

These maps show that life expectancy in Lancashire and South Cumbria is lower than the national average – by almost a decade in some areas. There is also a large variation in the number of years people can expect to live a healthy life. Babies born in this area today have a healthy life expectancy that is lower than the expected state pension age of 68. In some areas, healthy life expectancy is as low as 46.5 years, although this varies significantly across our communities.

Diseases that contribute to the gap in life expectancy between the most and least deprived areas are circulatory disease, cancer, respiratory conditions. Around 21,000 people across Lancashire & South Cumbria who are currently registered with a GP practice have 5 or more long-term health conditions, and a disproportionate number of these are from the areas of greatest disadvantage.



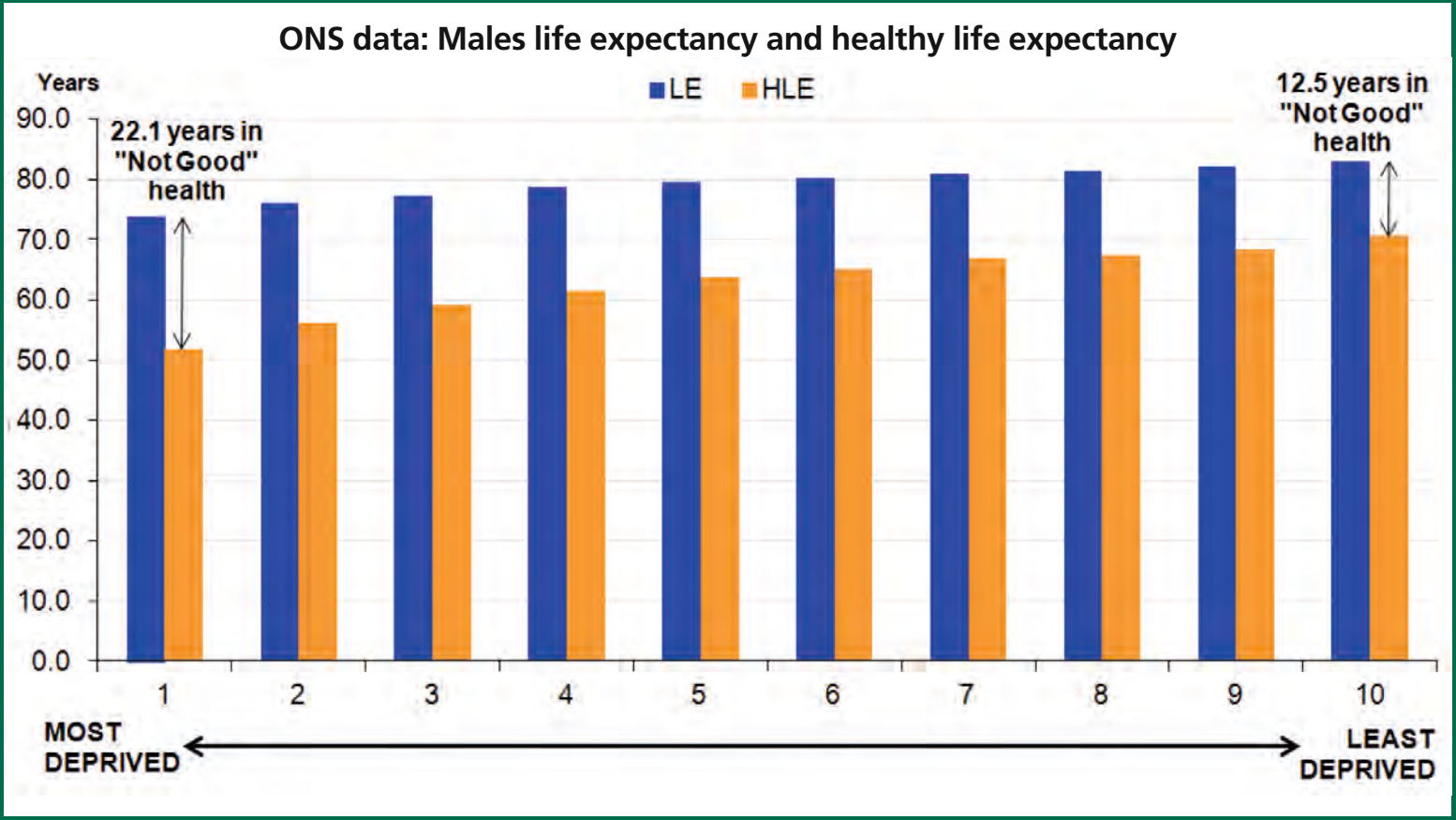


Number of years spent in ill health

This chart shows the national life expectancy and healthy life expectancy for Males by national declines in England for 2013-2015. As deprivation decreases (moving from left to right on graph), both life expectancy (LE) and healthy life expectancy (HLE) increase. This indicates a correlation of better income levels and health life expectancy in less deprived areas.

The gap between expected years spent in ill health also decreases in less deprived areas showing a 10 year difference in good health of the most and least deprived population groups.

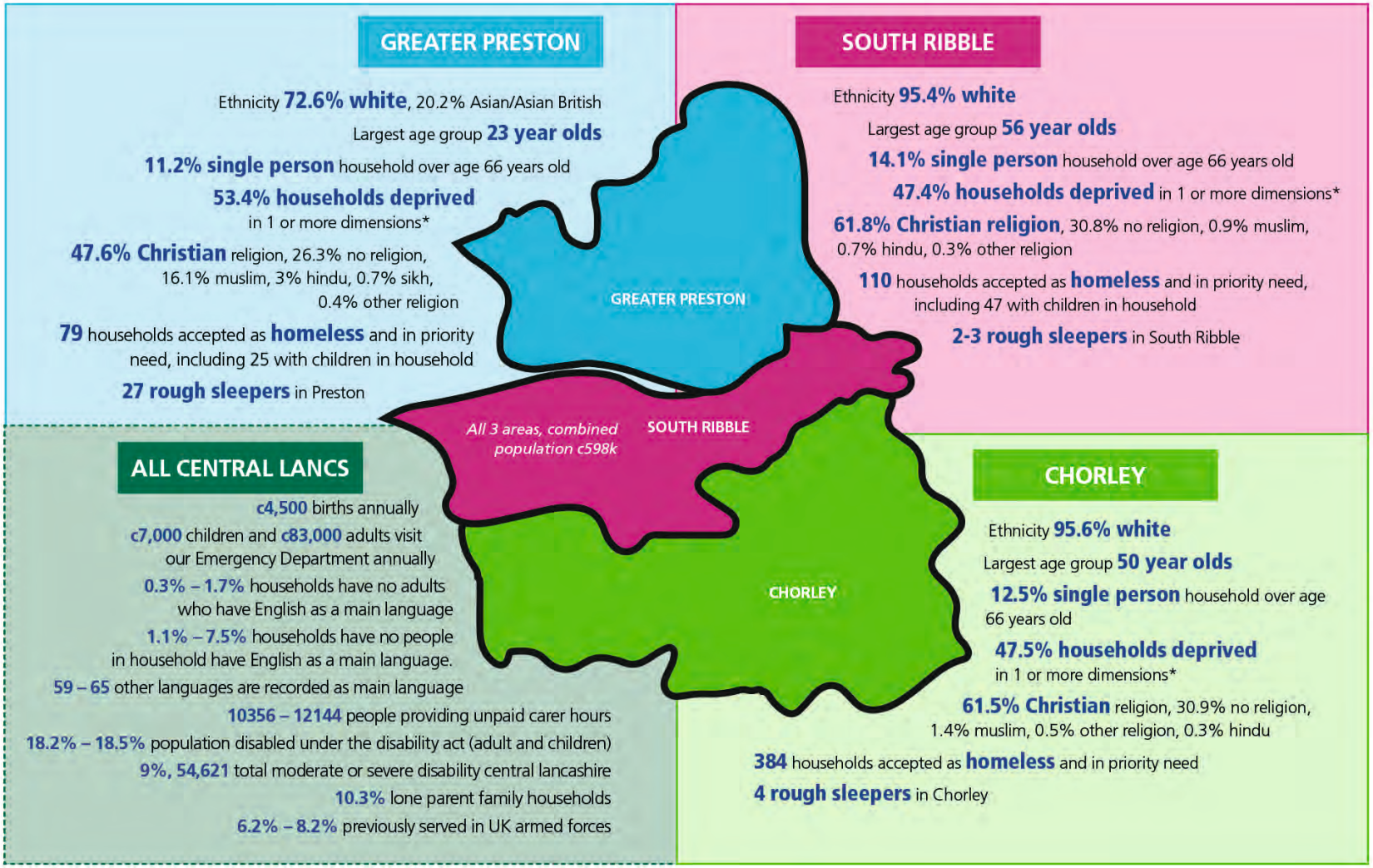
Source: ONS HLEand LE



Our population in Central Lancashire

Mapping population demographics shows the differences across areas and wards within our own locality and differing needs of each population.

Source: Data from 2021 Census
https://www.lancashire.gov.uk/lancashire-insight



**dimensions of deprivation used to classify households are based on education, employment, health and housing.*

Our partners in Central Lancashire

Successfully reducing health inequalities will require working in partnership with stakeholders in and outside of health. Across partner organisations there is a synergy in the ambition, but also individual responsibility where each organisation can help to connect either data, intelligence or programmes of work that have the same aims. The Place based health inequalities strategy is developed in partnership between the Lancashire & South Cumbria Integrated Care Board (ICB) and Lancashire County Council (LCC) through the Health & Wellbeing Boards. There is a health and well-being board for Chorley and for Preston.

Voluntary, Community, Faith and Social Enterprise Partners (VCFSE)

There are approximately 50 VCFSE partners actively working with LTHTR across Central Lancashire and ongoing work to engage with more partners.

Supporting to improve patients' and families experience inclusive of 9 protected characteristics:

- 9 protected characteristics
- Carers
- Bereavement
- Community support
- Health promotion and resources

Health & Social Care partners across the system

- Derian House Children's Hospice
- St Catherine's Hospice
- Lancashire & South Cumbria Integrated Care Board
- Lancashire & South Cumbria Foundation Trust
- North West Ambulance Service
- 3 Preston Primary Care Network
- 3 Chorley Primary Care Networks
- 3 South Ribble Primary Care Networks
- Preston City Council
- Chorley Council
- South Ribble Borough Council
- His Majesty's Prison Service
- Lancashire County Council

Joining together under the Lancashire and South Cumbria Integrated Care Partnership Strategy with the vision for a safer, fairer and healthier Lancashire. 3 key priorities

Achieving the very best start in life for our children, young people and families

Reducing the changes of heart disease, stroke, diabetes, dementia and cancer

Improving wellbeing and reducing addiction, self-harm and loneliness

Health and lifestyle factors in Central Lancashire

Health behaviours, such as diet and exercise, can improve or damage the health of individuals. These are determined by the choices available in the places where people live, learn, work and play. Behaviours such as stopping smoking, moderation of alcohol intake, healthy eating, physical activity, sexual practices and disease screening can reduce the risks of developing serious illnesses such as cancer, heart disease and type 2 diabetes.[2]

Health Factor	Chorley	South Ribble	Greater Preston	England average
Children overweight (obese) by age 4–5 years old	22.2%	21.1%	22.2%	21.3%
Hospital admission caused by unintentional/ deliberate injuries (0–14 yrs old)	98.1	108.9	99.5	75
Under 18s conception rate	19.4	14.4	20	13.1
Overweight (obesity) prevalence in adults	65.4%	66.4%	64.6%	64%
Smoking prevalence in adults	15%	13.6%	16.3%	12.7%
Smoking status at time of delivery	8.9%	9.4%	9.4%	8.8%
Admission episodes for alcohol related conditions	479	410	482	475
Estimated diabetes diagnosis rate	73%	75.6%	88.5%	78%
Cancers diagnosed stages 1 and 2	55.5%	54.3%	51.7%	54.4%
High anxiety score reported	17.9%	17.5%	25.8%	23.3%

Source: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework *2023 data, shown values per 1,000 population or %*

When compared to England average most health risk factors are higher in Central Lancashire.

Lancashire Teaching Hospitals Health Improvement Plan

Effective delivery of this work will rely on 3 key principles that will be threaded throughout this plan to ensure our organisation can embed and sustain change, and grow our understanding in reducing health inequalities.

This table describes the high-level structure and approach for our **Health Improvement Plan**.
Detailed drivers, actions and outcomes support the delivery and monitoring of the plan.

Principle	Driver	How will we do this?
To give everyone a 'health equity attitude'	Through better awareness, understanding and visibility we can then act to improve access, experience and outcomes for our patients	• **Health inequalities education**: a new approach to health equity education • **Health inequality data visibility**: mandated collection, sharing and use of data to understand inequalities • **Active health promotion**: for patients, families and colleagues • **Connection** – Understand our role as an anchor institution and the Social Values Framework.
To actively engage with local communities to improve services for their needs	Engaging our local communities and co-produce improvement must be at the centre of this work. We need to genuinely listen to understand with an appreciation that our communities are best placed to co-produce the solutions to the problems that we seek to solve.	• **Lived Experience**: Learning from the experience of people on whom a social or combination of issues has had a direct impact on the person • **Co-production**: A way of working together underpinned by principles that support inclusion, equity, shared decision and ownership for what is produced and the impact of has at all levels, especially strategically.
To take a population health approach to improvement work	An approach to be effective in enacting sustainable change that makes an impact to the group most in need.	• **Structure**:Following the 6-step approach for population health intervention • **Data led**: Using data to drive areas that require improvement • **Focussed**: Targeted population specific solutions, not generalised solutions that may not be effective

The Population Health approach

L&SC ICB have developed a population health model to provide a structured, consistent and effective approach across Lancashire and South Cumbria. Population health management takes a risk-based approach to improve health outcomes and reduce inequalities across an entire population.

Recover

Working with people and carers to enable those recovering from illness to live as full a life as possible, or receive excellent and equitable palliative care

Manage

Ensuring equitable access to the best possible healthcare at the earliest opportunity

Protect

Working with people with known conditions/risk factors to reduce their risk of ill health

COLLABORATE

Community participation

Data and Intelligence

Resource (Finance, Skills, People)

Predict

Using data, insight and ongoing dialogue with communities to identify early issues likely to lead to ill health

Prevent

Taking action with people and communities to improve lifestyles, social circumstances and our environment to improve health and wellbeing

Detect

Working proactively in integrated teams to find people who have a condition which increases their risk of ill health

Adults – Population health improvement work

Examples of improvement work already underway within the Lancashire Teaching Hospitals specific to adults.

	Improvement work	Improvement aim	Outcomes
ADULTS	**Race & Health Observatory project: Postpartum Haemorrhage for Black, Asian and Minority Ethnic**	Reduce post-partum haemorrhage (≥1000mL) experienced by black & ethnic minority women & birthing people by 50% (from 12% to 6%) by March 25.	Reduction in post-partum haemorrhage (≥1000mL) in women & birthing people from black & ethnic minority groups from 12% to 9%.
	Institute for Healthcare Improvement Accelerator Collaborative: Early cancer diagnosis for Black, Asian and Minority Ethnic	Engage population group to co-produce solutions to increase earlier stage cancer diagnosis.	Successful and continuing community engagement. Positive feedback from community with increased awareness of cancer symptoms and body vigilance.
	High Intensity User service	Reduce repeat emergency Department attendances using a psychosocial Multi-disciplinary Team model of intervention.	7/10 patients had a reduction in attendance, ranging from 25–100% fewer emergency presentations.
	Prisoner Referral to treatment	To reduce the time prisoners wait on the waiting list.	>65weeks reduced from 12 to 5. Prior to the work zero prisoners had a date to be treated, now all are dated to receive treatment by 45 weeks.
	Tobacco and Alcohol Cessation Team interventions	Increase in inpatient referrals to smoking cessation service and increase in patients receiving nicotine replacement therapy.	4 week quit rate increased by 433% Nicotine Replacement Therapy prescription increase from 14% in 2021 to 44% in 2023.

13% smoking prevalence in adults

54% cancers diagnosed at stages 1 & 2

65% overweight (obesity) prevalence in adults

569 admission episodes for alcohol related conditions

79% estimated diabetes diagnosis rate

**average across Central Lancashire. Shown values per 1,000 population or %*

Children – Population health improvement work

Examples of improvement work already underway within the Lancashire Teaching Hospitals for Children and Young People

	Improvement work	Improvement aim	Outcomes
CHILDREN	**Emergency Department navigator role in partnership with Lancashire Violence Reduction Network.**	Navigate 10 to 25-year-olds away from violence towards a more positive lifestyle.	Increase from 4 to 17 patients intercepted per month to support making positive plans to disrupt the cycle of violence.
	Paediatric complications of excessive weight gain service integration	Develop an integrated Child Excessive Weight service and referral pathway with three centres (Manchester, Alder hey and Preston) to provide care close to home.	Multi-disciplinary Team integration established. Hub and spoke model implemented with 33 follow up and 28 new patients.
	Children in Care team	Provide Individual Health Assessments and expand the service to include 16 and 17-year olds following increase in unaccompanied asylum seeker children.	Implemented a trauma informed training programme, aid understanding and approach to care leading to willingness to disclose and support underlying issues.
	Children's Elective Surgery Hub Chorley District General Hospital	Become accredited elective hub and reduce the number of children waiting for surgery by implementing dedicated theatre lists.	Dec 23: 108 patients waiting >65 weeks, now zero. Current there are 16 patients waiting for oral surgery.

18 under 18s conception rate

102 admissions caused by unintentional and deliberate injuries (0–14 yrs old)

22% children overweight (obese) by age 4–5 years old

25% 5 year-olds with visible dental decay

**average across Central Lancashire. Shown values per 1,000 population or %*

Community population health improvement work

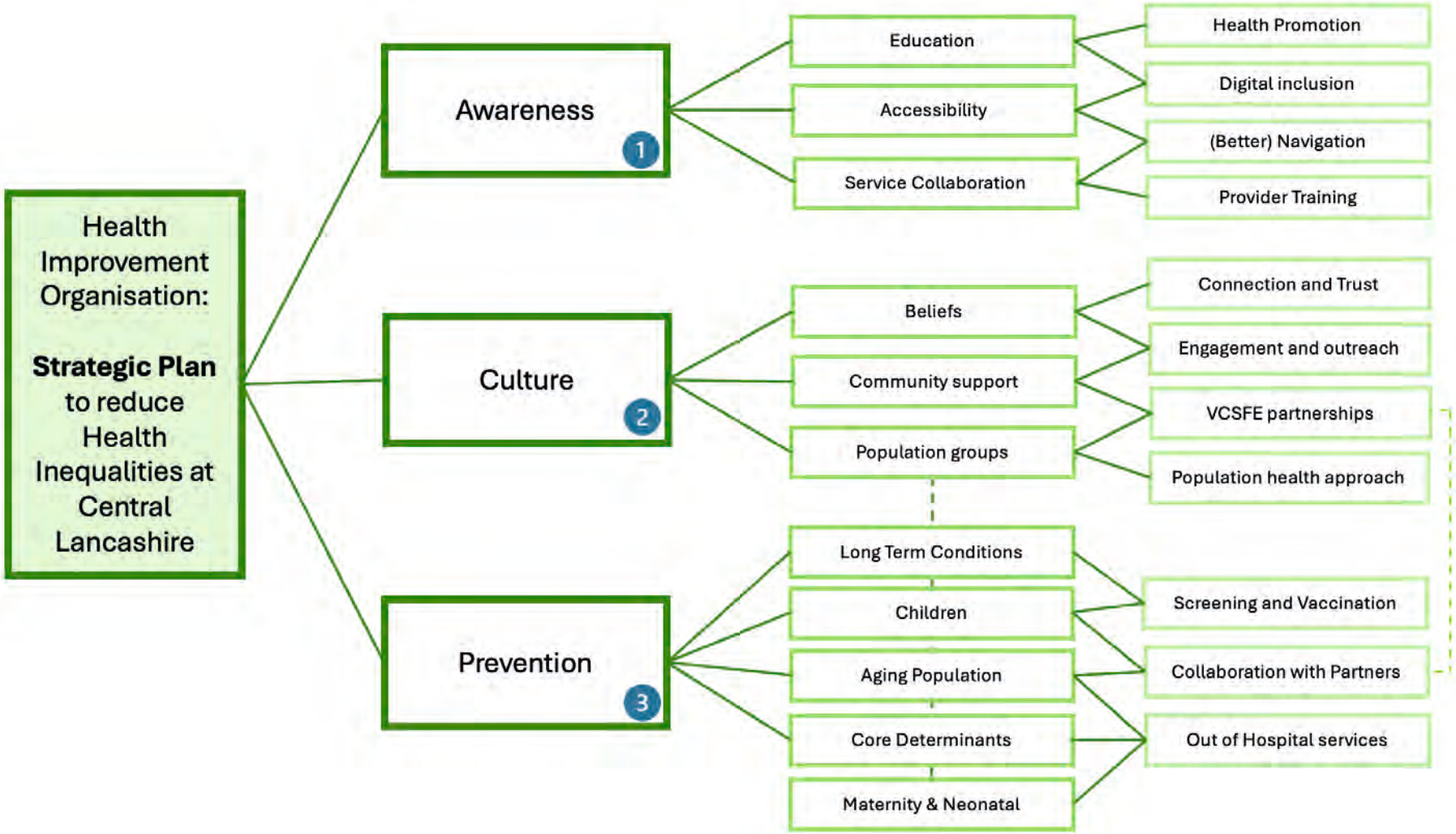
To align with our partners, it's important to have an awareness and understanding of the work underway within primary care and the community across Central Lancashire. This ensures we are joined up and effective in our work across Central Lancashire. Included below are examples of work underway within primary care networks that are focussed on either a specific population group or clinical areas requiring acceleration of prevention or interventions.

Targeted population improvement	Prevention and detection improvement
Enhanced health checks in the evening and weekends, including target on vulnerable groups	Promotion of national screening participation
Trauma informed care training for health professionals	Veterans breakfast club – focus on undiagnosed cardiovascular disease
Proactive identification of streets not accessing primary care	Hepatitis C and liver screening
Target newly diagnosed mental health patients	Suicide prevention, bereavement and mental health support
Target patients not engaged in primary care 3–5 years	Ethnic minority group prostate risk screening
Priority wards – provide outreach services targeting support	Living well events
Bilingual outreach workers	Children peer support programmes enhancing well being for children and young people age 10 – 19 and up to age 25 Special Educational Needs and Disabilities
Food banks and community support for families living in poverty	Oral health education, fluoride varnish programmes in schools, promoting regular dental checks and reduced sugar intake.

2024–2026 Action plan and measures: Strategic Drivers

The **Health Improvement Plan** has been developed using Quality Improvement methodology which includes structuring the plan using a driver diagram method. This helps to translate a high level improvement goal into a logical set of underpinning drivers and projects which have been split into strategic and operational drivers.

This plan details work specific for our Patients which features as part of the Trust Single Improvement Plan (SIP) with detailed timescales and metrics to monitor delivery. Following this plan for 2024 – 2026 a longer-term strategy will be developed as our organization grows its understanding and maturity in reducing health inequalities.

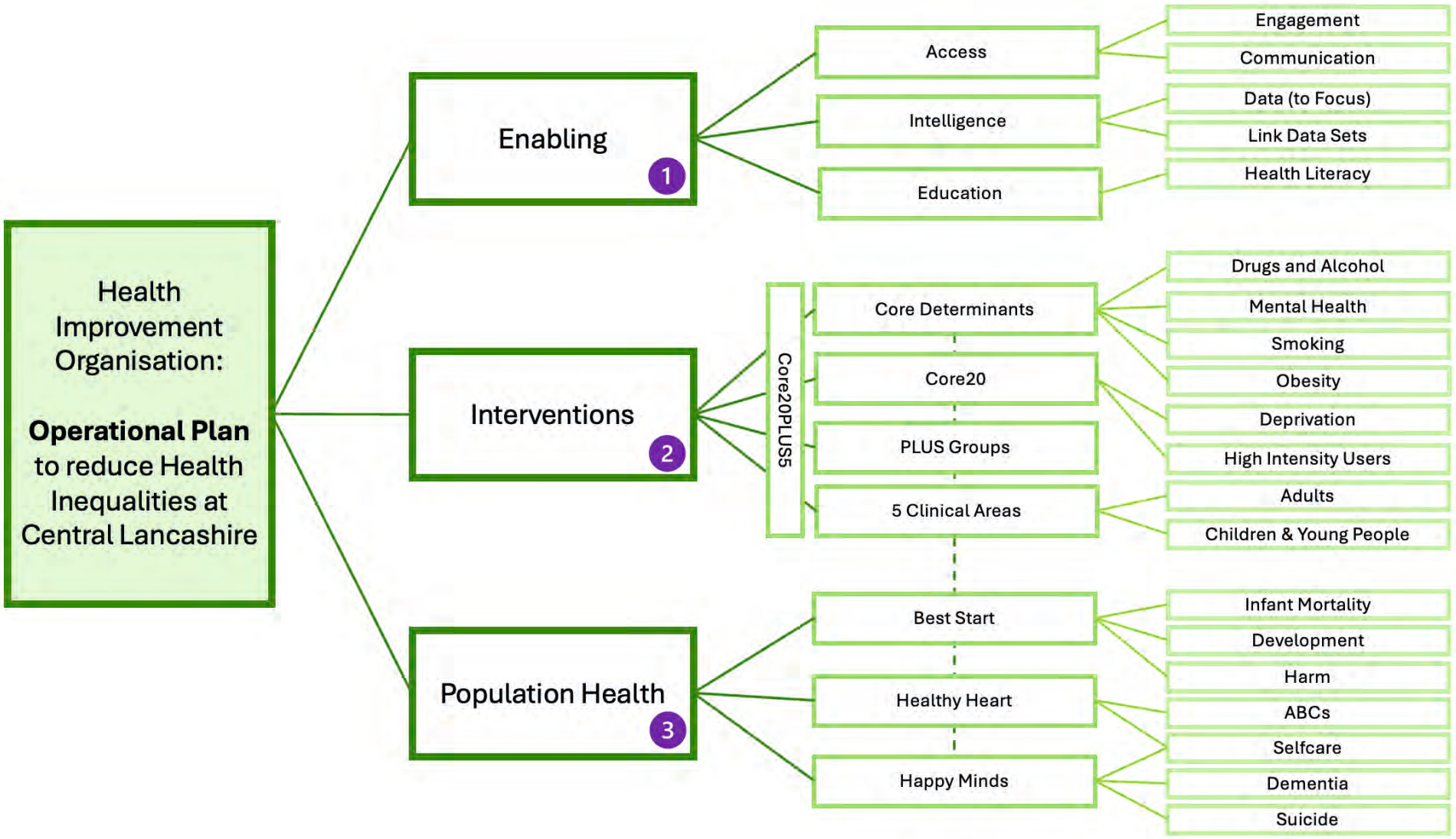


Strategic Actions

Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
1	AWARENESS	**EDUCATION**: Develop an educational offer that ranges from core skills to practitioner level understanding of health inequalities and Making Every Contact Count (MECC). Includes enhancing current EDI training provision to broaden scope and include health inequalities	Q4 2024–25	Increased awareness of health inequalities to make a shift in the way we deliver our services	% Completion of health inequality awareness training
		RESOURCES: Provide staff and public access to skills and resources to reduce inequalities by signposting to accessible digital health information through the Lancashire Health Hub	Q4 2024–25	Increase in uptake of services that support improving socio-economic and health issues	Patient assessment documentation to reflect the socioeconomic determinants of health
		ACCESS: Implement clear signage and differentiated access to patient information and increase use of digital translation solutions.	Q4 2024–25	Ensure digital and communication solutions don not create barriers to accessing our services	Provide explicit alternatives for easy read/non digital options
		SERVICE COLLABORATION: Explore partnership with PHE to provide signposting and support to patients, for example whilst waiting in ED or in discharge lounge	Q3 2024–25	Increase in uptake of services that support improving socio-economic and health issues	Patient discharge documentation reflects signposting undertaken regarding social determinants of health
2	CULTURE	**CONNECTIONS AND TRUST**: Engage in existing and emerging partnership networks beyond traditional health and social care providers to deeply listen and understand what our population requires. Engage across VCFSE partners to develop long term relationships across organisations	Ongoing	Following evidence-based practice to be effective in tackling barriers and sustaining improvements in this work	Outcomes to be determined based on engagement with VCFSE groups in response to feedback and codesign approaches
		ENGAGEMENT AND OUTREACH: Direct engagement with our local communities, inviting them to actively contribute what matters to them in health, and design our services that enable better access and experience for our communities	Ongoing		
		POPULATION HEALTH APPROACH: Take a targeted and specific population improvement methodology in this work that is effective in change to those most at need	Ongoing		

Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
3	PREVENTION	**SCREENING & VACCINATION**: Focus on delivering prevention improvement work linked to Core20PLUS5 including: • Pneumococcal and influenza vaccination status for COPD, Lung health checks, • Cancer Alliance led earlier cancer diagnosis programme,	Ongoing	Reduction of long-term conditions and preventable diseases	• % Pneumococcal and influenza vaccination vaccine uptake • % cancer diagnosis stage 1 & 2
		COLLABORATION WITH PARTNERS: Join up services expanding on work commenced with Care Connexions to bring services together from across organisations under one umbrella support of community physical health services.	2024–25	Making services more accessible by removing barriers and delivering what the patient need when it is needed by the most appropriate teams.	10% increase in the number of patients referred to Care Connexions by primary care for support services

2024–2026 Action plan and measures: Operational Drivers



Operational Plan

Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
1	ENABLING	EDUCATION: Develop an educational offer that ranges from core skills to practitioner level understanding health literacy	Q4 2 024–25	Increased awareness of health literacy to make a shift in the way we communicate	Train 100 leaders in health literacy training
		RESOURCES: Provide staff and public access to skills and resources to reduce inequalities by signposting to accessible digital health information through the Lancashire Health Hub	Q3 2024–25	Increase access to information that supports lifestyle changes and increases access to support	Evidence of signposting at discharge
		ACCESS: Implement clear signage and differentiated access to patient information and increase use of digital translation solutions	2025–26	Become an accredited health literacy friendly organisation and reduce waits and delays during procedures and appointments to improve patient experience	LTH Health Literacy Accreditation Create pathways that facilitate patients at increase risk of inequalities to access services with increased support
		INTELLIGENCE: Health equity data as a part of board performance packs focusing on unwarranted variation across UEC and Elective services for ethnicity and deprivation demographics	Q4 2024–25	Focussed work to enable reducing unwarranted variation and ensure equity in access to services	Evidence of change programmes enacted as a result of the data

Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
2	INTERVENTIONS	CORE DETERMINANTS: Promotion and connecting services that improve core determinants of health including: • Smoking drug and alcohol cessation interventions • Excessive childhood obesity clinics • Optimisation of elective patients through signposting services to support modifying risk factors ahead of surgery	Ongoing	Increase in uptake of interventions that improve core determinants of health affecting long term conditions for both adults and children and young people	Increased 4 week Quit rate Maintenance of mortality within expected range Evidence determinant changes following pre op health coaching
		CORE20: Focus on delivering targeted improvement work linked to Core20PLUS5 including: • High intensity user programme • Integrated neighbourhood teams • ED navigators	Ongoing	Reduced attendance in ED and inpatients admissions through promoting a cycle of change and different way to manage unmet needs	25% reduction attendance in ED of patients receiving intervention 25% reduction in admissions of patients receiving intervention 20% more 25years and under signposted for violence interventions
		5 PRIORITY CLINICAL AREAS: Focus on delivering accelerate improvement work to linked to Core20PLUS5 including: • Continuity of carer and Postpartum Hemorrhage for minority ethnic groups • Discharge referral to CCN and reduce salbutamol/weaning plan for asthmatic children • Diabetes real-time access to glucose monitor and insulin pumps for children • Reducing wait for tooth extractions for children under 10 yrs old	2025–26	Deliver focused improvement in areas leading to long term conditions in both adults and children	10% reduction in post partum haemorrhage for minority ethic groups 10% increase in smoking interventions 10% increase in alcohol interventions Decreased number of asthma attacks for children (% to be determined) 95% real time glucose monitoring in place, 60% insulin pump for children
		PLUS GROUPS: Focus on delivering targeted improvement work linked to Core20PLUS5 including: • Prisoner PTL management • Veteran status identification	2025–26	Demonstrate improvement in outcomes for groups most at need identified through LTH data.	Reduction >65 week patients in prisons Further groups to be identified as part of the data analysis Implement an approach to identifying Veteran status

Alignment	Driver	Contributing Work	Timeframe	Outcome	Measures (Outcome, process and balance)
3	POPULATION HEALTH	Work with partner organisations across health and social care to focus on key factors that impact population health for children and adults including • Safeguarding and Mental health champions in clinical areas • Develop an approach to patient and family education whilst interacting with services • Dementia strategy and access for early support fro families and patients	Ongoing	Families will understand how to access support for their loved ones	Determine a baseline of referral activity to support services and aim to increase this once baseline understood.

Governance and reporting

Leadership at every level of the organisation as well as a commitment to working with partners will be essential to successfully deliver this plan. We will continue to engage with our partner organisations building connections and relationships to ensure we work together an aligned approach across our Health & Social Care system.

Clear reporting will ensure we understand the progress we are making. The governance and reporting arrangements are outlined below

Annual Reporting

- We will publish on our website the national inequality data submission in line with duty under section 13SA of the National Health Service (NHS) Act 2006

Progress reports

- We will continue to produce twice annual reports to provide assurance on the progress on this topic to the Safety & Quality committee
- We will continue to report progress via Integrated Care Board quarterly stock take for System Oversight Framework (SOF)

Governance structure

- A working group is in place and includes colleagues from a wide variety of settings ranging from patient experience, operational, library and knowledge, improvement, clinical and data scientists.
- The Executive lead for Health Inequalities is Sarah Cullen, Chief Nursing Officer.
- The plan to reduce health inequalities is part of the Trust's Single Improvement Plan (SIP) within the Chief Nursing Officer's safety, quality and effectiveness portfolio, which will follow reporting arrangement as a part of the SIP governance structure.
- In addition to provide close oversight to the Trust Board, monthly chairs reports from the HIG are submitted into sub- board Safety & Quality committee as well as the twice annual detailed progress reports.

Acknowledgements

With thanks to

Dr Sakthi Karunanithi, Director Public Health at Lancashire County Council

Dr Tammy Boyce, Institute of Health Equity

Dr Heather Catt, Consultant of Public Health at Blackpool Teaching Hospitals NHS Foundation Trust

Dr Chris Chiswell, Consultant of Public Health at University Hospitals Morecambe Bay NHS Trust

The Lancashire and South Cumbria Population Health Academy

Glossary of terms

Term	Definition	Term	Definition
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust	**IHI**	Institute for Healthcare Improvement
GP	General Practitioner	**TACT**	Tobacco and Alcohol Care Team
LGBTQ+	Lesbian, gay, bisexual, transgender, queer or questioning, or another diverse gender identity	**ED**	Emergency Department
BAME	Black, Asian and Minority Ethnicity	**MDT**	Multi-Disciplinary Team
HLE	Health Life Expectancy	**PPH**	Post Partum Haemorrhage
LE	Life Expectancy	**NRT**	Nicotine Replacement Therapy
ONS	Office for National Statistics	**CEW**	Children's Excessive Weight
FT	Foundation Trust	**CDH**	Chorley District General Hospital
ICB	Integrated Care Board	**CYP**	Children and Young People
PCN	Primary Care Network	**Hep C**	Hepatitis C
VCFSE	Voluntary, community, faith and social enterprise partners	**CVD**	Cardiovascular Disease
L&SC	Lancashire and South Cumbria	**SEND**	Special Educational Needs and Disabilities

10. CONSISTENTLY DELIVER EXCELLENT CARE (SAFETY AND QUALITY)

10.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | K Smyth | 13:55

Item for assurance

REFERENCES

Only PDFs are attached

10.1 - Chair's report - Safety and Quality Committee - 29 Nov 2024 and 3 Jan 2025.pdf

Chair's Report to Board		
Chair: Non-Executive Director Ms Kate Smyth	Safety and Quality Committee	
Date: 29 November 2024 & 3 January 2025	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 Annual Staffing Report** • **Adult and Paediatric Audiology – Trust Response to CQC**

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	The Committee received an outline of the actions taken in response to a letter from the Care Quality Commission regarding paediatric audiology. The Board would receive a report and the Lancashire Teaching Hospitals response to the Care Quality Commission at the February Board meeting. The Committee received a report detailing a Regulation 28 notice issued to the Trust by HM Coroner for Lancashire and Blackburn with Darwen, following the conclusion of an inquest held on 27th September 2024. The report outlined the specifics of the case, the concerns raised, and the action plan formulated in response. The Committee confirmed it is assured regarding the actions taken to address the Regulation 28 notice and the lessons learned from the incident.
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	The Committee continued to have concerns on the position regarding the boarding of patients. Mitigations were in place to reduce the likelihood of harm but recognised the adverse experience this was contributing to. The challenges faced in diagnostics was noted by the Committee and it was agreed that further information regarding the modality of diagnostic would be included in diagnostics update via the FPC report. Any harms would be reported through the PSIRF quarterly report.
ASSURE **Assurance received; Matters of positive note.**	The committee received assurance reports relating to: Clinical Audit Effectiveness Quarterly PSIRF Thematic Review Outsourced Contracts Sepsis Update and Serious Incident Cases Review Health Improvement Plan 2024-26 Health and Safety Bi-annual Update of Mortality, PMRT and LEDER Bi-annual Medicines Management The reports provided an overview of areas of strength and areas that required continued focus.

	The new Lancashire Teaching Hospitals Health Improvement Plan 2024-26, the Adult, Children and Young People Safe Staffing report and the Maternity Safe Staffing report were endorsed by the Committee. The annual Health and Safety Report was presented. The Committee endorsed the review of the Health and Safety Improvement Plan and the development of a Health and Safety dashboard as key initiatives to enhance governance arrangements within the Trust. Due to the ageing estate and financial constraints, the Committee agreed that the use of the risk register to escalate any immediate risks outside of the annual report cycle would provide effective oversight. The Sub-contract Monitoring Assurance report provided the Committee with assurance of the contract management of the Trust's outsourced material subcontracts for clinical healthcare. The Bi-annual Medicines Governance report provided a summary of key performance metrics and improvement actions related to medicines management undertaken by pharmacy working with the multidisciplinary team medicines management have contributed to reducing and maintaining the proportion of medication incidents causing harm to an average of 4% (Model Hospital national benchmark 12%). The Bi-annual update of Mortality, Perinatal Mortality Review Tool (PMRT) and Learning Disability Mortality Review (LeDeR) provided assurance that the Trust had robust governance arrangements in place to review, report and learn from patient deaths.

Safety and Quality Committee

29 November 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 25 October 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log	12.35pm	✓	Decision	K Smyth
6.	Strategic Risk Register	12.40pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.50pm	✓	Assurance	C Gregory
7.2	Maternity and Neonatal Report	1.00pm	✓	Assurance	J Lambert
7.3	Children and Young People Staffing Report	1.10pm	✓	Assurance	S Cullen
7.4	Clinical Audit and Outcome Report	1.20pm	✓	Assurance	H Ugradar
7.5	Quarterly PSIRF Thematic Review and Learning Report	1.30pm	✓	Assurance	H Ugradar
7.6	Sub-contract Monitoring Assurance Report	1.40pm	✓	Assurance	S Stow A Gammell
7.7	Sepsis Update	1.50pm	✓	Assurance	C Roberts
7.8	Health Improvement Plan	2.00pm	✓	Information	S Cullen
8.	GOVERNANCE AND COMPLIANCE				
8.1	Annual Health and Safety Review	2.10pm	✓	Assurance	H Ugradar
8.2	Sepsis Serious Incident Cases Review	2.20pm	✓	Assurance	S Cullen
8.3	Maternity CQC Investigation 77860	2.30pm	✓	Information	S Cullen
8.4	Adult and Paediatric Audiology CQC	2.40pm	✓	Assurance	S Cullen

№	Item	Time	Encl.	Purpose	Presenter
8.5	Strategic risk register review	2.45pm	Verbal	Decision	K Smyth
8.6	Items to alert, advise or assure the Board.	2.50pm	Verbal	Information	K Smyth
8.7	Reflections on the meeting and adherence to the Board Compact	2.55pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	**Terms of Reference:** a) Medicines Governance Committee		✓		
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) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group g) Health and Safety Governance		✓		
9.4	Date, time and venue of next meeting: *3 January 2025, 12.30pm, Microsoft Teams*	3.00pm	Verbal	Information	K Smyth

Safety and Quality Committee

3 January 2025 | 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 29 November 2024	12.33pm	✓	Decision	K Smyth
5.	Matters arising and action log: FPC cross committee referral to the Safety and Quality Committee about monitoring the risk associated with long wait times for patients on elective care lists.	12.35pm	✓	Decision	K Smyth S Cullen
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	S Cullen
7.3	Bi-annual update of Mortality, PMRT and LEDER report	1.10pm	✓	Assurance	K Davies
7.4	Bi-annual Medicines Governance Update	1.20pm	✓	Assurance	G Price
7.5	Regulation 28 – Datix 88279 STEIS 2022/15957	1.30pm	✓	Assurance	S Cullen
7.6	CQC Audiology part 2 – Surgery RPH	1.40pm	✓	Information	S Cullen
8.	GOVERNANCE AND COMPLIANCE				
8.1	Strategic risk register review	2.00pm	Verbal	Decision	K Smyth
8.2	Items to alert, advise or assure the Board.	2.05pm	Verbal	Information	K Smyth
8.3	Reflections on the meeting and adherence to the Board Compact	2.10pm	✓	Assurance	K Smyth
9.	ITEMS FOR INFORMATION				

№	Item	Time	Encl.	Purpose	Presenter
9.1	Exception report from Divisional Improvement Forums		✓		
9.2	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group – **no meeting** g) Health and Safety Governance - – **no meeting** h) Mortality and End of Life Care Committee		✓		
9.3	Date, time and venue of next meeting: *31 January 2025, 12.30pm, Microsoft Teams*	2.15pm	Verbal	Information	K Smyth

10.2 ADULT AND PAEDIATRIC AUDIOLOGY ? TRUST RESPONSE TO CQC

Decision Item | S Morrison | 14.05

Item for assurance

REFERENCES

Only PDFs are attached

10.2 - CQC Paediatric Audiology response (1).pdf

Board of Directors

Paediatric Audiology Services – CQC Response			
Report to:	Board of Directors	**Date:**	6 February 2025
Report of:	Chief Nursing Officer	**Prepared by:**	Kate Hudson/Laura Wilkinson

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

Executive Summary:

The purpose of this paper is to outline the response to a letter received from the CQC regarding paediatric audiology services. The report provides the response and action plans following an independent review of pediatric audiology services in Fullwood (in the Womens and children's division) and Preston (in the surgery division).

The Care Quality Commission (CQC) wrote to all Trusts earlier in the year following an expert review undertaken by NHS Lothian in Scotland which found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children (Appendix 1).

These findings led to a review of the service provided by 4 NHS trusts in England which found similar failings. A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and Integrated Care Boards (ICBs) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements. The CQC have directed that ICB's should ensure there are plans in place so that trusts can implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems

The trust is not currently Improving Quality in Physiological Services (IQIP's) accredited or registered. In line with the CQC request, this is registered as a risk on the division's risk register. At this time, the Trust will not progress with IQIP's accreditation unless the ICB select to fund this, instead the areas of risk identified within the review will be managed as part of divisional governance arrangements.

In response to the request, the Trust has participated in a Paediatric Audiology Quality Assessment Tool (PASQAT) (Appendix 2) this fulfils the requirement of an external evidence-based assessment of the service. This was undertaken in July 2024 by NHS England. The benchmarking tool has identified areas that require improvement, and the Fulwood service has a live action plans in place to respond to these, with the Preston service action plan in development (Appendix 2&3).

There are no safety issues identified as part of the benchmarking exercise. A search of the Datix system has identified 0 incidents within the last 12 months relating to audiology where a child has experienced a delayed or missed diagnosis or treatment or not received timely follow up care and support.

The response to this will now be communicated to the CQC. The ICB are considering the preferred approach to the implementation of IQIPs. The responses have been scrutinized by Safety and Quality committee in November 2024 and January 2025.

The CQC have requested the outcome of this work is considered by the Board and assurances received demonstrating progress against the identified actions required.

RECOMMENDATION

The Board of Directors is asked to

i. Receive the response to the CQC
ii. Note the PASQAT and IQIPS recommendations and actions plans for assurance
iii. Confirm it is satisfied the information is used to formulate a response to the CQC

Appendix 1 - CQC Letter to provider CEO's regarding Paediatric Audiology service
Appendix 2 –Fullwood PASQAT and IQIP recommendations and action plan
Appendix 3 – Preston PASQAT 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

Safety and Quality Committee November 2024
Safety and Quality Committee January 2025

1. Background

The CQC wrote to all organisations in April 2024. The letter did not arrive in the Trust until 28 May 2024 leading to a delay in response, this has been explained and accepted by the CQC.

The letter contained within Appendix 1 outlined an expert review undertaken by NHS Lothian in Scotland found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.

These findings led to a review of the service provided by 4 NHS trusts in England which found similar failings. A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and ICBs to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

2. Discussion

The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC, they strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS.

Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care. CQC state that ICB's should ensure there are plans in place so that trusts can implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems.

The service is not IQIPs accredited or registered with IQIPs. In line with the CQC request, this is registered as a risk on the divisions risk register (Risk ID 1961).The risk of not being accredited will continue to be managed through the divisional governance arrangements.

NHS England have asked that where services that are not UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. The response to this request is the completion of the UKAS benchmarking tool for provider of audiology services. This has been completed and considered by the services and the Safety and quality committee and by the ICB working group. Each of the services in the ICB are undertaking this exercise. None are accredited at this time.

3. LTHTR paediatric audiology service

The LTHTR Paediatric Audiology service provides both secondary and tertiary audio vestibular care to children and young people with hearing and balance needs across the Lancashire and South Cumbria area to a population of 743,000. (This is smaller than the complete population as the catchment area is defined to certain areas)

Tertiary Service - Children and young people registered with a GP in Chorley and South Ribble, Greater Preston, Blackpool, Fylde and Wyre and Morecambe Bay.

Second Tier Service - Children and young people registered with a GP in Chorley & South Ribble and Greater Preston.

Referrals are accepted for children and young people aged of 0 - 19 years, and up to 20 years for young people with special educational needs. The service is designed to be a hub and spoke model to ensure access for patients within the community and adequate critical mass to maintain the specialist skills and quality of service provision.

In addition, LTHTR is one of the few sites recognised by the GMC and Royal Colleges for specialist training in paediatric audio vestibular medicine. The LTHTR centre is research active, promoting evidence-based practice through research and publication.

LTHTR Adult Audiology Service

The LTHTR Adult Audiology service provides Secondary Audiological Assessment, Diagnosis and Rehabilitation for the adult population of Central Lancashire (population size around 347,000). In doing so it directly supports our ENT service, takes referrals from other internal services, and provides GP Direct Referral of adult patients with Hearing, Tinnitus and Balance problems. In addition, the service provides the electrophysiological diagnostic hearing assessment of babies referred from the local newborn hearing screening programme as well as babies/older children referred from Paediatricians or the Paediatric Audiology Service.

4. Performance when compared to National Deaf Society Survey

The CQC outlined the risks within the letter referring that *'Childhood deafness is a significant health and developmental risk. A National Deaf Children's Society survey in 2023 identified a number of findings. LTHTR position (where possible) is detailed after each finding showed that:*

- **527,898 children are known to the hearing services.**
  At LTHTR this is 2,366.
- **In 2022 there were an estimated 8,405 children not supported by a hearing service.**
  It is not possible to define this.
- **Ninety-four percent of children referred to ear nose and throat (ENT) services were missing the six-week initial appointment target, with an average waiting time of 141 days.**
  At LTHTR the average wait for first appointment for ENT is 84 days.
- **More than half of respondents (52%) reported that their trusts were missing the 126-day target for grommets surgery. This was a rise of 23% since 2019. The average waiting time was now 178 days, with a maximum wait of 540 days.**
  At LTHTR the average wait for grommets is currently less than 30 days.
- **Most paediatric audiology services (79%) did not offer wax removal, and most of them referred children to ear nose and throat (ENT) services for this, leading to lengthy delays.**
  LTHTR provides a wax removal service in line with good practice guidance.
- **Thirty-nine percent of services failed to meet the 42-day waiting list target for an initial hearing assessment for babies and children who were not referred via newborn hearing screening.**
  At LTHTR the 42 day wait for initial hearing assessment for babies and children not referred via newborn screening is being met by the second tier service, but is exceeding this time for Tertiary service first appointments and Auditory Processing Disorder assessments.

Table 1: Wait times for hearing screening other than newborn hearing screening (Oct 2024 position)

Service	National Target	Average LTHTR wait times	Meet/Fail national Target
Non-Tertiary (2nd Tier audiologist)	42 days (6 weeks)	21 days (3 weeks)	Meets
Tertiary (consultant led)	42 days (6 weeks)	455 days (65 weeks)	Fail

- **Only 26 services (23%) reported that they were currently accredited by Improving Quality in Physiological Services (IQIPs).**
  LTHTR is not accredited or registered with IQIPs.

5. Assurance

The UKAS benchmarking tool for providers of audiology services considering accreditation to help them understand what stage they are at and where the focus of work is required has been completed in line with the CQC request. There is a detailed gap analysis process that has been undertaken by the Service Managers The findings have been considered by the service and the Fulwood has developed an action plan and Preston has action plan in development to respond to the areas that present the greatest risk and best opportunity to address whilst further discussions regarding accreditation take place.

There are risks identified as part of this self-assessment. There are currently 5 active risks highlighting a variety of concerns including estates, insufficient capacity and sustainability of the audiology service. These risks are monitored and reviewed regularly, with actions being assigned around gaps in assurances and controls. These are overseen by the specialty management and governance teams.

In addition to this, a Paediatric Audiology Quality Assessment Tool (PASQAT) has been completed and fulfils the requirements of the requested external evidence based assessment of the service. This was undertaken in July 2024 by NHS England.

The outcome of the Fulwood audiology review concluded the service was presenting a moderate risk at 72% and RPH presenting as a serious risk with the score at 45%. An action plan is contained within the appendix 2 and 3 demonstrating progress against each action.

CQC responses to specific questions

- **Whether you have achieved IQIPS accreditation, including whether there were any improvement recommendations made**
  LTHTR has not achieved IQIPS accreditation.
- **Whether you are working towards IQIPS accreditation.**
  LTHTR has undertaken the IQIPs gap analysis and has commenced actions to respond to the gaps identified. The decision to undertake IQIPs accreditation will be dependent on the decision to fund this from the Integrated Care Board (ICB).
- **What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.**
  The work to date has completed the gap analysis. The Board has received an overview of the service, gap analysis, incident and risk profile and the Paediatric Audiology Quality Assessment Tool outcomes and action plan.
- **The expected timeline for gaining accreditation.**
  A decision has not been made regarding this at this time given the financial implications of

accreditation, however, the service has commenced work to progress areas identified in the gap analysis.

- **The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.**
  A search of the Datix system has identified no incidents relating to audiology within the last 12 months.

6. Financial implications

Total Investment requested for CQC Response = £270k. Non-Recurrent Pay Cost of £124 per year until accreditation has been achieved and Total Non-Pay Cost over 4 years of £146k inc VAT and a registration cost of £146k per annum once accreditation is reached. The ICB are asked to coordinate the response to this letter of concern and therefore at this time no decisions have been made regarding the system approach to this and there is not a position on the provision of funds to support this.

7. Legal implications

The impact of failing to identify and treat children presents a risk to long term development for children and therefore increase risk of litigation.

8. Risks

The risk is identified on the risk register and is currently scoring a 3x3 (moderate x possible) = 9.

The title and number of the risk is - Risk Number 1961 - Non compliance with national standards (IQIPS accreditation). The risk relate to the lack of quality monitoring in place leading to a risk of reversable deafness for children.

There have been no incidents relating to the lack of quality management system to date.

9. Impact on stakeholders

Children and Young people and families may experience a suboptimal service as a result of reduced quality assurance monitoring.

10. Conclusion and next Steps

The report outlines the Trust's response to the concerns raised by the CQC regarding paediatric audiology. There is no evidence of harms on reviewing of the service. The services have undertaken and responded to the external assessments recommended with all remaining actions on track for delivery. The ICB is considering its position in relation to accreditation , whilst this decision is made the teams will continue to work towards the implementation of the standards to maintain safety.

11. Recommendations

The Board of Directors is asked to

I. Receive the response to the CQC
II. Note the PASQAT and IQIPS recommendations and actions plans for assurance
III. Confirm it is satisfied the information is used to formulate a response to the CQC

Appendix 1. CQC Letter to provider CEO's regarding Paediatric Audiology service
Appendix 2 –Fullwood PASQAT and IQIP recommendations and action plan
Appendix 3 – Preston PASQAT and IQIP recommendation

Audiology/PASQAT

Manager	Rebecca Cullen	Last Updated	Tue,07/01/2025 00:00
Team	Alysia Parkin/Sam Winterburn	Next Meeting	Tue,21/01/2025 00:00

ID	Domain	Risk Rating	Findings	Recommendations	Assigned to	Start Date	Due Date	Priority	Status	Actions
1	Calibration	Serious	Calibration certificate/s missing data regarding sound field standard. Room set up for sound field testing not specified on calibration certificate. Calibration certificate/s missing uncertainty of measurement Calibration certificate/s missing before & after adjustment values	Calibration required of Sound field Audiometer to include uncertainty of measurement / before & after adjustment values / Room set up for sound field testing.	SW	08/12/2024	28/02/2025	High	Inprogress	Already contacted Calibration Service to advise of omissions. Calibration certificates to be updated to address findings at next calibration. Due to Calibration service sickness, 2 pieces of equipment out of calibration. To be exchanged in clinic for calibrated equipment and to be calibrated on return-update due in April 2025.
2	Documentation	Moderate	Protocol/s not ratified/version controlled. No clarity over what constitutes an urgent referral	Development and version-controlled ratification of triage protocol to include urgent referrals.	SW/AUA/AH	08/12/2024	28/02/2025	Medium	InProgress	21/1/25 Clinician agreement for new policy. 28/2/25Ratification required at policy meeting.
	Documentation			Create documentation spreadsheet for SOPs	SW	08/12/2024	31/11/24	Medium	Completed	Documentation spreadsheet created and to be populated once reviewed documents ready to be peer reviewed to show progress.
3	VRA Rooms	Low	Photos of Carnforth Clinic not sent in but risk still remains low. Concerns that child can see tester during test. No viewing room window therefore tester should be behind child with camera insitu to enable viewing of face	Urgent review of facilities used for VRA testing with specific reference to current BSA Recommended Procedure (2024)	SW	08/12/2024	31/02/2025	Medium	InProgress	25/11/24 - Photos added to Padiatric Audiology Service Quality Assurance Tool sheet for future reference. Discussion of Visual Reinforcement Audiology room and concerns that child can see tester - temporary measures put into place during clinics however look into sourcing equipment to formally reduce risk of child seeing tester.
4	Audit	Serious	Audit plan does not reference British Acadamy of Audiology Quality Standards or other national standards. Audit plan does not specify completion dates	Inclusion of completion dates / annual audit cycle on audit plan	SW	08/12/2024	31/10/24	High	Completed	4/11/24 - Met with Audit lead - discussed audit and audits added to overall audit plan.
	Audit			Staff training on writing audit proposals, carrying out audit, and reporting outcomes may be beneficial.	SW	08/12/2024	30/09/24	High	Completed	Audit Management And Tracking training day organised for some members of staff - completed 18/9/24
5	Incident/Risk	Low Risk	No evidence of incidents or risks being managed at an appropriate governance level	Review of incidents/risks within the Paediatric Audiology service and how these are recorded/managed.	SW	08/12/2024	30/09/24	Medium	Completed	Arrange Multi Disciplinary Team to review risks - to include Datix team (when required) Triumvirate meetings have been arranged - first one 24/9/24 to review risks
	Incident/Risk			Staff training on recognising and reporting risks/incidents may be beneficial	SW	08/12/2024	30/09/24	High	Completed	7/1/25 - No further Datix training dates but assurance from Governance and Risk Manager that training provided within Heath & Safety mandatory training

Audiology/IQIPS

Manager	Rebecca Cullen
Team	Alysia Parkin/Sam Winterburn
Last Updated	##################
Next Meeting	##################

ID	Action Item	Assigned to	Start Date	Due Date	Priority	Progress	Status	Actions
1	IQIPS Gap analysis f	SW	24/07/2024	16/08/2024	High	100%	Completed	Spreadsheet completed
2	Add risk to register following audiology oversight group	SW/RC	25/07/2024	08/08/2024	High	100%	Completed	Added to the risk register active by 08/08/24. Risk paper created
3	Create a paper following the IQIPS Readiness tool completion to present at September Executive Safety and Quality Committee	RC/AP	18/08/2024	02/09/2024	High	100%	Completed	Paper has been completed
4	Progress to be delivered at divisional F&P on a monthly basis to highlight progress and risks	RC/AP	20/08/2024	ongoing	Medium	100%	Completed	First delivery at meeting 20/08/24 Updates taken to Finance and Perfomance Committee.
5	Example of patients booked on to audiologist led clinic from April - new patients	SW	12/07/2024	12/07/2024	High	100%	Completed	Example of patients provided to the Divisional Director
6	Investigate if activity for new patients is variable or block	LW/RP	25/07/2024	08/08/2024	Medium	100%	Completed	Variable for consultant 18 week new and block for all other activity
7	What additional resource is required in order to reduce waiting times	AP/SW	25/07/2024	31/01/2025	High	80%	InProgress	* Hyperacusis leaflet have been created to support consultant. *Dr Ahmed will provide oversight training for audiologists to accommodate and triage for consultant appointment or if advice and guidance is appropriate. * Funding secured for hyperacusis course in Feb. Awaiting confirmation of place
8	Identify what can be audiologist led	AP/SW	25/07/2024	31/01/2025	High	100%	Completed	7/1/25 - Dewax and balance pathways implemented. Audiologist to attend hyperacusis course in Feb 25 - to then
10	Tariff implications for moving dewax	RC/RP	25/07/2024	15/08/2024	Medium	95%	Completed	Audiologists trained and ready to change
11	Competencies for Audiologist to undertake dewax and balance clinincs	AA/SW	25/07/24	31/10/24	Medium	100%	Completed	Competencies to be recorded - documentation to be agreed Evidence being collated of all competencies completed. 30/10/24 - 2x balance competencies and 1 x dewax competencies completed so far. Balance clinics and audiologist led dewax clinics now live.
12	Review opportuniti	SW	25/07/2024	21/08/2024	Low	100%	Completed	ENT to make contact with proposal for Glue Ear pathway.
13	Check Adult audiolo	SW	25/07/2024	25/07/2024	High	100%	Completed	Not in a position to
14	Contact other paed	AP/SW	25/07/2024	22/08/2024	High	100%	Completed	Meeting with Clinical lead at Salford Royal to look at lean working and efficiencies - 22/8/24

Preston Audiology/PASQAT
for the Paediatric Diagnostic EP service

CBU manager	Michael Baxter (MB)			Last Updated	14.01.2025
Clinical lead	Chris Brockbank (CB)				
Team	Emily Halliwell (EH) Julie Bath (JB)			Next Meeting	12.02.2025

ID	Domain	Risk Rating	Findings	Recommendations	Assigned to	Start Date	Due Date	Priority	Progress Status	Actions	updates
1	Calibration	Serious Risk	Calibration certificate/s missing data regarding one or more stimulus type – there is no evidence that the Chirp stimulus has been calibrated which is the routine stimulus used for the ABR test at this site. Calibration may therefore be outside +/- 3dB tolerance (assumed as not detailed in calibration report) before adjustments	Urgent calibration required of ABR test equipment to include chirps, reference to relevant British Standard.	CB/EH	16.09.2024	11/11/2024	High	Completed	1. Ceased use of Chirp stimulus with immediate effect. 2. Equipment being sent for urgent calibration. 3. As there is only one EP deck loan equipment is in place to ensure continuity of service whilst the equipment is off site	**25.10.2024** Loan equipment on site and PAT tested for use until 11.11.2024 Purchase order now in place so the equipment can now be sent for calibration **08.11.2024** Calibration certifcate received
2	Documentation	Serious Risk	There is a process for triage but there is no documented protocol for this. There is reference to a draft assessment protocol in the resubmission however this has not been submitted. National guidelines are mentioned but not appropriately references. There are no clear indications on what constitutes an urgent referral.	There should be a written protocols for identification of urgent referrals, triage, assessment and onward management – it is recognised that some of these may be in place but have not been submitted and therefore this should be explored further. All SOPs, protocols and guidelines should reference national guidelines appropriately.	EH	16.09.2024	~~31/12/2024~~ 28/02/2025	High	In progress	1. SOP for triage to be re-written and signed off in SBU meeting	**14.01.2025** SOP drafted and date extended to allow time for the ratification process to be completed
3	VRA Rooms	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	Audit	No Risk	Further evidence has improved the score in this domain	N/A	EH	16.09.2024	~~01/12/2024~~ 28/02/2025	Medium	In progress	1. Audit plan to be finalised. 2. Audit to be presented through specialty governance meeting.	Plan being developed for audit programme review. Audits to be logged on AMAT system. **14.01.2025** The AMaT team attended the ENT audit meeting in Jan 2025 and this was discussed. Date extended to allow for the audit cycle to be formalised.
5	Incident/Risk	Serious Risk	No examples of incidents or risks provided. No incidents or risks within the last 3 months No evidence of ownership of incidents or risks	There is no evidence of ownership of risk and incidents and no formal recent incident logs were shared to demonstrate good governance	CB	16.09.2024	Immediate	High	Completed	1. Review arrangements for incident and risk reporting. 2. Monitor incident reporting through specialty governance meeting. 3. Produce reports that demonstrate good governace within the specialty.	Risk management report is shared at the monthly SBU meetings with process to report CBU risks into Divisional Safety & Quality Committee on regular basis. There is 1 risk documented regarding non compliance with national standards ie IQIPS accreditation.
6	Clinical Registration	No Risk	Further evidence has improved the score in this domain. All staff who work in the ABR service hold professional registration	N/A	CB	N/A	two yearly	n/a	Completed	1. Human Resource processes in place to moniotr professional registration.	n/a
7	ABR	Low Risk	Minor issues raised <50% testers. Minor issues were identified by the regional peer review.	None given	EH	16.09.2024	Ongoing	Medium	Completed	1. All clinicians qualified and partcipating in peer reviewing.	**14.01.2025** ABR is work intensive. It takes approex 23 hours to perform a ABR by a B7 audiologist. There are currently 2x B7 audiologists completing ABR. Service lead planning to meet with EHLT to review their staffing arrangement for ABR.

8 April 2024

Dear colleague,

Re: Paediatric audiology services

As you may be aware, an expert review undertaken by NHS Lothian in Scotland found failings in the standard of paediatric audiology services that resulted in delayed identification and missed treatment of children with hearing loss. This resulted in permanent, avoidable deafness for some children.

These findings led to a review of the service provided by 4 NHS trusts in England which found similar failing. A Paediatric Hearing Services Improvement Programme has been established by NHS England to support providers and integrated care boards (ICBs) to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements.

Childhood deafness is a significant health and developmental risk. A National Deaf Children's Society survey in 2023 showed that:

- 527,898 children are known to the hearing services.
- In 2022 there were an estimated 8,405 children not supported by a hearing service.
- Ninety-four percent of children referred to ear nose and throat (ENT) services were missing the six-week initial appointment target, with an average waiting time of 141 days.
- More than half of respondents (52%) reported that their trusts were missing the 126-day target for grommets surgery. This was a rise of 23% since 2019. The average waiting time was now 178 days, with a maximum wait of 540 days.
- Most paediatric audiology services (79%) did not offer wax removal, and most of them referred children to ear nose and throat (ENT) services for this, leading to lengthy delays.
- Thirty-nine percent of services failed to meet the 42-day waiting list target for an initial hearing assessment for babies and children who were not referred via newborn hearing screening.
- Only 26 services (23%) reported that they were currently accredited by Improving Quality in Physiological Services (IQIPs).

The main themes identified by providers in the same survey were long waiting lists, staffing issues, increasing demands on services, barriers to gaining Improving Quality in Physiological Services (IQIPs) accreditation and other resource or funding issues.

The total number of children with permanent deafness reported to be on services' caseloads has decreased by more than 7% since 2019. The incidence of permanent deafness generally remains stable, so this may suggest that some children have not yet been identified.

CQC are working closely with NHS England to help understand the current situation across the country regarding the level of assurance boards have about the quality of hearing services for children that they commission or provide.

The UKAS IQIPS (Improving quality in physiological services) is the only recognised accreditation standard for physiological science services inclusive of audiology services. Whilst accreditation cannot be mandated by CQC, we strongly encourage participation in UKAS diagnostic accreditation schemes, including IQIPS. Participation and performance in such schemes are evidence of good practice that is used to inform CQC's judgements about the safety and quality of care. ICB's should ensure there are plans in place so that trusts can implement, achieve, and maintain accreditation using the available tools, and that there is oversight of quality management systems.

Services that are not IQIPs accredited should formally register this as a quality risk in their quality reporting system.

Please can I ask that at the next full board meeting, the board considers the assurance that they have about the safety, quality, and accessibility of your children's hearing services. Following that consideration, the board should submit a report to CQC that makes clear:

- Whether you have achieved IQUIPS accreditation, including whether there were any improvement recommendations made.

- Whether you are working towards IQIPS accreditation.
- What stage that work has reached and the assurance the board has about paediatric audiology, using the IQIPS standards as a guide for the areas to tell us about.
- The expected timeline for gaining accreditation.
- The number and severity of incidents where a child has suffered detriment due to delayed or missed diagnosis or treatment or not received timely follow up care and support.

NHS England have asked that where services that are **not** UKAS IQIPS accredited, heads of services should provide an external evidence-based assessment of their provision. If your services are not UKAS IQIPS accredited, we would like you to include a copy of that assessment report when responding to this letter.

Boards may be aware that UKAS have a benchmarking tool for provider of audiology services considering accreditation to help them understand what stage they are at and where the focus of work may need to be. Please can you supply a copy of the completed tool if you have used it.

We are keen to understand the progress made towards accreditation and how the service across the county is improving over time. We would therefore ask that further to your initial report to CQC (as outlined above), an additional review of assurance is conducted at a subsequent board meeting and a further follow up report on progress is provided to us.

The intent of this letter is information gathering and to gain a picture of service provision and the speed with which improvements are being made across the country. We are wanting to collaborate with other stakeholders to do our part in bringing about improvements in the care and treatment of this cohort of children.

Information returns from providers will be shared with operational colleagues to add to the wider information held about providers. It may be used to assist in the determination of risk levels within services for children and young people, but at this point it is not the intent to undertake stand-alone site visits based on what we are told about the service in your trust. That does not mean we will not conduct a thematic review or bespoke assessment process in the future, but rather to reiterate that we want to focus on getting a clear picture about what is happening at provider level now.

For clarity, we require consideration by the full board at the next meeting. An initial response should be sent to CQC no later than 30 June 2024. A subsequent response should follow after the next full board meeting. If there is any reason this cannot be achieved, please do come back to us with the reasons and when you consider you might be able to tell us about your service.

Please send your responses to Terri Salt, the lead senior specialist for this work, by email to terri.salt@cqc.org.uk. Terri can also be contacted if you have any questions or queries about this letter.

Yours sincerely,

Prem Premachandran MBE
Medical Director
Care Quality Commission

10.3 MATERNITY AND NEONATAL SERVICES REPORT

Other | J Lambert | 14.10

Item for Assurance

REFERENCES

Only PDFs are attached

10.3 - Maternity and Neonatal Safety Report - Board of Directors February 2025.pdf

Board of Directors

Maternity and Neonatal Services Safety and CNST Validation Report

Report to:	Board of Directors	**Date:**	6 February 2025
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 report in relation to safe staffing and the safety, quality, assurance and oversight programmes of work including the Clinical Negligence for Trust (CNST) Maternity Incentive Scheme (MIS) final position at the end of the year 6 reporting period. The report covers the period up to December 2024 and has been scrutinised at Safety and Quality committee in January 2025.

Regarding the year 6 CNST MIS standards, quarterly validation and assurance visits have been undertaken throughout the year 6 MIS reporting period with the Local Maternity and Neonatal System (LMNS) on behalf of the ICB. The purpose of the visits is to review the evidence of compliance against each of the 10 standards. As of the 13 December 2024, the service confirms that all the evidence has been reviewed and signed off by the LMNS and that all ten CNST standards have been met (10/10).

To be eligible for the incentive scheme renumeration, there is also a requirement that at the end of the reporting period, for the Trust Board receive a joint presentation, detailing the progress against the safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for maternity services. This should occur prior to the Trust submission and declaration of compliance to NHS Resolution (NHSR) by the Trust Chief Executive Officer (CEO) and Integrated Care Board (ICB) Accountable Officer (AO) by 12 noon on 3 March 2025. The presentation is included in Appendix 1 (CNST MIS standards information pack) for approval by the Board of Directors.

The perinatal quality surveillance dashboard (PQSD) supplementary information pack is included in Appendix 2. Areas of increased pressure are demonstrated in the trends associated with the red flag reporting, delay in induction of labour, including transfer to Delivery Suite during the induction of labour process, delay in being assessed within 15 minutes by a midwife in MAS and a delay in the review by an obstetrician, within 30 minutes in maternity triage continue to be the highest reporting categories. Analysis of triage performance is overall positive with performance of triage within 30 minutes achieving 97.6% and within 15 mins 95.9%. Areas where this is not occurring are analysed within the report and highlight out of hours as the area that require improvement. Work is underway to address this.

Clinical indicators which are showing positive performance relate to antenatal booking and interventions to improve performance in these areas show signs of being effective. Although there has been an increase in

stillbirths in the month of December 2024, this is not statistically significant and 2024 has been the most improved rate overall since 2008.

In the Month of December 2024, sadly there was one case of maternal death at 26 weeks and 3 days. This was an unexpected death at home. Initial review of the case has been undertaken by the service. The woman was receiving maternity care but had numerous social complexities. This case has been reported to his majesty's coroner and has been accepted for review by the Maternity and Newborn Safety Investigations team (MNSI).

The service confirms that it awaits the final funding for the 6.86 WTE registered midwife (RM) funding in the financial planning round agreement in early 2025. This will align the service with the 2022 Birth Rate Plus requirements.

The fill rates for Registered Midwives (RM) (89%-day, 91% night) and Maternity Support Workers (MSW) (73% day and 90% night) in December 2024 demonstrates a stable position overall. The lower-than-expected fill rates for support workers during the day continue to be attributed to long term sickness on maternity A and close monitoring of the establishment is ongoing.

The vacancy is currently 9.72 WTE RM which reduces to 5.7 WTE in March 2025 following new starters and returners from maternity leave. The ability to recruit continues to be delayed by the additional measures that are in place associated with the financial recovery plan and the vacancy control process (VCP) is in progress to re-open the advert for registered midwives.

The CQC investigation into a maternity case continues and the Board will receive an update on this in due course.

The service confirms a stable position overall resulting from the improved midwifery staff in post and the stable leadership from the substantive obstetric workforce. Work continues in relation to monitoring and oversight of obstetric safe staffing models, induction of labour and maternity triage workstreams.

RECOMMENDATIONS

The Committee is asked to:

I. Approve the Maternity and Neonatal Service Update, noting the endorsement from the safety and quality committee

II. Receive the CNST Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans for oversight and assurance**.**

III. Note the presentation of the evidence, which was validated by the LMNS on the 13 December 2024, and confirms it is satisfied to approve the CEO to declare compliance with 10 CNST MIS standards and sign the declaration leading to this report being signed as approved by the CEO and ICB Accountable Officer for sign off by 3 March 2025.

1. CNST MIS Information Pack including the sign off presentation
2. Perinatal Quality Surveillance Supplementary Pack
3. Red Flags
4. Induction of labour trend data.

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 up until December 2024. The report triangulates workforce information with safety, patient experience and clinical effectiveness indicators for Board assurance and oversight. In addition, the CNST MIS final position at the end of the year 6 reporting period is detailed in the report prior to the Trust submission and declaration of compliance to NHS Resolution (NHSR) by the Trust Chief Executive Officer (CEO) and Integrated Care Board (ICB) Accountable Officer (AO) by 12 noon on 3 March 2025.

2. MATERNITY INCENTIVE SCHEME (MIS)

The ten MIS safety actions continue to drive standards for safer maternity and neonatal care based on NHS England's long-term plan to reduce stillbirth rates, maternal morbidity, neonatal mortality and serious brain injury by 50% by 2025.

A summary of the final position and progress for CNST MIS year 6 against all 85 actions within each of the safety standard is detailed below. (Table 1). In December 2024, the CNST standards were validated by the local Maternity and Neonatal System LMNS, and the evidence was signed off against all ten 10/10 standards.

Table 1 Safety Action Summary of Compliance.

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	0	6	6
2	0	0	0	2	2
3	0	0	0	4	4
4	0	0	0	20	20
5	0	0	0	6	6
6	0	0	0	6	6
7	0	0	0	7	7
8	0	0	0	17	17
9	0	0	0	9	9
10	0	0	0	8	8
Total	0	0	0	85	85

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

Table 2 provides an overview of the status of all 10 safety standards and provides a high-level summary of the actions taken to meet the requirements and achieve compliance.

Table 2 Details the status of all 10 safety actions

Safety Action 1 PMRT	Description	Progress	Evidence	Status
	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 22 cases reported within the reporting period, 16 of which were 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 confirms that it has met 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. For cases in the new reporting period, the service continues to report as defined by MBRRACE-UK	Appendix 1. Table 1,2,3	Validated
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 service confirms that validation of data submissions relating to activity in July 2024 has been undertaken and the MIS standards have been met for year 6.	Shared in previous reports	Validated
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 is ongoing as defined by MIS year 6.	Shared in previous reports	Validated
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 significant investment in the obstetric consultant roles and leadership. Business case is being collated for 2 tier model and an obstetric workforce action plan is ongoing.	Shared in previous reports	Validated
		Neonatal Medical A local workforce review of the neonatal medical staffing requirement to achieve British Association of BAPM standards was undertaken in 2023. Realignment of job plans, and use of the ORDER programme means that from February 2025 a 1:8 rota for all grades will be achieved. This will enable the neonatal service to declare BAPM compliance.	Shared in previous reports	Validated

		Neonatal Nursing: The Northwest Neonatal Network monitor staffing levels against BAPM standards using the Clinical Reference Group neonatal nurse calculator. Compliance with the standard is presented within the Activity Capacity Demand (ACD) report which was published 2023/24. The report confirms that the service has enough nurses within the establishment to be compliant to BAPM standards based on the average activity for the previous 3 years.	Shared in previous reports	Validated
		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.	Shared in previous reports	Validated
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.				
Safety Action 5 Midwifery Staffing	Description	Progress	Evidence Source	Status
	CAN YOU DEMONSTRATE AN EFFECTIVE SYSTEM OF MIDWIFERY WORKFORCE PLANNING TO THE REQUIRED STANDARD?	The second safe staffing report for 2024 was presented to the Board of Directors in October 2024. The funding to meet the requirements of Birth Rate plus 6.86 WTE was approved and will be enacted as part of the financial planning round in 25/26.	Bi-annual Safe staffing repots April and October 2024	Validated
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 91% compliant with the 70 cumulative actions. The service confirms that two (with a third planned) quarterly quality improvement discussions have taken place, and that sufficient progress has been made with full implementation of the care bundle. Therefore, the standard was externally verified by the LMNS/ Integrated Care Board in November 2024.	Appendix 1 CNST Validation report	Validated
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. The Continuous improvement plan				
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. The MNVP chair continues to attend the monthly maternity Safety and Quality meeting. Quarterly MNVP meetings continue to be held between service users and providers to collect safety intelligence and feedback in line with MIS year 6.	Shared in previous reports	Validated
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 – over 90% overall and for each eligible staff group. **BASIC NEONATAL LIFE SUPPORT** Compliance of the neonatal and medical newborn life support is tracked in line with MIS year 6. 90% achieved overall including midwifery neonatal medical and nursing including for each eligible staff group. **FETAL MONITORING** – over 90% achieved in all required staff groups 97% overall including for each eligible staff group.	Shared in early reports at the end of the reporting period on the 30 November 2024	Validated
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				
Safety Action 9	Description	Progress	Evidence	Status
	CAN YOU DEMONSTRATE THAT THERE IS CLEAR OVERSIGHT IN PLACE TO PROVIDE ASSURANCE TO THE BOARD ON MATERNITY AND NEONATAL, SAFETY AND QUALITY ISSUES?	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 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	Appendix 2	Validated
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.				
Safety Action 10	Description	Progress	Evidence	Status
	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?	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). Timeframe: Quarter Two 2024-2025 — New MNSI referrals: 2 Timeframe: Quarter Three 2024-2025. — New MNSI referrals: 1 – Maternal death	Appendix 1	Validated
A quarterly report is collated on AMAT to confirm that all qualifying cases have been report in line with MIS year 6.				

A detailed presentation of the evidential requirements for each standard, taken from the Board declaration tool is also included in Appendix 1 CNST MIS Information Pack) and confirms that all 85 actions and sub actions have been met.

To be eligible for payment under the CNST scheme, the Trust Board must confirm that they are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions. In addition, Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with: MBRRACE-UK data (safety action 1 standards a, b and c). NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria). National Neonatal Research Database (NNRD), MNSI and NHS Resolution for the number of qualifying incidents reportable (safety action 10, standard a). Trust submissions will also be sense checked with the CQC.

3.0 THE PERINATAL QUALITY SURVIELLENCE DASHBOARD- PART 2

Maternity staffing metrics are displayed on the perinatal quality surveillance dashboard (PQSD) each month which is submitted to the Safety and Quality Committee and presented to the Board of Directors for oversight. The statistical process control (SPC) charts detailed in the PQSD supplementary information pack, provides a data platform for interpreting the statistical significance of data points each month. Further development of this dashboard is ongoing with the Director of Midwifery and Clinical Director to refine this data to include regional or national comparator data where this is available. (Appendix 2)

3.1 CLINICAL SAFETY INDICATORS

3.1.1 STILLBIRTH

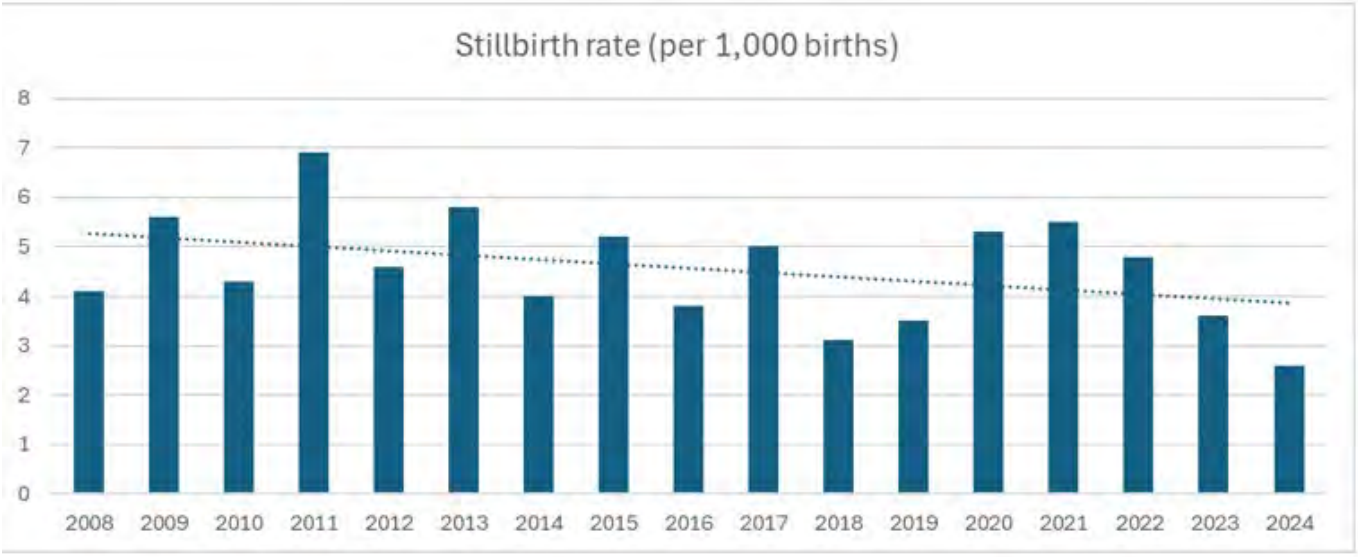
The stillbirth rate in England was updated nationally in October 2024 (MBRRACE) to 3.9 per 1000 births. The government ambition to achieve a 50% reduction in the stillbirth rate by 2025, compared to the 2010 rate continues to be the target aspiration. For the service the stretch target equates to a rate of 2.6 stillbirths per 1,000 births.

To understand local performance, the stillbirth rate continues to be monitored monthly by the service. The current mean still birth rate is 2.6 per 1000 births. (December 2024) In November 2024 there was one stillbirth and in December 2024 there were three stillbirths, two of which were at term. When the trend data was reviewed, the rate for December 2024 is equal to the highest rate across all other months, which is not unusually high based on expected variation. All cases have been referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) and PMRT for detailed review Perinatal Mortality Review Tool.

The service continues to work towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025. Ongoing work includes drawing on national guidance, using CNST safety standards as a lever for improvement and delivering on the Saving Babies Lives Care Bundle version 3. (SBLV3)

From a national perspective, the Office of National Statistics (ONS) data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. To understand this data in local context, a retrospective review of rates of stillbirth within the service has been undertaken and the local rates from 2008 have been collated for oversight. Chart 1 details the stillbirth rates per 1000 births each year. The national pattern described above aligns to local performance. It should be noted that higher rates were demonstrated between 2020 and 2022, with an improving position evident since 2023, with the lowest stillbirth rate recorded in 2024.

Chart 1: Trend data for stillbirths over time 2008-2024



The trajectory to meet the national ambition is unlikely to be a simple linear progression, particularly as the factors that lead to avoidable perinatal mortality are many and varied. However, the perinatal team continue to use the series of interventions described above to improve outcomes. Having the right number of experienced obstetricians and specialists in fetal and maternal medicine and neonatal consultants alongside an appropriately staffed midwife team will reduce variation and improve perinatal outcomes.

An issue has been identified in relation to internal data coding for stillbirths where the rate of stillbirth reported as lower than expected when compared to the cases reported externally by the service to MBRRACE. In response to this, it has been agreed that a process to validate the internal data will be implemented and this will be overseen by the Mortality and End of Life Committee for monitoring and oversight.

3.1.2 HYPOXIC-ISCHEMIC ENCEPHALOPATHY (HIE)

Rates of Hypoxic- ischemic encephalopathy are monitored by the neonatal service as an indicator of safe maternity and neonatal care. In November and December 2024 there were no cases of cooling or grade 2 or above HIE on Magnetic resonance imaging MRI scan at 7 days.

3.1.3 NEONATAL DEATH

In the month of November and December 2024 there were no neonatal deaths within 7 days.
The 2022 CQC investigation into the neonatal sepsis case continues, an update will be provided in due course.

3.1.4 MATERNAL DEATH

In the Month of December 2024, sadly there was one case of maternal death at 26 weeks and 3 days. This was an unexpected death at home. Initial review of the case has been undertaken by the service. The woman was receiving maternity care but had numerous social complexities. This case has been reported to his majesty's coroner and has been accepted for review by the Maternity and Newborn Safety Investigations team (MNSI).

3.1.5 BOOKING BY 9+6 and 12+6

Booking compliance has continued to meet the target defined by the antenatal and newborn key performance indicators consistently in 2024 and the statistical process control chart indicates an 8-point improvement in

performance. In December 2024, 61.3% of women were booked by 9+6 weeks gestation and 92.0% were booked by 12+6 weeks. The early bird sessions continue to be delivered and are evaluated well by women who attend. Progress is also being made with the translation of the early bird public health information into up to 10 most common languages.

4.0 SAFE STAFFING INDICATORS

The fill rates for Registered Midwives (RM) (89%-day, 91% night) and Maternity Support Workers (MSW) (73% day and 90% night) in December 2024 demonstrate a stable position. Several areas continue to have increased weekly sickness rates associated with seasonal absence which has affected fill rates in month and resulted in an increase in bank and agency spend associated with Delivery Suite, Maternity A and B and maternity assessment suite.

The implementation of the strengthened approval and oversight processes for bank and agency approval continues to be utilised to ensure that the service is maximising efficient use of resources whilst continuing to prioritise safe care. However, there is a continued requirement to use bank and agency to backfill unfilled shifts.

The rates of agency pay to align Lancashire Teaching Hospitals with other providers in the Integrated Care Board has been capped from the 1 January 2025. In response, the service continues to prioritise safety critical shifts being sent to bank. An initiative to recruit and convert regular agency workers to bank contracts is ongoing and to date 5 WTE midwives have joined the bank. Bank use provides greater stability for the service enables closer oversight of staff who are employed. The ability to use temporary staffing colleagues who are know the service also reduces unwarranted variation associated with being familiar with guidelines and process.

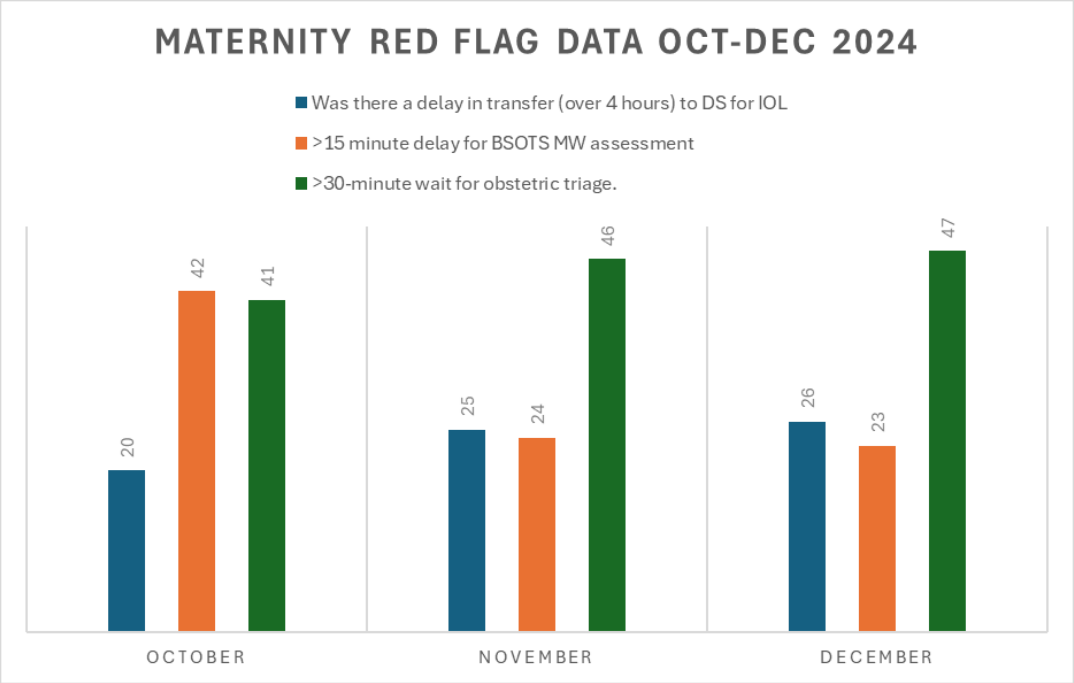
The vacancy is currently 9.72 WTE which will reduce to 5.7 WTE in March 2025 following new starters and returners from maternity leave. Recruitment to the vacancy has been delayed by actions taken to support the Trust financial recovery plan. The Vacancy Control Process (VCP) is being followed to ensure that safety critical midwifery posts are prioritised, but delays associated with the additional sign off requirements are affecting timescales for recruitment.

5.0 RED FLAGS QUARTERLY SUMMARY

The incidence of maternity red flags continues to be monitored. In addition, the red flags are added to the associated risks on the register for additional oversight by the Division. The service reported 475 maternity red flag Datix incidents in Quarter 3 and the full breakdown by category is provided in appendix 4.

The highest number of red flags were reported in the category of delays during the induction of labour and waiting for a review by an obstetrician in the maternity assessment suite (MAS). Chart 2 details red flag reports for each of the highest reporting categories. This data continues to indicate that induction of labour and maternity triage provision should continue to be prioritised.

Chart 2 Red Flag data trends Quarter 3 2024.



Whilst the red flags are acknowledged, in December 2024, 96% of women attending MAS were seen within the NICE recommended time frame of 15 minutes and 98% of women were seen within 30 minutes of arrival in the department. Further updates in relation to triage and induction are included later in the report.

6.0 PERINATAL QUALITY GOVERNANCE EXPERIENCE AND REGULATION

NHS NATIONAL CARE QUALITY COMMISION (CQC) MATERNITY INSECTION KEY LINES OF ENQUIRY TRIAGE AND INDUCTION OF LABOUR

Between October 2022 and December 2023, the Care Quality Commission (CQC) undertook a comprehensive review of 131 maternity services. Key themes were identified and included:

- Safety and Investigation Concerns
- Risk assessment and triage,
- staffing and Workforce
- Wellbeing health inequalities
- Inadequate Estates and Equipment.

The service has considered these themes in relation to the national maternity inspection programme and in relation the CQC must and should do actions associated with the inspection undertaken at Lancashire Teaching hospitals. Table 3 provides an update on the themes that were pertinent and focuses on maternity triage and workforce.

Table 3 Themes and Learning from national CQC maternity Inspections – Key Lines of Enquiry

Theme	Area of focus	Update	RAG
Risk assessment and triage	Patient prioritisation	Clinical prioritisation tool to mitigate risk and define safe waiting times is used as per BSOTS algorithms	Delivered
	Timeliness for initial assessment	Audits in place over 90% compliance with 15-minute review. Monitored via	Delivered

		perinatal quality surveillance tool and reported to Trust Board.	
	Oversight of those waiting	Waiting area is located in the department and women are assesses according to clinical presentation. They are then re-assessed in line with waiting times defined by BSOTS.	Delivered
	Staff training and competence	Maternity Assessment suite has core midwifery and support staff. All staff trained in BSOTS, and regular updates are provided which includes lessons learned.	Delivered
Telephone Triage	Call monitoring system available which monitors drop off rates and call waiting answered by a midwife	Audit system in place to monitor call drop off. Telecoms solution in progress. All staff are trained in the call handling and engineer work to install is completed. Awaiting confirmed start date aligned to the move of phase one of the planned work to ANC.	Completion date expected 31.01.2025
In person Triage	BSOTS–Birmingham Symptom-Specific Obstetric	Partial implementation of BSOTS using clinical prioritisation tool to mitigate risk and define safe waiting times. Tools available for use to stratify risk include MEOWS, SBAR and BSOTS algorisms	
	Triage System (recommended in the RCOG's Good Practice Paper on maternity triage 2022).	Benchmarking exercise against the RCOG what good looks like paper. Current compliance 86%. Outstanding actions associated with the telephone handling and answering system. As above.	Actions identified and in progress
Triage Environment	The environment should be designed to ensure a clear flow of women through triage	Waiting areas out of the direct line of sight of clinical triage staff. 2 private rooms and 5 couches, 1 ultrasound scan room	Delivered
Triage Safe Staffing Midwifery	Staffing should be aligned to the RCOG good practice paper 'maternity triage' 2022.	The service has effective triage systems had adequate staffing levels and space to manage flow of people into the service.3000-4500 births per year • One midwife 24/7 • One additional midwife for peak time of workload (usually 1–9pm) 1 to answer calls. The establishment	Delivered
Triage Safe Staffing Obstetric	Staffing should be aligned to the RCOG good	Paper ongoing to strengthen obstetric oversight 24/7. Current staffing includes Monday to Friday 9-	Board approval

	practice paper 'maternity triage' 2022	5pm provision. Wider work required to increase second tier cover.	planned April 2025

7.0 MATERNITY TRIAGE

Maternity triage continues to hold high profile in national, local and regulatory arena's due to the high risks associated with managing unplanned emergency maternity attendance. The service continues to see increasing numbers of women who attend the maternity unit with concerns about their pregnancy. While there are many contributory factors, such as access to primary care, the increase in women with multiple morbidities who become pregnant or women receiving complex maternal of fetal medicine care there is a knock-on effect is the additional pressure on triage which needs to be safely mitigated.

Investment in leadership, core staffing and the introduction of maternity support workers have stabilised the service. Work to improve obstetric oversight is ongoing and must be considered to strengthen review times for high-risk women, particularly out of hours.

A breakdown of performance for December 2024 is detailed in chart 3 and 4. Chart 3 includes the number of women reviewed in the maternity assessment suite in December 2024 including waiting times and chart 4 details the times when review by an obstetrician is delayed.

Chart 3 Initial review time for review by a midwife - December 2024.

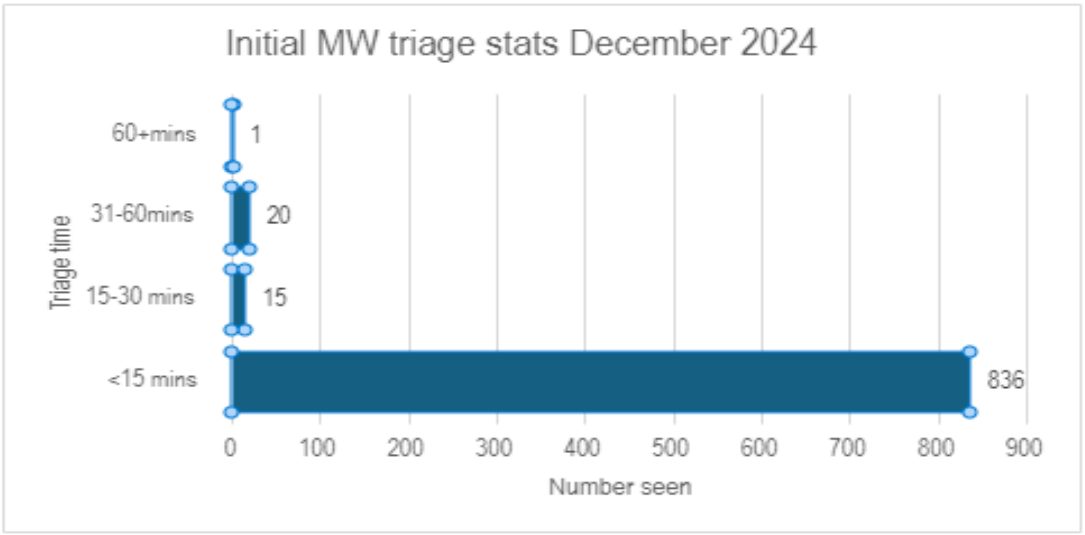
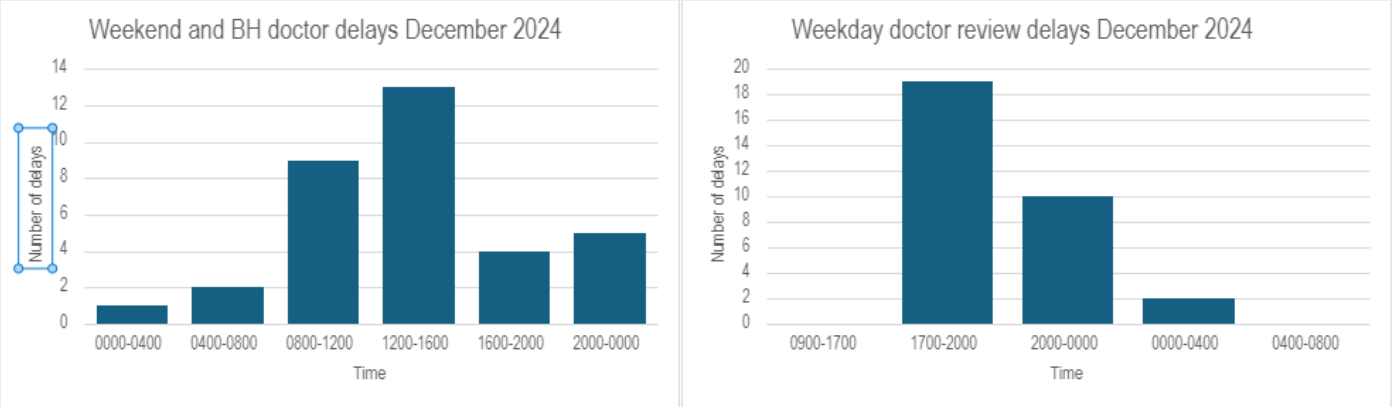


Chart 4 provides an overview of delays by time of day both in and out of hours. Analysis of the data demonstrates that most delays occur out of hours and at weekend, when a dedicated obstetrician is not assigned to cover the service. This confirms that the actions detailed in the obstetric workforce review to scope a 2-tier middle grade roster is required and will address the areas that are not routinely meeting the required standard.

Chart 4 Week Day and Weekend delays by time of Day.



The MIAA internal audit is ongoing in maternity triage to provide an external review of the provision of this service. The site visit was undertaken in December 202 and the review of the data is ongoing. The Committee will be updated of the outcome due course.

8.0 DELAYS IN INDUCTION OF LABOUR

A working party to ensure that delays in induction are tracked and monitored is ongoing and the outcomes will be shared to ensure that the profile of delays in induction are understood, and that the data can be used to shape the service and mitigate risks appropriately. It has been agreed with the Divisional Midwifery and Nursing Director that in addition to this, a multi-disciplinary rapid improvement event to deep dive the full process will be arranged, this is in response to induction being a focus for safety across the perinatal period.

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. When this happens, the records are reviewed to consider the impact and potential harm and all women receive a letter of apology and explanation.

9.0 OBSTETRIC WORKFORCE

The service confirms that it is fully recruited to all consultant posts and work is ongoing to review the job plans to maximise efficiency. Currently, the consultant rota presence is 90 hours per week.

The most recent workforce publication from the Royal College of Obstetrics and Gynaecology in 2022 acknowledges that maternity services are dynamic and that there is now a recognition that different units will agree different base levels of staffing according to their size, case mix, acuity and complexity of caseload. This flexibility exists to allow services to consider how best to safely staff the maternity and gynaecology units, whilst mitigating individual risks dependent on service requirements. Lancashire Teaching Hospitals has a major trauma centre, is the neurology referral centre and is now the maternal medicine centre for Lancashire and South Cumbria. This means that there will continue to be an increasingly complex group of women who require care within the maternal, fetal and neonatal care pathways.

In view of national recommendations, the medical workforce requirements need to consider models that balance the requirements for the maternity, gynaecology early pregnancy services. Given the needs of the maternal medicine centre and the fact that out of hours there is currently only one tier of middle grade doctors across

maternity and gynaecology, the service may be better served with a greater number of more experience middle grade doctors available on site 24/7 for immediate review. This would mean that fewer than 98 hours consultant presence hours would be required, but that the ability to avoid delays in time critical activity would be reduced. There would continue to be an immediate recourse to consultation support when required.

This alternative workforce plan is currently being explored. Considering reutilisation of workforce resource would meet all the national safety standards, providing wider opportunity to mitigate risks associated delays in treatment across maternity triage and EPAU. This would also potentially create a more cost-effective solution in the current context. The committee will be updated in due course.

10. 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.

There has been a statistical reduction in the numbers of intrauterine transfers has declined and this is evident in the SPC data analysis. This demonstrates a commitment by both services to accept intrauterine transfers. Intrauterine transfers will continue to be monitored.

11. CLOSURES OR DIVERTS

In the month of November 2024 there was one maternity divert. This was due to increased unit acuity on the night shift. The unit was diverted 6 hours and during this time 4 women were transferred to alternative providers for assessment. Two women gave birth and 2 were discharged back to our care. All women were contacted following this divert and there were no incidents of associated harm.

12. WELL-LED

SINGLE DELIVERY PLAN (SIP)

Progress against the maternity and Neonatal work stream for the Trust single delivery plan is ongoing. Workstreams are aligned to national priorities associated with the three-year single delivery plan, the implementation of the maternal medicine network, improving culture, creating financial stability associated with obstetric, midwifery and neonatal staffing and achievement of the MIS safety standards. The SIP progress is overseen at a weekly meeting ensuring that actions are ongoing, and issues are escalated as required.

13. PERINATAL CULTURE

The SCORE survey is now complete, and the perinatal team have met at the beginning of January 2025 to agree the final actions arising. The local action plan will be added to the divisional people plan and is anticipated to be finalised and shared in the February committee report 2025. Much of the safety intelligence derived from this work is already know to the team from the listening events and staff survey results and therefore several of the actions undertaken have been commenced.

14. CONTINUITY OF CARER (MCoC)

On a regular basis the safety and quality committee receive updates to confirm whether the service can safely continue with the established teams but would not be able to undertake further roll out until full staffing is achieved.

The preliminary work that was discussed in previous iterations of this report around the building blocks for an enhanced continuity teams is ongoing. An establishment review has been undertaken, specifically to determine whether the service can work differently in the future. Utilisation of the midwifery workforce is being scoped by the consultant midwife and plans are in development. Whilst the service fully acknowledges the benefits of this type of model, a change in provision cannot be considered until the establishment is filled. An update will be provided in due course.

15. CONCLUSION

This report provides an update in relation to the safety and quality programmes of work within the maternity and neonatal services. The report details the position against the workstreams set out by the CNST NHS Resolution for year 6 and confirms that the standards have been validated by the LMNS for sign off by the Chief Executive and Accountable Officer of the ICB.

The perinatal quality surveillance dashboard and the red flag reporting indicates areas that require ongoing focus relating to timely review in triage and induction of labour. There is an ongoing focus on induction of labour and the output from the planned improvement session will ensure that the safety and quality committee receive safety intelligence data relating to induction of labour. Both areas within the service are being monitored and tracked. Clinical indicators which are showing positive performance relate to antenatal booking and the still birth rate is showing the most improved rate overall since 2008.

16. RECOMMENDATIONS

The Board of Directors is asked to:

I. Approve the Maternity and Neonatal Service Update, noting the endorsement from the safety and quality committee

II. Receive the CNST Maternity Incentive Scheme (MIS) supplementary information pack and associated action plans for oversight and assurance**.**

III. Note the presentation of the evidence, which was validated by the LMNS on the 13 December 2024, and confirms it is satisfied to approve the CEO to declare compliance with 10 CNST MIS standards and sign the declaration leading to this report being signed as approved by the CEO and ICB Accountable Officer for sign off by 3 March 2025.

CLINICAL NEGLIGENCE SCHEME FOR TRUST INFORMATON PACK INCLUDING THE YEAR 6 MATERNITY INCENTIVE SCHEME JOINT PRESENTAION OF COMPLAINCE WITH ALL TEN STANDARDS

Appendix 1 CNST MIS Year 6 Information Pack Table 1 Overall position

No	Safety Action	LMNS/ICB Validated position (3.12 .2024)
1.	PMRT	
2.	MSDS	
3.	Transitional Care	
4.	Clinical Workforce	
5.	Midwifery Workforce	
6.	Saving Babies Lives (version 3)	
7.	MNVP	
8.	Training Plan	
9.	Board Assurance	
10.	MNSI/Early Notification	

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

SAFETY ACTION ONE – PMRT TABLE 1

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	22/22	
	Surveillance	16/16	
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	17/17	
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. 18/18	
		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		
	October 24		
	December 24		

PMRT CASES TO DATE SAFETY ACTION 1 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/ 151097	39+3	Neonatal death	Compassionate reorientation of care following the initiation of therapeutic cooling treatment.	Yes	91936	Yes	Yes	Referred to Maternity and Newborn Safety Investigations (MNSI) for external investigation. Classed as a PSII but investigation undertaken by MNSI all cases continue to require StEIS reporting. Formal DOC provided to the family.
151421	22+6	Neonatal death	Triplet 2. Extreme prematurity.	Yes	91959/2	Yes	Yes	
154424	41+5	Neonatal death	Admitted to maternity assessment unit with reduced fetal movements, terminal bradycardia identified on admission. Category one caesarean section, baby born in poor condition. Cooling commenced but decision made to compassionately reorientate care to palliative.	Yes	92488	Yes	Yes	Classed as a PSII but investigation undertaken by MNSI all cases continue to require StEIS reporting. Formal DOC provided to the family.
154842	24+3	Antepartum stillbirth	Admitted with reduced fetal movements and Fetal death In utero diagnosed.	Yes	92519	Yes	Yes	After action review performed; to proceed with PMRT investigation.
154826	27+5	Neonatal death	Admitted with spontaneous onset of labour, placental abruption identified on admission. Vaginal breech birth with entrapment of the aftercoming head.	Yes	92532	Yes	Yes	After action review performed; to proceed with PMRT investigation.
158232	33	Antepartum stillbirth	Multiple pregnancy, twin one feticide for complex congenital anomaly at St.Mary's hospital. Admitted unwell one week after the feticide and FDIU diagnosed.	Yes	92922	Yes	Yes	After action review 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, fetal death in utero diagnosed on admission to maternity.	Yes	93059	Yes	Yes	After action review performed, to proceed with PMRT investigation.
161087	23+6	Late fetal loss	Intrauterine transfer from Bolton for regional neurology bed following onset of seizures. Diagnosed with central pontine myelinolysis following transfer. Fetal death in-utero diagnosed 48 hours following transfer. Antenatally known to have hyperemesis and early onset fetal growth restriction and congenital anomaly suspected. Care provided in line with best interests.	Yes	93462	Yes	Yes	After action review performed with maternity assessment unit and neurology. Concerns with care identified by 'other' trust and investigation ongoing. PMRT review shared with other Trust.
168379	24	Neonatal death	Vaginal breech birth. Compassionate reorientation of care following a rapid deterioration. Postmortem scan showed Intraventricular Haemorrhage on the left side. Optimisation prior to birth with magnesium sulphate and anti-biotics not performed.	Yes	94527	Yes	Yes	After action review performed; to proceed with PMRT investigation.
PMRT ref 93827	22+4	Neonatal death	Extreme prematurity, admitted with labour and bleeding. Born at LTHTR and transferred to Royal Manchester Children's Hospital where the baby sadly died. Placental histology showed acute chorioamnionitis indicative of a maternal inflammatory response and a fetal inflammatory response.	Yes	93827	Yes	Yes	After action review performed; to proceed with PMRT investigation.

172448	26+2	Antepartum stillbirth	Multiple pregnancy. Under fetal medicine team for potential congenital fetal anomaly in pregnancy and had amniocentesis for both babies. Fetal death in-utero of twin 2 at 26 weeks and 2 days gestation. Pregnancy continued until 37+2 for benefit of twin 1.	Yes	94965	Yes	Yes	Investigation completed
170313	23+3	Neonatal death	Previous history of preterm birth. Cervical suture in this pregnancy. Suture removed at 23+3 following admission with ruptured membranes and baby went on to be born. Baby born with faint heart rate but parents declined resuscitation following prior informed counselling by the neonatal team.	Yes	94790	Yes	Yes	After action review performed; to proceed with PMRT investigation.
174623	23+6	Neonatal death	Mother involved in an accident receiving multiple serious. Baby delivered by emergency caesarean section due to placental abruption, 23 weeks and 6 days gestation. No heart rate at birth, resuscitation included adrenalin and emergency blood. Baby transferred to NICU but in the following hours remained in an unstable critical condition and died at 06:00.	Yes	95370	Yes	Review ongoing, deadline not yet met	After action review performed; to proceed with PMRT investigation.
175626	27+3	Neonatal death	Pre-labour prolonged ruptured membranes. Mother septic screened and commenced on sepsis pathway. Abnormal antenatal CTG and baby delivered by emergency caesarean section. Decision to re-orientate the baby's care to palliative on day 6.	Yes	95542	Yes	Yes	Investigation Completed
176480	22+5	Neonatal death	Intrauterine transfer from Blackpool Victoria Hospital. Extreme prematurity. Pre-labour rupture of membranes.	Yes	95653	Yes	Review ongoing, deadline not yet met	After action review performed; to proceed with PMRT investigation.
178664	33+6	Neonatal death	Out of hospital cardiac arrest at 27 days postnatal. Born at 33+6/40 and discharged from NICU at 37+5 weeks corrected gestation. Sudden Unexplained Death in Childhood process initiated alongside the Perinatal Mortality Review Tool review process and home office postmortem examination being undertaken.	Yes	95951	Yes	Review ongoing, deadline not yet met	Maternity service attended the joint after action review along with colleagues from the emergency department.
Datix: 180283 PMRT ref: 96161	28+4	Fetocide	This case is reported to MBRRACE but does not require surveillance or review	Yes	96161			
Datix: 18227 PMRT ref: 96388	35+3	Antepartum Stillbirth	Attended with absent fetal movements. FDIU confirmed via ultrasound Reported to MBRRACE surveillance and initial review completed. PMRT to be arranged once PM and histology are available. No concerns with care identified.	Yes	96388	Yes	Review ongoing, deadline not yet met	
Datix: 18442 PMRT ref: 96441	36+3	Neonatal death	Transferred having commenced cooling for level 3 Intensive care. Clinical condition was unstable and the decision to re-orientate was made with parents. Reported to MBRRACE. Initial joint review undertaken. However, this will be lead by Blackpool. (Antenatal and Intrapartum Care by BVH transferred following birth to LTH)	Yes	96441	Yes	Review ongoing, deadline not yet met	
Datix: 182834 PMRT ref: 96469	21+4	Neonatal death	Fetocide, however reported to MBRRACE as a NND as baby was born with signs of life. Feticide for Cardiac anomalies. Does not require surveillance or review.	Yes	96469			
Datix: PMRT ref: 96584	24+1	Fetocide	Fetocide: Congenital anomaly. Reported to MBRRACE Does not require surveillance or review.	Yes	96584			

Datix: 183923 PMRT ref: 96649	39+0	Antepartum Stillbirth	Attended triage on 25.12.2024 with H/O reduced fetal movement from 24.12.2024, FDIU confirmed. Reported to MBRRACE with surveillance and initial review completed. No issues with care identified. Awaiting placental histology.	Yes	183923		Review ongoing, deadline not yet met	
Datix: 184231 MNSI: MI-039188	26/40	Maternal death	Unexplained maternal death. Case to be reviewed by His Majesty's coroner. Reported to MBRRACE and surveillance, clinician information form and mothers' records sent with Trust AAR to MBRRACE. Accepted for MNSI	Yes	184231		Review ongoing, deadline not yet met	
Datix: 184488 PMRT ref: 96661	28+4	Antepartum Stillbirth	Antenatal fetal death of twin 1 at routine ultrasound. Under the care of fetal medicine. Twin 1 had exencephaly appearance with additional anomalies. Mother delivered Twin 2 after spontaneous labour at 28 +4. Baby admitted to NICU. Reported to MBRRACE, surveillance and initial review completed. Awaiting Trust review. PMRT to be arranged once histology available	Yes	96661		Review ongoing, deadline not yet met	
Datix: 185586 PMRT ref: 96845	40+6	Antepartum Stillbirth	Attended triage with RFM since 10.1.25 evening on 11.1.25. No FH on auscultation. Bedside USS confirmed FDIU, baby was born with no signs of life. Initial review identified learning for the service and a formal investigation is to be commissioned. Reported to MBRRACE, surveillance and review questions completed.	Yes	96845		Review ongoing, deadline not yet met	
Datix: 185771 PMRT ref: 96909	22+5	Neonatal death	Preterm 22+5, born with signs of life, transferred to NICU and passed away 14.1.25. Will be reported as NND. Reported to MBRRACE. Surveillance and initial review completed. PMRT to be undertaken once investigation complete	Yes	96909		Review ongoing, deadline not yet met	

Version	Date
V1	24.10.2024
V2	28.10.2024
V3	10.01.2025

PMRT ACTION PLAN SAFETY ACTION 1– DATIX 151097, PMRT 91936 TABLE 3

Action Plan: ND, MNSI MI-036837 Datix 151097

Organisation:	LTHTR
Lead Officer:	Jo Buxton
Position:	Divisional Clinical Governance and Risk Management Midwife
Tel:	01772 522711
Email:	Joanne.buxton@lthtr.nhs.uk
Address:	Royal Preston Hospital

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update	Current Status (1 2 3 4)
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner.	Refer to MNSI	Clinical governance and risk management midwife	19.02.2024	Complete. MNSI investigation number MI-036837	
		StEIS report	Clinical governance and risk management midwife	21.02.2024	Complete.	
		Formal duty of candour	Clinical governance and risk management midwife	19.02.2024	Complete – Formal Duty of Candour with MNSI information provided and consent for referral to MNSI gained from the family.	
2	**MNSI safety recommendation:** The Trust to ensure that all clinicians use the local assessment tool when reviewing CTG trace and to document findings of their independent systematic review.	Audit of CTG reviews for assurance of the use of the local assessment tool and documentation of findings.	Fetal Monitoring Lead Midwife	30.09.2024	Action complete. Monthly audits continue to provide on-going assurance.	
3	**MNSI finding:** On the maternity triage the management plan about the intrapartum care setting was unclear to the parents and this left the mother feeling anxious.	Inclusion of choice and personalisation session to be included on the Saving Babies Lives (SBL) mandatory study day in-line with Ockenden recommendations.	Consultant Midwife	30.04.2024	Complete. Included within the agenda of the monthly SBL study day since 4th March 2024.	

5	**MNSI finding:** Two of the four doses of adrenaline given to the baby as part of the resuscitation were not in-line with national guidance.	Alignment of local neonatal adrenaline guidance with national guidance.	Consultant neonatologist governance lead	~~30.11.2024~~ 31.01.2025	Guideline updated. Ratification and upload to Heritage awaited. 10.01.2025 Requested confirmation of change from neonatal team	
6	**MNSI finding:** In-line with local guidance the baby's temperature was required to be monitored at 30-minute intervals. The baby's temperature was measured at approx. two to three hours interval and ranged from 36.1. to 36.5 degrees. This meant the baby's temperature was not kept at the optimum range advocated in local and national guidance.	Learning from the incident to be communicated to staff via the Neonatal learning bulletin.	Neonatal Practice Educator	30.11.2024	Complete. MNSI report and findings shared with the Neonatal team for learning bulletin to be shared and this has been included in the Neonatal lessons of the week.	
7	**MNSI finding:** The clinicians were prepared to start active cooling treatment once the baby's condition stabilised. This meant that the range of the baby's temperature was between 36.1 and 36.5 degrees from 06:20 to 15:00 hours. Ongoing effort is required to ensure babies temperatures are maintained, in line with guidance, regardless of whether they will later require cooling treatment.	Learning from the incident to be communicated to staff via the Neonatal learning bulletin.	Neonatal Practice Educator	30.11.2024	Complete. MNSI report and findings shared with the Neonatal team for learning bulletin to be shared and this has been included in the Neonatal lessons of the week.	

Action Plan: RR, MNSI MI-036750 Datix 147628

Version	Date
V1	22.08.24
V2	*16.09.24*
V3	*25.09.24*

Organisation:	LTHTR
Lead Officer:	Jo Buxton
Position:	Divisional Clinical Governance and Risk Management Midwife
Tel:	01772 522711
Email:	joanne.buxton@lthtr.nhs.uk
Address:	Royal Preston Hospital

Status Key	
1	Not complete / not expected to meet timescales me
2	Actions on track to achieve deadlines
3	All actions complete.
4	All actions completed and evidence provided

Ref	Standard	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	**Ockenden safety action –** incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner.	Refer to MNSI	Clinical governance and risk management midwife	19.01.2024	Complete. MNSI investigation number MI-036750	
		StEIS report	Clinical governance and risk management midwife	24.01.2024	Complete.	
		Formal duty of candour	Clinical governance and risk management midwife	19.01.2024	Complete – Formal Duty of Candour with MNSI information provided and consent for referral to MNSI gained from the family.	
2	**MNSI safety recommendation:** The trust to ensure that initial triage assessments are undertaken in line with BSOTS including commencing continuous fetal monitoring when a mother presents with reduced fetal movements.	Continuous audit of Maternity Assessment Suite (MAS) attendance and delays in initial assessment to establish learning, themes and trends for sharing with the MAS team.	Maternity Assessment Suite Manager	23.09.2024	Triage assessment compliance monitored monthly and displayed on dashboard within maternity and neonatal paper to Trust Board. MAS action plan in place and monitored via Maternity Safety & Quality committee.	
3	**MNSI safety recommendation:** The trust to ensure that when a mother requires transfer between clinical areas, there is a robust and standardised process to assess fetal	Standard requirement for a CTG monitor to be available within obstetric theatre 2 and actions put in place to ensure continuous availability.	Fetal Monitoring Lead Midwife	26.01.2024	COMPLETE. CTG monitor available at all times. Monitored for assurance with the inclusion of obstetric theatre 2 in the monthly audit of CTG availability and usability.	

	well-being. This includes the availability and usability of CTGs within the operating theatre setting.					
4	**MNSI safety recommendation:** The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance.	Communication of the placental histology criteria to all staff.	Divisional Clinical Governance Midwife	31.08.2024	COMPLETE Placental histology criteria learning bulletin sent to all staff via closed social media and email.	
5	**MNSI findings** Local guidance does not clearly stipulate whose responsibility it is to make referrals to the maternal medicine network (MMN). A referral to MMN was indicated as early as possible in pregnancy to enable a joint discussion to take place within the MDT.	Clarification of the referral criteria to the maternal medicine network at the mother's booking appointment and processes in place for referral to the Trust Maternal Medicine team.	Clinical Governance Midwife	30.08.2024	COMPLETE Clarified with the lead midwife for maternal medicine that at the time of the mother's booking appointment the Trust was not yet a Maternal Medicine Centre and that the mother's condition would not have prompted a referral to the MMN based on the condition being a category A condition which, under the WHO categorisation of diseased, does not meet criteria for a referral. The trust has gained Maternal Medicine Centre status in Oct 2023 and from this there are clear referral processes in place to ensure that women meeting the criteria are reviewed and managed appropriately.	
6	**MNSI findings** The growth scan at 35 weeks indicated suboptimal growth and a further growth USS was indicated. There was no documentation of the pulsatility index which is an important factor when considering ongoing risk assessment.	Retrospective review of the growth scans to establish whether the PI should have been measured in-line with guidance.	Consultant Sonographer	30.09.2024	COMPLETE Consultant sonographer retrospectively reviewed the scans and advised that the images from the scan confirm acceptable measurements and do not appear over measured. The estimated fetal weight was above the 50th centile, at that time, Trust guidance was to only measure PI when growth below the 10th centile. It was noted that the doppler was normal at this scan and the baby was born before the final growth scan planned took place. Since the time of this incident the Trust has commenced recording of PI on all growth scans and this is recorded on the badgernet scan report.	
7	**MNSI findings** There was a 30-minute delay in the mother's required obstetric review due to competing clinical demands. The CTG trace showed reduced variability from the time of commencement. In the presence of RFM and abnormal CTG monitoring an early assessment was indicated.	Continuous audit of Maternity Assessment Suite (MAS) attendance and delays in initial obstetric review to establish learning, themes and trends for sharing with the MAS team. BSOTS risks on the risk register. Obstetric staffing model review.	MAS Manager / Clinical Director Obstetric Consultant	~~31.12.2024~~ 31.03.2025	Obstetric review compliance monitored monthly and displayed on dashboard within maternity and neonatal paper to Trust Board. MAS action plan in place and monitored via the Safety & Quality Committee. COMPLETE 10.01.2025 Review of the current Obstetric staffing model in progress to ensure appropriate obstetric coverage of the MAS service. ONGOING	

8	**MNSI findings** The baby was born on the 3rd centile and was unexpectedly small for gestational age.	Links with Trust Action 10. Retrospective review of growth scans.	Consultant Sonographer	26.01.2024	COMPLETE. Growth scans reviewed and no discrepancies with measurements for growth noted.	
9	**MNSI findings** The baby's blood glucose levels were below the expected range at birth and repeat blood glucose levels were not checked in line with national guidance.	Neonatal blood glucose monitoring guideline under review for alignment with national guidance.	Clinical Governance Lead Neonatal Consultant	~~30.11.2024~~ 31.01.2025	25.09.2024 - Neonatal blood glucose monitoring guideline reviewed for alignment with national guidance with version out for comments. Once comments received and incorporated guideline for ratifications and publication to Heritage. Audit for compliance with blood glucose monitoring as per the new guidance will commence and continue until assurance achieved. 10.01.2025 Awaiting evidence of completion	
10	**MNSI findings** MNSI considers that activation of the local escalation policy was indicated. This provides senior staff with the opportunity to assess the activity of the maternity unit and manage bed and staffing levels.	Implementation of the RCOG escalation toolkit.	Service Development Midwife`	31.07.2024	COMPLETE. Escalation workshops commenced July 2024 with all members of the MDT.	
11	**Trust Action:** Retrospective review of growth scans.	Links to MNSI finding 9. For retrospective review of growth scans in view of baby being born unexpectedly small for gestational age.	Consultant Sonographer	26.01.2024	COMPLETE. Scans reviewed with no discrepancies in growth measurements detailed.	
12	**Trust Action:** Communication with Obstetric Consultants and trainees.	Communication to Obstetric Consultants and trainees regarding the appropriateness of remote review for women attending the Maternity Assessment Suite.	Clinical Governance & Risk Management Midwife	31.12.2023	COMPLETE Learning template regarding attendance in MAS and face to face reviews shared with obstetric and midwifery teams	
13	**Trust Action:** Review of operating procedures for triage at night.	Actions to enable triage to remain in the same, ground floor location at night rather than move to the first floor maternity ward location.	Interim Divisional Director for Nursing and Midwifery	23.09.2024	Currently awaiting appointment of band 3 support workers to support the lone working at night. Once these positions are filled the service moving to a permanent location will be reviewed. Progress of this review of operating procedures is monitored through the MAS action log. This will be monitored by the Maternity Safety & Quality Committee.	

14	**Trust Action:** Confirm standard requirements for a CTG to be available in obstetric theatre 2.	Links to MNSI safety recommendation. Standard requirements for a CTG to be available within obstetric theatre 2 to be clarified and actions put in place to ensure continuous availability.	Fetal Monitoring Lead Midwife	26.01.2024	COMPLETE. Clarification received that there were no formal requirements for a CTG to be readily available within obstetric theatre 2. Actioned with agreement for CTG to be available at all times. Monitored for assurance with the inclusion of obstetric theatre 2 in the monthly audit of CTG availability and usability.	

SAFETY ACTION MNSI CASES TEN TABLE 4

MI number	Case Summary	Early Notification applicable	Early notification completed	Status of MNSI investigation	Final MNSI 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 complete.	Yes	Yes
36837	The mother attended the maternity assessment suite with reduced fetal movements for 24 hours and irregular uterine activity. Fetal heart rate monitoring was commenced which was assessed to be abnormal and the mother was transferred to the delivery suite for intrapartum care. Following transfer to delivery suite the CTG deteriorated, and a decision was made for caesarean section. The baby was born in poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated for 72 hours, the post cooling MRI showed moderate HIE.	Yes	Yes	Investigation complete.	Yes	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 complete.	Yes	Yes
37657	The mother attended the alongside birth centre in spontaneous labour at 41 weeks gestation. The baby was born in an unexpected poor condition, resuscitated and transferred to NICU. Therapeutic cooling treatment was initiated for 72 hours, the post cooling MRI showed no indication of HIE.	Yes	Yes	Investigation ongoing	Investigation ongoing	Yes
38553	The mother underwent induction of labour at 40 weeks and 5 days gestation, gestational diabetic and previous caesarean section. Following the onset of a fetal bradycardia, the obstetric team recommended that the birth be expedited by category one caesarean section however, the mother declined consent. Following further counselling by the obstetric team the mother did later consent to caesarean section, however, declined general anaesthetic. The baby was born by caesarean section under spinal anaesthetic, a uterine rupture was diagnosed on opening and the baby was in the abdomen. The baby was passed to the waiting neonatal team, resuscitated and transferred to the neonatal unit where therapeutic cooling treatment was initiated for 72 hours. The post cooling MRI scan showed no convincing features of HIE.	Yes	Yes	Investigation ongoing	Investigation ongoing	Yes
Not given at this time	The Maternity service was informed on the 27.12.24 of a maternal death at 26 weeks of pregnancy. The woman was known to the maternity services and there was a known history of domestic abuse which was disclosed to have occurred by a previous partner between 2018-2020, The case has been referred to the coroner, MBRRACE-UK have been notified and MNSI, however the family have not yet made contact directly with MNSI.	No	NA			

Lancashire Teaching Hospital Maternity Incentive Scheme Year 6

Final Report February 2025

1

NHS
Lancashire and South Cumbria
Integrated Care Board

LMNS Assurance Process 2024

- The Year 6 Quality Assurance Process has included a total of 4 visits during 2024.
- The LMNS reviews of the MIS programme of work were undertaken in June, September, November and December 2024.
- In September 2024, the Trust signed off 3 standards via the LMNS validation programme.
- In November 2024, the Trust signed off 7 safety actions signed off by the LMNS as fully compliant.
- In December 2024,Safety Action1, 8, and 10 were validated following the end of the reporting period on the 30th November 2024.
- To note as part of the LMNS Governance Meetings, MIS is a standing agenda item. Trusts formally present to panel members evidence relating to Safety Actions 3,4,5,7 and 9.

2

Findings from 13th December 2024 visit LMNS sign off

Lancashire and South Cumbria Integrated Care Board

	Safety Action	Status
1.	PMRT	Signed off
2.	MSDS	Signed off
3.	Transitional Care	Signed off
4.	Clinical Workforce	Signed off
5.	Midwifery Workforce	Signed off
6.	Saving Babies Lives (version 3)	Signed off
7.	MNVP	Signed off
8.	Training Plan	Signed off
9	Board Assurance	Signed off
10.	HSIB/Early Notification	Signed off

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

3

CNST Year 6 MIS declaration overview

NHS Lancashire and South Cumbria Integrated Care Board

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in -house', one day multi professional training?	Yes
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes

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Safety Action 1: PMRT

Lancashire and South Cumbria Integrated Care Board

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 8 December 2023 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE -UK within seven working days? (If no deaths, choose NA)	Yes
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
4	Were 60% of the reports published within 6 months of death?	Yes
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews, any themes identified, and consequent action plans.	Yes
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

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Safety Action 2: MSDS

Lancashire and South Cumbria Integrated Care Board

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

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 MSDS -only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes

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Safety Action 3: Transitional Care

Lancashire and South Cumbria Integrated Care Board

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement in itiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

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Safety Action 4: Clinical Workforce

Lancashire and South Cumbria Integrated Care Board

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short -term (2 weeks or less) locum doctors in Obsterics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They 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 Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long -term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored 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 https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	N/A

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Safety Action 4: Clinical Workforce Continued

NHS Lancashire and South Cumbria Integrated Care Board

Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	Yes
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
11	Was the above workforce action plan shared with the LMNS?	N/A
12	Was the above workforce action plan shared with the ODN?	N/A
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	Yes
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	N/A
15	Was the above workforce action plan shared with the LMNS?	N/A
16	Was the above workforce action plan shared with the ODN?	N/A

Safety Action 5: Midwifery Workforce

Lancashire and South Cumbria Integrated Care Board

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes / No /Not applicable)
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NIC E midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an upda te on all of the points below.	Yes
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.	Yes
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to c over any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortf all. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist mid wives.	Yes

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Safety Action 5: Midwifery Workforce

Lancashire and South Cumbria Integrated Care Board

4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.	Yes
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub requirement.**	N/A
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour	Yes
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A

Safety Action 6: Saving babies lives version 3

NHS Lancashire and South Cumbria Integrated Care Board

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	Yes
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	Yes
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	Yes
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	Yes
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	Yes
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	Yes

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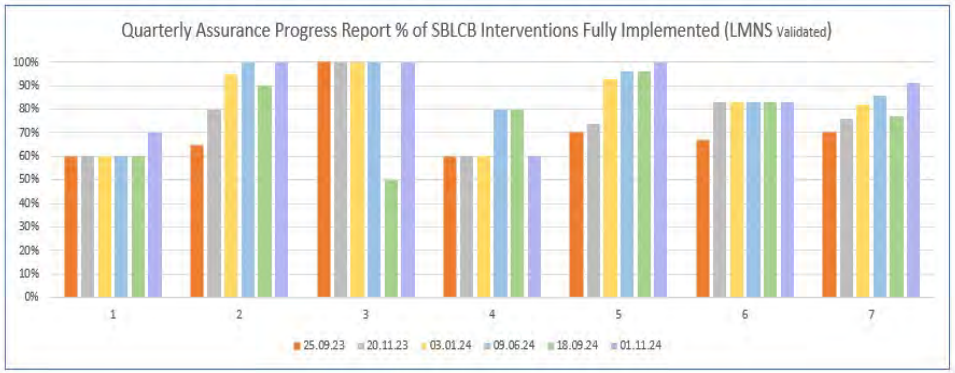
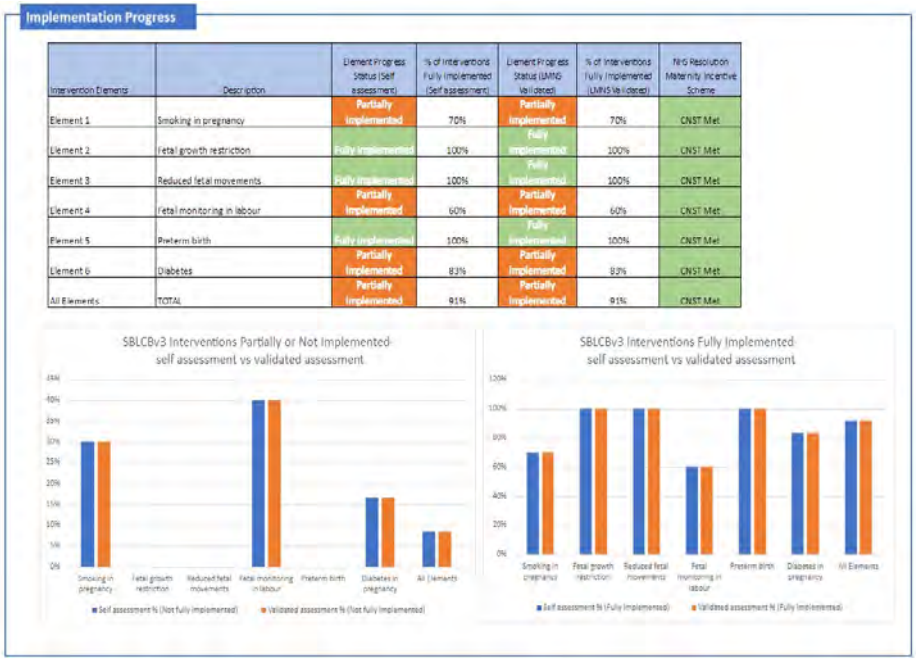
Safety Action 6: Saving Babies Lives

Lancashire and South Cumbria Integrated Care Board

Trust: Lancashire Teaching Hospital NHS Foundation Trust
ICB: Lancashire and South Cumbria Integrated Care Board

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5					
Review Quarter	Q1/2	Q2	Q3	Pelim	Q1	Q2					
Date	25.09.23	20.11.23	03.01.24	09.06.24	18.9.24	1.11.24					
Element 1	60%	60%	60%	60%	60%	70%					
Element 2	65%	80%	95%	100%	90%	100%					
Element 3	100%	100%	100%	100%	50%	100%					
Element 4	60%	60%	60%	80%	80%	60%					
Element 5	70%	74%	93%	96%	96%	100%					
Element 6	67%	83%	83%	83%	83%	83%					
Total	70%	76%	82%	86%	77%	91%					





Safety Action 7: Listening to service users

Lancashire and South Cumbria Integrated Care Board

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes / No /Not applicable)
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee	Yes

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Safety Action 7: Listening to service users

Lancashire and South Cumbria Integrated Care Board

3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes
7	Has progress on the coproduced action above been shared with the LMNS?	Yes

Safety Action 8: Training Plan

Lancashire and South Cumbria Integrated Care Board

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6 -month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co -located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes

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	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6 -month period from their start-date with the Trust?	N/A
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes
12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6 -month period from their start-date with the Trust?	N/A
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Safety Action 9: Board Assurance

Lancashire and South Cumbria Integrated Care Board

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust -level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes

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Safety Action 9: Board Assurance

NHS
Lancashire and South Cumbria
Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes	
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes	
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi -monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes	
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes	

Safety Action 10: MNSI Early Notification

NHS
Lancashire and South Cumbria
Integrated Care Board

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
7	Has the Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

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Summary

Lancashire and South Cumbria Integrated Care Board

	Risk / Issue	Actions
Alert Areas of concern or matters that need addressing urgently	*N/A*	*N/A*
Advise Areas of ongoing monitoring and any new developments	*N/A*	N/A
Assure Areas of assurance	*All 10 safety actions signed off as fully compliant in line with the technical guidance and evidence required and have been validated by the LMNS on behalf of the ICB*	

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Board Assurance Process CNST Year 6 2024

Lancashire and South Cumbria Integrated Care Board

To declare compliance the Trust Board Must

- ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
- ☑ There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.
- ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

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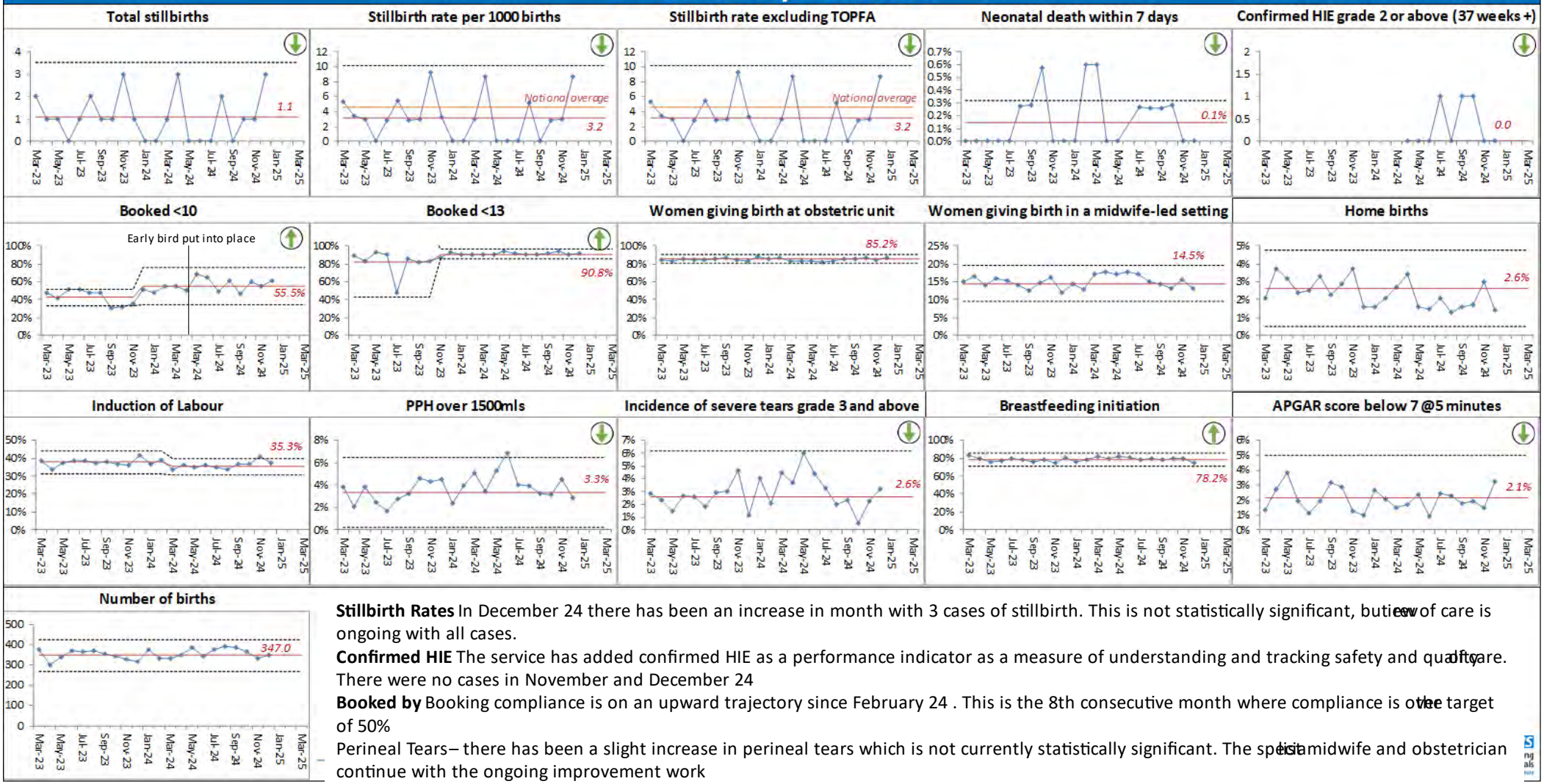
PERINATAL QUALITY SURVIELLENCE DASHBOARD
APPENDIX 2

Clinical Safety Indicators

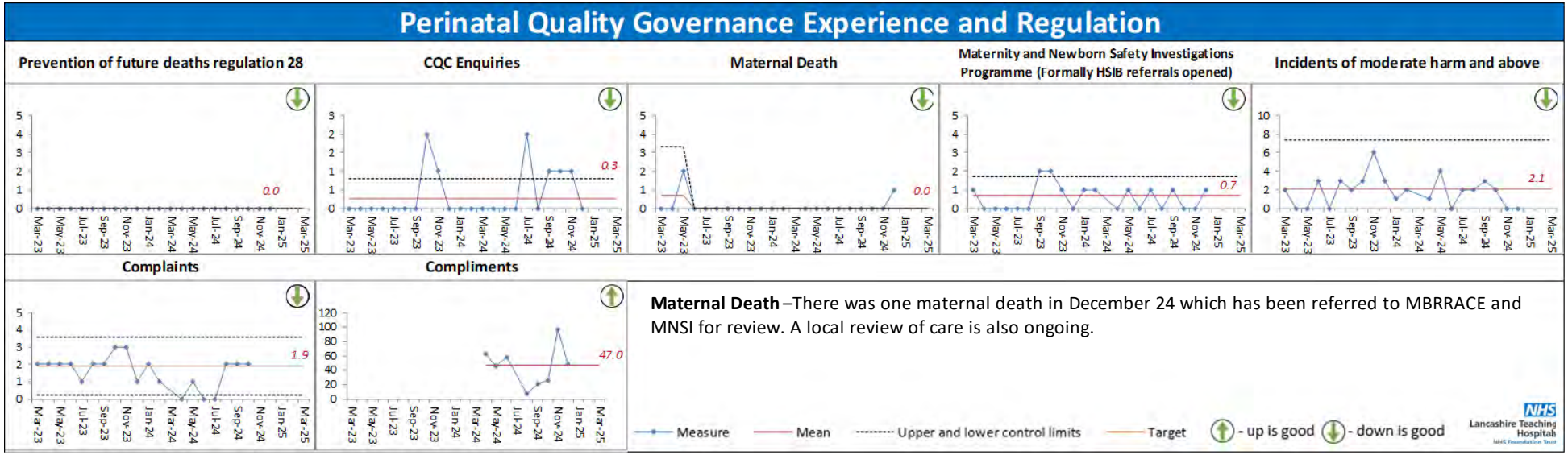


Stillbirth Rates In December 24 there has been an increase in month with 3 cases of stillbirth. This is not statistically significant, but review of care is ongoing with all cases.

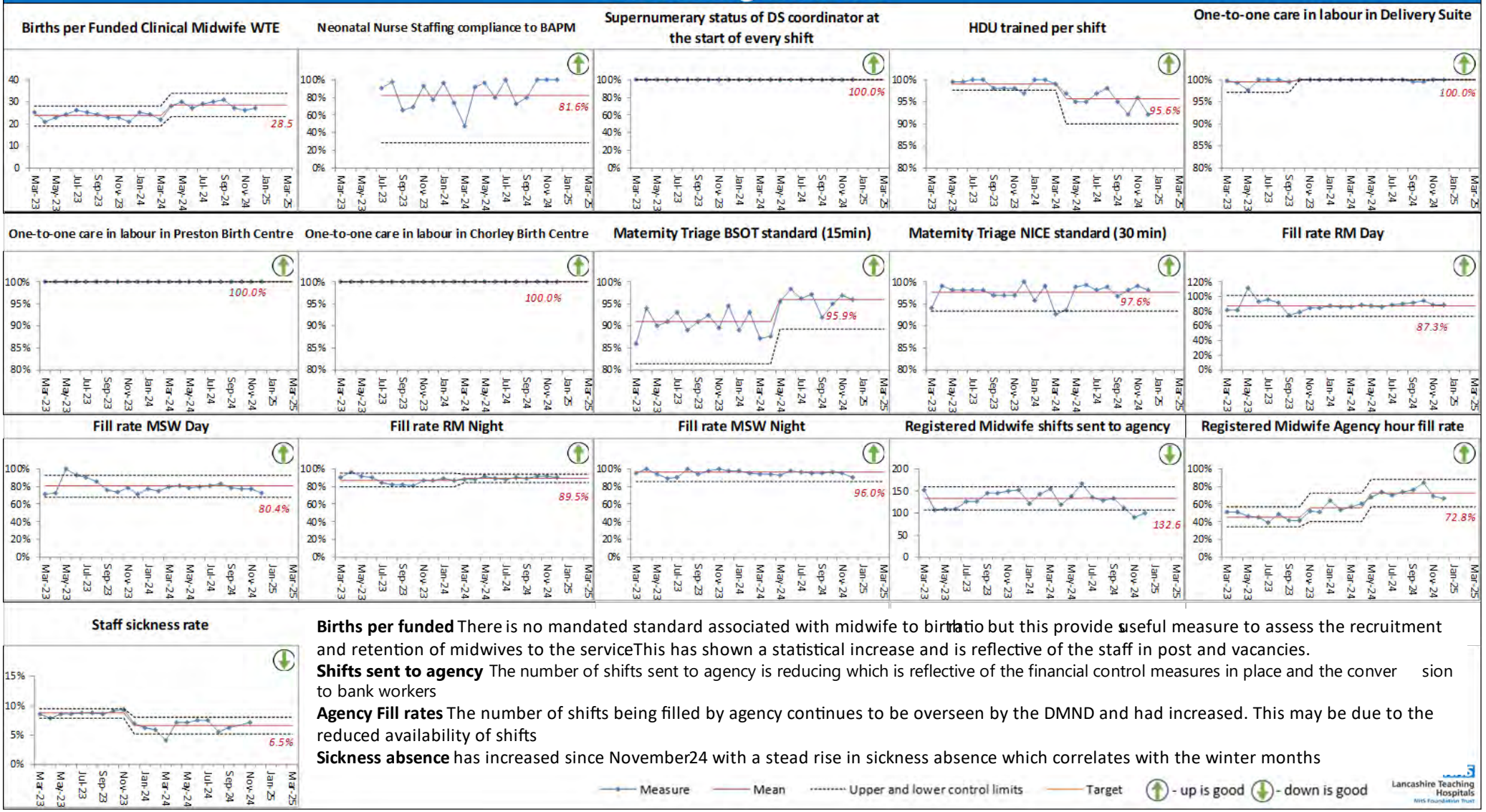
Confirmed HIE The service has added confirmed HIE as a performance indicator as a measure of understanding and tracking safety and quality of care. There were no cases in November and December 24

Booked by Booking compliance is on an upward trajectory since February 24 . This is the 8th consecutive month where compliance is over the target of 50%

Perineal Tears– there has been a slight increase in perineal tears which is not currently statistically significant. The specialist midwife and obstetrician continue with the ongoing improvement work


Perinatal Quality Governance Experience and Regulation
Prevention of future deaths regulation 28
CQC Enquiries
Maternal Death
Maternity and Newborn Safety Investigations Programme (Formally HSIB referrals opened)
Incidents of moderate harm and above
Complaints
Compliments
0.0
0.3
0.0
0.7
2.1
1.9
47.0
Maternal Death –There was one maternal death in December 24 which has been referred to MBRRACE and MNSI for review. A local review of care is also ongoing.
Measure
Mean
Upper and lower control limits
Target
- up is good
- down is good
Lancashire Teaching Hospitals

Safe staffing indicators



Births per funded There is no mandated standard associated with midwife to birth ratio but this provide s useful measure to assess the recruitment and retention of midwives to the serviceThis has shown a statistical increase and is reflective of the staff in post and vacancies.

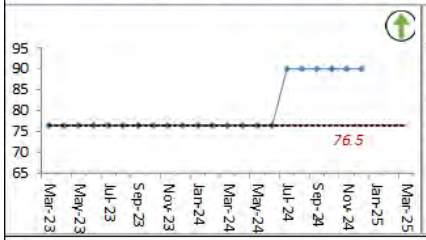
Shifts sent to agency The number of shifts sent to agency is reducing which is reflective of the financial control measures in place and the conver sion to bank workers

Agency Fill rates The number of shifts being filled by agency continues to be overseen by the DMND and had increased. This may be due to the reduced availability of shifts

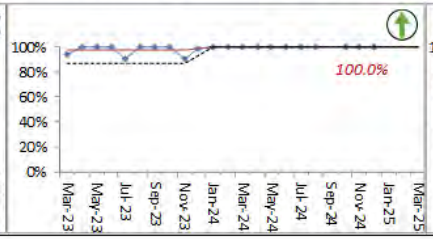
Sickness absence has increased since November24 with a stead rise in sickness absence which correlates with the winter months

Obstetric Medical Staffing

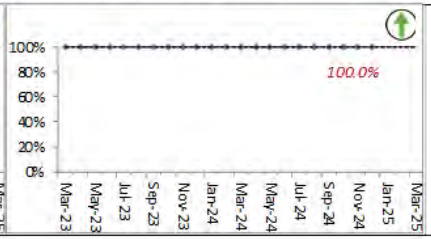
Number of Consultant hours on obstetric unit



RCOG obstetric benchmarking compliance



24-hour acute obstetric medical staffing fill rate

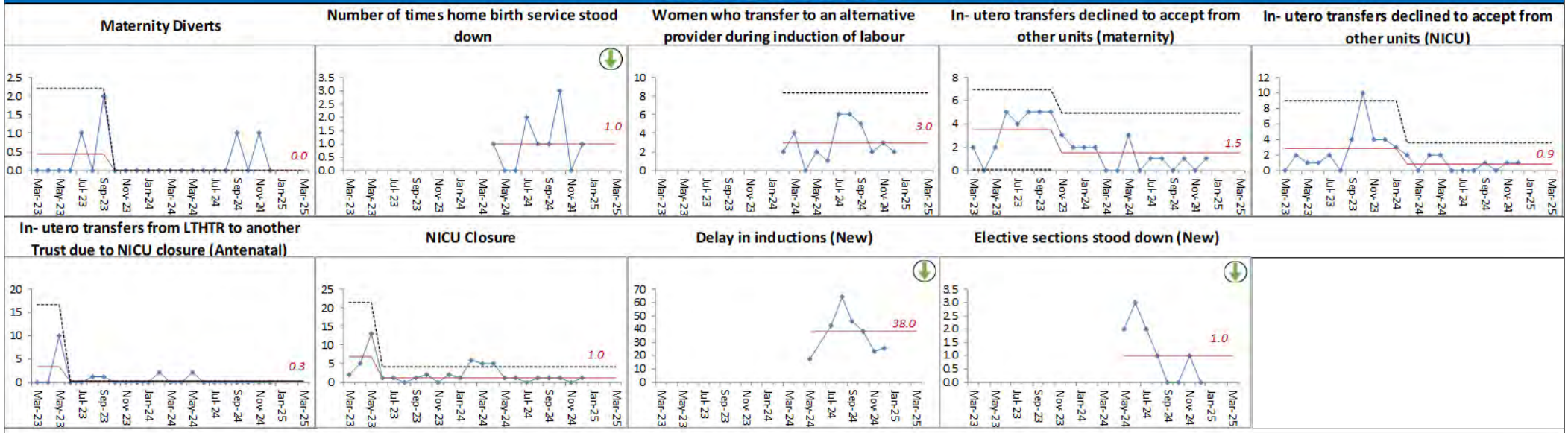


Consultant hours in the obstetric unit. The service continues to invest in consultant funding and the service confirms an increase in hours of 76.5 to 90 hours consultant cover. Work is ongoing to consider whether obstetric cover can be increased in the middle grade data and adjusted in the consultant hours

RCOG attendance remains at 100%

Consultant fill rates for acute care continues to be 100%

Clinical Escalation



The service has included new monitoring parameters to indicate pressure points in the service. This includes reporting where elective activity and mutual aid is accepted during delays in induction. A letter is sent to all women who transfer care due to capacity

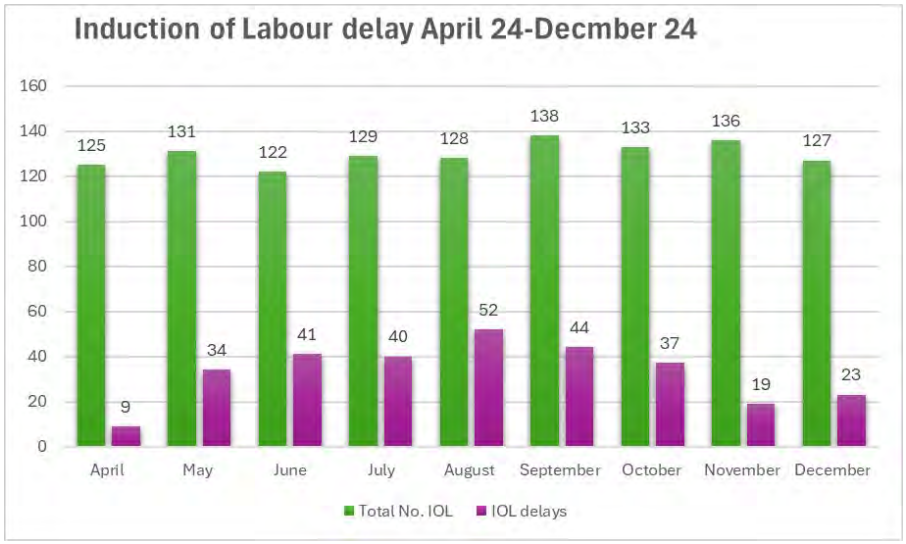
In- Utero Transfers (IUT) IUT decline rates have reduced for maternity. If this continues into February 25 this will demonstrate statistical reduction.

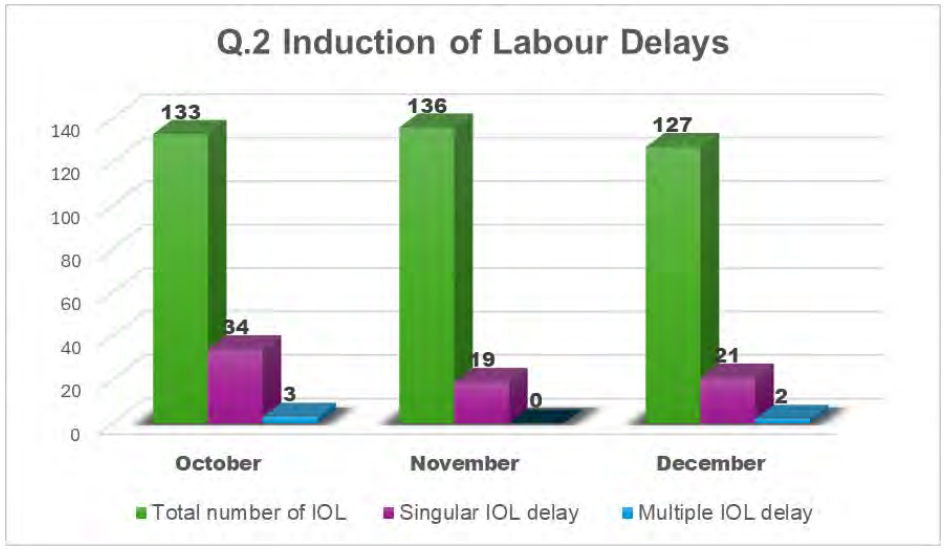
Measure — Mean ····· Upper and lower control limits — Target ↑ - up is good ↓ - down is good

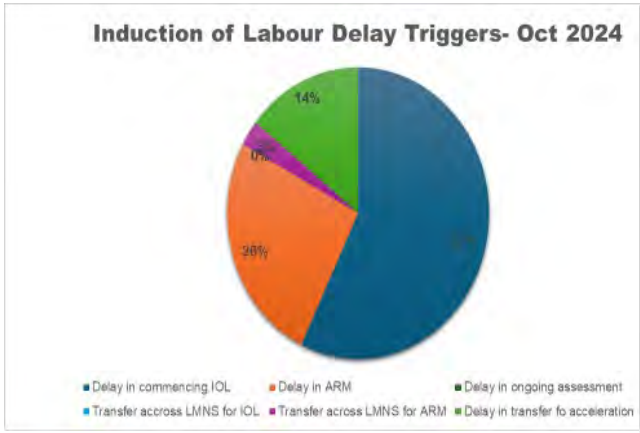
APPENDIX 4 RED FLAGS

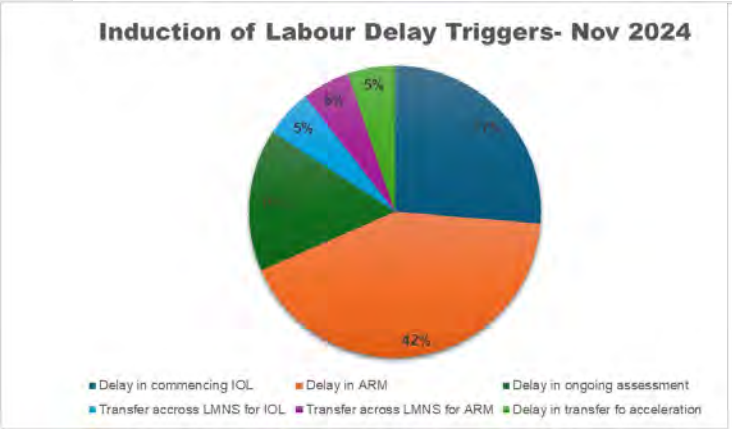
Red flag Reporting Metrics	Jan 24	Feb 24	Mar 24	April 24	May 24	Jun 24	July 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24
Delay in time critical activity	28	51	38	16	24	36	18	41	61	40	44	59
Missed or delayed care> 60 mins in washing or suturing	1	0	1	0	2	1	2	0	0	1	0	1
Failure for women to receive the medication required.	0	0	0	0	0	3	1	0	1	0	0	1
>30-minute wait for pain relief.	1	1	0	0	4	3	3	0	2	0	0	0
Lack of full examination when woman presents in labour.	1	0	1	0	0	2	1	0	4	0	0	0
>2-hour delay in induction?	23	9	18	9	16	20	22	42	34	21	9	7
Delay in recognition of and action of abnormal signs.	1	0	1	0	2	0	1	0	1	1	0	0
Inability to provide one to one care in labour?	0	0	0	0	3	4	4	1	4	0	0	0
>30-minute delay for assessment by a midwife when presenting in labour. Replaced by BSOTS												
>15 minute delay following presentation for BSOTS midwife assessment. (New parameter August 2023)	12	18	29	43	38	20	46	24	75	42	24	23
>30-minute wait for obstetric triage.	9	15	12	30	31	43	47	20	56	41	46	47
Was there a delay in transfer of a BSOTS red case from MAS? (New parameter Oct 22)	4	1	0	0	1	2	0	0	0	0	1	0
Was there a delay in transfer (over 4 hours) to delivery suite once a decision has been made for transfer for induction or augmentation? (New parameter Oct 22)	23	18	12	5	0	30	30	28	25	20	14	19
Was there a delay in transfer once labour was established? (New parameter Oct 22)	2	1	2	0	3	3	1	1	2	0	0	0
Was there a delay in transfer to delivery suite within 30 minutes where the MEWS was 6 or more or scoring a 3 on a single parameter? (New parameter Oct 22)	0	0	0	0	1	2	0	0	0	0	0	0
Was there a delay of more than 30 minutes to initiate the sepsis care bundle? (New parameter Oct 22)	0	0	0	0	0	0	0	0	0	0	0	0
Has there been a deferred date of planned induction of labour? (New parameter Oct 22)	0	1	1	0	1	1	1	0	2	0	0	0
Has there been any cancelled or delayed community work? (New parameter Oct 22)	28	38	28	95	12	13	25	5	28	4	0	0
Did redeployment of staff to other services/ sites/ wards occur? (New Parameter December 2023)	19	18	2	9	7	12	17	9	12	8	2	0
Total numbers of red flags	**156**	**170**	**146**	**207**	**145**	**195**	**219**	**171**	**307**	**178**	**140**	**157**

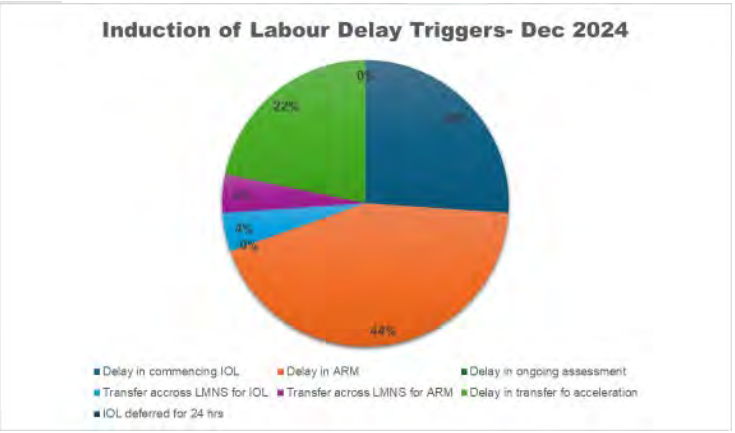
APPENDIX 4 INDUCTION OF LABOUR PERFORMANCE DECEMBER 2024.











11. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE)

11.1 INTEGRATED PERFORMANCE REPORT

Other | Executive Team | 14:20

including Finance update and Single Improvement Plan
Item for assurance

REFERENCES

Only PDFs are attached

11.1 - Integrated Performance Report as at 31 December 2024.pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Integrated Performance Report							
Report to:	Board of Directors			**Date:**	6th February 2025		
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 committee with an update on the Trust's performance as at the end of December 2024, unless otherwise stated.

Operational Performance Summary

UEC: Performance against the national 4-hour access standard has remained below the required target in December 2024, however performance did show improvement compared to November 2024. The Trust is slightly below the December 2024 national average of 71.1% and ranked 8th best performing in the NW Region for Dec 24. This is a static picture.
A fluctuating position can be seen in the over 60/30 minute and 15 min+ ambulance handovers, remaining markedly below the national target. Whilst there is a significant focus on ensuring timely release of ambulance resources via the use of a RATs provision (Rapid Assessment and Transfer), performance is closely linked to overcrowding within the Emergency Department which has increased in December. The percentage of patients with an ED LOS of 12 hours+ has increased in December versus the previous month and broadly mirrors the picture in December 2023. This remains a key area of focus within the UEC Improvement Plan and links closely to hospital bed occupancy and the number of patients who are classified as 'No criteria to reside' (NCTR).
The number of patients within this NCTR cohort remained high in December with 1230 bed days lost in occupation by patients who no longer need in patient acute hospital care.

Consequences of high bed occupancy above the target level in recent months had resulted in an increase in the number of patients 'boarded' in non-bed spaces however the December position remained consistent with the previous month at an average of 17 boarded patients in December. The number of escalation beds occupied increased from 11 in November to 15 in December. Actions to mitigate this focus on improving ward and board round processes, increasing the use of Same Day Emergency Care (SDEC) facilities, the roll out of continuous flow, improved discharge processes and mobilisation of the new AMU model of care.

Elective Recovery: December has seen a continued reduction in long waits for elective treatment with further reductions seen in the over 52 week waits 1444 (Dec 24) versus 1554 (Nov 24) this is the eight month of reduction and therefore a statistically significant change. Similar trends have been delivered in patients waiting 65 weeks with a December position showing a consistent level of 65-week month end breaches (21), these were due to capacity shortfalls. Comparison to the latest NW region position indicates that the Trust is currently 10th out of all acute and specialist trusts and 4th out of acute Trusts in terms of the overall number of 65-week waiters with ongoing reductions each week. Close monitoring of long waiting RTT clock stops is ongoing.

Cancer: 62-day compliance for December 24 (64.8%) is below trajectory however remains an unvalidated position and is expected to improve once validation is complete. The November performance was 67.2%, and marginally below the monthly trajectory. The unvalidated Faster Diagnosis Standard (FDS) performance is 4.4% above trajectory for December. The November performance was 78.9%, above the monthly trajectory. There remain a small number of tumour group areas with fragilities however improvement plans have been developed for each tumour group and are monitored closely.

Diagnostics: Performance against the Diagnostic access standard (DM01) deteriorated slightly in December and is under trajectory for the month. The Trust remains significantly below the national standard and review of the latest published data indicates that LTH is the worst performing NHS Trust in this area in the NW region. Key drivers of under-performance relate to Non-Obstetric Ultrasound (NOUS), endoscopy and echocardiology modalities. Mutual aid support has been requested from L&SC providers for echocardiography and additional administrative capacity is due to commence mid Jan 25 which will aid improve utilisation of the available capacity in endoscopy. A rapid improvement week is planned for mid Jan 25 and is looking at process issues within endoscopy.

Safety and Quality

Safe Staffing requirements
Nurse and Midwifery safe staffing reporting continues on a monthly basis through the safety and quality committee. The adult inpatient areas remain in a positive position with RN staff fill rates achieving >98% fill rates, despite the current HCA vacancy rate ranging between 14-16%, bank HCA's enable the fill rates to meet the required standard. The maternity fill rate position for registered midwives (RM) achieved 87% in month. The maternity support worker fill rate has reduced in month to 80% due to sickness and vacancy. The plan continues in relation to recruitment.

Patient Experience and Involvement
The number of complaints per 1000 beds days continues to demonstrate a reduced rate, this is a result of increased focus on local resolution for patients and families. The focus on patient experience continues with specific focus on the Urgent and Emergency improvement plans and inpatient pathways, the national inpatient surveys have provided specific areas of focus and feedback from patients, however, we recognise that the UEC pathway in totality has a significant impact of overall experience of patients, their families and staff and therefore this is a key priority of this programme of work.

The number of compliments continues to demonstrate a positive trajectory demonstrating the motivation experienced by teams in recognising formally the multiple numerous thank you's and positive acknowledgements that they receive.

STAR accreditation
STAR accreditation standards continue to exceed the internally set target. The Star accreditation process has been refreshed to introduce the mandatory standards that mirror areas that are consistently not achieving. This was predicted to initially negatively impact the outcomes within STAR with the aim to leading to an improvement. This can be seen in this month's data and is expected for some months whilst the improvement is enacted. The disaggregation of the whole Trust position from that of the higher risk ward, ED and theatre areas is now included to ensure additional oversight of areas that present increased risk.

HSMR
Mortality metrics remain stable and within expected parameters. The stillbirth rate in England was updated in October 2024 (MBRRACE) to 3.9 per 1000 births. LTHTR stillbirth rate is 2.8 per 1000 births. It should be noted a data quality error has been noted in the internal reporting of still births due to a coding issue. The data reported externally to MBRACE is accurate and shows performance in line with peer. There are actions in place to address this, however, it will take at least one quarter for the Telstra system to reflect the corrected position.

Pressure Ulcers
The pressure ulcer data is now presented against the average number of pressure ulcers reported in the last 3 years. There has been an increase in pressure ulcers in December, most likely reflective of the increase in delays through the UEC pathway. Care bundle best practice interventions and focus continue through divisional always safety-first forums.

Pressure ulcers are considered as a proxy for the standard of care delivered and an underpinning improvement plan is aimed at minimising both the overall numbers and the category severity of pressure ulcers recognising the poor experience that occurs for patients when a pressure ulcer is acquired in hospital. This work continues.

Maternity
The position for CNST MIS year 6 is detailed within the maternity neonatal report presented to Board on a bi-monthly. In February 2025, the CNST standards will be recommended considered for approval by the Board following the validation by the local Maternity and Neonatal System LMNS.

Boarding
The number of patients placed in spaces outside of a designated bed space, referred to as boarding, continues in response to supporting safety within the Emergency Department. It is recognised this is a symptom of the UEC system not working effectively and is a short-term measure until the system UEC plan is delivered and suitable capacity is created to meet the demand identified within the community. The average of 20 patients per day equating to 620 bed days is the December position. Feedback from staff and patients is indicating that ward moves later in the day are leading to further impact on their experiences therefore, the implementation of continuous boarding aims to improve this experience. This, as expected has been adversely affected over the Christmas period due to high occupancy levels however, this work is continuing.

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

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

Of the 75 actions identified within the action plan, 60 actions have been delivered, (a further 10 since the last report to Safety and Quality committee) and 11 actions have been assessed as on track for delivery demonstrating a significant amount of progress to date. Five actions have been stood down as no longer applicable.

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

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

People and Culture

The sickness absence rate remained above 6% throughout Quarter 3, and in Month 9 rose above 7%. This can be partly explained by a seasonal peak in virus related absence, although long term absence also increased. An increase in mental health related absence is a concern, and this particularly drives long-term absences. We are off plan with the target of an annualised reduction of 1% by the end of the financial year.

The number of reported violence and aggression incidents decreased in Month 9, although remained above 100 for the 6th month running. This is significantly above the monthly target and trajectory for improvement.

The turnover rate has returned to levels that are in line with organisational trends, following the peak in Month 7 which was due to the One LSC transfer.

The vacancy rate increased to over 7% in Month 9. This is due to increased vacancy control measures.

Financial Sustainability

Income and Expenditure
The Trust had submitted the final plan in line with the NHSE control total, a deficit of £21.9m. In month 6 the Trust received funding to cover the deficit the Trust now has a break-even plan.

At month 9 the Trust has a deficit of £26.3m an adverse position of £17.4m against a planned deficit of £8.9m. The main variances to plan are:
- £10.7m variance to Financial Recovery Plan Target
- £5.2m shortfall on income from urgent and emergency care capacity and investment funding to support frailty and intermediate care
- £1.1m fixed over-perfomance and impact of Industrial Action and IT outage

The Trust has operational pressures in:
- the acute medical pathways reflected in overspends in medical and nursing pay budgets
- capacity issues resulting in elective, day case and out-patient income under-performance

The Trust is reviewing its forecast recognising that it is a high risk plan with a number of efficiency schemes not yet delivering to plan, risks that have materialised since the plan was set and continued operational pressures.

Capital Position
Capital expenditure in the year to date at £42.9m is c£10.5m more than plan but this includes £18m for NHP land purchase which was not in the plan. Adjusting for this the YTD expenditure is £7.5m behind plan. No slippage is forecast by the end of year.

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 has been worked through the Capital Planning Forum, however it should be noted that this £3.2m reduction requires the Trust to defer expenditure on backlog maintenance and equipment replacement, and as a consequence this significantly increases the risks to operational areas.

Cash Position
The Trust has received £10m of revenue support from NHSE in addition to £21m additional income. Operational pressures associated with the revenue deficit mean that despite the receipt of these sums the Trust is utilising capital cash for revenue which is contrary to DHSC guidance.

Continuing operational pressures associated with the revenue deficit are adding to the cash burden in the plan and the Trust will require further cash support from DHSC in Q4.

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 9 the Trust has delivered £17.9m year to date, which is 66% of the plan of £27.3m however 53% of this was non-recurrent. Annually £21.7m; (£14m recurrently) has been delivered towards the £58m target which is 37%.

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.

Agency Cap
The Agency spend to month 9 was £8.2m, 1.9% of pay expenditure. This compares favourably to the agency cap of 3.2% of pay expenditure which has reduced from the cap of 3.7% in 2023/24.

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

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

Previous consideration

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

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

February 2025 Trust Board meeting with performance to December 2024

Excellent care with compassion

Always Safety First

@LancsHospitals

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Contents

Key to Metric Variation, Assurance Icons & Dashboard Headers

Lancashire Teaching Hospitals NHS Foundation Trust

Key to Metric Variance and Assurance Icons

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

Key to Metric SPC Chart and Variance and Assurance Icons

Mean
Process Limit
Improving special cause
Measure
Concerning special cause
Target

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

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

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

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

Report heading explanation

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

A flag is generated for metrics that are calculated as requring

The latest month target or threshold.

Data to the end of.

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

The name of the Metric

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

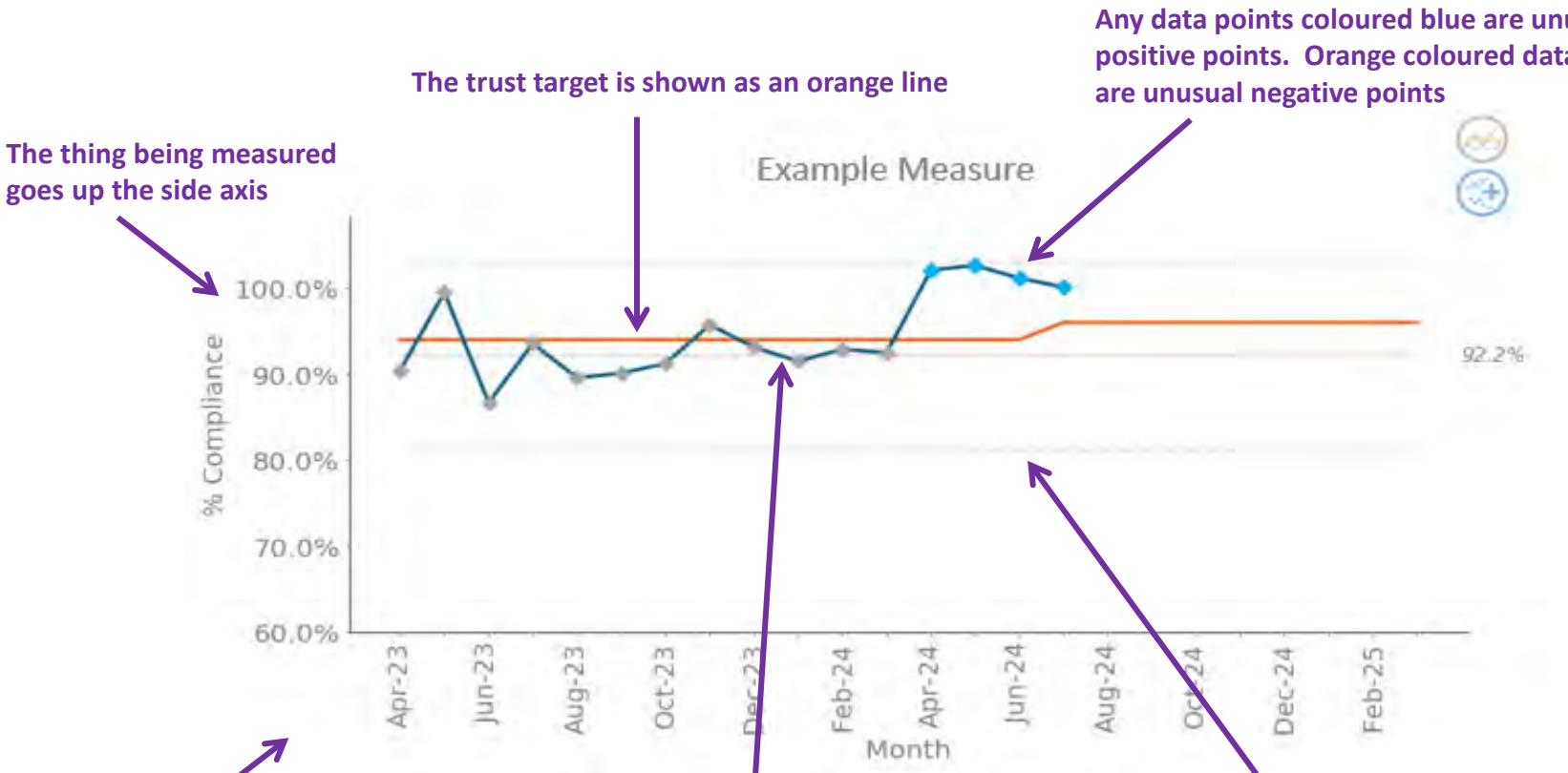
This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

Lancashire Teaching Hospitals NHS Foundation Trust

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



Rebasing is the recalculation of the mean and control limits when a statistically significant pattern indicating a sustained change is seen in the data - *not shown in this chart example*.

SPC KPI Metric Grid

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work	- Number of violence and aggression incidents toward staff - Vacancies (% FTE) - Compliance with 60 minute ambulance turnaround time target	- STAR Accreditation all trust (Silver and Above)
Normal variation - no recent change	- 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 Dept - 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% - Sickness Absence (% FTE)	- Staffing Fill Rate - Health Care Assistant - Staffing Fill Rate - Registered Midwife - Staffing Fill Rate - Maternity Support Worker - Complaints per 1000 bed days - C. diff perf against national trajectory - no more than 199 Hospital Acquired cases - Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Perinatal - Number of Stillbirths - Bed occupancy to 92% - Improve performance against the headline 62-day standard to 70% by March 2025 - 85% theatre utilisation - aggregate - Capped	- Staffing Fill Rate - Registered Nurse - Turnover (% FTE)
Recent positive pattern in the data	- 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 - Number of boarded patients	- Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety - Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026	

Non SPC Metrics flagged as a concern

% of must do's from QIP 2023 assessed as Green (i.e. delivered)

% of should do's from QIP 2023 assessed as Green (i.e. delivered)

I&E Normalised run rate

FRP schemes delivery

Non SPC Metrics

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

Safety & Quality
Operational Performance
People and Culture
Finance

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

People & Culture

Excellent care with compassion

Always Safety First

@LancsHospitals

Single Improvement Plan - Workforce

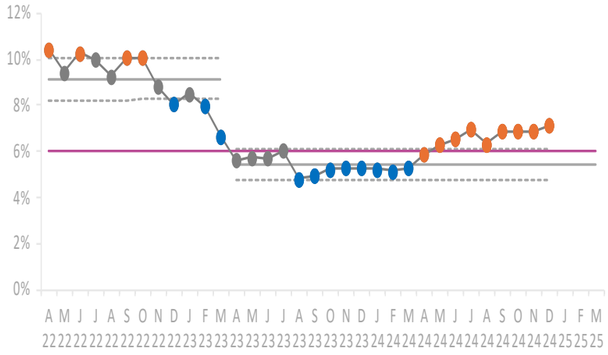
NHS Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		FY2425 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2425	Latest Month Target		
People and Culture	Vacancies (% FTE) (source: General Ledger)				≤ 6%		7.12%	M09
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.65%	M09
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.24%		7.16%	M09
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		105	M09
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				≥ 90%		95.42%	M09
	Appraisal compliance (% HC)				≥ 90%		90.67%	M09
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		50.99%	Q2

People & Culture - Workforce Assurance 1

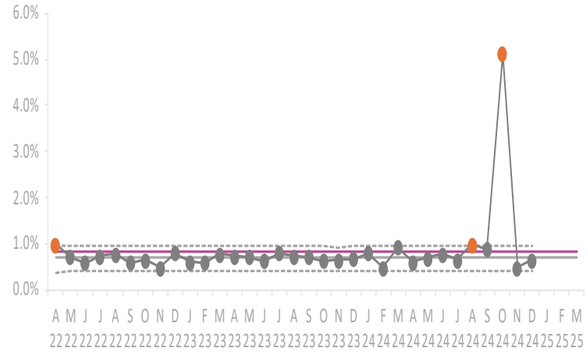
Lancashire Teaching Hospitals NHS Foundation Trust

GL Vacancy Rate (% FTE)



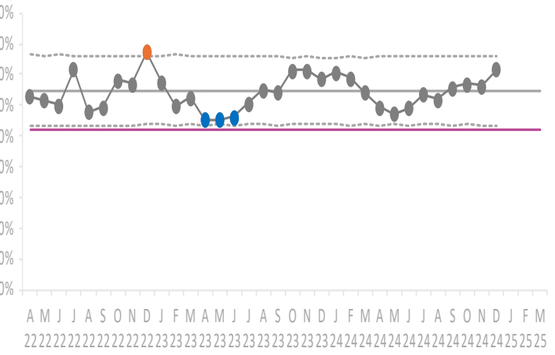
Latest
7.12%
Variance Type
Recent concerning pattern in the data
Mar 25 Target
≤ 6%
Target Achievement
Could both pass or fail target within expected variation

ESR Turnover (% FTE)



Latest
0.65%
Variance Type
Normal variation - no recent change
Mar 25 Target
≤ 10%
Target Achievement
Will consistently pass target within expected variation

Overall Sickness (% FTE)

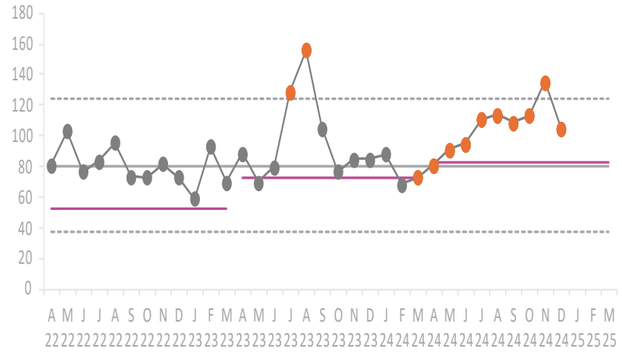


Latest
7.16%
Variance Type
Normal variation - no recent change
Mar 25 Target
≤ 5.24%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Vacancies (% FTE)	The vacancy rate continues to remain above target due to increased vacancy control measures in place	New vacancy controls have been communicated All posts up to pre-interview stage have been reviewed by divisional management teams and either held or moved to Executive Team buddy sessions for further discussion, check and challenge Chief Executive continuing to give final approval for advertising	EQIA process in place Vacancy rates monitored by Workforce Committee and Board
Turnover (% FTE)	Turnover is current below the 10% tolerance level. There have been no significant themes or trends in December of note in relation to spikes in turnover by professional group or length of service.	Launch of the online Probationary Conversations. All divisions have received their 6 monthly retention updates via divisional workforce committees, flagging any areas of concern, summarising leaver feedback etc, with an invite to provide additional support for any areas wanting to explore this further and receive support for bespoke work. In February will launch our new Stay Conversations, which enable central monitoring of volume of conversations and allow targeted action to be taken in areas with higher turnover.	Annual retention strategy update report provided to Workforce Committee. Delivery of retention strategic action plan at corporate level, working with Divisions, Departments and Teams to support improvement in hot spot areas. 6 monthly retention updates provided to Divisions. Monthly monitoring of leavers exit interview feedback. Monthly recruitment and retention working group.
Sickness Absence (% FTE)	Sickness absence rose to over 7% in December, which was significantly above target, although in line with seasonal trends in previous years.	Empactis implementation group established to drive the pilot of a digital sickness absence system New absence management resources for managers nearing completion, including 'How To' videos for Return to Work Interviews and Wellbeing Conversations New Attendance Management Policy pending approval Educational session for managers on making Occupational Health referrals delivered in January	The Workforce Committee cycle of business will be updated in 2025/6 to include two deep dive reports around sickness absence The action plan in response to the MIAA Sickness Absence audit is being monitored through Audit Committee Sickness Absence Financial Recovery Programme steering group meets fortnightly to oversee delivery of the sickness absence reduction plan Divisional sickness absence levels and actions are monitored through DIFs

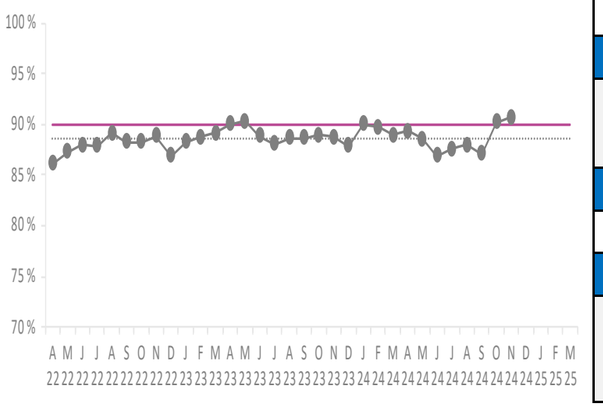
People & Culture - Workforce Assurance 2

Lancashire Teaching Hospitals NHS Foundation Trust



Latest
105
Variance Type
Recent concerning pattern in the data
Mar 25 Target
996
Target Achievement
Could both pass or fail target within expected variation

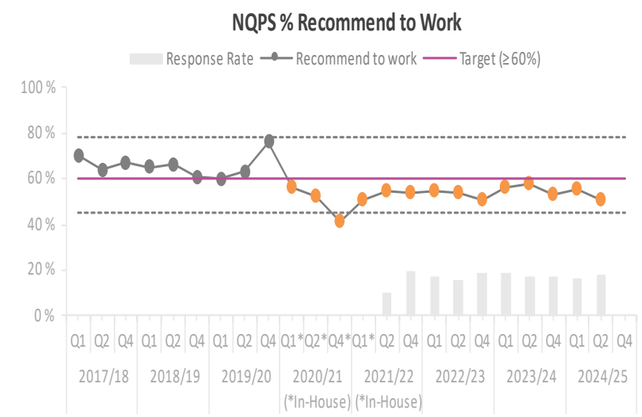
Latest
95.42%
Variance Type
Mar 25 Target
≥ 90%
Target Achievement



Latest
90.67%
Variance Type
Mar 25 Target
≥ 90%
Target Achievement

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	Violence and Aggression incidents reduced in December although remain high	Managers toolkit in development to support leaders to talk to teams around the continuum of violence and aggression, when to incident report and when to access security support Self-assessment against new national Violence Prevention and Reduction Standard being undertaken by Big Room Discussions being progressed with system colleagues around data analytics and benchmarking	Workforce Committee receive deep dive report around violence and aggression incidents twice yearly Data monitored through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Overall Core Skills Compliance is 95.42%. However, there are three Trust wide metrics that currently fall below the required compliance (Information Governance - 93%, Immediate Life Support, ILS- 73%, Paediatric Immediate Life Support, PILS - 67%) Target is 90% for all metrics, 95% national target for Information Governance.	Review delivery methodology and target audience for ILS and PILS. Proposed reduction to 90% compliance target for Information Governance based on new national guidelines. Increased focus on medical and dental compliance at divisional level.	New monthly compliance reports were published on 5th December 2024 which allow the data to be 'sliced' further to show a wide variety of different views such as by Division, SBU, and Professional Group. Moving and Handling Level 1 has now achieved compliance for 3 consecutive months, Moving and Handling Level 2 has now achieved compliance for 2 consecutive months. Resus Level 1 has achieved compliance target for 2 consecutive months.
Appraisal compliance (% HC)	Achieved compliance of 90.67%, this is the second month in a row we have seen the target being achieved. All divisions with the exception of medicine are now above the 90% compliance level.	Refreshed appraisal policy has been approved by JNCC, with it due to go to PRDG at end of January then ready to be published. Increased communications and managers guidance has been issued, via managers updates and leaders forums. The appraisal templates are in the process of being streamlined with new supportive guidance in development. As standard a monthly review of number of partially completed appraisals is completed, where appraisal dates have lapsed by 4 weeks, the next stage will be to develop an SOP to outline this process.	Achievement of compliance target. Personalised compliance reports sent to each staff member on monthly basis indicating when appraisal is due. Training and Appraisal compliance reports sent to each departmental manager on a monthly basis to allow for scheduling of appraisals. Managers have access to a real time managers dashboard via the learning management system. Annual strategic update reported to workforce committee.

People & Culture - Workforce Assurance 3



Latest
50.99%
Variance Type
Recent concerning pattern in the data
Mar 25 Target
60.0%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	The reported figure is that from Q2 in 2024, due to Q3 being reported through National Staff Survey and this remains embargoed. The level of staff engagement is below the 60% level of satisfaction we would aspire too. The national staff survey results indicate a further deterioration in levels of staff engagement for Q3.	Report of initial NHS Staff Survey Results for oversight has been provided to Workforce Committee. Analysis of data to compare 2024 results with previous years and Picker average to understand trends. The development of Divisional Packs to be shared in February. The development of an communication plan and associated resources. To initiate the development of a corporate level improvement plan.	National benchmarking results and Trust position reported to Workforce Committee. Progression of corporate level and divisional level action plans in response to levels of colleague engagement and satisfaction. Regular National Quarterly Pulse and use of TED enables interim measurement of levels of engagement at team and Trust levels

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Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Safety, Quality & Effectiveness

Excellent care with compassion

Always Safety First

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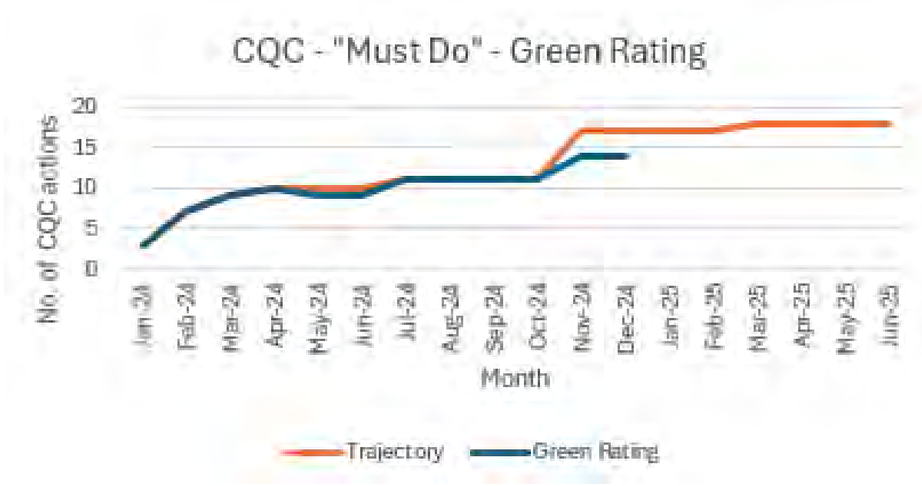
Single Improvement Plan - Safety, Quality & Effectiveness

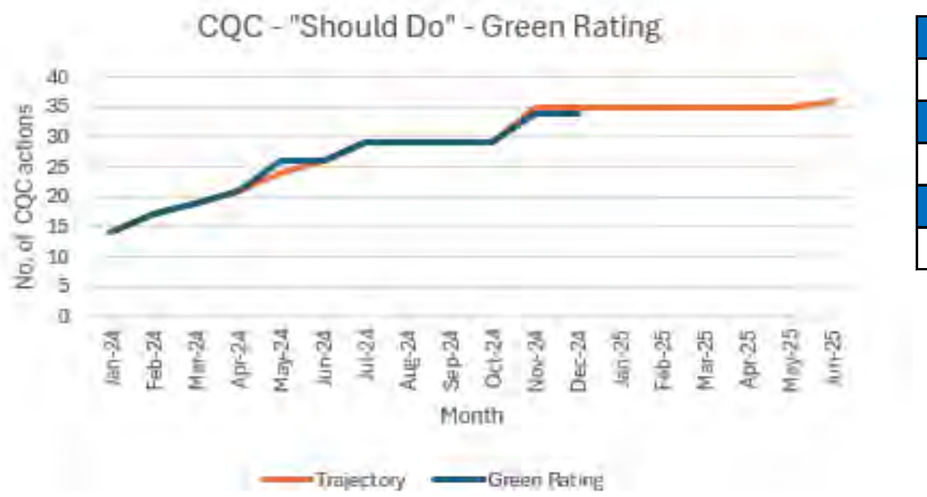
Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-25	Latest Month Target		
CQC	% of must do's from QIP 2023 assessed as Green (i.e. delivered)			⚑	18	17	14	Dec-24
	% of should do's from QIP 2023 assessed as Green (i.e. delivered)			⚑	36	35	34	Dec-24
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse	P			95%	95.0%	98.3%	Dec-24
	Staffing Fill Rate - Health Care Assistant				95%	95.0%	99.5%	Dec-24
	Staffing Fill Rate - Registered Midwife				95%	95.0%	93.1%	Dec-24
	Staffing Fill Rate - Maternity Support Worker			⚑	95%	95.0%	84.6%	Dec-24
Patient Experience and Involvement	Complaints per 1000 bed days				1.69	1.69	0.81	Dec-24
	STAR Accreditation all trust (Silver and Above)	P			75%	75.0%	85.0%	Dec-24
C Difficile Improvement	C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases				16	16	14	Dec-24
Always Safety First	Hospital Standardised Mortality Ratio (56 Basket – Adult)	Lower Than Expected					66.0	Aug-24
	Standardised Mortality Rate (All Diagnoses – Adult)	Lower Than Expected					70.1	Aug-24
	Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected					61.3	Aug-24
	Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected					94.6	Aug-24
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.48	3.48	3.48	Dec-24
Maternity	Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions				100%	100%	100%	Dec-24
	Perinatal - Number of Stillbirths				0	0	3	Dec-24

Safety & Quality Performance - CQC Assurance



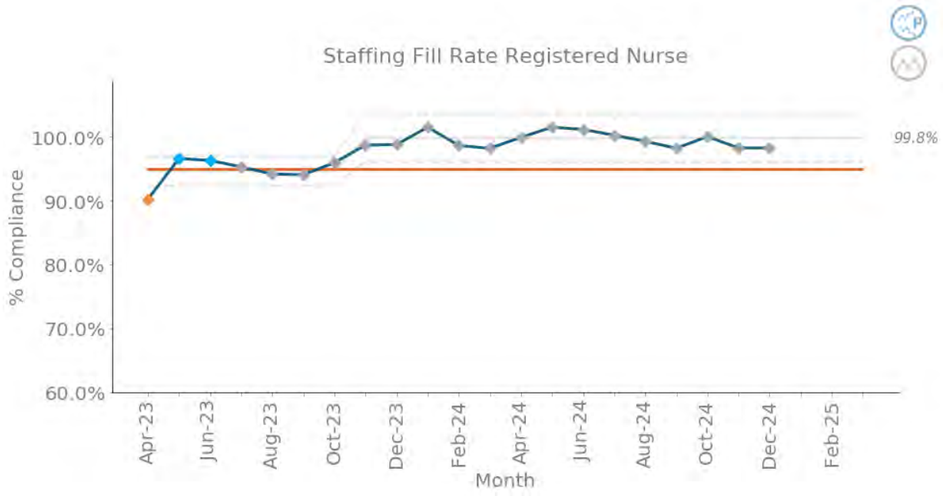
Latest
14
Month Target
17
Mar-25 Target
18



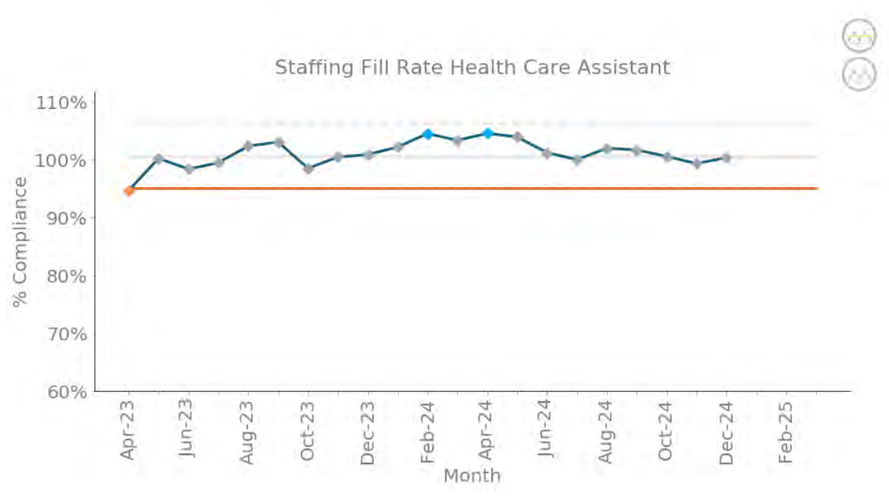
Latest
34
Month Target
35
Mar-25 Target
36

Metric	Summary	Action	Assurance
CQC - "Must do" (Number with Green rating)	At the end of December 2024, of the 54 ‘Must Do’s’ and ‘Should Do’s’ included in the 2023/2024 CQC Quality Improvement Plan (QIP), there are 48 (88%) recommendations assessed as ‘Green’ i.e., delivered, 3 (6%) as ‘Amber-Green’ i.e. ongoing and progress made and 3 (6%) 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 trust has made substantial progress in addressing the CQC’s "must-do" recommendations related to training and appraisals, with evidence of improved compliance rates in a number of modules and professional groups, and strengthened processes for training, supervision, and appraisal. However, recommendations related to Medical and Dental staff for specific core metrics in urgent and emergency care and medicine remain undelivered. Further efforts are being taken to address these shortfalls, with a focus on sustained engagement, protected time for training, and accountability mechanisms for non-compliance. At the end of December 2024 the trust has seen some improvements in medical staffing training compliance compared to previous months. - Paper documentation continues to be used for both fluid balance and vital signs in urgent and emergency care with monthly audits of deteriorating patients demonstrating improvements over the past six months. However, further monitoring is required particularly for fluid balance before assessing as delivered. In addition, an action was put in place to implement electronic vital signs and NEWS in ED to reduce reliance of paper forms and improve documentation standards. Unfortunately, the solution for ED to move to electronic vital signs did not pass user testing. An improved solution continues to be explored.	From the 18 ‘Must Do’ recommendations, 14 have been assessed as delivered and the themes of the 4 outstanding ‘Must Do’ recommendations are related to medical staff training compliance in urgent and emergency care and medicine and documentation specifically in relation to fluid balance and vital signs.
CQC - "Should do" (Number with Green rating)		- For timely medical review, when not receiving care on the correct medical specialty ward, job plans have been implemented to determine the frequency of reviews for each specialty, except for patients who no longer meet the criteria to remain on a medical outlier ward (these patients do not consistently receive medical reviews in accordance with policy). Additionally, arrangements are in place to ensure 24-hour access to medical review should a patient deteriorate, as per the NEWS policy. Recent data shows that 71.11% of medical patients received a daily senior review in October 2024. However, the ward round proforma has only been launched on the Clindoc app as of 26.11.24 and further interrogation of data is continuing to assess whether this recommendation has been fully delivered. - Phase 1 of Birth Rate plus was approved with midwifery staffing elements included in phase 2. All staff have been recruited to the Maternity Assessment Suite establishment but deadline extended for Phase 2. In recognition of the current financial envelope, staff are unlikely to be in post until the next financial year and therefore not yet delivered fully.	From the 36 ‘Should Do’ recommendations, 34 have been assessed as delivered and the themes of the outstanding 2 ‘Should Do’ recommendations are related to timely medical review when not being provided care and treatment on the correct medical speciality ward and midwifery staffing.

Safety & Quality Performance - Deliver Annual Safe Staffing Requirements Assurance



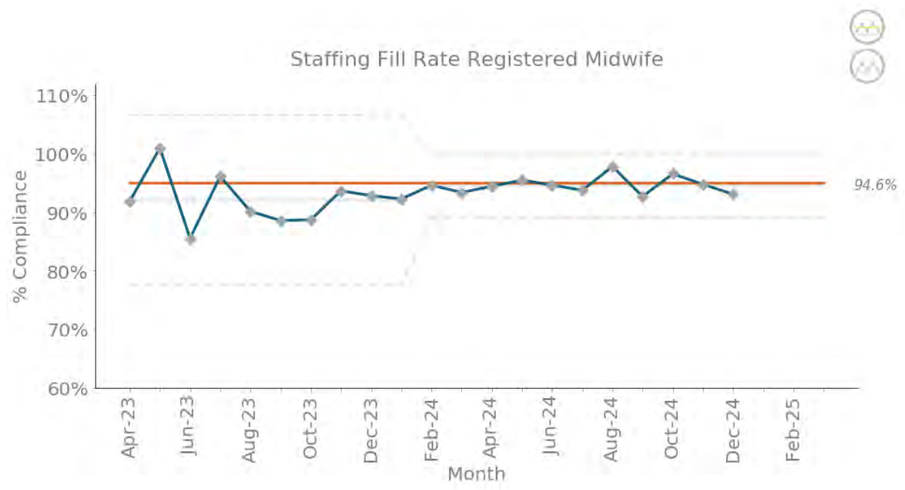
Latest
98.26%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Will consistently pass target within expected variation



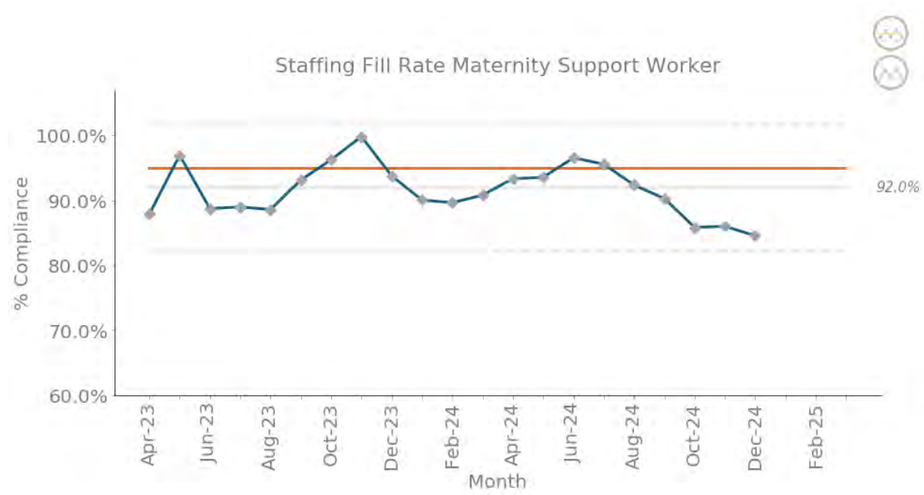
Latest
99.54%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The RN staffing fill rate for inpatient wards in December was 98%. Chorley District Hospital (CDH) RN fill rate for December was 102%, with Royal Preston Hospital (RPH) RN fill rate being 98%. The need for bank support remains to ensure safety is maintained, with a limited number of areas still requiring agency support. The implementation of strengthened approval processes for bank and agency is in place to ensure that as a Trust we are maximising the use of our resourced while maintaining safety for our patients and staff.	1. Ward managers work clinically as part of the clinical establishment with Matrons, if required, to support patient care. 2. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders as an interim measure following the introduction of strengthened approval processes for bank and agency.	1. Overall fill rate on average is between 112.4% and 85.7%. All clinical areas are showing a stable fill rate position, the Sellers ward at CDH is the only adult inpatient clinical areas that has an average mean fill rate lower then the 85% threshold used to prompt a review of safety metrics. The Sellers ward staffing needs fluctuate depending on demand which accounts for the reduced fill rate, no concerns have been noted relating to safety and quality of care. 2. Daily operational staffing meetings led by matrons, assess and respond to changes in pressure and demand based on acuity and dependancy, Red flags and professional judement. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated through a quarterley serious incident/PSIRF report.
Staffing Fill Rate Health Care Assistant	The HCA staffing fill rate for inpatient wards in December was 100%. Chorley District Hospital (CDH) fill rate for December was 97%, with Royal Preston Hospital (RPH) HCA fill rate being 101%. The need for bank support remains to ensure safety is maintained. The implementation of strengthened approval processes for bank is in place to ensure that as a Trust we are maximising the use of our resourced while maintaining safety for our patients and staff.	1. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders as an interim measure following the introduction of strengthened approval processes for bank use. 2. A review of Band 2 and Band 3 roles is being undertaken inline with national role guidanace. 3. Introduction of apprentiships into vacancies has commenced in the inpatient wards.	

Safety & Quality Performance - Deliver Annual Safe Staffing Requirements Assurance



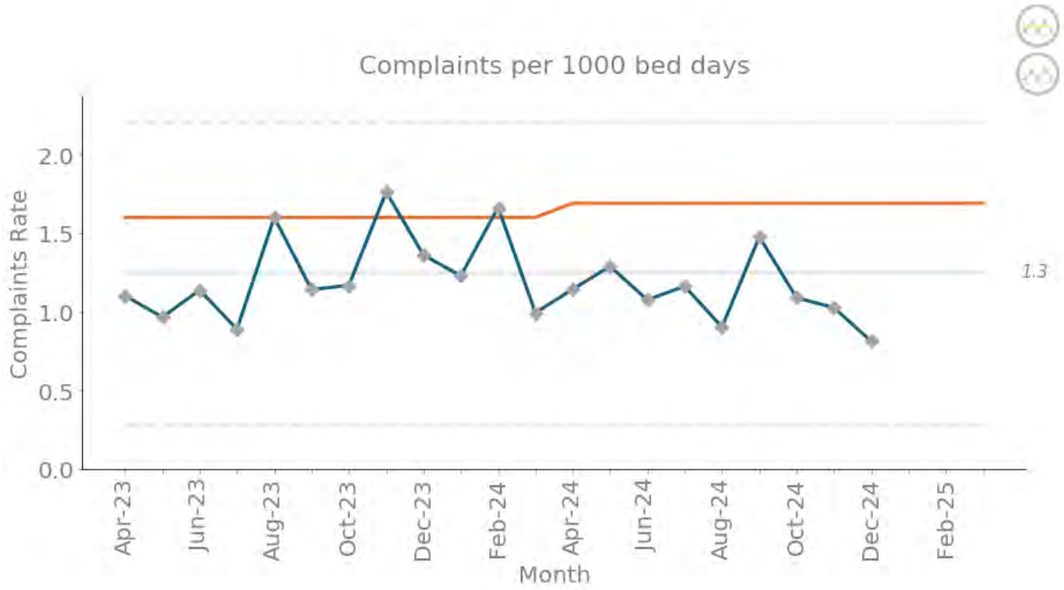
Latest
93.05%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
84.55%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The fill rates for Registered Midwives in December 2024 were (RM) (89% day, 91% night) demonstrates a stable position overall, with midwifery vacancies increasing slightly to 9.72 WTE. Delays associated with the financial recovery plan have affected recruitment timelines. Continued increased sickness absence has affected fill rates in month and resulted in bank and agency spend associated with Delivery Suite, Maternity A and B and Maternity Assessment Suite. The implementation of the strengthened approval and oversight processes for bank and agency approval continues to be utilised to ensure that the service is maximising efficient use of resources whilst continuing to prioritise safe care. However, there is a continued requirement to use bank and agency to backfill unfilled shifts.	1. Daily Safety Huddles led by matrons who respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Ward managers work clinically in addition to the 80/20 split when required during periods of high activity or reduced staffing. 3. Weekly roster efficiency reviews to ensure appropriate use of bank and agency 4. Recruitment of regular agency staff to the Trust bank. (5WTE) 5. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory	1. Fill rates for registered midwives overall have been stable in the last 6 months across day and night shift patterns. 2. The Safety and Quality committee review fill rate and minimum RM levels by area on a monthly basis. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report.
Staffing Fill Rate Maternity Support Worker	Continuing long term sickness on maternity A (3.5 WTE) which equates to 66% of the unregistered establishment continued into December 2024 . This is being managed in line with the Trust Policy. However, to maintain safe staffing levels, there continues to be a requirement to use bank to backfill shifts. The implementation of the strengthened approval and oversight processes for bank and agency approval continues to be utilised to ensure that the service is maximising efficient use of resources whilst continuing to prioritise safe care. However, there is a continued requirement to use bank and agency to backfill unfilled shifts.	1. Daily Safety Huddles led by matrons who respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Ward managers work clinically in addition to the 80/20 split when required during periods of high activity or reduced staffing. 3. Weekly roster efficiency reviews to ensure appropriate use of bank. 4. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory 5. Sickness management procedures reviewed by Workforce BP to ensure appropriate management.	1. Fill rates for MSW's on the day shift has been between 73% and 83% which is lower than the night shift rates. There is a focus on filling the night shifts as a priority. 2. The ability to manage and mitigate shortfalls is more challenging during the night when managers are not available to support. Night time fill rates are between 90% and 98%. 3. Biannual safe staffing procedures in place in line with National Quality Board guidance. 4. Monthly detailed maternity outcome reports enable close oversight of incidents that indicate if further action is required. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through the quarterly serious incident/PSIRF report.

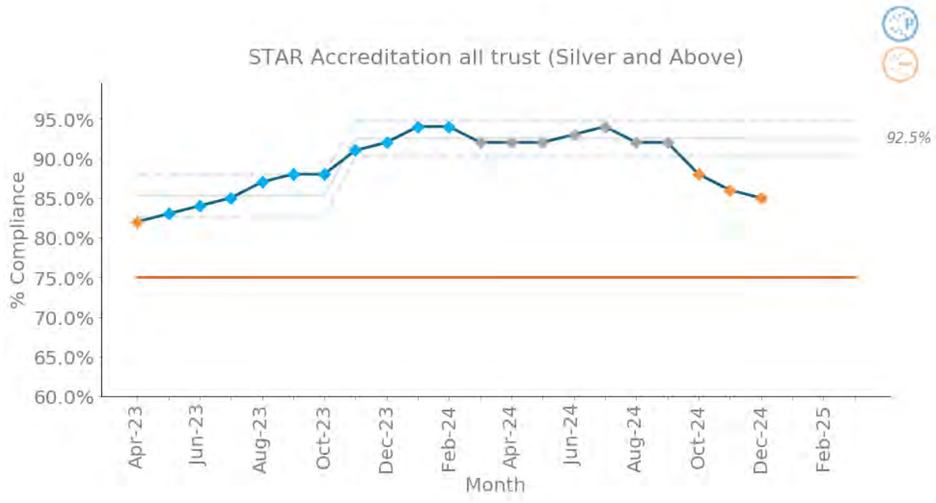
Safety & Quality Performance - Patient Experience and Involvement Assurance



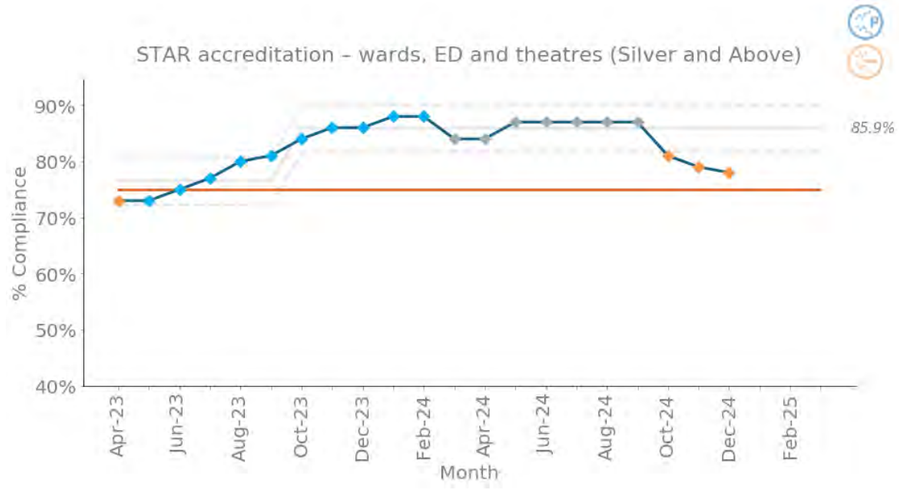
Latest
0.81
Variance Type
Normal variation - no recent change
Mar-25 Target
1.69
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	The number of complaints reduced by 132 when comparing 2022/23 to 2023/24 equating to 27.1% reduction. The target line represents the average number of complaints received over the previous 3 years. With the exception of 3 data points complaints received have remained below the previous 3 year average. The complaint incidence is measured against activity and presented as a per thousand bed day metric to ensure there is a recognition of any increase in activity. The theme of complaints relates to the Urgent and Emergency Pathway, communication, complex clinical presentations and unexpected clinical outcomes. The patient safety partners employed within the organisation are playing a critical role in reshaping the organisations approach to meaningful involvement and connection with patients and families. This is intended to create better relationships, build trust and confidence in our services and improve peoples overall experience. The patient experience and involvement strategy is in year 2.	1. Implement the patient experience and involvement strategy 2. Implement Patient Safety Incident Response Framework with a focus on meaningful patient and family engagement. 3. Implement the People Plan. 4. Identify an approach to training in meaningful engagement for the organisation. 5. Continued focus on local early resolution.	1. Twice annual patient experience reports to safety and Quality committee. 2. Friends and family reporting in place on paper and text for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses.

Safety & Quality Performance - Quality Assurance



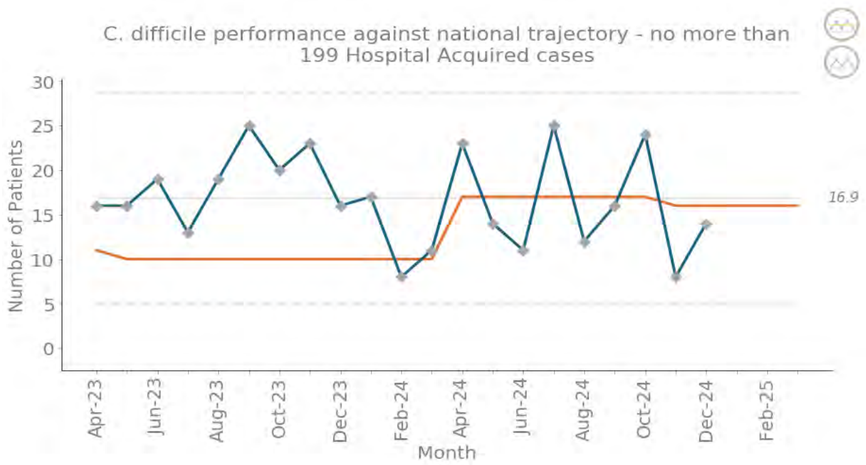
Latest
85.00%
Variance Type
Recent concerning pattern in the data
Mar-25 Target
75.00%
Target Achievement
Will consistently pass target within expected variation



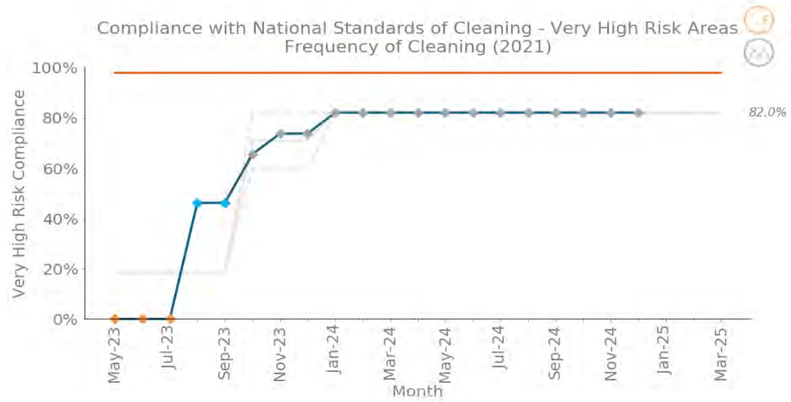
Latest
78.0%
Variance Type
Recent positive pattern in the data
Mar-25 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above) STAR accreditation – wards, ED and theatres (Silver and Above)	There are 124 clinical areas registered for the STAR Quality Assurance Framework, of which all 124 have received STAR accreditation visits. There is one clinical area with a red star rating , 18 areas with an amber rating and 105 areas rated green. This results in 19 bronze stars, 18 silver stars and 87 gold stars. There are 85% of areas rated silver or above. During December, there were 2 clinical areas with a reduced STAR rating from gold/silver stars to bronze star as they did not acheive the mandated critical standards. There were 2 clinical areas who each acheived their first gold star with other areas maintaining their current STAR rating. One area with a reduced 15 steps rating from A to C, was reassessed during November, it remained a C. One area achieved an improved 15 steps rating from C to B.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance porcesses and via STAR monthly reviews and STAR acreditation.visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings, the always safety first learning and improvement group and estates and facilities partnership board. The STAR report now included CQC (2023) actionplan standards. 3. STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 3 months. 4. The clinical area which acheived a red star rating and a reduced 15 steps rating of C had a follow up reassessments in 48 hours and 2 weeks and received a 15 steps reassessment within one month. 5. There is a divisional STAR action plan being developed by the divisional leadership team.	1. The STAR report is shared within the divisional leadership teams, good practice is shared and celebrated and that actions are developed where improvement is required. 2. Ward/department managers, matrons and professional leads provide assurance that actions are completed and monitored for effectiveness through the 1:1 with matrons and Divisional Nurse Directors. 3. The AMaT system supports with STAR audit data management and oversight and management of improvement actions. 4. There is a BI STAR page available to enable data triangulation.

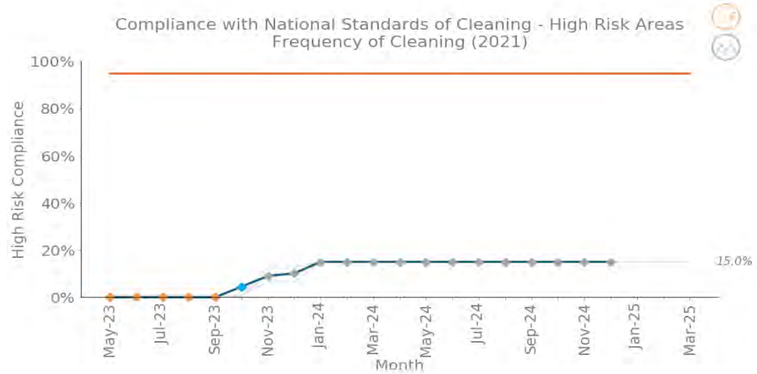
Safety & Quality Performance - C Difficile Improvement Programme Assurance



Latest
14
Variance Type
Normal variation - no recent change
Mar-25 Target
16
Target Achievement
Could both pass or fail target within expected variation



Latest
82.00%
Variance Type
Normal variation - no recent change
Mar-25 Target
98%
Target Achievement
Will consistently fail target within expected variation



Latest
15.00%
Variance Type
Normal variation - no recent change
Mar-25 Target
95%
Target Achievement
Will consistently fail target within expected variation

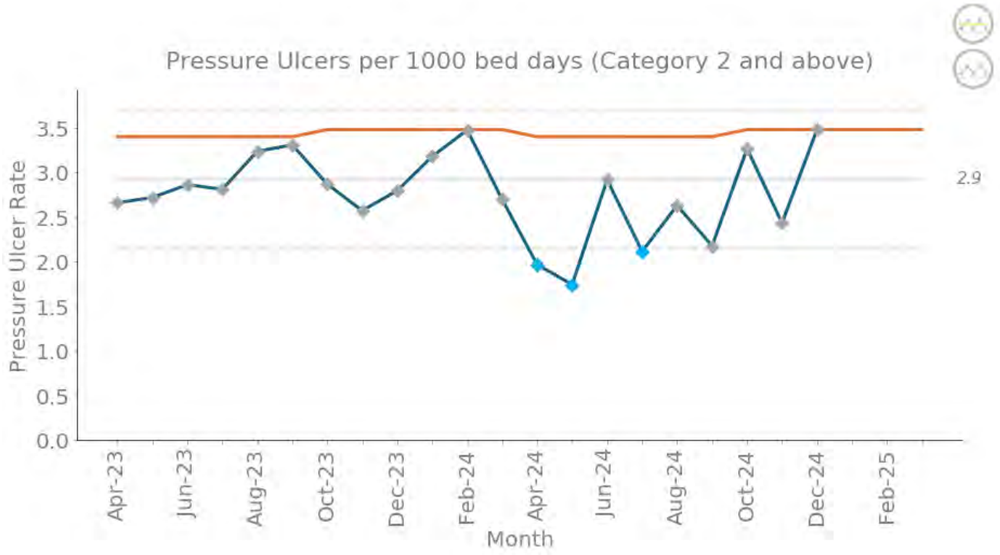
Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases	The increase in C.difficile is a recognised high risk and forms part of the principle risks for the organisation. There have been 147 Clostridium Difficile (CDI) cases against a national objective of 199 cases. The focused work on CDI reduction and the improvement plan continues to be monitiored through the Infection Control Committee and Estate and Clinical Partnership Board. The national cleaning standards frequency of cleaning is now visible and monitored through the dashboard alongside the quality checks of those areas not yet achiveing the frequency of cleaning standards.	1. To develop a business case to be compliant in high risk areas with national cleaning standards. This is expected to be completed ahead of 25/26 budget setting. 2. Continued focus on IPC in practice through STAR monthly and accreditation processes. 3. Established an estates and clinical partnership board to ensure prioritsation of areas with the estate that require risk mitigation. 4. Continue to monitor key performance assurance indicators through IPC committee. Ongoing 5. Purchase of UV light machines to treat exposed areas. Complete.	1. IPC BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard. 3. IPC monthly revalidation audits such as hand hygiene, commodes, environmental checks and mattress checks. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. NHS England review of IPC assurances.

Safety & Quality Performance - Always Safety First Assurance

	Latest	Achievement
Hospital Standardised Mortality Ratio (56 Basket – Adult)	66.0	Lower Than Expected
Standardised Mortality Rate (All Diagnoses – Adult)	70.1	Lower Than Expected
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	61.3	As Expected
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	94.6	As Expected

Metric	Summary	Action	Assurance
Hospital Standardised Mortality Ratio (56 Basket – Adult)	HSMR is within Upper and Lower Control Limits and lower than expected range compared to peer.	1. Continue with structured judgement review process. 2. Use mortality reviews to establish themes where care or experience could be improved. 3. Continue to work with the medical examiners office to review deaths in line with guidance. 4. Continue to use incident reporting processes where an incident occurs under Patient safety Incident Response Framework (PSIRF). 5. Continue to implement the 10 CNST safety actions for maternity and neonatal 6. Marthas rule (Call for Concern)implementation is underway.	1. Mortality and End of Life committee chaired by Deputy Chief Medical Officer with responsibility for mortality. 2. Twice annual reports to safety and Quality committee. 3. Telstra system utilised to generate mortality data ensuring objective peer data is used to establish reported key performance indicator. 4. Speak Up arrangements are well established in the organisation. 5. Maternity Neonatal report provides assurance of compliance with Maternity neonate Safety Investigation branch for appropriate cases. 6. The Child Death Overview process ensures peer review takes place of all child deaths and is reported through the annual safeguarding report and the mortality reporting arrangements. 7. ED and maternity and neonatal safety forums in place with executive leads identified to encourage speak up in high risk areas.
Standardised Mortality Rate (All Diagnoses – Adult)	SMR is within Upper and Lower Control Limits and lower than expected range compared to peer.		
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses) is within Upper and Lower Control Limits and within expected range compared to peer.		

Safety & Quality Performance - Always Safety First Assurance

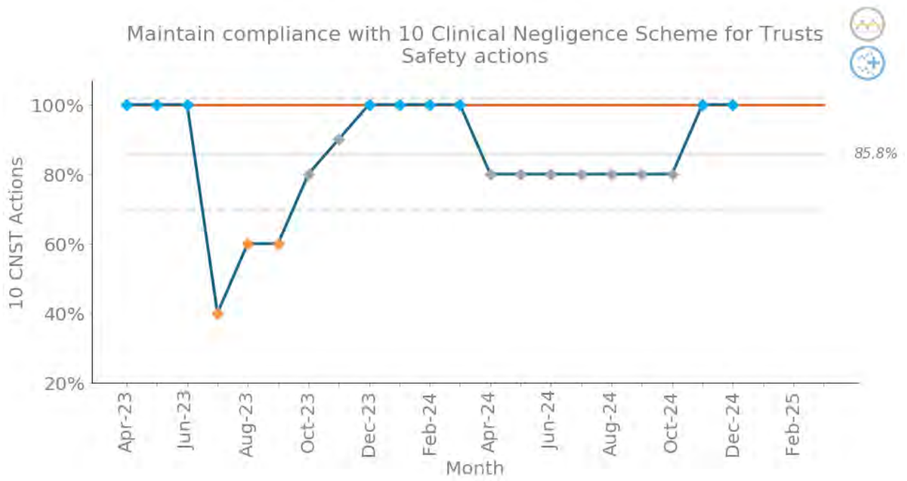


Latest
3.48
Variance Type
Normal variation - no recent change
Mar-25 Target
3.48
Target Achievement
Could both pass or fail target within expected variation

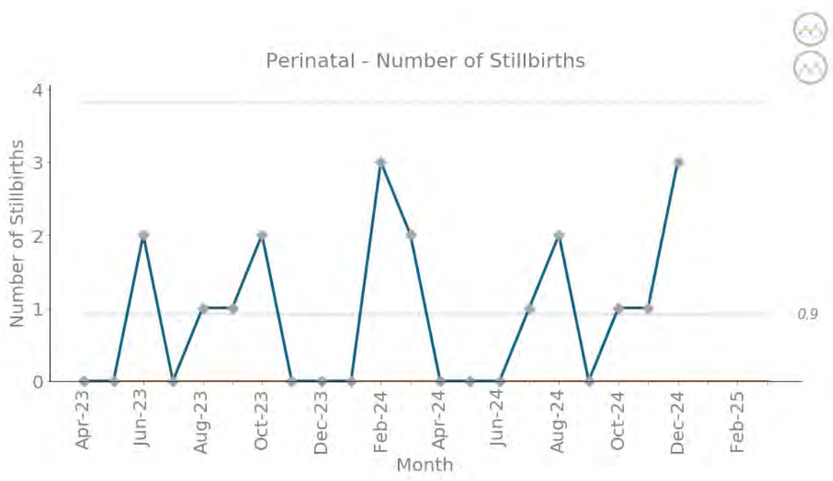
Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers are considered a proxy of care delivery. The target line represents the average number of pressure ulcers in the previous three years. With the exception of Feb 24 performance in this area is consistently improved, however, December has seen an increase, most likley linked to extended length of stay in the ED. Staffing flexibility is in place to respond to the increased occupancy however addressing the underlying issues associated with the UEC pathway remain the priority. A continued focus on the care interventions that reduce the liklihood of pressure ulcers continues . This work will remain a priority.	1. Organisational pressure ulcer improvement plan lead by the Deputy Chief Nursing Officer 2. Continued focus on Operational Performance Single Improvement plan. 3. STAR quality assurance fundamental standards includes intentional rounding which is linked to pressure relief treatment. 4. Education and awareness of pressure ulcer prevention continues.	1. Always Safety First strategy reporting twice yearly to safety and quality committee. 2. Always Safety First committees at divisional level responsible for overseeing the implementation of the codesigned pressure ulcer improvement programme. 3. Monitoring of pressure ulcer incidence continues to be recognised as a priority metric.

Safety & Quality Performance - Maternity Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



Latest
100.0%
Variance Type
Recent positive pattern in the data
Mar-25 Target
100.00%
Target Achievement
Could both pass or fail target within expected variation



Latest
3
Variance Type
Normal variation - no recent change
Mar-25 Target
0
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	The position for CNST MIS year 6 is detailed within the maternity neonatal report presented to Board on a bi monthly. In February 2025, the CNST standards will be recomended considered for approval by the Board following the validation by the local Maternity and Neonatal System LMNS.	1. Delivery of the Maternity Neonatal Improvement plan.	1. Monthly reporting to safety and quality committee. 2. ICB Local Maternity Neonatal System validation of CNST delivery of standards.
Perinatal - Number of Stillbirths	The stillbirth rate in England was updated in October 2024 (MBRRACE) to 3.9 per 1000 births. The government ambition to achieve a 50% reduction in the stillbirth rate by 2025 equates to a rate of 2.6 stillbirths per 1,000 births. LTHTR stillbirth rate is 2.8 per 1000 births.	1. Implementation of the 10 CNST maternity neonatal safety standards.	1. Monthly reporting to safety and quality committee. 2. Peer comparison data included within the reporting 3. National embrace reporting provides overview of national themes to ensure learning is understood nationally. 4. ICB Local Maternity Neonatal System validation of CNST delivery of standards.

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Financial Sustainability

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Single Improvement Plan - Financial Sustainability

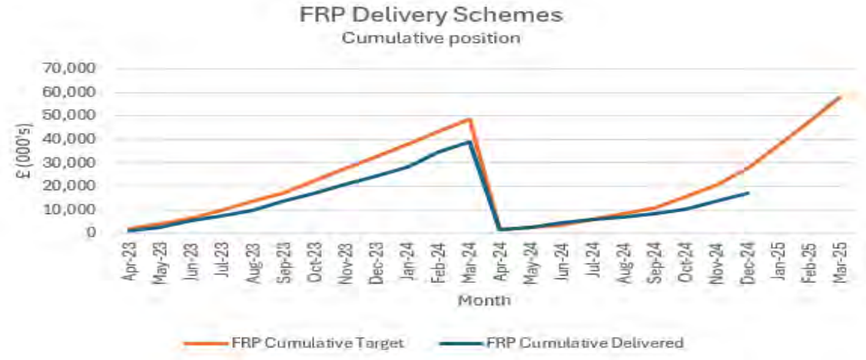
Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target (£ 000's)			Latest YTD Actual (£ 000's)	Latest Month
				Concern	Mar-25	Latest YTD Target		
Finance	I&E Normalised run rate					-8910	-26338	Dec-24
	FRP schemes delivery				58040	27733	17079	Dec-24

Single Improvement Plan - Financial Sustainability - Assurance

Lancashire Teaching Hospitals NHS Foundation Trust

Latest YTD Actual (,000s)
-26,338
Latest YTD Target (,000s)
-8,910
March 25 YTD Target (,000s)
-



Latest YTD Actual (,000s)
17,079
Latest YTD Target (,000s)
27,733
March 25 YTD Target (,000s)
58,040

Metric	Summary	Action	Assurance
I&E Normalised run rate	The Trust had submitted the final plan in line with the NHSE control total, a deficit of £21.9m. In month 6 the Trust received funding to cover the deficit the Trust now has a break-even plan. At month 9 the Trust has a deficit of £26.3m an adverse position of £17.4m against a planned deficit of £8.9m. The main variances to plan are: - £10.7m variance to Financial Recovery Plan Target - £5.2m shortfall on income from urgent and emergency care capacity and investment funding to support frailty and intermediate care - £1.1m fixed overperfomance and impact of Industrial Action and IT outage The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - capacity issues resulting in elective, day case and out patient income under performance The Trust is reviewing its forecast recognising that it is a high risk plan with a number of efficiency schemes not yet delivering to plan, risks that have materialised since the plan was set and continued operational pressures.	The Trust has appointed a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has been part of this review. The ICB has commissioned work into the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from NHSE and the Trust has committed to further grip and control measures to manage the in year position. The Trust has commissioned further external support in Q4 to support specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and developing savings schemes for 2025/26.	Turnaround Director ICB Review of UEC Pathway I&E Interventions and control measures ICB System Improvement Director Review Mandated national support from PWC
FRP schemes delivery	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 9 the Trust has delivered £17.9m year to date, which is 66% of the plan of £27.3m however 53% of this was non-recurrent. Annually £21.7m; (£14m recurrently) has been delivered towards the £58m target which is 37%.	The Trust has appointed a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure , governance and reporting has been part of this review. The Trust recognises that it will require additional external support to help with the delivery of the FRP as well as drafting the outline for the 2025/26 programme. Support has been commissioned for procurement, contract management and other specific workstreams. The Trust has engaged with the NHSE regional diagnostics team to support the improvement programme in this area.	Turnaround Director Weekly Finance Recovery Board Meetings as part of programme reset ICB System Improvement Director Review

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Operational Performance

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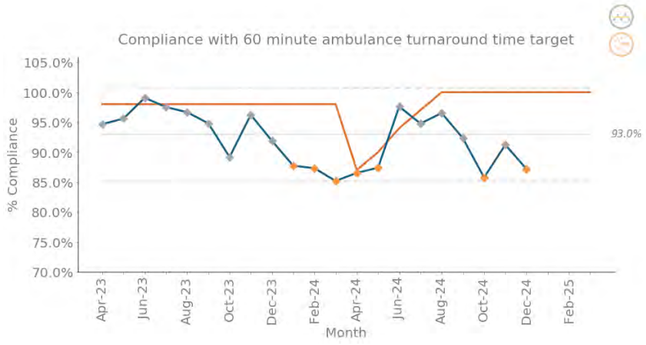
Single Improvement Plan - Operational Performance

Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		Assurance @ Mar-25	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-25	Latest Month Target		
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100%	100%	87.2%	Dec-24
	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025				78%	76.5%	70.5%	Dec-24
	Maximum wait of 12 hours as Total Time in Department				2%	4.0%	11.1%	Dec-24
UEC Flow	Bed occupancy to 92%				92%	93.5%	93.0%	Dec-24
	Number of boarded patients				0	0	17	Dec-24
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside to 5%				5%	5%	9.3%	Dec-24
Elective (diagnostics)	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%				98%	77.1%	47.4%	Dec-24
Elective (long waits)	52 week waits				0	656	1444	Dec-24
	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)				0	0	21	Dec-24
	Eliminate >78 week waits				0	0	0	Dec-24
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				85%	82.4%	85.2%	Dec-24
Elective (Cancer)	Improve performance against the headline 62-day standard to 70% by March 2025				70%	70.0%	64.8%	Dec-24
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026				77%	77.0%	81.4%	Dec-24

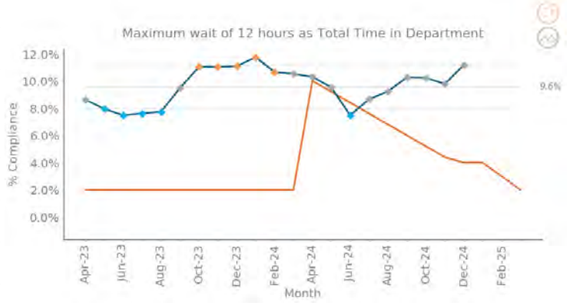
Operational Performance - UEC Assurance

NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest
87.2%
Variance Type
Recent concerning pattern in the data
Mar 25 Target
33%
Target Achievement
Could both pass or fail target within expected variation

Latest
70.50%
Variance Type
Normal variation - no recent change
Mar-25 Target
78.00%
Target Achievement
Will consistently fail the target within expected variation

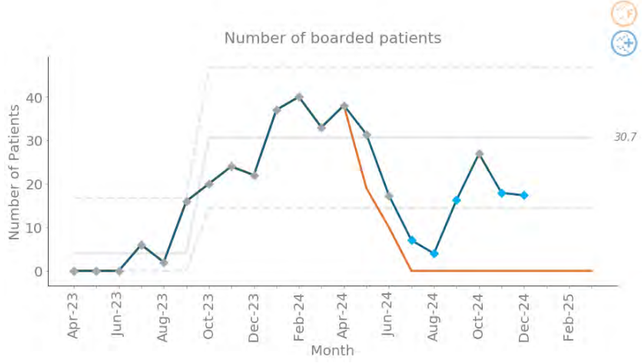


Latest
11.10%
Variance Type
Normal variation - no recent change
Mar-25 Target
2.00%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Compliance with 60 minute ambulance turnaround time target	In December, 439 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, an increase of 32 from last month. 300 patients waited over 60 minute to be handed over from NWAS to the Trust in December 24, an increase of 99 compared to November. Over 87% of patients were handed over within 60 minutes. The current position is within normal variation but is expected to consistently fail the target.	Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for December 24 indicates that the Trust is above the national performance position of 83.8% for 60 minute handovers and above the NW performance position of 83.5%.
ED 4 Hour Performance - Trust	Performance against the national 4 hour access standard improved in December 2024. The performance improvement was 0.6% compared to November. December experienced a slightly lower level of overall attends compared to November with on average 19 less patients attending per day during the month.	The UEC Improvement programme is focusing on measures to reduce the wait to be seen time, improving response times for patents referred to specialities and seeking to maximise referrals into SDEC. Targets have been set for each of these critical measures and is monitored via the UEC Improvement Board monthly. An 18% increase in the activity via Medical SDEC has been noted in Sept - Dec 24 versus April-Aug 24 inc.	The average time to triage in November remains at 26 minutes with time to treatment at 178 minutes. Both show a slight upward trend in December. The overall SDEC utilisation trend indicates that @ 31.9% of non elective activity is referred into SDEC locations. Comparison of 4 hour performance to national benchmarks indicates that the Trust is slightly below the national average for December of 71.1% and was ranked 8th out of 20 Trusts in the NW Region. There has been a recent positive pattern in the data with December showing a sustained improved position comparable to previous months.
Maximum of 12 Hours Total time in ED	The number of patients waiting over 12 hours (admitted and non-admitted) in ED increased in December to 11.1%, an increase of 1.3% compared to November. This follows a period of downward trend in October and November. Performance remains within normal variation.	The UEC improvement programme is focusing on reducing length of stay via improving board and ward round standards and driving down the days patients spend in hospital when they no longer require inpatient care.	Overall Bed Occupancy is at 93.0%, with a range from 93% - 97% in the current year. The level of boarded patients was sustained in December at an average of 17 patients per day. Whilst high, the position however it is still lower than the high of 31 in April 2024. Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

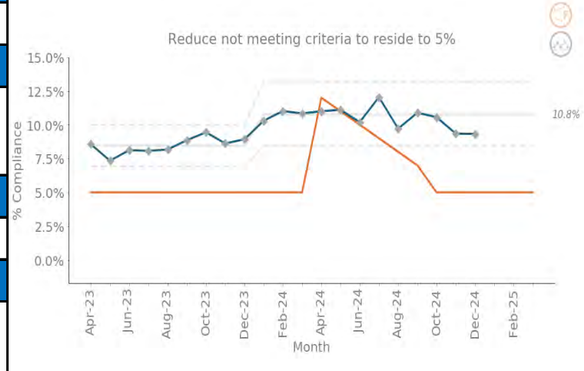
Operational Performance - UEC Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



Latest
17
Variance Type
Recent positive pattern in the data
Mar 25 Target
0
Target Achievement
Will consistently fail the target within expected variation

Latest
93.0%
Variance Type
Normal variation - no recent change
Mar 25 Target
92%
Target Achievement
Could both pass or fail target within expected variation

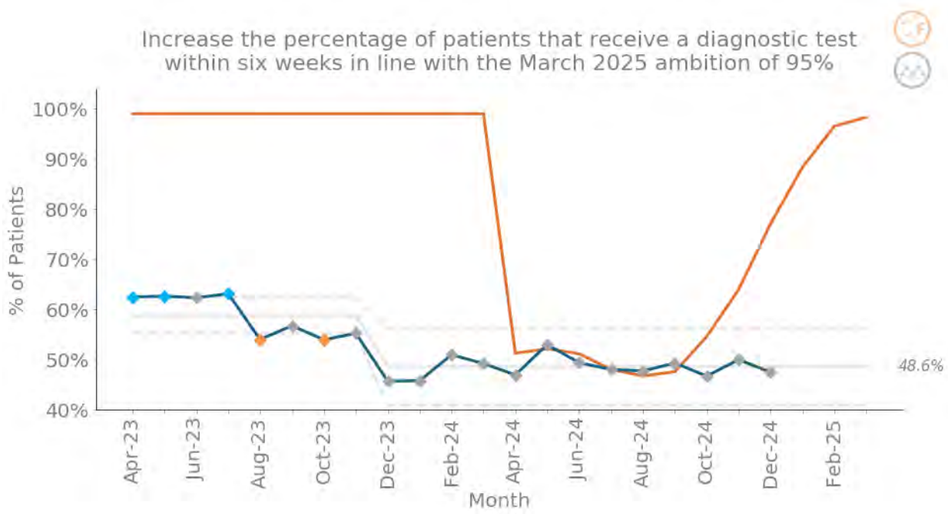


Latest
9.3%
Variance Type
Normal variation - no recent change
Mar 25 Target
5%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Number of Boarded Patients	On average 17 patients were boarded each day across both sites during December with 538 associated bed days. This is consistent with the November position. These are predominantly medical patients requiring admission to an acute medical ward. The current position is within normal variation but will consistently fail the target.	A focus on maximising use of the discharge lounge to reduce the need for boarding.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Bed Occupancy 92%	Overall Bed Occupancy is at 93.0%, with a range from 93% - 97% in the current year. Analysis of the recent run of performance indicates the Trust could pass or fail the target.	Actions to mitigate high occupancy and use boarded/escalation beds of focus on improving ward and board round processes, increasing the use of Same Day Emergency Care (SDEC) facilities, improved discharge processes and mobilisation of the new AMU model of care. However, it should be noted that all improvement areas will see incremental improvements throughout the course of the financial year.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey
Reduce NMC2R to 5%	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) remained consistent in December (9.3%) compared to the November position. The current position is within normal variation but is expected to continue to fail the national target of 5%.	There has been good utilisation of available capacity in the Home First service, but changes to the commissioning model for the Community Healthcare Hub (CHH) at Finney House have caused some delay to decision making as part of the discharge pathway. The Trust is working with system partners to resolve. Further data analysis is required relating to the number of bed days occupied whilst NMCTR.	Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Operational Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



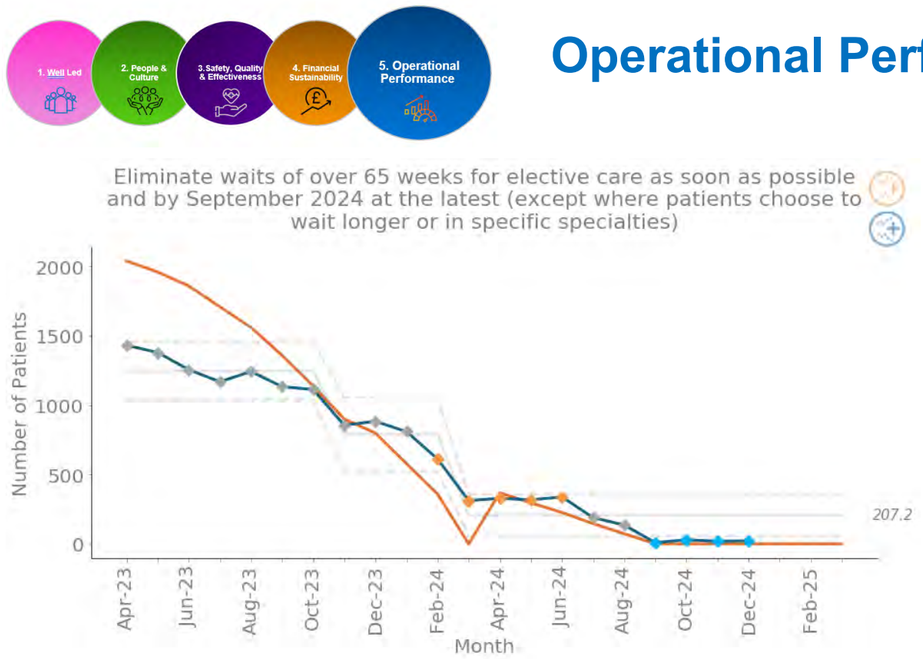
Latest
47.4%
Variance Type
Normal variation - no recent change
Mar 25 Target
98.0%
Target Achievement
Will consistently fail the target within expected variation

Latest
0
Variance Type
Recent positive pattern in the data
Mar 25 Target
0
Target Achievement
Will consistently fail the target within expected variation

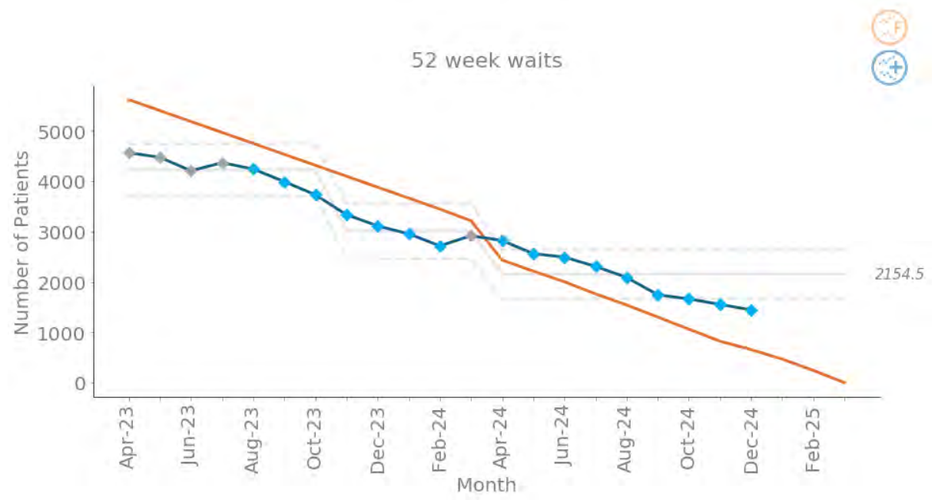
Metric	Summary	Action	Assurance
Increase the % of patients that receive a diagnostic test within 6 weeks	Diagnostics under 6 week performance was 47.4% in December compared to the November position of 49.9%, a slight deterioration of 2.5%. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance is within expected variation but expected to consistently fail the target.	The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. Mutual aid has been requested for echocardiology. A rapid improvement week has been held WC 13/01/25 to support productivity improvements and reduce process barriers to support improved utilisation of the available endoscopy capacity.	The areas of focus are capacity optimisation, productivity, transformation and system working. Weekly focussed PTL management meetings have been implemented. Review of the latest published data (Nov 24) indicates that LTH is the worst performing NHS Trust in the NW region, worst performing Trust in the ICB and significantly below the national average of 80.4%.
Eliminate > 78 Week Waits	The end of December 24 position was 0, This position has been maintained since May 2024.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the Elective Performance Review Group.	Close monitoring of the L&SC long waiting RTT performance is ongoing.

Operational Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



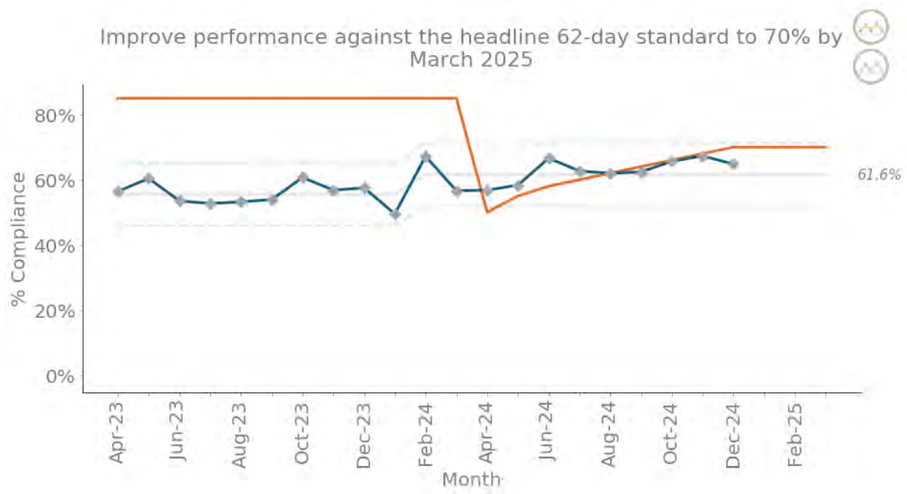
Latest
21
Variance Type
Recent positive pattern in the data
Mar 25 Target
0
Target Achievement
Will consistently fail the target within expected variation



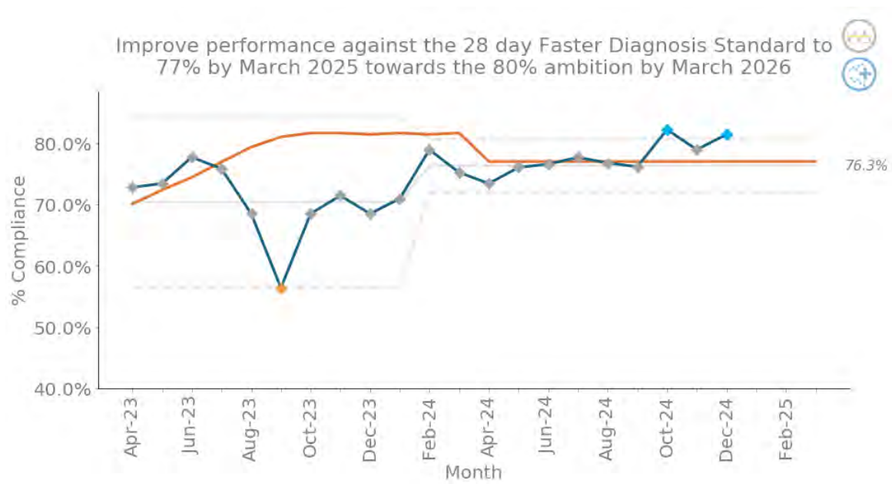
Latest
1444
Variance Type
Recent positive pattern in the data
Mar 25 Target
0
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Eliminate > 65 Week Waits	The downward trend in over 65 week waiters remained consistent with previous months with a position of 21 due to capacity shortfalls. There is a recent positive pattern in the data, however analysis would suggest that the target may be consistently failed.	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. Issues and risks are reviewed at the Elective Performance Review Group.	Monitoring of all premium cost activity is ongoing. Capacity & Demand modelling analysis and part of the Model Service Review programme. Once complete, capacity gaps will be appraised against benchmarking productivity opportunities. Comparison to the latest NW region position indicates that the Trust is currently 10th out of all acute and specialist trusts and 4th out of acute Trusts in terms of the overall number of 65 week waiters
Reduce the number of > 52 Week Waits	The downward trend in over 52 week waiters has been continued into December with a position of 1444, a further reduction of 110 from November. There is a recent positive pattern in the data, however the target may be consistently failed.	Capacity & Demand modelling is to be undertaken for all specialities and sub specialities. Focus on DNA reduction, PIFU and theatre utilisation is ongoing to maximise capacity.	Local monitoring of all speciality RTT clock stop/performance is undertaken via fortnightly Performance Recovery Group

Operational Performance - Cancer Assurance



Latest
64.8%
Variance Type
Normal variation - no recent change
Mar 25 Target
70%
Target Achievement
Could both pass or fail target within expected variation



Latest
81.4%
Variance Type
Recent positive pattern in the data
Mar 25 Target
77%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
62 Day Cancer Standard - 70% Target	Performance to the end of December (currently unvalidated and expected to meet the target) is slight below last month, and below the monthly target of 70%. Analysis shows performance is within expected variation, the target may or may not be achieved.	Whilst Cancer performance is improving there are a small number of tumour groups with the greatest collective contribution to current performance challenges, these are Colorectal, Lung and Urology. All tumour sites have improvement plans to achieve performance targets.	The Trust is currently below the latest national average performance of 69.4% (Nov 24). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group
28 Day Faster Diagnosis - 77% Target	Performance to the end of December (currently unvalidated and above target) is 4.4% above the annual target of 77%. Analysis indicates that the target may or may not be achieved.	Close monitoring of diagnostic turnaround times and associated capacity and demand is underway. Monitoring of opportunities to manage demand is ongoing.	The Trust is currently above the latest national average performance of 77.3% (Nov 24). Close monitoring turnaround times via the Diagnostic Improvement Group

11.2 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | T Whiteside | 14:40

Item for assurance

REFERENCES

Only PDFs are attached

11.2 - Chair's Report FPC Nov Dec 24.pdf

Chair's Report to Board		
Chair: T Whiteside	Committee: Finance and Performance	
Date(s): 22 November 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20 Fit for the Future - 15	⇨	None

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

- Cash position remains precarious with further variances against the Financial Recovery Plan emerging. Executives working through a plan to remedy including actions informed by the I&I report.
- Risks crystalising on the discrepancy between Commissioners' intentions and the Trust's affordability requirements, noting that actions were in progress to broker a resolution with the ICB.
- Continued pressure of mental health patients in the Emergency Department and the absence of funding for a sustainable solution. Alternatives are being explored jointly between ICB, LSCFT and LTH.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The level of scrutiny applied to the "Fit for the Future" risk exposure, with limited assurance on the adequacy of captured mitigations. Work to strengthen to be included in the transition to the New BAF/Principal Risks.
- Pace of progress of the Community Support Model, with decision on defined route forward expected at the January Special Board, following further detailed scrutiny by the Committee.
- Finney House planned options appraisal and assessment discussed, highlighting the potential for difficult decisions and the need for further assurance on option assessment consistency emphasised.

ASSURE

Assurance received; Matters of positive notes

- While operational performance challenges remained, actions taken, including the use of external expertise, are expected to yield improvements and bolster confidence in the plans. Continued high risks acknowledged in UEC and DM01, and ongoing collaborative efforts with the ICB and system partners on identified commissioning differences.
- Enhanced scrutiny and control over high-value contracts, particularly within the Limited Liability Partnerships.

Chair's Report to Board		
Chair: T Whiteside	Committee: Finance and Performance	
Date(s): 17 December 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20 Fit for the Future – 15	⇨	None

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

- **24/25 Financial Plan Risks:** The financial plan remains off trajectory, with concerns both over in-year and the knock-on effect into next year. This poses a substantial challenge and under-scored the need for clearer decision and mitigation options to be brought forward. Immediate actions taken to tighten cost containment controls to positively impact the run-rate.
- **25/26 Plan:** Assured on the scrutiny being applied to planning processes, with weekly Executive oversight instigated. Further assurance sought on adequacy of emerging plans to address required performance improvements, including closing the financial gap. Imposing top-down expectations discussed to compliment the bottom-up planning approach.
- **DM01:** Continued concern regarding the pace of improvement in the DM01 diagnostic performance. While there had been no further deterioration despite winter pressures, the metric remained a critical area of focus requiring further support and intervention.
- **Cybersecurity Risk:** The Committee recommended further consideration of elevating cybersecurity as a principal risk due to the increases in Cybersecurity threats.
- **Organisation Planning Controls**: Absence of an established framework for selecting and evaluating new organisational models (e.g. PCB - Clinical Blueprint and Pathology) to optimise resource utilisation against strategic goals was raised as a concern. This gap in strategic guidance risked inconsistent approaches and potential inefficiencies being introduced across the system.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Workforce Benchmarking:** the need for further assurance regarding clinical and non-clinical workforce arrangements, including understanding their benchmark performance and associated cost-effectiveness. Demand and capacity evaluation was deemed critical for addressing potential gaps and optimising resource allocation and will remain a focus of continued scrutiny.
- **SIP Risks and Dependencies:** Limited assurance received, with significant dependencies and risks associated with the current change agenda and transformation programmes. The potential compound effects of overlapping initiatives required careful oversight to avoid unintended consequences. Focus being applied to creation of a Trust PMO, greater specificity in milestones attainment related to required outcomes, and clear priority calls.

ASSURE

Assurance received; Matters of positive notes

- **Cybersecurity**: Partial assurance was provided regarding the current cybersecurity posture, with evidence of necessary controls in place, including ongoing efforts to address multifactor authentication and unsupported systems. However, this assurance was caveated with the recommendation to re-evaluate risk scoring and enhance financial clarity on planned upgrades.
- **Winter Resilience**: Assurance on the positive trajectory observed in urgent and emergency care (UEC) metrics despite winter pressures, signally improved resilience in managing patient flow and capacity.

Finance and Performance Committee

26 November 2024 | 9.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9.00am	Verbal	Information	T Whiteside
2.	Apologies for absence	9.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	9.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 22 October 2024	9.03am	✓	Decision	T Whiteside
5.	Matters arising and action log	9.05am	✓	Decision	T Whiteside
6.	Strategic Risk Register	9.10am	✓	Decision	S Regan
7.	OPERATIONAL PERFORMANCE				
7.1	Performance Assurance Progress Report	9.20am	✓	Assurance	K Foster-Greenwood
7.2	Community Service Integration Update	9.35am	✓	Assurance	C Granato
8.	FINANCIAL PERFORMANCE				
8.1	Month 7 Financial Position and General Financial Update a) I&I feedback b) Waivers	9.45am	✓	Assurance	D Stonehouse
8.2	Commissioning Intentions	10.00am	✓	Information	D Stonehouse
8.3	LLP Update	10.15am	✓	Assurance	N Pease
9.	STRATEGY & PLANNING				
9.1	Planning Controls Update	10.30am	✓	Assurance	G Doherty
9.2	Single Improvement Plan Review	10.45am	✓	Assurance	A Brotherton
9.3	External Dependencies Update	11.00am	✓	Information	G Doherty
9.4	Annual Operating Plan (to incorporate the approach to planning)	11.15am	✓	Assurance	G Doherty

№	Item	Time	Encl.	Purpose	Presenter
9.5	Finney House Options Update	11.30am	✓	Assurance	S Cullen
10. GOVERNANCE AND COMPLIANCE					
10.1	Items to Alert, Advise or Assure Board	11.45am	Verbal	Information	T Whiteside
10.2	Reflections on the meeting	11.55am	Verbal	Information	T Whiteside
11. ITEMS FOR INFORMATION					
11.1	Action Plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Chair's Reports**: (a) ICS, ICP, PCB System Update (b) EPRR (c) SIB Meeting Minutes		✓		
11.4	Date, time, and venue of next meeting: *17 December 2024, 9am-12pm, Microsoft Teams*	12.00pm	Verbal	Information	Chair

Finance and Performance Committee

17 December 2024 | 9.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9.00am	Verbal	Information	T Whiteside
2.	Apologies for absence	9.01am	Verbal	Information	T Whiteside
3.	Declaration of interests	9.02am	Verbal	Information	T Whiteside
4.	Minutes of the previous meeting held on 26 November 2024	9.03am	✓	Decision	T Whiteside
5.	Matters arising and action log	9.05am	✓	Decision	T Whiteside
6.	Strategic Risk Register	9.10am	✓	Decision	D Stonehouse/G Doherty
7.	FINANCIAL PERFORMANCE				
7.1	Month 8 Financial Position and General Financial Update inc. I&I feedback & Controls Update	9.25am	✓	Assurance	D Stonehouse
7.2	Procurement Update	9.40am	✓	Assurance	J Collins/J Roberts
7.3	Costing, costing transformation and patient-level costing *(In line with the national timetable*	9.55am	✓	Assurance	D Stonehouse
7.4	Corporate Services Benchmarking	10.10am	✓	Assurance	D Stonehouse
8.	STRATEGY & PLANNING				
8.1	Planning Controls inc. SIP progress & external dependencies	10.20am	✓	Assurance	G Doherty
8.2	Annual plan, forward plan preparation & 3-year trajectory	10.35am	✓	Assurance	G Doherty
8.3	Carpark Management Business Case	10.50am	✓	Information	I Ward
9.	OPERATIONAL PERFORMANCE				
9.1	Performance Assurance Progress Report inc. Winter Plan update.	11.00am	✓	Assurance	K Foster-Greenwood
10.	GOVERNANCE AND COMPLIANCE				
10.1	Cyber Security Update	11.15am	✓	Assurance	S Dobson

№	Item	Time	Encl.	Purpose	Presenter
10.2	Items to Alert, Advise or Assure Board	11.25am	Verbal	Information	T Whiteside
10.3	Reflections on the meeting	11.35am	Verbal	Information	T Whiteside
11.	ITEMS FOR INFORMATION				
11.1	Action Plans from Divisional Improvement Forums		✓		
11.2	Contract Performance		✓		
11.3	**Chair's Reports**: (a) ICS, ICP, PCB System Update (b) Digital and Health Informatics		✓ ✓		
11.4	Date, time, and venue of next meeting: *28 January 2025, 9am-12pm, Microsoft Teams*	11.40pm	Verbal	Information	Chair

11.3 AUDIT COMMITTEE CHAIR'S REPORT

Other | T Watkinson | 14.50

Item for Assurance

REFERENCES

Only PDFs are attached

11.3 - Chair's Report Audit Jan 25.pdf

Chair's Report to Board		
Chair: T Watkinson	Committee: Audit	
Date(s): 17 Jan 2025	Agenda attached for information	✓

Strategic Risks	trend	Items Recommended for approval
N/A		None

ALERT

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

- **Sickness Absence Internal Audit Report:** Limited assurance report findings but the positive and proactive response from executives and management to address the issues was recognised.
- **Insourcing LLPs Audit Report**: Significant concerns raised in the report, however a constructive management response and actions underway to address gaps in governance and compliance was noted.
- **Single Tender Waivers:** Lack of progress in reducing waivers and the continued use of these as a process workaround, which indicated underlying issues requiring resolution.
- **Pervasive Compliance Weakness:** Recurring theme of poor adherence to policies and procedures, particularly at middle management levels, which had been evident in several areas, including sickness management and procurement.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Year-End Accounts Preparation:** Preparations for the year-end accounts were progressing constructively, with critical accounting decisions being carefully managed.
- **Audit Plan Adjustment:** Deferral of the FRP audit due to overlapping external scrutiny; has been re-prioritised in the internal audit programme.

ASSURE

Assurance received; Matters of positive note.

- **Improved oversight and management of outstanding audit recommendations, supported by increased executive scrutiny and monthly reviews:** The need for further refinement in setting realistic timelines upfront to prevent delays in action completion was noted.

Audit Committee

16 January 2025 | 10.30am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.30am	Verbal	Information	T Watkinson
2.	Apologies for absence	10.31am	Verbal	Information	T Watkinson
3.	Declaration of interests	10.32am	Verbal	Information	T Watkinson
4.	Minutes of the previous meeting held on 19 September 2024	10.33am	✓	Decision	T Watkinson
5.	Matters arising and action log	10.34am	✓	Decision	T Watkinson
6.	LSC Audit Chairs' Meeting	10.35am	Verbal	Information	T Watkinson
7. INTERNAL AUDIT					
7.1	Internal Audit Progress Report	10.40am	✓	Assurance	MIAA
7.2	Planning 25/26	10.55am	Verbal	Discussion	MIAA
7.3	Combined Internal Audit and Anti-Fraud Follow-Up Summary Report	11.05am	✓	Assurance	MIAA
7.4	Counter-Fraud Progress Update (including previous investigations)	11.20am	✓	Assurance	MIAA
7.5	MIAA Internal Audit - Sickness	11.35am	✓	Assurance	MIAA
7.6	MIAA Internal Audit – Insourcing	11.50am	✓	Assurance	MIAA
8. GOVERNANCE AND RISK					
8.1	Annual Accounting Guidance & Year End Issues	12.05pm	✓	Assurance	B Patel
8.2	Single Tender Waiver Report	12.15pm	✓	Assurance	B Patel/M Doyle
8.3	Losses and Special Payments Report	12.30pm	✓	Decision	B Patel
8.4	Audit Risk Briefing	12.40pm	✓	Information	KPMG
8.5	Items to alert, advise and assure the Board	12.50pm	Verbal	Information	T Watkinson

№	Item	Time	Encl.	Purpose	Presenter
8.6	Reflections on the meeting	12.55pm	Verbal	Information	T Watkinson
9. ITEMS FOR INFORMATION					
9.1	Strategic Risk Report		✓		
9.2	Clinical Audit Programme Update		✓		
9.3	Monitoring of Internal Actions Report		✓		
9.4	KPMG Technical Update		✓		
	Date, time and venue of next meeting: *17 April 2025, 10.30am, Microsoft Teams*	1.00pm	Verbal	Information	T Watkinson

11.4 CHARITABLE FUNDS COMMITTEE CHAIR'S REPORT

Other | K Smyth | 15.00

Item for Assurance

REFERENCES

Only PDFs are attached

11.4 Chair's Report CFC Dec 24.pdf

Chair's Report to Board		
Chair: K Smyth	Committee: Charitable Funds Committee	
Date(s): 10 Dec 2024	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

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

ALERT

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

- The continued financial implications of the Trust's vacancy freeze, with specific impact on the charities' operations. This issue remained unresolved and required ongoing attention.
- Delays in the procurement process affecting the investment management review, necessitated by Trust-wide financial recovery priorities, had created challenges for compliance with the investment policy.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The conditional approval of the digital innovation project, subject to assurance on technology integration, governance, and procurement compliance, demonstrates the Committee's commitment to due diligence.
- The Committee will explore investment management benchmarking as an interim measure while procurement delays persist, ensuring informed decision-making regarding investment fees and value.

ASSURE

Assurance received; Matters of positive note.

- Charitable Funds demonstrated strong financial performance, exceeding income targets and operating under budget, reflecting a robust post-COVID recovery in fundraising efforts.
- Previous blockages in estates-related charitable projects had been resolved, ensuring that all pending projects were now progressing without delay.
- The updated policy on the use of Trust sites by external charities, prohibiting external fundraising, had been approved to strengthen governance measures, with clear processes for managing external engagements and ensuring alignment with Trust health and safety policies.

Charitable Funds Committee

10 December 2024 | 10.30am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chairman and quorum	10.30am	Verbal	Information	K Smyth
2.	Apologies for absence	10.31am	Verbal	Information	K Smyth
3.	Declaration of interests	10.32am	Verbal	Information	K Smyth
4.	a) Minutes of the previous meetings held on 17 September 2024 b) WR01-24	10.33am	✓	Decision	K Smyth
5.	Matters arising and action log	10.34am	✓	Decision	K Smyth
6.	STRATEGY AND PLANNING				
6.1	Hospitals' Charity update including Baby Beat	10.35am	✓	Assurance	D Hill
6.2	Rosemere Charity update including funding requests: a) RCF017-24/25 - PKB (Patients Know Best)	10.50am	✓	Decision	D Hill
6.3	Fundraising on Site Policy	11.05am	✓	Assurance	D Hill
7.	FINANCE AND PERFORMANCE				
7.1	Finance update including review of spending plan and balances	11.15am	✓	Assurance	B Patel
8.	GOVERNANCE AND COMPLIANCE				
8.1	Items to alert/advise/assure the Board	11.25am	Verbal	Information	K Smyth
8.2	Reflections on the meeting	11.35am	Verbal	Information	K Smyth
9.	ITEMS FOR INFORMATION				
9.1	Rosemere Management Committee Chair's report		✓		
	Date, time and venue of next meeting: *18th March 2024, 10.30am, MS Teams*	11.45am	Verbal	Information	K Smyth

12. GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH)

12.1 WORKFORCE COMMITTEE CHAIR'S REPORT

Other | V Crorken | 15.10

Item for assurance

REFERENCES

Only PDFs are attached

12.1 Chair's report - WFC Jan 2025.pdf

Chair's Report to Board		
Chair: Victoria Crorken	**Workforce Committee**	
Date(s): 14 January 2025	**Agenda attached for information**	✓

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

ALERT

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

- No items to report.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- The improvements in terms of rostering were ongoing, noting the substantial work being undertaken however investment was required to ensure programmes were implemented properly and in order for those programmes to be successful.
- Discussions were held around the Staff Survey and initial data sets and potential workforce risks ahead of national results being published.

ASSURE

Assurance received;

- The social value report recognised work around health inequalities and efforts to work with communities to assist them into employment.

Matters of positive note.

- The annual Equality, Diversity and Inclusion report provided a level of assurance on the actions being taken and are proportionately representative albeit with more work required.

Workforce Committee

14 January 2025 | 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 12 November 2024.	1.03pm	✓	Decision	V Crorken
5.	Matters arising and action log:	1.05pm	✓	Decision	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	✓	Information	K Downey
8. STRATEGY DELIVERY					
8.1	Health Roster Strategy Report	1.25pm	✓	Assurance	K Downey
9. TO DELIVER A RESPONSIVE, FUTURE FOCUSSED AND ENABLING SERVICE					
9.1	Annual Partnership Update Report	1.35pm	✓	Assurance	R O'Brien
10. TO BE INCLUSIVE AND SUPPORTIVE					
10.1	Workforce social and corporate responsibility update	1.45pm	✓	Assurance	L Graham
10.2	Annual Equality, Diversity and Inclusion Strategy Report	1.55pm	✓	Decision	L Graham
11. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
11.1	Staff Survey Report and Action Plan	2.05pm	✓	Information and Assurance	L Graham
12. GOVERNANCE AND COMPLIANCE					
12.1	EQIA of People Policies	2.10pm	✓	Information	N Pease

№	Item	Time	Encl.	Purpose	Presenter
12.2	Gender Pay Gap Report	2.20pm	✓	Decision	L Graham
12.3	Strategic Risk Register Review	2.30pm	✓	Assurance	S Regan
12.4	Reflections on the meeting	2.35pm	Verbal	Information	V Crorken
12.5	Items to alert, advise and assure the Board	2.40pm	Verbal	Information	V Crorken
13.	ITEMS FOR INFORMATION				
13.1	Exception report from the Divisional Improvement Forums Parts 1 and 2 (*divisional workforce metrics*)		✓	Information	N Pease
13.2	Chairs' Reports from Feeder Groups/Workstreams a) Temporary Staffing Group		✓		
13.3	Date, time, and venue of next meeting: *11 March 2025, 1.00pm via Microsoft Teams*		Verbal	Information	V Crorken

12.2 REPORT RECOMMENDED FOR APPROVAL: A. GENDER PAY REPORT AND REPORT RECOMMENDED FOR ASSURANCE: B. EQUALITY, DIVERSITY AND INCLUSION ANNUAL REPORT

Other | N Pease | 15.20

Report recommended for approval:
a. Gender Pay Report
Report recommended for assurance:
b. Equality, Diversity and Inclusion Annual Report

REFERENCES

Only PDFs are attached

12.2a - Gender Pay Gap Report 2024 v1.pdf

12.2b - EDI Annual Update 2024.pdf

Board of Directors Report

Gender Pay Gap Report			
Report to:	Board	**Date:**	6th February 2025
Report of:	Chief People Officer	**Prepared by:**	E. Hickman
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to present the findings and recommended actions based on the Gender Pay Gap report for 2024. The gender pay gap for our Trust is below the threshold for immediate action, as specified by the Equality and Human Rights Commission, and so should be regularly monitored.

In summary it was found that 75% of our workforce is female, with women occupying 75% of the lowest paid jobs and 67% of the highest paid jobs. The median gender pay gap was found to be at 3.20% which has remained static as reported in 2023. The Equality and Human Rights Commission set out in their criteria that where a pay gap is greater than 3% but less than 5% difference, the position should be regularly monitored,

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

This report details the findings analysis and subsequent proposed actions.

It is recommended that the Board

I. Receives and notes the report.
II. Approve the report for publishing on our Trust internet site by 30 March 2025

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 – 14th January 2025

INTRODUCTION

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

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

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

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

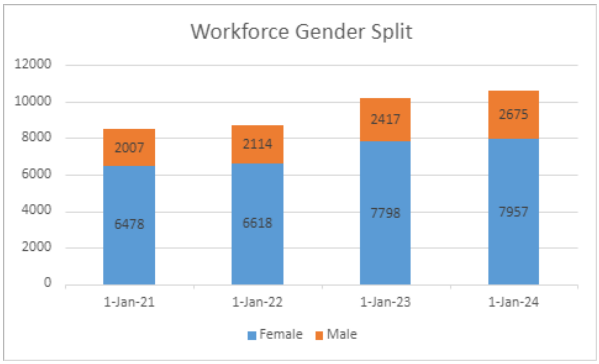
The Equality and Human Rights Commission has the power to enforce any failure to comply with the regulations. The Equality and Human Rights Commission states that where there is a difference in pay related to the gender of an employee, the following applies:

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

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

THE WORKFORCE PROFILE

OUR WORKFORCE IS 75% FEMALE AND 25% MALE



The gender profile of our workforce (Figure 1) continues to be predominantly female. The current (31 March 2024) split within the overall workforce remains consistent with the previous four Gender Pay Gap reports: **75% female, 25% male**.

Figure 1: Gender profile

WOMEN OCCUPY 75% OF THE LOWEST PAID JOBS AND 67% OF HIGHEST PAID JOBS

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

Quartile	2024		2023		2022		2021	
	No. Male | Female	% Male | Female	No. Male | Female	% Male | Female	No. Male | Female	% Male | Female	No. Male | Female	% Male | Female
1 – Lower	662 |1993	25% | 75%	582 |1968	23% | 77%	502 | 1,681	23% | 77%	467 | 1,654	22% | 78%
2 – Lower middle	632 | 2026	24% | 76%	579 | 1976	23% | 77%	494 | 1,689	23% | 77%	457 | 1,665	22% | 78%
3 – Upper middle	505 | 2154	19% | 81%	469 | 2084	18% | 82%	379 | 1,804	17% | 83%	385 | 1,736	18% | 82%
4 – Upper	876 | 1784	33% | 67%	787 | 1770	31% | 69%	739 | 1,444	34% | 66%	698 | 1,423	33% | 67%
Total	**2,675 | 7,957** (10,632 total)	**25% | 75%**	**2,417 | 7,798** (10,215 total)	**24% | 76%**	**2,114 | 6,618** (8,732 total)	**24% | 76%**	**2,007 | 6,478** (8,485 total)	**24% | 76%**

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

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

When analysing the percentage split of each gender workforce by quartile, it is evident that the greatest proportion of the male workforce occupies the upper quartile (33%) compared to the lower quartiles. The greatest proportion of the female workforce occupies the upper middle quartile (81%) with the lowest proportion (67%) of females occupying the upper quartile.

OUR GENDER PAY GAP

	Women's earnings are:
Mean gender pay gap in hourly pay	**22% lower**
Median gender pay gap in hourly pay	**3.2% lower**
Difference in **mean bonus** payments	**35.9% lower**
Difference in **median bonus** payments	**0%**
Women earn 78p for every £1 earned by Men	

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

Mean Hourly Rates	Male	Female	Difference	% Difference
2024	£24.02	£18.59	£5.43	22.0%
2023	£21.68	£17.13	£4.55	21.0%
2022	£24.69	£16.87	£7.81	31.7%
2021	£22.14	£16.00	£6.14	27.7%
2020	£21.79	£15.51	£6.29	28.8%
2019	£20.73	£15.11	£5.62	27.1%

Looking at the 2024 figures, male colleagues earn on average £5.43 per hour more than their female colleagues. This is an increase of £0.88 on the 2023 figure. As a percentage, men earn 22% more than women; an increase of 1 percentage point from 2023.

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

Median Hourly Rates	Male	Female	Difference	% Difference
2024	£17.31	£16.75	£0.56	3.2%
2023	£15.92	£15.41	£0.51	3.2%
2022	£15.64	£14.57	£1.07	6.8%
2021	£15.04	£14.02	£1.02	6.8%
2020	£14.45	£13.65	£0.79	5.5%
2019	£14.27	£13.34	£0.93	6.5%

Looking at the 2024 figures, the difference in the median pay for males and females is 3.2%, the same as it was in 2023. This represents a marked change from 6.8% in 2022 and now remains within the bracket for 'regular monitoring'.

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

1.30% OF WOMEN AND 7.68% OF MEN WERE PAID A BONUS

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

The findings presented indicate a mean bonus pay gap between males and females of 35.9% in 2024 a decrease from 45.9% the previous year. Since COVID, the usual CEA application and selection process for medical consultants has been set aside, with all eligible consultants being awarded an equal payment of £3,014.84. This resulted in no median bonus pay gap in 2022 - 2024.

The data also indicates that in 2024 the total number of female employees has decreased from 2023 numbers whilst the number of male employees has increased yet slight more male and female employees were awarded a bonus than in the previous year.

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

Mean Bonus	Male	Female	Difference	% Difference
2024	£8,213.47	£5,269.13	£2,944.34	35.9%
2023	£8,534.87	£4,621.28	£3,913.59	45.9%
2022	£10,441.88	£6,888.05	£3,553.83	34.0%
2021	£15,721.28	£11,812.87	£3,908.42	24.9%
2020	£16,134.24	£10,900.69	£5,233.55	32.4%

2019	£16,057.62	£11,625.67	£4,431.95	27.6%

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

Median Bonus	Male	Female	Difference	% Difference
2024	£3,014.84	£3,014.84	£0.00	0.0%
2023	£2,316.00	£2,316.00	£0.00	0.0%
2022	£3,818.66	£3,818.66	£0.00	0.0%
2021	£9,145.29	£6,032.04	£3,113.25	34.0%
2020	£12,063.96	£6,032.04	£6,031.92	50.0%
2019	£9,801.99	£5,991.50	£3,810.50	38.9%

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

2024	Total head count paid Bonus	Total No. of relevant employees	% paid bonus
Male	**240**	**3125**	**7.68%**
Female	**122**	**9403**	**1.30%**
2023	**Total head count paid Bonus**	**Total No. of relevant employees**	**% paid bonus**
Male	**230**	**3035**	**7.58%**
Female	**111**	**9622**	**1.15%**
2022	**Total head count paid Bonus**	**Total No. of relevant employees**	**% paid bonus**
Male	**233**	**2,203**	**10.6%**
Female	**101**	**7,195**	**1.4%**
2021	**Total head count paid Bonus**	**Total No. of relevant employees**	**% paid bonus**
Male	**109**	**2,072**	**5.3%**
Female	**31**	**6,926**	**0.4%**

FINANCIAL IMPLICATIONS

None

LEGAL IMPLICATIONS

None

RISKS

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

IMPACT ON STAKEHOLDERS

Not applicable

RECOMMENDATIONS

The gender pay gap is 3.20% which means no immediate action is required, however we do need to regularly monitor, as specified by the Equality and Human Rights Commission. As noted in previous Gender Pay reports, it is a challenge to identify clear actions which make a tangible difference, as in part our policies and processes (in some cases) work against us achieving a fairer gender pay balance. For example, we actively encourage our colleagues to work flexibly and, aligned to the NHS People Plan, we advertise all our vacancies as having access to flexible working opportunities from day one. Given flexible working is seen as an employee benefit, we want colleagues to take advantage of this, however it may have a negative impact on the gender pay gap, due to the higher proportion of our workforce being female overall and with females tending to work more within part time roles.

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

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

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

It is recommended that the Board;

I. Receive and note the report
II. Approve the report for publishing on our Trust internet site by 30 March 2025

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors Report

Equality, Diversity and Inclusion Strategy – Annual Report			
Report to:	Board	**Date:**	6 February 2025
Report of:	Chief People Officer	**Prepared by:**	A Davis
Part I	✓	**Part II**	

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

Executive Summary:

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

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

- The positive results we've seen in respect of the increase in colleagues sharing they have a long-term condition or disability on ESR coupled with the sustained growth in the percentage of colleagues recording through staff survey that the organisation has implemented workplace adjustments to support them in the workplace
- Progress in analysing organisational development data i.e. appraisal and staff survey results through a more intersectional lens
- Provision of Equality Impact Assessment training to support colleagues across the organisation in evidencing inclusive decision making in respect of policy creation, service improvement or changes and cost improvement plans etc.
- The focus on allyship and how colleagues can play their part in creating an inclusive workplace for others, including the launch of various toolkits covering Neurodiversity, general diversity and inclusion and sexual safety.
- An increase in outreach activity to support marginalised groups across our communities including; Breast Cancer Awareness and Breast Screening with Asian women, Prostate Cancer Awareness within the Windrush community and events to raise awareness of Prostate and Testicular Cancers across male prisoners.
- The introduction of Patient Safety Partner (PSP) roles
- Increased focus on the use of patient stories as a means of learning and further developing our service provision

The report outlines the measurable impact and presents the current demographic information on our community and our workforce. It highlights our performance and current benchmarks reported in other mandated reports such as the Workforce Race Equality Standard, Workforce Disability

Equality Standard, National Staff Survey and Gender Pay Gap, alongside other intervention level evaluation measures where applicable. It describes the future focus to ensure we continue to deliver the strategic aims, this includes:

- An expanded focus on intersectional reporting of our workforce centred data to help us interrogate our data across other areas i.e. talent management, retention, performance management etc. in a more meaningful way.
- Developing intelligence around our data collection capturing patient experience to ensure we hear from patient groups who have traditionally been hard to reach, including those who experience deprivation or other health inequalities.
- To further increase educational opportunities to support colleague and leaders understanding of their role in enabling equality, diversity and inclusion as well as bringing about improvements in health inequalities.
- To review process and approaches across the colleague lifecycle to understand how we can create more inclusive practices which support the recruitment, retention, staff satisfaction and career progression of colleagues with protected characteristics.

It is recommended that:

I. The Board approve the report for external publication.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Workforce Committee – 14th January 2025

EQUALITY, DIVERSITY & INCLUSION STRATEGY – ANNUAL REPORT 2024

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

INTRODUCTION

This is the third annual Equality, Diversity and Inclusion (EDI) update following the launch of our strategy 4 years ago, this report highlights the progress we have made against the five strategic aims underpinning our vision which is to be **"consciously inclusive in everything we do for colleagues and our communities"**.

The five strategic aims are:

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

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

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

- Analysing organisational development data i.e. appraisal and staff survey results through a more intersectional lens
- Provision of Equality Impact Assessment training to support colleagues across the organisation in evidencing inclusive decision making in respect of policy creation, service improvement or changes and cost improvement plans etc.
- An increase in outreach activity to support marginalised groups across our communities including; Breast Cancer Awareness and Breast Screening with Asian women, Prostate Cancer Awareness within the Windrush community and events to raise awareness of Prostate and Testicular Cancers across male prisoners.
- The introduction of Patient Safety Partner (PSP) roles
- Increased focus on the use of patient stories as a means of learning and further developing our service provision
- As part of a continuous improvement approach, the organisation has begun a project to gather data from the Friends and Family feedback test system with maternity services to ensure that health inequalities information is gathered.
- Updated Langauge and Interpreter Services policy to include multi-lingual staff to ensure they know that they can speak their own first culture language to patients of the same language instead of seeking an interpreter.

We have started to see some positive results from work we've undertaken to promote the sharing of long-term conditions or disabilities on Electronic Staff Records (ESR) with 6.2% of colleagues now recording a long-term condition or disability, as opposed to 4.9% two years ago. There has been a significant rise in requests to support line managers and colleagues in having supportive and inclusive conversations relating to neurodiversity which we hope is because of the work undertaken to raise awareness, and that this has started to signal a shift

in the stigma which has previously been associated with disclosing neurodiversity. There has been a sustained growth in the percentage of colleagues recording through staff survey that the organisation has implemented reasonable adjustments to support them in the workplace, this is currently at 78.3% which is higher than the national average and which demonstrates a year-on-year increase from 2021.

There has also been a focus on Allyship throughout the year, starting out with the Neurodiversity toolkit which contains a section on how to be an ally, continuing through the Inclusion Calendar promotional activity and awareness raising events (such as LGBTQ+ History Month) and then rounded off with the Being an Ally toolkit, launched in late summer. It's been a theme which has also been replicated in the cultural work which is ongoing i.e. How to be an Active Bystander, how to foster a culture of sexual safety etc and is vitally important that all colleagues understand the role they play in helping to foster a culture of inclusion and allyship to others.

Alongside the successes and areas of progress, we have also faced some challenges over the last 12 months; ensuring inclusion has a sustained focus amidst the pressures of increased activity and sustained financial challenges, the impact of those financial challenges resulting in the loss of the Pastoral Support Officer whose role was to support Internationally Educated Colleagues (IECs), the disruption to Inclusion forum activity caused partly by the long term absence of Chairs/Co-Chairs in addition to low attendance figures and changes in Executive Sponsors, not to mention the repercussions following the shocking murders in Southport and the resulting riots.

An increased focus in intersectional reporting will help us to interrogate our data in a more meaningful way e.g. understanding whether appraisal ratings and or talent management ratings are applied in similar ways across different colleague groups. We started the journey this year with appraisal ratings and responses to staff survey questions and will expand this further throughout the course of 2025. Whilst we continued to see improvements in some of our organisational EDI data, some areas fluctuate and others remain fixed (and unfavourable), so our focus for the coming year will be around how we can elicit a trend of sustained improvement over a longer period of time.

The information in this report represents the action and progress undertaken in compliance with our public sector duties as set out in the Public Sector Equality Duty and the Equality Act (2010), which requires public bodes to have due regard for the need to eliminate unlawful discrimination, harassment and victimisation; to advance equality of opportunity; and to foster good relations between people who share a protected characteristic and those who do not. Fostering good relations can be difficult to achieve when there are conflicting views or beliefs across protected characteristic groups or subgroups, as an example in summer the government shared their proposals to update the NHS Constitution for England including stressing the importance of biological sex in relation to same-sex accommodation and in relation to the provision of intimate care, a move which has been celebrated by some groups and which has raised concerns from Trans community members. 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 always consciously inclusive in everything we do.

As an organisation we need to ensure we proactively consider how our services, including potential future changes, will affect people who belong to different protected characteristic groups and work to accommodate the needs of all patient and colleague groups.

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

PRINCIPLE 1 – DEMONSTRATING COLLECTIVE COMMITMENT TO EDI

This principle seeks to hardwire EDI into all aspects of the way we provide care and go about our business within our organisation, to ensure we are consciously inclusive. The principles contained in this strategy demonstrate a clear commitment to actively ensure EDI is a core part of all organisational business, led from Board and cascaded across all roles and levels in the wider organisation.

Since publication of our strategy, the NHS equality, diversity and inclusion improvement plan was launched by NHS England in June 2023 detailing six high impact actions which are:

1. Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.
2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.
3. Develop and implement an improvement plan to eliminate pay gaps.
4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, onboarding and development programme for internationally recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

The High Impact Actions are being delivered via the EDI strategy action plan, this report will detail our progress with regards to what has already been implemented as well as share our future plans to ensure we deliver upon these recommendations and achieve the success metrics defined by NHS England. As noted in the NHS High Impact actions, demonstrating collective commitment comes from the very top of the organisation, with the objectives allocated to our Chief Executive, Chair and Board members in respect of Equality Diversity & Inclusion.

The EDI objectives for our Executive leads are noted below;

Silas Nicholls **Chief Executive Officer**	• Ensure the delivery of the Trust EDI plan with a focus on the feedback from staff surveys. Continue the development of the Trusts approach to health inequalities including its obligations as a major anchor institution.
Sarah Cullen **Chief Nursing Officer/** **Deputy Chief Executive**	• Lead the creation of the health inequalities plan for the organisation.
Neil Pease **Chief People Officer**	• Delivery of the inclusion strategy and the organisation objective to be consciously inclusive in all that we do. • Anchor organisation and health inequalities – Capitalise on our evolving role (new hospital programme) as an

	Anchor organisation whilst contributing to the broader social determinants of health – employment and educational attainment.
All Non-Executive Directors	• To gain assurance that the Trust is taking meaningful action to deliver its Equality, Diversity and Inclusion strategy plan, so as to improve the experience of patients and staff.

After the launch of the EDI Strategy, we made a pledge at a strategic level that every strategy published after that point would contain a section on equality, diversity and inclusion to support increased momentum and collective focus for improvement. As well as this, we would ensure that adequate consultation and involvement takes place with minority groups through colleague Inclusion Ambassador Forums and Patient Involvement Groups. With the recent announcement of the proposed site for the **New Hospital Programme** it will be more important than ever to ensure that the **development of a new estate incorporates a consciously inclusive approach** with strong, and continued, engagement and consultation with minoritised patient groups and colleagues to ensure an inclusive and accessible design for all.

FOR PATIENTS AND OUR COMMUNITIES

As part of our engagement, feedback and collaborative working we saw Healthwatch Lancashire '**Share for Better Care**' programmes across the organisation. Healthwatch engagement teams attend the Trusts involvement groups and lead on engagement to gather real time experiences and feedback from our patients and public across the organisation. Services users are provided with the opportunity to discuss anything with our external partners with freedom to express their feedback to an outside provision rather than directly to ourselves. This information is shared through our Patient Experience and Involvement group, who report through to the Safety and Quality Committee.

This year has seen our involvement with partners progress further into our communities to groups who may experience difficulties accessing our pathways, ensuring their voice is heard in the development of our services. This helps capture information on why service access feels restricted to some due to lack of knowledge or understanding.

In light of this we have engaged with our **breast screening services** to raise awareness with our local communities across central Lancashire. Involvement teams have attended local GP surgeries, local charities and health events throughout Lancashire. This has helped to provide the local community to access care earlier in their pathway.

Breast awareness within our community at The Asian Ladies Forum, Chorley, Lancashire

The organisation **supported the Colostomy UK campaign** for better public services for people living with stomas. We spoke with patients and our surgery colleagues who advised that this support was often overlooked. People living with stomas have additional needs and this simple change can remove potential anxiety when faced with a single visit somewhere.

We secured funding from our Patient Experience Charitable fund and set about transforming our high footfall public toilets across the Trust to ensure we met the needs of this group of people. Each public toilet was equipped with:

- A hook – to hang clothing and handbags while changing their stoma bags, giving more space in the cubicle;
- A shelf - to enable ostomates to spread out their items;
- A mirror – to enable people to see their stoma while changing;
- A disposable bin to avoid the sometimes embarrassing situations of having to dispose of their stoma bag in public view.

This helped ensure a stoma friendly accessible toilet, with no barriers or obstacles.

Our **Carers forum** has been a great example of how partnership working with patients and carers can improve and develop our services. The forum has collaborated with Lancashire Carers Service, with attendance and input from external partners, NCompass, Age UK, Healthwatch, Carers UK, Preston and District over 50's forum, Alzheimer's UK, Lancashire Fire and Rescue, Northwest Ambulance Service, Lancashire County Council, Disability NorthWest, NHS England and Improvement, and the Integrated Care Board. The collaboration has contributed to the carer's forum with:

- Lancashire Teaching Hospitals NHS Foundation Trust Carers Charter
- Discharge process and considerations
- Occupational Therapy and Physiotherapy inpatient services
- Do Not Attempt Cardiopulmonary Resuscitation Policy for staff
- The Dementia 'Forget Me Not' document
- Lancashire and South Cumbria Foundation Trust Carers Charter
- Virtual Ward Program
- Chaperone policy
- Prioritised Mealtimes Policy

The continuation and growth of partnership working to ensure inclusion of all communities. This work continues to educate and support our staff, helping us to develop our communication and accessibility to all diverse service users.

- The Visual Impairment Forum – direction/feedback on policy, service development and procedures;
- Galloways - Eye Liaison Officers on both sites to provide support to patients and staff;

- Age UK with their project of digital inclusion for patients and support to the carer's forum;
- NCompass for training staff in Deaf culture and basic British Sign Language (BSL);
- Quwwat Education Centre and Mosque with support from Imans for our Muslim community;
- Deafblind UK for ongoing staff training and support;
- Disability North West for guidance and support to our carer's forum;
- Guide Dogs UK for sighted guidance training both online and face to face for staff and volunteers;
- Co-Sign in providing BSL support for staff in the creation of video patient information leaflets.

Accessible information for all communities is important. This helps our patients to make informed decisions about their care. Patient information leaflets are overseen by a patient information group that consists of a diverse group of people who review the leaflets developed by our colleagues and feedback comments about the documents, making suggestions to ensure clarity and in easy read formats of the information provided.

Equally we ensure that our information is accessible to all by providing this information in various ways:

- Digital in a variety of languages, audio and videos with subtitles and British sign language;
- Paper format in a variety of languages, on coloured paper and large print for visual impairments and in Braille on request;
- Easy read leaflets;
- Communication books with photographs;
- Ward activities with audio players and USB talking magazines with a special focus on patient who are visually impaired or blind.

As well as this we have continued to engage and develop access to interpreter services in the following areas:

- Face to face language interpreters;
- Video calls in languages on demand via an online App;
- Telephone language interpreters;
- BSL Face to face interpreters;
- BSL in video calls on demand;
- Written translation into any languages for documents and letters;
- ReachDeck to ensure translation, audio and font control for our Trust website.

To enable to support our patients with hidden and physical disabilities we have an established reasonable adjustments flag on hospital records. The **Reasonable Adjustment Needs Flag** is a national record which indicates that reasonable adjustments are required for an individual and optionally include details of their significant impairments and key adjustments that should be considered for their appointment.

The **Registered Assistance Dogs policy** has been adapted to meet the needs of all patients. The law advises that dogs do not have to be registered in order to support their owner; we have ensured this is included in our policy with the support and guidance of forums such as the Lancashire Visual Impairment forum to ensure our position was correct and inclusive. We have also taken this element of the policy and advised staff that we should be completing the reasonable adjustments flag, so we are aware in advance of the support needed for these patients and why the dog is needed.

FOR COLLEAGUES

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

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

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

RAISING AWARENESS AND LIVING OUR COMMITMENT TO CREATING AN INCLUSIVE WORKPLACE

To ensure EDI remains a prominent part of our organisational narrative across the year, we create an **annual Inclusion calendar** which supports the promotion of several key inclusion calendar events.

The focus of the inclusion calendar is to identify which events we will actively promote across the year to create interest, raise awareness, share colleague/patient or community member experiences, educate colleagues, bust myths, or break down stereotypes or negative assumptions.

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

The calendar is planned on an annual basis, in conjunction with the Inclusion forum Chairs, ensuring a focus on important events which represent minority groups whilst also aiming to shine more of a spotlight on what matters to colleagues. There are so many inclusion days/weeks/months, it would be impossible for us to mark every event corporately, however we actively encourage teams and individuals to celebrate the events which are significant to them, their work colleagues or their patient population such as religious festivals and/or events relating to specific long-term conditions.

Examples over the last 12 months include;

INTERNATIONALLY EDUCATED COLLEAGUES (IECs) CELBRATION DAY

We have recruited over 650 internationally educated nurses, Midwives, Occupational Therapists, Speech and Language Therapists and other AHP's. The **International Recruitment Intranet page** has a range of resources available for colleagues to help support our IECs on the wards including; important Home Office Visa updates, English Language resources and Pastoral Support Resources. This also helps to manage expectations after they have received their NMC pins including the consideration of patient safety, completing and signing off competencies etc.

In June we held our second **celebration event for Internationally educated colleagues** which contained a presentation, a series of awards and a marketplace event with representatives from the Sahara Centre in Preston, HSBC and internal teams such as Health & Wellbeing, Leadership and OD and the EDI team. There were six award categories which colleagues could nominate individuals to receive, they ranged from the Caring and Compassionate Award, to the All Smiles Award.

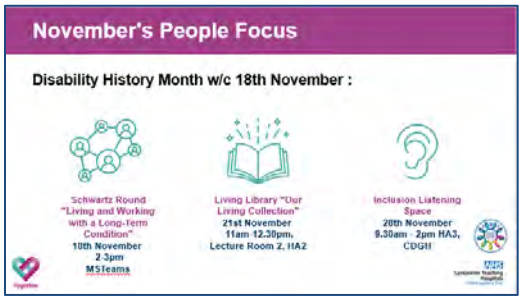
Unfortunately due to the financial challenges (and a resulting pause in targeted international recruitment campaigns) we lost the role of Pastoral Support Officer halfway through the year which will impact on our ability to meet NHS England's High Impact Action 5 "Implement a comprehensive induction, onboarding and development programme for internationally recruited staff". Over the coming year we will look at ways in which we can maintain and enhance the onboarding experience for internationally educated colleagues in addition to how we can support their teams to embrace them in an inclusive and compassionate way.

LGBTQ+ HISTORY MONTH

The theme for this year was "Under the Scope". The Chair of GLADD (The Association of LGBTQ+ Doctors and Dentists) gave a presentation on LGBTQ+ Health Inequalities, aspects of trans health and relevant historical figures and then Elizabeth Streeter (NHS England) talked more specifically about LGBTQ+ health inequalities. This was followed by a session on Allyship.

DISABILITY HISTORY MONTH

The middle of November marked the start of Disability History Month which was promoted as part of our November Leadership briefing session chaired by Silas Nicholls (Chief Executive Officer); our aims were to raise awareness, increase understanding and support colleagues across our organisation who have a long-term condition or disability. A range of events took place across the month including; a dedicated Schwartz Round "Living and Working with a Long-term condition", a relaunch of "Our Living Collection/Living Library" with new books, two Equali-tea parties and more besides.



There were a number of other inclusion celebration events throughout the year including; Neurodiversity Celebration Week, South Asian Heritage Month, National Staff Networks Day.

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

This year the Library Services team started a small collection of **non-English language leisure reading materials** using donations they received from colleagues. Books are available in

German, Hungarian and Polish and they are hoping to grow this further through raising awareness.

For the second year running we were unsuccessful in our application to attend **Preston Pride** in September. This was again a massive disappointment to the LGBTQ+ Inclusion forum members and EDI team yet we took the opportunity to mark the occasion by raising the Rainbow flag across both Preston and Chorley sites, through communicating about Pride and by running some pop-up stalls across the Trust.

EMBEDDING A ZERO TOLERANCE APPROACH TO DISCRIMINATION AND RACISM

We want to continue to use our position within the community as a provider of healthcare, but also as a large employer, to help influence wider community change by actively tackling discrimination and inequality faced by people from minoritised groups when either receiving care or whilst working for us.

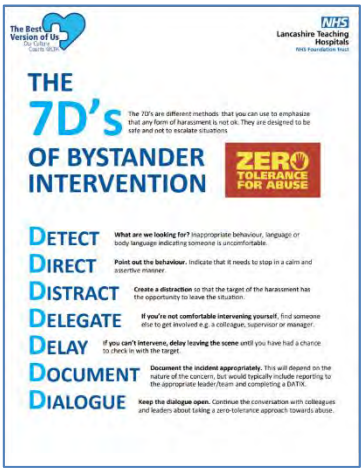
Last year, we made a commitment to embrace becoming an **actively anti-racist organisation**. This began with completing an initial review to benchmarking ourselves against each level of the NorthWest Black, Asian and Minority Ethnic Assembly Anti-racist framework (Bronze, Silver, Gold) to understand where our existing gaps are. In October of this year we submitted our evidence to support our assessment at Bronze level yet we were unsuccessful with feedback indicating our submission *"included some positive examples and demonstrated commitment to anti-racism. However many plans are still in development and need a bit longer to mature to be able to demonstrate improvement and impact*". We plan to resubmit our evidence for Bronze accreditation again in the first quarter of 2025.

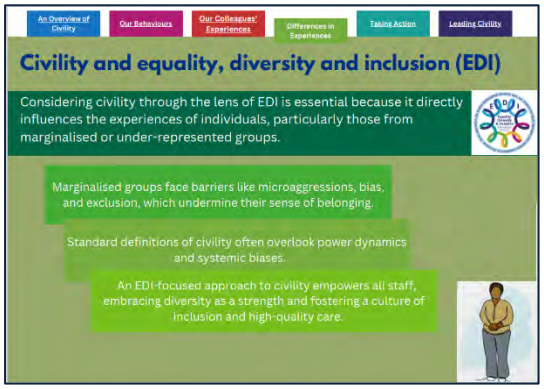
In November the NHS Race and Health Observatory shared **7 Anti-Racism principles** they asked organisations to embed throughout their practices and policies;

1. **Demonstrate Leadership**, by naming racism, engaging seriously and continuously with the ways in which racism impacts the lives of patients and the public and actively working to dismantle it.
2. **Acknowledge Structural Racism**. Understand and acknowledge that structural, institutional and interpersonal racism all impact on health, and be clear about where accountability lies for improvement and progress. Create transparent pathways for raising concerns and tangible steps for addressing them.
3. **Involve Racially Minoritised Communities**. Meaningfully involve racially minoritised individuals and communities in every stage of developing a service or intervention, including ensuring that teams and decision-making structures themselves are racially diverse and fundamentally inclusive.
4. **Data Transparency**. Collect and publish data on race inequity in its entirety, ensuring it directly informs policy, strategy and improvement. Where data is not available, change policies to ensure that data is collected.

5. **Identify Racial Bias**, in policies, decision making processes, and other areas within your organisation.
6. **Apply a Race-Critical Lens**, to the adoption of any interventions or improvements to be tested, and to the design and delivery of services.
7. **Evaluate and reflect**, on interventions using metrics that recognise the role of racism as a determinant of health. These evaluations should seek to understand the extent to which interventions mitigate the impacts of racism.

To continue with our aim to be an antidiscrimination and anti-racist organisation, we signed up to the **Organisational Sexual Safety Charter** in November 2023 which signalled our intent to take and enforce a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace - this includes behaviours, actions, gestures or comments of a sexual nature from patients or colleagues, that may make individuals feel uncomfortable, threatened, or unsafe. Feeling safe at work is fundamental to employee well-being, job satisfaction, and overall performance; such behaviour can have a significant impact on the mental and emotional well-being of staff and can lead to stress, anxiety, and even trauma.





The Sexual Safety work sits under a broader workstream, looking at creating the right organisational culture; one which honours **Civility, Kindness and Compassion**. Throughout 2024 a series of resources have been developed to further support colleagues to understand how we can all foster a safe, civil, kind, respectful and compassionate work environment, including with respect to sexually concerning behaviour, providing advice and guidance for responding to situations where you may be the victim of/witness to or informed about, sexual misconduct from colleagues and/or patients.

These resources include toolkits, top tips handouts, training sessions and posters. Content has been developed with a strong inclusive lens, recognising how certain groups of colleagues will be experiencing sexual harassment and abuse at a disproportionate rate.

In 2023 we delivered several lightening sessions for line managers in respect of **"Banter – when it's definitely not a laughing matter"** to explore what banter is and when (or why) we might use it to support us in the workplace but also to guard against when it may cross the line towards more negative behaviours. The session revisited cases which have progressed to Employment Tribunals to help provoke discussion around instances where banter crosses the line towards bullying, harassment or discrimination and encouraged line managers to consider their role in creating a safe environment for all colleagues alongside a collective commitment to "Calling it Out". This material has now been woven into the presentations designed to support Culture and Civility across the organisation.

OUR FUTURE COLLEAGUE FOCUS

- Achieve Bronze level of the NorthWest Black, Asian & Minority Ethnic Assembly Anti-racist framework. Ensuring we actively promote our Anti-Racism work internally and externally; making clear our commitment as an organisation.
- Embed the 7 Anti-Racism Principles recently shared by the NHS Race and Health Observatory.
- To explore ways in which to increase diversity at senior management and executive level.
- To review and revise our Trust values including more explicit reference to the behaviours and actions which support an inclusive culture within our organisation, and aligning to national or regional frameworks such as the NorthWest Anti-Racism Framework and the Sexual Safety Charter.
- Ensure our Freedom to Speak Up (FTSU) data and reporting mechanisms consider the intersectional trends that impact levels of risk and ability to speak up, raise concerns and report incidents.
- Explore ways to maintain and further enhance the onboarding experience for internationally educated colleagues.

OUR FUTURE PATIENT FOCUS

In order to be able to meet the NHS Accessible Information Standards and monitor our population to reduce health inequalities, systems need to be put in place in order to gather appropriate data. It is proposed in the coming year that the following areas will be considered and implemented:

- Develop a plan for outpatient areas to gather EDI information from patients attending for treatment in line with the NHS Accessible Information Standard.
- Develop a process for colleagues to gather information about any reasonable adjustments that patients may require.

- Expand the gathering of EDI information and intelligence from our Friends and Family test data to support reducing health inequalities.
- Ensure information is recorded on Harris Flex to be able to pull through data from patients records to be able to monitor health inequalities.
- Develop further forums that reach the patient voices we have not yet heard, thus working with population health, Place based partners and the integrated care board to ensure a standardised approach.
- Explore ways we can use digital and social platforms across the ward and departments to hear patient voices.
- Explore ways to increase the diversity across all patients' groups and forums

PRINCIPLE 2 – BEING EVIDENCE LED AND TRANSPARENT

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

BEING TRANSPARENT WITH OUR WORKFORCE EDI DATA

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

Our Workforce Diversity Headlines 2024

Headcount
10,665 *(10,348)*

Ethnic Minorities
26.6% *(26.2%)*

Disability
6.2% *(4.9%)*

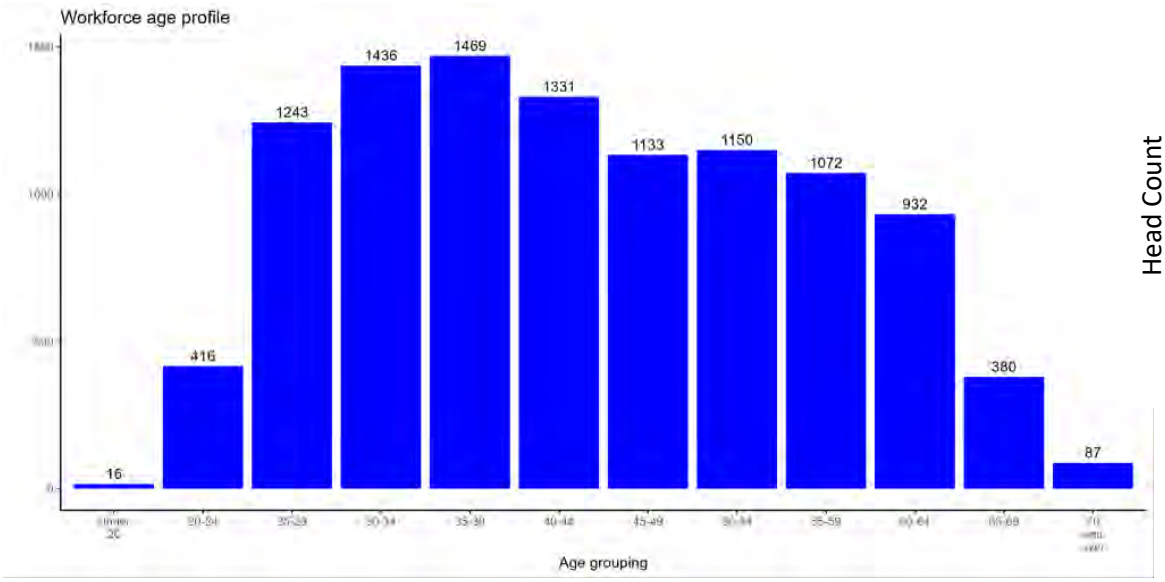
LGBT+
2.9% *(2.4%)*

Women
75.9% *(76.2%)*

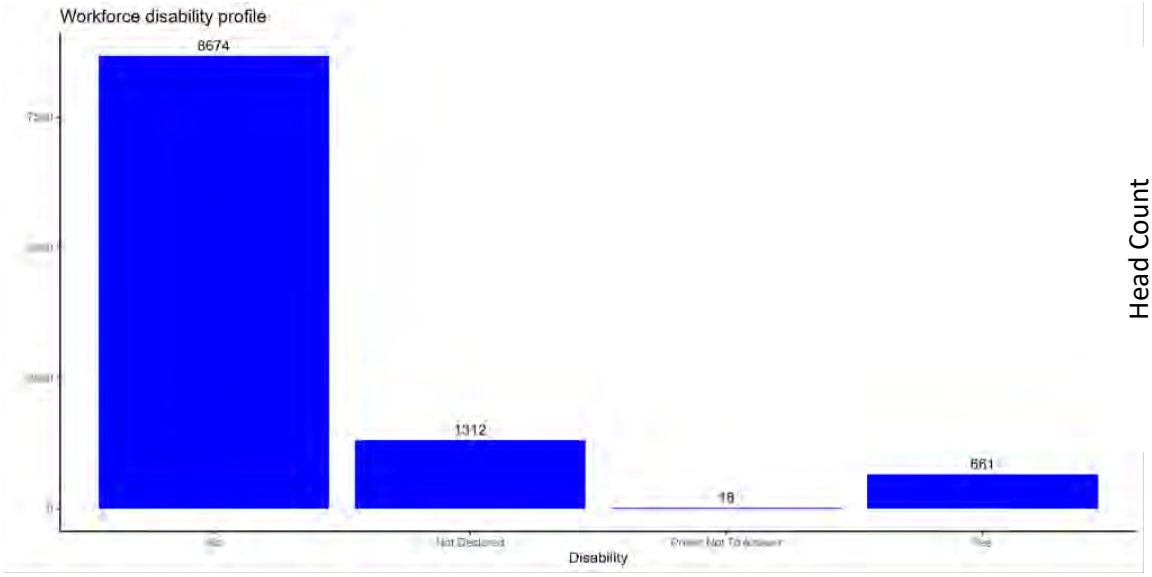
Married
53.1% *(53.3%)*

(2023 data shown in brackets)

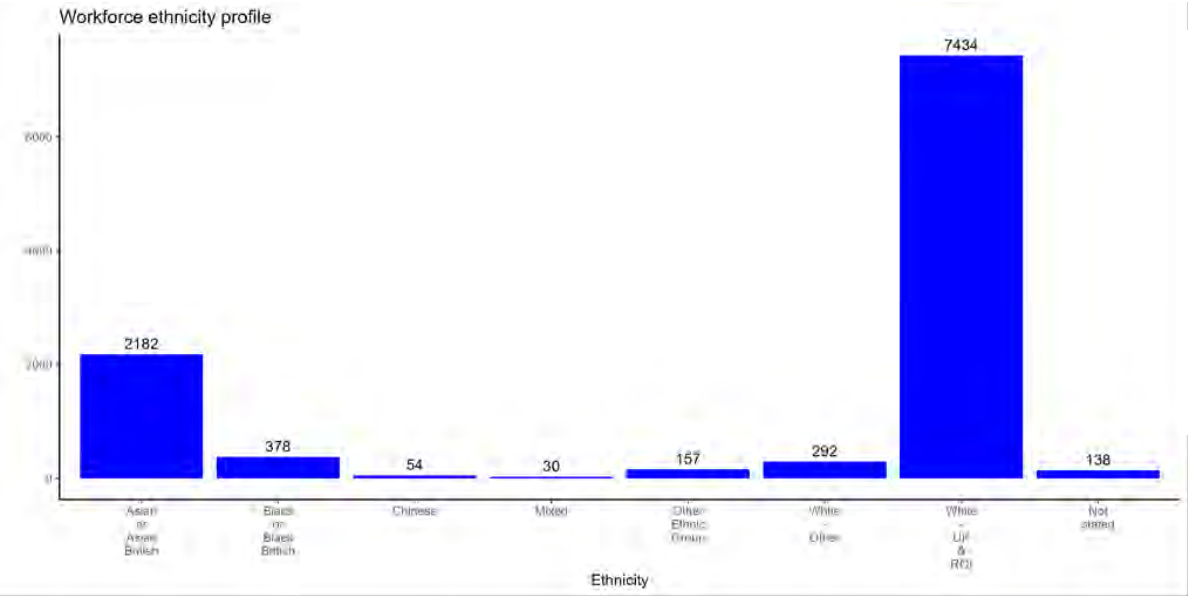
Graph 1 - Age Profile



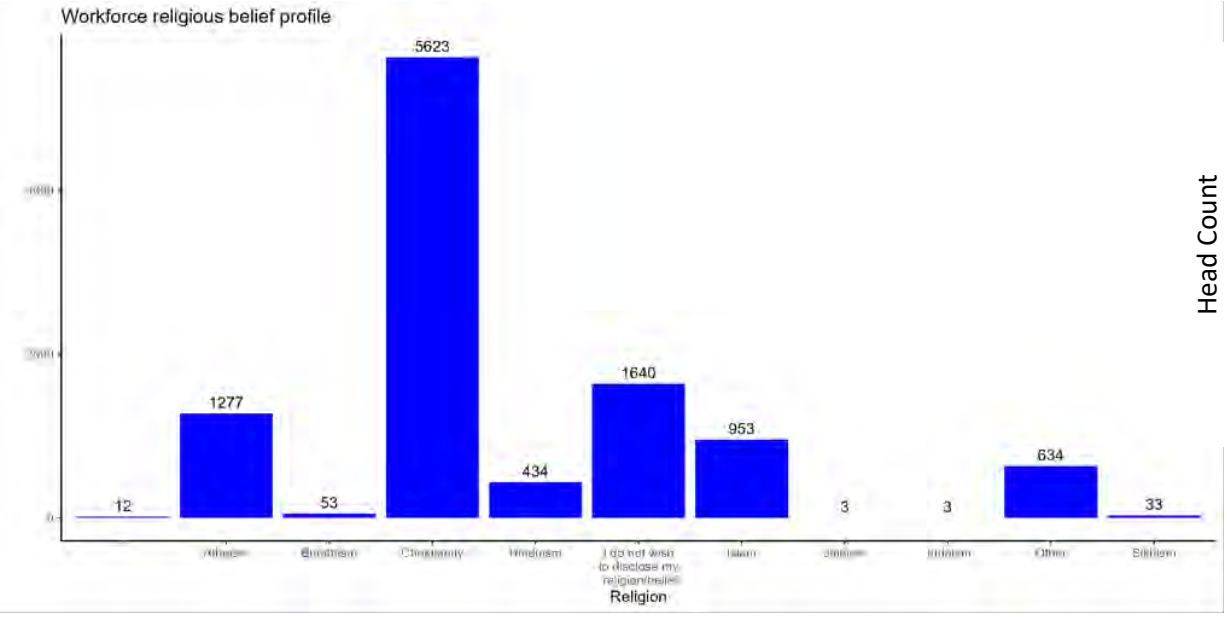
Graph 2 - Disability Profile



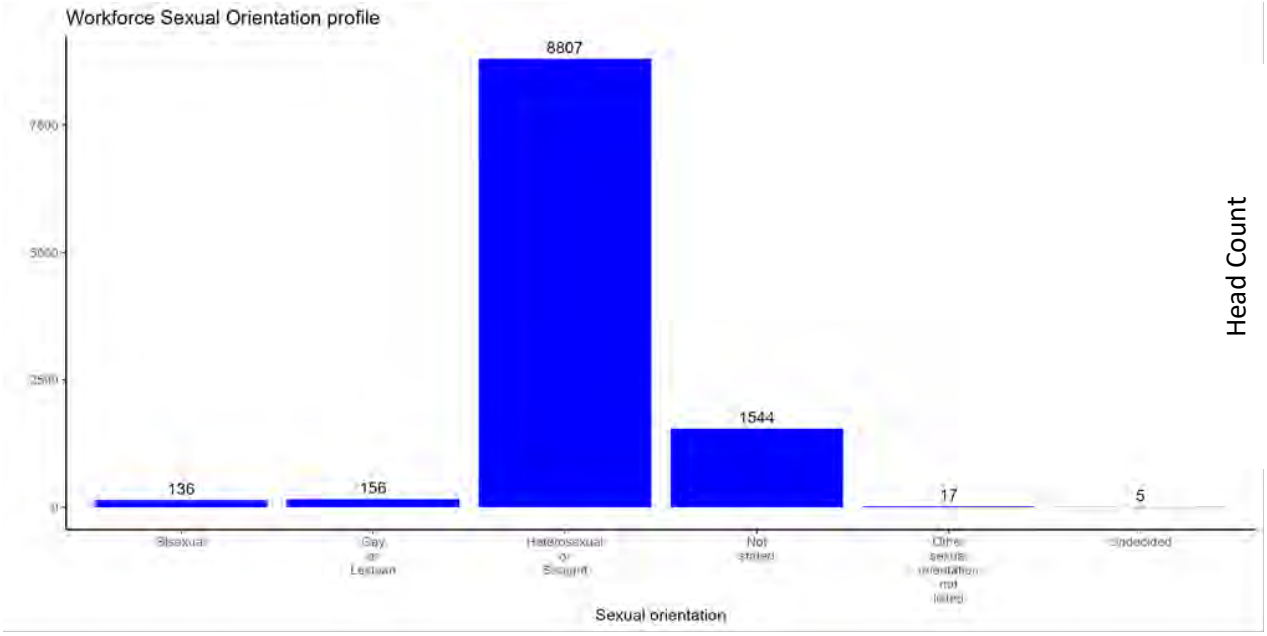
Graph 3 – Ethnicity Profile



Graph 4- Religion and Belief Profile



Graph 6 - Sexual Orientation Profile



Over the last 12 months, we have taken a number of opportunities to **promote and encourage colleagues to disclose any long-term conditions or disabilities** through the electronic staff record (ESR); in the Leaders at LTH VLOG for November, Sarah Cullen talked about Disability History Month, the gap in employment rates between disabled and non-disabled people, how we can bring our lived experiences of disability and LTC to the benefit of our teams and our patients and the importance of updating our Electronic Staff Record (ESR). Similar messages have been highlighted through the All Colleague and Leaders briefings, Managers Update sessions and through the Neurodiversity toolkit. This focus does seem to be making a difference as we can see the shift in the number of colleagues disclosing a disability/LTC from our last annual report has increased from 4.9% to 6.2%.

With the transfer of colleagues to One LSC in November of this year, our workforce demographic for next year will change. Aside from impacting our workforce demographic, it may also influence other areas such as the Workforce Race/Disability Equality metrics, in addition to how our staff survey data changes as a result. Appendix 1 and Appendix 2, display infographics capturing our annual WRES and WDES returns for 2024. The full reports can be found here.

Undertaking the annual **Equality Delivery System** (**known as EDS2022**) self-assessment process further supports our desire to be the transparent in our approach to delivering improvements for EDI as defined by the public sector equality duties (PSED). The purpose of EDS is to support NHS organisations to improve the services they provide for local communities and provide better work environments whilst meeting the requirements of the Equality Act 2010.

The completion of EDS2022 is mandated as part of our NHS Standard Contract, it is reported separately to Board outside of this annual update. The approach to completing EDS 2022 in 2024 was to work on a system level with colleagues across the Lancashire & South Cumbria Integrated Care System (L&SC ICS) whilst consulting, engaging and involving partners, patients, voluntary organisations and colleagues with protected characteristics via the Inclusion Ambassador Forums. To understand our performance against last year's EDS22 assessment, the report can be found here.

FOR COLLEAGUES

USING DATA AND LIVED EXPERIENCE TO IMPROVE CULTURE

Throughout the year the Board receives a number of **data sets and reports**, relating to equality diversity and inclusion, which are designed to help us understand lived experience, culture, priorities and progress we are making to reduce inequality across our organisation:

- **Workforce Race Equality Standard (WRES)**
- **Workforce Disability Equality Standard (WDES)**
- **Gender Pay Gap**
- **Ethnicity Pay Gap (introduced in 2024)**
- **Equality Delivery System (EDS22)**
- **NHS Staff Survey results broken down by protected characteristic**
- **Annual EDI Report**

Infographs detailing the headlines for the WRES, WDES and the Gender Pay Gap are contained in the appendices. All reports are discussed within Workforce Committee, with escalation (and in some cases approval) by Board to enable the national publication of our data set. In addition to the suite of reports noted above, Workforce Committee also receive the annual strategy update for the Our People Plan strategic aim – to create a positive organisational culture.

Since June we have started to deliver **equality impact assessment training for colleagues**, to enable those who; produce patient and colleague facing policies, processes, standard operating procedures or who make decisions about service developments/changes or financial improvement plans, to robustly and accurately complete equality impact assessments and improve the documented evidence of mitigations taken where impacts are recognised. To date 40 colleagues have attended the training with monthly sessions scheduled throughout 2025.

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

- Appraisal Policy
- Attendance Management Policy
- Performance Policy

- Probationary Policy and Procedure
- Annual Leave policy
- Management of the misuse and misappropriation of drugs, alcohol, intoxicants and other substances by staff
- Overtime Policy
- Roster Management Policy
- Apprenticeship Policy
- Trans and Non-Binary Policy
- Supporting Disability in the Workplace
- Equality, Diversity & Inclusion Policy
- Stress at Work Policy
- Retirement Policy
- Domestic Abuse Policy
- Code of Conduct Policy
- Disciplinary Policy
- Special Leave Policy

Our policy review and approval process sets out the need for an equality impact assessment to be undertaken for all policies in addition to the requirement for our Inclusion Ambassador forums to be consulted with when a policy is being developed or reviewed.

This year we have started to take more of an **intersectional approach to evaluation and reporting**, enabling us to identify unwarranted variations in experience for our colleagues. An example of this is in the **annual report on Appraisal** which goes to our Workforce Committee detailing compliance rates, colleague experience, impact and quality measures. For the first time this year, within this report, analysis was undertaken to understand variances in colleague experience of appraisal across ethnic minority groups and colleagues who have a disability or long-term condition.

It was clear to see colleagues with a LTC/disability report a poorer experience across all five appraisal questions (see table below). Whilst a lower percentage of colleagues from an ethnic minority group report having had an appraisal over the past 12 months, a greater percentage noted their immediate manager gives them clear feedback on their work, their appraisal helped them improve how they did their jobs, helped them agree clear objectives and left them feeling the organisation values their work.

		LTH Average 2023	Colleagues with a Disability/LTC	Ethnic Minority colleagues
Q9b	Immediate manager gives me clear feedback on my work	68.5%	65.2% (-3.3%)	71.6% (+3.1%)
q23a	Received appraisal in the past 12 months	82.6%	79.0% (-3.6%)	77.8% (-4.8%)
q23b	Appraisal helped me improve how I do my job	26.0%	19.0% (-7%)	49.2% (+ 23.3%)
q23c	Appraisal helped me agree clear objectives for my work	34.5%	27.5% (-7%)	52.4% (+17.9%)

		LTH Average 2023	Colleagues with a Disability/LTC	Ethnic Minority colleagues
q23d	Appraisal left me feeling organisation values my work	37.3%	29.3% (-8%)	49.1% (+11.8%)

Appraisal ratings were also analysed, cut by ethnicity addition to disability, **to see whether there was any variation in the overall performance scores attributed** to colleagues across different ethnic groups or those who have a long-term condition or disability. This showed the percentage of appraisal ratings allocated across each of the different ethnic groups followed a very similar pattern with 'Strong' being the most frequently awarded overall appraisal rating across groups and 'Developing' being the least frequently awarded, except for across the 'Other Ethnic Groups' colleagues where 'Outstanding' is the least frequently awarded. The analysis undertaken for colleagues who have disclosed a disability versus colleagues who have not disclosed a disability also showed a very similar pattern of score allocation across the groups with 'Developing' being the least awarded rating across both disabled and non-disabled groups (2.9% of colleagues in both groups received that rating) and 'Strong' being the most frequently awarded rating across both groups (allocated to 59.8% of disabled colleagues and 62.2% of non-disabled colleagues).

As a part of our **Workforce Disability Equality Standard (WDES)** and **Workforce Race Equality Standard (WRES)** analysis it was found that with regards to the **formal capability process, disabled colleagues are more likely to be engaged in this process** (being 2.07 times more likely to enter into the formal process). This represents a slight increase from 1.90 times more likely the previous year. The number of cases entering a formal capability process overall remains very low (10-15 for Disabled colleagues per year), therefore care must be taken when drawing any conclusions from the data. With regards to the **formal disciplinary process**, we have seen no movement in the percentage of colleagues from a minority ethnic background (compared to white colleagues) entering the formal stages with the results indicating that **ethnic minority colleagues are significantly less likely to enter the process** (0.44 times less likely) a figure which has reduced over the last couple of years. In 2025 we will be introducing training which supports leaders/managers to lead formal workforce processes inclusively and without bias – the training will be developed using the Equality Diversity Representatives training package previously delivered at regional level but will also factor in the lessons learned from investigations or research i.e. Too Hot to Handle report, the NMC Culture review findings.

If colleagues disclose that they have a long-term condition or a disability line managers are encouraged to undertake a supportive discussion and complete a **Supporting Disability or LTC in the Workplace conversation** which provides an opportunity for the line manager to understand their team member's health condition(s), how it impacts them within the workplace and how best we can support them in work (including details of any agreed workplace adjustments). Over the past 2 years we have incorporated a health and wellbeing section into appraisals which provides space for colleagues to record whether they have a Supporting Disability or LTC Agreement (SDA) in place or whether they need one, but do not have one. Analysis of completed appraisals completed across a 12-month period showed that;

4% recorded colleagues having a SDA in place
69% noted colleagues didn't have (or need) an SDA
3% stated colleagues didn't have an SDA, but they needed one
24% left the field blank

Further work needs to be undertaken to; ensure those colleagues who need a SDA are supported to have the conversation, to reduce the percentage of appraisals were the field is left blank and to assess the quality of the SDA conversations/agreements which have taken place.

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

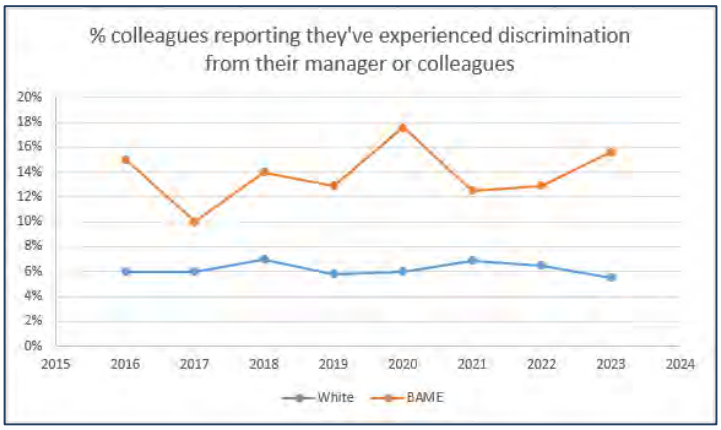
The **National Staff Survey** results are reviewed annually to understand if there are any differences in the experience of work for any of our minority groups. Through completing this analysis, we found a number of themes which include:

Bullying, Abuse, Violence and Aggression

- Colleagues who **have a disability or long-term condition (LTC)** reported experiencing greater levels of bullying, harassment, violence and abuse from patients, their relatives or members of the public (27%) than colleagues without a disability or LTC (19.9%). Similarly, it was found that colleagues with a disability or LTC reported experiencing higher levels of bullying or abuse from colleagues (23% versus 16% for non-disabled colleagues) and managers (11.7% versus 6.7% for non-disabled colleagues). In addition, colleagues with this protected characteristic indicated that they felt less secure in raising concerns (66.6% versus 71.9% for non-disabled colleagues) and less confident that, as an organisation, we would address them (47.8% versus 59.1% for non-disabled colleagues).
- It was found that colleagues from a **Chinese background** and colleagues who **identified as Irish** experienced the highest levels of bullying, harassment, violence and abuse from patients, their relatives or members of the public which mirrors the results from the previous year. Colleagues who **identified as Chinese** also reported the highest levels of harassment, bullying or abuse from managers whereas colleagues from **an Arab background** noted the highest levels of harassment, bullying or abuse from other colleagues (all when compared to the wider Trust average).
- Colleagues **below the age of 30** reported more experiences of bullying, harassment, violence and abuse from patients, their relatives or members of the public. Colleagues **between 41-50** reported experiencing greater levels of harassment, bullying or abuse from other colleagues when compared to the Trust average.

As already noted, a significant amount of work has been undertaken over the last year to raise awareness of the importance surrounding organisational culture, civility and Zero Tolerance with diversity and inclusion a conscious, purposefully visible thread throughout.

Listening Rooms were scheduled throughout Black History Month (October) and Disability History Month (November/December) to further explore metrics indicated as an outlier, namely **"Percentage of colleagues reporting they've experienced discrimination from their manager or colleagues" (WRES)** and **"Percentage of colleagues reporting they've experienced bullying and harassment from their managers/colleagues" (WDES)**.



Sadly, attendance numbers were very low so, with involvement from the chairs of the Ethnicity forum, an anonymous survey was created and shared with colleagues. The Equality, Diversity & Inclusion team will work with the Ethnicity and Living with Disability inclusion forums throughout 2025 to look at what we can do to gather experiences and understand colleague voices around this area with a view to improve experiences overall.

The end of this year sees us working to **review emerging national reports** published relating to racism or discrimination i.e. Too Hot to Handle report (Kline, Warmington, Capsticks, 2024) and the Nursing & Midwifery Council's Independent Culture Review (2024) to see what lessons we can learn and how we can apply any learning or resulting actions within our own organisation.

The actions which have been taken to bring about improvements in these areas form part of Our People Plan strategic action plan and the actions being delivered through the Freedom to Speak Up Strategy and the Reducing Violence and Aggression Strategy.

RESPONDING TO SIGNIFICANT AND IMPACTFUL EVENTS

July brought the shocking news of stabbings which had taken place in Southport at a local dance class, which tragically resulted in the deaths of three young girls. What followed in the days and weeks afterwards were a series of national and local riots and disturbances rooted in far-right extremism and Islamophobia. This had a significant impact on a number of colleagues across our organisation which was acknowledged through a series of corporate communication channels including; All Colleague briefings and Special Briefing Communications (VLOGS/Email bulletins) stipulating key messages;

- Islamophobia and Racism are not tolerated in our organisation
- Importance of raising concerns with reminders of channels to use
- Reminding colleagues how to use social media responsibly
- Reinforcing channels for practical, emotional, psychological and spiritual support
- Encouraging colleagues to support one another (especially line managers, asking them to proactively reach out and support team members who may be at increased risk of abuse or who may face additional barriers to speaking out)
- Reaffirming (and enhancing) security arrangements

A toolkit titled "How to be an Ally" was rapidly developed and launched to help all colleagues understand how they may be able to help support team colleagues from ethnic minority groups.

Our Ethnicity forum was not active at the time of the incident, however the MS Teams channel for the forum was used for colleagues to reach out and send messages of support to those impacted. Overall there was an increased focus on organisational and cultural values and a reminder for colleagues to access and utilise the Bystander Intervention Toolkit, creation of poster resources to help raise awareness of when behaviours may cross the line into racial discrimination or criminal offences etc.

We know from our WRES data that ethnic minority colleagues are nearly 3 times more likely to report experiencing discrimination from their manager, team leader or colleagues – this is a priority area for us to address in 2025 with support from the Inclusion forums, Trade Union representatives, Chaplaincy and Workforce teams.

COLLEAGUE ENGAGEMENT – Trust Average Engagement Score 6.9

- Colleagues **aged between 21-30** have the lowest engagement levels (overall score of 6.8), the most engaged groups are those **aged 16-20 and 31-40** (score of 7.0), with **those aged 66 and over** having the greatest levels of engagement with a score of 7.3.
- Colleagues **with a disability or long-term condition** were found to have lower levels of engagement (6.5) compared to colleagues without a disability (7.1).
- Colleagues who **identified as being Indian or Chinese** had the highest engagement scores at 7.6 closely followed by colleagues who are **African** at 7.4 and **Caribbean** at 7.3. These scores are higher than the organisation average and also higher than white colleagues (score of 6.8). Colleagues with lower staff engagement levels were those from **mixed or multiple ethnic groups** (score of 6.0).
- **Males and females** had similar levels of engagement with males scoring slightly lower (6.8 compared to females at 7.0). Colleagues who identify as **non-binary** had the lowest staff engagement levels at 4.6 with individuals who prefer not to say at 5.9.

- In terms of sexuality, levels of staff engagement were lowest for colleagues who **prefer not to say** (6.1) closely followed by colleagues who identify as **gay or lesbian**, with a score of 6.3 in comparison to heterosexual colleagues at 7.0.
- With regards to religion, colleagues who stated they would **prefer not to say** had the lowest staff engagement score (5.9) followed by colleagues who identified as having **no religion** (6.6). Colleagues whose religion is **Hindu** or **Sikh** had the highest engagement levels (7.7) followed by colleagues whose religion is **Buddhist** (7.4).

GENERAL STAFF SATISFACTION THEMES

- Colleagues **between 21-30 years reported experiencing higher levels of work-related stress and found work more emotionally exhausting and tiring, with feelings of burn out than other age groups**. Colleagues between 16-20 and 66+ recorded experiencing the lowest levels of work-related stress. With colleagues over the age of 66 years experiencing the greatest levels of satisfaction across the items measured in the National Staff Survey.

- **Disabled colleagues report far lower levels of satisfaction across the majority of the questions in the National Staff Survey**, including factors relating to their job such as ability to make suggestions to improve the work of their team/department, manage conflicting demands on time, feeling valued for their work. Through to how they feel working in their team; levels of respect and kindness demonstrated from colleagues and line managers and ability to access training and development opportunities.

- Across all the staff satisfaction questions, **Pakistani colleagues, colleagues from any other mixed/multiple ethnic background and colleagues from any other white ethnic minority background had the highest number of red RAG rated items** compared with other ethnic minority groups and the Trust average.

- Across all the staff satisfaction indicators, **colleagues who identify as gay, lesbian or 'prefer not to say' recorded lower levels of satisfaction through a higher number of red RAG rated items,** than heterosexual or bisexual colleagues. Colleagues who identify as 'Other' had the greatest number of green RAG rated responses, particularly across the sections relating to 'Your Manager' and 'Your Personal Development' when compared to the Trust average.

For the first time this year we obtained our Staff Satisfaction results by Ethnicity and Disability, cut by Division and Band so we can start to explore the experiences of colleagues at a more granular level and understand the extent to which colleague experience might vary depending on band/level of seniority, length of service or Division.

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

The actions identified to date include; increased awareness and understanding by team colleagues and line managers as to what inclusion means and how they can help support positive action. Greater analysis of data such as talent management categories and attendance of leadership development opportunities is also an area for further exploration in 2025.

FOR PATIENTS

The Trust has continued to work with communities based on their demographics to provide the opportunity to ensure underrepresented communities to understand what services are available for them. We have **developed and initiated awareness campaigns** within our local areas and have found this to be very effective in reaching out to these communities. The national inpatient survey, cancer and urgent and emergency care survey had no more than 3% feedback from those with a protected characteristic. The Maternity survey received 13%, all are under the national averages. As result we continue to work to improve being evidence led through ways described below.

The Macmillan team continue to work with disadvantaged people out in the community. They considered the breakdown of ethnicity of people accessing our services and saw there was a huge disparity between “White British” and other groups. Following this they met with the chair from the Sahara Centre in Preston and arranged a visit to carry out a scoping exercise. They found there were barriers to accessing medical services which included: non accessible appointment letters which were not in the patients first language, worries that the GP would be a member of the community and they would therefore know them, a lack of education and awareness, especially around self-examination.

Following this **awareness events were held at the Sahara centre** with breast and colorectal teams to promote awareness and self-examination. We also held events at the local mosque, and we now have a regular attendance at the Preston Muslim forum to ensure that information is cascaded throughout the community. Extended events also took place at the **Windrush centre**, where male clinical specialist nurses lead on discussions about prostate cancer awareness and, in order to reach the community, also attended the Windrush Festival on Avenham Park in the summer.

Focusing on the demographics within our local area we have engaged with the public and been able to establish patient groups.

Prisoners often face significant health inequalities compared to the general population. These disparities arise from a combination of factors including limited access to healthcare, pre-existing health conditions. Many prisoners enter the system with untreated or poorly managed health issues, which can be exacerbated by the lack of adequate medical care within prisons. Two **events were held at Wymott Male Category C prison** in Leyland, which were attended by a clinical nurse specialist to discuss prostate and testicular cancer. Both events were very well attended, and now the uptake in tests as a result of this are higher than in the past, this is a tremendous leap forward in the care of our prison population. Discussions are also being held regarding the instigation of a prison cancer support group, and they also share in our next Men's Health event in June 2025.

In children and young people (CYP) **severe obesity** is associated with adverse outcomes such as early-onset type 2 diabetes mellitus (T2DM), pre-diabetes, sleep apnoea, mental health problems and mobility issues. To tackle this work is being developed to provide an **integrated Northwest-wide service and referral pathway** with 3 centres (Manchester, Alder Hey and Preston) this will provide a high standard of care close to home and provide the opportunity to share and unify approaches and enhance management and treatment of all patients. This will provide a clear referral pathway with equitable access for the population across the Northwest region. Plans are also in place to develop a holistic family-based lifestyle intervention with a health coach (new role in secondary care) dietitian and physio service, along with implementing of a plan to offer new therapies. Progress to date has seen the setup of now established clinics within our community initially taking follow up patients, since further extended to include new patients, along with an established joint approach MDT with Manchester and Alder Hey.

OUR FUTURE COLLEAGUE FOCUS

- Use our existing data sources to help understand barriers to social mobility and career progression of colleagues from all social class backgrounds.
- Identify colleague groups or services where the numbers of Freedom to Speak up Concerns raised are low among colleagues from minority groups who may experience additional barriers to speaking up, identifying additional ways to promote and support those groups of colleagues.
- Continue to undertake equality impact assessments for Workforce and OD related ratings i.e. talent ratings, turnover, sickness absence, training attendance/evaluation and education metrics.
- Extend our ability to view outcome measures through the lens of protective characteristic data so we have the capability to understand our performance, incident or feedback data through the lens of different colleague groups and take action to reduce systemic inequalities.
- Develop and launch Equality Diversity training for leaders/managers to support them to lead formal workforce processes i.e. investigations, performance management inclusively and without bias.

- Working with the Ethnicity Inclusion forum to understand how discrimination is experienced for ethnic minority colleagues, with the intention to close the gap in experience relating to discrimination highlighted through staff survey.
- Explore quality of Supporting Disability or Long-Term Condition conversations/agreements.

OUR FUTURE PATIENT FOCUS

- Strengthen relationships within our communities by ensuring face to face involvement, listening to patient stories and experiences and putting their voices at the heart of our decision making.
- We have established connections although there is a lot more to do and we plan to build relationships with excluded groups and put this learning into our plans to ensure we continue to build and grow with our communities.
- Continue to provide accessible information, where necessary use interpreter services for languages and our Deaf communities with BSL to ensure public health information is understandable to all.
- Use our existing data sources to help understand barriers to social mobility and carer progression of colleagues from all social class backgrounds.
- Explore how to ensure we receive more diverse feedback from the national patient surveys.

PRINCIPLE 3 – RECOGNISING THE IMPORTANCE OF LIVED EXPERIENCE

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

FOR PATIENTS

Patient stories are a tool for staff to learn and to develop our services. This year we have seen the creation of many videos with patients telling their stories, sharing their experiences and emotions. With the creation of a one stop area on the staff intranet we are now able to share these experiences with our colleagues so they can see, hear and experience real life stories that are based around our services and our care. In the past these stories were only shared with the relevant departments or at a board meeting.

Due to sharing these experiences, we have seen a surge in the **creation of involvement forums** and groups by various departments. By creating these groups this enables our staff to truly understand the experiences of our patients and how to better create a positive patient experience and develop services with the patient at the heart of our services, their care and treatment. Our forums are collaborating with external charities and organisations to enable us to engage with wider group's thus capturing a larger representation of our communities.

Established patient forums include:

- Patient Experience and Involvement Group
- Patient Information Group
- Cancer Patient Information Group
- Carer Forum
- Cancer Patient and Carer Forum
- Specialist Mobility Rehabilitation Centre (SMRC) Mobility Matters
- SMRC - Complex Regional Pain Syndrome
- Youth Forum
- Maternity Voices Partnership
- Critical Care Ex Patients & Relatives Support Group
- Preston Dystonia\Migraine Group
- Renal Strategy Group
- Trache Patient Forum
- Lancashire Learning Disability and Autism Partnership
- Patient Research Group
- Saheliyaan Asian Ladies Forum

- VI (visual impairment) Forum

With the addition of some new forums:

- Endometriosis patient support group
- Sepsis patient support group

These groups provide a lot of information and support and are advertised externally using various methods so we can reach out to our communities. Feedback is now sought from forums to ensure that information is captured and actions taken.

In recognition of the patient lived experience we have used our patients, groups and forums to help **support the delivery of new pathways**, **environmental changes** and supported wards and teams with **changes** they would like to implement. A number of examples are listed below:

- The recruitment of 3 Patient Safety Partners.
- 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.
- The development of an eLearning training package regarding complaints, PALS concerns and local resolution.
- Increased number of Flow Coach Academy (FCA) big rooms and MCA projects using the patient voice as part of them.
- Increased training for staff in basic British sign language (BSL).
- Development of LTHTR proud awards using MAGNET principles.
- Personalised Stratified Follow-Up (PSFU) and health and wellbeing workshops and initiatives have started across various specialities

Some of the environmental and recruitment changes the patients have led or supported are noted**:**

- Recruitment to Maternity Neonates Voices Partnership Lead.
- Digitised food ordered with increased diverse options i.e. Vegan.
- Rebuilt 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.
- 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.
- The design of the new Day of Surgical Surgery Admission (DOSSA) currently being built.

FOR COLLEAGUES

INCLUSION AMBASSADOR FORUMS

We have **three Inclusion Ambassador forums** which have been established since 2019; **Ethnicity, Living with Disability and LGBTQ+.** The Inclusion Ambassador Forums are each chaired by one or two colleagues (who are usually members of the community group the forum represents) each forum has an allocated support member from the EDI team and sponsorship from members of our Board and Executive Team. In addition to the inclusion forums, we have **three support groups** which are also aligned to the health and wellbeing agenda; a **Menopause Group, a Carers Group and, an Endometriosis Awareness group**.

2024 has seen challenges in being able to maintain a consistent level of forum meetings due to; general volume of work activity, work commitments or long-term absence of Chairs and recruitment of new Chairs. There have also been changes within our Executive team which has meant the need to reallocate sponsorship roles. To mitigate these issues moving forwards, we have tried to ensure that we have more than one Chair in each forum to provide some contingency in case of absence etc. Our Executive team have also committed to protecting time for Chairs to support them in the delivery of their role. Forum chairs and Executive Sponsors have a role description which aligns with the national Staff Network guidance, which sets out role expectations.

The focus for 2025 is very much about supporting the new Chairs in their roles, re-establishing forum activity, setting objectives in conjunction with the membership which detail what the forum want to achieve over the next 12 months and ensuring greater promotion and visibility.

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

As already noted, we continue to **co-produce our workforce and organisational development policies with the Inclusion Ambassador Forums**, by sharing details of proposed policy changes for discussion, circulating drafted policies for feedback, seeking views on completed equality impact assessments and understanding the impact of how the application of our policies impacts on their lived experience. This has been evidenced within our Endometriosis group where we are seeking to influence the wording of standardised payroll letters which are sent to colleagues when they are due to s

In conjunction with Black History Month and Disability History Month, we have sought to gather the views of minoritised colleagues in relation to two key areas highlighted through the WRES (experience of discrimination) and the WDES (experience of bullying and harassment) by scheduling several **Listening Room sessions**. The aim was to understand the staff survey results in more detail i.e. what was their experience(s) within these areas, what would make a positive difference and what could bring about improvements. Attendance was low however

the feedback shared from colleagues who attended is invaluable, again reinforcing the importance of understanding the lived experience of colleagues.

INVITING COLLEAGUES TO SHARE THEIR EXPERIENCES

Every other month, we hold a **Schwartz Round** which is a great opportunity to listen to, and engage with, other colleagues from across our organisation, and to understand more about how it feels to deliver our roles in healthcare. A key focus of Schwartz Rounds is to encourage colleagues to see the person in the professional. We are more than our role, we are people too and often we do not get the opportunity to discuss the emotional impact our jobs can have on us. Schwartz Rounds support colleagues to connect on these issues and create cultures of kindness, compassion and empathy between one another. Over this year some of the topics have been;

The patient I will never forget
Why I do the job I do
Putting compassion to the test
Living and Working with a Long-term condition or disability

In December, as part of Disability History Month events, the Library Services team, the EDI team and the Living with Disability Inclusion Ambassador forums ran a **Living Collection/Living Library event**.

The principle behind the Living Collection/ Living Library is that the 'books' are colleagues with lived experience who usually belong to a minority group, and the 'readers' of the books are colleagues who are interested in learning more about other people's lived experiences, maybe also their challenges too. It enables more of a shared understanding of how others experience life, or our working environment. It also helps to challenge negative stereotypes or generalisations and busts myths, encouraging colleagues to consider how they may be able to utilise their learning to support others.

Titles of the books available to loan on the day were;

A Little Bit of Titty Chat
Look closer – see me…..please
That was a bit sketchy – From a wheelchair to the Wainwright mountains and back
The Other Side of Normal: A Nurse's Tale of Autism and ADHD
Normal for Me

As part of **World Multiple Sclerosis Day** in May Gemma Devine, a Healthcare Assistant on Rookwood A in Chorley shared her lived experience being diagnosed with MS (Multiple Sclerosis). Gemma said: "*I'd like to inspire people - if you have MS or any similar chronic illness, you can change your life for the better and carry on. I've been here around 15 months now, and I'm a Healthcare Assistant. I've been doing training on the job, currently I'm training to be a band 3, so I've come a long way. The Trust have also helped me with my working life by implementing workplace reasonable adjustments, and my manager completed a supporting disability in the workplace agreement*." She had an interview with the MS Society about her story, and the MS Trust have reached out to work with her as well.

NHS OVERSEAS WORKERS DAY

March saw colleagues across the Trust sharing their experiences of relocating to the UK as part of **NHS Overseas Workers Day** in March. Colleagues such as Akinkinmi Omotoso (Occupational Therapist) who said,

"Before moving to the UK, I practiced as an occupational therapist in Lagos, Nigeria, for over six years. The idea of relocating was a source of overwhelming fear, moving to a new country and staying that far away from all I was accustomed to. However, the Lancashire Teaching Hospital Trust eroded that fear with a well orchestrated plan, structured to help me ease into my new role. The next challenge was adapting to the cultural differences. Still, they anticipated this and enrolled me at Runshaw College to learn about communication and culture in the United Kingdom."

SUPPORTING THE DELIVERY OF WORKPLACE ADJUSTMENTS

As already mentioned, we have maintained a strong focus and narrative surrounding the creation of a compassionate culture to support a more seamless implementation of workplace adjustments for colleagues. **Workplace adjustments** are changes made to remove (or reduce) any disadvantage related to a colleague's disability or long-term condition when doing their job, or to remove (or reduce) any disadvantage related to a job applicant's disability or long-term condition when applying for a job. This has primarily been enabled through a number of 1:1 support sessions with individuals and/or line managers to aid them to have effective, supportive conversations, through which the **Supporting Disability Agreement** has been completed. The conversations enable a shared understanding of how an individual's disability or long-term condition affects them in the workplace and to agree what workplace adjustments would be beneficial. Using our awareness of the challenges experienced by colleagues in ordering and procuring equipment to support workplace adjustments, we have worked with colleagues in Procurement and Finance to define a process to support managers and colleagues to procure items in a more streamlined way.

As measured through the annual Workforce Disability Equality Standard (using Staff Survey data from 2023), we found that 78.3% of colleagues who have a disability or a long-term condition said the organisation has made **reasonable adjustments** to enable them to carry out their work. This is significantly above the national average for this measure (73.4%) and represents a sustained increase since 2021 (75.1% in 2022 and 72.6% in 2021).

RESPONDING TO HEALTH AND WELLBEING BEING NEEDS OF MINORITY GROUPS

We know that each and every one of our colleagues has their own unique, and diverse, wellbeing needs, so providing a wellbeing offer which is inclusive and aims to address health inequalities is important to us. Our Health and Wellbeing action plan outlines our five key commitments which are;

1. Ensure that our workforce, and future workforce, perceives us as an employer who takes positive action on health and wellbeing.
2. Reduce the incidence of colleagues experiencing musculoskeletal (MSK) injuries as a result of work and provide proactive support for colleagues experiencing MSK conditions
3. Develop a culture which reduces stigma around mental health, promotes resilience and provides a comprehensive model of support
4. Provide a work environment which encourages rest and hydration and enables colleagues to access healthy, nutritional choices
5. Protect our colleagues and patients from flu and COVID-19 viruses by ensuring optimum uptake of vaccinations.

Each year a 12-month campaign calendar is planned which incorporates a range of national and local health promotion campaigns that are closely aligned to our five key commitments.

Over the last year, we have further embedded and developed our offer of support to **Working Carers**. Our Intranet site which houses resources relating to carers, received 3,200 visits across the year which indicates a significant proportion of our workforce may be balancing caring responsibilities with work commitments. Our Special Leave policy has been updated to reflect an enhanced provision of Carer's Leave to support carers in attending planned appointments or treatment relating to the person they care for. It now consists of up to 37.5 hours paid leave and 37.5 hours unpaid leave (pro-rata for part time colleagues).

To support the commitment in respect of **mental health** an online referral form was launched, in addition to a manager's toolkit titled "Managing Mental Health and Risk". The most common reasons for referral into the Psychological Wellbeing Service were; anxiety and/or panic, stress and low mood/depression. A number of referrals were also received in respect of trauma/incidents, emotion regulation, relationship difficulties, neurodiversity and bereavement. Evaluation data shows that 91% of colleagues said the support they received helped them to stay in work. A range of other inventions have also been initiated in support of this area of work, such as;

- Rolling out the Making Every Contact Count (MECC) for Mental Health training programme

- Raising Awareness as part of Mental Health Awareness Week in May
- Re-launching our Mental Health First Aider training following a lengthy gap in delivery, 44 delegates attended the first three courses of 2024

Over the course of the last 12 months there has again been significant additional activity aligned to our Equality, Diversity and Inclusion (EDI) Strategy and designed to provide an inclusive health and wellbeing offer. We seek to address health inequalities in the workforce, support colleagues with protected characteristics to feel supported and well at work and provide guidance to colleagues who may experience financial challenges or other wellbeing challenges linked to deprivation.

- Collaboration with multiple teams including Chaplaincy, EDI, libraries, menopause advocates and volunteers (Pets as Therapy) to offer a series of Wellbeing Café events.

- Two junior doctor health and wellbeing events have been attended and supported, with approximately 100 attendees in total. Information shared relating to rest areas and break space, Schwartz Rounds, the psychological wellbeing service and stress management.

- The menopause support network has developed, attendance has increased, and each session now features a focus on a specific health topic, for example nutrition and physical activity during perimenopause and menopause.

- Wallet sized information cards, promoting the psychological wellbeing service and occupational health physiotherapy service have been designed and targeted for use within estates and facilities teams, where access to online information is limited.

- Pop-up information stands and educational sessions through collaboration with HSBC. Financial wellbeing information has been promoted including details of the financial help available through the Household Support Fund, 10% travel discount with Stagecoach, free wills month, Lancashire Carers Service Autumn/Winter magazine, the Holiday Activities and Food (HAF) programme offered by Lancashire County Council and a series of discounts available through the Vivup employee benefit offer.

- Sleep and alcohol 2-hour workshops have been delivered by the psychological wellbeing service during 2024, responding to the wellbeing needs of the workforce in accordance with the health needs assessment survey

In addition, over the course of the last 12 months a thorough review of the attendance management policy and procedure has been completed, this has included engagement with a broad range of stakeholders and benchmarking against local NHS Trusts. A proposed draft policy is currently working through the approval process, this includes an enhanced provision of paid time off for fertility treatment and documented flexibility relating to individual circumstances and intervention points for attendance management, where colleagues have a disability or long-term health condition.

The **Endometriosis Awareness group** was formed with a view to enabling the organisation to become an Endometriosis Friendly Employer. As an organisation who has a 75% (approx.) female workforce, and Endometriosis affecting 1 in 10 assigned female at birth, this is an area colleagues signposted would be beneficial for us to consider from a health and wellbeing perspective.

In December we held a Lunch and Launch event as part of Disability History Month promotions which shared some statistics in respect of Endometriosis, highlighted the resources which have been developed so far, but which have also been collated to support colleagues who may have the condition, in addition to their colleagues/line managers so they understand more about the condition and how best to accommodate and support them in the workplace. Several colleagues have shared their powerful, emotive stories, documenting what is has been like living with Endometriosis, these are accessible through the Endometriosis pages of the Intranet (under Health & Wellbeing).

We are planning a campaign to mark Endometriosis Awareness month in March 2025 and we will work alongside colleagues in Gynae, the Health & Wellbeing team, the Corporate Communications team and the Patient Experience & Involvement team to do this. Our focus is to work towards becoming an Endometriosis Friendly Employer, to ensure the views of colleagues and patients in relation to their lived experiences of Endometriosis are reflected in the programmes of work undertaken and the educational/supporting resources developed, and to highlight issues that may be experienced by colleagues with this long term condition, in our organisation and work collectively to identify potential solutions to address them.

OUR FUTURE COLLEAGUE FOCUS

- To improve the experience of work for our temporary workforce with protected characteristics to reflect that of our substantive colleagues.
- To consider the creation of a Rapid Access policy to expedite access to treatment for colleagues through Occupational Health where there is a significant risk of poor health impacting their ability to maintain attendance in work.
- Further evidence targeted health promotion interventions in protected characteristic groups to improve outcomes related to obesity, alcohol and tobacco.
- Review the effectiveness of Supporting Disability in the Workplace Agreement with every colleague who has a disability or long-term condition.

OUR FUTURE PATIENT FOCUS

- Work with diverse groups of patients, their families, carers and service users to shape wayfinding and signage to make it easier to navigate when in hospital and transferring care

between hospital and community services. This should include accessible interventions for those with additional needs.

- All pathway and service redesign will involve the patient voice, providing opportunity for co-design and consultation.
- Explore the use of social prescribing to promote health and wellbeing in community groups.
- Develop intelligence around our data collection to ensure that the organisation can capture those patients who have been traditionally hard to reach, such as those who experience deprivation or other health inequalities.
- Continue to support the delivery of the Patient Experience Portal (PeP portal)
- Explore ways to improve the Charity contributions for the patient experience fund
- Continue to use the feedback from patient forums to support changes in pathways
- Explore how to diversify the patient safety partners

PRINCIPLE 4 - BEING REPRESENTATIVE OF OUR COMMUNITY

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

FOR COLLEAGUES

PROPORTIONAL REPRESENTATION

Looking at the data below, which has been taken from the 2021 Census and compared against our workforce demographic, we are broadly representational of the communities we serve however as already mentioned, the demographic of our workforce is likely to change with the transfer of colleagues to One LSC.

	Greater Preston	South Ribble	Chorley	Lancs Teaching
Ethnicity	72.6% White 20.2% Asian/ Asian British 2.4% Black/ Black British 2.9% Mixed/ Multiple Ethnic Grps	95.4% White 2.1% Asian/ Asian British 0.5% Black/ Black British 1.8% Mixed/ Multiple Ethnic Grps	95.6% White 1.9% Asian/ Asian British 0.6% Black/ Black British 1.5% Mixed/ Multiple Ethnic Grps	69.7% White 20.5% Asian/ Asian British 3.5% Black/ Black British 0.3% Mixed/ Multiple Ethnic Grps
Largest age group	23 year olds	56 year olds	50 year olds	35-39 year olds
Religion	47.6% Christian 26.3% No religion 16.1% Muslim 3% Hindu 0.7% Sikh 0.4% Other	61.8% Christian 30.8% No religion 0.9% Muslim 0.7% Hindu 0.3% Other	61.5% Christian 30.9% No religion 1.4% Muslim 0.3% Hindu 0.5% Other	52.7% Christian 12% No religion 8.9% Muslim 4.1% Hindu 0.3% Sikh 5.9% Other
Disability	9.1% Disabled	7.2% Disabled	7.7% Disabled	6.2% Disabled
Sexuality	88.5% Heterosexual 1.6% Gay/Lesbian 1.8% Bisexual	92.1% Heterosexual 1.3% Gay/Lesbian 1.0% Bisexual	91.7% Heterosexual 1.3% Gay/Lesbian 1.0% Bisexual	82.6% Heterosexual 1.5% Gay/Lesbian 1.3% Bisexual

Data from Health Improvement Plan/Census 2021

Across our organisation we have a **lower representation of white colleagues** when compared to Greater Preston, South Ribble and Chorley and a **higher representation of Asian/Asian British colleagues**. We have the **highest percentage of Black/Black British colleagues** and the **lowest percentage of those identifying as belonging to**

Mixed/Multiple Ethnic groups when compared to Greater Preston, South Ribble and Chorley too.

In respect of religion or belief, we have a **lower percentage of colleagues who identify as not having a religion** when compared to Greater Preston, South Ribble and Chorley and a **higher percentage of colleagues identifying as Hindu or 'Other'**.

As already reflected within this report, we have a **lower percentage of colleagues declaring a disability or long-term condition** compared to the Greater Preston, South Ribble and Chorley community groups.

FURTHER INCREASING REPRESENTATION OF COLLEAGUES WITH PROTECTED CHARACTERISTICS

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

- We have seen **consistent increases in the percentage of colleagues recorded a disability or long-term condition across our workforce over the past 4 years**, with 5.8% of our non-clinical workforce and 6.1% of our clinical workforce currently identifying as having a disability or long-term condition. In spite of this we know we still have a significant disparity between the number of colleagues who have shared their disability on our Employee Staff Record system i.e., as at 31 March 23, 573 colleagues recorded they had a disability or long-term condition yet we understand from our National Staff Survey data that 1149 colleagues who completed the staff survey recorded they had a disability or long term condition. Given the proportion of people who take part in the survey is typically 40-50% of total workforce, we could be looking at many more than this in reality across our organisation.

	% colleagues recording a long-term condition or disability	
Year	**non-clinical**	**clinical**
2024	6.1%	5.8%
2023	4.7%	4.8%
2022	4.7%	4.0%
2021	4.2%	3.7%

It has been positive to note a stronger representation in non-clinical colleagues identifying as having a long-term condition or disability at bands 3, 4, 5, 8a, 8b, 8c and VSM, For the majority of bands, we have seen an increase in the percentage of colleagues with a disability/LTC, in bands 4, 5, and 8c the increases are over 2%.

For clinical roles, there has been an increase in the representation of colleagues with a disability/LTC in bands 2, 3, 4, 6, 7, and band 8a compared to the previous year.

- Through the annual Workforce Race Equality Standard report we found in the last 12 months that across a number of the agenda for change bands for clinical and non-clinical colleagues we have seen **an increase in the representation of ethnic minority colleagues within our workforce**. There was a slight decrease in representation of clinical ethnic minority colleagues overall (29.5% in 2023 and 27.3% in 2024) with the largest decrease (7.9%) noted at band 3.

Year	% ethnic minority colleagues	
	non-clinical	clinical
2024	18.9%	27.3%
2023	17.8%	29.5%
2022	16.3%	25.1%
2021	15.7%	20.9%

- The greatest representation of ethnic minority colleagues in non-clinical roles are in bands 3 and below (below band 1 tend to be apprentices) as well as in band 8c (13.8% of band 8c colleagues are from an ethnic minority background). Across all bands with the exception of apprentices and bands 1 and 2, ethnic minority colleagues are underrepresented when compared against the Trust wide ethnic minority workforce.
- From a clinical workforce perspective, the highest percentage representation of ethnic minority colleagues can be found in band 5 roles (49.5%), this could in part be due to the level of international recruitment which has taken place in the last couple of years. With the exception of band 5 clinical roles, again ethnic minority colleagues are underrepresented in all other bands when compared against the Trust wider ethnic minority workforce with the greatest gaps at band 8b and above.

- The **largest proportion of our workforce is aged between 30-39** (27.24%). The workforce is fairly evenly distributed across age bandings from 25 to 54 with most groups making up around 10-13% of the workforce. The groups that are lower in representation are the under 25s and over 60s meaning those colleagues are in the minority groups.

- The **predominant gender is female** at 75.9%, which is typical for NHS organisations.

Within both WRES and WDES reports we measure the **likelihood of both ethnic minority candidates and disabled candidates being appointed from shortlisting**. There has been a slight decline over the last 12 months in relation to the likelihood of disabled candidates being appointed from shortlisting (moving from 1.13 to 1.19), however this falls between the disparity ratio of 0.8 – 1.25 indicating there is no potential adverse effect on disabled candidates. For ethnic minority candidates the race disparity ratio for this indicator has deteriorated again moving to 1.40 in 2024 (from 1.34 in 2023 and 1.28 in 2022). This means that white candidates are 1.40 times more likely to be appointed from shortlisting than candidates from an ethnic minority background. The disparity ratio is above the range of 0.8 – 1.25, which means there is likely to be an adverse impact experienced by ethnic minority candidates, further action needs to be taken which will be supported by the work being undertaken across the ICS in respect of Inclusive Recruitment but also with the development and implementation of Equality Representatives training for all Recruiting Managers.

DEMONSTRATING OUR COMMITMENT TO EQUITABLE RECRUITMENT, DEVELOPMENT AND CAREER OPPORTUNITIES IN THE WORKPLACE

Over the past 12 months we have worked with the Head of Recruitment to review each step of our recruitment and selection process to identify areas where there may be the potential for bias/discrimination to influence decision making, and we have documented actions already taken to mitigate against this along with actions we can take to further reduce or eradicate the potential for bias. Sadly this area of work had to be placed on hold whilst a large proportion of the recruitment team were transferred to One LSC - it is an area we will be looking to recommence early in 2025. It's also one of the Lancashire & South Cumbria ICS EDI collaborative projects colleagues are working on progressing.

Our Leadership Development team continue to engage with each of the Inclusion forums, in addition to holding a marketplace stall at the Internationally Educated Nurses celebration event, in order to **promote the leadership, management and talent management development opportunities** we have in existence here at the Trust and to encourage colleagues to apply. A proportionate number of places have been ringfenced across accredited leadership development programmes as part of a positive action approach. The WRES metric in respect of 'Access to non-mandatory training and Continuous Professional Development' indicates that colleagues from ethnic minority colleagues as are likely to access these training and development opportunities as white colleagues.

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

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

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

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

In response to our **Working Smarter Pledge** to ensure flexible and agile working is firmly embedded within our organisation, it has been great to see our staff survey results (2023, published in 2024), in response to the question "Satisfied with opportunities for flexible working patterns" has increased year on year, with our latest figures (60.2%) reflecting the highest result in the last 5 years as well as being above the national average score.

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

DEVELOPING A DIVERSE TALENT POOL AND SUPPORTING CAREER PROGRESSION

Our WRES and WDES data (taken from staff survey results for 2023) tells us that:

- **53.9% of colleagues with a disability and 61% of colleagues without a disability believe our organisation provides equal opportunity for career progression or promotion**. The disparity ratio falls between 0.8 – 1.25 indicating for this metric there is no adverse impact for colleagues with a LTC or illness.
- **49.7% of ethnic minority colleagues and 62.4% of white colleagues believe our organisation provides equal opportunities for career progression and promotion**. This is an improvement on results from the previous year and brings the disparity ratio just inside the 0.8-1.25 guidelines for the first time in 5 years, indicating there is no adverse impact for ethnic minority colleagues.
- Colleagues from ethnic minority groups are just as likely (1.00) to be able to access non mandatory and continuous professional development than their white counterparts. This is a significant improvement from 2022, and we need to ensure this parity is maintained as far as is possible.
- **0% of the Board's voting membership had an ethnic minority background, compared with an overall workforce of 27.5%**. This indicates we have no ethnic minority representation at board level and therefore we are not proportionately representative of our workforce.
- **With 11.1% of the Board's voting membership identifying as having a long-term condition or disability, this is more than double the 5.5% of our workforce who have recorded they have a long-term condition or disability**. It is greater than the NHS average of 4.8% and also shows an increase over the last 2 years, from 10.5% in 2023 and 7.14% in 2022.

It has been fantastic to see greater visibility and representation at Executive level of colleagues who have a long-term condition or disability; Jennifer Foote, our Director of Corporate Affairs has spoken about their long-term condition in the Leaders at LTH VLOG in November (in support of Disability History Month) and has also signed up to be part of the Living Collection/Living Library by becoming a human book.

As highlighted earlier, Sarah Cullen, our Chief Nursing Officer/Deputy Chief Executive has also spoken publicly about the importance of disclosing their long-term condition/disability and around the importance of visibility at senior levels. Further actions are required to increase the diversity of Board membership from an ethnicity perspective however, the EDI team are meeting with our Chief People Officer, Ethnicity Inclusion Forum chairs and Union colleagues to discuss this further in January 2025 and will look at ways in which we can take some targeted actions around this which lead to visible change.

LEADERSHIP TO THE DISABLED NHS DIRECTORS NETWORK

Kate Smyth, one of our Non-Executive Directors, co-founded the Disabled NHS Directors Network in October 2020. The network is open to Executive and Non-Executive Directors with disabilities on the Boards of NHS Trusts, CCGS, ICSs, NHS Arms-Length Bodies, Community Interest Companies and Public Sector Mutuals providing NHS services. It was created to strengthen the collective impact and voice of disabled leaders and, through them, of disabled colleagues across the NHS in addition to providing a peer support network for disabled NHS directors.

Kate has been pivotal in supporting the development of a toolkit which has been shared nationally, titled **"Recruitment & Retention of Disabled People in the NHS: A Good Practice Toolkit".** Designed to enhance the recruitment and retention of disabled individuals, it outlines inclusive recruitment strategies, accessible hiring processes and explores retention of disabled colleagues from an organisational culture perspective.

In December, Kate was recognised in the **Shaw Trust Disability Power 100** for being one of the 100 most influential disabled people in the UK. Testimonials submitted in support of her nomination described her as a transformative leader who has significantly advanced disability representation and advocacy across the NHS and beyond; she was recognised for her impact, innovation and influence in changing the perceptions and stereotypes of disability.

ENCOURAGING SOCIAL MOBILITY AND WIDNENING ACCESS

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

The **Pre-Employment Programme** is an 8-week programme which supports long-term unemployed people to return to work, providing them with the necessary skills and resources to secure employment. In the last 12 months, this programme has enabled 18 people to return to employment with us, securing employment in healthcare and administrative posts across the organisation.

A two-week **Reboot Programme**, an opportunity for potential employees to sharpen their skills and improve their chances of landing their dream job with us. This is a hybrid programme, for those who are more 'job ready' than those enrolled onto the Pre-Employment programme, that combines face-to-face classroom learning with experience working in departments here at the Trust - the programme is designed to provide an insight into career pathways and equip attendees with the necessary knowledge, skills, behaviour and understanding of what it's like to work in a hospital setting. Over the last year, Reboot has supported 21 people to secure interviews for posts across the Trust, with 19 of those successfully gaining employment.

We also offer a 3 day **Ready, Steady, Apply** course which is designed to support candidates who are employment ready but who struggle with the application process, The programme offers guidance and interview tips, guaranteeing candidates an interview upon successful completion. Four people have been supported via this programme in the last 12 months, with all four gaining employment.

The **Preston Widening Access Programme** has been delivered annually since 2014, providing disadvantaged students in our local area with the knowledge and experience necessary to pursue medicine at the University of Manchester. This year, we welcomed 21 students to the January 2024 cohort, of which 19 successfully completed the programme and will receive guaranteed interviews for a place on the MBCHB Medicine at Manchester university, subject to UKCAT.

Finally, the **Work Familiarisation Programme** is designed to provide students with learning difficulties and disabilities an insight into the world of work. Following completion of the programme, students can participate in work experience for two hours a week over six weeks in an area they found interesting. In 2024, 47 students completed this programme, which represents an increase of 28 on last year's numbers.

Other activity which has taken place to inspire young people and adults to consider career choices within the NHS including; a Midwifery Engagement day, attending the SHOUT Apprenticeships Expo, holding a careers event at Health Academy 1 plus Speed Networking, Mock Interviews, Careers Fairs, assembly presentations, supporting statement writing, and GCSE options support. This has included providing tailored activities aimed at our diverse community where we have continued to support Muslim schools and school children with their career aspirations.

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

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

FOR PATIENTS

As an organisation who supports people with long-term conditions and disabilities, we have introduced several mechanisms through discussions with patients and organisations, these include:

- AccessAble an online detailed guide to our facilities, to aid informed choices on access which is regularly updated to ensure accurate up to date information about our sites
- Changing Place rooms across Preston and Chorley Hospitals and Preston Business Centre Specialist Mobility Rehabilitation Centre which are larger than average rooms created to provide a safe space toilet and washing facility
- Continued membership of the 'Hidden Disabilities Sunflower Scheme' which ensures support for all patients/visitors and staff whose disability may not be visible
- Continued support to staff with education provided on Deaf culture and basic British sign language
- Education for staff in sighted guiding for patients who are blind or who have visual impairments and/or assistance dogs

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The **volunteer role** is an important part of our network, enabling us to gather real time feedback from our service users at ground level. Following feedback through various channels this year saw the recruitment of volunteer hospital guides to help our patients and visitors navigate our sites. This has not only improved relations, it also helps patients feel confident when moving around our sites, knowing that they will arrive in time for appointments and have full support of a guide throughout their visit should they require. This service supports all patients, families and visitors to our Trust and is designed for all support physical and mental health needs. The volunteers have taken several courses in various topics to aid this service, including Deaf awareness from NCompass, Sighted Guiding courses from Guide Dogs UK and moving and handling from our Estates services to enable wheelchair use.

The **Patient Safety Partner** (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS. In November 2023 we welcomed three Patient Safety Partners to LTHTR. The PSPs offer support alongside our staff, patients, families, and carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisations) and this offers a great opportunity to share interests, experiences, and skills to help develop this new role and be part of our team. The main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do. PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained, improved and remains our priority, The roles of the patient safety partners (PSP) include:

- Membership of PSIRF committees whose responsibilities include the review and analysis of safety and incidents;
- Involvement in patient safety improvement projects;
- Working with organisation boards to consider how to improve safety;
- Involvement in staff patient safety training;
- Participation in investigation oversight groups.

OUR FUTURE COLLEAGUE FOCUS

- Commence an Equality Representatives training programme which supports inclusive recruitment practices in addition to formal workforce processes e.g. investigations.
- Recommence the work in respect of Inclusive Recruitment, ensuring all steps in our recruitment and selection processes have actions to mitigate against the potential for bias or discrimination.
- Develop a talent pool database of individuals across the organisation who are identified as Rising Stars and agree the positive action we will take to fill promotion opportunities with colleagues from underrepresented groups.
- Take further steps to increase the representation of minority colleagues, particularly at senior management and executive level, to ensure the diversity makeup across all minority and socioeconomic groups is broadly representative of the communities we serve at all levels of our organisation.
- Develop a talent pool database of individuals across the organisation who are identified as Rising Stars and agree the positive action we will take to fill promotion opportunities with colleagues from underrepresented groups.
- Continue to prioritise and promote the widening access work and programmes in the organisation in order to further enable social mobility through our attraction, recruitment, retention efforts.

OUR FUTURE PATIENT FOCUS

Patient, carer and service user engagement will remain at the heart of what we want to achieve as an organisation. In order to do this, we need to better understand the needs and any gaps that may exist within our communities. In the coming year we will:

- Continue to engage through our various forums and report through the Patient Experience and Involvement group to the Safety and Quality Committee.
- Involve our patients in service improvement through key forums.
- Monitor progress towards our annual national patient surveys.
- Demonstrate key learning from incidents, complaints and concerns.
- Monitor feedback through our Friends and Family test data.
- Increase Friends and Family test data by 10% in year.
- Develop systems and processes to identify where there are health inequalities and seek to address those issues.
- Explore the diversity of the patient safety partners.

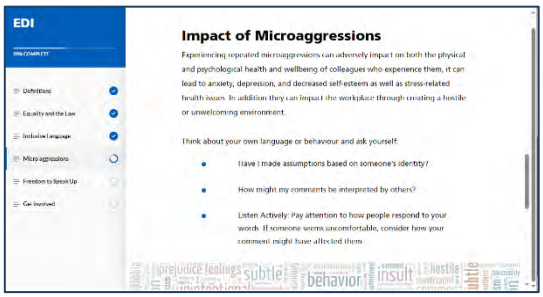
PRINCIPLE 5 – BRINGING ABOUT CHANGE THROUGH EDUCATION AND DEVELOPMENT

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

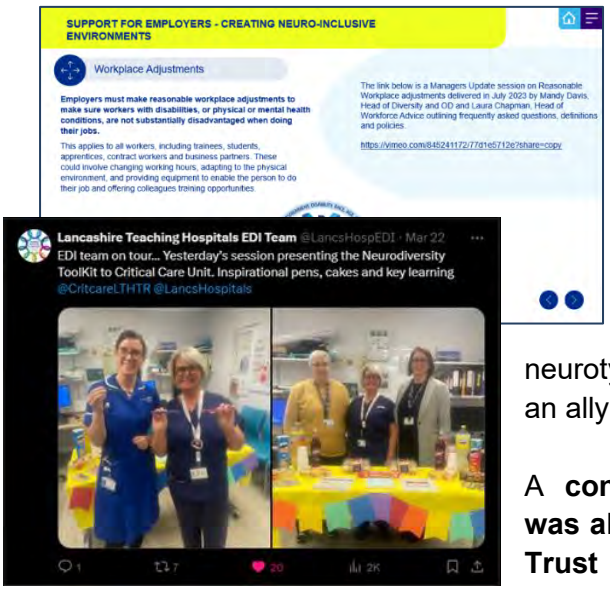
FOR COLLEAGUES

Some of the progress under this aim has already been reported under other aims including; delivery of the Equality Impact Assessment training for colleagues and teams who draft policies/guidelines and who scope service redesign or cost improvement programmes, our utilisation of Schwartz Rounds to focus on inclusion related topics such as Living and Working with a Long-term condition or Disability, the ongoing culture work which includes Sexual Safety and Civility with a strong and consistent focus on the impact of diversity and the relaunch of the Living Collection/Living Library.

GENERAL EDUCATION IN RESPECT OF DIVERSITY & INCLUSION



This year we have updated our **Core Skills Framework mandatory Equality, Diversity and Inclusion module** which needs to be completed by all colleagues, every 3 years. The aims of the module it relates to everyone's role, explore what constitutes discrimination and, understand how to be inclusive in respect of language including how microaggressions can exclude others. We have also updated our **Core People Management Skills** module in respect of Health and Wellbeing, to enable managers to understand how they can manage attendance in an inclusive and supportive way.



The **LTHTr Neurodiversity Toolkit** continues to be expanded and promoted widely across the organisation. It aims to; support us to become a more neuro-inclusive organisation, explore definitions of neurodiversity, help increase awareness of, destigmatise and celebrate neurodiversity whilst taking steps to accommodate challenges that neurodiverse individuals face, all of which will hopefully help neurotypical colleagues understand how they can act as an ally for neurodivergent colleagues and patients.

A **continuing professional development session was also recently held for all educators across the Trust** to support them in developing their knowledge

and understanding of Neurodiversity in Education. The first part of the session was titled “Adaptations to Teaching in a Neurodiverse Classroom” and introduced key concepts of neurodiversity focusing on conditions such as autism, ADHD and dyslexia. Those attending learned about the strengths and challenges of neurodivergent individuals and how they could adapt teaching strategies to support their learning needs. The next segment “The Big 3 - Understanding Anxiety, Depression and Stress” explored how these health challenges impact personal and professional life and provided some strategies for managing symptoms. The final section was about listening to the lived experiences of learners in our organisation, with a panel type discussion so learners could share their views and educators could ask questions in a safe and respectful space.

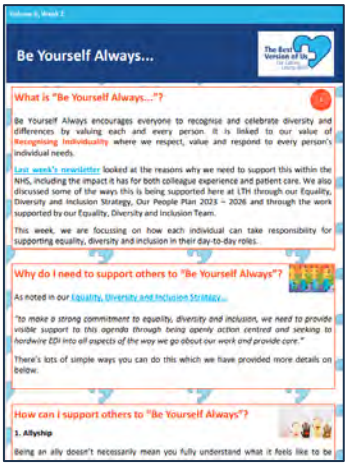
In response to the nationwide riots in late summer following the tragic murder of three young girls in Southport, we rapidly developed a **“Being an Ally” toolkit** in response to queries from colleagues asking how they could provide greater support to other team colleagues/friends who were being targeted as a result of the ensuing Islamophobia and hate from some people within the community. The toolkit explores where colleagues are currently on the Ally Continuum, looks at what it is to be an Ally and signposts how people can demonstrated allyship to different minority groups.

In conjunction with the **Endometriosis Awareness** group a series of resources have been developed (or collated) to aid greater understanding of the condition as it affects 1 in 10 people assigned female at birth and we have a predominantly female workforce (75%). Intranet pages have been developed as a central place of access, containing links to; colleague stories, web links to specialist support sites or related news articles/videos, posters which can be displayed within work areas and a reading list.

The **All Colleague and Leader briefings**, introduced by Silas (CEO) at the start of this year provide opportunities to hear from Silas and Executive team colleagues on some of the strategic issues or challenges facing our Trust and the wider NHS as a whole. Each session provides space for us to focus on our people i.e. our workforce, and over the year we have had the opportunity to talk with our colleagues, managers and leaders about the following EDI related topics; Workforce Race Equality Standard results, Workforce Disability Equality Standard results, Staff Inclusion forums, AntiRacist Framework, updating ESR to share their disability/long term condition status, Zero Tolerance approach, and Disability History month.

IMPROVED EXPERIENCE FOR COLLEAGUES WITH PROTECTED CHARACTERISTICS

We have continued to maintain our focus on supporting all colleagues to take a **Zero-Tolerance approach** towards negative behaviours and abuse. This was originally launched through the **Best Version of Us newsletters**, linked to the cultural behaviour Call It Out and our organisational value of Taking Personal Responsibility. In the last 12 months we have designed and created a Zero-Tolerance Toolkit for colleagues which is accessible via our intranet and to date, this has been accessed by 144 colleagues, and viewed 685 times, and a total of 65 colleagues have attended the live training session for this content. This was initially delivered as two separate sessions (one focusing on the responsibility of all colleagues, and the other aimed at all leaders), however it was subsequently felt it would be valuable to combine the messaging to support awareness and professional development. The aims of this combined session are to support all colleagues to understand their personal responsibilities towards upholding a Zero-Tolerance approach towards abuse; this includes reviewing our organisational approach to zero-tolerance and how we encourage all colleagues to take this approach in their day-to-day work and exploring leadership responsibilities to support zero-tolerance in their teams.



The content developed last year in respect of "**Banter – When it's definitely not a laughing matter**" has been woven into the presentations relating to Civility

LEADERSHIP AND MANAGEMENT SKILLS

We have continued to support education and communication in respect of **Workplace Adjustments**; supporting managers and leaders to understand their responsibilities and requirements in line with legislation, our Supporting Disability in the Workplace policy and our Trust Values. A member of the EDI team has been nominated as first line support for workplace adjustment requests or queries and we have detailed a pathway for colleagues and line managers to follow if they require (or require support with) the procurement of equipment to support workplace adjustments.

As already noted, the figures for the last 3 years show a steady increase in the number of colleagues completing staff survey, who are reflecting that they have been supported in the establishment of workplace adjustments 78.3% in 2023, 75.1% in 2022, 72.6% in 2021 which is progressing in the right direction.

Noted earlier in this report, two years ago we incorporated a health and wellbeing section into appraisals which provides space for colleagues to record whether they have a Supporting Disability or LTC Agreement (SDA) in place or whether they need one, but do not have one. 76% of colleagues completed the question in appraisal to indicate whether they had an SDA in place (4%) whether they didn't need one (69%) or whether they needed one but didn't have one (3%).

Further work needs to be undertaken to; ensure those colleagues who need a conversation in respect of supporting disability at work are supported to have the conversation, to reduce the percentage of appraisals were the field is left blank and to assess the quality of the SDA conversations/agreements which have taken place.

Our monthly **Manager's Update sessions** are a way of us keeping our leaders and managers up to date on everything they need to know to support them in managing their teams effectively. The 90-minute long sessions provide; guidance, regular updates on policy related matters, opportunities to ask questions from topic specialists and signpost where leaders and managers can go for further training, support or help. Over the last year there have been a range of topics which relate to areas already discussed and highlighted within his report, including; Supporting Sexual Safety in the Workplace, Appraisal, Supporting your Team's Wellbeing, Flexible Working, Reasonable Workplace Adjustments, creating a Culture of Civility and Kindness and more. Sessions are really well attended with numbers in excess of 100 managers regularly attending.

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

EDI Colleagues from across Lancashire & South Cumbria ICS have assembled to explore ways in which we can work more collaboratively for collective benefit, particularly as a means of gaining some pace and traction in respect of particular programmes of work. A number of projects were identified at the end of 2023 and which we are still progressing as we come to the end of 2024, these are;

- **Cultural Awareness** – content for the proposed online learning package has been collated, it will be given to the Blended Learning team to create as a module which can be shared across all organisations in the ICS.
- **Reasonable Adjustments** – East Lancs have created a business case for someone to assist with Reasonable Adjustments, some organisations are finding that colleagues are on long term sick as they are unable to secure workplace adjustments to support their return to work.
- **Inclusive Recruitment** – work already undertaken/resources already developed, have been gathered.
- **Delivering on Anti-Racism**
- **Staff Network Chair Development** – three sessions have been delivered in 2024, the Northwest Leadership Academy have commissioned sessions to support this work, further information will be shared in February 2025.
- **Reciprocal Mentoring** – this project paused for a period of time as the lead was on long term sickness absence. Lancashire & South Cumbria FT have re-launched their Reciprocal Mentoring Scheme, it is hoped they will be able to share resources across the wider ICS to enable this project to recommence.

FOR PATIENTS

Last year saw the creation of the **Patient Experience Champion role** within all departments and areas across the organisation. The results of this have been welcomed with over 170 champions trained and supported in involvement services and leading on improvements within their area. They have empowered other colleagues by driving forward our support services and ensuring their areas are up to date with all resources, activities and information. The momentum has been kept up with regular meetings, patient stories to inspire and sharing of all the good work that has been actioned. Celebrating work within the individual areas has proved a big inspiration for staff and enables our patients to benefit from all services, as the knowledge is shared throughout the Trust. This role also makes a real difference by providing an individual to speak to straight away and thus improving the patient/carer experience by dealing with issues instantly.

The organisation is committed to bringing about change through **education and training**, and within the past 12 months has developed two eLearning packages to resolve concerns through local resolution to prevent these from becoming formal complaints. Of course patients have the right to complain as part of the Health and Social Care Act and the Trust has also developed a **Complaints Handling eLearning package** to support colleagues in responding to complaints and reaching the best possible outcome as well as demonstrating learning and clear leadership.

We have had **3 national surveys** this year and as a result of this implemented divisional and Trust wide meetings to ensure that the results from what our patients have said are reflected in upon and action taken. These plans are monitored on a monthly basis to ensure that future surveys and feedback is improved.

OUR FUTURE COLLEAGUE FOCUS

- Create a series of micro-learning modules to support knowledge development, and to increase the confidence, of colleagues and line managers in relation to equality, diversity and inclusion across the organisation.
- Revisit our Trust Values and Leadership in Lancs Framework behaviours, making more explicit reference to inclusive behaviours which honour and further embed the culture work including aspects such as sexual safety.
- Foster a restorative, just and learning culture by integrating learning from concerns and complaints made by colleagues into the organisation's learning to improve processes.
- Continue to ring fence a proportionally representative percentage of accredited (e.g. Institute of Leadership and Management Level 2, Consultant Leadership Development etc.) non-accredited (e.g. Continuous Improvement Programmes, Core People Management Skills, Senior Leadership Development etc.) taught programmes for colleagues with protected characteristics.
- Deliver Equality Diversity Representatives training to colleagues to support recruitment, performance, disciplinary and grievance processes Develop and deliver a comprehensive induction, onboarding and development programme for internationally educated colleagues which encompasses both professional and pastoral support.

- Quality assure the completion of Supporting Disability in the Workplace agreements to determine the effectiveness of the conversation and resulting workplace adjustments with colleagues who have an identified long-term condition or disability.
- Work with EDI colleagues across Lancashire & South Cumbria to finalise and share the agreed collaborative projects.

OUR FUTURE PATIENT FOCUS

- To foster a restorative, just and learning culture by integrating learning from concerns and complaints made by patients, families and carers into the organisations learning to improve processes.
- Improve compliance in relation to training for the PALs and Complaints training
- Improve the national inpatient and urgent and emergency care savers with delivery of the action plans
- Explore the use of social media to more proactive and less reactive to support education for patients
- Develop a new Patient Experience Strategy

FINANCIAL IMPLICATIONS

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

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

LEGAL IMPLICATIONS

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

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

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

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

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

RISKS

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

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

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

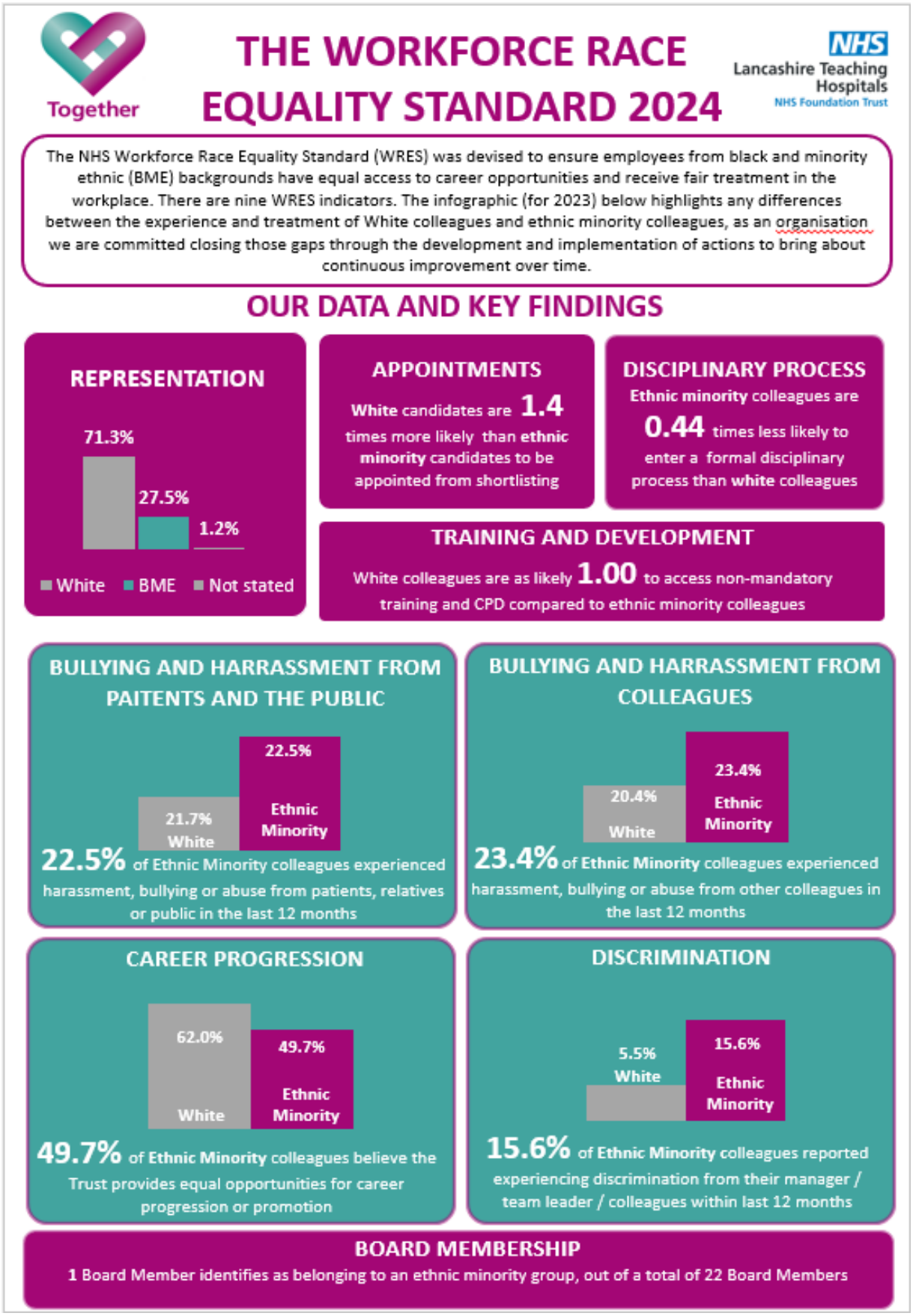
IMPACT ON STAKEHOLDERS

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

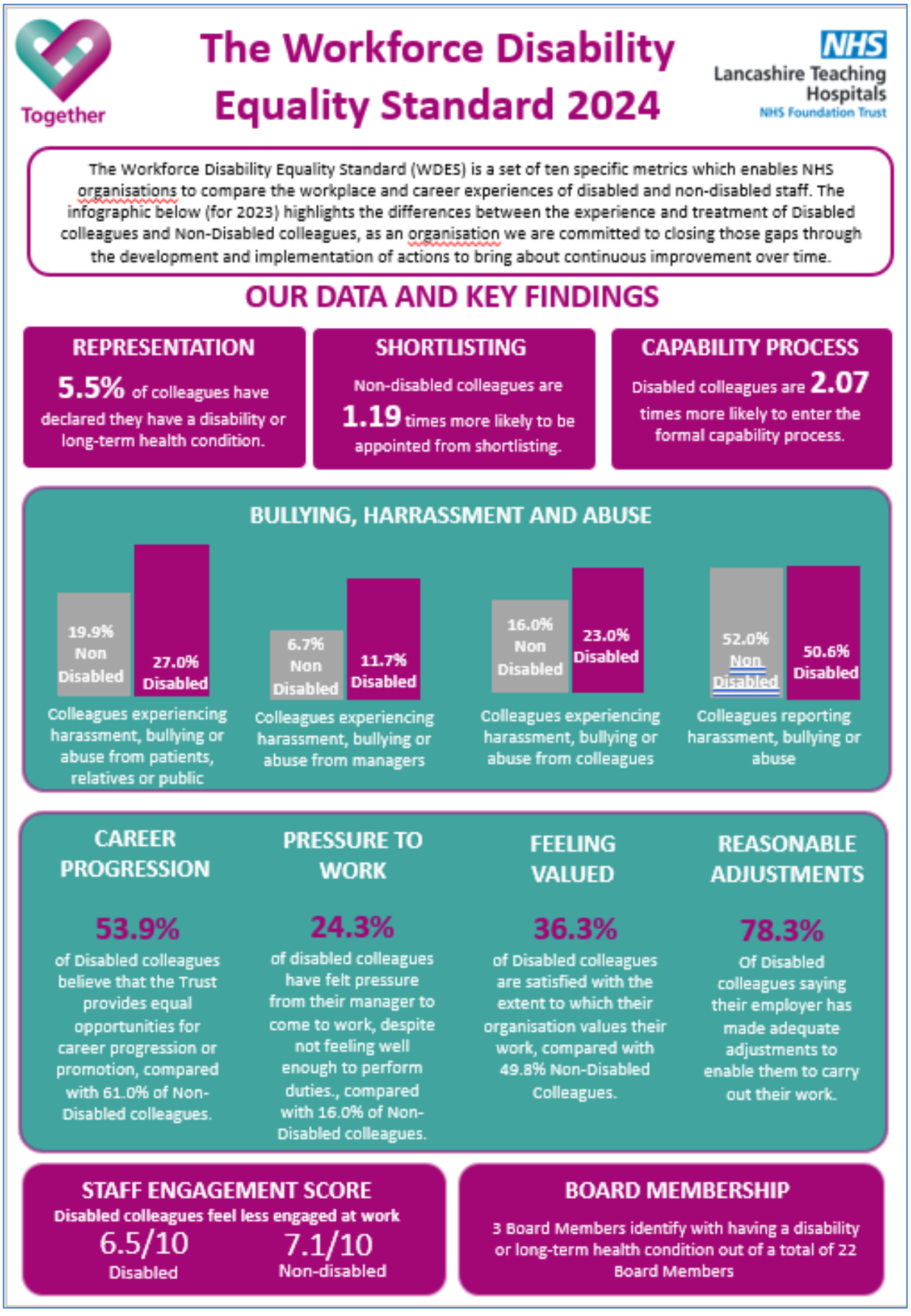
RECOMMENDATIONS

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

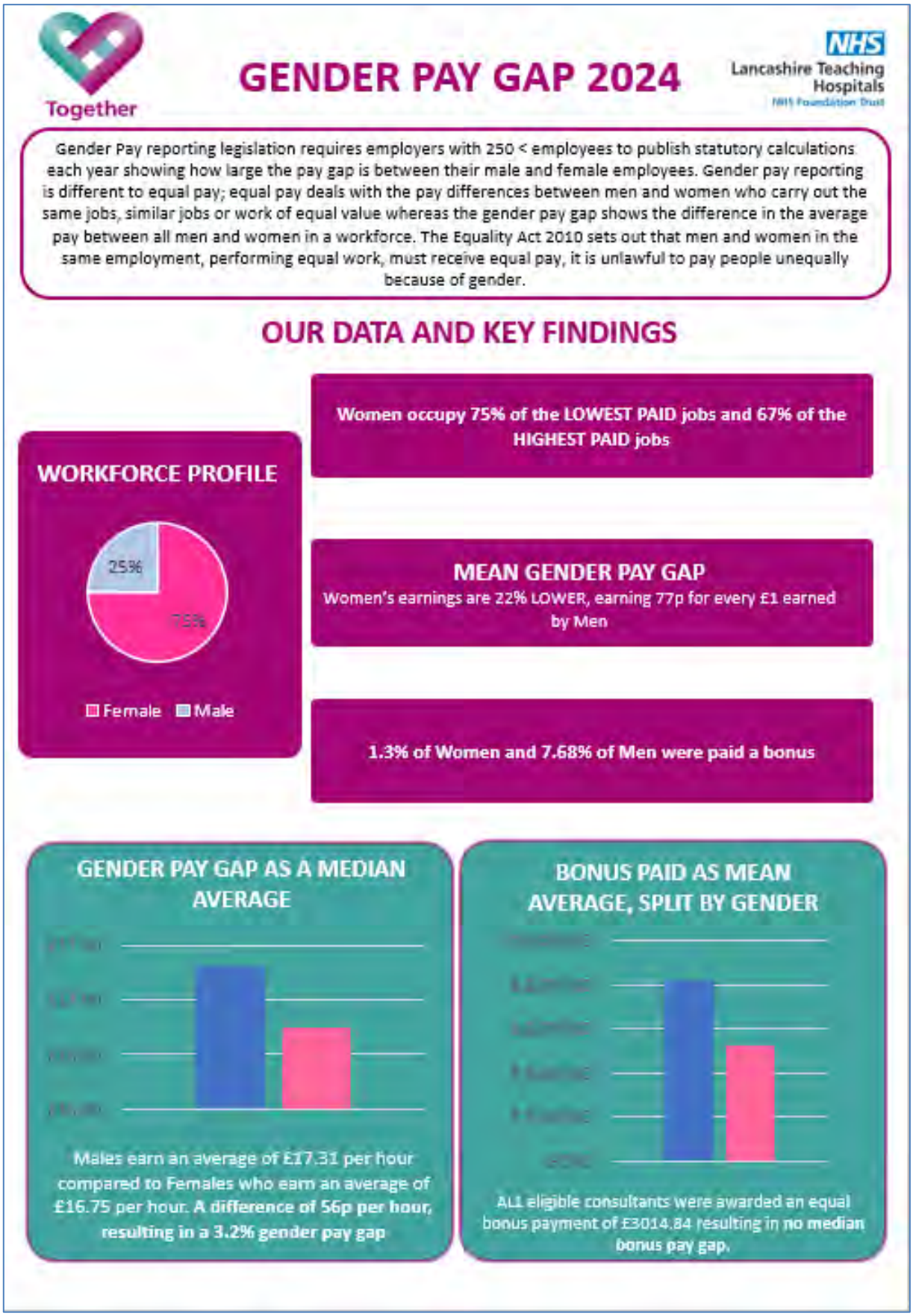
APPENDIX 1


Together
THE WORKFORCE RACE EQUALITY STANDARD 2024
NHS
Lancashire Teaching Hospitals
NHS Foundation Trust
The NHS Workforce Race Equality Standard (WRES) was devised to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. There are nine WRES indicators. The infographic (for 2023) below highlights any differences between the experience and treatment of White colleagues and ethnic minority colleagues, as an organisation we are committed closing those gaps through the development and implementation of actions to bring about continuous improvement over time.
OUR DATA AND KEY FINDINGS
REPRESENTATION
71.3%
27.5%
1.2%
White
BME
Not stated
APPOINTMENTS
White candidates are 1.4 times more likely than ethnic minority candidates to be appointed from shortlisting
DISCIPLINARY PROCESS
Ethnic minority colleagues are 0.44 times less likely to enter a formal disciplinary process than white colleagues
TRAINING AND DEVELOPMENT
White colleagues are as likely 1.00 to access non-mandatory training and CPD compared to ethnic minority colleagues
BULLYING AND HARRASSMENT FROM PAITENTS AND THE PUBLIC
22.5%
Ethnic Minority
21.7%
White
22.5% of Ethnic Minority colleagues experienced harassment, bullying or abuse from patients, relatives or public in the last 12 months
BULLYING AND HARRASSMENT FROM COLLEAGUES
23.4%
Ethnic Minority
20.4%
White
23.4% of Ethnic Minority colleagues experienced harassment, bullying or abuse from other colleagues in the last 12 months
CAREER PROGRESSION
62.0%
White
49.7%
Ethnic Minority
49.7% of Ethnic Minority colleagues believe the Trust provides equal opportunities for career progression or promotion
DISCRIMINATION
5.5%
White
15.6%
Ethnic Minority
15.6% of Ethnic Minority colleagues reported experiencing discrimination from their manager / team leader / colleagues within last 12 months
BOARD MEMBERSHIP
1 Board Member identifies as belonging to an ethnic minority group, out of a total of 22 Board Members

APPENDIX 2


Together
The Workforce Disability Equality Standard 2024
NHS
Lancashire Teaching Hospitals
NHS Foundation Trust
The Workforce Disability Equality Standard (WDES) is a set of ten specific metrics which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The infographic below (for 2023) highlights the differences between the experience and treatment of Disabled colleagues and Non-Disabled colleagues, as an organisation we are committed to closing those gaps through the development and implementation of actions to bring about continuous improvement over time.
OUR DATA AND KEY FINDINGS
REPRESENTATION
5.5% of colleagues have declared they have a disability or long-term health condition.
SHORTLISTING
Non-disabled colleagues are 1.19 times more likely to be appointed from shortlisting.
CAPABILITY PROCESS
Disabled colleagues are 2.07 times more likely to enter the formal capability process.
BULLYING, HARRASSMENT AND ABUSE
19.9% Non Disabled
27.0% Disabled
Colleagues experiencing harassment, bullying or abuse from patients, relatives or public
6.7% Non Disabled
11.7% Disabled
Colleagues experiencing harassment, bullying or abuse from managers
16.0% Non Disabled
23.0% Disabled
Colleagues experiencing harassment, bullying or abuse from colleagues
52.0% Non Disabled
50.6% Disabled
Colleagues reporting harassment, bullying or abuse
CAREER PROGRESSION
53.9%
of Disabled colleagues believe that the Trust provides equal opportunities for career progression or promotion, compared with 61.0% of Non-Disabled colleagues.
PRESSURE TO WORK
24.3%
of disabled colleagues have felt pressure from their manager to come to work, despite not feeling well enough to perform duties., compared with 16.0% of Non-Disabled colleagues.
FEELING VALUED
36.3%
of Disabled colleagues are satisfied with the extent to which their organisation values their work, compared with 49.8% Non-Disabled Colleagues.
REASONABLE ADJUSTMENTS
78.3%
Of Disabled colleagues saying their employer has made adequate adjustments to enable them to carry out their work.
STAFF ENGAGEMENT SCORE
Disabled colleagues feel less engaged at work
6.5/10
Disabled
7.1/10
Non-disabled
BOARD MEMBERSHIP
3 Board Members identify with having a disability or long-term health condition out of a total of 22 Board Members

APPENDIX 3


Together
GENDER PAY GAP 2024
NHS
Lancashire Teaching Hospitals
NHS Foundation Trust
Gender Pay reporting legislation requires employers with 250 < employees to publish statutory calculations each year showing how large the pay gap is between their male and female employees. Gender pay reporting is different to equal pay; equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value whereas the gender pay gap shows the difference in the average pay between all men and women in a workforce. The Equality Act 2010 sets out that men and women in the same employment, performing equal work, must receive equal pay, it is unlawful to pay people unequally because of gender.
OUR DATA AND KEY FINDINGS
WORKFORCE PROFILE
25%
75%
Female
Male
Women occupy 75% of the LOWEST PAID jobs and 67% of the HIGHEST PAID jobs
MEAN GENDER PAY GAP
Women's earnings are 22% LOWER, earning 77p for every £1 earned by Men
1.3% of Women and 7.68% of Men were paid a bonus
GENDER PAY GAP AS A MEDIAN AVERAGE
Males earn an average of £17.31 per hour compared to Females who earn an average of £16.75 per hour. A difference of 56p per hour, resulting in a 3.2% gender pay gap
BONUS PAID AS MEAN AVERAGE, SPLIT BY GENDER
ALL eligible consultants were awarded an equal bonus payment of £3014.84 resulting in no median bonus pay gap.

13. GOVERNANCE AND COMPLIANCE

13.1 SCHEME OF RESERVATION AND DELEGATION

Decision Item | J Foote | 15.40

REFERENCES

Only PDFs are attached

13.1 - Review of Scheme of Reservation and Delegation - SoRD.pdf

Board of Directors

Review of Scheme of Reservation and Delegation (SoRD)			
Report to:	Board of Directors	**Date:**	6 February 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	J Foote

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

Executive Summary:

The purpose of the report is to consider a revised and redrafted SoRD for adoption and to approve the relation of the authority limits schedule to be an annex of the Standing Financial Instructions.

The Board is asked to
1. review the SoRD and if so minded approve it for adoption;
2. approve the relocation of the authority limits document, as set out as an appendix to the report, as an annex to the SFIs

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

EMT 27 January 2025

1. Introduction

A review of corporate governance documentation was undertaken externally in October. It was noted that the SoRD was drafted as an instrument of financial governance, rather than setting out the delegations from the Board of Directors. An action was taken to review and redraft to ensure compliance.

2. Background

A scheme of delegation usually sits with the Standing Orders of the Board as part of the raft of framework documents guiding the corporate governance of the Trust. The SoRD currently in use by the Trust is more reflective of the authority and limitations on spending limits. These are necessary but sit more easily as an annex to the Standing Financial Instructions (SFIs).

The SoRD was redrafted and is presented to Board for adoption. A review of the SFIs is also ongoing but is proving to require a more in-depth review than initially anticipated. Whilst this review is ongoing it is proposed to publish the current authority limits as an annex to the SFIs so that they are not lost to the organisation and continue to be live during the SFI review. No changes have been made to any financial limit but some references found to be in duplication of statements elsewhere have been removed from the version attached.

In addition the revised SoRD makes it explicitly clear that delegated authority cannot generally be delegated onwards and must instead revert upwards. This was a recommendation from a recent internal audit report.

Specific reference is made to the powers in vested in the NHP Assurance Committee. A steer is required from the Board as to whether this committee is merely stood down or whether it is dis-established. The SoRD will be updated to reflect this steer.

3. Financial implications

No additional resource required.

4. Legal implications

The SoRD is a required governance document.

5. Risks

The clarity of delegation as now set out in the SoRD allows for a transparency of application of corporate governance. The new SoRD and the newly published authority limits will need to be the subject of a clear comms campaign to ensure that all staff are aware of their responsibilities under both documents.

6. Impact on stakeholders

It is important for staff to be aware of the contents of both the SoRD and the SFIs as failure to comply could result in disciplinary action.

7. Recommendations

The Board is asked to

1. review the SoRD and if so minded approve it for adoption;
2. approve the relocation of the authority limits document, as set out as an appendix to the report, as an annex to the SFIs

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

1. INTRODUCTION

1.1 The Standing Orders for the Board of Directors sets out the arrangements for the Board of Directors' exercise of functions by delegation.

1.2 The purpose of this document is to clarify the powers reserved to the Board – generally matters for which it is held accountable to NHS England. The Board remains accountable for all its functions, even those delegated to individual Executive Directors and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.3 Authority ultimately rests with the Board of Directors and may revert at any time at the discretion of the Board.

1.4 Authority delegated by the Board of Directors to any other board, committee or individual may not be delegated on by them (other than in the capacity of an officer acting in the absence of another and as explicitly allowed for) unless specifically allowed by statute.

Role of the Chief Executive

1.5 The Chief Executive shall exercise all powers of the Trust, which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee, on behalf of the Board. The Chief Executive may nominate other Executive Directors to make decisions under these powers in to facilitate the exigencies of the service unless they are specifically reserved by the Board for the CEO alone.

Caution over the use of delegated powers

1.6 Powers are delegated to Executive Directors on the understanding that they will not exercise delegated powers in a matter that in their judgment is likely to be a cause for public concern.

Executive Directors' ability to delegate their own delegated powers

1.7 Authority is delegated from the Board and may not be delegated onwards.

Absence of Executive Directors to whom powers have been delegated

1.8 In the absence of an Executive Director to whom powers have been delegated, those powers shall be exercised by that director's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to them may be exercised by the Deputy Chief Executive or an Executive Director in the role of acting Chief Executive (as expressly appointed to by the Board).

Role of the Council of Governors

1.8 The role of the Council of Governors is set out in statute and articulated in the Trust Constitution. The Council of Governors has no authority to delegate any of its powers.

Role Of Non-Executive Directors

1.9 The role of non-executive directors is to provide oversight and assurance collectively as part of a unitary board. Individual non-executive directors carry no delegated authority unless expressly set out in this scheme of delegation.

2. RESERVATION OF POWERS TO THE BOARD

Accountability

2.1 The Code of Governance for Provider Trusts which has been adopted by the Foundation Trust requires the Board of Directors to determine those matters on which decisions are reserved for itself. Board members share corporate responsibility for all decisions of the Board. These reserved matters are set out below.

General enabling provision

2.2 The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

2.3 The following matters have been reserved to the Board:

Regulation and control

2.3.1 To ensure that the Trust works within the terms of its licence, its Constitution, mandatory guidance issued by NHS England, relevant statutory requirements and contractual obligations.

2.3.2 To approve the Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business.

2.3.3 To approve the Terms of Reference of Committees of the Board, such terms to include as appropriate, the delegation of powers from the Board to committees.

2.3.4 To approve arrangements for dealing with complaints.

2.3.5 To adopt the senior management structure to facilitate the discharge of business by the Trust and to agree modifications thereto.

2.3.6 To receive reports from committees including those which the Trust is required by NHSE or other regulation to establish and to take appropriate action thereon.

2.3.7 To confirm the recommendations of the Trust's committees where the committees do not have executive powers.

2.3.8 To ratify any urgent decisions taken on behalf of the Board by the Chair and the Chief Executive in accordance with Standing Orders.

2.3.9 To approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust within current legislation and the regulatory framework of the Charities Commission.

2.3.10 To approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2.3.11 To approve the Annual Governance Statement.

2.3.12 To approve the division of responsibilities between the Chair and Chief Executive.

2.3.13 To suspend, vary or amend Standing Orders.

2.3.14 To approve the Board Assurance Framework.

Appointments and dismissals

2.3.15 The Board shall appoint a Non-Executive Director to act as Vice Chair

2.3.16 The Non-Executive Directors of the Board shall appoint the Chief Executive Officer

2.3.17 The Non-Executive Directors of the Board and the CEO shall appoint Executive Directors

2.3.18 The Board shall appoint the Company Secretary.

Policy determination

2.3.19 To approve and review periodically, policies which have wide ranging strategic and/or financial and/or probity implications for the Trust and are fundamental to the Trust's business.

2.3.20 To ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of code of conduct, and other ethical concerns.

Strategy, business plans and budgets

2.3.21 To approve budgets.

2.3.22 To approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature in accordance with the limits set within the Standing Financial Instructions or within any limits or lock mechanisms as may be imposed by NHSE from time to time.

2.3.23 To define the strategic aims and objectives of the Trust.

2.3.24 To approve the Trust's annual business plan and 3 year strategic business plan.

2.3.25 To approve and monitor the Trust's structure and arrangements for the management of risk, including statutory compliance.

2.3.26 To approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by NHSE or other regulatory body.

2.3.27 To approve investments in other organisations including acquisitions and mergers.

2.3.28 To approve any proposal to materially alter the specification or means of provision of any commissioner requested service (subject to compliance with the Trust's licence).

2.3.29 To approve the Trust's capital programme and subsequent amendments in line with the Standing Financial Instructions.

2.3.30 To approve private finance initiative (PFI) proposals.

2.3.31 To approve business cases for the introduction or discontinuance of any significant activity or operation (with gross annual income or expenditure at the level set out in the Standing Financial Instructions).

Financial and performance reporting arrangements

2.3.32 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees, associate directors and officers of the trust as set out in management policy statements. All monitoring returns required by the Integrated Care Board, NHS England and the Charity Commission shall be reported, at least in summary, to the Board.

2.3.33 To approve banking arrangements.

Audit arrangements

2.3.34 The appointment (and where necessary dismissal) of the internal auditors.

2.3.35 To receive the annual management letter received from the external auditor and agree the proposed action, taking account of the advice, where appropriate of the Audit Committee.

2.3.36 To approve the appointment (and where necessary dismissal) of external auditors for the separate audit of funds held on trust (charitable funds).

2.3.37 To receive an annual report from the internal auditor and agree action on recommendations where appropriate of the Audit Committee.

Direct operational decisions

2.3.38 To approve proposals for the disposal of, or relinquishing of control over, any relevant asset (subject to compliance with the Trust's licence).

2.3.39 To approve proposals for the acquisition, disposal or change of use of land and/or buildings:
i. in line with guidance issued by NHS England; and
ii. where the disposal involves disposal of a relevant asset, subject to compliance with the Trust's licence.

2.3.40 To approve losses and compensations at the levels set out in the Standing Financial Instructions.

2.3.41 To approve severance payments in line with relevant HM Treasury guidance.

2.3.42 The discharge of functions as trustees with regard to the charitable funds held by the Trust, in accordance with the requirements of the Charity Commission.

2.3.43 To approve all loans including the working capital facility, and major finance leases at the limits set out in the Scheme of Delegation.

2.3.44 To approve the use of assets that are not "relevant assets" as security for a loan.

2.3.45 To approve income and expenditure in excess of the financial limits set out in the Standing Financial Instructions.

Annual report and accounts

2.3.46 To receive and approve the Foundation Trust's annual report and annual accounts prior to being laid before Parliament.

2.4 The powers retained to itself by the Board as set out in Standing Orders may in emergency be exercised by the Chair in conjunction with the CEO.

3. DELEGATION OF POWERS

Delegation to committees

3.1 The Board of Directors may determine that certain of its powers shall be exercised by standing committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors, in accordance with Standing Orders The membership of any committee with delegated authority shall comprise only of voting directors of the Board.

3.1.1 **ARTE Committee**: The appointment and removal of executive directors; the remuneration of those posts within the trust designated as very senior managers (Executive Management Team); the terms and conditions of employment of the same.

3.1.2 **Audit Committee**: Matters relating to the oversight of risk, control and assurance of the organisation, with the authority to obtain legal or other independent advice without the approval of or reversion to the Board of directors..

3.1.3 **New Hospitals Programme Committee**: delegated authority as set out in the scheme of delegation for the New Hospitals Programme Committee, including but not limited to the approval of associated business cases, contract approval, expenditure levels; acquisition and disposal of land. These delegations shall remain in operation for the duration of the New Hospitals Programme and shall revert to the Board should the NHP cease or a moratorium be placed on its operation.

3.1.4 **Finance and Performance Committee**: the approval of policies as they may relate to the terms of reference of the committee.

3.1.5 **Safety and Quality Committee**: the approval of policies as they may relate to the terms of reference of the committee.

3.1.6 **Charitable Funds Committee:** management and oversight of matters relating to the exercise of the Trust's role as a charitable trustee, including the investment of charitable funds and approval of charitable donations.

Delegation to the Provider Collaborative Board (as a Joint Committee)

3.2 The Board of Directors may determine that certain of its powers shall be exercised by the Provider Collaborative Board (PCB) as a Joint Committee. Such powers shall be articulated in the Terms of Reference of the PCB and may be rescinded by the Board on its sole determination at any time.

Delegation to Trust Management Board

3.3 The Trust Management Board being the highest collective level of management authority within the Trust shall: approve business cases in line with levels as set out in Standing Financial Instructions; approve policies as may be decided by the Board of Directors from time to time.

3.4 For the exigency of the service any authority delegated to the TMB may revert to the CEO at his discretion.

Delegation to the CEO as Accounting Officer

3.5 The responsibilities of the CEO as Accounting Officer are defined through the Foundation Trust Accounting Officer memorandum.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/451565/NHS_Foundation_Trust_Accounting_Officer_Memorandum.pdf

3.6 The CEO and Trust Chair shall be delegated to sign the Annual Report and Accounts on behalf of the Trust.

Delegation to the Chief Finance Officer

3.6 The CEO shall delegate the day-to-day management responsibility for the following functions to the Chief Finance Officer. However, as Accounting Officer the CEO retains responsibility for the overall organisation, management and staffing of the Foundation Trust and for its procedures in financial and other matters.

3.7 The Accounting Officer (CEO) may delegate to the Chief Finance Officer the authority to vary or suspend any financial control mechanism in response to budgetary constraints, financial management requirements or direction for the ICB/NHSE. Such changes or variations shall be recorded, including the duration of the variation.

Deputy CEO

3.8 A member of the Executive Management Team designated as the DCEO may carry out any of the functions delegated to the CEO in the short absence of the CEO.

3.9 If the CEO is absent for a period of time longer than 6 weeks the Board shall expressly delegate a member of the Executive Management Team to act as Interim CEO.

Delegation Under Regulatory Requirements

3.10 The following individuals are delegated to act in the associated regulatory capacity:

3.10.1 **Caldicott Guardian:** The Chief Medical Officer shall be responsible for the protection of health and care information as required under the Caldicott principles.

3.10.2 **CQC Nominee:** The Chief Nursing Officer shall ensure compliance with the Health and Social Care Act 2008 (CQC nominated individual)

3.10.3 **SIRO:** The Directors of Corporate Affairs shall have overall responsibility for Information Risk across the Trust.

Other Delegations

3.11 Authority to bind the organisation contractually or allocate financial resource is given to named roles or levels of role within the organisation and is as set out in the Standing Financial Instructions,

3.12 The Director of Corporate Affairs and the Head of Legal and Claims shall instruct on all legal issues for the Trust.

3.12 The Director of Corporate Affairs or the Deputy Chief Executive Officer shall be the authorised signatory in respect of the initiation or defence of legal proceedings as they relate to the Trust.

3.13 The Chief Nursing Officer shall be the authorised signatory for Court documents for clinical negligence claims.

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
1. MANAGEMENT OF BUDGETS **1.1 Keep income and expenditure within budget**						
1.1.1 At individual budget level						✓
1.1.2 For the totality of budgets supervised by a budget supervisor					✓	
1.1.3 For the totality of services managed by a chief officer				Chief officer		
1.1.4 For the totality of the Trust's services		✓				
1.2 Transfer income and expenditure from one budget to another Provided that: i. The proposed use of income and expenditure accords with the Trust's and directorates' business plans, ii. The directorate will be able to keep its revenue expenditure within budget, iii. The use of any savings which have occurred as a result of plans not being implemented have the approval of the Chief Executive, and :						
1.2.1 Within the budget holder's responsibility						✓+ Chief Executive for 3.2 (iii)
1.2.2 Between budget holders within the Budget Supervisor's responsibility					✓+ Chief Executive for 3.2 (iii)	
1.2.3 Between budget holders within the Directorate				Chief Officer + Chief Executive for 3.2 (iii)		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
1.2.4 Between Directorates				Chief Officer + Chief Operating Officer + Chief Executive for 3.2 (iii)		
1.3 Adjust income and expenditure budgets in respect of income generation schemes funded from non-NHS sources for:						
1.3.1 Net income up to and including £10,000 in any one year				Chief Officer		
1.3.2 Net income over £10,000 in any one year.			✓+ Chief Officer	Chief Officer + Finance Director		
1.3.3 Gross income over £50,000 in any one year			✓+ Chief Officer	Chief Officer + Finance Director		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
2. REQUISITIONING, ORDERING AND PAYMENT OF GOODS AND SERVICES FOR ALL REQUISITIONS, ORDERS AND PAYMENTS (all limits include all taxes) Provided that: i. funds are available, ii. the purchase is appropriate to the budget, iii. the purchase is in accordance with the business plan and contracts, iv. the order does not exceed a period of one year, v. if the requisition relates to leases or tenancy agreements, the Finance Director has been notified before making any commitment, vi. if the expenditure is capital, and is included within the approved capital programme, the approval of the appropriate delegated officer must be obtained, vii. if the expenditure is capital and is not included within the approved capital programme, the written approval of the Chief Executive to commit expenditure and, if appropriate, to proceed to tender has been obtained, viii. the necessary quotations or tenders and approval to the acceptance of the selected supplier have been obtained, and ix. the supplier has not offered any gifts, rewards or other benefits						
2.1 Authorise goods and services excluding capital and drugs	For finance leases					

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
2.1.1 Financial limits (all limits relate to the total costs over the term of the contract) and are subject to any overrides or additional locks as directed by NHSE	>£1,000,000*	Up to £1,000,000	Up to £500,000	Corporate and divisional directors including Operations Director of Finance up to £200,000 All other Chief Officers (including Clinical Directors, Senior Assistant Finance Director and General Managers) <£150,000 (CBM)	Budget supervisors (including Assistant Finance Directors) <£25,000 (SBM)	Budget holders <£10,000
2.2 Authorise drug expenditure		>£1,000,000	<£1,000,000	<£150,000 Chief Pharmacist	<£50,000 Senior Pharmacist	
2.3 Commit non-pay expenditure where there is no budget (subject to the provisos in section 2)		✓				
2.4 Accept goods on trial or loan (limits are based on cost to purchase and as defined in s.2.1) Provided that: i. the Trust is not committed to purchase the goods ii. all other requirements, such as health and safety and insurance have been satisfied iii. the Trust's procedures have been followed iv. the Finance Director has been informed v. if of a capital nature, the Director of Estates and Facilities has been informed (unless IT, when the Finance Director should be informed)		✓	✓	✓ Chief officer and finance director + Director of Estates and Facilities for 2.4(v)	✓ + Finance director + Director of Estates and Facilities for 2.4(v)	✓ Or operational managers up to specified limit + Finance Director + IT technical support manager for IT + Director of Estates and Facilities for 2.4(v)
2.5 Deal with bankruptcies and company liquidations			✓			

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
2.6 Purchase from petty cash				£50	£50	£50
2.7 Authorise contracts for expenditure and subsequent variations to contracts						
Financial limits as defined in section 2.1		✓	✓	✓ Chief Officer + Finance Director for Information Technology	✓ + IT technical support manager for Information Technology	✓ + IT technical support for Information Technology

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
Provided that: i. contacts over £5,000 are in writing, ii. contracts over £500,000 and in respect of building and engineering work are executed under the common seal, and contract has been approved by the Head of Procurement (except where exemption has been granted by the Head of Procurement e.g. works)				+ Finance Director for 2.0(v) + Delegated Officer for 2.0(vi) + Chief Executive for 2.0(vii) + approval of quotes and tenders via the procurement department and approval of contracts by the Head of Procurement	+ Finance Director for 2.0(v) + Delegated Officer for 2.0(vi) + Chief Executive for 2.0(vii) + approval of quotes and tenders via the procurement department and approval of contracts by the Head of Procurement	+ Finance Director for 2.0(v) + Delegated Officer for 2.0(vi) + Chief Executive for 2.0(vii) + approval of quotes and tenders via the procurement department and approval of contracts by the Head of Procurement

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
3. QUOTATION, TENDERING AND CONTRACT PROCEDURES (all limits include taxes)						
The following requirements for the purchase or sale of goods and/or services must be fulfilled unless the Trust, their purchasing agent or the Department of Health has arranged a contract: i. make the purchase or sale via the Trust's Procurement Manager, ii. obtain appropriate purchasing and service/product specification advice from the Head of Procurement at the outset of the decision to procure goods/services which will allow sufficient time for procurement to invite competitive quotes/tenders. The approval of the Chief Executive must be obtained if this advice is to be disregarded and iii. follow Public Procurement Regulations via the Procurement Department						
3.1.1 Request that the Procurement Department obtain at least 3 written quotes	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £10,000 up to £30,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1
3.1.2 Request that the Procurement Department obtain at least 3 written competitive tenders	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	Over £30,000 up to £100,000 via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
3.1.3 Comply with Public Procurement Regulations via the Procurement Department	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1	over £100,000 Via the Procurement Department and in accordance with conditions and limits set out in section 2.0 and 2.1
3.2 Open tenders in accordance with Trust Policy and Procedures All relevant officers who may be involved in the potential purchase of specific goods or services through a tendering process must sign a pre-tender declaration at the earliest opportunity and before the tender specification is drafted. *E-tendering route* For electronic tendering via the Procurement Department, tender documents returned are locked by the external e-tendering provider until the closing date and time. Nominated Trust Procurement Officer(s) have the authority to open submissions therefore making them visible for evaluation and scoring. The exception to this is where the estimated aggregate contract value exceeds £500,000, where the Nominated Trust Procurement Officer shall be required to seek approval from two Board Directors to proceed with: (a) the opening of submissions, and (b) the evaluation of the tender	>£500,000 Two Board Directors			<£500,000 Procurement Officer		
3.2.1 Capital expenditure through non e-tendering (based on pre tender estimate) * independent senior manager must not be from the originating department	>£500,000 Two Board Directors			<£500,000 Director of Estates and Facilities + Independent Senior Manager *		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
3.2.2 Revenue Income or Expenditure through non E Tendering route (based on pre tender estimate) * independent senior manager must not be from the originating department	>£500,000 Two Board Directors			<£500,000 Procurement Manager + Independent Senior Manager*		
3.3 Accept lowest tender or quotation for capital expenditure from the approved capital programme Provided that any excess is reported to the Board of Directors	Board of Directors: >£2,000,000 and > 25% in excess of the approved sum	<£2,000,000 and < 25% in excess of the approved sum	<£500,000 and <10% in excess of the approved sum + Director of Estates and Facilities			
3.4 Accept the lowest tender or quotation for revenue expenditure or the highest for revenue income (Financial Limits as defined in section 2.1)		✓	✓	✓ Chief Officer	✓	✓
3.5 Accept other than the lowest tender or quotation for revenue expenditure or the highest for revenue income Provided that there are good and sufficient reasons that are set out in a permanent record, copied to the Procurement Department and available to the auditor at any time.		>£100,000	<£100,000 + Chief Officer	<£10,000 Chief Officer		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
3.6 Accept other than the lowest tender or quotation for capital expenditure from the approved capital programme Provided that any excess is reported to the Board of Directors and there are good and sufficient reasons that are set out in a permanent record, copied to the Procurement Department and available to the auditor at any time.	Board of Directors: >£2,000,000 and >25% in excess of sum approved	<£2,000,000 and <25% in excess of sum approved	<£500,000 and <10% in excess of sum approved in capital programme + Director of Estates and Facilities			
3.7 Waive quotations and/or tenders Provided that the price paid or received is fair and reasonable as far as practicable, and i. The procurement manager is consulted ii. competition for building and engineering or construction and maintenance is not waived (other than in accordance with ESTATECODE) iii. There must be good and sufficient reasons that are set out in a permanent record, copied to the Procurement Department and available to the auditor at any time.		>£100,000 + advice from Procurement Manager	<£100,000 + advice from Procurement Manager	<£10,000 Chief Officer + advice from Procurement Manager		
3.8 Agree prepayments falling outside the approved financial procedures			✓			
3.9 Receive, endorse and ensure the safe custody of tenders				Relevant director		
3.10 Decision to re-tender if number of tenders returned were lower than those required by 5.1				Relevant director		
3.11 Decide the admissibility of tenders e.g. if late		✓				
3.12 Decide to accept a lower number of quotations and/or tenders than those detailed in 5.1		✓				

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
4 ENGAGEMENT OF NON-NHS AND BANK STAFF (All limits include all taxes) **4.1 Engage non-medical consultancy staff** Financial Limits as defined in section 2.1. Provided that: i. the guidance from the Audit Commission is followed ii. the requirements for non-pay expenditure are fulfilled (section 2.0) iii. those engaged are not classified as self-employed unless they meet the criteria (by asking the Finance Director) and have signed a contract		✓	✓	✓ Chief Officer + Chief Finance Officer where necessary as per 4.1 (iii)	✓ + CFOr where necessary as per 4.1 (iii)	✓ + CFO where necessary as per 4.1 (iii)
4.3 Book bank and agency staff Financial Limits as defined in section 4.1 Provided that the requirements for expenditure have been fulfilled (see Section 2.0)		✓	✓	✓ Chief Officer	✓	✓
5. AUTHORISATION OF DRUGS NOT LISTED ON FORMULARY **5.1 Prescribe drugs not listed on the Trust's formulary**				✓ Chief Pharmacist		
5.2 Add drugs to the Trust's formulary Provided that funds are available	Drugs and Therapeutics Committee					
5.3 Add drugs to the Trust's formulary where funds are not currently available		✓				
6. INCOME: SETTING FEES AND CHARGES **6.1 Set charges for patient services contracts**			✓ + Chief Officer			
6.2 Set all other prices Provided the Finance Director is consulted				Chief Officer + Finance Director		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
7.2 Authorise contracts for income and subsequent variations for patient services			✓			
7.3 Authorise contracts for income and subsequent variations for all other contracts Financial Limits as defined in section 4.1 Provided that the contracts are in writing, and contracts over £500,000 in respect of building and engineering work are executed under the common seal		✓	✓	✓ Chief officer	✓	✓
7.4 Sign tenancy agreements and extend leases in respect of accommodation for staff: 7.4.1 for not more than one year and within the agreed policies, procedures and prices 7.4.2 over £1,000 per month or for more than 1 year, provided that leases over 3 years are executed under common seal			Chief Finance Officer & Company Secretary	Director of Estates and Facilities		
7.5 Let premises to outside organisations for no more than one year, provided that the price has been agreed with the Chief Finance Officer				Director of Estates and Facilities		
7.6 Let premises to outside organisations for more than one year Provided that: i. the price has been agreed with the CFO ii. any change in use of the premises has been approved by the Board of Directors iii. for finance leases, the premises are not protected under the provider licence with NHS Improvement iv. leases over three years are executed under common seal	Board of Directors for 7.6(ii)	✓ + CFO	✓ + Chief Executive and Board of Directors for 7.6(ii)			
7.7 Set rent levels Provided that the Operations Director of Finance has been consulted				Director of Estates and Facilities		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
8. CONDEMNING AND DISPOSING OF ASSETS All limits include all taxes and are based on replacement value **8.1 Condemn obsolete, redundant or irreparable assets or assets which cannot be repaired cost effectively** Provided that: i. a written request from the Chief Officer has been received ii. appropriate technical advice has been received iii. a record, in a form approved by the Operations Director of Finance, is held iv. the Operations Director of Finance has been notified in accordance with the capital assets procedure and the losses, write-offs and special payments procedure where appropriate.		>£100,000	<£100,000 and For 8.1(iii) and (iv)	>£30,000 Director of Estates and Facilities + CFO for (iii) <£30,000 + CFO for (iii)		<£5,000 + Assistant Director of Financial Services +CFOfor (iv)
8.2 Condemn obsolete, redundant or out of date drugs Provided that: i. the appropriate records are held ii. the requirements of EL(97)22 for controlled drugs are followed iii. where appropriate, the procedure for losses, write-offs and special payments is followed		>£150,000		<£150,000 Chief Pharmacist		
9. LOSSES, WRITE-OFFS AND SPECIAL PAYMENTS Provided that relevant SFI has been considered			Ensure losses and special payments are reported to the Audit Committee			
10.4 All other losses and special payments		>£100,000	> £10,000 < £100,000	< £10,000		

Description	Board of Directors/ Chair/Committee	Chief Executive	Chief Finance Officer	Directors/senior managers		
				Chief Officer/ Director/Senior Manager	Budget supervisor	Budget holder
11. CAPITAL SCHEMES All limits include all taxes **11.1 Select architects, quantity surveyors, consultant engineers or other professional advisers within EU regulations**				Director of Estates and Facilities or Chief Information Officer		
11.2 Monitor and report financial progress on all capital schemes			✓ + Director of Estates and Facilities (Estates and medical equipment schemes) or Chief Information Officer (I.T. schemes)			
11.3 Approve the introduction of new schemes to, or the deletion of existing schemes from, the capital programme Provided that the cost can be contained within the approved capital programme and the changes are reported to the Board on a quarterly basis		>£1,000,000	<£1,000,000			
12.2 Negotiate arrangements regarding the administration of a will with executors and discharge them from their duty			>£150,000	Head of Charities up to £150,000		
14.5 Apply for temporary overdraft within the terms agreed with NHS England			✓			
14.6 Take out insurance policies			✓ + relevant director			
14.7 Approve business cases (based on gross annual income or gross annual expenditure) NB may be subject to additional lock procedures as imposed by NHSE	>£1,000,000 Board of Directors	<£1,000,000				
14.8 Engagement of Consultants (excluding capital projects)	<£50,000 Submit application for approval to NHS England		>£50,000			

14. ITEMS FOR INFORMATION

14.1 REGISTER OF INTERESTS

REFERENCES

Only PDFs are attached

14.1 - BOD Register of Interests - 30 January 2025.pdf

Board of Directors: Register of Interests – 30 January 2025

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Name	Position	Declared Interest
NON-EXECUTIVE DIRECTORS		
Dr Tim Ballard	Non-Executive Director	• Care Quality Commission National Clinical Advisor for General Practice, Independent Primary Care, Digital Health and Environmental Sustainability • GP locum at Slaidburn Country Practice • Chair of the Brabin's Trust • Fellow of the Royal College of General Practitioners
Ms Victoria Crorken	Non-Executive Director	• Director of Lancashire Hospitals Services (LHS) Ltd • Senior Security, Compliance and Resilience Manager at the Co-op Group Ltd
Professor Paul O'Neill	Vice Chair/Non-Executive Director	• Emeritus Professor at University of Manchester • General Medical Council Associate – Medical Education
Mr Uzair Patel	Non-Executive Director	• Natwest Group employee • Trustee of Torus Foundation • Director of Papa Love Mango Limited (non-trading company) • Director of Pehlwani Limited (non-trading company)
Ms Kate Smyth	Non-Executive Director	• Lay Leader at the Yorkshire and Humber Patient Safety Translational Research Centre • Member and volunteer at Calderdale and Huddersfield Foundation Trust • Spouse is a Non-Executive Director of East Lancashire Hospitals NHS Trust • Member of the Cabinet Office Disability Unit - North-West Regional Stakeholder Network • Co-chair of the Disabled NHS Directors Network • Member of the ICB People Board
Mr Mike Thomas	Chair	• Chair, NHSENW People Board • Chair, Lancashire & South Cumbria PCB • Deputy Chair, Westmorland and Furness Health and Wellbeing Board • Chair, Making Space
Mr Tim Watkinson	Non-Executive Director/Senior Independent Director	• Independent Member of the UK Statistics Authority's Audit and Risk Assurance Committee

Mrs Tricia Whiteside	Non-Executive Director	• Daughter working for North-West Ambulance Service • Member of the Integrated Care Board (ICB) Patient Involvement and Engagement Advisory Committee • Member of the Lancashire Constabulary Ethics Advisory Committee
EXECUTIVE DIRECTORS (VOTING BOARD MEMBERS)		
Ms Katie Foster-Greenwood	Chief Operating Officer	• No interests to declare
Ms Sarah Morrison	Chief Nursing Officer	• Son is a member of the Administrative Bank • Sister is Clinical Business Manager in the Women's and Children's Division • Trustee at St Catherine's Hospice
Mr Silas Nicholls	Chief Executive Officer	• Fiancée is Partner with Weightmans Solicitors LLP • Visiting Professor of the University of Bolton
Dr Geraldine Skailes	Chief Medical Officer	• No interests to declare
Mr David Stonehouse	Interim Chief Finance Officer	• Honorary Treasurer Age UK Norfolk
CORPORATE DIRECTORS (NON-VOTING BOARD MEMBERS)		
Mrs Ailsa Brotherton	Director of Continuous Improvement	• Honorary Professorial role at University of Central Lancashire • Honorary Clinical Professor at UCLAN • Co-Chair of the British Association of Parenteral & Enteral Nutrition Facility
Mrs Naomi Duggan	Director of Communications and Engagement	• Son is Regional Editor North-West at Newsquest
Mrs J Foote MBE	Director of Corporate Affairs	• Director of Lancashire Hospitals Services (LHS) Ltd
Dr Neil Pease	Chief People Officer	• No interests to declare

14.2 MEMBERSHIP STRATEGY 2025-28

REFERENCES

Only PDFs are attached

14.2 - Board - Membership Strategy Report - NC.pdf

Board of Directors Report

Membership Strategy 2025-2028 Update			
Report to:	Board of Directors	**Date:**	6 February 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	N Compton
Part I	✓	**Part II**	

Purpose of Report
To share the Membership Strategy 2025-28 as approved by the Council of Governors on 21st January 2025.

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

Executive Summary:

The Council of Governors approved the **Membership Strategy 2025-2028**, subject to final formatting adjustments before publication. The Board is asked to note the Membership Strategy as submitted to the Council, prior to these formatting amendments.

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

Council of Governors

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Membership Strategy

Membership Strategy 2025-28

communicating · engaging · representing

Membership

Excellent care with compassion

@LancsHospitals

Introduction and Purpose of Strategy

Lancashire Teaching Hospitals NHS Foundation Trust is established as a public benefit corporation under the National Health Service Act 2006. This status requires it to be subject to local accountability. This is achieved through offering the public in its area membership of the Trust and having a council of governors elected from, and by, this membership.

As a foundation trust, we are required to have a membership strategy in place, together with a clear work plan for its implementation.

This document sets out the strategy for how we will maintain and develop our membership over the next three years.

The strategy has been produced following consultation with governors and has been approved by the Council of Governors and the Trust Board of Directors.

Our Values

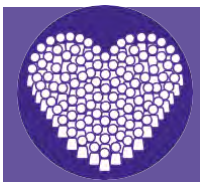
Lancashire Teaching Hospitals NHS Foundation Trust's mission is to provide excellent care with compassion.

We have three equally important strategic aims:

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

We are constantly striving to improve, and working towards becoming an outstanding, high performing organisation.

Our values define who we are and how we behave.



Being caring and compassionate

Being caring and compassionate is at the heart of everything we do, we will understand what each person needs and strive to make a positive difference in whatever way we can.

Recognising individuality

We appreciate differences, making staff and patients feel respected and valued.

Seeking to involve

We will actively get involved and encourage others to contribute and share their ideas, information, knowledge and skills in order to provide a joined up service.

Building team spirit

We will work together as one team with shared goals doing what it takes to provide the best possible service.

Taking personal responsibility

We are each accountable for achieving improvements to obtain the highest standards of care in the most professional way, resulting in a service we can all be proud of.

Lancashire Teaching Hospitals NHS Foundation Trust serves a large and diverse population providing acute and specialist services across Lancashire and South Cumbria as part of the Lancashire and South Cumbria Integrated Care System. The Trust operates from a number of sites including Royal Preston Hospital, Chorley and South Ribble Hospital, the Specialist Mobility and Rehabilitation Centre and Broadoaks Child Development Centre.

Whilst providing a range of district general hospital services to the local population of Preston, Chorley and South Ribble, the Trust also provides a range of specialist hospital services to the wider population of Lancashire and South Cumbria.

Eligibility for Membership

The Trust has two membership constituencies:

- Public Membership.
- Staff Membership.

Public Constituency

All members of the public who are 16 years old or over and who live within the Northwest of England are eligible to become members (see appendix 1)

Staff Constituency

All members of Trust staff automatically become members providing they are employed under a contract of employment which has either no fixed term or a fixed term of at least 12 months, or who exercise functions for the purposes of the Trust other than under a contract of employment continuously for a period of at least 12 months.

Members may only join the membership in one category. Should a member of the public subsequently be recruited as an employee of the Trust, staff membership will supersede public membership.

Exclusions to Membership

A person may not become a member of the Foundation Trust if within the last five years they have been involved as a perpetrator in a serious incidence of violence at any of the Foundation Trust's hospitals or facilities or against any of the Foundation Trust's employees or other persons.

Vision for the Membership

Our vision is to have an informed and stable membership who can 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.

Our Council of Governors, elected from and by the membership, will be effective in representing the membership, the views of the public at large, and supporting the Board in formulating strategy, shaping culture and ensuring accountability of our non-executive directors.

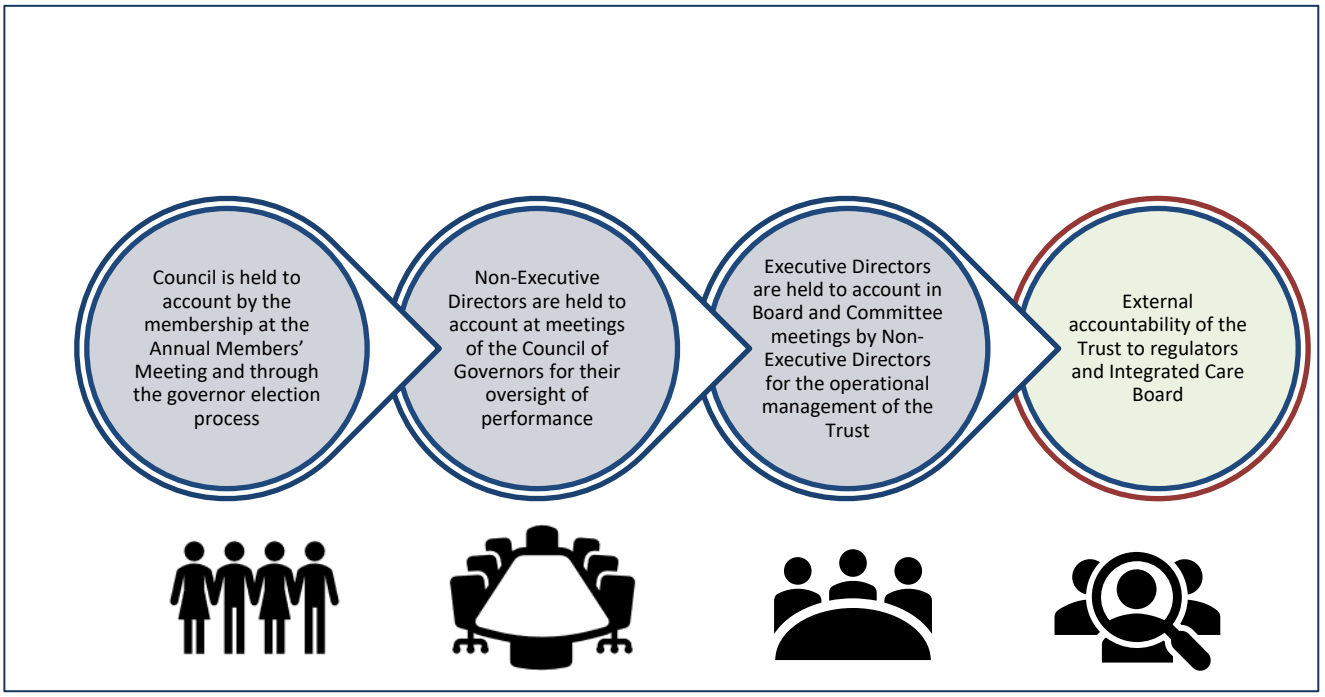
We will make every effort to be inclusive in our approach to involvement, by striving to provide opportunities for our membership that reflect the social and cultural mix of our area.

Objectives for 2025-2028

1. To enable the membership of the Trust to be representative of the diversity of the population it serves.
2. To raise awareness amongst foundation trust members, both staff and public, of their role and the opportunities available to them as members of the Trust.
3. To ensure members' views are represented in shaping the delivery of services.
4. To ensure members are kept informed of future plans for the services provided by the Trust and have the opportunity to shape those services.

Representing the Interests of Members

The governance of a Foundation Trust is complex, and comprises three pillars of governance: membership, council and board. Each pillar holds others to account and in turn is held accountable itself for its performance and decisions. This enables transparency in what we do in that all those involved are heard, involved and required to explain the reason for their decisions.



How the Strategy will be Delivered

The objectives outlined in this strategy will be delivered via the following actions:

- Using a variety of media to inform and attract new members.
- Promoting both staff and public membership, and the role of governors across our sites.
- Undertaking targeted membership recruitment activities through local community events.
- Continuing to ensure our members are kept up to date about service developments in our Hospitals through Trust Matters.
- Increasing our media focus on the role of governors and the importance of members, including providing information about membership on our Trust TV screens and website.
- Developing links with local organisations to promote the role of membership.
- Developing links with the council of governors from other local foundation trusts to work in partnership on promoting the role of membership in foundation trusts.
- Promote the opportunity to members to become involved in patient groups and research groups.
- Use hospital patient forums and special interest groups to engage with and access new members.
- Inclusion in the Trust Engagement Strategy to recognise the importance of the member voice.

How we will measure success

We will monitor how we deliver against the objectives we have outlined in this strategy through:

- Oversight by membership sub-group
- An annual report to Council of Governors
- Membership participation in the Annual Members' Meeting

Compliance with guidance and legislation

Implementing the Membership Strategy 2025-28 will enable the Trust to ensure compliance with a range of legislation and best practice, including:

- National Health Service Act 2006 (duty to involve)
- NHS Constitution for England, 2013
- The 2022 Addendum to Your Statutory Duties: A reference guide for NHS foundation trust governors
- our provider license, issued by the regulator
- the NHS Foundation Trust Code of Governance
- Health and Social Care Act 2012

The Health and Social Care Act 2012 seeks to improve accountability and strengthen the collective voice of patients. In doing so, the Act places a new responsibility upon governors to represent not only the views of members, but also the views of the public.

The Lancashire and South Cumbria Integrated Care System

Our membership area is available to staff and anyone living in the following areas:

Blackburn with Darwen	Oldham
Blackpool	Rochdale
Bolton	Salford
Bury	Sefton
Cheshire East	St. Helens
Cheshire West	Stockport
Cumbria	Tameside
Halton	Trafford
Knowsley	Warrington
Liverpool	Wigan
Lancashire	Wirral
Manchester	

14.3 DATE, TIME AND VENUE OF NEXT MEETING:

Information Item | M Thomas | 15.45

3 April 2025, 1.00pm, Lecture Room 1, Education Centre 1, Royal Preston Hospital