Council of Governors

28 July 2022 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Noting	E Adia
2.	Apologies for absence	1.01pm	Verbal	Noting	E Adia
3.	Declaration of interests	1.02pm	Verbal	Noting	E Adia
4.	Minutes of the previous meeting held on 28 April 2022	1.03pm	✓	Approval	E Adia
5.	Matters arising and action log update	1.04pm	✓	Noting	E Adia
6.	Chairman and Chief Executive's opening remarks	1.05pm	Verbal	Noting	E Adia/ K McGee
7.	Update from Chair of each Subgroup	1.20pm	Verbal	Noting	J Miller/ P Spadlo
8.	STRATEGY AND PERFORMANCE				
8.1	Patient Experience Annual Report 2021/22	1.30pm	✓	Noting	S Cullen
8.2	Non-Executive Director update – Education, Training and Research Committee Chair	1.45pm	Pres	Noting	P O'Neill
8.3	Education and Research Strategy update	1.55pm	Pres	Noting	K Hemsworth/ N Verstraelen
8.4	New Hospitals Programme update	2.10pm	Verbal	Discussion	J Hawker
8.5	Operational (Annual) Plan 2022/23	2.25pm	Pres	Noting	G Doherty
9.	GOVERNANCE AND COMPLIANCE				
9.1	Non-Executive Director update – Charitable Funds Committee Chair	2.35pm	Pres	Noting	K Smyth
9.2	Re-appointment of Non-Executive Director	2.45pm	✓	Approval	J Foote
9.3	Governor 360-degree feedback	2.50pm	Verbal	Approval	K Swindley

№	Item	Time	Encl.	Purpose	Presenter
9.4	Annual Report and Accounts 2021/22 (laid before Parliament)	3.00pm	✓	Noting	J Foote/ B Patel
9.5	Presentation from External Auditor: (a) ISA 260 report (b) Annual Audit report	3.05pm	✓	Discussion	C Paisley
9.6	Annual Members' Meeting report	3.20pm	✓	Approval	J Foote
9.7	Update on hybrid virtual meetings for Council Workshops and Development Sessions	3.30pm	Verbal	Approval	J Foote
9.8	Council Development Plan 2021/22 update	3.40pm	✓	Noting	J Foote
10.	ITEMS FOR INFORMATION (taken as read)				
10.1	Quality Account 2021/22		✓		
10.2	Governor opportunities and activities summary		✓		
10.3	Governor issues report		✓		
10.4	**Minutes of Governor Subgroups**: (a) Care and Safety Subgroup – 24 March and 16 May 2022 (b) Membership Subgroup – 4 April 2022 (c) Chairs, Deputy Chairs and Lead Governor – 4 April 2022		✓		
10.5	Date, time and venue of next meeting: *3 November 2022, 10.00am, Microsoft Teams*	3.45pm	Verbal	Noting	E Adia
11.	REVIEW OF MEETING PERFORMANCE				
11.1	Discussion on how the meeting in public has been conducted	3.46pm	Verbal	Discussion	All
12.	RESOLUTION TO REMOVE PRESS AND PUBLIC				
12.1	Resolution to exclude members of the press and public	3.50pm	Verbal	Approval	E Adia

Council of Governors Public Meeting

26 April 2022 | 10.00am | Microsoft Teams

PRESENT	DESIGNATION	26/4/22	28/7/22	3/11/22	26/1/23
CHAIRMAN AND GOVERNORS					
Professor E Adia (Chair)	Chairman	P			
Dr Keith Ackers	Public Governor	P			
Will Adams	Appointed Governor (Local Authority)	A			
Pav Akhtar	Public Governor	P			
Takhsin Akhtar	Public Governor	P			
Rebecca Allcock	Staff Governor	P			
Peter Askew	Public Governor	P			
Sean Barnes	Public Governor	P			
Alistair Bradley	Appointed Governor (Local Authority)	P			
Sheila Brennan	Public Governor	P			
Paul Brooks	Public Governor	P			
Anneen Carlisle	Staff Governor	P			
David Cook	Public Governor	P			
Kristinna Counsell	Public Governor	P			
Dr Margaret France	Public Governor	P			
Steve Heywood	Public Governor	P			
Waqas Khan	Staff Governor	A			
Lynne Lynch	Public Governor	P			
Janet Miller	Public Governor	P			
Jacinta Nwachukwu	Appointed Governor (Universities)	A			
Eddie Pope	Appointed Governor (Local Authority)	A			
Frank Robinson	Public Governor	P			
Suleman Sarwar	Appointed Governor (Local Authority)	P			
Anne Simpson	Public Governor	A			
Mike Simpson	Public Governor	P			
Piotr Spadlo	Staff Governor	P			
David Watson	Public Governor	P			
Paul Wharton-Hardman	Public Governor	P			
IN ATTENDANCE					
Karen Brewin *(minutes)*	Associate Company Secretary	P			
Ailsa Brotherton	Director of Continuous Improvement	-			
Faith Button	Chief Operating Officer	-			
Victoria Crorken	Non-Executive Director	P			
Sarah Cullen	Director of Nursing, Midwifery & AHPs	-			
Stephen Dobson	Chief Information Officer	-			
Gary Doherty	Director of Strategy and Planning	-			
Naomi Duggan	Director of Communications	P			
Kevin McGee	Chief Executive	P			
Professor P O'Neill	Non-Executive Director	-			
Ann Pennell	Non-Executive Director	P			
Dr Gerry Skailes	Medical Director	-			
Kate Smyth	Non-Executive Director	P			
Karen Swindley	Workforce and Education Director	P			
Tim Watkinson	Non-Executive Director	P			

Jim Whitaker	Non-Executive Director	P			
Tricia Whiteside	Non-Executive Director	P			
Jonathan Wood	Deputy Chief Executive/Finance Director	-			

P – present | **A** – apologies | **D** – Deputy
***Quorum**: 9 members must be present of which at least 1 must be a Public Governor; 1 must be a Staff Governor; and 1 must be an Appointed Governor*

PRESENTERS IN ATTANDANCE	
Minute 34/22	Louisa Graham, Deputy Director of Workforce and Organisational Development
Minute 35/22	Jerry Hawker, Executive Director – New Hospitals Programme

27/22 Chair and quorum

Professor E Adia noted that due notice of the meeting had been given to each member and that a quorum was present. Accordingly, the Chair declared the meeting duly convened and constituted and extended a warm welcome to all those present.

28/22 Apologies for absence

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

29/22 Declaration of interests

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

30/22 Minutes of the previous meeting

The minutes of the meeting held on 27 January 2022 were approved as a true and accurate record, subject to amendment to minute 8/22 on page 5, penultimate paragraph. It was noted that Paul Brooks had raised the question regarding Blood Bike volunteers rather than David Cook.

31/22 Matters arising and action log

A copy of the action log had been circulated with the agenda and it was noted that all actions had been completed to time. In respect of the one remaining action (37/21, Nursing, Midwifery, AHPs and Care Givers Strategy) it was noted that this action would remain open until the update, delayed due to Covid-19, had been provided to the Council.

32/22 Chairman's and Chief Executive's opening remarks

The Chairman extended a warm welcome and congratulated the three new Governors (Sheila Brennan, Kristinna Council and Paul Wharton-Hardman) who were attending their first Council meeting following the 2022 Governor election. Congratulations were also extended to the re-elected Governors along with Janet Miller who had been elected as Lead Governor for 2022/23.

Interviews had been held last week to appoint two Associated Non-Executive Directors and the Chairman was delighted to confirm the appointment of Michael Wearden and Peter Wilson. It was important to note the original intention was to utilise the Associate Non-Executive Director route to attempt to increase diversity on the Board although on

the day the two appointees were the strongest candidates. The Chairman was working with the Chief Executive and Workforce and Education Director to look at a potential diversity route with an Executive Search Agency and whether there were opportunities to increase the diversity of the Board in the future.

K McGee confirmed the Trust was at the point of closing down the previous financial year. Since taking up the Chief Executive Officer role in September 2021, the majority of time had been spent navigating the Covid-19 (Omicron) outbreak and pre- and post-winter pressures. Thanks were extended to all those associated with the organisation, including Governors, Board members, Executive Director colleagues, clinicians, managers and all staff within the Trust who had supported the Trust and communities served throughout the previous year and helped the Trust to manage some significant pressures. Moving into the new financial year, preparations were well underway to develop financial, performance and operational plans which would need to be submitted to NHS England and NHS Improvement (NHSE/I) at the end of the week. Whilst individual plans would be developed by each of the five local Trusts, they would be submitted to NHSE/I as a system plan. Targets for the year would be delivered by individual organisations and would be aggregated across all of the five Trusts to ensure there was a joint system approach to delivery as part of the move to integration and how organisations worked together in a different way to develop and improve healthcare.

The Trust remained operationally under pressure and last week had up to 140 inpatient beds occupied by Omicron-positive patients. The numbers had started to decline with around 110 patients yesterday which reflected the reduction in community infection rates. When following the modelling, it was expected the numbers of Omicron infected people would reduce significantly over the coming weeks which would help the extremely compromised bed base seen over the last few months. As infection numbers reduced, the Trust would be able to revert ward areas to conventional use and allow a return to the normal rhythm of patients flowing through the organisation which was important for both the Trust and the system to manage the large number of 104-week waiters. The Trust would also be focusing nationally on recovery and delivery of cancer activity.

In the coming months there was an intention to recalibrate the bed base and focus on core activity and capacity. The Nightingale Surge Unit had been used extensively with up to 49 patients in the facility during the last week which had helped to allow the Trust to continue with elective recovery, particularly during the winter period. The Nightingale facility would be decommissioned towards the end of May/beginning of June which should coincide with the additional capacity being introduced at Chorley and South Ribble Hospital which evidenced ongoing development of and investment in the Chorley site.

There would be financial pressures faced by the NHS during the coming year. Whilst the Trust had received additional funding over the last two years to support Covid-19, those resources would not be available in 2022/23 so the Trust would need to continue to right-size the organisation which would be important moving forward.

Work was also being undertaken around the clinical strategy across the system. Attempts were being made to split the elective and emergency workload to separate as much elective from non-elective as possible, particularly at Chorley to ring-fence day case activity and protect that capacity from winter pressures. The intention was to look to do this across the system, not just within the Trust, to use capacity in a different way

and think about the recurrent work needed to separate elective from emergency care. That work dovetailed with work being undertaken around the New Hospitals Programme (NHP) and the Executive Director for the Programme (J Hawker) would be joining the meeting later to provide an update. K McGee commended the work undertaken to date to deliver balance on NHP shortlisted options on which to engage which provided real options for the future, thinking about clinical and organisational strategies for the future.

In summary, it would be extremely busy going into the new financial year, characterised by elective and emergency activity, and staff and services would continue to be affected by ongoing activity and Covid-19 infection outbreaks.

A question was raised regarding long waiting times in the Emergency Department at Preston and whether there were any actions that could be taken to improve the situation. K McGee explained there were extreme pressures and long waits seen nationally in all Emergency Departments in terms of both ambulance handover times and patients in the Emergency Department waiting to be seen which, in turn, when it was agreed to admit the patient then waiting in the Emergency Department was further impacted by the difficulties in identifying an inpatient bed. An inordinate amount of work was being undertaken around the Preston Emergency Department and whilst it was acknowledged ambulance handover times needed to be improved, the Trust was good when compared to national figures. However, the reality was the Emergency Department at Preston was too small and one of the most cramped environments the Chief Executive had seen people working in. It was noted that all the Emergency Department team delivered excellent care although the environment was not fit for purpose. In addition, inpatient beds were occupied by patients not meeting the criteria to reside in an acute bed which negatively impacted on patients being delayed in the Emergency Department once a decision had been taken to admit. The Trust was also working collaboratively on patient flow to ensure external capacity was available to release the pressure within the hospital. Notwithstanding the NHP, a business case was being developed to obtain capital to allow right-sizing of the Emergency Department to ensure patients were seen with dignity and respect as the NHP was several years in the future and action was required now. Therefore, lots of work was underway to ensure external flow to discharge patients and, in the medium-term, work was being completed to provide a larger emergency footprint. It was noted that Preston was the Major Trauma Centre for Lancashire and South Cumbria which would require wrap-around of all services to ensure the facility was fit for the future.

P Brooks noted that on 2 May 2022 the Northwest Blood Bikes would be celebrating 10 years aligned to the Trust. K McGee acknowledged this would be an important milestone and N Duggan would ensure appropriate communications were developed.

Reference was made to investment in the Preston Emergency Department a number of years ago and clarification was requested on whether the investment had been insufficient. K McGee advised that the number and acuity of patients presenting along with the number of patients needing to be admitted into the acute medical unit meant the current configuration of the Emergency Department was not fit for purpose with small narrow corridors therefore lots of work on the environment was needed both in the short and long term. In respect of historic investment, K Swindley noted that a small amount of capital had been received which had been provided to support winter pressures and development of a rapid assessment and treatment space (RATS) within the Emergency Department however the investment was never intended to address the fundamental issues relating to the department's environment.

In response to a question regarding whether additional funding had been identified to increase staffing levels in the Emergency Department, K McGee confirmed there was a rolling recruitment programme although there were continual issues due to shortages in specialties and trained staff, including medical and nursing staff. There was also a shortage of allied health professionals (AHP) who were vital in terms of discharging patients from hospital. The Trust was also working with local education and Universities and the international recruitment programme had been integral to increasing nurse staffing levels during the last year. It was noted that every Trust in the country had been affected during the last few months as community infection rates and staff sickness had increased. All organisations would need to work together and it would be vital how they looked after staff in respect of long-term recruitment, working as part of the wider Lancashire and South Cumbria integrated care system to grasp opportunities to ensure staff were attracted. There was also a need to invest in staff to ensure people wanted to come to work and live in Lancashire and South Cumbria as organisations would be in a competitive market therefore reputation, both as a Trust and the wider system, would be crucial.

33/22 Update from Chair of each Subgroup

The Chairs of the respective Membership and Care and Safety Subgroups provided an overview of the topics discussed at recent meetings and the following points were noted:

(a) Membership Subgroup – P Akhtar

- P Akhtar confirmed he had now stood down as Subgroup Chair and P Spadlo had been appointed for 2022/23. Thanks were extended to colleagues for their support during his term of office and congratulations extended to P Spadlo.
- The Council was reminded the Membership Management and Engagement Strategy had been approved in January and the Subgroup was looking at better reach and engagement with the wider community and how policies and practices in the Trust could provide that influence.
- The Subgroup was cognisant of the need to attract talent in terms of employees which linked to the points raised in the previous item.
- The Subgroup was aware of the high levels of deprivation and inequalities leading to more health/outcome inequalities and access to care, and the need to strengthen the relationship to work with the Trust to develop solutions was recognised.
- Beyond the Membership Management and Engagement Strategy, the Subgroup had looked at the action plan and how that could be taken forward with members of the Subgroup nominated to undertake certain tasks.
- Importantly, the Governors were not undertaking the work in isolation but working in partnership with Trust activities, for example working to attract young members, working with the Widening Partnership Team, and working with N Duggan and the Communications team.
- P Spadlo confirmed it had been a pleasure to work with P Akhtar over the past 12 months and hoped he would continue to join future Subgroup meetings.

The Chair thanked P Akhtar on behalf of Governors for his dedication to the Chair role and noted that great progress had been made during his term of office. Thanks were also extended to P Spadlo for taking on the Chair role for the coming year.

(b) Care and Safety Subgroup (CaSS) – J Miller

- Since the last Council meeting, the Subgroup had met on 24 March 2022.
- Updates were received during the meeting regarding ongoing work on Safety-II, the patient experience strategy, and the work of the patient experience involvement and improvement groups. An outline of the results of the internal patient experience survey was provided during the meeting. A working group had also been convened to look at patient letters.
- The Deputy Chief Information Officer (Janet Young) delivered a presentation on data science to provide Governors with greater understanding.
- Updates were also provided on estates and facilities and patient experience and involvement issues which were both standing items on the agenda.
- Colleagues raised concerns covering ambulance handover times, the cost of lateral flow tests for people wanting to visit loved ones, and the theft of the ATM machine at Chorley and South Ribble Hospital. Discussion was also held regarding laminated signage and the difficulties for sight-impaired people reading signage with a high gloss finish and it was confirmed that new signage was being progressed.
- Reference was made to people feeling they needed to raise issues or concerns on social media, including a post about the Changing Places facility at Chorley.

Reference was made by a Non-Executive Director to an earlier comment regarding responses in the patient experience survey where patients had indicated they felt unsafe and asked whether the specific issue was known. J Miller referred to issues regarding lack of communication around Covid-19 restrictions for visitors and empty stores cages blocking disabled parking bays although the latter had been picked up and was being resolved with the staff responsible for stores cages. At this point, the Chair reminded the meeting that Non-Executive Directors were observers during Council meetings and would not want to set a precedent of asking questions during the meeting.

A question was raised in chat regarding whether there would be budget challenges if areas were fully staffed. K McGee explained that there would always be staff vacancies and turnover. It was known locally, regionally and nationally that there was a workforce shortage in clinical specialties as mentioned earlier in the meeting therefore the Trust needed to employ more agency staff than it would want. If a recurrent bed base and space could be re-established it would be possible to keep agency costs to a minimum which would help with the finance strategy. In addition, work was ongoing across the system to attempt to agree a consistent rate for agency pay to ensure providers did not outbid each other and raise costs for staffing. K Swindley confirmed that some progress had been made in terms of streamlining agency pay although during periods of high pressure adhering to capped agency rates did become a difficult decision for organisations. A review was being undertaken and a rapid improvement event was being introduced to ensure consistency and avoid inflating agency pay rates.

34/22 Workforce and Organisational Development Strategy update

L Graham joined the meeting and delivered a presentation providing an overview of progress made during the last 12 months against the six primary drivers of the Workforce and Organisational Development Strategy ‘Our People Plan’. It was agreed that the slide presentation would be circulated to Governors following the meeting.

The Chair referred to a comment in chat regarding feedback received from students and the perception they were filling staffing gaps and asked what work was being undertaken to ensure students currently on placement at the Trust had a positive experience to help them choose to work in the organisation once they had qualified. L Graham explained that pastoral support had been introduced for students particularly those newly recruited. There was also a range of forums providing the opportunity to consult with students to understand their feedback and any improvement actions needed. K Swindley added that, from a student experience point of view, feedback varied greatly from area to area and response rates were generally low but feedback results were presented to and monitored by the Education, Training and Research Committee and further quality assurance processes were being introduced to understand the issues being raised. The main theme from the limited information received was the ability to support students in areas with significant staffing shortages and a number of Clinical Educator posts had been introduced although this did not take away from the experience of the student and the problem was difficult to resolve whilst the Trust was under considerable pressure.

- **The Council received the presentation and noted the contents.**
- **The slide presentation would be circulated to Governors.**

35/22 New Hospitals Programme update

J Hawker joined the meeting and delivered a presentation providing an update on the status of the NHP, a recap on timelines, what had been progressed during the last three months and next steps. A copy of the slide presentation would be circulated to Governors following the meeting.

J Hawker confirmed that much of the work to date had been about building a strong foundation and the next stage would be about understanding the status of the NHP. The pre-consultation business case (PCBC) would provide the details behind the shortlisted options, what the infrastructure design would look like for each option, what would happen to specific areas (for example the ward block and emergency services), and how future challenges would be met. An important element of the PCBC would address the question of where a new hospital may be built which would include considerations such as suitability, access roads, utilities, and how it would support the work of other partners, such as education. Over the coming months, the clinical strategy would also be considered, working with the Provider Collaborative Board to look at the wider hospital clinical strategy for the future. Part of this work would involve considerations around digital technology, single room suites and how they would be configured, ward sizes for the future, and all those elements would be considered against each of the four shortlisted options. Finally, benefits realisation would be equally important to ensure return on investment and over the coming months the benefits of each option would be reflected upon, including what the option would bring to the population in terms of health outcomes, staff recruitment and retention, and thinking about how the options would contribute to wider social value and how it would support future economic growth. It was important to note the PCBC would be completed and considered by the national NHP team before any move to consultation. It was expected development of the PCBC would take up to six months to complete and during that time the NHP team would continue to engage with all stakeholders.

Reference was made to the timescale for building work to commence in 2025 and clarification was requested on when it was expected building work would be completed. In addition, the current Emergency Department at Preston was not fit for purpose and clarification was requested on what effect the NHP would have on a new Emergency Department. In terms of the timeline for building work, J Hawker explained the NHP team needed to work with the government around the timeline and it was expected, working on a start date of 2025, that building work should be completed around 2030. However, it was hoped with much of the work around modern methods of construction and modular design build that the start and completion dates for building work could narrow. With regard to the Emergency Department, the work undertaken to date was very much looking at an Emergency Care Village in line with work undertaken around the model of care, taking into account lessons learned from the Covid-19 pandemic but also looking at same day emergency care and bringing services together to ensure flow was as strong and positive as it could be for both patients and staff.

- **The Council received the presentation and noted the contents.**
- **The slide presentation would be circulated to Governors.**

36/22 Lead Governor appointment

A report had been circulated with the agenda confirming the outcome of the recent virtual ballot to appoint the Lead Governor for the next 12 months up to and including 31 March 2023. K Swindley provided an overview of the contents and confirmed that Janet Miller had received the majority of votes and had taken up the post with immediate effect.

- **The Council noted the results of the 2022 ballot and the appointment of Janet Miller as Lead Governor for the next 12 months up to and including 31 March 2023.**

37/22 Nominations Committee appointments

A report had been circulated with the agenda confirming the outcome of the recent virtual ballot to appoint members of the Nominations Committee following expiry of membership of the staff Governor and the two substitute Governors (elected and appointed). K Swindley provided an overview of the contents and confirmed those Governors who had received the majority votes in each constituency.

The Council was reminded of the tied position last year and amendment of the terms of reference for the Nominations Committee to increase the membership by one elected Governor last year. The term of office of one of the elected Governors had come to an end in March 2022 therefore the membership had been brought back in line with the Committee's terms of reference and Trust Constitution. It was noted that the Governors had taken up their roles with immediate effect and their term of membership would be for two years up to and including 31 March 2024.

A question was raised regarding whether removing the additional elected Governor would have a negative effect on the continuity of experience on the Committee. K Swindley confirmed that could always have been the case at any point in time, for example if Governors chose to stand-down from the Committee. It was not felt to be appropriate to retain the tied vote arrangement and the right thing from a governance perspective was to return to the Trust Constitution and Committee terms of reference.

- **The Council noted the results of the ballot and the appointment of members to the Nominations Committee for the two-year period 1 April 2022 to 31 March 2024.**

38/22 Non-Executive Directors' Champions roles

Following receipt of guidance published by NHS England and NHS Improvement setting out a new approach to ensuring Board oversight of important issues making it more manageable for Non-Executive Directors to discharge their responsibilities, a report had been circulated with the agenda containing matrices of the current responsibilities of each Non-Executive Director.

K Swindley explained that over the years the Non-Executive Director role had expanded therefore the Board had received the information to provide assurance that the Trust was complying with the guidance and had appropriate arrangements in place. The second appendix outlined the Non-Executive Directors representation on Committees of the Board which had been reviewed and updated following the Committee effectiveness reviews undertaken in 2021. Finally, the third appendix outlined other activities in which Non-Executive Directors were involved both internally and externally.

Reference was made to the Non-Executive Director Champion for doctors' disciplinary cases and clarification was requested on the acronym MHPS. K Swindley confirmed that 'Maintaining High Professional Standards' was the national policy for doctors' disciplinary cases and rather than identify a single Non-Executive Director Champion for all disciplinary cases, a Non-Executive Director was identified on a case-by-case basis when such issues arose.

- **The Council noted the contents of the report and the assurance provided that the refreshed national guidance was being met in terms of Non-Executive Director roles.**
- **The Council noted the changes to quorum and membership arrangements as outlined in the executive summary and subsequent amendments to those Committee terms of reference.**

39/22 Update on Council and Subgroup Virtual Meetings

K Swindley reminded the Council of the previous discussions regarding virtual meetings and a decision would be required regarding the meetings the Council would hold virtually and those that would be held in person, where appropriate and in consideration of fluctuating Covid-19 infection rates.

It was noted the Board had agreed that formal meetings would continue to be held virtually and as Board workshops and development sessions were more informal these would be held in person. To ensure consistency, the Council was asked whether a similar approach could be agreed for formal Council and Subgroup meetings being held virtually and Council workshops and development sessions being held in person. It was interesting to note that during the recent Governor induction session feedback had been received that virtual meetings were helpful to people rather than returning to face-to-face meetings and since virtual working had been introduced attendance levels had improved.

In terms of balance of formal meetings being held online and workshop/development sessions being held in person, the Chair asked whether the Council strongly disagreed with that proposition.

Whilst there was no opposition to holding virtual Council and Subgroups meetings, a lengthy discussion was held regarding the possibility of holding hybrid workshops and development sessions. It was recognised Council members had both positive and negative experiences and there were advantages and disadvantages to a hybrid approach. The main concern was whether the technology within the Trust, and potentially external venues, would support a hybrid approach and such meetings were difficult to chair and ensure all participants had an equal experience to fully contribute to the sessions. The Chair reflected on Board workshops/development sessions where part of the arrangements involved group work before returning to the plenary therefore breakout rooms would be required along with physical space which could become unwieldy during a hybrid session. However, it was agreed that hybrid sessions would be explored and feedback provided at the next Council meeting.

- **Council members supported and agreed to continue to hold virtual Council and Subgroup meetings in the future.**
- **K Swindley to explore the possibility of a hybrid model for Council Workshops and Development Sessions with feedback being provided at the next Council meeting.**

40/22 Council Development Plan update

A report had been circulated with the agenda providing a further update on the current status of the Council Development Plan since last reported at the January 2022 meeting and K Swindley provided an overview of the contents for information.

It was pleasing to note the number of actions either fully or partly delivered (green and amber RAG-rated) and some of the actions related to discussions held earlier today, for example hybrid meetings. Progress was being made with reviewing the Trust Constitution and Governors were thanked for their involvement in the working group to review the contents. With regard to the content of Governor Workshops, it was noted that a discussion was scheduled at the May Governor Development Session. There was still a need to undertake an assessment of whether all Governors were meeting the minimum requirements of their role, which had been planned pre-pandemic, and to address any shortfalls.

In summary, good progress had been made with the Council Development Plan and some areas required input from the new Company Secretary who was due to commence on 1 July 2022.

In response to a question regarding the status of Governors photo boards, K Swindley agreed to check on progress with the Communications Team and would ensure newly appointed Governors were included.

- **The Council received the report and noted the contents.**
- **K Swindley to speak to the Communications Team and check progress with erecting Governor photo boards on both hospital sites.**

41/22 Items for information

The following reports were circulated with the agenda and the contents noted for information:

(i) 2022 Governor Elections
(ii) Governor opportunities and activities
(iii) Governor issues report
(iv) Minutes of Governor Subgroups:
- Care and Safety Subgroup – 17 January 2022
- Membership Subgroup – 7 February 2022
- Chairs, Deputy Chairs and Lead Governor – 10 January 2022

42/22 Date, time and venue of next meeting

The next meeting of the Council of Governors will be held on Thursday, 28 July 2022 at 1.00pm using MS Teams.

43/22 Reflections on how the meeting had been conducted

There were no reflections put forward on how the Council meeting had been conducted.

44/22 Resolution to exclude press and public

The Council resolved to exclude press and public from the meeting.

Action log: Council of Governors (part I) – 26 April 2022

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	37/21	29 Apr 2021	*Nursing, Midwifery, AHPs and Care Givers' Strategy* – a further update to be provided in six months.	S Cullen	To be confirmed	**Update for 26 October 2021** – reporting on the strategy stood down due to the pandemic.
2.	39/22	26 Apr 2022	*Update on Council and Subgroup virtual meetings* – explore the possibility of a hybrid model for Council Workshops and Development Sessions with feedback provided at the next Council meeting.	K Swindley	28 Jul 2022	**Update for 28 July 2022** – a hybrid model is under consideration. However, due to a resurgence in Covid-19 current arrangements remain in place.
3.	40/22	26 Apr 2022	*Council Development Plan update* – liaise with the Communications team and check progress with erecting Governor photo boards on both hospital sites.	K Swindley	28 Jul 2022	**Update for 28 July 2022** – this action is included as part of the communication plan. The type of boards is currently being revisited to ensure ease of updating Governor photos.

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

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	34/22	26 Apr 2022	*Workforce and Organisational Development Strategy* – slide presentation to be circulated to Governors.	K Brewin	26 Apr 2022	**Completed** **Update for 28 July 2022** – slides emailed to Governors (26 April 2022).
2.	35/22	26 Apr 2022	*New Hospitals Programme* – slide presentation to be circulated to Governors.	K Brewin	26 Apr 2022	**Completed** **Update for 28 July 2022** – slides emailed to Governors (26 April 2022).

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Patient Experience Annual Report 2021/2022							
Report to:	Council of Governors			**Date:**	28 July 2022		
Report of:	Nursing, Midwifery and Allied Health Professional Director			**Prepared by:**	C Musonza, C. Silcock		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☐	**For noting**	☐	**For discussion**	☒	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Council of Governors with the outcomes associated with the Patient Experience and Involvement Strategy 2018-2021 and close the strategy. A refreshed strategy is being codesigned with stakeholders and will be presented to the committee in July 2022.

This report contains information on outcome metrics associated with patient experience, in summary these are:

I. Updates on each of the commitments made within the 2017-2021 strategy with associated outcomes. (Appendix 1)
II. Friends and Family Test (FFT) data demonstrates an upward trend in services except for patients in ED.
III. Complaints remain relatively static with the 35-day response compliance at >95%.
IV. The STAR quality assurance monthly and accreditation review focus on patient experience with >75% of areas achieving a silver or above rating
V. Intelligence triangulated from STAR and complaints has led to an increase in ward management resource for the wards with >28 beds to improve experience.
VI. The adverse impact of suboptimal patient flow and staffing levels on patient experience.
VII. There have been 5 Parliamentary Health Service Ombudsman (PHSO) referrals in the last 12 months.
VIII. National inpatient survey results have shown maintained positive outcomes in maternity and cancer, improved position for children, movement to a nationally median position for ED and lower than expected performance for adult inpatients.
IX. Development of two key internal forums and several partnership arrangements with community partners.
X. Live feedback and evaluation from patients and staff on how LTHTR is performing in relation to patient experience.
XI. Live feedback from patients on what safety means to them to inform the codesign of the next strategy.
XII. The introduction of patients as partners at LTHTR.
XIII. Evidence of research activity within the sphere of patient experience specifically with Imperial college relating to capture of experience and improving transitions for older people from hospital to home.

The focus on improving inpatient experience will remain a priority for the next strategy and whilst it is positive to note some improvement in the Emergency Department survey, neither survey are achieving the standard the organisation aspires to meet.

It is recommended the Council of Governors:

I. Receive the report and discusses the contents.
II. Notes the closure of the 2018-2021 Patient Experience and Involvement Strategy and the plan to approve the new strategy in Safety and Quality committee in September 2022.

Appendix 1 – Patient Experience and Involvement Strategy outcomes

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 June 2022.

1. Introduction and context

The mission of Lancashire Teaching Hospitals is 'Excellent care with compassion'. The Trust published its three year Patient Experience and Involvement Strategy in 2018-2021 and whilst this has been impacted by the COVID-19 pandemic, there are many achievements to celebrate.

The next strategy is being codesigned and will be presented to Safety and Quality committee in July 2022. The metrics used to measure outcomes relating to patient experience are:

- Friends and Family Test (FFT) data
- Complaints and concerns
- Parliamentary Health Service Ombudsman (PHSO) cases
- Compliments and Thank You messages
- National inpatient survey results
- Patient Experience Involvement Group
- Patient Experience and Involvement groups

2. Discussion

2.1 Reflection on Patient Experience and Involvement strategy 2018-2021

To ensure the closure of the strategy accurately reflected the views of patients and colleagues delivering services, a number of facilitated discussions were held as part of the evaluation process.

The four commitments for Patient Experience and involvement 2018-2021 where revisited to establish a summary on progress made. The four commitments for the strategy were:

1. Improve outcomes and reduce harm
2. Create a good care environment
3. Improve capacity and patient flow
4. Deliver a positive experience

2.2 Where are we now?

We asked patients, relatives, carers, staff, our governors and partner organisations to contribute to answering the question – Where are we now?

What have we achieved from our current strategy, what are we good at?

Shared views from our patients/carers, staff, governors and other stakeholders:

- Established one team for complaints/compliments and PALS to improve the patient experience. The Patient Experience and Patient Advice and Liaison Service (PALS) teamwork alongside staff, patients/carers and other stakeholders.
- Improvements have been made achieved in the continuity of carer agenda within maternity services.

- Representation from clinical/divisional teams at the Patient Experience Improvement Group and Patient Experience and Involvement Group has improved and colleagues feel better able to shape the agenda and progress improvement.
- Staff have been collaborating with the patient experience agenda and are involved in the strategy, initiatives have been embedded.
- Teams need to take responsibility for communicating improvement work as part of the future strategy.
- Continuous improvement methodology has been embraced in the patient experience and involvement agenda and the patient involvement in the Patient Experience Improvement group and big rooms has been a strength.
- Accessible information standards have progressed, although work to do in this area.
- During the last two years there has been a focus on the accessible information, with more diversity in what is produced. All patient information leaflets are available in a variety of languages and easy read versions on request. Paper copies are available or a link to a digital copy, whichever suits the patient/carer.
- The last 12 months has seen a positive move to use video sign language and with the help of the British Sign Language Interpreters the quality of information to the deaf community has improved.
- Our patient information can also be provided in different formats, such as larger font and on different coloured paper to aid service users with sight impairments.
- The Trust website has 'ReachDeck' which is a facility that allows patients/carers to change the font size, language and have audio on all documents.
- Learning disabilities, reasonable adjustment is flagged has been launched on QuadraMed. A focus on health and wellbeing aims to reduce health inequalities for people with a Learning Disability and / or Autism. This includes the LeDeR Steering group – understanding vulnerabilities, lessons learned for agencies in relation to a patient's journey and the consideration of family/carer experience in supporting the patient (for example visiting during COVID).
- The 'reasonable adjustments' Quadramed tab on the internal system was developed last year. Front line staff are recording what reasonable adjustments the service user has expressed that they need, or what would enhance their patient experience. This may include a larger room, due to a large wheelchair and a carer present, or it could be a hoist, an interpreter or clear masks for a lip reader. Training is continuing and ongoing with staff and a handy guidebook is now being produced by IT with a focus from our Organisational Development leads to ensure we reach all staff.
- The forums ensure multi-agency working to ensure a shared vision for patient experience.
- Accessibility for deaf patients has witnessed achievement and requires continued support from staff, carers and patients
- Continued progress in patient information leaflets standards.
- Recognising the needs from patients in all ethnic and religious groups, embraced within the trust for the past 12 months which has been a very positive step forward for patients.
- The chaplaincy teams diversity has increased through the employment of two Iman's, as have the volunteers from multiple faiths.
- Volunteers are available for patients when requested, regardless of need including end of life care or a friendly ward visit.
- An established religious inclusion calendar has enabled greater diversity within the Trust to celebrate and recognise the different celebrations/feast days within different faiths.

- The catering department has ensured food is available that incorporates different faiths with a focus on events such as Ramadan and having food available after sunset.
- The Chaplaincy area has extended, creating different prayer areas that accommodate different faiths. This is for access for all our patients and visitors to the Trust and allows people the quiet time to pray, in an environment that is suited to their needs.
- Introduced the 'Behind the bed boards' to state 'what matters to you' as a patient.
- The number of areas has continued to increased incorporating all clinical areas, the number of areas has grown from 107 to 124.
- STAR outcomes demonstrate 2 areas are achieving a red rating, 26 areas are achieving an amber rating, 95 areas are achieving a green rating and one new area is awaiting their first STAR visit. This has resulted in 28 bronze stars, 66 silver stars and 29 gold stars. The trust has achieved the Big Plan ambition of 75% of areas achieving silver or above stars.

2.3 What matters to our patients?

Recognising the need to focus on outcomes and reduction of harm, the development of the Always Safety First (ASF) programme of work led to the development of a strategy launched in 2021. As part of this strategy, there was a commitment to involve patients in their care and treatment in relation to safety, to meet the requirements of the national Framework for Involving Patients in Patient Safety.

On 7th February 2022 a pilot initiative was commenced by the Patient Experience and PALS team by visiting wards across the organisation to visit patients and ask them a series of questions. The pilot was initiated to ascertain what safety means to patients.

We asked patients the following questions.

- Have you felt safe and if so, why was that?
- Have you felt unsafe at any time and why was that?
- Overall, what has been positive/negative about your hospital stay?
- Overall, what improvements do you think we could make?

Over the course of three weeks 383 patients were spoken to on the adult inpatient wards across Preston and Chorley hospitals and engaged in conversation. Overall, 362 patients said that they felt safe, with 21 reporting they did not feel safe. A summary of the narrative is shown in image 1 to illustrate the feedback on the expectations of what mattered to the patients in relation to safety. This is important context in considering the report to retain what matters to the patient at the centre of the strategy. This has provided a test of change in collecting feedback in a proactive way and further tests will evolve as a result of this work.

Image 1 – Patient feedback (n383) on what safety means to them 7 Feb 2022.

2.4 Patient Experience and Involvement Group

The purpose of the Patient Experience and Involvement Group provides an opportunity for diverse feedback and involvement from patients, carers and other stakeholders in championing the agenda for patient experience within Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR). Ideas from the meetings have enabled prioritisation of improvement activity via the Patient Experience Improvement Group. Membership extends to over 30 diverse members of the community, enabling specialist input and attention to detail on areas that require improvement.

2.5 Patient Experience Improvement group

The purpose of the Patient Experience Improvement Group is to provide opportunity for learning, share good practice, promote safety and embed continuous improvement projects to enhance patient experience within Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR). It provides a forum for advice, sharing and learning and to input collectively into testing approaches, using Continuous Improvement methodology, to support the delivery of the Patient Experience Strategy. There are two live projects at this time:

I. Patient contribution to case notes (PCCN)
II. Patient lost property

3. Patient experience feedback

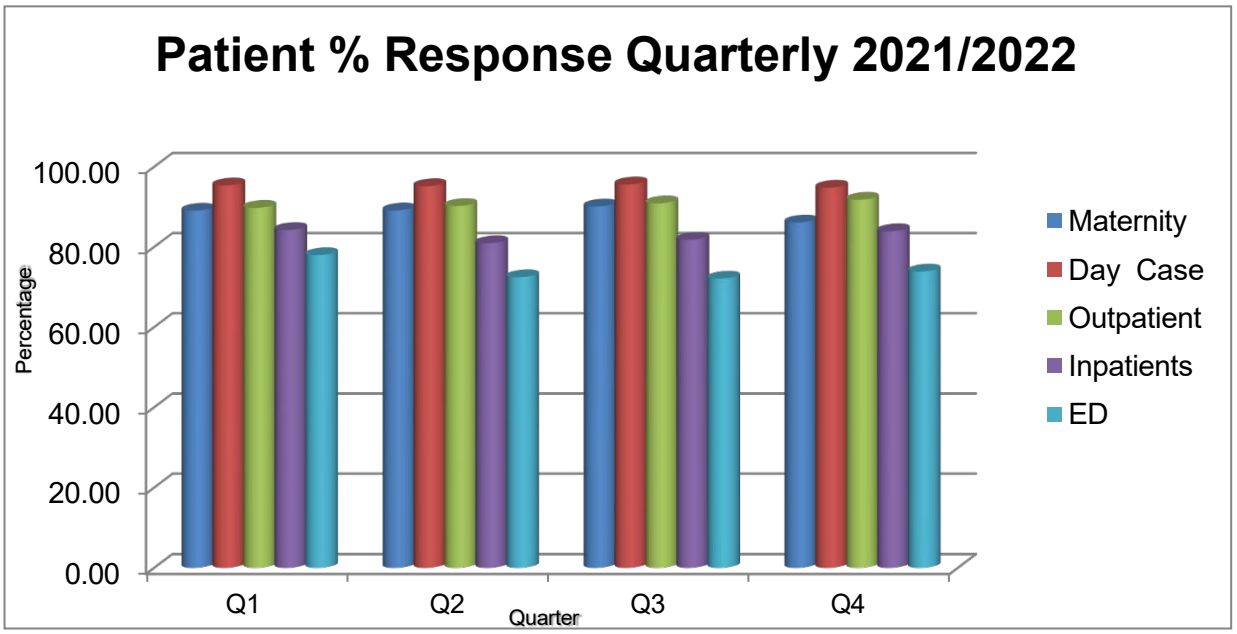
Improving patient experience is a key priority for the organisation.

3.1 Friends and Family Test (FFT)

The Friends and Family Test (FFT) is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. The national requirement is to report on the following areas, whilst not a national requirement children and neonates have been added to this function to ensure a holistic view is understood.

- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department
- Children and neonatal

Graph 1 – Quarterly percentage of positive responses Friends and Family

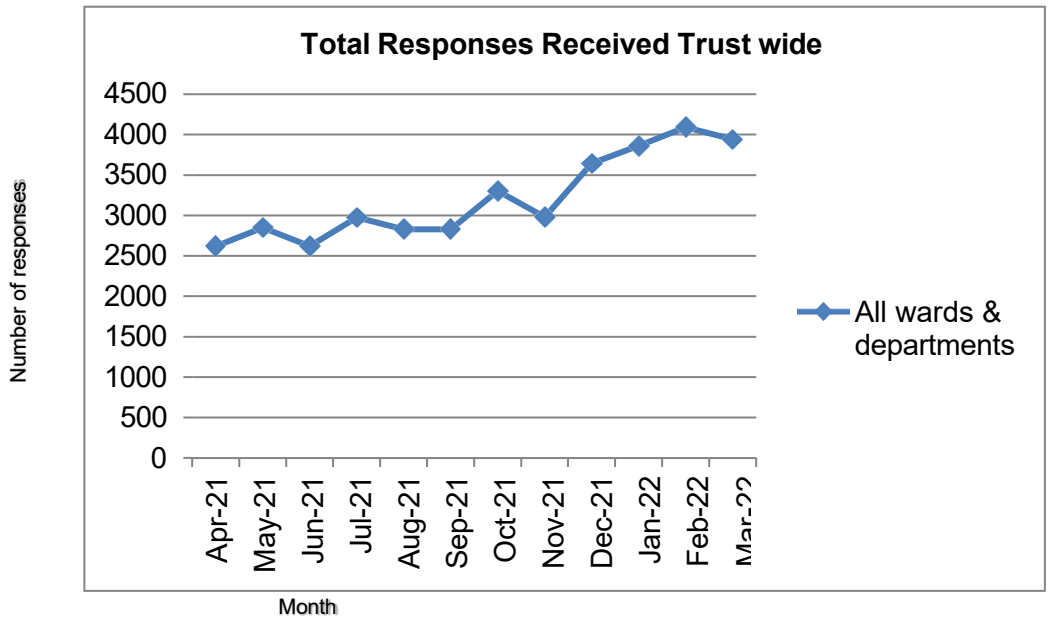


Source: FFT data

Table 2 – Quarterly positive feedback results

2020/21	Positive feedback % 2021/22			
Dept	**Q1**	**Q2**	**Q3**	**Q4**
Maternity	89%	89%	90%	86%
Day case	95%	95%	95%	95%
Outpatient	90%	90%	91%	92%
Inpatient	84%	81%	82%	84%
ED	78%	72%	72%	74%
CYP inpatients	78%	79%	76%	93%
CYP Daycase	95%	96%	92%	94%
CYP ED	73%	63%	60%	69%
CYP outpatients	84%	86%	87%	89%
Neonatal	100%	100%	100%	100%

Graph 2 Friends and Family % Response



Source: FFT data

The data in graph 3 demonstrates an overall increase in responses. In March 2020, due to COVID-19, a decision was taken to stop using paper surveys and IPad's/tablets due to the risk of contamination, however following infection prevention and control procedures and safety for patients, the organisation can now use all methods of collecting patient feedback. Since April 2021 – March 2022 we have received 1468 surveys completed using the QR codes/online links, 2829 paper surveys, 3684 telephone surveys and 36,128 SMS surveys. There have been 30 additional bespoke surveys created to the 15 Friends and Family Test surveys demonstrating growth in accessing feedback to inform service development and improvement.

Image 3 - Cloud presentation of FFT feedback the period of April 2021 – March 2022

3.2 Complaints and Concerns

Table 3 - Comparator data for Complaints 2019 to 2022

Year	Complaints received	Increase/reduction
2019-20	457	-253
2020-21	361	-96
2021-22	580	+219

Source: LTHTR Datix

During 2021/2022 the Trust received 580 formal complaints, an increase of 264 from 2020/2021. The increase represents a percentage of 10%. In the previous year there was a substantial reduction in complaints, during the COVID-19 pandemic. The trend in the ratio of complaints to patient contacts is detailed in Table 4.

Table 4 - Trend of ratio of complaints per patient contact 2016 to 2021

Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints to patient contacts
2019-20	457	576,447	1:1,261
2020-21	361	821,526	1:1,292
2021-22	580	717,213	1:1,237

Source: LTHTR Datix

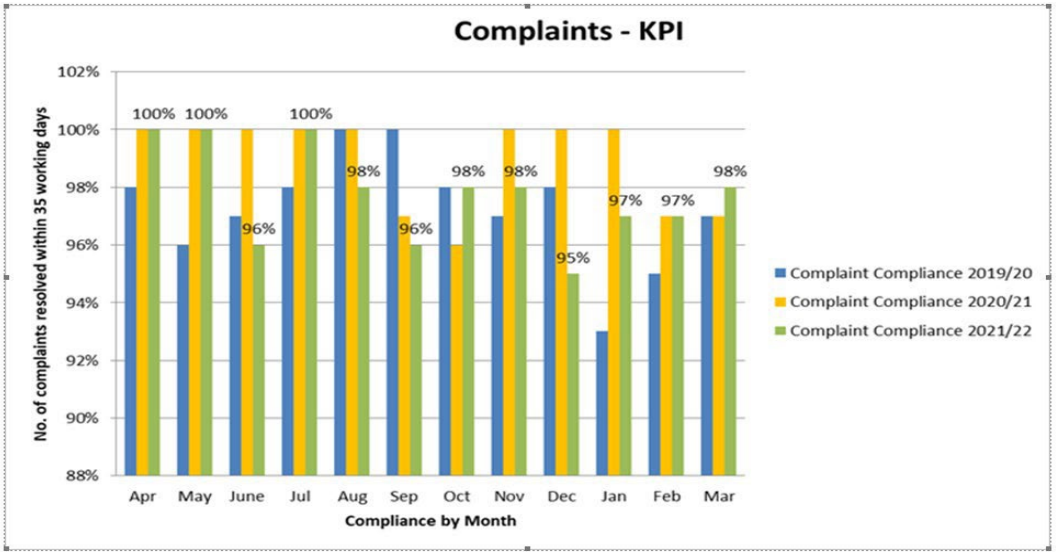
Of the 580 complaints received between April 2021 to March 2022, 509 (87.5%) related to care or services provided at the Royal Preston Hospital (RPH), 69 (12%) to care or services provided at Chorley and South Ribble Hospital (CDH) and 2 (0.5%) to care or services provided by offsite services.

Table 5 - Number of Complaints by Division – April 2021 to March 2022

Division	Number (%)	Division	Number (%)
Medicine	247 (42.5%)	Women and Children's Services	79 (14%)
Surgery	198 (34%)	Diagnostics and Clinical Support	48 (8%)
Estates and Facilities	2 (0.5%)	Corporate Services	46 (1%)

Source: LTHTR Datix

Graph 3 Complaints answered within the 35 working day period March 2020 – March 2021



Complaint regulations guide providers that complaint outcomes must be categorised into being upheld, partially upheld or not upheld. Investigations that were undertaken into the 580 closed complaints concluded that 56 (10%) of the complaints had been upheld, 284 (49.5 %) were partly upheld and 165 (28%) had not been not upheld. The 5 (0.5%) remaining records were cases that were withdrawn, and 70 (12%) cases remain currently open. The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 99% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team.

- During the period between April 2021 and March 2022, 27 second letters were received.
- A total of 544 formal complaints were closed during the period 1 April 2021 to 31 March 2022.
- 98% of complaints received in 2021/22 were closed within the 35-day timescale.
- The Patient Experience and PALS Team have dealt with a total of 1,749 concerns and 7,347 enquiries.

The implementation of the risk maturity plan has led to the introduction of Datix 2 (the governance reporting system) for patient experience, this will provide opportunities going forward to ensure that there is a more complete understanding of the themes and trends from all concerns, not only complaints.

3.3 Complaints themes and trends

Consent, confidentiality or communication is the highest theme through all divisional complaints.
Clinical assessment and treatment are consistently the next highest theme, followed by staff attitude and behavior and nursing care.

The number of complaints in large wards with more than 28 beds has historically been consistently higher than other areas. This has contributed towards the decision to increase the leadership from one to two ward manager in the large wards with the aim of ensuring increased visibility for patients and relatives and increased oversight of the issues that may lead to adverse experiences.

The number of complaints that site the Emergency Department and the extended wait or delay in accessing treatment is a recognised theme and the internal and external system wide actions relating to flow are critical in addressing this component of experience. Whilst these issues are resolved action has been taken to increase the number and skill mix of nurses and doctors within the department alongside improvements in the equipment available to attempt to mitigate extended waits.

The Children's ED department has featured as a theme and a response in improving the allocation of Doctors and increasing the Registered Nurse (RN) and HealthCare Assistants (HCA) from Two RN to three RN per shift and one HCA to two HCA per shift appears to be improving the experience of patients and relatives in this area.

Staffing levels undoubtedly impact on the experience of patients, during the pandemic this has been amplified with sickness levels at 11% at their peak. A robust and ambitious international nurse recruitment programme has led to a reduction in RN vacancies from circa 250-350RN vacancies per year to 30 in March 2021. Plans are in place to continue this and to anticipate the loss of RN through turnover and overrecruit to reduce the impact of this. Unusually, the number of HC has been impacted by the pandemic leading to circa 250 vacancies, this has a significant impact on the ability to deliver timely care and robust recruitment activity is underway to address this.

The impact of the pandemic is leading to an increase in complaints. Therefore, a crude reduction in the restoration period is unlikely to realise the ambition. Therefore, the big plan target is focused on the reduction of complaints due to communication and civility. This aligns to the culture improvement work underway across the organisation.

3.4 The Parliamentary Health Service Ombudsman (PHSO)

Complainants have the right to request that the Parliamentary and Health Services Ombudsman (PHSO) undertakes an independent review into their complaint in instances where local resolution has not been achieved.

Between the period 1 April 2021 to 31 March 2022 there were:

- 5 cases referred to the PHSO; 1 was not upheld and 4 are ongoing.
- During this period the PHSO sent final reports for 4 cases which were opened prior to April 2021 and the outcome of these were that 3 were not upheld and 1 was partly upheld.
- There are a further 3 cases referred to the PHSO prior to April 2021 which are still under investigation by the PHSO and a final decision is yet to be reached.
- 2 cases have been referred to the PHSO which are being actioned through the PHSO's local dispute resolution process; 1 has been resolved, 1 is ongoing – a meeting date is to be arranged.

3.5 Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2021/22 a total of 2,071 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. It is noted that the number of compliments received has significantly decreased this year. This may be as a result of the impact of the COVID-19 pandemic and the need to suspend visiting for a period of time. In addition, staff have had to prioritise clinical care which may have prevented them from logging compliments.

From April 2020, as part of the changes to Datix and subsequent rollout of the improvements, an additional module has been added to the tool to enable departments to record compliments directly onto the system and this also allows upload of associated documents. Additionally, it will provide teams with the opportunity to celebrate success locally and as part of their wider teams and divisions.

4. National Survey Results

There are several national surveys carried out across the organisation each year that provide a snapshot in terms of the experiences of patients. All surveys are administered externally by Picker UK and the results form part of the intelligence informing priorities of work. (A high level overview is provided here, the detail has been considered in previous committees)

4.1 Maternity Survey 2020

Lancashire Teaching Hospitals NHS Foundation Trust is ranked 11th out of the 66 Trusts nationally surveyed by Picker. This compared to ranking of 10 out of 63 in the previous year's survey. The response rate to the Maternity survey had a significantly higher response rate to the national average at 59% compared nationally as 54%.

There were no areas identified where the Trust was significantly better than the 2019 survey.

We were significantly worse than the last survey on the following 5 questions

- Not left alone when worried (during labour and birth) – 81%, compared to 91% in 2019
- Treated with kindness and understanding (in hospital after birth) – 95%, compared to 100% in 2019
- Had a telephone number for midwives (postnatal) – 94%, compared to 99% in 2019

- Received help and advice about feeding their baby (first six weeks after birth) – 91%, compared to 100% in 2019
- Received help and advice from health professionals about their baby's health and progress (first six weeks after birth) – 91%, compared to 100% in 2019

We were significantly better than the national Picker average on the following questions

- Given a choice about where postnatal care would take place – 52% compared to 38%
- Given enough information about where to have baby – 89% compared to 78%
- Offered a choice of where to have baby – 92% compared to 80%
- Involved enough in decision to be induced – 93% compared to 83%
- Received support or advice about feeding their baby during evenings, nights or weekends – 79% compared to 70%

We were significantly worse than the national Picker average on the following questions

- Received help and advice about feeding their baby (first six weeks after birth) – 81% compared to 86%
- Felt midwives aware of medical history (postnatal) – 72% compared to 73%
- Had a telephone number for midwives (postnatal) – 94% compared to 95%
- Felt midwives or doctor aware of medical history (antenatal) – 82% compared to 83%
- Felt midwives listened (postnatal) – 95% compared to 96%

Overall, the results for our Trust showed:

- 97% Treated with respect and dignity (during labour and birth)
- 95% Had confidence and trust in staff (during labour and birth)
- 96% Involved enough in decisions about their care (during labour and birth)

4.2 Children and Young People's Survey 2020

There was an increase for year 2020 in satisfaction of the parents, children and young people surveyed based on the 2018 survey. Lancashire Teaching Hospitals NHS Foundation Trust is ranked 31st out of the 67 Trusts nationally. This is compared to the 2018 survey, where the Trust was ranked 58th out of 66 Trusts surveyed. Parents rated experience of care as 7 out of 10 or more and this is at par with the Picker national average.

We were significantly better than the last survey on the following 7 questions

- Parents had new members of staff introduce themselves – 97%, compared to 92% in 2018
- Parent felt that Wi-Fi was good enough for child to do what they wanted – 81%, compared to 57% in 2018
- Parent kept informed by staff about what was happening – 90%, compared to 92% in 2018
- Parent had access to hot drinks facilities in hospital – 84%, compared to 74% in 2018
- Parent felt that staff were available when child needed attention – 97%, compared to 93% in 2018
- Parent felt hospital room or ward was clean – 99%, compared to 96% in 2018
- Child felt hospital was quiet enough to sleep – 86%, compared to 68% in 2018

We were significantly worse than the last survey on the following question

- Parents felt that there was not enough for their child to do – 73%, compared to 91% in 2018

We were significantly better than the Picker average on the following 2 questions

- Parent had access to hot drinks facilities in hospital – 84%, compared to 78%
- Parent able to prepare food in hospital – 70%, compared to 41%

We were significantly worse than the Picker average on the following question

- Parent rated overnight facilities as good or very good – 50%, compared to 69%

Overall the results for our Trust showed:

- 93% Parent felt well looked after by staff
- 93% Child felt well looked after in hospital
- 94% Parent felt staff agreed a plan with them for child's care

4.3 Urgent and Emergency Care Survey 2020

The results demonstrate an improved position for the Emergency Departments compared to the last National Picker survey in 2018. Lancashire Teaching Hospitals NHS Foundation Trust is ranked 34th out of 66 Trusts nationally. This is compared to the 2018 survey, where the Trust was ranked 47th out of 69 Trusts surveyed. Patients rated experience of care as 7 out of 10 or more and this is above the Picker national average.

We were significantly better than the last survey on the following 3 questions

- Waited under an hour in the ambulance – 97%, compared to 89% in 2018
- Waited under an hour in A&E to speak to a doctor/nurse – 90%, compared to 82% in 2018
- Staff helped control pain – 90%, compared to 84% in 2018

We were significantly worse than the last survey on the following question

- Right amount of information given on condition or treatment – 74%, compared to 83% in 2018

We were significantly better than the Picker average on the following questions

- Understood results of tests – 99%, compared to 97%
- Saw the cleaning of surfaces – 82%, compared to 74%
- Saw tissues available – 83%, compared to 78%
- Did not feel threatened by other patients or visitors – 96%, compared to 93%
- Staff discussed transport arrangements before leaving A&E – 61%, compared to 50%

We were significantly worse than the Picker average on the following question

- Spent under 12 hours in A&E – 88%, compared to 94%

When rated against all 126 Emergency Departments the trust overall scores demonstrated 'about the same' therefore comparable to similar organisations.

Overall, the results for our Trust showed:

- 88% rated care as 7/10 or more
- 97% treated with respect and dignity
- 95% doctors and nurses listened to patients

4.4 Inpatient Survey 2020

Lancashire Teaching Hospitals NHS Foundation Trust is ranked 61st out of the 71 Trusts surveyed by Picker. This is a deteriorated position compared to the 2019 survey where the Trust was ranked 51st out of 77 Trusts surveyed, both years lower than the aspiration of the Trust. It is worth noting that some of the benchmarking asked this year was not part of the survey in 2019 survey. Patients rated quality of care as 11% compared to 8.1% from the previous survey; this is below national average of 13.7% although it was an improvement for the organisation. Experience of care was rated at 80% which is a drop from the previous survey of 83% which remains lower than the national average of 85.3%.

We were significantly better than the last survey on the following 2 questions

- Nurses answered questions clearly – 97%, compared to 94% in 2019
- Given written/printed information about what they should or should not do after leaving hospital – 72%, compared to 64% in 2019

There were no areas identified as significantly worse than the 2019 survey. There were no areas identified as significantly better than the Picker average.

We were significantly worse than the Picker average on the following 4 questions

- Got enough help from staff to eat meals – 77%, compared to 85% in 2019
- Staff did not contradict each other about care and treatment – 65%, compared to 66% in 2019
- Right amount of information given on condition or treatment – 77%, compared to 80% in 2019
- Rated overall experience as 7/10 or more – 80%, compared to 83% in 2019

Overall the results for our Trust showed:

- 80% rated experience as 7/10 or more
- 98% treated with respect or dignity
- 98% had confidence and trust

Table 6 - Summation of Picker survey results

Survey title	Position 2021	Previous position	Number of areas improved comparison to previous survey	Number of areas deteriorated in comparison to previous survey
Maternity	11 out of 66 Trusts	10 out of 63 Trusts	5	35
Children and Young People's Survey 2020	31 out 67 Trusts	58 out of 66 Trusts	41	17
Urgent and Emergency Care Survey 2020	34 out of 66 Trusts	47 out 69 Trusts	11	15
Inpatient Survey 2020	61 out 71 Trusts	51 out 77 Trusts	14	9

4.5 National Cancer Patient Experience Survey

The Cancer Patient Experience Survey 2020 differs from all previous years in that it involved only 55 NHS Trusts as it was completed voluntarily due to the pandemic. As not all NHS Trusts participated in the survey no comparisons to scores nationally are shown. A total of 546 patients responded out of a total of 922 patients, resulting in a response rate of 59%

A total of 52 questions were used in the 2020 survey, of these 47 can be compared to questions in 2019. Compared to the 2019 survey rating of 8.9, the Trust has maintained this satisfaction score of 8.9 overall however Urology scored 9.4.

Overall the trust was rated:

- 89% rated overall care as very good/good
- 80% Patients definitely involved as much as they wanted in decisions about care
- 93% patients were given the name of a CNS who would support them
- 88% Patient found it very or quite easy to contact their CNS
- 90% patients always felt they were treated with respect and dignity while in hospital
- 97% Patients were told by staff who to contact after leaving hospital

When comparing the results to 2019 the trust scored significantly higher in 4 questions

- Patient given a care plan
- Confidence in ward nurses treating them
- Nearly always enough nurses on duty
- Hospital staff asked what name they preferred to be called by

When comparing the results to 2019 the trust scored significantly lower in 1 question

- Hospital staff told patients they could get free prescriptions

Each of the survey areas have access to the surveys and the qualitative feedback. This is used to inform future improvement work that will be reflected within the next three year strategy.

5 Financial implications

None

6 Legal implications

None

7 Risks

Inpatient experience is the most significant risk specifically relating to the emergency pathway continues to deteriorate. This is a contributing factor to the Exit Block operational risk that has remained escalated to Board since December 2021.

8 Impact on stakeholders

Non in addition to those cited in the report.

9 Conclusion

The volume of activity and energy underway to engage with, listen and work in partnership with patients and families to respond to lived experience and ensure true learning takes place is significant. FFT data is indicating an upward trend over the year in all areas except ED.

The patient experience and involvement strategy (2018-2021) was co-produced with staff and patients and has guided the activity that has taken place leading to a number of tangible improvements, these include; the inclusion of patient experience in the safety strategy, accessible actions and improvements within specific pathways including children, however, the impact of the pandemic has limited some elements of delivery and impacted patients and families in ways unlikely to be fully understood for some time.

Sustained high performance in relation to the maternity and cancer survey is positive given the context of the pandemic and whilst complaints have increased, the due diligence in ensuring quality remains a focus, response rates for friends and family returns to pre pandemic levels and identifying staff communication as an area of focus within ‘The Big Plan’ aims to focus on what is within the control of the organisation and align this to the broader organisational culture improvement work. Complaints when measured against activity remain consistent over the last 3 years with complaints response compliance consistently above the internally set 95% standard to receive a response within 35 working days.

The focus on improving inpatient experience will remain a priority for the next strategy and whilst it is positive to note some improvement in the Emergency Department survey, neither survey are achieving the standard the organisation aspires to meet. The impact of extended waits on experience should not be underestimated and triangulates as a theme through complaints and feedback, as does the impact of reduced staffing as a result of the pandemic and longstanding vacancies. There is evidence of an improved RN vacancy position moving from 250 to 30 vacant positions despite an increase of bed base in excess of 100 beds in the last 2 years. It should be noted it will take a further 9 months to realise the full benefit of this owing to the preceptorship period of new recruits. HCA staffing shortfalls and the internal and external requirements for flow continue to be system priority and one that must be seen as a key experience measure.

A number of experience projects that have commenced in early 2022 including, patient contribution to case notes, mental health self-harm risk assessment, access to translators, participation in research, visiting arrangements, continuity of carer, improved children's facilities and staffing, essential carers, patients as partners, live feedback collection, reasonable adjustments flags, activity boxes, patient information will continue into the next patient experience and involvement strategy 2022 - 2025. This will be presented to Safety and Quality committee in July 2022.

10 Recommendation

It is recommended the Council of Governors:

1. Receive the report and discusses the contents.
2. Notes the closure of the 2018-2021 Patient Experience and Involvement Strategy and the plan to approve the new strategy in Safety and Quality committee in September 2022.

Appendix 1

Patient Experience and Involvement Strategy 2018-2021 Closure May 2022

1. Deliver a positive experience

What you told us...	How we will improve...	What will good look like?...	Have we delivered?	What we achieved
Information received can be difficult to understand and not in the right format for me	Introduce and maintain the accessible information standard in all areas and produce patient information that is reviewed by patients Create a patient reader group to develop information that is understandable	Information is provided in a consistent way in all areas throughout the hospital that is accessible for everyone Patient feedback will be used to create communication to patients	✔	- **Created an established, controlled and audited system. All patient information leaflets are coded, with version control and a review date. Templates are set with accessibility option information provided. A contract with printers and internal ordering system ensures all leaflets are provided in a professional manner with an emphasis to staff around guidance for production only through contracted services. This ensures the patient receives current, professionally presented information.** - **Continue to work towards achieving the accessible information standard.** - **The Patient Information Group (PIG) oversees all new documents to ensure these standards are met. PIG consists of various clinical staff with roles covering areas including pharmacy, library services, blended learning and governance. Along with this there are staff from medical graphics, administrators, workforce partners and representation from our Public Trust Governors and Healthwatch. Patients past and present and carers are also included in the membership representing various backgrounds such as LGBTQ+, physical disabilities.** - **All patient information leaflets are available in a variety of languages and easy read versions on request. Paper copies and link available.** - **Patient experience and involvement group designed the language adopted in relation to the raising concerns with ward manager or matron welcome boards at the entrance to each clinical department.** - **Safety 1 and 2 bulletins have moved to being displayed in public to demonstrate transparency.** - **PALS team now part of the hospital radio to promote speaking up if worried.** - **22 forums in place to listen to patients across the various specialties.**
There are limited ways to give feedback if I do not use a telephone	Increase the number of areas with paper methods to collect feedback	Actions taken as a result of the feedback will be visible in clinical areas in a 'you said, we did' format The response rate to Friends and Family will increase New ways of collecting feedback will be evident	✔	- **Governance boards in place including you said, we did area. The completion of this is monitored through STAR.** - **Paper Friend and Family forms were suspended due to COVID-19, these have now been reintroduced and increase in feedback rates increased. See Graph 1.** - **Since April 2021 – March 2022, 1468 surveys completed using the QR codes/online links, 2829 paper surveys, 3684 telephone surveys and 36,128 SMS surveys. We currently have 543 members of staff with access to the friends and family test system.**

- **A number of involvement groups are in place to ensure patient who wish to be more actively involved.**

Graph 1- Total friends and family response rates

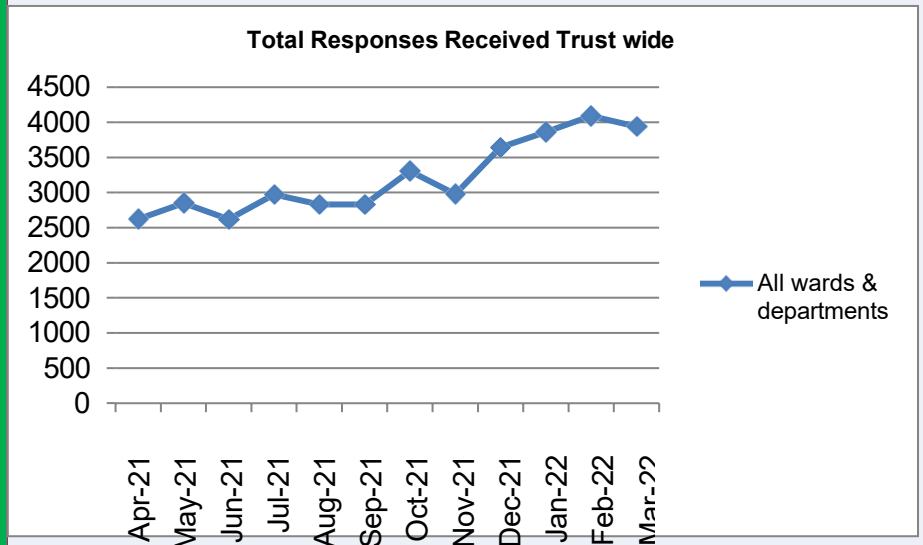
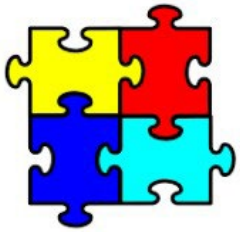


Table 1 - Quarterly percentage of response rates

2020/21	Positive feedback % 2021/22			
Dept	**Q1**	**Q2**	**Q3**	**Q4**
Maternity	89%	89%	90%	86%
Day case	95%	95%	95%	95%
Outpatient	90%	90%	91%	92%
Inpatient	84%	81%	82%	84%
ED	78%	72%	72%	74%
CYP inpatients	78%	79%	76%	93%
CYP Day case	95%	96%	92%	94%
CYP ED	73%	63%	60%	69%
CYP outpatients	84%	86%	87%	89%
Neonatal	100%	100%	100%	100%

Staff are not consistent in the way they introduce themselves	Introduce #hellomynameis boards introducing teams Introduce #hellomynameis name badges Resources to support teams live the values will be introduced	Patients will report improved experiences 15 steps will show improvements	✔	- **#hellomyname is badges and boards are in place** - **Values plus organisational development resources launched** - **What our values mean to our patient's resources coproduced with patients.** - **National Picker survey results demonstrate a deteriorated position in inpatients, improved position in children's, a sustained positive position in maternity and cancer.** - **Friends and Family Test (FFT) data demonstrates an upward trend in services except for patients in ED.** - **Lancashire Teaching Hospitals NHS Foundation Trust have been selected by Imperial College London NHS Foundation Trust to be a 'Phase 1' site to test this innovative approach to using patient experience feedback in real-time. This is an exciting opportunity to test with the potential to better develop the use of experiences of our care and services. To date, the digital infrastructure has been worked upon, early testing is provisionally planned for quarter two 2022-2023.** - **The STAR quality assurance monthly and accreditation review focus on patient experience with >75% of areas achieving a silver or above rating.**
Patients with mental health and learning disabilities have a poorer patient experience than those that do not	Identify specialist resource to improve the experience of patients across all pathways for patients with mental health and learning disabilities Use national learning from reports such as 'Treat as One' and 'Leader' to benchmark our services to improve the experience of patients in this group Provide opportunities to interact with partner organisations and patients to learn	Create guidelines and best practice for patients in these groups Seek experiences from patients in these groups Work in partnership with health economy services Provision of changing places at Royal Preston	✔	- **Mental health, learning Disability, Autism and dementia matron created with specialist nurses for dementia, learning disability and mental health in place.** - **A specialist midwifery team and community Paediatric team are in place and work directly with patients and families to ensure specific needs are care planned and responded to.** - **LeDer reviews now incorporated into mortality reviews on a bi annual basis.** - **Participation with national learning disability audit has been completed for 4 consecutive years. 2021 data is awaited.** - **Learning disabilities, reasonable adjustment is flagged has been launched on QuadraMed.** - **The 'reasonable adjustments' Quadramed tab on the internal system was developed 2021. Front line staff are recording what reasonable adjustments the service user has expressed that they need, or what would enhance their patient experience.** - **The frequent sharing of patient stories takes place at the safeguarding operational group and board, disability champions meeting, with learning fed into the LeDeR Steering Group.** - **Consultation in March 2022 at the Learning Disability Partnership Board (including multi-agency partners and people with a learning disability) into the LTHTR Learning Disability and Autism Strategy, this will be launched in 2022 with an agreed focus on re-establishing the 'Live Healthier, Live Longer'.** - **Specific experience forums in place to ensure experiences and needs are heard and responded to.** - **The community learning disability and autism forums made the decision that there was a requirement for a separate symbol for learning disability**

				and autism that could be used behind patient beds, attached to notes and act as a prompt to consider reasonable adjustments. - **The development, consultation and implementation of all age Mental Health Strategy (October 2021-2025) which notes patient experience as a commitment, aims to increase the skills and knowledge of our workforce in delivering patient centered care, and has a future vision for co-production with experts by experience.** - **https://intranet.lthtr.nhs.uk/download.cfm?ver=116480** - **The development of the Children and Young Person Emotional Health and Wellbeing friends and family feedback form aims to improve feedback from children experience emotional and mental health disturbances. Outcomes not yet available.** - **The dementia strategy was launched in 2021 see link: https://intranet.lthtr.nhs.uk/dementia** - **The establishment of the Dementia Strategy Task and Finish Groups including people living with dementia, families, carers, governors, patient experience lead and multi-agency partners (for example, Alzheimer's society and NCompass).** - **The development of the Dementia Corridor to raise the profile of dementia, signpost and provide simple activity suggestions is supporting improved practice in this area.** **Image 1 Learning Disability organisation symbol**  **Image 2 Autism organisation symbol**  - **Changing places at Preston was opened in 2021. There are now 3 changing places, one on each of the sites.** - **In 2017 Lancashire & South Cumbria Health and Care Partnership had its SEND Inspection undertaken by Ofsted and CQC and we were found to have serious weaknesses in twelve areas. A revisit in 2020 showed improvement in 7 areas and 5 remaining areas required further work. A**

				further visit on 29th September 2021 showed sufficient progress had been made in the remaining 5 areas and Lancashire is now no longer under a formal monitoring regime.

I want to be involved in decisions about service improvement	Create a forum for patients to discuss changes to the way we deliver services
	
	Introduce patient surveys and Friends and Family in children and young people and neonatal intensive care
	
	We will use local communities to help us recruit leaders
		Community based forums open to all to participate in discussion
		
		We will act on information and publish this
			✔	- **Up to the pandemic an annual 'Our health' day was run to formally engage with the community and focuses on reducing health inequalities, topics are selected by the community groups.**
				- **The forums in place are;**
				  ○ **Youth Forum**
				  ○ **Carers Forum**
				  ○ **Patient Information Group**
				  ○ **Cancer Patient Forum**
				  ○ **Cancer Patient Information Group**
				  ○ **Dermatology Psoriasis Support Group**
				  ○ **Upper GI Cancer Support Group**
				  ○ **Mobility Matters Forum - SMRC**
				  ○ **Complex Pain Syndrome Support Forum - SMRC**
				  ○ **Critical Care Ex Patients and Relatives Support Group**
				  ○ **Trache Forum**
				  ○ **Patient Research Group**
				  ○ **Patient Ethics Reference Group**
				  ○ **Renal Dialysis Service Group**
				  ○ **Preston Dystonia\Migraine support Group**
				
				A number of additional forums are hosted in partnership with external health and social care colleagues;
				
				  ○ **Lancashire Learning Disability and Autism Partnership**
				  ○ **Gynaecology Patient Forum - with vine house**
				  ○ **Maternity Voice Partnership**
				  ○ **PAG (Patient Advisory Group)**
				  ○ **PPCV (Patient, Public and Carers Voice)**
				  ○ **Asian Ladies Forum**
				  ○ **Lancashire County Council**
				- **The outcome of these will inform the learning disability strategy that will be published in 2022.**
				- **Focus groups for senior leadership appointments include representatives from the patient experience and improvement group.**
				- **Learning Disability week is the 20-26th June 22 and will be used to listen post pandemic to patients with a learning disability to ensure the strategy includes post COVID-19 needs.**

<table>
<tr><td></td><td></td><td></td><td></td><td>Image 3
 
</td></tr>
<tr><td>I want my partner to stay with me when I have had a baby</td><td>Work with parents to design how this can work</td><td>Mothers can choose if they wish a partner to stay</td><td>✔</td><td>- This option has been impacted at times during the pandemic. There are facilities available within all birth settings to support this. Photographs of the unit can be seen here.
https://www.lancsteachinghospitals.nhs.uk/birth-centres</td></tr>
<tr><td>I want to feel confident with my first 15 steps</td><td>Introduce the 15 steps methodology to all areas in the Trust

Work with patients to undertake 15 steps as part of STAR quality assurance process</td><td>See an improvement in the scoring

Improvement in the use of feedback to drive change in local departments</td><td>✔</td><td>- 15 step methodology is a fundamental part of the STAR quality assurance process and is reflected in the STAR policy. This is now undertaken in the walk up to the unit being audited to include the broader experience prior to the unit. In normal times patients or governors
- The outcome of the 15 steps is reported in the monthly STAR report. Any rating of C or below is immediately escalated to the divisional management team and matron.

Table 2- STAR 15 step outcome data for 2021/22
<table>
<tr><th></th><th>A
Very confident</th><th>B
Confident</th><th>C
Not very confident</th><th>D
Not confident at all</th></tr>
<tr><td>Trust Overall</td><td>88</td><td>33</td><td>2</td><td>0</td></tr>
</table></td></tr>
<tr><td>I don’t want to wait to access the children’s ward</td><td>Invest in new access systems so we can keep children safe and reduce time waiting for parents

Create facilities on the ward that reduces the need to leave the ward as often</td><td>Parents will report being able to access the ward without delay</td><td>✔</td><td>- New access system purchased and implemented
- Parent facilities upgraded in the ward

Feedback on the picker survey demonstrated better than average performance in:
- Parent had access to hot drinks facilities in hospital – 84%, compared to 78% in 2018
- Parent able to prepare food in hospital – 70%, compared to 41% in 2018</td></tr>
</table>

				However, the survey also highlighted performance significantly worse than peer - **Parent rated overnight facilities as good or very good – 50%, compared to 69%**
I want the theatre setting to feel as calm as the delivery suite	Work with parents to adapt the way we treat the theatre experience	Patient stories will be used to continuously improve this experience	✔	- **There are now 40 Flow Coaching Academy (FCA) Big Rooms and 61 trained coaches These meet weekly and are focused on pathway level improvements. As part of the FCA methodology, coaches are taught to use patient stories in each of the big room meets to ensure the patient remains at the centre of the improvement work and continuous learning and listening takes place.** - **Patient stories are a part of each board meeting and feature within the governance arrangements at divisional and specialty level across the organisation.** - **The maternity and neonatal improvement programme is progressing and reports to Board and Safety and Quality committee monthly. As part of this an improvement coach is focused within maternity services as part of an Institute for Health Improvement (IHI) programme where the experiences of women are used to improve services. Examples of improvement work in response to women's and families' experiences include:** ○ **Theatre as a birth room project** ○ **Skin to skin time** ○ **Introduction of new maternity triage system** ○ **Safer sleeping campaigns** ○ **ICON managing crying babies**
I want to go outside as part of my recovery	Create spaces where patients can experience outdoors as an inpatient	Patient stories	✔	- **A number if improvements have been made to the external environment that facilitate outside experiences as part of recovery from illness these include upgrades in the following areas;** ○ **Bereavement gardens** ○ **Neurosurgical garden** ○ **Neurorehabilitation garden** ○ **Critical care space, designed to enable patients who are on long term ventilation to experience outdoor stimulation** ○ **The areas for development and in the next plan are:** ○ **Community dementia garden** ○ **Faith celebration lighting** ○ **Baby bereavement space** ○ **Children's outdoor space**
As a cancer patient I want to be able to access support in different ways	We will continue support groups and look for different ways to support patients	Options will be available for patients that can be chosen depending on what they need	✔	- **Improvements for cancer patients include:** - **Launch of the End of Life CARING charter** - **When comparing the results to 2019 the trust scored significantly higher in 4 questions** ○ **Patient given a care plan** ○ **Confidence in ward nurses treating them** ○ **Nearly always enough nurses on duty** ○ **Hospital staff asked what name they preferred to be called by** - **Overall results demonstrated:** ○ **89% rated overall care as very good/good**

				○ **80% Patients definitely involved as much as they wanted in decisions about care** ○ **93% patients were given the name of a CNS who would support them** ○ **88% Patient found it very or quite easy to contact their CNS** ○ **90% patients always felt they were treated with respect and dignity while in hospital** ○ **97% Patients were told by staff who to contact after leaving hospital** **Actions taken to develop services experienced by patients with Cancer** ○ **Macmillan Right by You manager in post to ensure personalised care in cancer is rolled out** ○ **All Patients have access to support / CNS at diagnosis;** ○ **Holistic Needs assessments are offered to all patients at diagnosis and post treatment;** ○ **Treatment Summaries are provided post treatment;** ○ **Patient Stratified follow up pathways implemented for Breast Colorectal and Urology and for all tumour site s by 2024 plan being developed with the alliance.** ○ **Development and expansion of the Macmillan Cancer Information and Support Service, (MCISS) has been completed to improve patient access to information and support and ensure information and support is available to all inpatients and day surgery patients, improving educational and training for staff in these areas. Increase support available for all patients for employment and financial advice provided by the MCISS.This will need to include promotion of free prescriptions for patients**
I want to feel supported and able to stay with my loved one at the end of life	We will create space for relatives to stay at the end of life and be comfortable and rest	Relatives will feel able to stay if they choose	✔	- **There are now 18 beds available for loved ones to stay with relatives at the end of life and 40 aromatherapy diffusers in place, one for each ward to create a more peaceful ambience for patients and relatives.** - **At the earliest opportunity restrictions on end of life support were lifted for families, although the pandemic has significantly impacted this experience.** - **There is a plan to create a number of peaceful relaxation rooms for relatives within the main ward block in line with the CARING commitment.**
I want to be able to rest and access refreshments and hygiene facilities whilst I am visiting my child	Create a space that allows parents to relax and stay close to their child	Parents will feel able to stay and relax whilst looking after their child	✔	- **Improvements have been made in relation to parent stay conditions through the provision of improved beds and kitchen facilities.** - **Wash facilities and ease of access to these is a limiting factor at this time and will be addressed as part of the refurbishment in the children's ward.**
Other improvement work			✔	- **Introduced the Badgernet Digital system application. To date 96.9% of pregnant service users have registered and logged in to use the Badgernet application to access their digital record** - **Co-produced our access guidance with our Maternity Voice Partnership** - **Relocated some of our antenatal clinics in the Chorley Birth Centre where access is easier for our service users** - **Introduced a printed maternity pathway card that details when pregnant women need to attend for their scans** - **Developed a Birth Choices leaflet that outlines the risks and benefits of all places of birth**

				- **Implemented the real birth application that offers parent craft education in multiple languages** - **Continued to offer access to all our services throughout the pandemic for our families** - **Continued to offer all places of birth despite the pressures of Covid.**

2. Improve outcomes and reduce harm

What you told us...	How we will improve...	What will good look like?...	Have we delivered?	What we achieved
Important information can be lost between nursing and residential homes	Create a system to ensure important information is held together	See an improvement in the scoring Improvement in the use of feedback to drive change in local departments	✔	- **Whilst some work has been delivered. There remains improvement opportunities in this area.** - **Monthly carers forum created to inform improvements in all areas of care including discharge.** - **Care home collaborative meetings in place to strengthen relationships across the system and improve communication and handover of care.** - **Trusted assessors created to prevent duplication for nursing and residential homes.** - **Change in approach to the management of adverse discharges to create a more learning focused procedure with adult social care, the community and hospital teams.** - **The Picker inpatient survey demonstrated strengths and areas to improve in relation to discharge. These include:** o **Discharge without delay improved from 59% in 2019 to 66% in 2021 which is above the Picker average of 63.8%.** o **Patients scored the Trust low on information provision as compared to the national average on medication, symptoms and after care upon discharge.** o **Patients transport arrangements after discharge were scored above the national average with 61% and the Picker national score of 50%.**
As a deaf person it is difficult to access services	Talk to our local community partners and agree how this can be improved We will increase the access to level 3 interpreters We will recruit volunteers who can meet and greet using sign language	Volunteers employed who are BSL proficient Mystery shopper visits will demonstrate improvements The use of BSL interpreters will increase	✔	- **Whilst some work has been delivered. There remains improvement opportunities in this area.** - **Training on BSL has commenced within the organisation.** - **Deafways have been instrumental in developing how the Trust moves forward with translation services, providing advice and guidance on the best services to use, such as the video translation service. They were involved with the development of the refreshed Translation and Interpreter Services Policy and Procedure and the procurement of a new service to support this. Deafway have supported the organisation to produce a poster to help staff recognise the needs of the deaf community and influenced the purchased of more than 100 hearing loops installed across the organisation. They have worked with the Trust to provide a short film on the experiences of the deaf in hospital and what it is like to be deaf. This is to raise awareness for those who are not deaf.**
As visually impaired it is difficult to find my way around the hospital	Create the capacity for volunteers to walk with patients who need assistance	Build into the volunteer role and provide awareness training The availability of this support 7 days per week	✔	- **Whilst some work has been delivered. There remains improvement opportunities in this area.** - **Volunteers are available at the main entrances and it is possible to contact PALS ahead of visits and for someone to meet the patient at the entrance and guide them to the department. This is not available 7 days per week and out of hours and this is an area to focus on as part of the next stage of improvement work.**

I want to be able to contribute to shaping the way my hospital provides services	Create forums where patients and representatives of our local community can provide their views and opinions Build patient stories into meetings throughout the Trust to maintain focus on patients experience	There will be no business cases or changes without the involvement of users There will be working groups used to design new ways of working	✔	- **Whilst some work has been delivered. There remains improvement opportunities in this area.** - **Quality Impact Assessment policy introduced and applicable to all cost improvements.** - **Patient stories used to inform improvement work.** - **Increase in the forums used across all specialties.** - **Tests of change in capturing live patient feedback proactively using the PALS team have commenced.** - **The pilot was initiated to ascertain what safety means to patients.** - **Further work to implement routine patient views into all work.**
I cannot always access information in my first language	Increase the availability of information in different languages	Ability to access information in different languages and formats	✔	- **Providers of interpretation services increased from one to two to expand coverage.** - **Language options available in all leaflets and website.**

As a pregnant woman I want to be able to access care early in pregnancy	Review pathways with women to increase early access	Time to see a midwife in early pregnancy will reduce	✔	- **Metric on maternity dashboard are indicating**
				  ○ **In 10 of the 12 previous months 90% or more women were booked to see a midwife by 12weeks, 6 days.**
				  ○ **The next phase of improvement is to increase the number of women booking to see a midwife by 9weeks and 6 days. (currently achieved standard in 4 of the 12 previous months)**

I want to have more contact with the same midwife so I can build a relationship with them	Explore how continuity of care can be improved	Women will have a named midwife throughout the pregnancy and will report improved experience as a result of this	✔	- **The implementation of continuity of carer has continued. However, due to current staff vacancies this has been partially paused in some areas to respond to provision of one to one care in labour.** - **Investment case prepared for full implementation of continuity of carer and monitored via CNST report to Board.**
I don't want to be separated from my baby if they need intravenous antibiotics	Work with women to reduce the time spent away from their baby	Reduction in the time spent away from their baby Improvement in the experience of women through the safety thermometer questions	✔	- **Safety thermometer stood down as part of the pandemic.** - **Implementation of transitional care on the maternity ward now provides the opportunity for mums to stay with babies on the ward rather than being separated and baby staying in neonatal unit and mum being on the ward. This is compliant with the requirements of CNST.**
I miss socialising when in hospital	Introduce dining companions Introduce reading groups Create the capacity to create social spaces	Share good practice and use this to recruit more volunteers	✔	- **Whilst some work has been delivered. There remains improvement opportunities in this area.** - **Social spaces and dining companion have been negatively impacted by the pandemic.** - **Plan to introduce essential carer role as part of new patient experience and involvement strategy.**
I want to receive my mummy's milk when I leave the neonatal intensive care unit	Work with mums to understand how we can do this more often Understand the psychological needs of parents when a baby is in the neonatal unit	National neonatal audit results will show an improvement in this area Parents will report being supported psychologically in various ways	✔	- **100% friends and family satisfaction results in neonatal intensive care.** - **2 complaints in the previous 12 months.** - **>70% of mums and babies leave with breast feeding initiated.** - **Between 59-71% of babies have initiated breast feeding in the neonatal unit.**

I want to receive one to one care when I am in labour	Invest in maternity staffing to always achieve this	Monitor this and achieve it every time	✔	- **This metric is monitored in each place of birth and forms part of the maternity dashboard. 99% of one to one care in labour has been achieved in 9 of the 12 previous months. 97% in 2 months and 95% in one month.** - **Mitigations in place include the caveat that there are no times when a midwife is caring for two women in active labour.** - **Staffing plan in place to work towards 100% compliance.**
I want to have skin to skin contact with my baby when they are born, even in theatre	Change the way we work to protect the time after birth for this skin to skin contact	All babies when well enough will have this time protected with their mummy and we will record when this happens	✔	- **Process in place to facilitate skin to skin time in all settings.** - **Improvements in blood glucose levels have led to a reduction in admission to the neonatal intensive care unit.**
Other developmental work				- **Introduction of the Always Safety First strategy to focus on improving outcomes for patients. Link https://intranet.lthtr.nhs.uk/download.cfm?ver=104739** - **Introduction of Patients delayed due to covid workstream, overview presented to safety and quality committee April 2022.** - **Publication of the Clinical strategy 2022.** - **Triangulation of outcome data demonstrated performance in wards with >28 beds was lower. In response to this a test of change for 18 months has commenced to measure the benefits of increased ward management capacity for the large wards, this will be evaluated over the 18 month period to inform long term strategy.**
Other				- **Reducing risk of self harm** **The implementation of the Mental Health Risk Tool and e-learning package which emphasis the need for collaboration with patients to understand triggers, helpful strategies and collaborating a risk management plan.** - **The continued drive for parallel assessment by Mental Health Liaison Team (MHLT) and Children and Young People's Mental Health Services (CAMHS) aims to improve outcomes for this group of patients.**

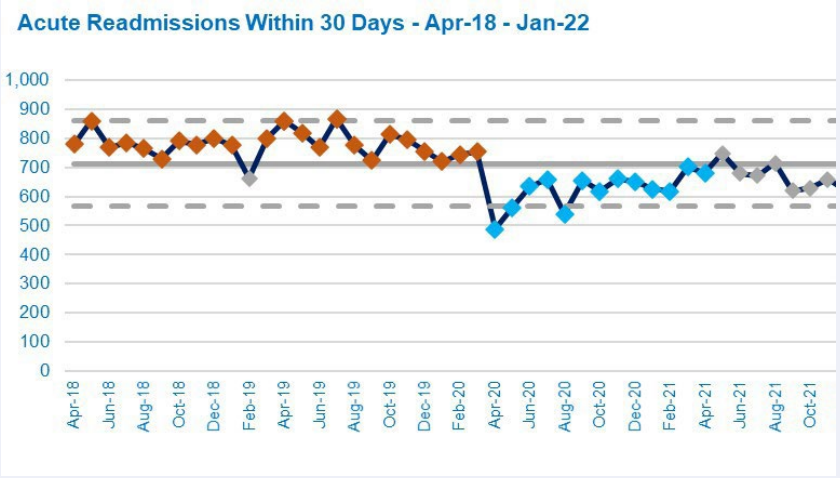
3. Create a good care environment

What you told us...	How we will improve...	What will good look like?...	Have we delivered?	What we achieved
I don't want to complain in writing but I'd like to raise a concern	Create new ways of accessing someone to raise concerns with Develop a proactive approach to asking 'what matters to you' Leaders will focus attention on local resolution Information will be easily available to direct you to how to raise a concern that is not a complaint	Reduction in the number of complaints Increase in the use of the patient advice and liaison service Increased visibility of matron Identification of the person in charge	X	- Whilst some work has been delivered. There remains improvement opportunities in this area. - Welcome to the department boards created with photographs of the matron/professional lead and unit/ward manager with contact details. - Matron calling cards created. - Contact details of PALS at the entrance of every ward. - Shift leader lanyards implemented. - Increase in PALS and reduced complaints pre pandemic, this position has now reverted and further work under way to relocate PALS on main hospital sites, initiate same day response to enquiries. - Complaints quality review undertaken and learning shared. Plan to include patient group review of complaint style and approach to improve the experience of receiving a complaint. - Introduced a satisfaction survey as part of complaints responses. Results not yet ready to share.
I want you to know the things that matter to me and my family	Create ways to build this into every interaction so our teams know what matters to you	Boards at the patients bedside to encourage patients and families to write what matters to me Increased use of passports of care and forget me not documents	✔	- Behind the bed boards designed with patients and framed using 'what matters to you' approach. - Passports and forget me not compliance monitored as part of STAR.
I told you I have a learning disability and have different needs	Design with you a way to tell this to our teams so they can provide you with the support you need	A new learning disability symbol will be launched Improved patient stories from learning disability patients and families Passports of care will be in use consistently for patients who need them	✔	- Symbols designed with patients (as above) and launched with reasonable adjustment flag on Quadramed. - LEDER review outcomes shared with teams - National learning Disability audit data used to drive improvement.
I don't always know who is in charge or who I should speak to	Create welcome boards with the details of the leaders Develop ways to identify who is the shift leader	It will be clear who is the leader of the shift Patients will feel able to talk to teams about their experiences Patient stories from these interactions will be shared at team meetings	✔	- Welcome boards in place - Shift leader lanyards in place. - STAR monthly assurance questions ask questions of 5 patients regarding their experience of care in every clinical area. - You said we did part of the governance boards and use confirmed as part of STAR.
I want to feel more comfortable when I am staying with my child or person I care for	Create changes to the environment to create facilities that are comfortable	Visitors will report feeling comfortable and able to rest	✔	- Whilst some work has been delivered. There remains improvement opportunities in this area. - Parent facilities upgraded in the ward - Feedback on the picker survey demonstrated better than average performance in: - Parent had access to hot drinks facilities in hospital – 84%, compared to 78% in 2018 - Parent able to prepare food in hospital – 70%, compared to 41% in 2018

				However, the survey also highlighted performance significantly worse than peer **- Parent rated overnight facilities as good or very good – 50%, compared to 69%**
I want to make sure that my informal comments are dealt with and acknowledged properly	Develop new ways of sharing action from feedback with our patients	We will publish more information about the comments we receive on our website and the changes we make	✔	**- Whilst some work has been delivered. There remains improvement opportunities in this area.** **- Governance boards in public area share with patients and the public what you said, we did.** **- New website under development at this time, plan to share more publicly feedback and response to this.**
I want to be treated as a parent even when I have experienced loss	Provide compassionate, meaningful opportunities to talk with the team about what matters to you at this time Redesign the way care is delivered in these circumstances	Experience of parents will be improved The provision of one to one care during this time	✔	**- Bereavement suite created within delivery suite** **- Baby loss area created on gynaecology ward.** **- Bereavement team, multifaith pastoral care team and bereavement midwife in place.** **- Big room on end of life care in place and focusing on bereavement care.** **- Launch of CARING model of end of life care.**
Other				**- Upgrade of Childrens high dependency area** **- Development of a enhanced level of care respiratory unit** **- £21m of upgrade and expansion of critical care facilities** **- Development of ophthalmology centre at CDH** **- Development of new day case facilities at CDH** **- The STAR quality assurance framework provides a comprehensive structure to providing high quality care. The outcomes are monitored as part of the Big plan and consist of a monthly 17 question audit, focused on the fundamentals of safe and effective care delivery and a comprehensive accreditation visit. The outcomes of which year to date are included in Image 4.** **The audit questions are updated every 6 months in response to incidents or areas of feedback and concerns from patients and families. It should be noted the review has reduced to annually as a consequence of the pandemic.**

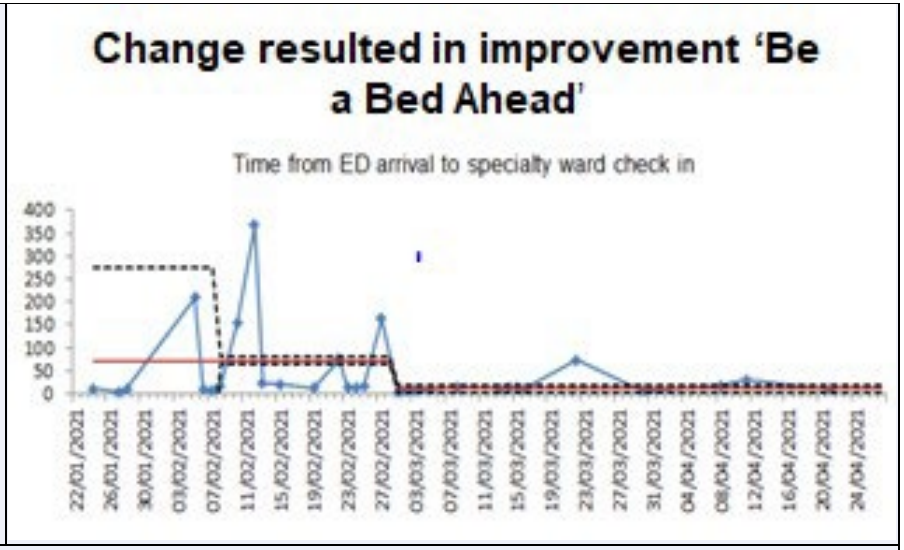
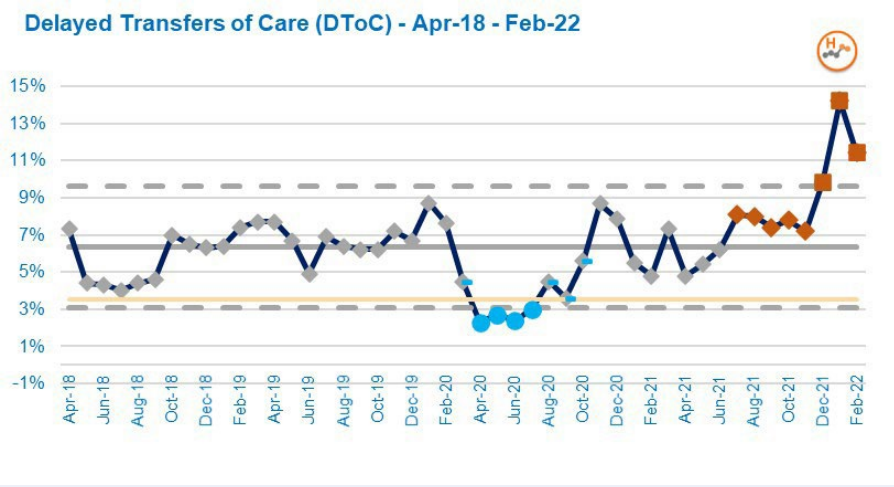
				Image 4

4. Improve capacity and patient flow

What you told us...	How we will improve...	What will good look like?...	Have we delivered?	What we achieved
I don't always know who to contact when I leave hospital if I am worried	Provide information in various formats on how to do this	Reduced readmissions as a result of feeling worried	✔	- Improvement in readmissions achieved and maintained. Unable to evidence this is associated with feeling worried. - Research study commenced on improving information and self management for patients prior to leaving hospitals 
I want to understand my medications on discharge so I know what to do when I get home	Focus on how we counsel patients around medications and ensure patients leave with clear instructions	Improved outcomes on the patient survey Reduction in concerns after discharge	✔	- Whilst some work has been delivered. There remains improvement opportunities in this area. - Pharmacy have ipads in place for digital translator access to ensure they can advise medication details to the service users from any communities and background. - The Picker inpatient survey scored the trust lower than picker average on quality of information on medication symptoms following discharge. - Pharmacy provision has been redesigned to better meet the needs of the service. Consultation complete. Key performance indicators included in the Divisional Improvement Forums (DIF's) and pharmacy oversight increased at Safety and Quality committee from once to twice annual.
I want help to understand the options for nursing and residential homes and how I can get help with this	Discharge teams will be a point of contact for families to support the transition out of hospital Early discussions about discharge will help patients and families to feel informed	Positive feedback received following the discharge process from patients	✔	- Whilst some work has been delivered. There remains improvement opportunities in this area. - Clinical Discharge lead and operational lead with matron appointed to take responsibility for leading improvement work and manage the experience of patients and families. - Discharge facilitators in place for all inpatient wards with progression to a 7 day per week service. - Discharge leadership in place 7 days per week.

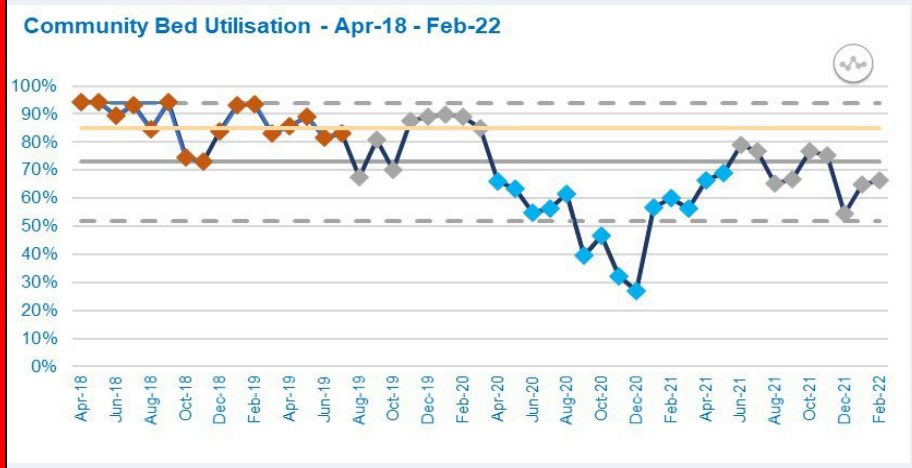
				- **The Picker 2021 inpatient survey indicates the Trust is lower than national average scoring 74% versus a national average of 78%.** - **Initiation of weekly review of all patients in hospital longer than 7 days.** - **Inclusion of this data into divisional improvement forums to create a golden thread and understanding of patient level data to drive improvement.** - **Discharge Audit undertaken by MIAA demonstrating Substantial assurance on a case review of 40 case notes.** - **Thematic review of adverse discharges undertaken 6 monthly to focus and learn from incidents in partnership with adult social care and Lancashire South Cumbria Foundation Trust (LSCFT).** **This area remains an ongoing priority.**
I want to feel involved with my local hospital	Create a schedule of interactive days to involve the local communities in Lancashire Teaching Hospitals	See the learning from the events	✔	- **Patients as Partners proposal included in the Always Safety First Safety Strategy.** - **User forums in place (as previously described)** - **Council of Governors work in partnership with STAR assurance visits and events to provide feedback and shape services.**
I want to know when I should come into hospital and when I should go to another healthcare provider for treatment	Develop information about where to access local services	Provide information on the website to signpost patients to the right services	✔	- **Positive messages regarding choosing well published in line with NHSE/I.** - **Communication regarding choosing appropriately at CDH ED.** - **Website upgrade in progress.**

I want to move less around different wards in the hospital	We will focus our continuous improvement work on ensuring patients are in the right place at the right time	There will be less patients in hospital for prolonged lengths of time, resulting in more space in the hospital to ensure our patients go to the right place at the right time	✔	- **Whilst some work has been delivered. There remains improvement opportunities in this area.**
				- **Number of tests of change to demonstrate ability to provide care for more patients outside of the hospital facilitated. These include:**
				  ○ **Hospital at Home service**
				  ○ **Digital health**
				  ○ **Avondale community ward**
				- **Transition of Level 2+3 neurorehabilitation care into the community setting.**
				- **System Chief Operating Role created to lead system changes in alternatives to hospital.**
				- **Be a bed ahead improvement programme demonstrated where improvement could take place. This has not been sustained secondary to Covid, however, refreshed plans in place in progress.**

				 -
I want my experience in the Emergency Department to improve	Focus on the movement of patients in a timely way through the hospital to support the emergency teams to assess patients sooner Ensure the staffing resource is suitable for the number of patients visiting our department Improve the environment in ED	Patients will tell us in our Friends and Family feedback	**X**	- **Emergency department increased in size in response to increase in demand and the staffing levels increased to support this. (Previous paper containing detail presented to safety and Quality committee).** - **Emergency Department upgraded, created Rapid Assessment and Treatment Area, children specific area, majors upgrade and a covid positive area within the ED.** - **The friends and family test in ED is not reaching the required standard this is most likely related to the impact of the long lengths of stay.** - **Delayed transfer of care not yet demonstrating improvement required due to system related challenges.** 

I want to be involved directly with the care of my loved ones and have access to them	Develop a Carers' Charter to support our patients Review visiting times ensuring they are flexible for all	Access to the Carers' Charter Provide open visiting for carers to encourage socialisation Patients and visitors report increased satisfaction with visiting arrangements	✔	- **Carers charter cocreated and implemented in line with johns campaign.** - **Plan to introduce and launch essential carer approach with the next patient experience and involvement strategy** - **Parents supported to stay with babies on neonatal, children's ward and as partners within maternity services.** - **Flexibility and open visiting adopted for essential carers, end of life and children and maternity. Restricted and impacted during the pandemic. Plan to revert to open visiting in June 2022.**
I don't want to be in hospital longer than I need to be because I cannot access support	Focus on providing appropriate support and reasonable adjustments to meet patient need	Provide access to remote interpreting services to support a faster response to care Include monitoring of reasonable adjustments for patients through the accessible information standard	✔	- **Whilst some work has been delivered. There remains improvement opportunities in this area.** - **Interpretation services and options have increased and the ability to use via iPads and trollies at clinical service level has increased.** - **>100 additional hearing loops installed** - **3 changing places in sit on each of the sites** - **Ability to plan ahead journeys through PALs to ensure reasonable adjustments are accommodated.** - **Reasonable adjustment flag on Quadramed and further work to embed this is underway and will continue.** - **Desire to connect community GP record and recoding of protective characteristics with hospital record to reduce duplication and ensure adjustments can be anticipated by the service to reduce duplication for patients and families.**

I want to understand more about my diagnosis and treatment	Ward round master classes will introduce a standardised way of interacting on ward rounds
	
	Nurses will be present on ward rounds and communication will take place offering patients the chance to ask questions
	
	Theatre staff will meet vulnerable patients pre theatre and explain what will happen
		Ward rounds will involve the patient and they will feel informed about their diagnosis and treatment plan
		
		Nurses will know the discharge plans for patients and communicate frequently with families as partners in care
			✔	- **Whilst some work has been delivered. There remains improvement opportunities in this area.**
				- **The PCCN was created to provide a genuine co-production of clinical notes, which brings healthcare professionals and patients/family to a closer understanding of overall care. It was created to find what 'Matters to them' and not 'what is the matter with them'. This empowers the patient and family members to record and address what matters to them.**
				- **There has been significant progress in the past 12 month with the roll out of the Patient Contribution to Case Notes to all surgical wards and the following pieces of work indicate the progress made so far:**
				  ○ **The development of the E-Learning tool has been implemented**
				  ○ **New patient PCCN magnets to indicate that the patient has been asked if they have a PCCN with them and also as a reminder for clinicians to ask the patient about their PCCN**
				  ○ **The development of the Core Group with key stakeholders meet monthly**
				  ○ **An easy read version with a BSL video have been developed for inclusivity of all**
				  ○ **The development of the PCCN webpage and intranet page**
				  ○ **Patient experience feedback with recorded video's**
				  ○ **Development of the inclusion of the PCCN on Datix**
				  ○ **Changes to STAR audit to include the PCCN**
				  ○ **Driver diagram created to support the project**
				- **With such a fundamental change in approach, the embeddedness of this will continue over the next 12 months.**
				- **The perfect ward round improvement project aims to build in the evidence based components of clinical care and patient involvement. This project continues and is yet to reach its completion.**
				- **Discharge arrangements in place as described earlier in the report.**

I want more access to therapy earlier in my journey so I don't lose the ability to be independent	Review the provision of therapy services focusing on enabling patients to maintain independence	Patient's time will not be wasted in hospital Patient's length of stay in hospital will reduce There will be a reduction in delays to intermediate care Volunteer programmes will support patients transition from hospital to home	X	- **Whilst some work has been delivered. There remains improvement opportunities in this area.** - **Average length of stay is within the median expected time for all specialties with the exception of neurosurgery and neurology.** - **Patients not meeting criteria to reside are identified daily board rounds with proactive approaches to valuing patients' time.** - **Intermediate delays have not been reduced at this time.** - **Third sector organisations in place to support transition from hospital to home.** - **Therapy provision increased in critical care.** - **Identified need to invest in therapy provision in acute services to reduce length of stay, business case being developed for this and will progress in 2022.** - **Increase in home first slots through system partnership arrangements.** - **Ready, steady go therapy active project initiated on inpatient wards, making rehabilitation everybody's business.** 

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Re-appointment of Non-Executive Director			
Report to:	Council of Governors	**Date:**	28 July 2022
Report of:	Company Secretary	**Prepared by:**	K Brewin
Part I	✓	**Part II**	

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

Executive Summary:

Under Schedule 7, paragraph 17(1) of the National Health Service Act 2006, it is for the Council of Governors to appoint, re-appoint or remove the Non-Executive Directors. The purpose of this report is to provide information for the Council to consider re-appointment of Mrs T Whiteside whose first term of office is due to expire on 8 September 2022.

In line with the Trust's Constitution (paragraph 12.6), any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors have approved. All Non-Executive Directors successfully completed their 2020/21 annual appraisals which were again supported by 360-degree feedback from Board colleagues. Discussions have been held with Mrs T Whiteside who confirmed her intention to serve for a further term, as determined by the Trust Constitution and subject to approval by the Council of Governors.

Further supporting information is provided in the main body of the report.

It is recommended that the Council approve the Nominations Committee recommendation to re-appoint Mrs T Whiteside for a second term of office from 9 September 2022 up to and including 8 September 2025.

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

Nominations Committee (21 March 2022)
Council of Governors part II (26 April 2022)

1. Role and responsibilities of the Non-Executive Director

A Non-Executive Director works alongside other Non-Executive and Executive Directors as equal members of the Board of Directors. They share responsibility with the other Directors for the decisions made by the Board and for the success of the organisation in leading the local improvement of healthcare services.

Non-Executive Directors use their individual skills alongside their personal experience as a member of the community to:

- provide independent judgement and advice on issues of strategy, vision, performance, resources and standards of conduct and to constructively challenge, influence and help the Executive Team develop proposals on such strategies to enable the organisation to fulfil its leadership responsibilities for healthcare of the local community;
- ensure that the Board sets challenging objectives for improving its performance across the range of its functions;
- monitor, in accordance with agreed Board procedures, the performance and conduct of management in meeting agreed goals and objectives and statutory responsibilities, including the preparation of annual reports and annual accounts and other statutory duties;
- contribute to the determination of appropriate levels of remuneration for identified senior staff;
- take an active part in Committees established by the Board of Directors to exercise delegated responsibility;
- as a member of Committees of the Board, appoint, remove, support, encourage and where appropriate 'mentor' senior Executives;
- bring independent judgement and experience from outside the Trust and apply this to the benefit of the Trust, its stakeholders and its wider community;
- assist fellow Directors in providing entrepreneurial leadership to the Trust within a framework of prudent and effective controls, which enable risk to be assessed and managed;
- assist fellow Directors in setting the Trust's values and standards and ensure that its obligations to its stakeholders and the wider community are understood and fairly balanced at all times;
- ensure that the organisation values diversity in its workforce and demonstrates equality of opportunity in its treatment of staff and patients and in all aspects of its business; and
- engage positively and collaboratively in Board discussion of agenda items and act as an ambassador for the Trust in engagement with stakeholders including the local community.

2. Discussion

The following provides an overview of previous experience, key skills, knowledge and experience and the roles undertaken by Mrs T Whiteside that provide assurance to the Board.

2.1 Overview of previous experience, skills and knowledge

A transformational leader with a wealth of financial services experience having held a number of senior leadership roles within large Fortune 500 and FTSE100 organisations. Her experience gathered over 25 years includes owning aspects of global control frameworks and assuring compliance to the expected standards of control, establishing Strategic Change Portfolios, operational delivery of integration programmes following organisational merges/acquisitions and lead upon significant business transformation.

Over the previous 10 years she successful established her consultancy business which provided interim management support, with focus on setting up new operational functions and building sustainable internal capabilities, creating portfolios of strategic change to improve operational performance and financial stability, strengthening governance and control regimes, consulting on risk management strategies, and positively responding to increased regulatory scrutiny.

2.2 **Roles undertaken within the Trust and wider system**

Supports a significant portfolio, both internally and externally, that provides assurances to the Board and her internal duties include:

- Chair of the Finance and Performance Committee
- Member of the Appointments, Remuneration and Terms of Employment Committee
- Member of the Audit Committee
- Member of the Charitable Funds Committee
- Member of the IM&T Strategy Board
- Member of the New Hospitals Programme (NHP) Trust Engagement Group
- Member of the Pathology Non-Executive Director Engagement Group
- Non-Executive Director NHP Champion
- Non-Executive Director Pathology Champion
- Non-Executive Director Place Champion
- Non-Executive Director Communication and Engagement Champion
- In attendance at the Governor Membership Subgroup

In terms of external activity, involvement in and/or attends at:

- Pathology Partnership Board
- NHP Strategic Oversight Group
- NHP Governance Advisory Group
- NHP Communication and Engagement Review Group

2.5 **Additional duties**

In addition to the portfolio described, she undertakes a range of additional duties, such as Board Workshops and Development sessions and attends virtual events such as Fab Feedback Friday and STAR accreditation awards. She also attends ad hoc Committee meetings where she is not a member to ensure she is sighted on issues and assurance across all Non-Executive Directors' portfolios.

There were unique challenges faced from March 2020, particularly in respect of the Covid-19 pandemic, which necessitated a number of extraordinary part II Board meetings being convened and she demonstrated a flexible and agile approach to accommodate the arrangements usually at short notice.

2.6 **Annual appraisal**

She has been appraised by the Chairman of the Trust in each of her years of appointment and has consistently met the objectives agreed. She again met the objectives at her most recent appraisal in September 2021 for the period 2020/21.

The 2021/22 Non-Executive Directors' appraisals are commencing in August 2022. This year the appraisals are supported through 360-degree feedback from Governors, following the offer of training in the process which was completed in Q1 of 2022/23.

3. Financial implications

There are no financial implications arising from this report.

4. Legal implications

The relevant section within the Trust's constitution regarding re-appointments (para. 12.6) states that:

"The Chair and the Non-Executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting. Any re-appointment of a Non-Executive Director by the Council of Governors shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors has approved.

A Non-Executive Director (including the Chair) may serve on the Board of Directors for longer than six (6) consecutive years, subject to annual re-appointment. A Non-Executive Director of the Trust (including the Chair) may not hold office for longer than a maximum of nine (9) years in aggregate in the capacity of either the Chair or a Non-Executive Director of the Trust."

The relevant sections of the NHS Foundation Trust Code of Governance relating to re-appointments are as follows:

"The Board of Directors and the Council of Governors should also satisfy themselves that plans are in place for orderly succession for appointments to the Board, so as to maintain an appropriate balance of skills and experience within the NHS Foundation Trust and on the Board." (Supporting principle B.2.c)

"The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors. Once suitable candidates have been identified the Nominations Committee should make recommendations to the Council of Governors." (Provision B.2.5)

"All Non-Executive Directors and Elected Governors should be submitted for re-appointment or re-election at regular intervals…The Council of Governors should ensure planned and progressive refreshing of the Non-Executive Directors." (Supporting principle B.7.a)

"In the case of re-appointment of Non-Executive Directors, the Chairperson should confirm to the Governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role. Any term beyond six years (e.g. two three-year terms) for a Non-Executive Director should be subject to particularly rigorous review, and should take into account the need for progressive refreshing of the Board. Non-Executive Directors may, in exceptional circumstances, serve longer than six years (e.g. two three-year terms following authorisation of the NHS Foundation Trust) but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a Non-Executive's independence." (Provision B.7.1)."

5. Risks

Should the Council of Governors not recommend re-appointment of the Non-Executive Director then there is a risk to the composition of the Board of Directors and the ability for the business of the Trust to be delivered in line with the Trust's Constitution and its Provider Licence.

6. Impact on stakeholders

There is no impact on stakeholders arising from this report.

7. Recommendations

It is recommended that the Council approve the Nominations Committee recommendation to re-appoint Mrs T Whiteside for a second term of office from 9 September 2022 up to and including 8 September 2025.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Annual Report and Accounts 2021-22 (laid before Parliament)							
Report to:	Council of Governors			**Date:**	28 July 2022		
Report of:	Company Secretary			**Prepared by:**	K Brewin		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☐	**For noting**	☒	**For discussion**	☐	**For information**	☐

Executive Summary:

The Annual Report and Financial Accounts for 2021-22, including the Annual Governance Statement, were laid before Parliament on 6 July 2022, in accordance with the statutory deadline and following the process for e-laying this year outlined by the Department of Health and Social Care.

The report is attached and will also be published on the Trust's website following the Board of Directors meeting on 4 August 2022.

The Council is asked to receive the report and note the contents.

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

Audit Committee (16 June 2022)

1. Introduction

The Annual Report and Financial Accounts for 2021-22, including the Annual Governance Statement, were laid before Parliament on 6 July 2022, in accordance with the statutory deadline and following the process for e-laying this year outlined by the Department of Health and Social Care.

The report is attached and will also be published on the Trust's website following the Board of Directors meeting on 4 August 2022.

2. Financial implications

There are no financial implications associated with the contents of this report.

3. Legal implications

There are no legal implications associated with the contents of this report.

4. Risks

There are no risks associated with the contents of this report.

5. Impact on stakeholders

There is no impact on stakeholder associated with the contents of this report.

6. Recommendation

The Council is asked to receive the report and note the contents.

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2021–22

Excellent care with compassion

Always Safety First

@LancsHospitals

Lancashire Teaching Hospitals NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS 2021–22

Presented to Parliament pursuant to schedule 7,
paragraph 25(4) (a) of the National Health Service Act 2006

CONTENTS

This symbol indicates that more information is available on our website:

www.lancsteachinghospitals.nhs.uk

CHAIRMAN'S AND CHIEF EXECUTIVE'S WELCOME

Like other Trusts across the country, 2021–22 has been another year of unprecedented challenges. However, our colleagues have once again demonstrated unwavering dedication and resilience to provide patients across our communities with the excellent care and compassion they deserve.

Despite the ongoing Covid-19 pandemic and increasing operational pressures, we are extremely proud of what we have collectively achieved and, as such, are delighted to share our Annual Report and Accounts 2021–22.

It is important that we begin our welcome by saying a sincere 'thank you' to all Lancashire Teaching Hospitals colleagues who have contributed towards the achievements, targets and developments highlighted in this report. In the face of adversity, their efforts throughout 2021–22 have been nothing short of incredible and it is still amazing to see the positivity and kindness displayed on a day-to-day basis.

We must also express our thanks towards the many wider system partners who have all, despite their own challenges and circumstances, proven that collaboration can truly have a positive impact on patient care across Lancashire and South Cumbria. Clear evidence of system wide working strengthens the need for further collaboration in the future to drive up quality, standardise best practice and reduce unwarranted variation and duplication.

A heartfelt thank you also goes out to our local communities who have once again displayed extraordinary support towards our Hospitals which makes an incredible difference to us all. This includes our extended Trust family made up of volunteers and governors who have given an enormous amount of their time and assistance throughout the Covid-19 pandemic.

Finally, we must also thank our former Chief Executive, Karen Partington, who after 40 years' service in the NHS, of which 11 were spent as Chief Executive at Lancashire Teaching Hospitals, retired during the financial year. Happy retirement, Karen.

Throughout 2021–22, the Covid-19 pandemic has continued to increase operational pressures and impact on the Trust's performance. The emergence of the Omicron variant throughout the winter period led to high levels of bed occupancy, delayed discharges and reduced workforce capacity. Alongside this difficult backdrop, the Trust has transitioned towards the restoration of services, particularly the mandated elective recovery programme and has implemented a number of important measures to help towards compliance against expected standard. This can be explored in our report's Performance Analysis from page 17.

For much of the year, visiting was restricted and stringent infection prevention and control practices were observed to help reduce nosocomial infections within our hospitals. However, we regularly reviewed our visiting criteria in line with infection rates to make every effort, where possible, to allow patients to see their loved ones. As we now see a reduction in Covid-19 cases both within our Hospitals and the local community, alongside the Government's latest 'Living with COVID-19' guidance, it is important that we do not become complacent and continue to follow the relevant measures appropriate to keep our patients, staff and our local communities safe.

Colleagues have gone the extra mile to successfully manage vaccination centres across Chorley and South Ribble Hospital, Royal Preston Hospital and St John's Vaccination Hub in Preston City Centre – helping to deliver over 100,000 doses of the vaccine to our local communities. Alongside this, we must also acknowledge the sustained efforts towards vaccinating colleagues prior to Government revoking vaccination as a condition of deployment from April 2022. Teams across the Trust were instrumental in helping to support staff members to make an informed choice and we must recognise the significant volume of additional work undertaken during this period.

The pandemic and associated operational pressures in 2021–22 have meant that savings have been delivered but largely on a non-recurrent basis, and the Trust has received significant additional income to support the pandemic response. Going forward, significant financial improvement is required to deliver break even and more about financial sustainability is available on page 99.

Amid the challenges faced by the Trust, it is incredible to see the range of major service developments undertaken during the year, particularly at Chorley and South Ribble Hospital. The Trust is committed to developing the services offered from the Chorley site and have recently opened the state-of-the-art Lancashire Eye Centre and invested in new day case theatres and facilities. We are excited to also be opening a new modular ward in June 2022 and are committed to continuing our policy of expansion at Chorley into the future.

Meanwhile, Royal Preston Hospital has seen the refurbishment of its 24-bed Ribblesdale Ward in October 2021 to support oncology patients with a wide range of clinical needs and end of life care. This was followed by the opening of the demountable Nightingale Surge Hub in January 2022 which has significantly helped the wider system to manage discharges more effectively by providing additional resilience to help de-escalate pressures, particularly in our Emergency Departments, at exceptionally busy periods. You can read about many of the Major Service Developments from page 50.

It is also important to recognise and celebrate our existing facilities which have evolved over time and continue to provide an excellent service to our local communities. In February, our Radiotherapy department celebrated 25 years of service based at Royal Preston Hospital. The department opened in 1997 and was initially conceived as a subsidiary department in northern Lancashire for The Christie. Today, the department provides external beam radiotherapy for the whole adult population of Lancashire and South Cumbria and has continued to diagnose and treat the public throughout the Covid-19 pandemic.

Equally, it is important to highlight the tremendous achievements of our staff and departments who have been recognised nationally for their incredible work over the last 12 months. Many colleagues have been awarded honorary professorships, have been recognised with Honours or have scooped prestigious accolades or accreditations. Much more about these can be found on the Trust website.

The Trust is committed to embedding a culture of continuous improvement across our organisation and has supported staff to embed and sustain positive change within the first year of our Continuous Improvement Strategy. We have supported divisions and corporate teams to implement improvement priorities and in September 2021 launched our Always Safety First Strategy in response to the NHS National Patient Safety Strategy. We are now maturing into this strategy and can demonstrate shared learning and best practice and the formation of a continuous improvement culture. You can read more about CI on page 36.

Education and Training continues to play an important role in supporting the development of our current and future workforce at Lancashire Teaching Hospitals. Innovative ideas to bolster the nursing and medical workforce have come into fruition over the last year such as the recent cohort of seven students to qualify as registered nurses on the Trust's 18-month degree apprenticeship alongside Northumbria University. There are now 48 more students currently on the programme in hospitals across Lancashire and South Cumbria as it goes from strength to strength. More about education can be seen on pages 75–77.

As we now look towards the future, the Government's New Hospitals Programme presents us with a once-in-a-generation opportunity to transform our region's hospitals by 2030. Significant work has taken place throughout 2021–22 which has led towards the announcement of a shortlist of proposals for new hospital facilities in our region. We must now explore the best use of our resources, and really consider the financial affordability and the return of that investment, as well as how practically deliverable the options are as an integral part of developing the business case. It is worth noting, however, that the programme will not halt current investment into our Preston site and we would encourage our local communities to get involved with engagement activity and events where possible to help shape our future hospital facilities. More about the New Hospitals Programme is available on page 54.

Going forward, it is clear that partnership working is key in helping to improve health and healthcare for the people of Lancashire and South Cumbria. Together we aim to drive up quality by sharing skills and best practice, pooling our resources and standardising the way we work to reduce variation and duplication. We want to ensure patients have equal access to the same high-quality care wherever they live. We also want our colleagues to have the same high-quality experience wherever they work. More than the sum of our parts, by working together all of the Trusts benefit and will achieve more for our patients, communities and colleagues than if we worked separately.

Finally, as the NHS and system landscape shifts into a new era of integrated care, it is important to note that our Chairman, Professor Ebrahim Adia, will be taking on the role as a Non-Executive Director (designate) of the new Integrated Care Board from September 2022, and will therefore be stepping down from the role as Chair of the Trust at the end of August 2022. We are sure that Ibby's understanding of the Trust along with the many positive relationships that have built will be of benefit both to Lancashire Teaching Hospitals and to our constituents in the future.

Thank you once again to our communities, partners and key stakeholders for your overwhelming support.

Professor Ebrahim Adia
Chairman
28 June 2022

Kevin McGee OBE
Chief Executive
28 June 2022

Lancashire Teaching Hospitals NHS Foundation Trust

PERFORMANCE REPORT 2021–22

OVERVIEW OF PERFORMANCE

The purpose of this report is to inform the users of the Trust's performance and to help them assess how the Directors have performed in promoting the success of the Trust.

This report is prepared in accordance with sections 414A, 414C and 414D of the Companies Act 2006 (as inserted/amended by the Companies Act 2006 except for sections 414A(5) and (6) and 414D(2) which are not relevant. For the purposes of this report, we have treated ourselves as a quoted company. Additional information on our forward plans is available in our operational plan on our website. Information on any mandatory disclosures included within this report is provided on pages 82 to 85.

The accounts contained within this report have been prepared under a direction issued by NHS Improvement under the National Health Service Act 2006.

Who we are

Lancashire Teaching Hospitals NHS Foundation Trust was established on 1 April 2005 as a public benefit corporation authorised under the Health and Social Care (Community Health and Standards) Act 2003. We are registered with the Care Quality Commission (CQC) without conditions to provide the following regulated activities:

- diagnostic and screening services
- maternity and midwifery services
- surgical procedures
- termination of pregnancies
- treatment of disease, disorder or injury
- management of supply of blood and blood-derived products
- assessment or medical treatment for persons detained under the Mental Health Act 1983
- vaccination hub satellite service

We are a large acute Trust providing district general hospital services to over 395,000 people in Chorley, Preston and South Ribble and specialist care to 1.8m people across Lancashire and South Cumbria.

Our mission is to always provide excellent care with compassion which we do from three facilities:

- Chorley and South Ribble Hospital
- Royal Preston Hospital
- the Specialist Mobility and Rehabilitation Centre (based at Preston Business Centre)

We are a values driven organisation. Our values were designed by our staff and patients and are embedded in the way we work on a day-to-day basis:

- **Caring and compassionate:** We treat everyone with dignity and respect, doing everything we can to show we care.
- **Recognising individuality:** We respect, value and respond to every person's individual needs.
- **Seeking to involve:** We will always involve you in making decisions about your care and treatment, and are always open and honest.
- **Team working:** We work together as one team, and involve patients, families, and other services, to provide the best care possible.
- **Taking personal responsibility:** We each take personal responsibility to give the highest standards of care and deliver a service we can always be proud of.

We believe that to provide the best care, we need to continually improve the way in which we provide services. If we are to be the best, we need to continually seek improvement and embrace change, empowering our teams to develop ideas and drive them forward. In order to do this, we have adopted a Continuous Improvement approach and developed a strategy to support this.

Our strategic objectives are:

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

The delivery of excellent services to our local patients through the provision of district general hospital services is at the core of what we do. To achieve this we need to ensure we focus on meeting key quality and performance indicators so our patients can be assured of safe and responsive services.

As well as providing healthcare for our local patients, we are proud to be the regional centre for a range of specialist services. These services include:

- Adult Allergy and Clinical Immunology
- Cancer (including radiotherapy, drug therapies and cancer surgery)
- Disablement services such as artificial limbs and wheelchairs
- Major Trauma
- Neurosciences including neurosurgery and neurology (brain surgery and nervous system diseases)
- Renal (kidney diseases)
- Specialist vascular surgery

Our portfolio of services will continue to develop as the strategy for the provision of services across our region is developed by our Commissioners, but the delivery of specialist services will remain at the heart of our purpose and the decisions we take in our day-to-day activities will be taken in the context of ensuring we remain as the Lancashire and South Cumbria Integrated Care System specialist hospital.

When we were established in 2005 we were the first Trust in the county to be awarded 'teaching hospitals' status. We believe that developing the workforce of the future is central to delivering high quality healthcare into the future. We know we are a local leader in respect of our education, training and research and as the only NIHR Clinical Research Facility in Lancashire and South Cumbria, and a leading provider of undergraduate education, we will continue to drive forward the ambitions described in our education and research strategies.

Our business model

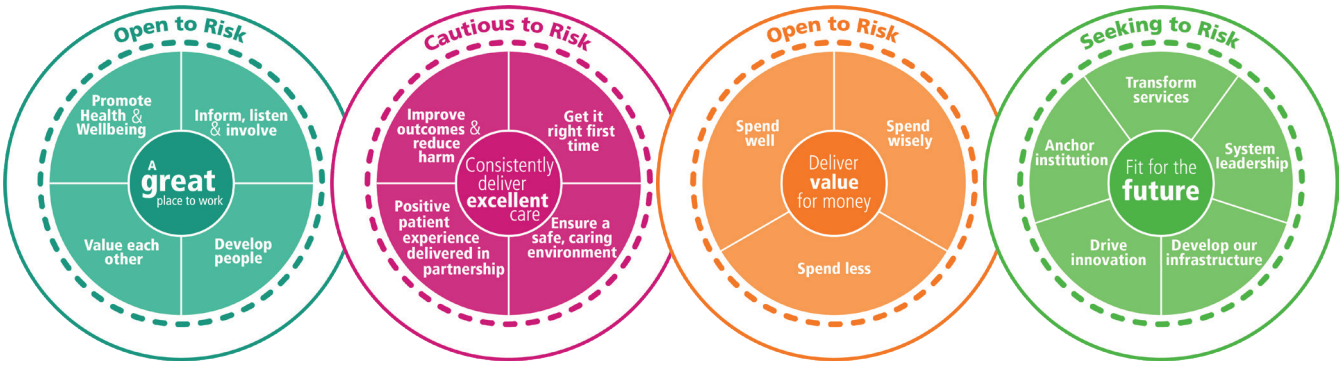
The governance structure of a Foundation Trust is prescribed through legislation and is reflected within our Constitution. All Foundation Trusts are required to have a Board of Directors and a Council of Governors as well as a membership scheme, which is open to members of the public and staff who work at the Foundation Trust. Members vote to elect governors and can also stand for election themselves. The Council of Governors is responsible for representing the interests of NHS Foundation Trust members and the public and staff in the governance of the Trust. It remains the responsibility of the Board to design and then implement agreed priorities, objectives and the overall strategy of the organisation. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The Board of Directors retains the overall responsibility for decision-making within the organisation, except where the Council has statutory responsibilities. The Board does, however, work closely with the Council in formulating its forward plans. A schedule of matters reserved to the Board is in place and this document details the matters reserved to the Board, as well as providing more detailed information on the respective roles of the Council of Governors and the Board of Directors.

Our strategic framework

We have three equally important strategic objectives:

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

These strategic objectives are underpinned by our four ambitions, which together provide the framework for our strategy and business planning processes.



Our strategic objectives, together with our four ambitions, provide the focus and drive for performance, clinical quality and safety, financial delivery and the long term sustainability of services in the context of system working.

Our updated Strategy (Our Big Plan 2022–25) will be launched in April 2022 and identifies clear delivery outcomes for each of its three years. The detailed metrics within the plan are refreshed annually to ensure they remain current in the context of both national and local changes.

Integrated Care System (ICS) in Central Lancashire

This year has seen significant national developments in relation to health and care reorganisation and emerging guidance for delivering integrated care for the benefit of our population and staff. Integrated care systems (ICSs) are partnerships of NHS organisations, councils and key partners from the voluntary community and social enterprise sector, working together across a local area to meet health and care needs, co-ordinate services and improve population health. Clinical Commissioning Groups (CCGs) are a key partner, and in Lancashire and South Cumbria, all ICS partners are working together to improve health and care services and help the 1.8m population to live longer, healthier lives.

In line with the NHS Long Term Plan (2019), all parts of England had to be served by an ICS from April 2021. In Lancashire and South Cumbria the ICS has been developing for a number of years meaning that the partnership was already relatively mature.

From April 2021, a Strategic Commissioning Committee replaced the Joint Committee of Clinical Commissioning Groups (CCGs), with a primary role to focus on delivery and decision-making for the Lancashire and South Cumbria population with the authority to make decisions at a Lancashire and South Cumbria level. The Committee brings the leadership of the eight Lancashire and South Cumbria CCGs together with ICS strategic commissioning leaders who have collectively committed to improve and transform health and care services across the area, delivering the highest quality of care possible within the resources available.

To support the close down of the eight CCGs and the establishment of the Integrated Care Board (ICB) in Lancashire and South Cumbria, a number of sub-committees and groups were established to oversee the progress and deal with any challenges across the system. This included the ICS Development Oversight Group and the Human Resources Reference Group.

A national ICS Design Framework was published in June 2021, setting out expectations of how NHS organisations were expected to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies and an ICS Partnership, subject to legislation. Published in July, the Health and Care Bill (2021) defined the new NHS bodies as Integrated Care Boards (ICBs) which would replace CCGs, and the partnerships as Integrated Care Partnerships (ICPs).

Following a robust national recruitment process, David Flory CBE was confirmed as the Chair Designate of the NHS Lancashire and South Cumbria ICB in July 2021 and Kevin Lavery was appointed as Chief Executive Designate of the NHS Lancashire and South Cumbria ICB in November 2021.

A national extension of the ICB establishment timeline was announced in December 2021 with a new date for establishment of 1 July 2022. Work continued through quarter four to reach a state of readiness for shadow arrangements to be in place from April 2022, whilst respecting the existing statutory arrangements. This mirrors the national approach, as the updated ICB Establishment Timeline confirmed ambitions to complete as many activities as possible by the end of March 2022, with exceptions related only to those actions that are dependent upon national guidance and/or legislation. For these, the intention is to have them completed by the end of May 2022.

Central Lancashire Place Based Partnership

The Central Lancashire Partnership (CLP) aims 'to make Chorley, Preston and South Ribble a great place to live, work and grow' working and listening to our communities to improve health and wellbeing through a reduction in inequalities.

Over the past 12 months the CLP's System Delivery Board has agreed a number of partnership-level priorities for delivery, following a rigorous clinically and professionally led priority setting process, led by our Clinical and Professional Forum. The process was informed by disease profile data, specific to Central Lancashire, developed by the Determinants of Health Service Delivery Board and resulted in a small number of bespoke priorities which have been our focus this year.

System Delivery Board	Priorities for delivery
Urgent and Emergency Care	System Flow and Discharge Winter Planning Admission Avoidance
Elective Care	Recovery and Restoration of services Outpatient Transformation Diagnostics Elective Pathway Transformation
Determinants of Health	We will improve health and wellbeing through the reduction in health inequalities
Primary and Community Care	Intermediate Care Neighbourhood Development
Children's, Young People and Maternity	Acute Paediatrics Neurodevelopmental Pathway Transition services

Key outcomes of this year's delivery functions are listed below and members have reported the benefits of the partnership approach

System Delivery Board	Key Outcomes
Urgent and Emergency Care	• Delivered the 2021/22 winter plan as a number one priority in response to unprecedented challenges (winter, Omicron, Level 4 national incident) – 17 key winter schemes to provide extra capacity and resilience for hospital and out of hospital services • Mobilised significant additional capacity • Secured and co-ordinated funding into priority service areas • Strengthened performance, monitoring and reporting arrangements
Elective Care	• Developed ICS-wide ophthalmology programme – implementing procurement for single community service • Mobilised the Community Diagnostic Centre (Preston Healthport) • Worked at local and system level to restore elective services including the use of the independent sector where applicable
Determinants of Health	• Preston health and engagement event • Direction of case finding activities to key areas of deprivation • Detailed ward profiles of our most challenged areas • Engaged and collaborative multi-agency working groups • Extension of the Covid-19 vulnerable project
Primary and Community Care	• The Primary Care Network and Integrated Care teams priorities have been merged and refocused on development of neighbourhoods • The development of mixed agency teams in neighbourhoods creates an infrastructure that also supports the population health agenda • The system-wide plan for integrated care has been developed
Children's, Young People and Maternity	• Plans are in place to roll-out patient-initiated follow-up • A significant reduction in did not attend rates (4%) has been seen • Saturday clinics arranged to manage neuromuscular backlog with AHP support from Alder Hey • Review of Cystic Fibrosis, Epilepsy, Diabetes, Special Educational Needs and Disability and Rheumatology, and Ear, Nose and Throat surgery pathways • Clear identification of the Autism Spectrum Disorder waiting list from all partners, with a standardised definition of wait times and regular contact with children and families

Partnership working has continued to be of vital importance as partners have responded to the ongoing pandemic and winter challenges. Partners have built on existing joined-up practice and support services to extend and enhance support during the Omicron wave and winter.

In terms of development of the Place-based Partnership itself, we have made good progress this year across the following domains:

- **Improving the quality of services** – the culture of the partnership has developed to enable issues or concerns to be escalated quickly and extraordinary meetings have been called where required for the unique challenges of Omicron and pandemic-related pressures.
- **Maximising the use of resources** – the partnership has mobilised a digital and operational and strategic estates group which ensures that we have support functions working in partnership.
- **Success measures** – the partnership delivery boards have shared dashboards to monitor their progress against agreed priorities.
- **Population Health Management** – the Determinants of Health Board has been mobilised and contains senior and operational staff from all partners. The board has shared in depth knowledge about our population and the support and services on offer. The group has also conducted a number of joined-up interventions and thereby improved existing offers to the people who need it.
- **Listening to and communicating with our communities** – we have developed a place-based plan for engagement.
- **Valuing and developing the workforce** – we are working on a targeted people-based plan to address the key workforce challenges that we face in Central Lancashire.
- **Governance** – we hold ourselves to an agreed set of behaviours and value at place and we have continued to refine the governance structure to enable an integrated approach to the delivery of services and rapid escalation should it be required.
- **Collaboration with our partner places and the Lancashire and South Cumbria system** – this has seen each place taking the lead to develop and implement elements of the strategic narrative required to see our places and the overarching health and care system continue to mature.
- **Partnership maturity** – we undertook two peer-to-peer reviews during 2021/22 with Board members scoring the partnership's progress against a number of domains. Our key areas of strength were around leadership, governance and decision-making, place-based leadership and collaboration and planning integrated services.

Next year as a partnership we will be focusing on the formal transition arrangements as required by the White Paper and working towards an initial gateway process in June to ensure that the Central Lancashire partnership is ready for the new challenges ahead.

Our principal issues and risks

The Trust continues to identify potential risks to achieving its strategic developments as part of our good governance processes. The Board Assurance Framework is used to identify these strategic risks alongside actions being taken to mitigate such risks. This enables the Board of Directors to evaluate whether we have the systems, policies and people in place to operate in a manner that is effective in driving the delivery of the Trust's corporate objectives.

During 2021–22, the principal risks related to:

- Consistently deliver excellent care
- Deliver value for money
- Be a great place to work
- Be fit for the future including sustained delivery of specialist services
- Drive innovation through world class education, training and research

All the principal risks listed are reported to the Board of Directors and appropriate Committees of the Board for reviewing, monitoring and reporting the effectiveness of controls and mitigation plans identified to achieve the risk target as determined by the risk appetite approved by the Board.

The Annual Governance Statement, contained on pages 88 to 102, further outlines the Trust's approach to risk and how it manages these. The Trust has developed a clear risk mitigation strategy to deal with the recovery and restoration of services post-pandemic and the evolving external environment and will continue to engage and strengthen relationships with patients, staff, public and strategic partners to ensure long-term sustainability in the delivery of its strategic objectives.

The organisational culture is built on trust, openness, transparency and empowerment with clear lines of accountability and responsibility underpinned by continuous learning and improvement. The Annual Governance Statement also includes the Trust's system of internal control which is designed to manage risk for the organisation. The Trust continues to perform well against the objectives of internal control and delivery of regulatory requirements and has delivered compliance with a number of standards and metrics (please refer to the separate Quality Account 2021–22 for full details). However, it is acknowledged that this has been a difficult year as a result of the continued effect of Covid-19 which has impacted delivery of a number of key metrics including, but not limited to Clostridium difficile, 104 week waits and the 12-hour Emergency Department metrics. The Trust remains focused on all relevant metrics and continues to work closely with system partners going forward.

Our performance

The NHS faced unprecedented times in 2021–22 and, like all other NHS Trusts across the country, Lancashire Teaching Hospitals NHS Foundation Trust has been significantly challenged by the Covid-19 pandemic. As a result, performance across the board, both emergency and elective, has been significantly impacted with operational pressures experienced throughout the year resulting in non-compliance in relation to a number of key standards. The performance position is outlined in the Performance Analysis section on page 17.

Going concern

The accounts have been prepared on a going concern basis which the Directors believe to be appropriate for the following reasons.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

Guidance from the Department of Health and Social Care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. There are no such conversations regarding this Trust and as such it is regarded as a going concern.

Emergency funding arrangements put into place by the Department of Health and Social Care in response to the Covid-19 pandemic continued in 2021–22. These have had the effect of ensuring that the Trust was able to break-even during 2021–22, and the continuation of some of the emergency measures into 2022–23 means the Trust will receive further funding during 2022–23. The receipt of these funds and additional funds to support restoration activities mean that the Trust had been able to set a plan for 2022–23 which is a deficit of £11.5m which has been significantly reduced from the pre-pandemic levels which were £78m.

It is clear that outside of the pandemic response the Trust remains in a deficit position and will need to work with its partners across the local healthcare system, Provider Collaborative Board and the Integrated Care Board to achieve efficiencies and maximise the use of its assets to achieve a sustainable financial balance.

In addition to the matters referred to above, the Trust has not been informed by NHS England that there is any prospect of its dissolution within the next twelve months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

Based on these indications the Directors believe that it remains appropriate to prepare the accounts on a going concern basis.

PERFORMANCE ANALYSIS

Lancashire Teaching Hospitals NHS Foundation Trust's performance is measured against a range of patient safety, access and experience indicators identified in the NHSI compliance framework and the acute services contract.

The NHS continued to face significant challenges in 2021–22 and like all other NHS Trusts across the country Lancashire Teaching Hospitals NHS Foundation Trust has continued to experience pressures as a result of the Covid-19 pandemic. Performance across the board, both emergency and elective has been impacted with operational pressures and infection prevention control measures experienced through the year resulting in non-compliance in relation to a number of key standards.

Whole health economy system pressures in response to Covid-19 demand resulted in high bed occupancy throughout the year with the need to focus both on Covid-19 non-elective activity and elective recovery as mandated nationally. The number of patients not meeting the criteria to reside rose as Covid-19 outbreaks in community settings increased. This, together with Covid-19 demand as a result of the Omicron variant, resulted in significant capacity and demand pressures. Workforce capacity to undertake elective activity was also impacted by Covid-19 related absence throughout December 2021 and January 2022.

A health economy system wide action plan is in place to address the urgent care system and pressures; with identified primary and social care initiatives/schemes delivering a level of sustainability across the health economy. In 2021–22 the Trust took a lead role in bringing together operational delivery of the system wide urgent and emergency care programme, including key transformational work streams identified and prioritised by all system partners. Discharge arrangements reflecting national policy changes brought in as a result of Covid-19 and the provision of community capacity to support are being progressed through these arrangements.

Since the beginning of the Covid-19 pandemic the Trust has put in place a range of measures including:

- Additional medicine bed capacity to meet increased demand
- Re-zoning of our estate to meet Infection Prevention and Control (IPC) requirements
- Delivery of Same Day Emergency Care (SDECs), moving to a 24/7 model
- Additional ITU surge beds with additional staffing through redeployment
- Implemented digital health to reduce inappropriate admissions to hospital
- Nightingale Surge Hub capacity to support increased demand as a result of the Omicron variant of Covid-19

These actions have all helped to support the Trust during these unprecedented times and enabled the Trust to achieve compliance against a range of measures within the risk assessment framework, including one of the national cancer waiting times standards. However, the Trust has failed to achieve its objectives in relation to the 4-hour Emergency Department target, the 18-week incomplete access target, and the 62-day cancer treatment standard. The significant growth in the number of long waiters in both RTT and cancer pathways has been directly impacted by the Covid-19 pandemic and the need to cease some elective activity during the pandemic peak periods and prioritise only urgent elective activity as part of the elective restoration plan.

The summary position detailing performance in 2021–22 is shown in the table below:

KPI's 2021–22 Compared To 2020–21

Indicator	2020–21	2021–22	Current Period
A&E - 4 hour standard	85.56	78.3	% - Cumulative to end Mar 2021 Position includes both ED and UCC locations.
Cancer - 2 week rule (All Referrals) - New method	88.0	77.7	% - Cumulative to end Mar 2022
Cancer - 2 week rule - Referrals with breast symptoms	52.8	54.6	% - Cumulative to end Mar 2022
Cancer - 31 day target	89.5	87.2	% - Cumulative to end Mar 2022
Cancer - 31 Day Target - Subsequent treatment – Surgery	77.8	72.4	% - Cumulative to end Mar 2022
Cancer - 31 Day Target - Subsequent treatment – Drug	97.9	99.3	% - Cumulative to end Mar 2022
Cancer - 31 Day Target - Subsequent treatment -Radiotherapy	97.7	97.7	% - Cumulative to end Mar 2022
Cancer - 62 day Target	64.0	55.8	% - Cumulative to end Mar 2022
Cancer - 62 Day Target - Referrals from NSS (Summary)	57.3	58.6	% - Cumulative to end Mar 2022
28 day faster diagnosis standard – compliance	80.3	72.0	% - Cumulative to end Mar 2022
MRSA	0	1	Cumulative to end Mar 2022
C.difficile Infections	100	129	Cumulative to end Mar 2022
18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	54.2	58.5	% - sum of Apr-Mar 2021–22
% of patients waiting over 6 weeks for a diagnostic test	43.12	45.07	% - Cumulative to end Mar 2022

**The MRSA indicator is no longer a national target however we continue to report performance against this metric to the Board and show it as a compliant measure with one reported case during 2021–22.*

Our finances

Income Generation

As a consequence of the Covid-19 pandemic there was a new financial regime to minimise the detrimental impact on the performance of the organisation.

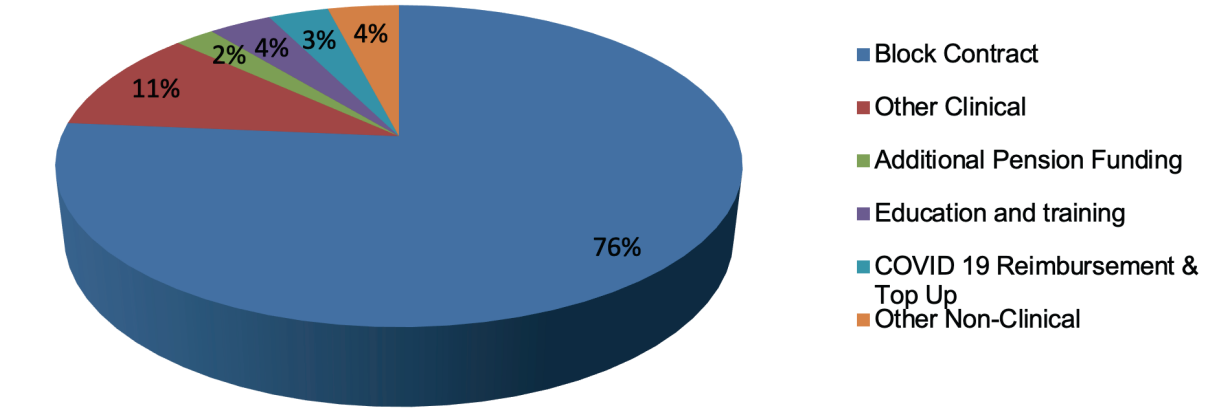
Income from commissioners was received through a block contract basis to minimise the financial effect of reduced patient activity.

During 2021–22 the Trust generated income from patient care, including through a block contract of £660m, an increase of 18% from 2020–21.

The Trust received reimbursement and top up funding of £22m to cover the additional costs associated with the Covid-19 pandemic and the restoration of elective activity.

A further £61m was generated from other income sources which includes training levies, research funding, car parking, catering and retail outlets and from providing services to other organisations.

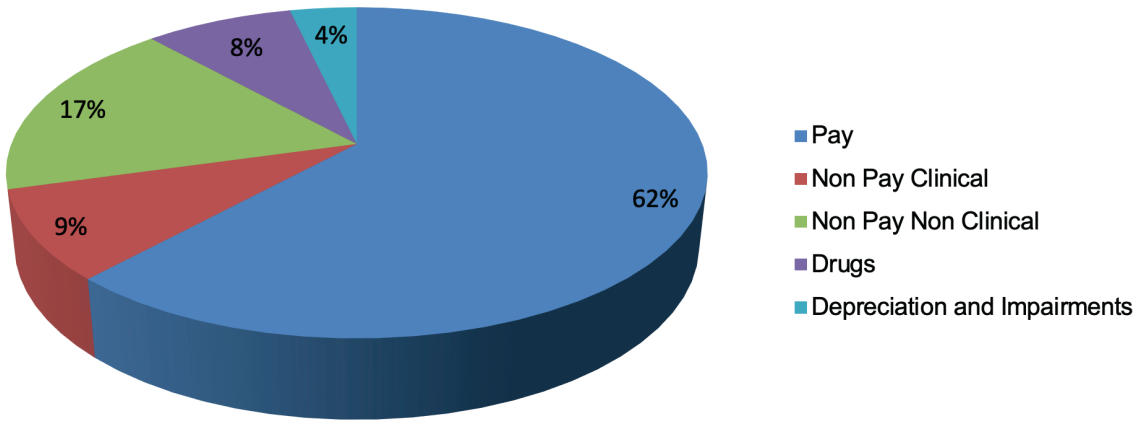
Income Analysis



Expenditure

Operating expenditure (excluding impairments) for the year was £734m (20–21 £670m), the graph below shows the main categories of expenditure at the Trust. The main reason for the rise in costs can be attributed to restoration of elective and outpatient activity.

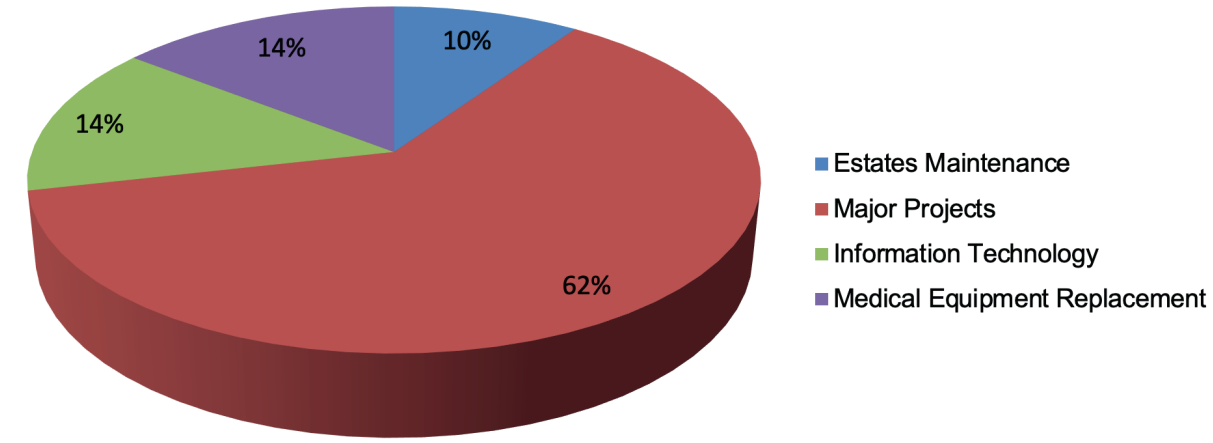
Expenditure



Capital Investment

In 2021–22, £41m was invested in the Trust's capital programme to maintain the asset base of the Trust as illustrated in the chart below. Major projects completed in year included the Ophthalmology unit at Chorley and South Ribble Hospital, Chorley day case theatres, and the refurbishment of the Ribblesdale Ward. Also included in the major projects are ongoing projects such as the new modular building (Cuerden) at Chorley and South Ribble Hospital £6m was spent on new and replacement medical equipment.

Capital Expenditure



Forward Look

The operational and financial planning process for 2022–23 has been developed in line with the expectations set out in the national planning guidance. The key focus of the guidance is to restore NHS and care services within a new financial framework. Core to the new framework are system allocations, systems to deliver a balanced break-even financial plan, move to local ownership of population-based allocations and multi-year capital allocations. The key requirements of that national guidance include the following:

- **Policy for outpatient follow up reduction** – Contribution of Outpatient follow up fixed at 85% of 2019–20 baseline to deliver 25% reduction in outpatient follow up by March 2023 supported by GP contract changes to support achievement of this aim
- **Covid-19 de-escalation** – Covid-19/Infection Prevention Control arrangements were reviewed end of March 2022 to support the convergence of activity back to pre-pandemic levels of productivity
- **Capital** – Three-year capital allocations at ICB level allowing for strategic decision making across the system
- **Cost improvement** – Nationally set as 1.1% as a minimum: target set for Lancashire and South Cumbria providers at 5% or £26.8m (3% recurrent, 2% non-recurrent)
- **Restoration** – Elective funding fully allocated to commissioners on a fair share basis target to deliver 104% activity over and above 2019–20 levels using the Independent Sector (IS) where available
- **Wider system allocation reductions** – Assumption that local authority funded schemes i.e discharge to assess will cease on 31 March 2022 and not be supported by NHS funding
- **National move to tighten financial control** – Increased focus on financial discipline, control and rigour nationally including increased scrutiny on agency caps

The LTH financial plan for 2022–23 has been agreed as part of the wider LSC ICB system plan that requires a balanced plan to be produced. All parties in the system agreed a range of measures to achieve a balanced financial plan. To build a financially sustainable Trust for the future, there will be a renewed focus on cost improvement during 2022–23. A cost improvement target of 5% for 2022–23 has been agreed with the ICB and the Trust has identified and allocated risk rated targets to divisions and activities, and will monitor performance using the cost improvement reporting mechanism. Performance against cost improvement will be reported monthly to the Finance and Performance Committee. The Trust continues to work in partnership within the Integrated Care System and Central Lancashire Integrated Care Partnership and is part of the new hospital programme looking at site development in future years.

Better Payment Practice Code (BPPC)

We aim to treat all suppliers ethically and to comply with the BPPC target, which states that we should aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. For 2021–22 we paid 95% of invoices to this timescale.

	NHS		NON-NHS		TOTAL	
	No.	Value £	No.	Value £	No.	Value £
Invoices paid within 30 days	2,666	123,397	91,633	368,556	92,299	491,953
Invoices not paid within that 30 day period	716	8,305	25,158	18,595	25,874	26,900
Total Invoices	**3,382**	**131,702**	**116,791**	**387,151**	**120,173**	**518,853**
BPPC	**78.8%**	**93.7%**	**78.5%**	**95.2%**	**78.5%**	**94.8%**
Total amount of any liability to pay interest	0	0	0	0	0	0

Reconciliation of underlying trading position for year ending 31 March 2022

In 2021–22 the Trust received top-up and reimbursement funding which amounted to £73.9m (2020–21: £96.8m). The Trust delivered an accounting deficit for the year of £11.2m (2020–21: £6.0m). After adjustment for accounting movements relating to impairment charges and income and expenditure for donated assets, the Trust delivered a revised trading surplus of £0.0m (2020–21: £2.1m).

	Group	
	2021/22	2020/21
	£000	£000
Deficit for the year pre Top-Up	(85,067)	(102,864)
Base Top-Up Income	73,872	68,329
Retrospective Top-Up Income	0	28,500
Deficit for the year	(11,195)	(6,035)
Add back I&E impairments	9,411	11,866
Add back losses on transfers by absorption	1,054	0
Remove net donated income	(1,086)	(1,390)
Remove DHSC centrally procured inventories (donated)	1,840	(2,342)
Revised trading surplus	**24**	**2,099**

Being a Good Corporate Citizen

The Trust works in a number of ways to control the impact it has on the environment and to drive forward the Trust's Green Plan, setting out our plans for sustainable development. During 2021–22 the organisation has:

- Purchased renewable electricity from the National Grid for all of our sites, reducing our carbon footprint.
- Invested in equipment to better monitor water usage, to help identify areas of excessive usage and assist in identifying leaks. This has seen a reduction in our water consumption over the last 12 months.
- Continued to install efficient modern boilers to further reduce our gas consumption, resulting in lower carbon emissions and reducing the overall cost to the Trust of purchasing gas.
- As part of our capital development programme, constructed all new buildings and refurbished our existing estate to achieve higher levels of energy efficiency. For example, investing in the use of low-energy LED lighting and install LED as standard in any new developments or refurbishment schemes.
- Installed electric vehicle charging points across all our main sites to promote sustainable travel and help reduce Scope 3 carbon emissions.
- Continued to offer park-and-ride facilities served by free shuttle buses to reduce the impact of staff travel.
- Removed single-use plastics in a number of areas and replaced them with more sustainable alternatives.
- Worked with the NHS Carbon and Energy Fund to undertake a feasibility study on a longer-term project to de-carbonise the heating system at Royal Preston Hospital.
- Continue to work towards sustainable waste management. The Trust does not landfill any of its non-clinical waste streams which are either recycled or recovered.
- Ensured a number of waste streams are separately segregated for recycling, including cardboard, plastics bottles, confidential waste paper, waste electrical and electronic equipment, wood, mattresses, batteries, fluorescent tubes, cooking and engine oil, IT consumables and scrap metal.
- Ensured garden waste is composted and food waste from our catering service is sent for recovery via anaerobic digestion.
- Where feasible, ensured surplus furniture and equipment is re-allocated and re-used via the online Warp-It system rather than scrapped.

Social, community and human rights issues

The creation of a co-produced social value strategy to include social value statements and key value indicator measures will support the Trust in aligning equality, diversity and inclusion priorities and mobilising change and improvement in this area. A key component of this strategy is achieving accreditation of the social value quality mark.

To support the social value responsibilities and ambitions the organisation has to be an anchor institution, there are a number of programmes of work which are being undertaken to help support the reduction of social deprivation in our communities, reduce unemployment, increase education and skills as well as reduce discrimination and marginalisation of members of our community with protected characteristics which in turn should support wider societal goals leading to improvements in local population health.

The strategic actions outlined here are all focused on improving our communities, adding value to the organisation itself, as well as demonstrating the ethical and moral practices we undertake which are aligned with our values, desired corporate reputation and employment brand. The strategic actions are under three key headings:

Equality, Diversity and Inclusion

The work undertaken with regards to equality, diversity and inclusion and support our social and corporate responsibilities includes:

- Work towards our workforce being proportionally representative of our community through refocusing our recruitment practices, development, succession planning and retention practices.
- Enhancing the development, promotion and retention of colleagues with protected characteristics across all levels to support colleagues to achieve their career aspirations and potential.
- Further educating all colleagues in respect of equality, diversity and inclusion to ensure they have a greater understanding and awareness of their role in reducing discrimination.
- Engaging with colleagues from minority groups to understand what would make a positive difference to their experience of work.

Employment and Employability

To support the levelling up of our communities and reduction in discrimination, the Trust continues to undertake a number of actions which contribute to creating a positive work experience, high quality careers and employment opportunities, these are:

- Develop workforce policies through co-production and consultation in order to create a supportive, inclusive way of working that enable staff to perform well at work in a just, fair, transparent culture.
- Continuing to evolve and grow our volunteer network, through the creation of new volunteer roles to support our evolving services and seeking to increase the diversity of our volunteers.
- Prioritising our Widening Participation agenda so we support social mobility for individuals from diverse backgrounds to facilitate and encourage them to take up a career with us as a healthcare provider and local employer.
- Ensuring colleagues have a positive experience across the whole employment lifecycle, where they feel engaged, have a meaningful career, are supported to have a positive work life balance, have their personal needs accommodated and able to work longer through flexible retirement options.

Health Equality and Wellbeing Support

To ensure our colleagues, who are also our community members remain well and feel able to flourish in work we have delivered a number of actions which are aligned to the social responsibility strategic aims, these are:

- Ensuring all colleagues have the opportunity on a regular basis to revisit or put in place where appropriate a 'Supporting Disability at Work Agreement', or risk assessment to provide reasonable adjustments and supportive actions.
- Implementing new ways to support colleagues who have caring responsibilities, this has been achieved through creating a package of support and working towards implementation of a Carers' Passport.
- Delivering targeted wellbeing campaigns to tackle health inequalities in our workforce, this has included the provision of food hubs, engaging with retailers to sell fresh fruit and vegetables on site, providing financial advice and counselling, and offering staff health checks to colleagues with protected characteristics.
- Continuing to support colleagues mental and physical wellbeing during the ongoing Covid-19 pandemic, through regular risk assessment, mental health listening events and psychological support.
- Providing a range of wellbeing offers which has included the Time to Change campaign, promoting the cycle to work scheme, and having a greater nature and environmental focus which encourages colleagues to spend more time outdoors.
- Using out mobile education unit to engage with the local community through attendance at local community events such as Windrush, the Health Mela where we promote health screening in the community and provide myth-busting around miss-held beliefs about treatment options.

Counter fraud

We have a policy in respect of countering fraud and corruption which includes contact details of the national helpline and a local independent counter fraud officer. The Trust has an accredited anti-fraud specialist provided by Mersey Internal Audit Agency (MIAA) and they deliver the service in line with NHS Counter Fraud Authority's standards.

Health and safety performance

The Trust's policy is to safeguard the health and safety of all our employees, patients, visitors and anyone who may be affected by our activities by ensuring we are compliant with the Health and Safety at Work Act (1974). This is the primary legislation covering occupational health and safety in the United Kingdom (UK) and defines the fundamental structure and authority for the regulation and enforcement of workplace health, safety and welfare within the UK. The delivery of health and safety performance oversight and management and health and safety governance operationally is managed by the corporate governance department whilst strategically remains in the portfolio of the Finance Director. The delivery of physical health and safety oversight and management is managed by the Director of Estates and Facilities within the portfolio of the Finance Director.

There are two key Committees that manage and contribute to health and safety across the Trust, these being:

Health and Safety Governance Group – this group is attended by managers from all the Trust's clinical divisions and key corporate teams. The Health and Safety Governance Group reports to the Finance and Performance Committee and is chaired by the Associate Director of Governance. The cycle of business for the Health and Safety Governance Group includes the following areas:

- Action plan progress including any inspections
- POSH audit progress
- Audit schedule
- Fire safety
- Security
- Violence-Prevention-Reduction Standard
- Asbestos (via Chair's report)
- Waste (via Chair's report)
- Sharps safety (via Chair's report)
- Medical devices management (via Chair's report)
- Legionella water safety (via Chairs report)
- Infection prevention and control (via Chairs report)
- Radiation Protection Committee (via Chairs report)
- Joint Consultative Committee (via Chairs report)
- Incident reporting
- Health and safety
- RIDDOR
- Claims updates
- Occupational Health
- Compliance with relevant Safety Alerts
- Occupational Health update
- Moving and Handling update

Physical health and safety is overseen by the Health and Safety Manager to represent the estates division. They have a significant remit of reviewing and managing physical health and safety across the hospital sites. Health and safety performance oversight and management of health and safety governance operationally is delegated to the Health and Safety Manager. The Staff Side health and safety partnership lead is a member of the Health and Safety Governance Group. Their remit is to:

- Raise the profile of health and safety representatives within the organisation, so that staff and managers understand the support the role can offer and when there needs to be consultation with the representatives
- Contribute to the development of training and e-Learning modules related to leadership responsibilities for health and safety
- Proactively engage in the development, review and update of health and safety related policies including researching legislative changes
- Work collaboratively with the Health and Wellbeing team to support implementation of the aspects of their strategy which are linked with health and safety in particular stress and Covid-19 risk assessments
- Contribute to the development of the Violence Prevention and Reduction Strategy and implementation of the actions
- Work with the Physical Risk team to improve the quality and completion rates of risk assessments including undertaking audits
- Work with the Health and Safety Manager to support robust health and safety governance
- Support implementation of specific actions related to the POSHH audit and Health and Safety Executive inspections

Health and Safety Joint Consultative Committee (HSJCC) – the Committee is a forum for engagement with staff representatives on safety matters, meeting the statutory requirements of the Safety Representatives and Safety Committee Regulations 1977 (as amended) and the Health and Safety (Consultation with Employees) Regulations 1996. The meetings are productive and create positive engagement from all. The Associate Director of Governance attends HSJCC meetings and the elected Staff Side health and safety partnership lead is also a member of the HSJCC. This further supports engagement and involvement of staff representatives with the health and safety governance agenda.

The Trust also has a number of responsible officers whose role it is to co-ordinate and lead health and safety within their own particular area or service and these roles are supported with a programme and training to further upskill the Trust in health and safety management.

Prohibition or enforcement notices

The Trust has not received any prohibition or enforcement notices during the year.

Overseas operations

The Trust does not have any subsidiaries overseas.

This Performance Report is signed on behalf of the Board of Directors by:

Kevin McGee OBE
Chief Executive
28 June 2022

Lancashire Teaching Hospitals NHS Foundation Trust

ACCOUNTABILITY REPORT 2021–22

DIRECTORS' REPORT

The Directors present their annual report on the activities of Lancashire Teaching Hospitals NHS Foundation Trust.

This Directors' report is prepared in accordance with:

- sections 415, 416 and 418 of the Companies Act 2006 (section 415(4) and (5) and sections 418(5) and (6) do not apply to NHS Foundation Trusts) as inserted by SI 2013 (1970)
- Regulation 10 and Schedule 7 to the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008. All the requirements of schedule 7 applicable to the Trust are disclosed within the report
- additional disclosures required by the Treasury's Financial Reporting Manual
- additional disclosures required by NHSI in its Annual Reporting Manual

Our Board of Directors

Our Board of Directors is a unitary Board, and has a wide range of skills with a number of Directors having a medical, nursing or other health professional background. The Non-Executive Directors have wide-ranging expertise and experience, with backgrounds in finance, audit, IT, estates, commerce, quality and service improvement, health and social care, risk, governance and regulation, and education. The Board is balanced and complete in its composition, and appropriate to the requirements of the organisation.

Please note that (I) indicates that the Non-Executive Director is considered independent.

Non-Executive Directors

Professor Ebrahim Adia (Chairman) (I)

Appointment: 2 December 2019 to 1 December 2022

Ebrahim is currently Pro Vice-Chancellor at the University of Central Lancashire and a member of the Senior Executive Team.

Previously, Ebrahim served as Vice-Chair of a Primary Care Trust and as a Non-Executive Director of an NHS Foundation Trust. He has also served as Deputy Leader of Bolton Council and is currently an Elected Member.

Tim Watkinson, Vice Chairman (I)

Appointment: 1 April 2016 to 31 March 2023

Tim is a qualified accountant with over 25 years' experience in senior audit positions in the public sector. He was previously the Group Chief Internal Auditor for the Ministry of Justice and prior to that was a District Auditor with the Audit Commission, including terms of office in Lancashire County Council, Preston City Council and Chorley Borough Council. Tim has led national teams and taken a lead role for the Audit Commission in the development of methodology for improving the performance of local authorities. Tim has experience of working in major accountancy firms providing audit and consultancy services to the public sector including the NHS. He has also been employed as an accountant and a Chief Internal Auditor within the NHS.

Tim is the Vice Chairman of the Trust and the Chair of the Trust's Audit Committee. He is also the Non-Executive Board lead for Freedom to Speak Up and a member of the Rosemere Management Committee. Outside the Trust, Tim is an independent member of the UK Statistics Authority's Audit and Risk Assurance Committee.

Victoria Crorken, Non-Executive Director (I)

Appointment: 24 January 2022 to 23 January 2025

Victoria is an experienced senior leader within public sector and commercial environments. With 26 years' operational policing experience in Lancashire Constabulary, she has a deep understanding of the complex socio-economic and health challenges within local communities and has developed collaborative cross-sector partnerships to tackle inequality. Currently the Head of Risk for the Co-op Group Ltd, Victoria led the transformational change of the Crime, Security, Regulatory Compliance and Business Resilience strategy and her particular areas of expertise are stakeholder partnership collaborations, governance, risk management and regulatory oversight. Victoria has an MBA from the University of Central Lancashire Business School and is also the Vice-Chair of Governors for Co-op Academy Leeds.

Professor Paul O'Neill, Senior Independent Director (I)

Appointment: 4 March 2019 to 3 March 2025

Paul is Professor Emeritus at the Manchester University and Consultant Physician with special interests in elderly care and stroke medicine. He has been the Head of School and Deputy Dean for the Faculty of Medical and Human Sciences. He received a National Teaching Fellowship and has published extensively in medical education and clinical research, as well as co-authoring six books. Internationally, Paul was a member of Faculty for the Harvard-Macy medical educators programme and acts as an education consultant internationally. On behalf of the Medical Schools Council, he led the work on devising a new selection system for the Foundation Programme implemented in 2012. His has an interest in patient and public involvement in medical education and established the Doubleday Centre for Patient Experience at Manchester. In 2013, he was awarded the President's Medal of the Academy of Medical Educators for his achievements. Paul continues to work extensively for the General Medical Council in quality assuring undergraduate and postgraduate medical education and is a Consultant at the Manchester University Foundation Trust. Paul is the Chair of the Trust's Education, Training and Research Committee.

Paul was appointed as Senior Independent Director on 31 August 2019.

Ann Pennell, Non-Executive Director (I)

Appointment: 7 January 2019 to 6 January 2025

Ann has had a long Executive career in local Government including senior roles in children's services, corporate improvement and housing. She has held Non-Executive Director posts at Cheshire and Wirral Partnership NHS Foundation Trust and prior to that, she was Non-Executive Director and Vice Chairman at Southport and Ormskirk Hospital NHS Trust. Ann is the Chair of the Trust's Safety and Quality Committee and Non-Executive Director Lead for maternity safety and safeguarding. Ann is also the Trust's Board-level Maternity Safety Champion.

Kate Smyth, Non-Executive Director (I)

Appointment: 4 February 2019 to 3 February 2025

Kate was a chartered town planner and worked in planning and economic development for many years in local authorities across the North West. She then ran her own consultancy business for 25 years specialising in economic development and disability, and has extensive experience working in the public and community and voluntary sectors. From 2012 to 2019, she was the Lay Member (Patient and Public Involvement) at Calderdale CCG. Kate was also the equality lead and the lead for deprivation, poverty and housing. From 2010 to 2019, she was an independent Board member (latterly, the Deputy Chair) at Kirklees Neighbourhood Housing and the equality champion. She is currently a Lay Leader at Yorkshire and Humber Patient Safety Translational Research Centre and in 2019 was appointed to the North West Regional Stakeholder Network, established by the Cabinet Office Disability Unit. In March 2021, Kate was elected as Co-Chair of the Disabled NHS Directors' Network. Kate is the Chair of the Trust's Charitable Funds Committee.

Jim Whitaker, Non-Executive Director (I)

Appointment: 3 July 2017 to 2 July 2023

Jim is an experienced Executive currently working at BT Enterprise, where he is Director of Project Management. During his career, Jim has led many large scale IT transformation programmes for customers in the UK and abroad; these have typically been high complexity and operationally critical in nature. He has worked with customers in many sectors including Government, Defence, Investment Banking and Retail. Jim is a Chartered IT Professional with the British Computer Society and holds project management qualifications, which include APM RPP, MSP and Prince 2. His areas of particular expertise are strategic planning, managing change, governance, and risk management. Jim is the Chair of the Trust's Workforce Committee.

Tricia Whiteside, Non-Executive Director (I)

Appointment: 9 September 2019 to 8 September 2022

Tricia is a transformational leader with a wealth of financial services experience having held a number of senior leadership roles within large Fortune 500 and FTSE100 organisations. Her experience gathered over 25 years includes owning aspects of global control frameworks and assuring compliance to the expected standards of control, establishing Strategic Change Portfolios, operational delivery of integration programmes following organisational merges/acquisitions and lead upon significant business transformation. Over the last 11 years she successfully established her consultancy business which provided interim management support, with focus on setting up new operational functions and building sustainable internal capabilities, creating portfolios of strategic change to improve operational performance and financial stability, strengthening governance and control regimes, consulting on risk management strategies, and positively responding to increased regulatory scrutiny. Tricia is the Chair of the Trust's Finance and Performance Committee.

Executive Directors

Kevin McGee OBE

Permanent post – appointment from 1 September 2021

Kevin brings with him a wealth of experience within the NHS having held director and Chief Executive positions for over 23 years. In addition to his role at the Trust, Kevin is also the Chief Executive Lead for the Lancashire and South Cumbria Provider Collaborative.

Easier in his career, Kevin, who is a qualified accountant, was Director of Finance and Information for North Sefton and West Lancashire Community Trust (1998–1999) and Ashworth Special Hospital Authority (1999–2000).

Kevin first came to Lancashire in 2000, joining University Hospitals of Morecambe Bay as the Director of Finance (2000–2004) before he became Chief Operating Officer (2004–2006) and then Acting Chief Executive (2006–2007).

Kevin them moved to NHS North Lancashire as the Director of Commissioning and Performance Management (2007–2010).

Kevin briefly left Lancashire for a four-year stint to take up Chief Executive roles at Heart of Birmingham Primary Care Trust (2010–2011) and George Elliot Hospital (2011–2014) before he returned to the County as Chief Executive at East Lancashire Hospitals NHS Trust in 2014. In 2019 he also became Chief Executive for Blackpool Teaching Hospitals NHS Foundation Trust and maintained responsibility for both Trusts until taking up his current role.

Kevin was awarded an OBE in the New Year's Honours list 2022 for services to the NHS.

Faith Button, Chief Operating Officer

Permanent post – appointment from 1 May 2019

After graduating Faith joined the NHS and has worked in a number of acute Trusts in senior roles in London and the South with over 20 years' experience. She has a strong background in senior operational management and performance management having been a Director of Performance at her last two Trusts. She joined the Trust in 2017 having been the Deputy Chief Operating Officer and was appointed to Chief Operating Officer in May 2019. Faith is the interim Chief Operating Officer across the Integrated Care Partnership.

Sarah Cullen, Nursing, Midwifery and AHP Director

Permanent post – appointment from 1 August 2019

Sarah is a Registered Nurse with experience in a variety of nursing and operational roles in a broad range of specialties. Sarah spent 18 years of her career at University Hospitals of Morecambe Bay and joined Lancashire Teaching Hospitals in 2017 as the Deputy Nursing, Midwifery and AHP Director becoming the Executive Nursing, Midwifery and AHP Director in 2019. Sarah is the Executive lead with responsibility for the hospital charity, governance, maternity, children and safeguarding. She is also a trustee of the post graduate education charity.

Gerry Skailes, Medical Director

Permanent post – appointment from 1 March 2018

Gerry graduated from Guys Hospital in London and spent the early years of her medical training in London and the South Coast before moving to the Christie Hospital to undertake specialist training in Clinical Oncology. She was appointed as a Consultant at the Royal Preston Hospital in 1997 with an interest in treating lung and gynecological cancers. She has held a number of leadership roles within the Trust and North West region including Clinical Lead for the Lancashire and South Cumbria Cancer Alliance and Deputy Medical Director of the Trust. Gerry continues to work as a Consultant in Oncology undertaking a weekly Acute Oncology ward round and is actively involved in a number of the ICP and ICS Committees. Gerry was appointed as the Trust's full-time Medical Director from March 2018 and is also our Caldicott Guardian.

Karen Swindley, Workforce and Education Director

Permanent post – appointment from 1 November 2011
(Strategy, Workforce and Education Director from 1 December 2018 up to 29 January 2022)

Karen was appointed to the role of Director of Workforce and Education in November 2011 prior to this appointment, having previously worked as Associate Director of Human Resources Development in the Trust since 2001. Having been employed in the NHS for over 26 years, she has held a number of senior posts in education, training and organisational development both in the NHS and the private sector. Karen is responsible for leadership and management of human resources, training and education, and research. Following the appointment of a Director of Strategy and Planning in January 2022, the strategic portfolio managed by Karen since December 2018 was realigned to that role. Outside of the Trust she is the Chairman and Trustee of Derian House Children's Hospice.

Jonathan Wood, Finance Director / Deputy Chief Executive

Permanent post – appointment from 1 August 2019

After graduating, Jonathan joined the North Western financial management training scheme in 1992 where he worked with a number of Health Authorities within Greater Manchester. Since qualifying he has worked for a number of NHS organisations, including Salford Royal, the North West Strategic Health Authority, East Lancashire Hospitals NHS Trust and Leeds Teaching Hospitals NHS Foundation Trust. He has supported a number of hospital developments over the years and enjoys working with teams in resolving complex problems.

Non-voting Board members

Ailsa Brotherton, Director of Continuous Improvement

Permanent post – appointment from 1 December 2017

Ailsa joined the Trust in 2017 from Manchester Foundation Trust where she was the Director of Transformation for the Single Hospital Programme. Prior to this Ailsa held clinical quality and improvement roles with the Trust Development Authority/NHSI. She has also held a post-doctoral senior research fellow post, has a Masters in Leadership (Quality Improvement) from Ashridge Business School and is a Health Foundation Generation Q Fellow. Ailsa has extensive experience of designing and delivering quality improvement and large scale change programmes. In 2019 Ailsa was awarded an honorary professorship in the School of Health and Wellbeing at the University of Central Lancashire and is working with our academic partners to ensure all our improvement programmes are evidence based and evaluated. She is a member of the Safety and Quality Committee, Education, Training and Research Committee and Workforce Committee and is a member of the national Improvement Directors' network.

Corporate Directors

Stephen Dobson, ICP Chief Information Officer

Permanent post – appointment from 1 April 2020

Stephen joined the Trust in April 2020 from Greater Manchester's Health and Care Partnership where he was the Chief Digital Officer. Prior to this Stephen spent eight years as Chief Information Officer for Wrightington, Wigan and Leigh NHS Foundation Trust. He has also spent over 10 years working for Pfizer Pharmaceuticals within the USA and UK within a variety of roles including Pharmacogenomics, Clinical Trials, Informatics and Knowledge Management. Stephen has a PhD in Molecular Genetics and extensive experience leading digital programmes. Stephen attends the Finance and Performance Committee.

Gary Doherty, Director of Strategy and Planning

Fixed-term post as Director of Service Development from 1 December 2020 to 29 January 2022

Permanent post – appointment from 30 January 2022

Gary joined the Trust in February 2020 and is an experienced NHS leader having worked in operational and planning roles at a range of levels including Chief Executive. He has over 25 years NHS experience and has worked in both the English and Welsh NHS, mainly in hospital provision but also at a regional level for the Department of Health. Gary attends the Safety and Quality and Finance and Performance Committees.

Naomi Duggan, Director of Communications and Engagement

Permanent post – appointment from 1 April 2020

Naomi joined the Trust in April 2020 in this newly created Director post, having previously undertaken a similar role at University Hospitals of North Midlands from October 2016 where she was a member of the Board and Executive team. Prior to this, Naomi has held senior communications and engagement roles at Tameside and Glossop Primary Care Trust, Oldham Metropolitan Borough Council and within private sector retail.

Naomi has run her own consultancy business and after her first degree she started her career as a Management trainee on the Blue Chip British Coal Corporation graduate scheme. Naomi has worked on a number of transformational projects for the NHS including Better Care Together in Morecambe Bay and Healthier Together in Greater Manchester, as well as controversial retail schemes which needed positive engagement to win the hearts and minds of a range of key stakeholders in order to secure planning permission and political and community support.

A graduate of Leeds University, Naomi has an MBA from Leeds University Business School, a Postgraduate certificate in Marketing from Sheffield Business School and the Chartered Institute of Marketing Diploma. She is also a member of the Chartered Institute of Public Relations.

Board members whose term of office ended during 2021–22

The following Board members' terms of office ended during 2021–22:

Geoff Rossington, Non-Executive Director (I)

Appointment: 4 September 2017 to 3 September 2023

Geoff stepped down from his role as a Non-Executive Director with effect from 30 September 2022.

Karen Partington, Chief Executive

Permanent post – appointment from 1 October 2011 to 31 December 2021

At the start of 2021, Karen indicated her intention to retire from the role of Chief Executive with effect from 31 December 2021. Between 1 September and 31 December 2021 Karen took up a portfolio of work across a number of partner organisations.

Appointment and removal of Non-Executive Directors

Appointment and, if appropriate, removal of Non-Executive Directors is the responsibility of the Council of Governors. When appointments are required to be made, usually for a three-year term, a Nominations Committee of the Council oversees the process and makes recommendations to the full Council as to appointments. The procedure for removal of the Chairman and other Non-Executive Directors is laid out in our Constitution which is available on our website or on request from the Company Secretary.

Division of responsibilities

There is a clear division of responsibilities between the Chairman and the Chief Executive. The Chairman ensures the Board has a strategy which delivers a service that meets the expectations of the communities we serve and that the organisation has an Executive Team with the ability to deliver the strategy. The Chairman facilitates the contribution of the Non-Executive Directors and their constructive relationships with the Executive Directors. The Chief Executive is responsible for leadership of the Executive Team, for implementing our strategy and delivering our overall objectives, and for ensuring that we have appropriate risk management systems in place.

Declaration of interests

All Directors have a responsibility to declare relevant interests, as defined within our Constitution. These declarations are made to the Company Secretary, reported formally to the Board and entered into a register which is available to the public. The register is also published on our website, and a copy is available on request from the Company Secretary.

Independence of Directors

The role of Non-Executive Directors is to bring strong, independent oversight to the Board and all Non-Executive Directors are currently considered to be independent. The Board is made up of a majority of independent Non-Executive Directors who have the skills to challenge management objectively. There is also a strong belief in the importance of ensuring continuity of corporate knowledge, whilst developing and supporting new skills and experience brought to the Board by new Non-Executive Directors.

Decisions on reappointments of Non-Executive Directors are made by the Council of Governors. A reappointment of a Non-Executive Director beyond six years is based on careful consideration of the continued independence of the individual Director and recognising the need to introduce new skills to the Board. Non-Executive Directors who are appointed beyond six years are always subject to annual reappointment, and the maximum term of office is nine years in aggregate, in line with the Trust's Constitution.

In recognition of our role as a teaching hospital, one of our Non-Executive Director posts is held by a University representative. This allows the post holder to use their detailed knowledge and their experiences within the field of academia to play a key role on the Board and this post is occupied by Professor Paul O'Neill, who was re-appointed on 4 March 2022 for a second three-year term.

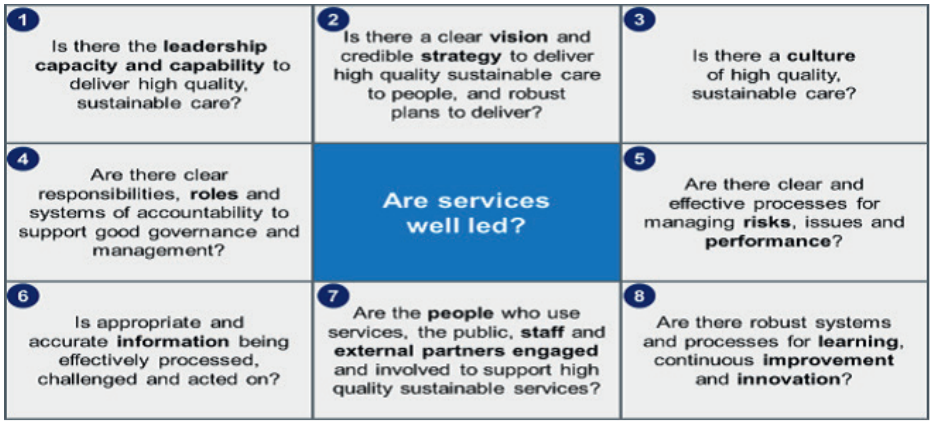
Board meeting attendance summary 2021–22

Present	1st Apr 2021	3rd June 2021	5th Aug 2021	7th Oct 2021	2nd Dec 2021	3rd Feb 2022	A	B	Percentage of meetings attended
Ebrahim Adia	P	P	P	P	P	Ab	6	5	84%
Ailsa Brotherton	P	P	P	P	P	P	6	6	100%
Faith Button	P	P	P	P	P	P	6	6	100%
Victoria Crorken						P	1	1	100%
Sarah Cullen	P	P	P	P	P	P	6	6	100%
Stephen Dobson	P	P	P	P	P	P	6	6	100%
Gary Doherty	P	P	P	P	P	P	6	6	100%
Naomi Duggan	Ab	P	P	P	P	P	6	5	84%
Kevin McGee				P	P	Ab	3	2	67%
Paul O'Neill	P	P	P	P	P	P	6	6	100%
Karen Partington	P	P	P				3	3	100%
Ann Pennell	Ab	P	P	P	P	P	6	5	84%
Geoff Rossington	P	P	P				3	3	100%
Gerry Skailes	P	P	P	P	P	P	6	6	100%
Kate Smyth	P	P	P	P	P	P	6	6	100%
Karen Swindley	P	P	P	P	Ab	P	6	5	84%
Tim Watkinson	P	Ab	P	P	P	P	6	5	84%
Jim Whitaker	Ab	P	Ab	P	Ab	P	6	3	50%
Tricia Whiteside	P	P	P	P	P	Ab	6	5	84%
Jonathan Wood	P	Ab	P	P	P	P	6	5	84%

P = Present | Ab = Absent | A = Maximum number of meetings the Director could have attended | B = Meetings attended

Evaluating performance and effectiveness

In line with NHSI requirements that Trusts carry out a developmental review of their leadership and governance every three years, the Trust commissioned an independent review in 2020. The review was conducted in line with the Well Led Framework which consists of eight key lines of enquiry (KLOEs) and details descriptions of good practice that organisations and reviewers can use to inform their judgements. The eight KLOEs within the framework are as follows:



The overall conclusion of the review was that Lancashire Teaching Hospitals NHS Foundation Trust is well led with the final report indicating a good level of awareness around the strengths of the organisation, as well as reflecting areas where greater improvement is required.

Update on progress with the Well Led and Governance Maturity Plan 2021–2023

The Well Lead and Governance Maturity Plan has been developed to drive improvement in the 'well led' domain of the organisation. It incorporates recommendations based on the MIAA Risk Maturity Self-Assessment tool. Phase 1 of the plan focused on governance and risk maturity and delivery was tested as part of the internal audit plan in 2020–21 and assurance of delivery confirmed.

The Well Led and Governance Maturity Plan has incorporated recommendations from the MIAA developmental well led review and will be updated following each developmental review going forward remaining a responsive, live document. There are two associated plans that support the delivery of this. The first is the Board development plan incorporating the Board Safety and Experience programme. Progress against this reports directly to Board, and the second is the Executive Management Group development plan that has been created following the MIAA development leadership review and will be monitored going forward through Executive Management Group.

Further information on performance and effectiveness can be found in the Annual Governance Statement.

The Modern Slavery Act 2015

The Trust has zero tolerance to slavery and human trafficking and is committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our service. The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and, as such, we have a strict set of ethical values that we use as guidance with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles. The summary below sets out the steps the Trust takes to ensure that slavery and human trafficking is not taking place in our supply chains or in any part of our service:

- **Assessing risk related to human trafficking and forced labour associated with our supply base**: we do this by supply chain mapping and developing risk-ratings on labour practices of our suppliers to understand which markets are most vulnerable to slavery risk.
- **Developing a 'Supplier Code of Conduct'**: we will issue our Supplier Code of Conduct to our existing key suppliers as well as those that are in a market perceived to be of a higher risk (for example, catering, cleaning, clothing and construction). The Supplier Code of Conduct will also be included within our tendering process. We will request confirmation from all our existing and new suppliers that they are compliant with our Supplier Code of Conduct.
- **Monitoring supplier compliance with the Act**: we will request confirmation from our key suppliers that they are compliant with the Act.
- **Training and provision of advice and support for our staff**: we are further developing our advice and training about slavery and human trafficking for Trust staff through our Safeguarding Team to increase awareness of the issues and how staff should tackle them.
- **Monitoring contracts**: we continually review the employment or human rights contract clauses in supplier contracts
- **Addressing non-compliance**: we will assess any instances of non-compliance with the Act on a case-by-case basis and will then tailor remedial action appropriately.

Political donations

The Trust has neither made nor received any political donations during 2021–22.

Directors' declaration

All Directors have confirmed that, so far as they are aware, there is no relevant audit information of which the auditor is not aware and that they have taken all steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information. All Directors understand that it is their responsibility to prepare the annual report and accounts, and that they consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable, and to provide the information necessary for patients, regulators and other stakeholders to assess the performance of Lancashire Teaching Hospitals NHS Foundation Trust, including our business model and strategy.

If you would like to make contact with a Director please contact the Company Secretary by email: **company.secretary@lthtr.nhs.uk** or telephone **01772 522010**.

Also available on our website:

Register of directors' interests
Director biographies
Statement on the division of responsibilities between Chairman and Chief Executive

QUALITY IMPROVEMENT

Below highlights some of the key developments made by the Trust to improve service quality and an overview of the Trust's arrangements in place to govern service quality. Additional information on quality is available in our 2021–22 Quality Account which will be available on the Trust website at the end of June 2022 and within our Annual Governance Statement (pages 88 to 102).

Continuous Improvement

The Trust has launched its second Continuous Improvement Strategy and the implementation of the delivery of the first year of this strategy has been delivered throughout the year. The Always Safety First improvement programme has been delivered in line with the Always Safety First Strategy (the Trust's response to the national Patient Safety Strategy), facilitating improvement in safety metrics across the organisation.

Cohort one of the Lancashire and South Cumbria Flow Coaching Academy has been delivered with the establishment of fourteen Big Rooms: Brain Cancer; Chemotherapy; Deteriorating Patients; Enhanced Care; End of Life; Endoscopy; Ear, Nose and Throat; Gynaecology; Lung Cancer; Nutrition; Respiratory; Transition into Adult Services; Heart Valve Transplant; and Vascular Surgery. The four Big Rooms from the initial training in Sheffield are continuing: Colorectal Cancer; Frailty; Inflammatory Bowel Disease; and Sepsis.

The second cohort of the Microsystem Coaching Academy programme has been delivered though there has been an impact of Covid-19 on the delivery of the programme.

There has been a significant focus throughout the year on building continuous improvement capability across the organisation through the delivery of the Continuous Improvement Building Capability Strategy in line with the NHS Improvement report and dosing formula for provider organisations for year one of the strategy.

Continuous improvement support has been provided to a number of the divisions and corporate teams with the design, testing and implementation of improvement priorities in response to specific requests (out with the formal improvement programmes), often in response to organisational pressures. In year, this has included supporting pharmacy to use a continuous improvement methodology to reduce medicines wastage, supporting the pain management psychology team to streamline referral processes, supporting the patient experience team to drive improvements in patient experience (including participating in the Imperial College and Health Foundation Scale, Spread and Embed Research Project), supporting the referral and triage process for the Nightingale Hub to ensure improved flow of patients into the Unit, utilising a continuous improvement approach to support the adoption of patient initiated follow up, testing of the National Rapid Release Policy for ambulance handovers, co-ordinating the Lancashire and South Cumbria Together Improvement Weeks in response to operational pressures, improvement project in maternity triage assessment unit and a patient flow improvement programme.

Always Safety First

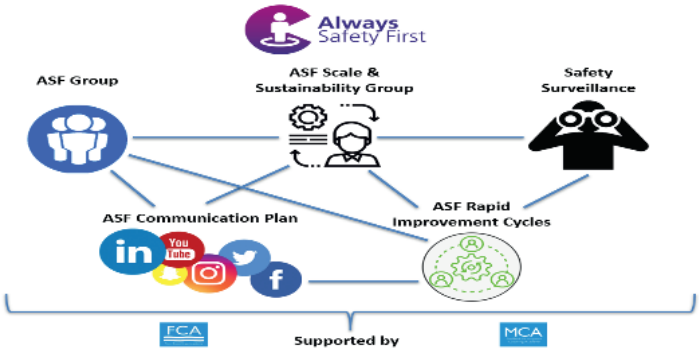
The Trust Board recognises the benefits of embedding a culture of continuous improvement across our organisation, supporting our staff to design, test, embed and sustain changes that benefit patients and our local population. To achieve a culture of continuous improvement in our patient safety metrics, the Trust developed Always Safety First, our long-term approach to transforming the way services are delivered for the better, utilising a robust improvement methodology. Always Safety First is based on proactive regular review of our safety metrics and safety intelligence to inform our priorities, improvement co-designed with our staff and patients, shared governance, collaborative working across divisions and clinical specialties, and learning to improve. Our work is underpinned by a real-time safety surveillance system, making our data visible from Ward to Board. Always Safety First is focused on achieving high reliability through standardisation, system redesign and ongoing development of pathways of care, built on a philosophy of continuous improvement led by frontline clinical staff.

How is our Continuous Improvement in patient safety, access and patient experience delivered?

In September 2021, the Trust launched its Always Safety First Strategy, which is our Trust response to the NHS National Patient Safety Strategy. This ambitious strategy outlines our plans and aspirations to improve quality of care and safety for our patients, service users and staff. To support the delivery of this strategy and Always Safety First Group was formed, chaired by our Trust Patient Safety Specialists with representation from a wide group of staff across the organisation. This specialist multi-disciplinary group is enabling a culture of continuous improvement and cross system working to build the will to improve safety, making safety everyone's role. By reviewing systematic data from harms, incidents, and our safety surveillance system the group is initiating new targeted programme design and delivery to tackle our biggest challenges around safety, including pressure ulcers and medication safety.

The Always Safety First programme is now maturing in its delivery and our teams are building on the learning from the initial launch and facilitation of virtual collaborative learning sessions. At these sessions participating teams were brought together to learn about the improvement interventions to be embedded, share learning and best practice, building improvement capability and actively participating, forming a positive continuous improvement culture.

We are now developing an Always Safety First Phase II approach which is focusing much more on the scale and sustainability of our improvements which were developed and tested through our founding Breakthrough Series Collaboratives. This new approach will combine our learning and new improvement methods to deliver rapid testing and development of change solutions, which can then be guided through a formal scale and sustainability process, supported by measurement, communication and governance to ensure our new improved ways of working are embedded.



Research participation in clinical research

In 2021–22 the number of patients recruited to participate in research approved by a Research Ethics Committee was 2,404 (to 22 March 2022) and by year end if likely to pass 2,500.

The Trust recruited 2,246 patients to National Institute for Health Research (NIHR) portfolio adopted studies in this period. It granted local confirmation for 74 new portfolio studies to commence during that time which is our best performance ever and a 50% uplift on performance last year. The Trust recruited a further 108 participants to non-portfolio studies. In total, there are currently 216 active research studies recruiting patients at the Trust.

Due to the ongoing pandemic and following guidance from the NIHR, we suspended a large number of studies to focus on Covid-19 research but have successfully re-opened studies and currently have 95% of all studies re-open to recruitment. This provides us with a balanced portfolio of studies including those related to Covid-19.

Key achievements to note are:

- Re-awarding of the NIHR Lancashire Clinical Research Facility status with 33% uplift in funding for 2022–25 of £1m
- Nichola Verstraelen completing her three years as NIHR 70@70 representative and being asked to lead an NHSE project on a research toolkit for the Matron's Handbook
- Research Scholars: having never had a successful application for the NIHR Northwest Coast Clinical Research Network's Scholar scheme (to train new consultant-level clinicians and nursing and allied health professionals as investigators), we are pleased to report that in year we have had four successful applications this time, the joint highest in the region. Congratulations to Dr Rob Shorten (Clinical Scientist), Dr Katherine Prior (Respiratory Consultant), Dr Malabika Ghosh (Occupational Therapy) and Sarah Edney (Speech and Language Therapy).

PATIENT EXPERIENCE 2021–22 PERFORMANCE REPORT

Patient care

Delivering excellent care with compassion relies on positive patient experiences within the organisation. Actively seeking to listen to the experience of patients, staff and families is a fundamental part of learning from lived experience. This year has seen the conclusion of our three-year Patient Experience and Involvement Strategy 2018–2021. The next Patient Experience and Involvement Strategy 2022–2025 is being coproduced and will be launched in quarter 2 of 2022. The delivery of the Patient Experience and Involvement Strategy 2021–22 has been underpinned by a fully diverse and inclusive Patient Experience and Involvement Group. The group consists of governors, patient representatives, carers, voluntary sector organisations and staff members and throughout the year has continued to shape and prioritise the focus of improvement work. This group reports directly into the Safety and Quality Committee.

Metrics that are used to determine outcomes relating to experience include.

- Friends and Family numeric and narrative responses
- Complaints
- Parliamentary Health Service Ombudsman (PHSO) reviews
- Compliments and Thank You messages
- National patient survey results

A comprehensive Patient Experience and Patient Advice and Liaison Service (PALS) team function in partnership with teams across the organisation and aim to provide a responsive, patient focused service supporting improvement in all services in partnership with teams and in a proactive way.

Experience is tested as part of the STAR quality assurance process and includes a 15-step process involving laypeople (outside of Covid-19 conditions) and governors to speak to patients and test their experience of care. More than 75% of areas are now achieving a silver rated or above STAR outcome. This is a core metric of Our Big Plan and is measured and monitored in the Safety and Quality Committee and by the Board of Directors.

A number of patient engagement forums are facilitated across the organisation and to ensure patients with protected characteristics, who are more likely to experience adverse outcomes, there are specific focused programmes of work to improve the experience of patients and families. Examples of this work include but are not limited to increasing the multi-faith services, increase in the number of induction loops, introduction of patient contribution to case notes, creation of dementia corridors and outside therapeutic areas.

Complaints and Concerns

Comparator data for Complaints 2015 to 2022

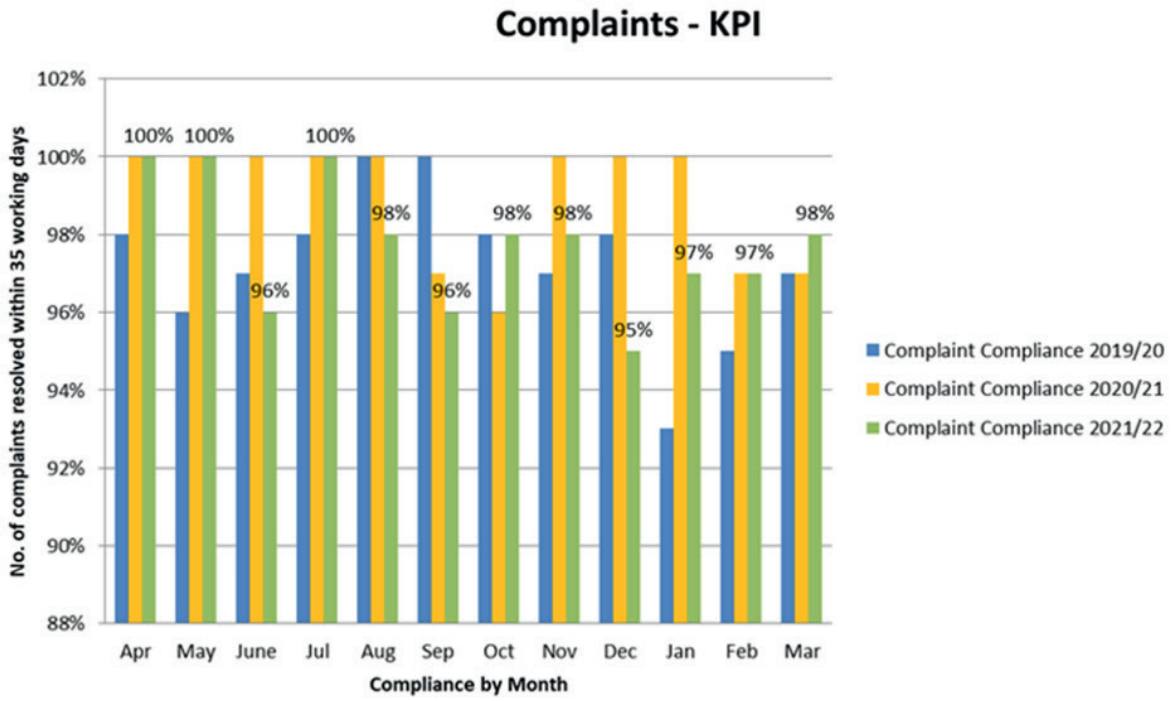
Year	Complaints received	Increase/reduction
2015–16	575	-4
2016–17	595	+20
2017–18	553	-42
2018–19	710	+157
2019–20	457	-253
2020–21	361	-96
2021–22	580	+219

Source: LTHTR Datix

During 2021–22 the Trust received 580 formal complaints, an increase of 264 (10%) from 2020–21. The impact of the pandemic led to fewer complaints in the previous two years and it is evident the number of complaints has now stabilised in comparison to the years pre-pandemic. The number of patients raising concerns relating to reduced visiting and extended waits on waiting lists has increased.

Of the 580 complaints received between April 2021 to March 2022, 509 (87.5%) related to care or services provided at the Royal Preston Hospital, 69 (12%) to care or services provided at Chorley and South Ribble Hospital and two (0.5%) to care or services provided by offsite services. In addition to the 580 complaints received, the Patient Experience and PALS team also responded to seven cases which were deemed to be outside of the timescale set out under the NHS Complaints Procedure.

Complaints answered within 35 days (April 2021 to March 2022)



Source: LTHTR Datix

Investigations that were undertaken into the 580 closed complaints concluded that 56 (10%) of the complaints had been upheld. 284 (49.5%) were partly upheld and 165 (28%) had not been upheld. The five (0.5%) remaining records were cases that were withdrawn, and 70 (12%) cases remain open.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 99% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team.

Second letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the year we received 27 second letters.

A total of 544 formal complaints were closed during the period 1 April 2021 to 31 March 2022 and 98% of complaints were closed within the 35-day timescale. Of note the organisation is not mandated to respond within 35 days, however the standard set is to ensure that complainants receive timely responses. During 2021–22 the Patient Experience and PALS Team have dealt with a total of 1,749 concerns and 7,347 enquiries.

The implementation of the governance and risk maturity plan across the organisation has led to the introduction of Datix 2 (the governance reporting system) for patient experience. This will provide opportunities going forward to ensure that there is a more complete understanding of the themes and trends from all concerns, not only complaints.

Complaints by division

Number of Complaints by Division (April 2021 to March 2022)

Division	Number (%)	Division	Number (%)
Medicine	247 (42.5%)	Women and Children's Services	79 (14%)
Surgery	198 (34%)	Diagnostics and Clinical Support	48 (8%)
Estates and Facilities	2 (0.5%)	Corporate Services	46 (1%)

Source: LTHTR Datix

Themes from complaints

Communication is the most common cause for complaints, this has been compounded by the limited access families have experienced in the previous year. Steps have been taken to mitigate this for patients and families including the use of media however the impact has been most significant. The new Always Safety First strategy includes communication and safety culture as core components of achieving safety and will introduce communication training as part of this. The Big Rooms feature patient stories to ensure the patient is in the room and central to the improvement work and, where possible, patients themselves will attend and share their experience first-hand, increasing the impact of the experience and provide a driver for change and improvement.

Parliamentary Health Service Ombudsman (PHSO)

Complainants have the right to request that the PHSO undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1 April 2021 to 31 March 2022 there were five cases referred to the PHSO; one was not upheld and four are ongoing. During this period the PHSO sent final reports for four cases which were opened prior to April 2021 and the outcome of these were that three were not upheld and one was partly upheld. There were a further three cases referred to the PHSO prior to April 2021 which are still under investigation and a final decision is yet to be reached. Also, during this period a further two cases have been referred to the PHSO which are being actioned through the PHSO's local dispute resolution process: one has been resolved, and one is ongoing and a meeting date is to be arranged.

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2021–22 a total of 2,071 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office.

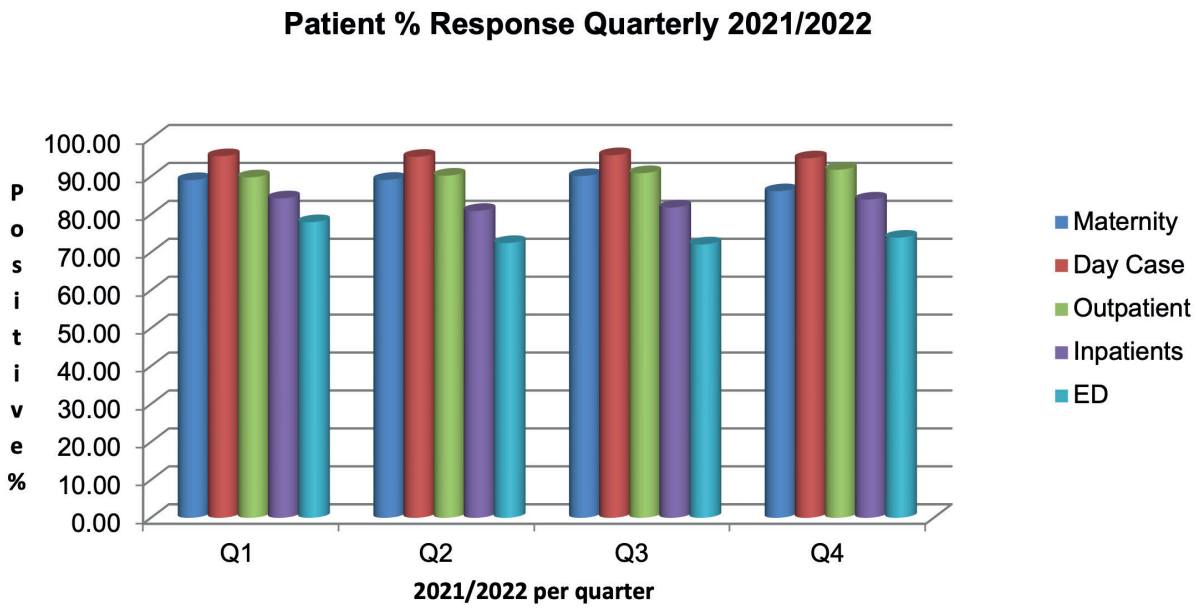
Patient experience feedback

Friends and Family Test (FFT)

The FFT is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. FFT is reported at departmental level, to the Safety and Quality Committee and through to the Board of Directors. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

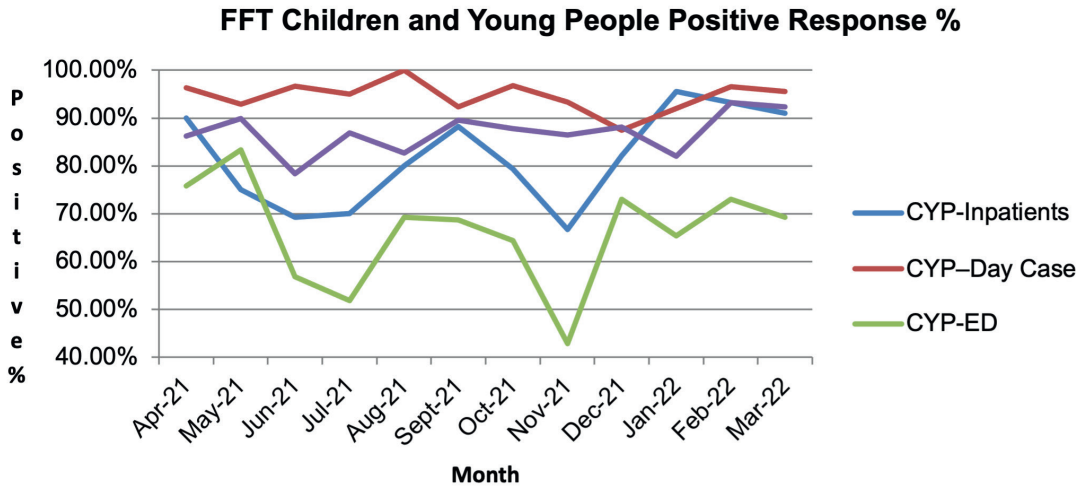
Quarterly percentage of positive responses (FFT)



Source: FFT data CIVICA

Historically, a target of 90% was set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department. Maternity achieved the target in quarter 3, day case has consistently achieved in excess of 90% throughout the year, and outpatients have achieved the target for the past three quarters. Inpatients and the Emergency Department remained under the target percentage in all four quarters.

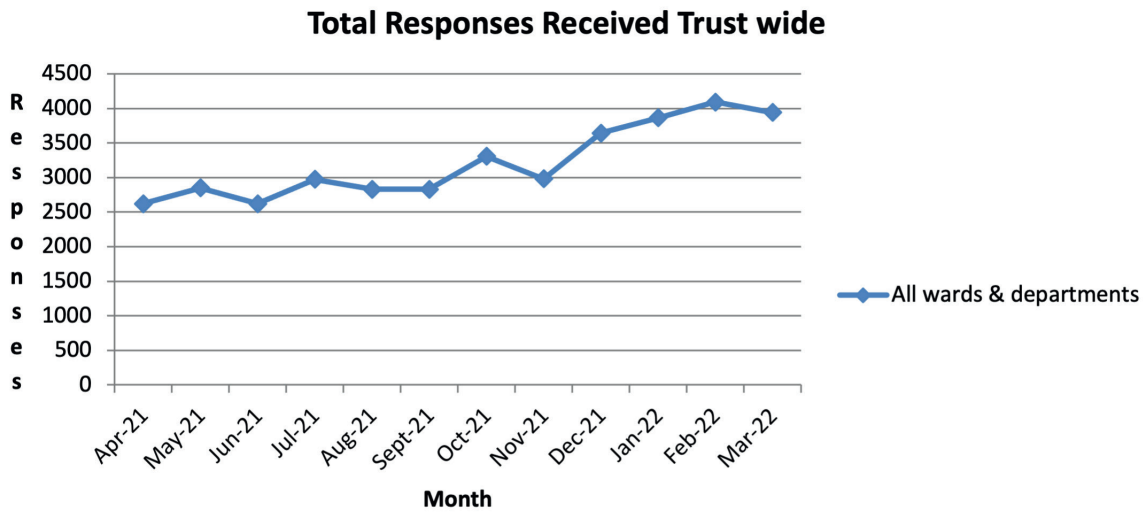
Children and Young People (CYP) quarterly percentage of positive responses (FFT)



Source: FFT data CIVICA

Although not a national requirement, the Trust undertakes surveys in Children and Young People's Services to ensure an equitable approach to measurement of experience. The neonatal service has maintained a positive response rate of 100% throughout the year. Children within the Emergency Department have been adversely affected by increased in demand associated with Respiratory Synctol Virus (RSV). The department has increased in size and staffing numbers to reflect continued growth in demand. This is evaluating more positively alongside increasing the number of written responses provided on site now the Covid-19 restrictions have lifted.

Friends and Family percentage response



Source: FFT data CIVICA

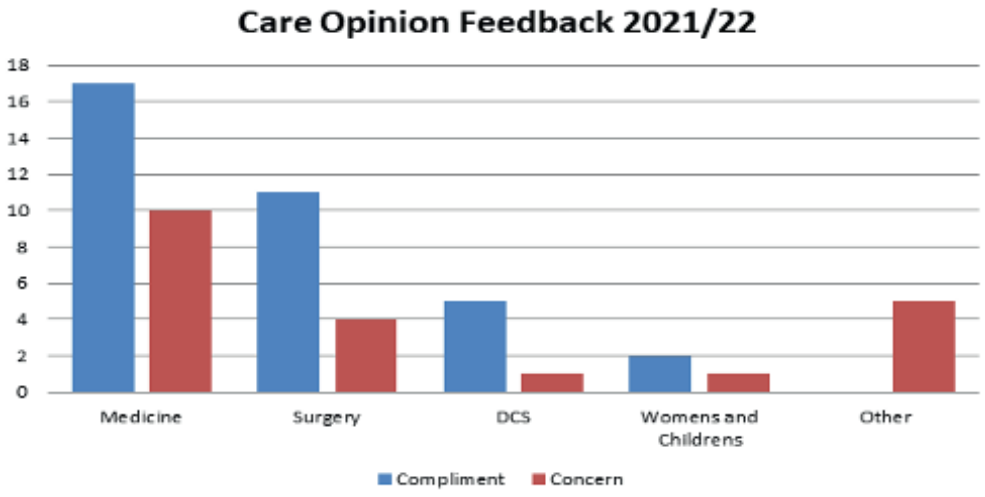
The data above demonstrates an overall increase in responses. The number of responses for FFT has gradually increased over the last 12 months as paper responses and QR codes have been introduced. Since April 2021 to March 2022, we have received 1,468 surveys completed using the QR codes/online links, 2,829 paper surveys, 3,684 telephone surveys and 36,128 SMS surveys. 30 bespoke surveys have been created in additional to the 15 FFT surveys.

Care Opinion website (www.careopinion.org.uk)

Care Opinion is a place where patients can share their experience of health or care services and help make them better for everyone. It provides patients with the ability to post reviews for both Royal Preston (which includes Preston Business Centre) and Chorley and South Ribble Hospitals.

The Care Opinion website is monitored and responded to on a regular basis by the Patient Experience and PALS Team. All reviews are responded to in order to acknowledge them, provide assurance that their feedback will be shared and provide the Patient Experience and PALS Team contact details for those who wish their concerns to be raised or looked into further. All feedback and compliments are logged on Datix and shared with the relevant divisions and staff. A CCG quarterly quality report is provided from the reviews left on Care Opinion and shared with the Trust Governance team.

It is difficult to establish themes due to the low numbers provided. During the past financial year, there have been a total of 57 reviews posted on the website consisting of 35 compliments and 22 concerns.



Health Inequalities

Mental Health, Learning Disabilities, Autism and Dementia

In recognition of the impact mental health, learning disabilities, autism and dementia may have on outcomes, work continues to provide specific focus on experience in these groups. These include;

Mental Health:

- Development, consultation and implementation of all age Mental Health Strategy (October 2021–2025) which notes patient experience as a commitment, aims to increase the skills and knowledge of the workforce in delivering patient centred care, and has a future vision for co-production with experts by experience.
- Development of the Children and Young Person Emotional Health and Wellbeing friends and family feedback form, in collaboration with the Paediatric teams.
- Implementation of the Mental Health Risk Tool and e-learning package which emphasises the need for collaboration with patients to understand triggers, helpful strategies and collaborating a risk management plan.
- Continued drive for parallel assessment by the Mental Health Liaison Team (MHLT) and Children and Young People's Mental Health Services (CAMHS), documentation from our mental health services and joint working.

Learning Disability and Autism:

- Continued provision of easy read information (including a PALS leaflet) and social stories for patients – increasing the information shared to discuss care options, for patients to understand their health needs and access healthcare, making adaptions/easy read options to increase the patients ability to consent and to reduce any anxieties the patient may have in their journey.
- Continued focus on use of the Hospital Passport (noted as good practice by LeDeR 'Learning from Lives and Deaths – people with a learning disability and autistic people') and within the Special Educational Needs and Disability agenda.
- Identifying, flagging and ensuring reasonable adjustments to best support patients – working across the Trust with specialist teams.
- Active multi-disciplinary team involvement and linking into the CCG where care and treatment reviews and care, education and treatment reviews are indicated.
- Consultation in March 2022 at the Learning Disability Partnership Board (including multi-agency partners and people with a learning disability) into the Trust's proposed Learning Disability and Autism Strategy. With an agreed focus on re-establishing the 'Live Healthier, Live Longer' co-production groups, importance of Hospital Passports recognised and easy read to support decision-making (or mental capacity act and best interest decision-making where capacity is questioned).
- The completion of the 4th year of NHSE/I Learning Disabilities Benchmarking Standards (results of 2021 not yet available). Available patient feedback in 2020 – five out of 50 responses, 2019 – 16 out of 50 responses and 2018 – four out of 50 responses which will guide completion of the Learning Disabilities and Autism Strategy 2022.
- Biannual review of learning disability deaths, specific learning from deaths shared and triangulated with national learning.

Dementia:

- Development, consultation, and implementation of the Dementia Strategy (July 2021–2025).
- Establishment of the Dementia Strategy Task and Finish Groups including people living with dementia, families, carers, governors, patient experience lead and multi-agency partners (for example, Alzheimer's Society and NCompass).
- Development of the Dementia Corridor to raise the profile of dementia, signpost and provide simple activity suggestions.
- Development of single-use activity packs during Covid-19, access to resources on the intranet, purchasing of dementia-friendly activities for the Emergency Departments at both hospitals and specified medical wards, and the development of reminiscence therapy boxes (yet to be fully implemented in 2022) – with the message that activity maintains cognition and engagement provides a therapeutic environment.

National Patient Survey Results

There are several national surveys carried out across the organisation each year that provide a snapshot in terms of the experiences of patients. All surveys are administered externally by Picker UK and the results are provided once the CQC removes their embargo. The results are then published to ensure transparency of information. The surveys carried out in 2020 for Inpatients, Children and Young People and Maternity have all shown an improved position for the Trust.

National Picker Surveys Summary

The information below provides a narrative on the results of the four National Patient Picker Surveys that have been reported on during 2021–22. These are Maternity, Children and Young people, Inpatient and Urgent and Emergency Care. All areas show an improved position on the previous surveys.

Maternity Survey 2020

Lancashire Teaching Hospitals NHS Foundation Trust is ranked 11th out of the 66 Trusts nationally surveyed by Picker. This is compared to the 2019 survey, where the Trust was ranked 10th out of 63 Trusts surveyed. The response rate to the Maternity survey had a significantly higher response rate (59%) compared to the national average of 54%.

There were no areas identified where the Trust was significantly better than the 2019 survey:

- We were significantly worse than the last survey on the following five questions
- Not left alone when worried (during labour and birth) – 81% compared to 91% in 2019
- Treated with kindness and understanding (in hospital after birth) – 95% compared to 100% in 2019
- Had a telephone number for midwives (postnatal) – 94% compared to 99% in 2019
- Received help and advice about feeding their baby (first six weeks after birth) – 91% compared to 100% in 2019
- Received help and advice from health professionals about their baby's health and progress (first six weeks after birth) – 91% compared to 100% in 2019

We were significantly better than the national Picker average on the following five questions:

- Given a choice about where postnatal care would take place – 52% compared to 38%
- Given enough information about where to have baby – 89% compared to 78%
- Offered a choice of where to have baby – 92% compared to 80%
- Involved enough in decision to be induced – 93% compared to 83%
- Received support or advice about feeding their baby during evenings, nights or weekends – 79% compared to 70%

We were significantly worse than the national Picker average on the following five question:

- Received help and advice about feeding their baby (first six weeks after birth) – 81% compared to 86%
- Felt midwives aware of medical history (postnatal) – 72% compared to 73%
- Had a telephone number for midwives (postnatal) – 94% compared to 95%
- Felt midwives or doctor aware of medical history (antenatal) – 82% compared to 83%
- Felt midwives listened (postnatal) – 95% compared to 96%

Overall, the results for our Trust showed:

- 97% treated with respect and dignity (during labour and birth)
- 95% had confidence and trust in staff (during labour and birth)
- 96% involved enough in decisions about their care (during labour and birth)

Key theme summation

It is worth noting that percentage deterioration was around 3% points on the majority of the domains. There were 11 new measures introduced in the latest survey and the Trust performed above Picker average for 2021 on all the measures. Significant performance on the new measures was around providing information during hospital interventions. With a marked improvement on discharge without delay from 59.6% in 2019 to 66.3% in 2021 which is above the Picker average of 63.8%. Good progress regards supporting patients with mental health interventions and providing information where the Trust performed above Picker average in the newly introduced outcome measure. The Trust performed significantly better in six domains and there was no significant difference in 46 areas as compared to other Trusts.

Children and Young People's Survey 2020

We have seen an increase for the year 2020 in satisfaction of the parents, children and young people surveyed based on the 2018 survey. The Trust is ranked 31st out of the 67 Trusts nationally. This is compared to the 2018 survey, where the Trust was ranked 58th out of 66 Trusts surveyed. Parents rated experience of care as seven out of 10 or more and this is at par with the Picker national average.

We were significantly better than the last survey on the following seven questions:

- Parents had new members of staff introduce themselves – 97% compared to 92% in 2018
- Parent felt that Wi-Fi was good enough for child to do what they wanted – 81% compared to 57% in 2018
- Parent kept informed by staff about what was happening – 90% compared to 92% in 2018
- Parent had access to hot drinks facilities in hospital – 84% compared to 74% in 2018
- Parent felt that staff were available when child needed attention – 97% compared to 93% in 2018
- Parent felt hospital room or ward was clean – 99% compared to 96% in 2018
- Child felt hospital was quiet enough to sleep – 86% compared to 68% in 2018

We were significantly worse than the last survey on the following question:

- Parents felt that there was not enough for their child to do – 73% compared to 91% in 2018

We were significantly better than the Picker average on the following two questions:

- Parent had access to hot drinks facilities in hospital – 84% compared to 78%
- Parent able to prepare food in hospital – 70% compared to 41%

We were significantly worse than the Picker average on the following question:

- Parent rated overnight facilities as good or very good – 50% compared to 69%

Overall, the results for our Trust showed:

- 93% parent felt well looked after by staff
- 93% child felt well looked after in hospital
- 94% parent felt staff agreed a plan with them for child's care

Key theme summation

Parents rated experience of care as seven out of 10 or more and this is at par with the Picker national average. This was noted to be an improvement from the previous survey in comparison from 86% to 91.8% in patient experience. The Trust performed significantly better in 21 domains and there was no significant difference in 62 areas as compared to other Trusts. The percentage improvement was around 2% on most of the domains with a 1% deterioration in the domains which had reduced outcomes. Improvement on children feeling the ward was suitable for their age from 92.5% to 97.8% compared to previous survey results. There is a significant deterioration in parents feeling that there is enough therapeutic activities from 90.6% to 73.3% compared to previous survey results. This has moved the organisation below the Picker national average of 79.6%. Domain of therapeutic activities witnessed a significant drop in satisfaction.

Wi-Fi facilities were noted to be 80.8% and above the Picker national average of 69.9%. This is a significant improvement from a percentage score of 57% in the previous Trust survey. Overnight facilities were noted to be below the national Picker average. However, in terms of promoting better sleep, there was a marked improvement from 68.3% to 85.7% compared to the previous survey. This is still below the national Picker average of 87.8%. After care arrangements following discharge were still below the Picker national average although the Trust achieved about 2% increase in most areas under the domain compared to previous survey.

Urgent and Emergency Care Survey 2020

The results demonstrate an improved position for the Emergency Departments compared to the last National Picker survey in 2018. The Trust is ranked 34th out of 66 Trusts nationally. This is compared to the 2018 survey, where the Trust was ranked 47th out of 69 Trusts surveyed. Patients rated experience of care as seven or more out of 10 and this is above the Picker national average.

We were significantly better than the last survey on the following three questions:

- Waited under an hour in the ambulance – 97% compared to 89% in 2018
- Waited under an hour in A&E to speak to a doctor/nurse – 90% compared to 82% in 2018
- Staff helped control pain – 90% compared to 84% in 2018
- We were significantly worse than the last survey on the following question
- Right amount of information given on condition or treatment – 74% compared to 83% in 2018

We were significantly better than the Picker average on the following five questions:

- Understood results of tests – 99% compared to 97%
- Saw the cleaning of surfaces – 82% compared to 74%
- Saw tissues available – 83% compared to 78%
- Did not feel threatened by other patients or visitors – 96% compared to 93%
- Staff discussed transport arrangements before leaving A&E – 61% compared to 50%

We were significantly worse than the Picker average on the following question:

- Spent under 12 hours in A&E – 88% compared to 94%

When rated against all 126 Emergency Departments the Trust's overall scores demonstrated 'about the same' therefore comparable to similar organisations.

Overall, the results for our Trust showed:

- 88% rated care as seven or more out of 10
- 97% treated with respect and dignity
- 95% doctors and nurses listened to patients

Key theme summation

Patients rated experience of care as seven or more out of 10 and this is above the Picker national average. This was noted to be an improvement from the previous survey – 80% to 88.2% versus the Picker average score of 85.6%. The Trust performed significantly worse in five domains and there was no significant difference in 38 areas as compared to other Trusts.

The shift on improvement or deteriorated areas was plus or minus 3% in the majority of areas. It is worth noting that there were 16 domains measured in the current survey that were not indicated in the previous year. The current survey indicated that 90.1% of patients waited under an hour to speak to a nurse/doctor compared to 81.9% from the previous survey. This is above the national Picker average of 86.6%. This is mirrored positively with 96.5% of patients reporting that they waited under an hour in the ambulance compared to 89.2% in the previous survey. This is above the national Picker average of 95.3%.

Right amount of information being given to patients deteriorated from 82.6% to 74.2% with the Picker national average percentage score at 77.5%. A similar percentage drop on patients being given test results before discharge from 82% to 76% which is below the Picker average score of 80.4%. Pain management satisfaction witnessed a percentage improvement from 84.2% to 90.3% which is above the Picker national average. The Trust performed better in all domains on cleanliness compared to the national Picker average, scoring higher in comparison to the previous survey. Patients on the whole reported that they felt safe from other patients and visitors with a score above the national Picker average.

Positive satisfaction was also noted on social distancing as the Trust score was above the national average. Patients scored the Trust low on information provision as compared to the national average on medication, symptoms and after care upon discharge. Patient transport arrangements after discharge were scored above the national average with 61.2% against the Picker national score of 49.6%.

The Trust performed low in comparison to other Trusts on patients waiting under 12 hours in A&E with a score of 87.7% compared with the national Picker average of 94.1%. However, the Trust performed highly on supporting patients whilst waiting, with a score of 65.9% compared to national average of 58.8%. Positive results were also noted in the domain of dignity and respect where the Trust performed above the national average.

Inpatient Survey 2020

The Trust is ranked 61st out of the 71 Trusts surveyed by Picker. This is compared to the 2019 survey where the Trust was ranked 51st out of 77 Trusts surveyed. This year has seen a reduction in satisfaction of the inpatients surveyed based on last year. It is worth noting that some of the benchmarking asked this year was not part of the survey in 2019 survey. Patients rated quality of care as 11% compared to 8.1% from the previous survey; this is below the national average of 13.7% although it was an improvement for the organisation. Experience of care was rated at 80.2% which is a slight drop from the previous survey of 82.8% which remains lower than the national average of 85.3%.

We were significantly better than the last survey on the following two questions:

- Nurses answered questions clearly – 97% compared to 94% in 2019
- Given written/printed information about what they should or should not do after leaving hospital – 72% compared to 64% in 2019

There were no areas identified as significantly worse than the 2019 survey. There were no areas identified as significantly better than the Picker average.

We were significantly worse than the Picker average on the following 4 questions:

- Got enough help from staff to eat meals – 77% compared to 85% in 2019
- Staff did not contradict each other about care and treatment – 65% compared to 66% in 2019
- Right amount of information given on condition or treatment – 77% compared to 80% in 2019
- Rated overall experience as seven or more out of 10 – 80% compared to 83% in 2019

Overall, the results for our Trust showed:

- 80% rated experience as seven or more out of 10
- 98% treated with respect or dignity
- 98% had confidence and trust

Key theme summation

The percentage improvement was around plus or minus 2% on the majority of the domains. With a plus or minus 1% deterioration in the domains which had reduced outcomes. Patients rated quality of care as 11% compared to 8.1% from the previous survey: this is below national average of 13.7% although it was an improvement for the organisation. Experience of care was rated at 80.2% which is a slight drop from the previous survey of 82.8% which remains lower than the national average of 85.3%.

There were 17 more domains rated in the current survey where the Trust performed marginally lower than the national average with a percentage gap of about plus or minus two points.

The Trust gained a marginal improvement on dignity, respect, and confidentiality although the organisation scores are still below the national Picker average. Patients rated the Trust the same on the discharge support plan which remains below the national average of 78.4% when compared to year-on-year for the Trust of 74.4%. The survey indicated a below national average score year-on-year on staff contradicting each other on information regarding treatment and care. The Trust continues to make improvements on food satisfaction although it remains below national average at 63.5% compared to the Picker average score of 70.2%. Patients rated the organisation below national average on promoting better sleep. This was mirrored in the rating score on staff providing information on why patients need to move wards at night as it remains below the national average. Staffing numbers were rated as an improvement from the previous year although it remains below the national average .

Summation of results

Survey title	Position 2021	Previous position	Number of areas improved comparison to previous survey	Number of areas deteriorated in comparison to previous survey
Maternity	11 out of 66 Trusts	10 out of 63 Trusts	5	35
Children and Young People's Survey 2020	31 out 67 Trusts	58 out of 66 Trusts	41	17
Urgent and Emergency Care Survey 2020	34 out of 66 Trusts	47 out 69 Trusts	11	15
Inpatient Survey 2020	61 out 71 Trusts	51 out 77 Trusts	14	9

National Cancer Patient Experience Survey

The Cancer Patient Experience Survey 2020 is the tenth iteration of the survey first undertaken in 2010. The Cancer Patient Experience Survey 2020 published November 2021 provides analysis of the experiences of care provided for adults aged 16 or over with a confirmed diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment, in the months of April, May and June 2020. The survey is carried out annually with the previous Cancer Patient Experience Survey undertaken in 2019.

The Cancer Patient Experience Survey 2020 differs from all previous years in that it involved only 55 NHS Trusts as it was voluntary due to the pandemic. As not all NHS Trusts participated in the survey no comparisons to scores nationally are shown. Out of 33,266 people, 19,610 people responded to the survey, yielding a response rate of 59%. The Trust response rate was 59%.

A total of 52 questions were used in the 2020 survey, of these 47 can be compared to questions in 2019. Compared to the 2019 survey rating of 8.9, the Trust has maintained a satisfaction score of 8.9 overall however Urology scored 9.4.

The following questions were included in phase one of the Cancer Dashboard developed by Public Health England and NHS England:

- 89% rated overall care as very good/good
- 80% patients definitely involved as much as they wanted in decisions about care
- 93% patients were given the name of a Cancer Nurse Specialist (CNS) who would support them
- 88% patient found it very or quite easy to contact their CNS

- 90% patients always felt they were treated with respect and dignity while in hospital
- 97% patients were told by staff who to contact after leaving hospital

When comparing the results to 2019 the Trust scored significantly higher in four questions:

- Patient given a care plan
- Confidence in ward nurses treating them
- Nearly always enough nurses on duty
- Hospital staff asked the patient what name they preferred to be called by

When comparing the results to 2019 the Trust scored significantly lower in one question:

- Hospital staff told patients they could get free prescriptions

Actions taken to develop services experienced by patients with Cancer

- Each multi-disciplinary team to complete annual action plans. Monitoring of the action plans will be through the tumour site operational meetings and the Network Site Specific Group (NSSG) CNS meetings, overseen by the Trust Lead Cancer Nurse. Any tumour specific actions are added to the Quality Surveillance Work Programme to facilitate change.
- Due to low numbers of responders' local surveys are performed every two years for Sarcoma and Brain to enable monitoring on an ongoing basis.
- Macmillan Right by You manager in post to ensure personalised care in cancer has been rolled out
- All Patients have access to support / CNS at diagnosis.
- Holistic needs assessments are offered to all patients at diagnosis and post treatment.
- Treatment summaries are provided post treatment.
- Patient stratified follow up pathways implemented for Breast Colorectal and Urology and for all tumour sites by 2024 – plan being developed with the Cancer Alliance.
- Development and expansion of the Macmillan Cancer Information and Support Service, (MCISS) has been completed to improve patient access to information and support and ensure information and support is available to all inpatients and day surgery patients, improving educational and training for staff in these areas. Increased support available for all patients for employment and financial advice provided by the MCISS. This will need to include promotion of free prescriptions for patients

Summary of actions to improve patient experience

- Recruit and embed Patient Safety Partners in order to provide patients with a voice as part of the Always Safety First programme of work.
- Continually embed Always Safety First Live Patient Feedback and general live feedback initiative
- Sharing of patient lived experience in team meetings
- Quarterly complaints quality review
- Embrace and continually develop Patient Experience and Involvement Group
- Continuously develop and evolve to always incorporate what matters to patients/carers in the STAR Quality Assurance Framework
- Promote co-production via Patient Contribution to Case Notes project
- Participate in the Imperial College project
- Continue progress in supporting women in the maternity division with mental health interventions
- Therapeutic activities review is required in the Children and Young People's division to promote engagement.
- Ensure real-time feedback is gathered and reported upon within all inpatient wards
- Demonstrate change through continuous improvement from the benchmarking of lost property
- Develop a Patient Experience and PALS Newsletter to share feedback and learning

- Develop an e-learning package for leaders to understand the principles of local resolution, concerns and complaints and what a good response looks like
- Ensure communication of involvement projects is delivered in a structured approach to all Trust staff and accessible to everyone and in all areas
- Extend involvement in the local community and through support groups/forums to learn what patients want and achieve improvements
- Continue to provide forums for patients, carers and families to learn and act on information
- Focus on projects with diverse communities, appreciating differences with a view to delivering a positive patient experience

MAJOR SERVICE DEVELOPMENTS

Despite the well-documented challenges presented by the Covid-19 pandemic, we continued to implement a number of major service developments during 2021–22. This is testament to the resilience of our hard working and dedicated staff and key partners who have remained committed to improving the care we deliver to our patients and the experience they received. The major service developments during the past year are outlined below.

Surgical Enhanced Care Unit (SECU) at Chorley and South Ribble Hospital

In May 2021, we opened the Surgical Enhanced Care Unit (SECU) at Chorley and South Ribble Hospital. It is important to keep surgical patients Covid-19 free and SECU offers an elective 'green stream' for patients whose operations have been postponed due to the pandemic. This means that patients isolate at home before their operation, are tested upon arrival and throughout their stay. The unit comprises four beds and operations focus on orthopaedic patients as well as some other specialities.

The unit provides more optimal levels of monitoring for patients after surgery than would be expected on a postoperative ward but who do not require admission to critical care. SECU patients therefore get enhanced care, whilst postoperative critical care beds are preserved for those who really need them.

New renal services

Our Trust is responsible for providing renal services across Lancashire and South Cumbria. Accessibility and travel times is an important issue for patients and we have therefore focused on providing more local facilities.

In July 2021, we opened the Furness Renal Centre in Ulverston, bringing both haemodialysis treatment and outpatient clinic facilities closer to home for patients. Read more on the Trust website.

Shortly after, in October 2021, we opened the John Sagar Renal Centre in Burnley, named in tribute to East Lancashire gentleman John Sagar, who was the former Chair of the Lancashire and South Cumbria Kidney Patients Association. Read more on the Trust website.

We have also recently partnered with East Lancashire Hospitals NHS Trust to build a new renal dialysis centre on the Royal Blackburn Teaching Hospital site to improve services in East Lancashire. The purpose-built facility will feature 24 dialysis stations as well as clinical facilities. More about the development is available on the Trust website.

Ribblesdale refurbishment

In October 2021, we opened Rosemere Cancer Centre's new 24-bed Ribblesdale Ward at Royal Preston Hospital.

The Ribblesdale Ward is the only inpatient oncology-specific ward in Lancashire and South Cumbria and supports patients with a wide range of clinical needs and end of life care. The ward was transformed after receiving funding of over £1m from the Rosemere Cancer Foundation following its hugely successful 20th anniversary appeal.

The state-of-the-art ward consists of shared and single bedroom spaces for patients being cared for by a specialist cancer team, with additional areas for relatives to visit their loved ones. Nature-inspired interiors will promote a healthy recovery and positive wellbeing through bespoke wood designs that feature back-lit art panels, floor vectors, and skylights that can be tailored to the time of day. More about the development is available on the Trust website.

Chorley and South Ribble Hospital Day Case Theatres

In November 2021, we opened three new day case theatres at Chorley and South Ribble Hospital. The new theatres, which now make nine in total, are a much welcomed addition to the site and will help for patients who are currently awaiting elective procedures.

The multi-million pound project, developed by construction company Tilbury Douglas, has already welcomed many patients, with many more scheduled for treatment over the coming months. The theatres will treat patients from across Lancashire and South Cumbria for a range of surgical specialty day case procedures such as Orthopaedic, Plastic Surgery and General Surgery. Read more on the Trust website.

Lancashire Eye Centre

Following a multi-million point investment, we were delighted to officially open our new Ophthalmology development at Chorley and South Ribble Hospital in December 2021. Known as the Lancashire Eye Centre, this modern technologically advanced facility provides increased capacity to patients across Lancashire and South Cumbria including urgent and emergency clinics, cataract services and other specialist ophthalmic services including glaucoma, retina, paediatric, neuro-ophthalmic, oculoplastic and cornea.

The three-tier building includes a dedicated outpatient and diagnostic space as well as three additional theatres to provide extra capacity for patients requiring a variety of day case procedures.

The new unit has been designed with the patient experience at the forefront. The various segments of the building are even colour coded to ease patient navigation and improve accessibility for those who need additional support. Read more on the Trust website.

Nightingale Surge Hub Preston

Originally planned to deal with a potential surge in the number of cases of the Omicron variant of Covid-19, it was agreed with NHS England that Preston's Nightingale Surge Hub would open in January 2022 to help alleviate sustained and severe pressures and high bed occupancy across the Lancashire and South Cumbria ICS.

The hub is a high quality and well-equipped space, which provides care for low acuity patients awaiting discharge who do not have Covid-19. With the additional bed base allowing us to free up space within Lancashire's emergency departments and within its hospitals, the use of the facility was extended from the initial three month period until the end of June 2022. Read more on the Trust website.

Covid-19 Vaccination Programme

Following the opening of our original vaccination hub at Royal Preston Hospital on 8 December 2020, our services have expanded to delivering doses from Chorley and South Ribble Hospital and from February 2021, St John's Vaccination Hub in Preston.

Throughout 2021–22, teams from multi-disciplinary divisions across Lancashire Teaching Hospitals have helped to deliver over 100,000 Covid-19 vaccinations from first doses to fourth doses. Countless staff and volunteers have worked incredibly hard to deliver the service to ensure everyone who wishes to receive a Covid-19 vaccine is able to receive the vaccine at a convenient location.

STAKEHOLDER RELATIONS

Stakeholder relations have never been more important than during the pandemic, ensuring communities have been proactively informed and engaged along the way, helping them to protect themselves and their loved ones from the effects of Covid-19 as well as understanding how they can continue to access other services safely. This joint aim of maintaining and enhancing patient care has driven increased collaborative working amongst NHS and social care professionals and provides a strong foundation for further collaborative working as changes to the NHS architecture come into effect.

Whilst difficult to capture the full extent of this work in full, the below provides several key examples:

Joint Hospital and Out of Hospital Cell

The Trust has been integral to a number of command and control cell structures including the Joint Hospital and Out of Hospital Cell.

The role of the cells has been to provide Executive strategic oversight and decision making, co-ordinate joint activity, review risk and mitigation and ensure effective links between sub-cells, places, Trusts, CCGs, Councils and other partners.

This has included the provision of mutual aid and shared responsibility for patient care across the whole system, breaking down traditional barriers and ensuring a more equitable approach.

Lancashire and South Cumbria Provider Collaborative

Five NHS provider Trusts in Lancashire and South Cumbria have formed a collaborative to improve local healthcare, including: Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire and South Cumbria NHS Foundation Trust, Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust.

The aim of the collaborative is to reduce health inequalities and improve services by providing patients with equal access to the same high-quality care wherever they live.

The collaborative has a clear vision which is to work together as one to ensure the best health and wellbeing of our population, high-quality services, a happy and resilient workforce and financial sustainability.

Throughout the 2021–22 year, a new governance architecture has been in development and a Provider Collaborative Board (PCB) agreed with membership including David Flory as Independent Chair and Kevin McGee as PCB lead Chief Executive Officer with other provider Trust Chief Executives and Chairs making up the PCB. Subgroups have also been established with lead Trust Executives representing professional groups.

Lancashire and South Cumbria Integrated Care Board (ICB)

A new Health and Care Bill (2021) is currently going through Parliament aiming to join up health and social care through Integrated Care Systems (ICSs), so that NHS, local councils and other organisations will work together.

If the Bill is passed, the eight CCGs in Lancashire and South Cumbria will be closed down and a new organisation will be set up, known as an Integrated Care Board (ICB). Locally, this will be called NHS Lancashire and South Cumbria.

Work has been ongoing throughout 2021–22 to establish the ICB subject to the passage Bill through Parliament from 1 July 2022.

Appointments have been made to a number of designate positions who will help to drive health and care services across the region with the purpose of the organisation to:

- Improve outcomes (population health and care)
- Tackle inequalities in outcomes and access
- Enhance productivity and value for money
- Support broader social economic development

Lancashire and South Cumbria Pathology Collaboration

Work has been progressing to form a single pathology service for Lancashire and South Cumbria and there is an absolute commitment from all partners in the collaboration to deliver the benefits this will bring in relation to quality, resilience and improved outcomes for patients.

All acute Trust partners (including Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals Morecambe Bay NHS Foundation Trust) are represented on the Pathology Collaboration Board and have been fully involved in the development of the plans to date and sighted on the direction of travel. The strategic case and outline business case for the future service has been agreed by all Trusts and their respective Trust Boards.

At the time of writing, the Pathology Collaboration Board has taken a pragmatic decision to pause any further work on the development of a single service and the full business case associated with the future delivery model for the service to ensure that all employees who work in pathology services have been fully engaged and listened to in developing the vision for how the service will run in future. The pause will also ensure that all options have been explored for securing the capital required for developing the future service. There are no plans for any privatisation initiatives in any form for pathology services across Lancashire and South Cumbria.

This pause in the programme of work will provide a positive opportunity to do some further and more in-depth engagement with the pathology workforce. This will be done with transparency and undertaken in partnership so that the Board can be confident that all options have been explored before moving forwards together with this important work.

New Hospitals Programme

The New Hospitals Programme has progressed at pace throughout 2021–22 to provide communities in Lancashire and South Cumbria with a once-in-a-generation opportunity to transform our local hospitals by 2030.

By creating a network of brand new and refurbished facilities, the Programme will help local people live longer, healthier lives. By doing this, it will also make Lancashire and South Cumbria a world-leading centre of excellence for hospital care.

In March 2022, the Programme announced its shortlist or proposals which plans to develop new, cutting-edge facilities, offering the absolute best in modern healthcare and addressing significant problems with the ageing Royal Preston Hospital and Royal Lancaster Infirmary buildings.

The shortlisted proposals are:

- A new Royal Lancaster Infirmary on a new site, with partial rebuild/refurbishment of Royal Preston Hospital
- A new Royal Preston Hospital on a new site, with partial rebuild/refurbishment of Royal Lancaster Infirmary
- Investment at both Royal Lancaster Infirmary and Royal Preston Hospital, allowing partial rebuilding work on both existing sites
- Two new hospitals to replace Royal Lancaster Infirmary and Royal Preston Hospital (new sites)

These proposals also include investment in Furness General Hospital, required due to its geographically remote location, its proximity to some of the UK's major strategic national assets, and its need to meet NHS environmental goals.

Communications

Throughout the last 12 months the Communications team has continued to be involved in activity at a national, regional ICS and local ICP level. The Trust has been proactive in facilitating television, radio and press interviews, particularly surrounding the importance of Covid-19 vaccinations and wider NHS England messaging. The Trust has also facilitated the filming of an observational Channel 5 documentary aiming to provide insight into the work of the Coroner's office on behalf of Lancashire County Council. We have also launched a new website to provide patients, visitors and key stakeholders with a more user-friendly, vibrant and accessible site. Social media activity continues to grow and colleagues continue to receive a range of internal communications in email, print, digital and video format.

Education, research and innovation

Lancashire Teaching Hospitals continues to be at the forefront of education, research and innovation across the region.

The Trust continues to support its partnership with the University of Lancaster and Lancashire and South Cumbria NHS Foundation Trust to deliver the National Institute for Health and care Research (NIHR) Clinical Research Facility. The Trust has embedded research across its services with 90 active Research Champions and Research Boards in every clinical area.

The UK Clinical Research Facility Network (UKCRF Network) collaborates with CRFs and other experimental medicine infrastructure across the UK and Ireland to develop, share and implement excellence in operational practice to ensure the efficient and effective delivery of studies, and drive forward initiatives that improve quality of patient experience. In March 2021, the Trust's Head of Research and Innovation (Paul Brown) was appointed the UKCRF Interim Director to continue leading this work and promote the UK as the place for broader investment in and economic growth from health research.

The Trust has also been involved in a number of Covid-19 research trials, many of which were Department of Health priorities while continuing its work alongside the University of Central Lancashire (UCLan) which has resulted in further honorary appointments at professorial level.

The Trust continues to have positive stakeholder relationships with Manchester Medical School and other local Academic Institutions and has successfully graduated its first cohort of staff from its ICS level Assistant Practitioner to Registered Nurse apprenticeship programme alongside Northumbria University.

There continues to be a priority focus on innovation and the Trust is benefiting from close working relations with the UCLan to develop our innovation pathway, linking with small and medium-sized enterprises. This is demonstrable with the recent work of Professor Shondipon Laha for work alongside academia and business to trial lip reading software that uses AI algorithms to decipher speech from lip movements, for patients with a tracheostomy.

National networks

Executive team members have maintained their membership in professional networks throughout the year to ensure partnership working at a national level. These include the Medical Directors' network, the Chief Nurses' network, the Chief Operating Officers' network, the Human Resources Directors' network, the Finance Directors' network, the Improvement Directors' network and the Communications Directors' network. This has enabled shared learning nationally to adopt best practice for our local population and included shared learning with the wider networks from innovation and best practice adopted within our Trust.

Non-Executive Director, Kate Smyth, also continues her work with the Disabled NHS Directors' Network after co-founding the network in 2020. The Network set out to raise the standards of disability across all NHS Boards, raise awareness of the benefits of diversity in leadership positions, provide a supportive environment for members to share issues and lobby for improved selection processes for Non-Executives and Lay Members to ensure more accurate representation of the communities that Boards represent – especially in relation to disabled people. The Network is currently producing an accessible website which is set to go live in 2022–23.

Local Networks

The Trust now has four established Inclusion Ambassador Forums which include: Living with Disabilities Forum, LGBTQ+ Forum, Black, Asian and Minority Ethnic Forum and Multi-faith Forum. The Forums help provide a voice, give support, discuss issues, review policies/procedures and educate colleagues to truly embrace and celebrate difference. The Forums have Board level sponsors and help promote Lancashire Teaching Hospitals as an inclusive employer.

We understand that it is important that our patients, their loved ones and the local population are involved in decision making about the care and services that we provide. Patient and Public Involvement (PPI) provides a platform for staff to engage and consult with patients and the public to identify their needs. The Trust has several service user groups and forums covering all different aspects of patient care. The most recent is the establishment of a Carers' Forum in collaboration with Lancashire Carers Services and n-compass.

REMUNERATION REPORT

The NHS Foundation Trust annual reporting manual requires NHS Foundation Trusts to prepare a remuneration report in their annual report and accounts. The reporting manual and NHSI requires that this remuneration report complies with:

- Sections 420 to 422 of the Companies Act 2006 (section 420(2) and (3), section 421(3) and (4) and section 422 (2) and (3) do not apply to NHS Foundation Trusts
- Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations")
- Parts 2 and 4 of Schedule 8 of the Regulations as adopted by NHS Improvement in the reporting manual
- Elements of the NHS Foundation Trust Code of Governance.

Remuneration Committees

There are two Committees which deal with the appointment, remuneration and other terms of employment of our Directors. The Nominations Committee, as a Committee of the Council of Governors, is concerned with the Chairman and other Non-Executive Directors. The Appointments, Remuneration and Terms of Employment (ARTE) Committee, as a Committee of the Board, deals with the pay and conditions of senior Executives.

Nominations Committee

The Committee comprises the Chairman (except where there is a conflict of interest in relation to the Chairman's role, when the Vice Chairman or Senior Independent Director will attend), three elected governors and one appointed governor. The elected governors have a nominated deputy who attends in their place if they are unable to attend themselves, as does the appointed governor representative. The Company Secretary and the Workforce and Education Director provide support to the Committee as appropriate, and the Chief Executive is invited to attend all meetings.

The Council of Governors appoint the members of the Nominations Committee for a two-year period and elections are held to replace any Committee member who ceases to be a governor following the annual governor elections or retirement of a governor in-year. In 2021–22 the ballot for appointment to the Nominations Committee resulted in a tied vote for the elected governor seat therefore the terms of reference were flexed for the year to cover this exceptional circumstance and membership was brought back in balance at the end of March 2022.

The composition of the Committee during 2021–22 is detailed in the attendance summary below.

Nominations Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Ebrahim Adia, Chairman	8	8	100%
Professor Paul O'Neill, Senior Independent Director	2	2	100%
Rebecca Allcock, Staff Governor	9	6	67%
Alistair Bradley, Appointed Governor	9	7	78%
Steve Heywood, Public Governor	9	9	100%
Janet Miller, Public Governor	8	8	100%
Mike Simpson, Public Governor	9	8	89%
Substitutes			
Pav Akhtar, Public Governor	0	0	-
Eddie Pope, Appointed Governor	0	0	-

A = maximum number of meetings the member could have attended | B = number of meetings the member actually attended

Work of the Committee

During 2021–22, the Committee met on nine occasions which enabled it to:

- Receive, consider and recommend to the Council of Governors proposals for changes to remuneration of Non-Executive Directors taking account of the recommendations in the Ockenden Review for a designated Non-Executive Safety Champion
- Receive, discuss and approve the job description, person specification, recruitment process and longlist/shortlist for the replacement Non-Executive Director, followed by approval of the recommended candidate
- Receive information on the intention to recruit Associate Non-Executive Director posts to provide opportunities for aspiring Non-Executive Directors, including involvement in the shortlisting process
- Review and agree the terms of reference of the Nominations Committee
- Receive feedback on the outcome of the Chairman's appraisal for 2020–21
- Receive feedback on the outcome of the Non-Executive Directors' appraisals for 2020–21
- Receive, consider and recommend to the Council of Governors re-appointment of four Non-Executive Directors whose terms of office were due to come to an end during 2021–22
- Receive, discuss and approve the job description, person specification and recruitment process for the replacement Chairman

Following the resignation of Geoff Rossington from his Non-Executive Director role, Victoria Crorken was appointed and joined the Trust in January 2022. Victoria's profile can be found on page 28 of the report.

Appointments, Remuneration and Terms of Employment Committee

All Non-Executive Directors are members of the Committee. The Chief Executive and Workforce and Education Director are normally in attendance at meetings of the Committee, except when their positions are being discussed. The Workforce and Education Director also attends meetings as appropriate to provide advice and expertise and the Committee has the option to seek further professional advice as required.

During 2021–22 the Committee did not use any independent advice or services from any Director of the Trust to materially assist in consideration of any matters although did obtain advice from its solicitors (Hempsons). During the year, the Committee did commission advice and services of an Executive Search Agency (Gatenby Sanderson) to provide support in the recruitment of the Chief Executive and the replacement Non-Executive Director. The Executive Search Agency was appointed through the recognised procurement framework at a total cost of £19,000 and £15,750 respectively, excluding vat.

Appointments, Remuneration and Terms of Employment Committee attendance summary

Name of Committee member	A	B	Percentage of meetings attended (%)
Ebrahim Adia	11	11	100%
Victoria Crorken	2	2	100%
Paul O'Neill	11	6	55%
Ann Pennell	11	9	82%
Geoff Rossington	7	5	71%
Kate Smyth	11	11	100%
Tim Watkinson	11	10	91%
Jim Whitaker	11	8	73%
Tricia Whiteside	11	6	55%

A = maximum number of meetings the member could have attended | B = number of meetings the member actually attended

Work of the Committee

During 2021–22, the Committee met on 11 occasions with the majority of its focus in the first part of the year on the appointment of a replacement Chief Executive. In addition, Committee meetings involved a range of business in line with its terms of reference which enabled it to:

- Consider and approve the exit strategy for the outgoing Chief Executive
- Consider and approve the process for competitive recruitment of a substantive Director of Strategy and Planning, followed by approval of the appointment
- Receive feedback on the outcome of Executive Directors' appraisals for 2020–21
- Consider and approve revisions to the Very Senior Managers' remuneration policy
- Receive and approve changes to the Fit and Proper Person Test policy

As part of its cycle of business every three years the Committee undertakes a benchmarking exercise to review the baseline salaries of senior managers for which it is responsible. Such a review was undertaken in 2021–22. A review of salaries also takes place when a post becomes vacant in order to ensure that when the post is being advertised, the salary level is competitive within the current market.

As mentioned earlier, during 2021–22 the Committee approved two Executive Director appointments – the Chief Executive and a substantive Director of Strategy and Planning. The Committee also approved alignment of the Director of Communications and Engagement and Company Secretary under the terms and conditions of the Appointments, Remuneration and Terms of Employment Committee.

ANNUAL STATEMENT ON REMUNERATION

At Lancashire Teaching Hospitals, we understand that our Executive remuneration policy is key to attracting and retaining talented individuals to deliver our business plan, whilst at the same time recognising the constraints that public sector austerity measures bring.

In line with the Trust's agreed policy, the annual national pay award was applied to all VSM posts in the year. In addition, during 2021–22, in line with the Trust's VSM remuneration policy and ARTE Committee's terms of reference, a salary review was undertaken for all very senior managers. This review was based on national benchmarking data for comparable organisations and was completed in November 2021. The review identified that a number of posts within the Trust were paid below the median for comparable organisations and a decision was taken to adjust salary levels to the national median. This resulted in changes to the salaries of the Medical Director, Nursing, Midwifery and AHP Director and the Chief Operating Officer.

Professor Ebrahim Adia
Chairman of the Appointments, Remuneration and Terms of Employment Committee

SENIOR MANAGERS' REMUNERATION POLICY

As detailed in the Chairman's statement above, the remuneration policy is designed to attract and retain talented individuals to deliver the Trust's objectives at the most senior level, with a recognition that the policy has to take account of the pressures on public sector finances.

This report outlines the approach adopted by the ARTE Committee when setting the remuneration of the Executive Directors and the other Executives who have authority or responsibility for directing or controlling the major activities of the organisation. The following posts have been designated as fitting this criterion by the Committee and are collectively referred to as the senior Executives within this report:

Executive Directors

- Chief Executive
- Deputy Chief Executive/Finance Director
- Nursing, Midwifery and AHP Director
- Medical Director
- Chief Operating Officer
- Workforce and Education Director

Other Executives

- Director of Communications and Engagement
- Director of Continuous Improvement
- Director of Strategy and Planning
- ICP Chief Information Officer
- Company Secretary

Details on membership of the ARTE Committee and individual attendance can be found on page 58 of this report.

Our policy on Executive pay

Our policy on the remuneration of senior Executives is set out in a policy document approved by the ARTE Committee. When setting levels of remuneration, the Committee takes into account the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health. In addition the Committee takes into account the need to ensure good use of public funds and delivering value for money. The maximum of any component of senior managers' remuneration is determined by the ARTE Committee.

Each year, the Chief Executive undertakes appraisals for each of the senior Executives, and the Chairman undertakes the Chief Executive's appraisal. The results of these appraisals are presented to the ARTE Committee and they are used to inform the Committee's discussions. The Committee considers matters holistically when considering Executive remuneration, such as the individual Executive's performance, the collective performance of the Executive Team and the performance of the organisation as a whole. A revised process for senior Executive appraisal was implemented in 2019–20.

The remuneration package for senior Executives comprises:

Salary: As determined by the ARTE Committee and reviewed annually

Senior Executives do not receive any additional benefits that are not provided to staff as part of the standard AFC contract arrangements. No senior Executives have tailored arrangements outside of those described above.

The remuneration package for Non-Executive Directors comprises:

Salary: As determined by the Council of Governors and reviewed in line with the national guidance on remuneration of Non-Executive Directors. Current rates are:

- £13,000 p.a. for Non-Executive Directors
- £2,000 p.a. as additional responsibility payment payable to the Vice Chair, Senior Independent Director and Ockenden Champion
- £50,500 p.a. up to 30 November 2021 and £55,000 p.a. from 1 December 2021 for the Chairman

Additional benefits: Gym membership discounts with NHS identification

- Access to NHS staff benefits offered by retailers
- Onsite therapies at discounted rates
- Salary sacrifice schemes

There is no provision for bonuses to be paid to any senior manager within the Trust.

All senior Executives are employed on contracts with a six-month notice period. In the event that the contract is terminated without the Executive receiving full notice, compensation is limited to the payment of salary for the contractual notice period. No additional provision is made within the contracts for compensation for early termination and there is no provision for any additional benefit, over and above standard NHS pension arrangements, in the event of early retirement. In line with all other employees, senior Executives may have access to mutually agreed resignation schemes (MARS) where these have been authorised.

Our Non-Executive Directors are requested to provide three months' notice in the event that they wish to resign before their term of office comes to an end. They are not entitled to any compensation for early termination.

During the year no Executive Director, Non-Executive Director or Very Senior Manager received a payment for loss of office.

Annual report on remuneration

Details of the total number of Board members in post during 2021–22 are included on pages 27 to 32. Details of our Council of Governors are included on page 105, together with information on expenses paid to them in 2021–22.

Business expenses

As with all staff, we reimburse the business expenses of Non-Executive Directors and senior Executives that are necessarily incurred during the course of their employment, including sundry expenses such as car parking and transport costs such as rail fares.

The expenses paid to Directors during the year were:

	2020–21	2021–22
Total number of Directors in office as at 31 March:	19	19
Number of Directors receiving expenses:	4	6
Aggregate sum of expenses paid to Directors (£00s):	£258	£1,747

Salary and pension contributions of all Directors and senior Executives

Information on the salary and pension contributions of all Directors and senior Executives is provided in the tables on the following pages. This information in these tables, and in the remainder of this remuneration report, has been subject to audit by KPMG LLP. Additional information is available in the notes to the accounts.

Each of the Chief Executive's, the Finance Director's and the Medical Director's salary is above £150,000 per annum but within or below the national average, when benchmarking against other Trusts. In order to ensure the level of remuneration paid by the Trust is reasonable, on an annual basis we carry out a rigorous process of benchmarking against all other Trusts (including Trusts with comparable income, with comparable headcount, by Trust type and by region). We also take into account the individual Executive's performance, the collective performance of the Executive Team and the performance of the organisation as a whole. Furthermore, we consider the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health and Social Care. Taking such factors into account, the ARTE Committee considers the remuneration for the Chief Executive, the Finance Director and the Medical Director to be reasonable.

Remuneration Report 2021–22:

		2020/21				2021/22			
Name	**Title**	**Salary and Fee** (bands of £5,000)	**Taxable Benefits** (to the nearest £100)	**All pension related benefits** (bands of £2,500)	**TOTAL of all items** (bands of £5,000)	**Salary and Fees** (bands of £5,000)	**Taxable Benefits** (to the nearest £100)	**All pension related benefits** (bands of £2,500)	**TOTAL of all items** (bands of £5,000)
		£'000	**£**	**£'000**	**£'000**	**£'000**	**£**	**£'000**	**£'000**
Kevin McGee	Chief Executive Officer (from 1st Sept 2021)	0	0	0	0	150–155	4,700	0	155–160
Karen Partington	Chief Executive Officer (left 31st Dec 2021)	180–185	0	10.0–12.5	195–200	140–145	0	55.0–57.5	195–200
Faith Button	Chief Operating Officer	135–140	0	37.5–40.0	170–175	140–145	0	65.0–67.5	205–210
Jonathan Wood	Finance Director / Deputy Chief Executive	165–170	0	140.0–142.5	305–310	170–175	0	65.0–67.5	240–245
Geraldine Skailes	Medical Director	170–175	0	42.5–45.0	210–215	185–190	0	145.0–147.5	330–335
Sarah Cullen	Nursing, Midwifery and AHP Director	130–135	0	62.5–65.0	190–195	130–135	800	30.0–32.5	160–165

Karen Swindley	Strategy, Workforce and Education Director	130–135	0	27.5–30.0	160–165	135–140	0	52.5–55.0	190–195
Ailsa Brotherton	Director of Continuous Improvement	105–110	0	22.5–25.0	130–135	110–115	0	67.5–70.0	180–185
Stephen Dobson	Chief Information Officer	105–110	0	0	105–110	115–120	0	37.5–40.0	150–155
Gary Doherty	Director of Service Development (from 1st Dec 2020)	55–60	0	0	55–60	130–135	0	0	130–135
Naomi Duggan	Director of Communications and Engagement (from 4th Nov 2021)	0	0	0	0	45–50	0	35.0–37.5	80–85
Ebrahim Adia	Chairman	40–45	200	0	40–45	45–50	0	0	45–50
Tim Watkinson	Vice Chairman	15–20	0	0	15–20	15–20	0	0	15–20
Ann Pennell	Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
James Whitaker	Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
Geoff Rossington	Non-Executive Director (left 30th Sept 2021)	10–15	0	0	10–15	5–10	100	0	5–10
Kate Smyth	Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
Paul O'Neill	Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
Tricia Whiteside	Non-Executive Director	10–15	0	0	10–15	10–15	0	0	10–15
Victoria Crorken	Non-Executive Director (from 24th Jan 2022)	0	0	0	0	0–5	0	0	0–5

Notes: All members have been in post for the whole year unless otherwise stated
Non-Executive Directors do not receive any pensionable remuneration
The role of Director of Communications and Engagement changed to a senior management role under the ARTE Committee in November 2021

Pension benefit:

	2021/22							
	Real increase in pension at pension age (bands of £2,500)	**Real increase in pension lump sum at pension age** (bands of £2,500)	**Total accrued pension at pension age at 31 March 2022** (bands of £5,000)	**Lump sum at pension age related to accrued pension at 31 March 2022** (bands of £5,000)	**Cash Equivalent Transfer Value at 1 April 2021**	**Real increase in Cash Equivalent Transfer Value** (CETV)	**Cash Equivalent Transfer Value at 31 March 2022**	**Employer's contribution to stakeholder pension**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Kevin McGee Chief Executive (1)	0	0	0	0	0	0	0	0
Karen Partington Chief Executive	2.5–5.0	2.5–5.0	95–100	285–290	2,232	95	2,369	0
Jonathan Wood Finance Director / Deputy Chief Executive	2.5–5.0	2.5–5.0	70–75	150–155	1,238	95	1,339	0
Geraldine Skailes Medical Director	7.5–10.0	12.5–15.0	85–90	215–220	1,739	201	1,949	0
Sarah Cullen Nursing, Midwifery and AHP Director	0.0–2.5	0	30–35	55–60	426	34	462	0
Ailsa Brotherton Director of Continuous Improvement	2.5–5.0	0	55–60	0	793	77	875	0
Karen Swindley Strategy, Workforce and Education Director	2.5–5.0	0.0–2.5	50–55	100–105	930	78	1,013	0
Faith Button Chief Operating Officer	2.5–5.0	2.5–5.0	40–45	85–90	628	71	702	0
Stephen Dobson Chief Information Officer	2.5–5.0	0	20–25	0	283	43	328	0
Naomi Duggan Director of Communications and Engagement	0.0-2.5	0	20–25	0	263	16	305	0

Notes

(1) Kevin McGee joined the board in September 2021 and his accrued pension benefits at that point are not available, therefore the increases in benefits cannot be calculated. He has also chosen not to be covered by the NHS pension arrangements during the reporting year having opted out in April 2021.
(2) Gary Doherty chose not to be covered by the NHS pension arrangements during the reporting year, having opted out of the scheme in October 2017.

Details of off-payroll arrangements for any senior managers are included within the Staff Report on page 79. There are no current off-payroll arrangements for Board level posts.

We are required to disclose the relationship between the remuneration of the highest-paid director in our organisation against the 25th percentile, median and 75th percentile of total remuneration of our organisation's workforce.

The banded remuneration of the highest-paid director in Lancashire Teaching Hospitals NHS Foundation Trust in the financial year 2021–22 was £260,000 - £265,000 (2020–21, £180,000 - £185,000). This is a change between years of 41.5% (2020–21, 0%). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

The increase between years for the remuneration of the highest-paid director is the result of a new appointment to the post having been vacated in year.

Set out below, the total remuneration of the employee at the 25th percentile, median and 75th percentile, is further broken down to disclose the salary component. The pay ratio shows the relationship between the remuneration of the highest-paid director in Lancashire Teaching Hospitals NHS Foundation Trust against each percentile of the remuneration of the organisation's workforce.

Pay ratio information table:

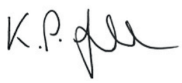
	2021/2022			2020/21			
	25th percentile	Median	75th percentile	25th percentile	Median restated	Median audited	75th percentile
Total remuneration (£)	20,863	27,739	40,139	20,227	26,970	30,269	38,890
Salary component of total remuneration (£)	20,863	27,739	40,139	20,227	26,970	30,269	38,890
Pay ratio information	12.6	9.5	6.5	9.0	6.8	6.1	4.7

In 2021–22, 2 (2020–21 restated, 34 / 2020–21 audited, 0) employees received remuneration in excess of the highest-paid director in 2021–22. Remuneration ranged from £18 to £313,536 (2020–21 restated, £11 to £325,509 / 2020–21 audited £852 - £184,862). Some prior year numbers have been restated to include all elements of pay that had been incorrectly excluded from the 2020–21 calculation.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The average percentage change from the previous financial year for salaries and allowances (based on total for all employees on an annualised basis, divided by fill time equivalent number of employees; both excluding the highest-paid director) for employees of the Trust as a whole is 4.2% (2020–21, 3.8%). On the same basis, the average percentage change from the previous financial year for performance pay and bonuses payable is down 7.3% (2020–21, down 12.6%).

This Remuneration Report is signed on behalf of the Board of Directors by:



Kevin McGee OBE
Chief Executive
28 June 2022

STAFF REPORT

Our people

As at 31 March 2022, we employed 9,379 substantive members of staff. This number is broken down as show in the below table; note that some staff hold roles that fall under different staff groups, thus the figures in the below table do not sum to the stated distinct headcount.

Staff Group	Headcount
Additional Clinical Services	2,141
Additional Professional, Scientific and Technical	209
Administrative and Clerical *(including Non-Executive Directors)*	1,787
Allied Health Professionals	611
Estates and Ancillary	861
Healthcare Scientists	274
Medical and Dental *(excluding Lead Employer Doctors)*	776
Nursing and Midwifery Registered	2,726
Total	**9,385**

A comparison of our workforce over the past three financial years is provided in the table below, and our staff turnover can be accessed via the information published by NHS Digital at the following link: NHS workforce statistics - NHS Digital.

	2021–22 HC	% of Total HC	2020–21 HC	% of Total HC	2019–20 HC	% of Total HC
Age (years)						
Under 20	57	0.6 %	61	0.7 %	45	0.5 %
20 - 29	1,778	19.0 %	1,404	15.8 %	1,096	12.9 %
30 - 39	2,359	25.2 %	2,161	24.3 %	2,034	24.0 %
40 - 49	2,091	22.3 %	2,043	23.0 %	1,950	23.0 %
50 - 59	2,157	23.0 %	2,173	24.4 %	2,179	25.7 %
60 - 69	890	9.5 %	998	11.2 %	1,093	12.9 %
70 and over	47	0.5 %	53	0.6 %	86	1.0 %
Ethnicity						
BAME: Asian	1,637	17.5 %	1,308	14.7 %	1,176	13.9 %
BAME: Black	196	2.1 %	153	1.7 %	136	1.6 %
BAME: Mixed	141	1.5 %	136	1.5 %	116	1.4 %

BAME: Other	144	1.5 %	120	1.3 %	109	1.3 %
White: Other	267	2.8 %	254	2.9 %	241	2.8 %
White: UK & ROI	6,897	73.5 %	6,847	77.0 %	6,623	78.1 %
Not Stated	97	1.0 %	75	0.8 %	82	1.0 %
	2021–22 HC	**% of Total HC**	**2020–21 HC**	**% of Total HC**	**2019–20 HC**	**% of Total HC**
Gender						
Male	2,200	23.5 %	2,068	23.3 %	1,883	22.2 %
Female	7,179	76.5 %	6,825	76.7 %	6,600	77.8 %
Recorded Disability	396	4.2 %	346	3.9 %	294	3.5 %

As at 31 March 2022, the gender split of our Board of Directors (including Non-Executive Directors) was six male and eight female. The gender split of our senior executives, as defined by the Appointment, Remuneration and Terms of Employment Committee, was four male and six female, with an average age of 51.67 years.

As an organisation we are required to publish our Gender Pay Gap report annually – here is the link to our Trust website where the Gender Pay Gap report is housed:

https://www.lancsteachinghospitals.nhs.uk/equality-and-diversity.

Attendance management

Sickness absence data is reported on a calendar year basis (January to December 2021):

Figures Converted by Department of Health to Best Estimates of Required Data Items:	
Average FTE 2021	7,964
Adjusted FTE days lost *(to Cabinet Office definitions)*	105,896
Average sick days per FTE	13.3
Statistics published by NHS Digital from ESR Data Warehouse:	
FTE days available	2,906,798
FTE days recorded sickness absence	171,788

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse
Period covered: 1 January 2021 to 31 December 2021

The 12-month average sickness absence rate for the period 1 April 2021 to 31 March 2022 was 5.98%, compared to 5.48% in the previous year. There have been rising trends in both long-term and short-term sickness absence throughout the year which have contributed to staffing pressures, particularly when compounded by an annualised Covid-19 absence rate of 1.68% (compared to 2.99% in 2020).

A number of factors have driven the increased sickness absence rate, including prolonged long-term absence because NHS surgery or treatment has been delayed as a result of the pandemic; and Covid-19 related sickness absence. Colleagues who have tested positive for Covid-19 have frequently been too unwell to return to work after the initial self-isolation period and a number are absent from work due to 'Long Covid'. It is important to recognise that colleagues have been working under considerable pressure for the last two years; and burnout, exhaustion and trauma are increasingly reasons for colleagues seeking support from our wellbeing services.

Supporting the mental health of our workforce is a high priority for us and during the year we have further expanded our psychological wellbeing offer with new mindfulness programmes and group therapy pathways, complementing access to a range of individual psychological therapies. Group support sessions have also been delivered for colleagues from Black and Asian Minority Ethnic backgrounds, those returning to work following shielding and individuals redeployed as a result of the pandemic. We have also worked closely with the Lancashire and South Cumbria Resilience Hub ensuring that colleagues experiencing Covid-19 related trauma access the most appropriate support pathway. A range of lifestyle and social factors can affect mental health and our externally delivered Employee Assistance Programme, which offers advice and support around issues such as family relationships, addiction and finance has been well received by colleagues, with access trebling in the last twelve months.

Our wellbeing strategy is holistic and other key achievements include:

- the launch of a Carers' Passport and information resources for carers
- establishment of a support network and education for colleagues experiencing menopause and other significant hormonal changes
- introduction of wellbeing conversations in appraisal
- appointment of a Board level Wellbeing Champion
- a new flexible working policy which broadens access to flexible working opportunities
- implementation of agile working as a long-term strategy
- upgrade of junior doctor mess areas and refurbishment of a centralised break area at Chorley; and the opening of a sleep pod area at Preston. These schemes have been made possible through charitable donations and grants
- provision of physical health checks (including Vitamin D screening, antibody screening, blood pressure and BMI checks) for colleagues at higher risk of serious illness from Covid-19
- introduction of Schwartz Rounds which provide a forum in which colleagues can come together to reflect on the emotional rewards and challenges of delivering healthcare
- development of a violence prevention and reduction strategy
- delivery of approximately 6,300 flu vaccinations and 25,000 Covid-19 vaccinations to colleagues

We were delighted to be reaccredited with the Workplace Wellbeing Charter in summer 2021, achieving the highest standard of excellence in five out of eight standards and external recognition of our continuous improvement journey in supporting health and wellbeing.

Priorities for the next year include the refurbishment of a number of local break areas and the development of Charters restaurant as a modernised rest and recreation space, improving access to food and drink for shift workers, enabling access to the physiotherapy gyms for colleagues and a renewed focus on preventing musculoskeletal injury at work. We will also be working closely with colleagues from the Lancashire and South Cumbria ICS to share practice and develop system-wide wellbeing approaches.

Equality and diversity

To achieve our vision statement of providing Excellent Care with Compassion, we have in the last six months developed an Equality, Diversity and Inclusion Strategy for 2021–2026. The vision behind the strategy is to be 'consciously inclusive in everything we do for our colleagues and communities'. Through this we commit to treating everyone we come into contact be they patients, their families, carers, colleagues, temporary workers, volunteers and colleagues from other organisations with dignity, respect, kindness and understanding. The strategy was developed jointly with governors and colleagues via our Ambassador Forums.

The Equality, Diversity and Inclusion strategy spans patients, our communities and our workforce. The strategy outlines a set of five principles which aim to provide a framework of ideas and options to create systemic changes, these are:

1. **Demonstrating collective commitment to equality, diversity and inclusion**
2. **Being evidence-led and transparent**
3. **Recognising the importance of lived experienced**
4. **Being representative of our community**
5. **Bringing about change through education and development**

Since the strategy has been published in November 2021 a number of key programmes of work have been progressed, these include:

- creation of a standardised approach for all Trust-wide strategies to ensure adequate consideration to equality and inclusion is given under its remit including the requirement to evidence co-production and consultation with minority groups and the need for specific actions which support the delivery of the equality and diversity agenda.
- scoping and creation of a holistic zero tolerance approach which includes a refreshed communication campaign, sets of expectations, development and awareness activities, a toolkit and policy.
- a process for monitoring of protected characteristics of our patients to include all protected characteristics.
- Ensuring all workforce policies are gender neutral with the content, approach described in the policy and supporting equality impact assessments being reviewed by relevant Ambassador Groups.

The Equality, Diversity and Inclusion Strategy Group monitor progress against the delivery and tangible impact of the actions outlined in the strategy. The group also provides support, guidance, direction and engagement to our divisions in the localisation of equality, diversity and inclusion actions in clinical services and to improve colleagues with protected characteristics experience of work. The Equality, Diversity and Inclusion Strategy Group reports to the Board of Directors, with aspects of the strategy reporting to the Workforce Committee. Both the Board and the Workforce Committee receive a number of key equality-driven performance reports within its routine cycle of business alongside strategy update-specific reports.

Staff engagement and consultation

The staff engagement approach is driven through the Workforce and Organisational Development Strategy with a distinct strategic aim which encompasses the underpinning programmes of work. The approach to measuring, understanding and improving staff engagement, satisfaction and experience of work is delivered through the following methods:

- **Annual National Staff Survey** – this is undertaken electronically (during September to November each year) with all colleagues invited to participate including temporary bank colleagues. Colleagues are invited to organisation-wide 'Sprint Sessions' where they are encouraged to share their views about specific aspects of their satisfaction. In conjunction with this, divisions are encouraged to engage with their teams to share the results and invite views on what would support improvement. Both corporate-level and divisional-level action plans are drawn up and progressed, with the Trust's Workforce Committee and divisional Workforce Committees responsible for oversight.

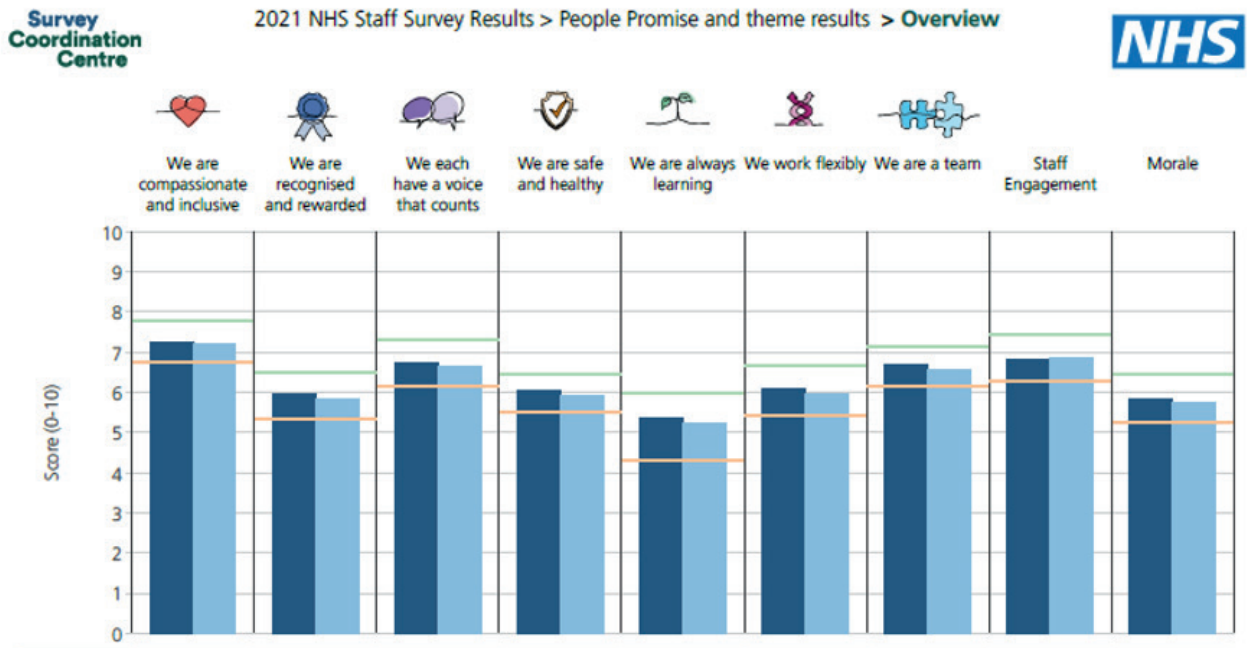
- **National Quarterly Pulse Survey** – this is undertaken electronically (in quarters one, two and four) with all colleagues invited to participate. The response rate for this engagement method is typically between 15–20%, going forward a priority will be to find ways to increase participation and demonstrate progress and improvements to colleagues based on their feedback.
- **Annual Cultural Values Assessment** – this is undertaken electronically (during May and June each year) with all colleagues invited to participate including temporary bank colleagues. The response rate in 2021 for this assessment was 35%. A new strategy for 2022 is in place which aims to see increases in participation and a more holistic approach to further engaging colleagues to outline the culture and the steps they believe would support culture change and achievement of the desired cultural values.
- **Team Engagement and Development (TED) Tool** – the TED tool has been used across the organisation for the last six years. In 2021–22 the TED tool has been sponsored by NHS England and NHS Improvement to enable the tool to be used by other Trusts. The TED tool is designed to be used by team leaders to enable them to have a conversation with their team about their levels of team effectiveness and engagement. TED enables team leaders to understand what matters to their team, to drive up levels of satisfaction which should in turn improve overall organisational performance as measures through the annual staff survey. A key priority in 2022–23 will be to ensure all teams use the TED tool on an annual basis as described in the organisation's Big Plan.

NHS Staff survey

The NHS staff survey is conducted annually. In 2021 the nine indicators were refreshed as were a number of the question items in the survey itself in order to be in line with the National People Promise, therefore it was not possible to compare each of the nine indicators like to like across the last three years. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

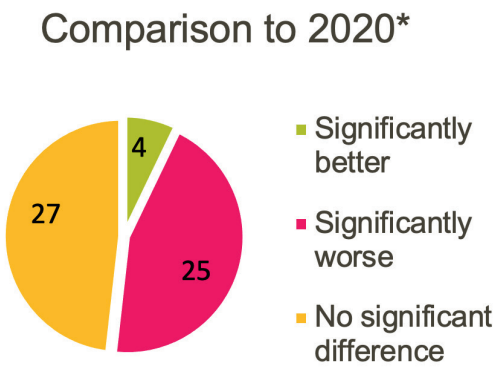
The response rate to the 2021 survey was 45% (this is 5% lower than the 2020 response rate of 50%) and is broadly in line with the national average of 46%. Scores for each indicator together with that of the survey benchmarking group (Acute and Acute and Community Trusts) are presented below.

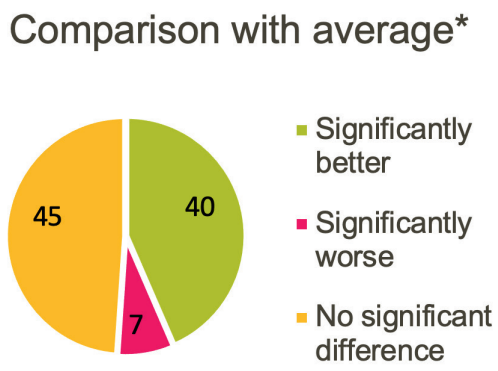
In summary against the nine elements, we have performed at or above the national average for all the people promise elements in 2021: this is the first time we have achieved this. Whilst we are not yet reaching our aspiration of being the best in the NHS, we have a positive level of engagement and satisfaction from which to move forward.



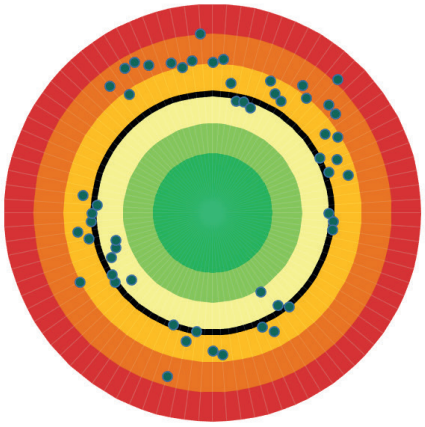
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.2	6.0	6.7	6.0	5.4	6.1	6.7	6.8	5.8
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,981	4,052	3,930	3,976	3,823	4,029	3,996	4,050	4,046

In summary out of the 117 questions asked as part of the survey, 92 can be scored positively, with 60 of these able to be historically compared. The pie charts below show how our 2021 scores have compared against how we performed in 2020 and against the Picker average. The narrative which follows provides the themes.

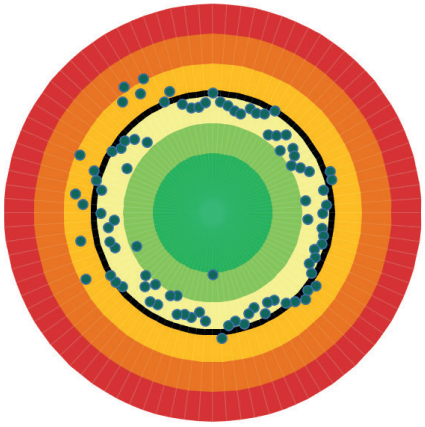


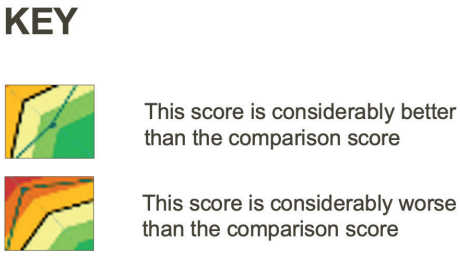


Current scores vs. historical scores



Current scores vs. similar organisations





Staff Engagement

The scores below detail the overall staff engagement score for 2021 and the breakdown of scores for items which measure the three facets of team engagement, namely motivation, involvement and advocacy. The results compare our scores against our 2020 results and the national average for this year. As indicated below, all but two of the items for staff engagement have seen a deterioration since 2020 results, however when comparing our Trust scores against the national benchmarking average we have scored above average in the majority of areas, with the exception of advocacy around care, recommending as a place of work and colleagues looking forward to going to work. Detailed findings are in the table and narrative.

Description	Organisation 2020	Organisation 2021	National Average
Motivation	**7.2**	↓ **7.0**	**7.0**
I look forward to going to work.	**56.8%**	↓ 51.8%	**52%**
I am enthusiastic about my job.	74.1%	↓ 68.7%	**67.6%**
Time passes quickly when I am working.	77.2%	↓ 75.5%	**72.9%**
Involvement	**6.8**	↑ **6.9**	**6.7**
There are frequent opportunities for me to show initiative in my role.	73.6%	↓ 74.8%	**72.4%**
I am able to make suggestions to improve the work of my team / department.	76.5%	↓ 73.6%	**69.8%**
I am able to make improvements happen in my area of work.	55.5%	↓ 53.7%	**53.3%**
Advocacy	**7.0**	↓ **6.6**	**6.8**
Care of patients/service users is my organisation's top priority.	78.8%	↓ 72.6%	**75.5%**
I would recommend my organisation as a place to work.	63.6%	↓ 56.2%	**58.4%**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	69.1%	↓ 61.9%	**66.9%**
Overall Staff Engagement Score	**7.0**	↓ **6.8**	**6.8**

To summarise the staff engagement findings:

- Our 2021 results are broadly in line with the national average benchmarking data.
- Our overall staff engagement score has slightly reduced since 2020 by 0.2 points, however, is at the national average.
- We saw deterioration in engagement levels for the questions relating to motivation specifically in relation looking forwards to going to work and feeling enthusiastic about work, however, these scores were in line with national average.
- Scores remained largely stable for involvement and above the national average, with increase in satisfaction for opportunities to show initiative, however, a slight dip in colleagues feeling able to make suggestions in areas of work, and for the item about making improvements happen.
- The overall score for advocacy saw the greatest drop since last year, reducing by 0.4 points and is 0.2 points below the national average. This score is driven by a deteriorating perception in our colleagues with regards to if they would recommend the organisation as a place of work and if a friend or relative needed treatment they would be happy with the standard of care.

Future priorities and targets

There are a number of key priorities and targets to be achieved in the next 12 months which will be delivered through the Workforce and Organisational Development Strategy and the priorities outlined below will be incorporated within the strategic aims and have clear impact measures. Progress against priorities and measurement of impact will be reported to the Workforce Committee through the regular cycle of business.

Co-production and consultation

The key priorities and area of focus following publication of the staff survey results are to engage colleagues across the organisation in understanding what is driving their lower levels of engagement and satisfaction with regards to advocacy (specifically recommend the organisation as a place to work, care of patients is the organisation's top priority and if a friend or relative needed care or treatment I would be happy with the standard of care provided by this organisation). Following consultation, actions will be developed through co-production with colleagues, managers, staff side colleagues and Inclusion Ambassador Forums.

Supporting teams to improve

Other areas of focus will be to support the teams who have lower levels of staff engagement and satisfaction, seeking to undertake more in-depth work to understand the causes and influencing factors which are driving lower scores. The work will include providing Workforce, Organisational Development and, where appropriate, Continuous Improvement team support, working in partnership with multi-disciplinary team managers to address areas of concern or dissatisfaction.

Improving the experience of colleagues with protected characteristics

We will continue to prioritise, understand and improve the experience of work colleagues who have protected characteristics. This will be achieved through co-production with Ambassador Groups and the Equality, Diversity and Inclusion Strategy Group to formulate strategic-level action plans whilst simultaneously working with divisions to address more localised or context-specific areas for improvement. Progress will be measured through the annual staff survey, the Workforce Race Equality Standard and the Workforce Disability Equality Standard on an annual basis.

Feeling healthy and safe at work

As indicated by the 2021 results we need to continue to invest in the health and wellbeing of our workforce, by continuing to advance the health and wellbeing offer, providing psychological and physical wellbeing support. Furthermore, we recognise that as part of future priorities we need to ensure our colleagues feel supported for their whole selves and managers have the awareness and competence to have supportive conversations with colleagues with regards to protected characteristics, factors which may impact on wellbeing at work (such as disability, levels of pressure) and how home life may impact on wellbeing at work (such as caring responsibilities).

In 2022 we will deliver a refreshed zero tolerance approach which is aligned to both the Health and Safety Strategy and the Equality, Diversity and Inclusion Strategy. This approach is designed to support colleagues to feel protected from violence, aggression and harassment in work so they feel safe, able to fulfil their duties without fear, whilst feeling secure in the knowledge that the organisation and their team is there to support them.

Culture change

We will seek to continue on our culture change journey, taking a review of our cultural values in May 2022, helping us to take stock as well as to understand corporately the current culture colleagues experience and the cultural values they aspire to be present in the way we go about our work. As part of the culture change programme of work, we will continue to promote the civility at work agenda, roll out of our shared responsibility framework and delivery of culture counts training to raise the awareness of managers of how to talk and bring about cultural change.

Reward and recognition

Colleagues continue to work in challenging circumstances. In 2022 we will refresh our reward and recognition approach to find new ways to value the work of our teams and individual colleagues.

Volunteers

Our volunteers provide a huge service to the Trust giving up their time to provide support to our patients, families, visitors and staff. Many of our volunteers support us because of a personal connection to our hospitals or because they want to give something back. For others, it is an opportunity to develop new skills, knowledge and experience to support their employability prospects. Whatever their reason, we truly value the role they play and the contribution they make.

At the present time we have approximately 570 volunteers registered with us. This included Baby Beat, third party volunteers such as Royal Voluntary Service (RVS), Families and Babies, Galloways and Macmillan. We currently have 120 volunteers who are actively supporting our wards and departments.

During the year we have linked with colleagues across other Trusts in Lancashire and South Cumbria and wider partner organisations to work collectively to mobilise our volunteer resources across the region in support of the pandemic and Covid-19 vaccination. Some of the roles and activities undertaken by our volunteers during 2021–22 include:

- **Marshalling vaccination clinics** – helping facilitate and act as marshals at our busy mass vaccination areas
- **Meet and Greet and assistance** – helping patients and visitors to find their way and assisting with wheelchair transportation. Feedback from patients tells us how valued this is
- **Mask distribution** – support at Meet and Greet desks ensuring visitors are wearing masks
- **Chaplaincy support** – visiting patients and providing pastoral support. This has been particularly important whilst visitor restrictions have been in place and so valued by our patients
- **Therapy dog** – two specially trained dogs and their volunteer handlers have been visiting specific patients. They have also been visiting staff and teams on a weekly basis to help support morale. The feedback on this has been very positive
- **Clinic support** – outpatient clinics, blood clinics, cardiorespiratory and discharge lounge
- **Administrative support** – helping with photocopying, envelope filling, delivering information and making phone calls
- **Ward and clinic support** – helping with hot drinks and snacks for patients and staff as necessary, arranging flowers and undertaking errands

Engagement

We have worked hard to keep in touch with all our volunteers whether they are actively volunteering or not throughout the year, including:

- sending them the CEO communication briefs
- informing them of new volunteering opportunities that they may be interested in trying
- sending regular email updates on anything of interest taking place within the Trust and also the health and wellbeing newsletters and information
- having an open-door approach on both sites when active volunteers can arrange to meet us, socially distanced, to discuss any issues they may have and telephone support is always available on both sites

We celebrated Volunteers Week in 2021 by handing out boxes of treats to all our active volunteers which was really well received. We also sent all active volunteers a special card which was designed by one of our own volunteers to say 'Thank You'.

Raising visibility of our volunteers and the work they do

We have invested in new uniforms for all volunteers this year. After engaging with our volunteers, we opted for a bright colour to make them more visible and so they can be easily identified alongside all the different staff uniforms. We will be launching a media information package to inform staff, patients and visitors about the change to branding and how to identify a volunteer for assistance.

Colleagues and networks

To stay in touch with colleagues across our networks, we attend regular virtual meetings with the National Association of Voluntary Service Managers as well as the NHS England Futures Platform. This has enabled us to discuss and share ideas, best practices and to hear what others up and down the country are doing. We have recorded videos with our volunteers service and submitted then to local Universities to share and work with our recruitment colleagues to promote volunteering at community events and job centres.

Recruitment

We have welcomed a number of new volunteers throughout 2021/22. We have also seen volunteers try completely new roles to support Covid-19 vaccination hubs, after years in their original role. Feedback received shows this has been really motivating and all volunteers have reported learning lots of new skills.

We have been engaging with staff groups to develop new roles and increase the profile of volunteers across the Trust.

Going forward, linked to our equality and diversity plan, we will be concentrating on improving representation across our volunteers. We will be looking at ways to engage and share the roles and opportunities we have with all ages, backgrounds and ethnicity.

We have developed our social media channels and increased recruitment activity on Facebook, Instagram, LinkedIn and Twitter.

Identifying where volunteers are needed

We have been considering ways to expand the support volunteers can offer and developing new roles. These include:

- **Discharge lounge** – to assist with beverages, chatting and message running
- **Dementia team** – to assist with distraction therapy
- **Gardening** – to manage and maintain therapy gardens
- **Patient Experience and PALS team** – assisting with distributing and collecting new boxes for response cards to the Friends and Family Test survey

We plan to do more work this year ensuring all wards and departments can easily engage with us if they want to request a volunteer and simplify the process.

Key areas and priorities

Some of our key areas of focus over the next 12 months are:

- Develop and deliver a volunteer service recovery plan to return our volunteers to the roles they love, as well as continuing to attract and recruit new volunteers from all backgrounds and communities.
- Launch the volunteer handbook and monthly newsletter.
- Audit our volunteer electronic staff record and investigate new methods of recording volunteer movement and attendance on rosters, so we can provide better visibility of the impact our volunteers continue to make.
- Develop the profile and visibility of volunteers across the Trust which will include the development of a new intranet site with information for our managers.

- Continue engagement with colleagues around new roles such as support for winter pressures, volunteer use in the Emergency Department and dementia support. We want to ensure best use of volunteering to facilitate the release of additional nursing and clinical time and support the achievement of the Trust's targets, for example 4-hour A&E and discharge, development of Befriender, distraction therapy and discharge support volunteer programmes, as part of existing ward volunteer roles.
- To raise the profile of how volunteers can proactively support service delivery ensuring our volunteers are embedded into clinical areas and are pro-actively supported in the workplace.
- Improve positive celebration of volunteering through case studies, awards, tweets, posters and communications for an immersive and uplifting culture of volunteering.
- Develop a volunteer action plan as a result of Big Conversation feedback.
- Conduct a bespoke volunteer engagement survey and implement actions as a result.

Learning and Development

The Education and Training team has focused on a range of key deliverables during 2021–22, many of which have been linked to reinitiating areas of work that have been placed on hold during the pandemic. This section provides an overview of key achievements with further detail available in the Education and Training annual report which is produced in June each year.

Mandatory training compliance improved during 2021–22 with core skills training compliance demonstrated in 19 out of 26 Core Skills Training Framework (CSTF) domains, including conflict resolution which was introduced as a new training domain in February 2021. This was from a baseline of compliance in nine out of 26 subjects in April 2021. Face-to-face training components were suspended during 2021–22 due to ongoing critical service pressures and these are the areas where CSTF compliance remains challenged, namely resuscitation and moving and handling. These training components will be restored in May 2022. In addition, there has been a review of core skills training for postgraduate trainees and a robust system has been developed and implemented that ensures alignment with CSTF and enables a proactive approach to driving training compliance.

Medical device training compliance has increased from 69.5% to 74.4% during 2021–22, with progression towards 90% compliance impacted by service and staffing pressures. All medical devices now have a training risk assessment recorded. Targeted work has focused on high intensity medical device users with significant improvements in compliance in Critical Care and the Emergency Department. Work is ongoing to improve medical device competency training including a refresh of target audience to ensure devices are assessed against the correct staff.

The Clinical Skills Education team has expanded during 2021–22 to establish a dedicated mask-fitting service in line with the national framework for FFP3 resilience. Over the last year the team has carried out over 3,000 mask fit tests on staff and this ongoing programme will ensure the Trust can maintain emergency preparedness, resilience and response. Despite the challenges associated with Covid-19 safe working protocols, over 2,000 face-to-face clinical skills teaching sessions were delivered as part of supporting 363 new international nurses, 469 newly qualified nurses on the Preceptorship programme, 300 medical students and existing nursing, allied health profession and medical staff as well as developing teaching models to deliver over 500 teaching sessions through remote technology. The resuscitation defibrillator replacement programme commenced in December 2021 and this will ultimately replace all defibrillators with modernised equipment. Other activity includes:

- Integrated approach to delivering adult and paediatric life support training
- 286 healthcare assistants completed the induction programme
- 22 days of clinical competency assessment medical student examinations
- Breaking Bad News video produced to support staff working with very sick or dying patients and their relatives

The Student, Trainee and Placement Support (STAPS) team has successfully placed 798 students into clinical environments. During 2021–22 the team has further embedded its multi-professional focus with an expansion of the Clinical Placement Support team aligned to the growth in student and learner volumes. With a continued commitment to support the government's targets for workforce growth, the placement expansion programme has continued during the last year with focus on digital enhancements to support placement learning. Rotational learning models have been introduced so that students and learners can broaden their exposure across clinical

environments. In addition, the Collaborative Learning in Practice placement model has been introduced in Dietetics and, if successful, will be further rolled out to other allied health professionals. Learner boards are being installed across ward and clinical areas which provide enhanced information for learners in the Trust. Our health and wellbeing support offer for students and learners has been enhanced through a full review of the service delivery modek which has resulted in the service being offered internally with growth in the service provision to accommodate the growing numbers of learners. The STAPS team has continued to engage in a broad range of external activity to support workforce developments at local, regional and national level. Some key examples include:

- Ongoing engagement in the national and regional Reducing Pre-registration Attrition and Improving Retention (RePAIR) programmes
- As part of the RePAIR programme, implemented the Practice Development programme which will be fully evaluated during the next financial year
- Engagement with the Enabling Effective Learning Environments programme, including being awarded £80,000 to host the InPlace project on behalf of the region to scope implementation of placement management software

The Postgraduate Medical Education (PGME) team has successfully developed the Skills in Practice course with 35 trainees during 2021–22. With the Covid-19 restrictions for overseas trainees being lifted, numbers undertaking this course will increase in future years. Other achievements in PGME include:

- 300 trainee portfolios completed
- 41 trainee supervisors completed new portfolio system training sessions
- Additional Longitudinal Integrated Foundation Training (LIFT) track awarded for Foundation Trainees
- Increased from four to seven Staff, Associate Specialist and Specialty (SAS) courses

The Medical Intern Programme (MIP) that successfully launched in 2020 has seen a second cohort of nine international doctors recruited, with a 100% programme retention rate to date. The nine doctors recruited to the 2020 cohort have all applied to go on to specialty training therefore will be remaining in the UK. The current focus of the programme is to extend across the Lancashire and South Cumbria area with Blackpool Teaching Hospitals NHS Foundation Trust being the first Trust partner to agree a planned intake in 2022. Work is now focusing on adopting the principles of MIP to develop a similar programme for middle grade doctors. These programmes are important in offering additional medical workforce supply to address some of the chronic medical workforce shortages.

The Professional Education Department (PED) team supports the development of innovative non-medical professional workforce supply solutions. The first cohort from the Registered Degree Nurse Apprenticeship (RDNA) completed in March 2022 with all seven qualifiers taking up registered nurse employment in the Trust. There are currently 60 learners on the RDNA programme with 35 due to complete in 2022–23. A further 30 places are available following which the funding available to support the apprentices will be fully used and opportunities for continued delivery of the programme will need to be explored. Other achievements of the PED team include:

- Delivering clinical skills sessions for 102 Bolton University adult nursing students
- Supporting trainee Nurse Associates with 16 qualifying in 2021–22
- Delivering the support requirements for 363 international nurses recruited during 2021–22
- Securing £77,000 for upskilling for Physician Associates

During 2021–22 the Nurse Training Programme has progressed at pace, largely focused on the procurement process to ensure an academic partner. This programme of work will progress to full implementation in 2022–23 and aims to offer an additional pre-registration nursing pathway that:

- supports widened access to pre-registration nursing
- enables multiple small cohorts offering multiple programme exit points
- focuses on growing our own workforce through a significantly enhanced proportion of programme delivery being hospital-based

Apprenticeships continue to offer significant benefits to the Trust, including pathways to meaningful employment and a range of apprenticeships that deliver workforce supply and skills gaps. Over the required four-year reporting period, the Trust achieved 2.85 of new staff apprenticeship starts against a public sector target of 2.4%. The portfolio of apprenticeship pathways offered internally has been reviewed during 2021–22 and an agreed outcome to focus on delivering the Level 3 Healthcare Support Worker and Learning Mentor pathways and deliver leadership and management development through non-apprenticeship programmes. Over the past 12 months the pathways have delivered 98 qualified learning mentors with 10 awaiting end point assessment results, and 58 senior healthcare support workers. The Trust has achieved 70.8% qualification and achievement rate against a target of 62%. An inspection by the Office for Standards in Education, Children's Services and Skills (Ofsted) is expected and the team has been preparing for the inspection through a self-assessment against the Education Inspection Framework.

The Widening Participation team continues to offer career inspiring pathways to employment to our local community. Despite the impact of ongoing Covid-19 safe working restrictions, the team has delivered a number of events and programmes targeted towards those at a disadvantage who aspire to a career in the NHS. We work in collaboration with a wide range of organisations such as local colleges, Department for Work and Pensions, Prince's Trust, Lancashire County Council, SHOUT network and care charities, which ensures we extend our reach into local communities. During 2021–22 key achievements include:

- Promotional material developed and published to support obtaining future sponsorship for the LIFE Centre
- Supported 68 unemployed people back into work
- Provided 24 learners with online work experience
- Supported 16 students on the Preston Widening Access Programme
- Work Familiarisation Programme for 28 learners with additional learning needs
- 3 full weeks of virtual careers events

The Education Governance (EG) team is responsible for collecting learner feedback and monitoring compliance against internal and external quality standards. Significant progress has been made this year to align internal activity against the new Health Education England Quality Framework, NHS Education Contract 2021–2024 and wider governance framework, with improved reporting across all programme areas to be implemented across the divisions from 2022–23. In 2021–22 the EG team oversaw the successful re-accreditation of both Matrix and Skills for Health quality kite marks, implemented more rigorous governance processes for our apprenticeship provision introducing Programme Quality Review Panels and structured audits, as well as forging closer links with divisions through the expansion of the allied health professionals' quality assurance process. The team undertook 194 focus groups and carried out 45 internal surveys during 2021–22 with data used to evidence compliance, support continuous quality improvement and the development of action plans. In addition, a new policy for education complaints, compliments and suggestions has been developed and implemented. Other key achievements to note include:

- Successfully awarded in excess of £700,000 to support workforce upskilling and training recovery
- Over 96,000 page views of the refreshed Health Academy website
- Working across the Lancashire and South Cumbria ICS to prepare for the introduction of T Level placements
- Completion of the mandatory training Skills Passport project delivering enhanced alignment of mandatory training across ICS partners and identification of potential ongoing system improvements that could be delivered with additional investment
- Ongoing focus on digital developments to embed immersive and virtual reality technology that enhance the learner experience and offer alternative approaches to educational delivery

Occupational health

2021 was a period of change for our Occupational Health provider, Wellbeing Partners, with one of the original three partners in the joint venture, Bolton NHS Foundation Trust, withdrawing from the partnership in April 2021. We have since refreshed the partnership agreement with our remaining partner, Wigan, Wrightington and Leigh NHS Foundation Trust and reviewed service level agreements for the provision of core occupational health services. As part of the change process, we have brought physiotherapy and counselling services for colleagues back in-house, enabling more effective alignment with our proactive and preventative health and wellbeing offer.

Staff costs

			2021/22	2020/21
	Permanent	Other	Total	Total
	£0	£0	£0	£0
Salaries and wages	316,873	32,077	348,950	331,155
Social security costs	30,612	3,150	33,762	31,273
Apprenticeship levy	1,577	160	1,737	1,586
Employer's contributions to NHS pensions	49,388	5,020	54,408	50,463
Pension cost – other	161	16	177	176
Other post-employment benefits			0	-
Other employment benefits			0	-
Termination benefits			0	-
Temporary staff		21,021	21,021	19,274
NHS charitable funds staff			0	-
Total gross staff costs	398,611	61,444	460,055	433,927
Recoveries in respect of seconded staff			0	-
Total staff costs	398,611	61,444	460,055	433,927
Of which				
Costs capitalised as part of assets	-	-	-	-

Consultancy costs	
2021/22	2020/21
£0	£0
116,000	19,000

Average number of employees (WTE basis)

			2021/22	2020/21
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	961	63	**1,024**	934
Ambulance staff	2	0	**2**	2
Administration and estates	1,312	72	**1,384**	1,319
Healthcare assistants and other support staff **	2,703	400	**3,103**	2,927
Nursing, midwifery and health visiting staff	2,239	315	**2,554**	2,397
Nursing, midwifery and health visiting learners			**0**	-
Scientific, therapeutic and technical staff	718	14	**732**	711
Healthcare science staff	243	4	**247**	239
Social care staff			**0**	-
Other	34		**34**	23
Total average numbers	8,212	868	**9,080**	8,552
Of which:				
Number of employees engaged on capital projects	-	-	-	-

*** The PY number has been restated (was 4,264) due to a double count being identified in the working paper.*

Pensions/retirement benefits and senior employees' remuneration

Accounting policies for pensions and other retirement policies and details of senior employees' remuneration are set out in the notes to the accounts and on pages 61 to 64 of this report.

Off-payroll arrangements

Table 1: The number of off-payroll engagements as at 31 March 2022 earning at least £245 per day:

Number of existing engagements as of 31 March 2022	1
Of which:	
Number that have existed for less than one year at time of reporting	0
Number that have existed for between one and two years at time of reporting	1
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four years or more	0

Table 2: All off-payroll appointments engaged at any point during the year ending 31 March 2022 and earning more than £245 per day:

Number of off-payroll workers engaged during the year ended 31 March 2022	1
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	1
Number of engagements reassessed for consistency/assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0
Number of engagements where the status was disputed under provisions in the off-payroll legislation	0
Number of engagements that saw a change to IR35 status following review	0

Table 3: All off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022 Trusts must also disclose:

Number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed Board members and/or senior officials with significant financial responsibility during the financial year. This figure must include both off-payroll and on-payroll engagements	0

Staff exit packages

	2021/22			2020/21		
Exit package cost band	**Number of compulsory redundancies Number**	**Number of other departures agreed Number**	**Total number of exit packages Number**	**Number of compulsory redundancies Number**	**Number of other departures agreed Number**	**Total number of exit packages Number**
<£10,000	1	2	**3**	0	0	**0**
£10,000 - £25,000	0	1	**1**	0	1	**1**
£25,001 - £50,000	1	0	**1**	1	0	**1**
£50,001 - £100,000	0	1	**1**	0	0	**0**
£100,001 - £150,000	0	0	**0**	0	0	**0**
£150,001 - £200,000	0	0	**0**	0	0	**0**
> £200,000	0	0	**0**	0	0	**0**
Total number of exit packages by type	**2**	**4**	**6**	**1**	**1**	**2**
Total resource cost	£40,000	£103,000	£143,000	£41,000	£11,000	£52,000

Exit packages: non-compulsory departure payments

	2021/22		2020/21	
	Payments Agreements Number	Total Value of Agreements £000	Payments Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	1	16	1	11
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	2	7	0	0
Exit payments following Employment Tribunals or court orders	1	80	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**4**	**103**	**1**	**11**
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Value of special severance payments approved by NHS Improvement

Minimum value	£0
Maximum value	£0
Median value	£0

Facilities and Time Off for Union Representatives

The 2021–22 collation and reporting of facilities and time off for union representatives falls outside of the timing of this report. Based on 2020–21 however the organisation had a headcount of 46 local trade union representatives, equating to 38.88 whole-time equivalents. Two of these were seconded into our Partnership team for 100% of working hours. Of the remaining representatives:

- One representative had between 51% and 99% of their working hours as facilities time
- 14 representatives had between 1% and 50% of their working hours as facilities time
- 29 representatives had 0% of their working time as facilities time

The hours spent totalled 2,297.25 and of these 476 hours (20.72%) were for paid trade union duties. The total cost of facility time was £44,855.97, representing 0.0001128% of the pay bill.

DISCLOSURES SET OUT IN THE NHS FOUNDATION TRUST CODE OF GOVERNANCE

The purpose of the code of governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice but requires a number of disclosures to be made within the annual report.

The NHS Foundation Trust code of governance contains guidance on good corporate governance. NHSI, as the healthcare sector regulator, is keen to ensure that NHS Foundation Trusts have the autonomy and flexibility to ensure their structures and processes work well for their individual organisations, whilst making sure they meet overall requirements. For this reason, the code is designed around a 'comply or explain' approach.

Lancashire Teaching Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust is committed to the principles of the Code, which is supported by its robust internal governance arrangements, meets the statutory disclosure requirements in this annual report and also adheres to all other 'comply or explain' requirements.

Comply or explain

NHSI recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for non-compliance with the code should be explained. This 'comply or explain' approach has been in successful operation for many years in the private sector and within the NHS Foundation Trust sector. In providing an explanation for non-compliance, NHS Foundation Trusts are encouraged to demonstrate how its actual practices are consistent with the principle to which the particular provision relates.

Whilst the majority of disclosures are made on a 'comply or explain' basis, there are other disclosures and statements (which we have termed 'mandatory disclosures' in this report) that we are required to make, even where we are fully compliant with the provision.

Mandatory disclosures

Code ref.	Summary of requirement	See page(s):
A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the Boards and which are delegated to the executive management of the board of directors.	11, 32, 104
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	27–29, 33, 57, 58, 115
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	104, 105
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	105, 106
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	27–29, 32

Code ref.	Summary of requirement	See page(s):
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	27–29
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	27–32
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	32, 56, 57
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	NOT APPLICABLE
B.3.1	A Chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	27
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	52–55, 103, 104
FT ARM	If, during the financial year, the governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.	NOT EXERCISED
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	33, 34, 57, 60, 88–102
B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	33, 34, 95, 102
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	35, 87, 112
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	88–102, 111–112
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	114
C3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	NOT APPLICABLE

Code ref.	Summary of requirement	See page(s):
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	111–115
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	NOT APPLICABLE
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	103, 106, 107, 109, 110
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	108–110
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS Foundation Trust's website and in the annual report.	35, 107, 110
FT ARM	The annual report should include: a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; information on the number of members and the number of members in each constituency; and a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	108–110
FT ARM	The annual report should disclose details of company Directorships or other material interests in companies held by governors and/or Directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust.	94, 104

'FT ARM' indicates that the disclosure is required by the NHS Foundation Trust Annual Reporting Manual rather than the code of governance.

Other disclosures in the public interest

NHS Foundation Trusts are public benefit corporations and it is considered to be best practice for the annual report to include 'public interest disclosures' on the Foundation Trust's activities and policies in the areas set out below.

Summary of disclosure	See page(s):
Actions taken to maintain or develop the provision of information to, and consultation with, employees.	68–72
The foundation trust's policies in relation to disabled employees and equal opportunities.	22, 23, 89, 94, 95
Information on health and safety performance and occupational health.	24, 25, 72, 78, 89, 91
Information on policies and procedures with respect to countering fraud and corruption.	24, 89, 111, 115
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.	21
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year.	54, 95, 98
Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas.	54, 95, 98
Any other public and patient involvement activities.	55, 100
The number of and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Note 5.1 to the accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Note 2.5 to the accounts
A statement that the NHS Foundation Trust has complied with the cost allocation and charging guidance issued by HM Treasury.	
Sickness absence data.	66, 67
Details of serious incidents involving data loss or confidentiality breach.	95, 100

Voluntary disclosures

We have also included a number of 'voluntary disclosures' (as defined by the Foundation Trust annual reporting manual) in this report. These can be found as follows:

Summary of disclosure	See page(s):
Sustainability / environmental reporting	22
Equality reporting	22, 23, 66, 68, 72, 95
Slavery and human trafficking statement (Modern Slavery Act 2015)	34

NHS SYSTEM OVERSIGHT FRAMEWORK

NHS England and NHS Improvement's NHS System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes:

- quality of care, access and outcomes
- preventing ill health and reducing inequalities
- finance and use of resources
- people
- leadership and capability

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

NHS England and NHS Improvement placed the Trust in segment 3.

On 12 November 2021 enforcement undertakings were revised and these were formally accepted by the Trust on 2 December 2021. For details of the enforcement undertakings and the Trust's progress made against them, please see the Annual Governance Statement (pages 88 to 102)

This segmentation information is the Trust's position as at 31 March 2022.

Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England and NHS Improvement website:

https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the accounting officer of Lancashire Teaching Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Lancashire Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Lancashire Teaching Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

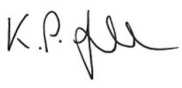
In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Kevin McGee OBE
Chief Executive
28 June 2022

ANNUAL GOVERNANCE STATEMENT 2021–22

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Lancashire Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and accountability

The Chief Executive, with overall responsibility for risk within the Trust, ensures the work of the Committees of the Board, including sub-groups, is reviewed by the Board of Directors. The Chief Executive has overall responsibility for having effective risk management systems in place within the Trust, and for meeting all statutory requirements and adhering to guidance issued by NHSI and other regulatory bodies in respect of risk and governance.

The Trust ensures it has capacity to handle risk achieved through delegated responsibilities in place as defined in the Scheme of Reservation and Delegation of Powers and the Risk Management Strategy, both documents being approved by the Board of Directors. The Strategy outlines the Trust's approach to risk, accountability arrangements and the risk management process including identification, analysis, evaluation and approval of the risk appetite.

The accountability arrangements for risk management in 2021–22 involved the following:

(a). the Board of Directors has overall responsibility for ensuring robust systems of internal control, encouraging a culture of risk management, routinely considering risks and defining its appetite for risk;

(b). the Committees of the Board undertake the detailed scrutiny of those risks that fall within their terms of reference on behalf of the Board of Directors, recommending new or revised risks to the Board as appropriate;

(c). the Audit Committee on behalf of the Board of Directors ensures that the Trust's risk management systems and processes are robust;

(d). the Executive Management Group reviews risks relevant to its remit and advises all Committees of the Board on potential/existing strategically significant risks, as well as liaising with the Divisional Management Boards to ensure the consistency of risk reporting and also overseeing the Trust's Risk Register;

(e). the Chief Executive, as the Trust's Accountable Officer, has overall responsibility for the risk management processes and Risk Management Strategy;

(f). the Nursing, Midwifery and AHP Director, supported by the Associate Director of Governance, advises the Trust Board on all matters relating to governance, risk and quality;

(g). each member of the Executive Team has responsibility for the identification and management of risks within their executive portfolios;

(h). the Executive Finance Director/Deputy Chief Executive has responsibility for ensuring that the Trust had sound financial arrangements that are controlled and monitored through financial regulations and policies;

(i). the Chief Information Officer is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs reporting; and

(j). the Director of Governance was the Nominated Individual with the CQC and upon their retirement in October 2021 the role transferred to the Deputy Associate Director of Risk and Assurance as the Nominated Individual with the CQC from November 2021 through to the end of May 2022. The Associate Director of Risk and Assurance commences in post with effect from May 2022 and will become the Nominated Individual with the CQC taking over directly from the Deputy Associate Director of Risk and Assurance from the beginning of June 2022.

The Board Assurance Framework and Risk Register have been regularly scrutinised and reviewed through the Trust's governance structure and have been subject to various internal and external reviews. The Trust's strategic intentions, policies, procedures, Board Assurance Framework and supporting documentation are openly accessible via the intranet for all staff to reference.

The existing organisational management structure and Risk Management Strategy illustrates the Trust's commitment to effective governance and quality governance including risk management processes. As Accounting Officer, I have overall accountability for risk management within the Trust, however our Risk Management Strategy describes the responsibility of every member of staff to recognise, respond to, report, record and reduce risks while they are undertaking work for the Trust.

Training and learning

Trust policies are available on the Trust's intranet and internet and relevant staff are encouraged to participate in the consultation of new and updated policies. Newly approved policies are published through a network of policy leads and also in the monthly briefing issued to staff.

To ensure that the Trust's approach to risk management is successfully implemented and maintained, staff of all levels are appropriately trained in key elements of risk management. All staff are required to regularly update their knowledge and skills and maintain their personal awareness of their responsibilities for risk management via an ongoing training programme which includes adverse incidents, health and safety, fire safety, infection control and prevention, safeguarding children and vulnerable adults, information governance, moving and handling, conflict resolution, complaints handling, care, fraud awareness, and equality and inclusion. This training is mandatory for all staff and is identified via a training needs analysis that is reflected in the Trust's Induction and Mandatory Training Policy.

Through a comprehensive training programme, which includes governance and risk management awareness, all staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and training needs analysis.

Monitoring of training compliance and escalation arrangements are in place via the Education, Training and Research Committee and the Divisional Improvement Forums to ensure that the Trust maintains the good performance seen and can ensure targeted action in respect of areas or staff groups where performance is not at the required level, for example bank staff. Where performance is below expected levels, the Trust Executive Team oversees tailored support for the Divisions and Corporate Teams in line with the Accountability and Oversight Framework to underpin sustainable improvement and delivery of plans, objectives and required outcomes.

To support continuous improvement during 2021–22 the series of risk maturity workshops held during 2020/21 continue across the Trust's Corporate Services as well as the four clinical divisions. The purpose of these workshops is to support an improvement in the quality of operational risks on the risk register, including staff understanding of controls, assurances and connectivity of operational risks registers with strategic ambitions and the Board Assurance Framework.

The Trust also delivers additional risk management training and development to Board members (both Executive and Non-Executive Directors). During 2021–22 a risk maturity workshop has taken place with Executive and Non-Executive Directors and as a result of these the Board has reviewed and updated the risk appetite statement developed during 2020–21 to ensure it remains fit for purpose.

The risk and control framework

The management of risk

The development of effective risk management across the organisation is underpinned by clear processes and procedures which include:

(a). overarching strategic aims for risk management;

(b). the Trust's Risk Management Strategy;

(c). the Trust's Risk Management Policy;

(d). the organisational process for risk identification and analysis;

(e). a definition of significant risk and acceptable risk within the organisation;

(f). organisational risk management structures;

(g). the development and application of risk registers within the organisation;

(h). incident reporting;

(i). the accountability and responsibility arrangements for risk management; and

(j). the Board Assurance Framework.

Throughout the reporting period the Safety and Quality Committee, Finance and Performance Committee, Workforce Committee and Education, Training and Research Committee were the Committees of the Board charged with scrutinising the arrangements in place for specific areas of risk. They are supported by a number of sub-groups, including:

- Divisional Management Groups
- Health and Safety Group
- Infection Prevention and Control Committee
- Medicines Governance Committee
- Patient Experience Improvement Group
- Safeguarding Board
- Mortality and End of Life Care Committee
- Safety and Learning Group
- Capital Planning Forum
- Information Governance Forum
- Emergency Preparedness, Resilience and Response Committee
- Always Safety First Committee
- Raising Concerns Group

These arrangements are supported by the work of the Audit Committee which receives assurances on the effectiveness of the risk management framework annually by receiving the Head of Internal Audit Opinion. This is based on a robust Internal Audit Programme which tests key aspects of the Trust's governance arrangements through a series of reviews undertaken throughout the year which are also reported to the Audit Committee.

The Risk Management Strategy

The Trust's Risk Management Strategy provides a framework for managing risk within the Trust and outlines the objectives of risk management; the structure in place to support the management of risk across the organisations; and the systems and processes to ensure identification, management and control of risk.

The strategy defines risk in the context of clinical, health and safety, organisational, business, information, financial or environmental risk and also provides a definition of risk management. It details the Trust's approach to:

- the provision of high-quality services to the public in ways aimed at securing the best outcome for all involved. To this end, the Trust ensures that appropriate measures are in place to reduce or minimise risks to everyone for whom we have a responsibility;
- the implementation of policies and training to ensure that all appropriate staff are competent to identify risks, are aware of the steps needed to address them and have authority to act;
- management action to assess all identified risks and the steps needed to minimise them. This comprises continuous evaluation, monitoring and reassessment of these risks and the resultant actions required;
- the designation of Executive Officers with responsibility for implementation of the strategy and the execution of risk management through operational and monitoring committees, as described in the Risk Management Strategy;
- action plans to maintain compliance with the requirements for CQC registration, which contribute to delivery of the risk control framework and registration standards assurance; and
- the process by which risks are evaluated and controlled throughout the organisation. In support of the Risk Management Strategy, a range of policies exist that provide clear guidance for staff on how to deal with concerns, complaints, claims, accidents and incidents on behalf of patients, visitors or themselves.

Each division has governance arrangements in place including a systematic process for assessing and identifying risk in line with the strategy. The risk assessments are rated and this information is utilised to populate the relevant divisional risk register via our online system. Responsibility for the management and control of a particular risk rests with the division concerned.

Risks are escalated to the Executive Management Group when an action to control a particular risk falls outside the control or responsibility of that division, or where local control measures are considered to be potentially inadequate, require significant financial investment or the risk is 'rated high'. The Group may escalate a particular risk to the appropriate Committee of the Board for further consideration when required.

The Trust has in place a Board Assurance Framework (BAF), which is designed to provide a structure and process to enable the Trust to identify those strategic and operational risks that may compromise the achievement of the Trust's high level strategic objectives and is made up of two parts: the **Strategic Risk Register,** those risks that threaten the delivery of the strategic objectives and are not likely to change over time, and the **Operational Risk Register**, those risks that sit on the divisional and corporate risk registers and may affect and relate to the day-to-day running of the organisation. They mainly affect internal functioning and delivery and are managed at the appropriate level within the organisation.

Strategic risks are removed from the BAF and managed through the operational risk register once the target score falls below 15 and Board approval is given. Responsibility for reviewing and updating the risk and providing assurance to the Board on the controls and mitigations in place is retained by the relevant Executive Director. The BAF is also presented in full to the Audit Committee at each meeting once given approval by the Board. The Audit Committee has gained assurance over the processes for identifying, understanding, monitoring and addressing current and future risks and agreed to escalate as an example of good practice to the Board.

All operational risks are categorised in line with the Trust Ambition that they predominantly impact upon. As operational risks are aligned to the strategic ambitions rather than strategic aims, any operational risks associated with the strategic aims are realigned to a strategic ambition as appropriate. Any higher scoring operational 15+ risks are also presented to Committees of the Board to which the strategic ambitions are aligned.

Over the last 12 months, work has continued to review and cleanse the operational risk register and strengthen the Accountability Framework and risk KPI's continue to show improvements. This focus on risk maturity, despite the pressures of Covid-19 has seen a reduction in risks overall from 503 in April 2021 to 482 in March 2022. This has been achieved through continued embeddedness of risk management within the Trust by various means, including:

- Streamlining/amalgamation of similar risks within Divisional operational risk registers
- Focus on long-standing risks amongst Divisional operational risk registers
- Robust action plans which support the mitigation of risks across the Trust
- Deep dive review of operational risks leading to updated controls, assurances and risks being identified as being sufficiently controlled in line with the Trust Risk Appetite Statement.

Over the last 12 months the proportion of high risks on the operational risk register has increased from 75 in April 2021 to 93 in March 2022 and is reflective of pressures experienced from the Covid-19 pandemic and adjusting to living with Covid. High risk themes in March 2022 which were less prevalent in April 2021 include:

- Physical environment/estate being suboptimal
- Use of escalation areas
- Mental health care provision
- Suboptimal staffing
- Suboptimal capacity to meet targets/manage backlog following Covid-19
- Increase demand for high dependency care

There is a continued focus on risk maturity, despite the pressures of Covid-19 this is being achieved through continued embeddedness of risk management within the Trust by various means, including:

- The Risk Management Strategy, which is available to all staff through the Trust's internet and intranet sites.
- Effective use of the strategic risk registers and operational risk registers at both divisional and corporate level and the BAF.
- Integrating the use of the risk appetite and defining the components and nomenclature of the BAF throughout the organisation i.e. Strategic Risk Register + Operational Risk Register = BAF and improve staff understanding of this.
- Compliance with the mechanisms for the reporting of all accidents and incidents using an online incident reporting system.
- Ensuring that there is a robust process in place to escalate all risks, including divisional risks, with a rating of 15+ to the Board via the BAF.
- Redesigning and relaunching the Datix Risk Register module to support improvement programmes.
- Extending the use of dashboards to include themes, risk appetite, heat-maps, trajectory of risk and qualitative narrative on actions and mitigations.
- Implementation of governance dashboards for each division, monitored as part of the accountability framework in divisional improvement forums with specific risk key.
- Strengthening of divisional accountability and holding to account processes through Divisional Boards and the Accountability Framework through challenging performance of risk at Clinical Business Unit and Speciality Business Unit level.
- Enhancing training and support at all levels of the organisation in line with the National Patient Safety Strategy
- Engaging with the Board of Directors using risk information to drive the Board workshop agenda.
- Enhancing lessons learned from risk management integrated into the learning to improve bulletins.
- The Executive Management Group as a forum to discuss risk and share learning from the management of risks cross divisionally with the Executive Team. This is achieved through presentation of a high risks report which contains key performance indicators each month alongside divisional and corporate risk registers on a cyclical basis.

- Actively monitoring all serious incidents at the Safety and Quality Committee on a quarterly basis and the Board annually.
- Using outcomes from complaints, incidents, claims, STAR visits and internal and external reviews, to mitigate future risks and aggregating these to identify Trust-wide risks.
- Connecting performance across the Trust at Board, Committee, Divisional and Speciality level using integrated performance reports which provides Ward to Board reporting that includes a range of metrics encompassing each of the elements of Our Big Plan by strategic ambition and includes quality, operations, finance and workforce.
- Creating an open and accountable reporting culture whereby staff are encouraged to identify and report risk issues.
- Report cover sheets linked to the Trust strategic aims and ambitions.
- Information within specific reports are categorised by and presented by strategic ambitions – for example, Chief Executive's report and integrated performance report.
- Risks within Committee papers are connected to strategic risks within the BAF.
- 'Freedom to Speak Up' team in place and 'Valuing Your Voice' designated inbox for staff to raise concerns, both of which are promoted within the Trust and triangulated with other processes for management, improvement and shared learning.
- Use of a quality impact assessment policy which links to the planning framework and outlines the requirements of divisional management and Board members in assessing and monitoring the impact of service changes with a quarterly report presented to the Safety and Quality Committee.
- Quality impact assessment policy outlines requirements of Board members in describing service.

Principal risks

The most significant risks that threaten the achievement of the Trust's aims and ambitions are identified within the BAF, alongside controls and assurances which describe how the Trust manages and mitigates these risks. These are robustly monitored by the Board and Committees of the Board to ensure achievement of the Trust's strategic objectives.

During 2021–22, the principal risks related to:

- **The inability to consistently deliver excellent care**, provide a positive patient experience and demonstrate sufficient responsiveness in the organisation's recovery and restoration plans due to a shortage of suitably trained staff and high occupancy levels further impacted by Covid-19 and the requirement to configure services differently to accommodate infection status.

  To mitigate this, the Trust continues to execute novel and targeted recruitment and retention campaigns, expand and develop relationships with community leaders and partners with increased focus on reducing health inequalities, reduce inefficiencies in internal processes and strengthen system wide partnerships to enhance the flow of patients in and out of the hospital. During 2021–22, the Trust continued to respond to the pandemic in undertaking recovery and restoration plans by using the established control structure and by continuing to incorporate lessons learned and innovative solutions from the pandemic response. The Trust has also increased the bed base to respond to extended lengths of stay within the Emergency Department as a result of continued increases in patients no longer meeting the criteria to reside.
- **The inability to deliver value for money** due to the ageing hospital estate and workforce challenges associated with multi-site clinical delivery. An ongoing reliance on temporary workforce continues to materially impact the financial pressures. System-wide solutions are being sought to adopt optimum service configurations and improve operational efficiencies, including the New Hospitals Programme. This will support effective financial management by delivery of planned efficiencies that enables provision of sustainable services by ensuring the Trust's estate, infrastructure and plans are all focused on the long term, supported by effective business and clinical systems. The Trust is working to deliver its plans for the second half of 2021–22 noting that delivery of these plans continues to have material risks which in the main relate to external factors.

- **The inability to be a great place to work** due to the increasing psychological impact of the Covid-19 pandemic on staff resilience, coupled with local and national workforce shortages and an ageing estate. To ensure effective and sustainable solutions are implemented, the Trust has increased the provision of psychological support for staff, identified innovative ways of engaging with staff and enhanced its focus on equality, diversity and inclusion. Over the next four years, the Trust will be participating in the Magnet4Europe research study which has a specific aim to improve the mental health and wellbeing of staff and reduce staff burnout.
- **The inability to be fit for the future including sustained delivery of specialist services** due to the ability to develop and implement key change programmes within required timescales. To mitigate this, we continue to successfully drive change through the Trust's Our Big Plan Strategy, Governance and Risk Maturity Programme, Continuous Improvement Strategy, the Clinical Strategy and a number of other key programmes of work, including research. Over the next 12 months, the Trust will continue to enact the new ways of working as a result of the Covid-19 pandemic and maintain and enhance relationships it has developed with system partners.
- **The inability to drive innovation through world class education, training and research**. The impact of the pandemic on social distancing and recruitment continues to impact the Trust's education, training and research functions, although travel and Covid-19 restrictions are starting to reduce. However, to continue to mitigate the impact the Trust continues to operate through the use of virtual, original and hi-tech solutions as part of the Trust's ambition to develop our reputation as a provider of choice, sustain our position in the market, support business growth and our status as a teaching hospital.

All the principal risks listed are reported to the Trust Board and appropriate Committees of the Board for reviewing, monitoring and reporting the effectiveness of controls and mitigation plans identified to achieve the risk target as determined by the risk appetite approved by the Trust Board.

Internal and External Assurance

The Board receives independent assurance that the Trust's Risk Management System is in a place that meets the requirements of Risk Management Standards through the process of internal and external audit, including the CQC inspections, Royal College Reviews, national audits and national staff surveys.

Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust was last subject to a full inspection between 2 July and 8 August 2019. Services that were inspected were Urgent and Emergency Services and Medical Care at Royal Preston Hospital and Chorley and South Ribble Hospital and Surgery and Critical Care at Royal Preston Hospital only. Overall, we retained a rating of 'Requires Improvement', with 'Good' for caring and a new 'Good' for well led.

The Foundation Trust is fully compliant with the registration requirements of the CQC.

Declarations of Interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff, as defined by the Trust's Policy TP-200 Code of Conduct, within the past twelve months and as required by the 'Managing Conflicts of Interest in the NHS' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and Diversity Legislation

Control measures are in place to ensure that all the organisation's obligations under equality and diversity legislation are complied with and as a requirement for NHS healthcare providers through the NHS Standard Contract the Trust completes and publishes compliance against the Workforce Race Equality Standard process and the Workforce Disability Equality Standard.

Safety Triangulation Accreditation System

The Trust ensures assurance of delivery of CQC standards and recommendations through the Trust's Safety Triangulation Accreditation System (STAR) which provides evidence of the standard of care delivery, including what works well and where further improvements are required through:

- **STAR Monthly reviews** – 17 audit questions are undertaken by the Matron or Professional Lead for each area.
- **STAR Accreditation Visits** – an in-depth CQC-style audit is undertaken by the Quality Assurance Team with support from staff, governors and volunteers from across the Trust.

New Hospitals Programme

The Trust will transform its ageing infrastructure through the Government's flagship New Hospitals Programme and has agreed to work collaboratively with University Hospitals of Morecambe Bay NHS Foundation Trust to maximise seed funding and healthcare opportunities to develop infrastructure plans which will range in scale across the region. The transformation will provide residents and other service users with access to up-to-date facilities. Currently a number of options appraisals are being consulted on and the New Hospitals Programme Lead provides regular updates to Committees and the Board of Directors.

Well Led Review

Currently the CQC has rated the Trust as Good for Well Led and a review by MIAA last year also concluded that the Trust is Well Led. The Trust, as a whole, reviews its own leadership and governance arrangements periodically, in line with the requirements of NHSI that providers carry out developmental reviews.

Effectiveness of Governance and Risk Maturity

The effectiveness of the Trust's governance structures continued to be internally tested during 2021–22 via the Annual Internal Audit Programme.

Following a review of the Trust's divisional governance arrangements by the Quality Governance Lead from the Nursing Directorate at NHSE/I that identified the Trust as an exemplar organisation, the Trust continues to work with organisations that have been signposted by NHSE/I as requiring additional governance support.

In January 2022 MIAA concluded a review of the NHS England Serious Incident Framework with the overall objective to identify and evaluate the controls in place to ensure that the Trust is compliant with regard to reporting and investigating serious incidents, and there are appropriate mechanisms for learning in order to reduce the risk of reoccurrence. The review provided 'Substantial Assurance' that there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently. However, for one objective for timeliness of StEIS initial and 72-hour reporting the review provided 'Limited Assurance'. An action plan has been developed and reported to Audit Committee advising that of the eight recommendations made seven have been delivered and one recommendation is on track for delivery by the agreed timescales.

Clinical Audit

With respect to clinical audit, the Trust has an annual clinical audit and effectiveness plan for the year 2021–22 which incorporates national audits, corporate audits, audits associated with Trust-wide priorities, audit of national guidelines as well as other audits commissioned specifically in response to areas of identified risk and concern. The Audit Committee and the Safety and Quality Committee both receive audit and effectiveness reports to provide assurance that the Trust has effective controls in place and is responsive to areas of concern, which may have been highlighted through the audit process, as well as audit outcomes which demonstrates best practice.

Head of Internal Audit Opinion 2021–22

The overall opinion for the period 1 April 2021 to 31 March 2022 provides Substantial Assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Safety and Quality

The Trust has in place a range of mechanisms for managing and monitoring risks in respect of safety and quality including:

- A Patient Experience and Involvement Strategy 2018–2021. This will be refreshed in 2022.
- A Safety and Quality Committee which meets monthly and is chaired by a Non-Executive Director.
- Publication of an Annual Quality Account as a separate document to the Annual Report.
- The integrated performance report (IPR) includes a quality report, which highlights progress against the key quality objectives in year, submitted monthly to the Trust Board.
- Arrangements and monitoring processes to ensure ongoing compliance with NICE guidance and service accreditation standards.
- The Medical Director is the Trust Lead for mortality and reports regularly to the Safety and Quality Committee in respect of mortality.
- STAR Quality Assurance Framework is transacted in all clinical departments.
- A Board Safety and Experience Programme is in place to maintain Board visibility and contact with staff delivering services. These have been conducted virtually during the pandemic.
- A safe staffing dashboard is in place to monitor nurse staffing levels across all wards and departments and a monthly staffing report is presented to the Safety and Quality Committee through the mandated safe staffing report. This is triangulated with measures of harm (for example hospital acquired infections) and patient experience (friends and family test) for maternity services, children and neonatal services and adult inpatients including the Emergency Department.
- The Trust routinely considers and acts upon the recommendations of national quality benchmarking exercises, e.g. national patient surveys and other national publications e.g. the Ockenden Report.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient and Public Involvement representatives, such as HealthWatch and Trust governors.
- Patient and staff stories are presented to the Trust Board and actions and lessons learned are widely shared.
- Any whistleblowing concerns raised to the CQC are presented to the Safety and Quality Committee for further consideration and challenge.
- A robust process for the management of all patient safety and medical device alerts, field safety notices, estates and facilities alerts, service disruption alerts and all alerts that arise as a result of actions identified by NHSI or other national bodies are acted upon.
- Where appropriate, risk alerts are made to partner organisations in line with statutory responsibilities, such as for safeguarding purposes.
- Operational and quality breaches are discussed at the relevant operational and governance forums and CCG meetings with remedial action plans enacted.

Capacity and Flow Waiting

The NHS continues to be faced with unprecedented times in 2021–22 and like all other NHS Trusts across the country Lancashire Teaching Hospitals continues to be challenged by the Covid-19 pandemic. As a result, performance across the board, both emergency and elective, remains impacted with operational pressures experienced through the year resulting in non-compliance in relation to a number of key standards.

A whole health economy system pressure in response to Covid-19 demand resulted in high bed occupancy throughout the year and then additional pressures with the requirement to transition to restoration of services. A health economy system-wide action plan remains in place to address the urgent care system and pressures; with identified primary and social care initiatives/schemes delivering a level of sustainability across the health economy.

During 2021–22 as the impact of the Covid-19 pandemic continues to be felt the Trust has a range of measures in place including:

- Additional medicine bed capacity to meet increases in demand
- Re-zoning of our estate to meet infection, prevention and control requirements
- Same Day Emergency Care
- Integrated frailty model and a dedicated rehabilitation ward
- Additional Critical Care Unit surge beds with additional staffing through redeployment
- Implemented digital health to reduce inappropriate admissions to hospital
- Use of continuous improvement methodology to make improvements in discharge including delayed transfers of care and reducing length of stay

Alongside internal work, the Trust continues to undertake collaborative work with other partners in the local health economy through:

- A health economy-wide action plan to address the urgent care system and pressures; with identified primary and social care initiatives/schemes expected to deliver a level of sustainability across the health economy.
- A range of continuous improvement and transformational work streams of which patient flow has a significant work plan attached.
- The Flow Coaching Academy which applies team coaching skills and improvement science at care pathway level to improve patient flow and experience through the healthcare system.

We recognise that the longevity of system resilience is dependent on all stakeholders across our local health economy and we anticipate that there will be continued operational and subsequent compliance issues against key access targets during 2022–23 with the development of the Trust's new Planning Framework that identifies areas of improvement and their level of contribution to safety, quality, patient and staff experience and financial improvements.

Financial Sustainability

During the 2021–22 financial year the Trust's underlying financial deficit position has been temporarily addressed by the arrangements put in place by the Department of Health and Social Care to support the NHS to deal with the pandemic. This has resulted in the Trust delivering a small surplus in the financial year. Ongoing changes to the financial regime for Trusts with the shift away from activity-based payment to block income contracts have also helped give greater certainty over income levels. However existing expenditure trends continue in that usage of agency staff at premium rates, and significant operational pressures remain in place. This means that the Trust expects to revert to an overspending position at some point in the future and is planning its budgets for 2022–23 and beyond to include the assumption that significant financial improvement is required to deliver break even.

The pandemic and associated operational pressures in 2021–22 have meant that savings have been delivered but largely on a non-recurrent basis, and the Trust has received significant additional income to support the pandemic response.

At the end of 2021–22 there remained two outstanding areas in relation to our existing enforcement undertakings to the regulator:

(i). Long term sustainability: With respect to the Trust's long-term sustainability, both clinically and financially, we recognise that sustainable financial balance needs to come through engagement with the wider health economy; this requires not only the Trust to achieve service efficiencies but to maximise the use of its sites and support the wider transformational change in service delivery. The Trust is an activity participant in the ICS delivery boards which aim to implement robust pathways of care. We are also working within the ICS on specific projects to maximise efficiency opportunities. These arrangements will transition to the ICB from 1 July 2022. We along with our local and system partners are together seeking sustainable solutions through the New Hospitals Programme we are working towards producing a range of options for the future provision of services. We will then complete a pre-consultation business case containing evidence of the work undertaken through the solution design process, following which a formal public consultation will be required.

(ii). Funding conditions and spending approvals: With respect to this undertaking the Trust will endeavour to adhere to the terms and conditions relating to financing that is provided, will comply with reporting requests that are made by NHS England and NHS Improvement, and will comply with any spending approvals processes that are deemed necessary by NHS England and NHS Improvement.

Review of economy, efficiency and effectiveness of the use of resources

We have continued to develop our systems and processes to help us deliver an improvement in the financial performance, including:

- Trust-wide commitment to the adoption of a Continuous Improvement approach, which has involved undertaking extensive staff engagement to identify priorities for improvement and is informing the development of a system wide Continuous Improvement Strategy for the whole health economy;
- approval of the annual budget by the Board;
- monthly Finance and Performance Committee meetings to ensure Directors meet their respective financial targets reporting to the Board;
- monthly Divisional Improvement Forums attended by members of the Executive Team to ensure that Divisions meet the required level of performance for key areas;
- continued grip and control activities for both requisitions and filling of vacancies by the Vacancy Control Panel, by ensuring established vacancy prior to recruitment and review of budgets before approval to recruit, improvements have been made to the business planning processes with a clearer separation of business cases with a return on investment and net funding which might be required for a development or safety and quality issue;
- we have further strengthened the budget setting processes to give greater visibility to not only agreeing a budget but also to agreeing a funded establishment. We have had our nursing controls and establishment reviewed by NHS England and NHS Improvement which gave a positive assurance on our approach;
- the Divisions continue to play an active part in ongoing review of financial performance including cost improvement requirements;
- monthly reporting to the Board of Directors on key performance indicators covering finance and activity; quality and safety; and workforce targets through the Integrated Performance Report; and
- the Trust continues to have in place a Quality Impact Assessment and robust governance systems that require clinical approval of all cost improvement programme schemes that have a clinical impact.

Going concern

Guidance from the Department of Health and Social care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. There are no such conversations regarding this Trust and as such it is regarded as a going concern.

Greener NHS programme

The Trust published its Green Plan in January 2022 where it has confirmed its commitment to working towards the 'Delivering a Net Zero Health Service' standards for the Greener NHS programme.

The ICS Governance and a Trust Clinical Strategy

In support of the draft strategy 'Our Integrated Care System Strategy' published by the ICS, the Trust is supporting clear governance arrangements for the planning and delivery of the Trust's Clinical Strategy. This in turn enhances the requirements for the CQC's assessment on Use of Resources as it acts as an enabler for best use of public sector investment to be considered on a population health outcomes basis incorporating the wider determinants of health with the Trust recognised by the ICP and System Delivery Boards as an anchor institution. The Trust is committed to the development of ICS arrangements as it seeks to deliver improved health and wellbeing of local communities, joined-up care closer to home and safe and sustainable, high-quality services and reduce inequalities. However, the Trust is cognisant of the challenges associated with any proposed reconfiguration and the interdependences and risks which may impact on the Trust as a result of decisions outside the Trust's control being made at an ICS level.

Workforce

To ensure that short, medium and long-term workforce strategies and staffing systems are in place, the Trust has an annual workforce plan in place aligned to the Operational Planning cycle and with a focus on resourcing strategies to fill our long term, or hard to fill, workforce gaps.

This is reviewed and approved by the Workforce Committee and commended to Board. The workforce plan has taken into account changes to services, investment and cost improvement plans, recruitment issues, turnover, and predictive workforce supply. It also considers external factors that may influence services including commissioning strategies, local demographics, service transformations, service sustainability, nursing acuity reviews and local workforce challenges such as gaps in establishment, retention issues, roles which are difficult to fill, new roles, training opportunities and apprenticeships.

To balance workforce supply and demand, workforce plans and regular skills gap analysis have taken place to inform localised or profession-specific recruitment and retention plans, these plans detail the programme of activity to reduce gaps through proactive campaigns.

Actions have also been identified to look at opportunities to work across the ICS to support workforce supply. The plan continues to provide details of our recovery programme in relation to workforce including strategies to look after our people and help them recover, new ways of working and delivering care, growth for the future and any continued Covid-19 workforce resource planning.

Monthly recruitment trajectories are produced to monitor and review progress against the plan for hard to fill roles. These include medical, nursing and more lately health care support worker roles. Regular updates are provided to the Trust's Workforce Committee in relation to recruitment. A significant recruitment strategy for the future is a focus on international recruitment for registered nurses.

Succession plans are in place at Trust and divisional level to ensure a continual supply of staff with the skills to be effective in business-critical roles in the future.

Developing workforce safeguards reports are presented to the Safety and Quality Committee.

Since the start of the pandemic, staffing levels have been closely monitored to ensure safe staffing levels could be maintained and this was overseen by the Strategic Operations Group, weekly Nurse, Midwifery and AHP Operational Groups and daily safe staffing review meetings.

Patient and Public Involvement in managing risk

The Trust works with a multitude of partners including NHSE, CCGs, local Councils (including social care and education), Police, Prisons and the voluntary sector, together with the Trust's regulators. The Executive Team and senior managers work closely with the partners, to provide a local integrated service to our public and stakeholders.

The key ways in which public stakeholders are involved in managing risks which impact on them include:

- the Council of Governors at quarterly meetings take the opportunity to hold the Non-Executive Director members of the Board to account on its performance, including quality and risk;
- the Trust's commitment to the commissioners, Chief Officer and Chief Executive meetings and consultation as required with the Overview and Scrutiny Committees and Healthwatch;
- consultation for the Quality Account involves key stakeholders;
- consultation with key stakeholders regarding key change programmes, service development and capital schemes – including the OHOC programme; and
- Executive Team, senior management and clinician involvement in the ICS and associated meetings.

In addition, the Trust is involved in a range of multi-agency arrangements which assist with the management of risks across wider health and social care systems. As a member of the Lancashire and South Cumbria ICS, the Trust works with representatives from NHS providers in Lancashire with local GPs, social care colleagues and representatives of the voluntary sector for the integration of health and social care.

Data Quality and Information governance

It is recognised that good quality information is vital to enable individual staff and the organisation to evidence they are delivering high quality care.

Information Governance

The confidentiality and security of information regarding patients, staff and the Trust are maintained through governance and control policies, all of which support current legislation and are reviewed on a regular basis. Personal information is, increasingly, held electronically within secure IT systems. It is inevitable that in a complex NHS organisation a small number of data security incidents occur. The Trust is diligent in its reporting and investigation of such incidents, in line with statutory, regulatory and best practice obligations. Any incident involving a breach of personal data is handled under the Trust's risk and control framework, graded and the more serious incidents are reported to the Department of Health and the Information Commissioner's Office (ICO) where appropriate.

The Trust experienced four externally reportable serious incidents in the 2021–22 period, only one of which reached the reporting criteria sent to the ICO. This incident was in relation to an allegation for unauthorised access and full internal onward processes followed. All four incidents were reported using the Data Protection and Security Toolkit.

As part of our annual assessment, the Data Security and Protection Toolkit (DSPT) is reviewed annually and updated to ensure Trust standards are aligned with current best practice. The status for the 2021–22 DSPT is 'standards met'.

The Trust has established a dedicated information risk framework with Information Asset Owners throughout the organisation which is embedded with responsibilities in ensuring information assets are handled and managed appropriately. There are robust and effective systems, procedures and practices to identify, manage and control information risks. Alongside training and awareness, incident management is part of the risk management framework and is a mechanism for the immediate reporting and investigation of actual or suspected information security breaches and potential vulnerabilities or weaknesses within the organisation. This will ensure compliance in line with the General Data Protection Regulations (GDPR) and Data Protection legislation.

Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance/Records Committee which is accountable to the Finance and Performance Committee. The Information Governance Committee is chaired by the Medical Director who is also the Caldicott Guardian. The Board appointed Senior Information Risk Owner (SIRO), is the Finance Director.

The Information Governance Management Framework brings together all the statutory requirements, standards and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development of the Information Governance Management Framework is informed by the results from Data Security and Protection Toolkit assessment and by participation in the Information Governance Assurance Framework.

Annual Quality Account

In line with the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 prior to the pandemic there was a requirement to prepare quality accounts for each financial year. However, during the year 2020–21 NHSI issued guidance that NHS Foundation Trust Boards were not required to produce a Quality Account due to the impact of the pandemic. The Trust made the decision to continue with business as usual and a Quality Account for 2020–21 was produced.

NHSE/I has updated the guidance for 2021–22 and confirmed that NHS Foundation Trusts are no longer required to produce a Quality Report as part of their Annual Report. This is confirmed in the FT Annual Reporting Manual for 2021–22. NHS Foundation Trusts will continue to produce a separate Quality Account for 2021–22. There is no national requirement for NHS Trusts or NHS Foundation Trusts to obtain external auditor assurance on the Quality Account with approval from within the Trust's own governance procedures being sufficient.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, I have detailed some examples of the work undertaken and the role of the Board, the Audit Committee, the BAF, internal audit and external audit in this process:

- The Head of Internal Audit, which provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. The Head of Internal Audit Opinion for 2021–22 is that Substantial Assurance can be given that there is an adequate system of internal control. Despite Substantial Assurance that there is an adequate system of internal control, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.
- The Assurance Framework and the monthly performance reports, which provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.
- The internal audit plan, which is risk-based, and reported to the Audit Committee at the beginning of every year. Progress reports are then presented to the Audit Committee on a regular basis, with the facility to highlight any major issues. The Chair of the Audit Committee can, in turn, raise any areas of concern at the Board, plus the minutes of the Audit Committee and a Committee Chair's report are considered at Board meetings.
- Internal audit's review on the Assurance Framework and the effectiveness of the system of internal control as part of the annual internal audit plan to assist in the review of effectiveness, which concluded the Trust's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board.

- The Board undertakes bi-monthly reviews of the Assurance Framework and the Committees of the Board at each meeting undertake detailed scrutiny of assurance received or gaps identified in relation to risks assigned to that particular Committee.
- The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.
- The Executive Directors and senior managers meet on a weekly basis and have a process whereby key issues such as performance management, action plans arising from external reviews and risk management are considered both on a planned timetable and an ad-hoc basis if there is a need.
- All relevant Committees have a clear timetable of meetings, cycles of business and a clear reporting structure to allow issues to be raised.
- The findings of the MIAA Well Led review noted governance structures were working effectively.

All of the above measures serve to provide ongoing assurance to me, the Executive Team and the Trust Board of the effectiveness of the system of internal control.

Conclusion

In conclusion, my review confirms that Lancashire Teaching Hospitals NHS Foundation Trust has an adequate system of internal control and that there have been no significant control issues in the Trust in 2021–22. Where control issues have been identified, action has been taken or action/improvement plans are in place to address such issues.

The Trust Board recognises the challenges that the Trust faces to make the necessary service improvements and achieve financial sustainability, which will require solutions across the health system. The Trust will work collaboratively towards making these improvements during 2022–23, whilst responding to the consequences and additional pressures arising from Covid-19. Where appropriate these action/improvement plans will be tested via relevant external scrutiny and review processes. The challenges the Board has focused on to deliver the Trust's aims and ambitions are robustly articulated in the strategic risk register that underpins the BAF in line with the Risk Management Strategy.

This Annual Governance Statement is signed on behalf of the Board of Directors by:

Kevin McGee OBE
Chief Executive
28 June 2022

COUNCIL OF GOVERNORS' REPORT

Our Council of Governors comprises elected and appointed governors who represent the interests of the members and the wider public. They also have an important role in holding the Board to account through the Non-Executive Directors.

The Council of Governors has an essential function in influencing how we develop our services to meet the needs of patients, members and the wider community in the best way possible.

At the end of 2021–22, the Council comprised 31 governor seats, of which: 18 are elected governors who represent the public constituency; four are elected governors who represent the staff constituencies; five are appointed by our partnership organisations (our five partner organisations being Older Adults (third sector), Preston and Western Lancashire Racial Equality and Diversity Council, the Trust's Volunteers, the Universities including University of Central Lancashire, Lancaster University and University of Manchester, and the Trust's Youth Forum); and four are appointed by local authorities (being Lancashire County Council, Preston City Council, Chorley Council and South Ribble Borough Council).

The Chairman also chairs the Council of Governors and the Chief Executive usually attends formal meetings. Other Directors and senior managers attend some meetings, depending on the issues under discussion. Many governors also commit a significant amount of time outside of formal meetings to be involved in subgroups and in other ways to fulfil their role of representing the views of their constituents.

Elections

The governors election process takes place between January and March each year, and governors generally serve a three-year term of office, beginning in April. At the end of March 2022, the terms of office of seven public governors and the volunteer governor came to an end. 866 votes were cast in the public election: this represents a turnout of 8.8%. As the Trust's Constitution is currently undergoing a detailed review it was agreed to leave the volunteer governor seat vacant until this work had been completed.

Ahead of this year's election process, we carried out various governor recruitment activities to promote the role of the governor, such as: issuing dedicated pre-election mailing to all members; advertising governor vacancies within our latest edition of Trust Matters and advertising on media screens on both hospital sites; held a virtual pre-election workshop to encourage members to stand for election; and used social media to highlight the election opportunities.

Committees and working groups

The Council of Governors has one formal Committee, the Nominations Committee, and more detail on the work of the Committee is provided within the remuneration report on pages 56 and 57. There are two core governor working subgroups in place to consider specific issues in more detail than is possible at formal Council meetings. The subgroups focus on care and safety, and our membership. Both the subgroups have clear terms of reference and report their activities to formal Council of Governors' meetings. Each subgroup also has a Non-Executive Director in attendance. Each subgroup also has a Non-Executive Director in attendance.

Understanding the views of Governors and Members

Directors develop an understanding of the views of governors and members about the organisation through attendance at the Annual Members' Meeting, Council of Governors' meetings and workshops, linkages with the Council subgroups and an annual interactive forward planning session with the Board each year. The impact of the pandemic has meant physical attendance at members' events and meetings during 2021–22 was in the main not possible. As much activity as possible continued through the use of digital technology to meer the requirement for safe working conditions.

A successful virtual Annual Members' Meeting was held virtually for the second year on 29 September 2021 with good attendance from staff, Trust members and the general public. As part of the meeting there was an insightful and well-planned presentation delivered by Dr Sathiya Kandasamy and members of the paediatric directorate team regarding children's respiratory diseases. The meeting contained general and financial highlights from 2021–22 and the Executive team took part in a questions and answers session with responses not covered during the session being posted on the Trust's website following the meeting.

During the year we continued to focus on improving the relationship between the Board and governors through a number of ways, including the following:

(i). we encourage governor attendance at Board meetings (in the capacity of observer) and governor attendance is recorded within the Board minutes. Attendance has increased during the past two years through the benefit of attending Board meetings virtually;

(ii). there is Non-Executive Director representation at each of our core governor subgroup meetings;

(iii). Board members are invited to every Council of Governors' meeting and Non-Executive Directors in particular are invited to comment on the Trust's performance. Non-Executive Directors also deliver presentations to the Council on a cyclical basis outlining their involvement and providing insight into their roles and responsibilities of the Committees of the Board. Governors have the opportunity to ask them questions and seek assurances that Non-Executive Directors are holding the Executive team to account.

(iv). as part of the Trust's forward planning process, the Board and the Council of Governors have a joint interactive workshop every September where Board members and governors review the Trust's priorities for the year ahead and governors provide feedback from members and the wider public on such priorities;

(v). joint visits and events were again held virtually, such as Fab Feedback Fridays and STAR accreditation awards. These virtual visits allowed departments and teams to showcase their achievements and highlight issues which are important to them that may need support from the Board and/or governors to resolve.

Board and Council engagement

As the Chairman chairs both the Board of Directors and the Council of Governors, he is an important link between the two bodies. As mentioned earlier, to strengthen communication and engagement further there is Non-Executive Director representation on each of the core governor subgroups. This is particularly helpful in understanding relevant issues and promoting ways in which services and facilities can be developed to meet the needs of patients, staff and the wider community, which is integral to the forward planning process. There are a range of other ways in which the two bodies work together, including joint Board and Council development sessions and written communications.

To help governors fulfil their important role of holding the Board to account, governors receive updates on progress against Our Big Plan at their quarterly Council of Governors' meetings. We have also encouraged governors' attendance at Board meetings as a way in which Governors can view Non-Executive Directors providing challenge and scrutiny to the Executive Team: this has worked well and attendance has increased using digital technology. Non-Executive Directors also routinely attend Council of Governors' meetings which provides governors with the opportunity to report their activities to Non-Executive Directors and to raise questions. Regular briefings are also provided to governors on topical issues. In line with good practice, we also have a policy on engagement between the Board and Council, which was reviewed and refreshed during 2021–22. We have an established lead governor role and during 2021–22 this was held by public governor, Steve Heywood.

The importance of joint working between the Board and the Council is acknowledged by the members of both bodies, who are committed to building on the progress that they have made in this area. The benefits of sharing good practice across NHS organisations is recognised and governors benefit from networks with colleagues in other Foundation Trusts in the North West as well as involvement in events arranged by organisations such as NHS Providers and MIAA. This interaction has been impacted by the Covid-19 pandemic although opportunities have been provided more recently for engagement using digital technology.

Declaration of interests

All governors have a responsibility to declare relevant interests as defined in our Constitution. These declarations are made to the Company Secretary and are subsequently reported to the Council and entered into a register. The register is published on our website or is available on request from the Company Secretary.

Attendance summary

There were four formal Council meetings during 2021–22, which were quarterly meetings scheduled for April, July and October 2021 and January 2022.

The table below shows governors' attendance at Council meetings:

Name of governor	Term of office	Type of governor	A	B	Percentage of meetings attended (%)
Keith Ackers	01/04/20 – 31/03/23	Public	4	3	75%
Will Adams	01/04/21 – 31/03/24	Appointed	3	2	67%
Pav Akhtar	01/04/18 – 31/03/24	Public	4	4	100%
Takhsin Akhtar	01/04/19 – 31/03/22	Public	4	4	100%
Rebecca Allcock	01/04/17 – 31/03/23	Staff: other healthcare professionals and healthcare scientists	4	3	75%
Peter Askew	01/04/19 – 31/03/22	Public	4	3	75%
Sean Barnes*	01/04/21 – 31/03/24	Public	4	1	25%
Alistair Bradley	18/05/19 – 31/05/22	Appointed	4	3	75%
Paul Brooks	01/04/20 – 31/03/23	Public	4	2	50%
Anneen Carlisle	01/04/20 – 31/03/23	Staff: nurses and midwives	4	1	25%
David Cook	01/04/20 – 31/03/23	Public	4	4	100%
Margaret France	01/04/17 – 31/03/23	Public	4	3	75%
Hazel Hammond	01/04/19 – 31/03/22	Public	4	1	25%
Steve Heywood	01/04/16 – 31/03/22	Public	4	4	100%
Trudi Kay	01/04/19 – 31/03/22	Public	4	4	100%
Waqas Khan	01/04/21 – 31/03/24	Staff: doctors and dentists	4	1	25%
Lynne Lynch	31/03/18 – 31/03/24	Public	4	4	100%
Janet Miller	01/04/17 – 31/03/23	Public	4	4	100%
Shirley Murray	08/04/19 – 31/03/22	Appointed: volunteers	4	4	100%
Jacinta Nwachukwu	01/07/20 – 30/11/22	Appointed: Universities	4	0	0%
Janet Oats	01/04/19 – 31/03/22	Public	4	2	50%
Eddie Pope	15/06/18 – 31/07/22	Appointed	4	0	0%
Frank Robinson	01/04/20 – 31/03/23	Public	4	4	100%
Suleman Sarwar	01/04/21 – 31/03/24	Appointed	3	3	100%
Anne Simpson	01/04/20 – 31/03/23	Public	4	3	75%
Michael Simpson	01/04/18 – 31/03/22	Public	4	4	100%
Piotr Spadlo	01/04/21 – 31/03/24	Staff: non-clinical	4	3	75%
David Watson	01/04/20 – 31/03/23	Public	4	4	100%
No governor currently represented for Preston and Western Lancashire Racial Equality Council					
No governor currently represented for the Older Adults (third sector)					
No governor currently represented for the Youth Forum					

*A = maximum number of meetings the governor could have attended during 2021–22 | B = number of meetings the governor actually attended during 2021–22 *Absence due to recognised exceptional circumstances*

Director attendance at Council of Governors' meetings

The following Directors attended Council meetings during 2021–22:

- Ebrahim Adia, Chairman
- Faith Button, Chief Operating Officer
- Victoria Crorken, Non-Executive Director
- Sarah Cullen, Nursing, Midwifery and AHP Director
- Naomi Duggan, Director of Communications and Engagement
- Kevin McGee, Chief Executive
- Paul O'Neill, Non-Executive Director
- Karen Partington, Chief Executive
- Ann Pennell, Non-Executive Director
- Geoff Rossington, Non-Executive Director (until 30 September 2021)
- Gerry Skailes, Medical Director
- Kate Smyth, Non-Executive Director
- Karen Swindley, Workforce and Education Director
- Tim Watkinson, Non-Executive Director
- Jim Whitaker, Non-Executive Director
- Tricia Whiteside, Non-Executive Director

Governor training and development

The importance of providing effective training and development opportunities for our governors is understood and is achieved in a number of ways.

On appointment, governors receive formal induction training to enable them to understand the context in which they are carrying out their role, including information on their statutory duties, as well as practical information such as the various subgroups available to them. The induction covers areas such as the local and national context, the role of regulatory bodies, the Foundation Trust provider licence, as well as practical details such as the calendar of meetings and the ways in which they will be expected to contribute in formal and subgroup meetings. Emphasis is placed on the respective roles of the Board and the Council of Governors. We recognise that induction should not be a 'one-off' session but should be a continuous process, with skills and knowledge being identified and developed at an early stage.

We have a structured Governor Development Programme for governors to enable them to fulfil their statutory role as effectively as possible. A number of governor workshops and development sessions are held each year that form a key part of the governor development process, the topics of which are largely governor-led. The opportunity is also taken at workshops for updates on operational performance, communications with the regulator and topical issues affecting the Trust.

During 2021–22, our governors have participated in a number of workshops which included the following topics:

- A joint development session with the Board to discuss the draft Case for Change for the New Hospitals Programme. The session was led by the New Hospitals Programme Director supported by the Trust's Finance Director/Deputy Chief Executive
- A focused discussion facilitated by the Director of Communications and Engagement on the draft Communications and Engagement Strategy for the New Hospitals Programme
- A facilitated session by Hempsons LLP on the Role of the Council of Governors
- A joint development session with the Board involving break-out groups led by Executive Directors with a mix of Board members and governors to discuss learning and the Trust's readiness for a CQC inspection

- A rare opportunity which allowed governors to meet in person at an off-site location facilitated by the Workforce and Education Director, which helped to build relationships amongst governors who had not had the opportunity to meet face-to-face since the onset of the pandemic
- A dedicated session for governors to hear first-hand about system reform, particularly developments relating to system and place-based partnerships and the ongoing evolution of the Lancashire and South Cumbria Provider Collaborative

In previous years governors were encouraged to attend external education and training events although the opportunity to attend such events has been limited during the ongoing pandemic. Events have started to be re-introduced and it is expected as we start to live with Covid-19 then the opportunities for governors to attend topical events will increase to help governors learn from experiences of other organisations, share the information with governor colleagues, and on an individual basis help governors to develop and enable them to work better collectively.

Expenses claimed by Governors

Whilst governors do not receive payment for their work with us, we have a policy of reimbursing any necessary expenditure. During 2021–22 the following expenses were claimed by our governors:

	2020–21	2021–22
Total number of governors in office (as at 31 March)	27	28
Total number claiming expenses:	3	0
Aggregate sum of expenses (£00s):	£1	£0

Contacting your Governors

If you wish to contact a governor then please email: **governor@lthtr.nhs.uk** or alternatively contact the Company Secretary email: **company.secretary@lthtr.nhs.uk.**

MEMBERSHIP REPORT

Membership is free and aims to give local people and staff a greater influence on the provision and development of our services.

Public membership is open to members of the public aged 16 or over who live in our membership area which comprises all of the component electoral wards in the following Local Authority areas:

Blackburn with Darwen	Blackpool	Bolton
Bury	Cheshire East	Cheshire West
Cumbria	Halton	Knowsley
Liverpool	Lancashire	Manchester
Oldham	Rochdale	Salford
Sefton	St Helens	Stockport
Tameside	Trafford	Warrington
Wigan	Wirral	

Eligible staff members automatically become Foundation Trust members unless they choose to opt out. Staff eligible for Foundation Trust membership are those who either:

- hold a permanent contract of employment with us;
- are contracted to work for a period of 12 months or longer or have held a series of temporary contracts adding up to more than 12 months; or
- are employed by the private sector or other partners (for example local Government or other NHS Trusts) and work at the Trust on a permanent basis or fixed-term contract of 12 months or more.

Our membership

Lancashire Teaching Hospitals NHS Foundation Trust has one of the largest membership populations in the North West although this was largely established when Foundation Trust status was gained in 2005. Since then there has been limited recruitment and consequently a slow overall reduction in total membership although this showed an increase in the staff constituency during 2021–22. The table below shows member numbers by constituency including the percentage change compared to the previous year:

Constituency	31 March 2022	31 March 2021	Difference	% Difference
Public	9,767	10,233	- 466	- 4.55%
Staff	9,335	8,357	+ 978	+ 11.70%
Total Membership	19,102	18,590	+ 512	+ 2.75%

During 2021–22 regular data cleansing was carried out to ensure that records continue to be as accurate as possible. This has resulted in a number of members being removed from the database for reasons such as people moving out of the catchment area and also ensuring that deceased members have been removed, minimising potential distress to relatives caused by sending out communications addressed to them.

It has been difficult to hold targeted recruitment activity during the past couple of years due to the pandemic and the impact of social distancing regulations. However, the membership database has continued to be updated with many members confirming their preference for receiving information from the Trust by email. This helps with more effective and efficient engagement with members as well as reducing expenditure on printing and postage costs. We do, however, recognise that not all members will have access to digital technology and we continue to use a mix of digital and postal mediums to communicate and engage with our members.

Our strategy

Our Membership Management and Engagement Strategy 2022–25 received the approval of the Council of Governors on 27 January 2022 and sets out how our membership community will remain involved and also develop. Our vision for the membership is to have an informed, engaged and involved membership which is able to fully represent the needs and experiences of its community by actively participating in influencing and shaping how services are provided.

The strategy will positively impact on the overarching membership objectives to engage members and ensure they are actively involved in planning and delivery of services to represent and reflect the needs of patients and the local community served. The strategy will help to communicate information about developments and ensure the information received is tailored to members' selected level of involvement, setting a clear and measurable direction of travel for the next three years that can improve patient care. The strategy will also enable members to stand for election to the Council of Governors and to elect Governor representatives.

The strategy outlines five objectives that are incorporated into the membership engagement plans; the objectives of the strategy are to:

- Ensure that the membership of the Trust is representative of the diversity of the population it serves, particularly by increasing membership and engagement with young people and those from Black, Asian and minority ethnic groups
- Raise awareness amongst Foundation Trust members of their role and the opportunities available to them as members of the Trust
- Ensure that there is regular and effective engagement between members and governors so that members' views can be represented in shaping the delivery of services and the strategy of the Trust
- Ensure members are kept informed of future plans for the services provided by the Trust and have opportunity to shape those services, particularly through engagement in the New Hospitals Programme
- Improve our membership offer

Review of 2021–22

Many of our traditional opportunities to meet with members and the public face-to-face have been put on hold by Covid-19, for example Health Melas, NHS Health Careers, and individual event days on site at Chorley and/or Preston. However, as the year progressed it was possible to attend some events in public such as the Windrush Festival and Preston Pride. Governors have adapted the way they engage with their constituencies and have introduced events such as the bi-monthly Governor Coffee Catch-up using digital technology. Moving into 2022–23, governors will be supported if opportunities to hold such events in public arise although it is possible attendance will be limited by people's personal concerns about the risks of attending group events.

Trust Matters, our members' magazine, is produced twice a year providing up-to-date information to members regarding the Trust's service developments and delivery against strategic priorities. The magazine also includes a dedicated section in which governors are able to inform members of the various ways in which they represent them and report back to members on how they have helped influence decision-making and service development from their views and feedback.

Through the magazine, we would normally take the opportunity to ask members if they would like governors to visit them in the community. As a consequence of the Covid-19 pandemic, governors have not been permitted to engage with members face-to-face due to national social distancing requirements which has impacted them being able to listen to people's views; provide feedback to the Trust's senior management, recruit new members or raise the governor profile and that of the membership.

The Trust hosted its second virtual Annual Members' Meeting on 29 September 2021. The event provided an opportunity for patients, staff members and the public to find out about what had been happening at Royal Preston Hospital and Chorley and South Ribble Hospital and gave a detailed update on the progress and innovations the Trust had made during the last year. At the meeting, the Trust's Directors shared a review of the organisation's 2020–21 annual report and accounts and an outline of the plans for 2021–22 and beyond. This was followed by an insightful and well-planned presentation delivered by Dr Sathiya Kandasamy and members of the paediatric directorate regarding children's respiratory diseases.

The online meeting was run via Microsoft Teams Live; a link to join the meeting was available to anybody who wanted to join the meeting with a summary of the Trust's performance plans for the year ahead. Bringing the event online allowed the Trust to retain the interactive element during the questions and answers session with the Trust's Executive team which is always a dynamic and informative part of the evening. The virtual Annual Members' Meeting attracted good attendance when compared to previous years as it allowed people to join from their own homes or places of work. Following the live meeting, a link to watch a recording of the event was published on the Trust's website which benefited those unable to join the live presentation as they were able to watch it at their convenience and from their own home or place of work.

In partnership with the Communications and Engagement team, social media has continued to prove a useful tool throughout the year to promote Trust events, elections to the Council of Governors and to provide information to the public and members.

Governors can also ensure that constituents' views are shared with the Board of Directors as part of joint planning work which is carried out each year.

Assessment of the membership and ensuring representativeness

As a Foundation Trust, we are required to have a membership strategy in place, together with a clear work plan for its implementation. The refreshed three-year Membership Management and Engagement Strategy (2022–25) was approved earlier this year by the council of governors and the Trust Board. The strategy will be subject to a short review each year by the Governor Membership Subgroup to test for any significant changes in the Trust or membership which may impact on delivery of the strategy.

Our vision for our membership is to have an informed, engaged and involved membership who are able to fully represent the needs and experiences of our community by actively participating in influencing and shaping how our services are provided both now and in the future.

We aim to have a council of governors elected from and by the membership which is effective in representing the membership and supporting the Board in formulating strategy, shaping culture and ensuring accountability.

It is important that membership of the Trust is recognised as relevant to all sections of the population. We will make every effort to be inclusive in our approach to involvement, by striving to ensure that the membership reflects the social and cultural mix of our population. There are sections of the membership where there continues to be under-representation in young people and ethnic minority groups. During 2022–23, we plan to focus on these areas in order to promote the benefits of membership.

Further details and a copy of our three-year Membership Management and Engagement Strategy can be found on the Trust website.

Members can contact the Corporate Affairs Office via:
Website: https://www.lancsteachinghospitals.nhs.uk/get-involved
Email: **foundation@lthtr.nhs.uk**

Members can contact governors direct via:
Email: **governor@lthtr.nhs.uk**

Also available on our website:

Further information on our membership scheme
Information on our annual members' meetings

AUDIT COMMITTEE REPORT

I am pleased to present the Audit Committee report for 2021–22. The Committee's role is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities.

Introduction

In essence the Audit Committee's remit is to assure the Board that the systems and processes that the Trust relies upon that inform its financial statements, its operational decision making and its compliance with healthcare and governance standards are accurate, robust and can be relied upon. The Committee's work is focused on providing the Trust Board with these assurances, which allow the Board to discharge its own responsibilities with regard to the outputs of our systems and processes with confidence.

Our Committee is made up of four independent Non-Executive Directors. The four members currently are: Ann Pennell, Jim Whitaker, Tricia Whiteside and myself (Tim Watkinson) with each member selected on the basis of their individual skills and attributes. Tricia is an experienced consultant in the financial services sector, with a range of relevant project management and financial knowledge and experience and is also the Chair of the Trust's Finance and Performance Committee. Jim is a Chartered IT Professional with the British Computer Society and his areas of particular expertise are strategic planning, managing change, governance and risk management and he is also the Chair of the Trust's Workforce Committee. Ann has had a long Executive career in local Government including senior roles in children's services, corporate improvement and housing, and has particular expertise in governance, strategic planning and quality and service improvement and she is also the Chair of the Trust's Safety and Quality Committee. My background is as a qualified accountant with over 25 years' experience in senior audit positions in the public sector, including the roles as Group Chief Internal Auditor for the Ministry of Justice and District Auditor for the Audit Commission. I was previously a Chief Internal Auditor in the NHS.

The Audit Committee has met four times between 1 April 2021 and 31 March 2022 and is assisted in its work through the routine attendance at meetings of our internal and external auditors and our counter-fraud specialist. If required, the Committee can also access independent legal or other professional advice to help in its work.

It is the responsibility of the Chief Executive, as the Accountable Officer of the Trust, to establish and maintain processes for governance and he is supported in this by a number of Executive Directors. The regular attendance of the Finance Director, Nursing, Midwifery and AHP Director and the Associate Director of Governance, as a result of their lead roles in matters to be addressed by the Committee, is of further assistance to us.

As last year, the Trust's overriding priority has been responding to the impact of Covid-19, in terms of providing direct care, the impact of the virus on the Trust's services and staffing capability and the delivery of the vaccination programme. The way in which the Trust has delivered its services and its governance arrangements, including the NHS financial control frameworks, have again all been significantly affected by the pandemic.

The Trust has sought to maintain strong oversight and governance during the year with all Board and Council of Governors meetings, and all meetings of Committees of the Board continuing to take place through the medium of Microsoft Teams. The Audit Committee has met (virtually) in accordance with the agreed schedule throughout the year.

Financial Reporting

The Audit Committee has reviewed the 2021–22 annual financial statements and has delegated responsibility from the Board for the approval of these statements.

In discharging its responsibilities, the Committee has particular focused on:

- compliance with financial reporting standards;
- areas requiring significant judgements in applying accounting policies;
- the accounting policies; and
- whether the accounts and annual report are a fair reflection of the Trust's performance.

The Committee considered the financial statements audit risks including the areas where the Trust has applied judgement in the treatment of revenues and costs to ensure that annual accounts represented a true and fair position of the Trust's finances.

The external audit plan for 2021–22 highlighted as significant audit opinion risks:

(i). the valuation of land and buildings,

(ii). fraud risk from expenditure recognition,

(iii). fraud risk from revenue recognition,

(iv). management override of controls,

(v). fraud risk from revenue recognition, and

(vi). IFRS 16 implementation.

The Committee was assured that these identified risks are common across NHS bodies of our size and nature and are included as 'rebuttable presumptions' or in recognition of the inherent risk to an organisation of our size and complexity within the NHS.

During the year the Audit Committee received reports from internal audit on the Trust's financial systems and capital expenditure processes, the discussion about which has given the Committee further assurances on these systems. The overall objective of the internal auditors' work was to provide an opinion on the key controls within the systems for financial reporting, budgetary control, general ledger, treasury management, accounts receivable and accounts payable. For all these reviews the internal auditors have provided either high or substantial assurance.

The Committee routinely reviews management reports on losses and special payments, single tender waivers and off payroll arrangements to consider their appropriateness and correct implementation of management controls. We have continued to express some concern at the value of transactions processed following the application of single tender waivers although improvements have been seen following work undertaken to ensure that the use of this process is minimized. During the year, Internal audit completed an audit assignment on single tender waivers which provided Substantial Assurance that there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

The Committee has considered the appropriateness of the accounts being prepared on a going concern basis and drawn on the views of management and the external auditors to support the conclusion that it is appropriate for the accounts to be prepared on this basis. The Committee has also considered and agreed with the proposal to consolidate the accounts of the Lancashire Hospitals Services (Pharmacy) Limited subsidiary but not to consolidate the accounts for the Trust's Charities, as in previous years.

Overall assurances on integrated governance, risk management and internal control.

With respect to the internal audit reports issued this year, the table below confirms the assurance levels provided and the Committee has reviewed and discussed the work carried out by the internal auditors:

No	Audit	Assurance Level
(i)	Key financial systems (general ledger, budgetary control, accounts payable, accounts receivable, and treasury management)	4 – High 1 – Substantial
(ii)	Vacancy Approval and Control	High
(iii)	Discharge processes including weekends	Substantial
(iv)	Ockenden Review	Substantial
(v)	Serious Incidents (8 elements)	7 – Substantial 1 – Limited
(vi)	Personnel Files (ESR HR / payroll)	Limited
(vii)	Conflicts of Interest	Limited
(viii)	Assurance Framework	No opinion
(ix)	Risk management – divisional risk maturity	Work in progress
(x)	Data Protection and Security Toolkit	Work in progress
(xi)	Data quality framework	Work in progress
(xii)	Waiting list management	Work in progress
(xiii)	Critical applications – FM first	Work in progress

The Committee receives all internal audit reports and pays particular attention to any 'Limited Assurance' or 'No Assurance' internal audit reports. Any significant issues arising out of such reports are escalated by the Committee to the Board. In addition, the Limited Assurance reports have been escalated to responsible Committees of the Board with Executive Leads invited to attend the Audit Committee to provide assurance on the delivery of the audit recommendations. There were no reports during the year providing Moderate or No Assurance.

The internal auditors also completed a review on the assurance framework but provided no overall opinion.

As was the case last year, some of the 2021–22 audit work was impacted by Covid-19 as elements of the audits required management input on a personal level or access to clinical areas which was not possible during the ongoing pandemic restrictions. It is commendable that during the year MIAA managed to complete the agreed programme of work for the year and have been able to provide the Trust with a Head of Audit Opinion supported by sufficient audit work.

The Committee has also ensured that the internal plan has reflected specific heightened risk factors, to include reviews such as vacancy controls, waiting list management and cyber security.

The Director of Internal Audit has provided an overall opinion of Substantial Assurance based on the work of internal audit during 2021–22.

The Committee draws heavily on the conclusions from the work of internal audit but also on the Committee members' own knowledge of the Trust, as members of the Trust Board. It has been another challenging year for the Trust, managing the Covid-19 pandemic, and it is reassuring to receive reports that confirm the general level of basic controls over the financial systems remain robust. The overall source of assurance comes from the work of the Audit Committee, but the other Committees of the Board also have a role in providing assurance to the Board and work collaboratively to provide this assurance with frequent cross-referrals between the Committees of the Board.

In addition, a number of reports on systems and processes reviewed by internal audit received High or Substantial Assurance. However, the Trust has continued to experience some difficulty in meeting its operational targets and the Trust's underlying financial position is unsustainable. The Committee will continue to seek assurance on the steps being taken to ensure improvements can be made in 2022–23 and beyond, recognising that the solutions are dependant on the Trust being able to work collaboratively with partners in the Integrated Care System of Lancashire and South Cumbria.

Compliance

During the year, the newly revised NHS System Oversight Framework was published and NHSE confirmed that the Trust was being placed in segment three. NHSE undertook a review of enforcement actions pertaining to breaches of the Health and Social Care Act 2012, as prevailing undertakings do not reflect the current financial position. A draft set of undertakings (relating to financial planning, and funding conditions and spending approvals) were shared with the Trust in a letter dated 12 November 2021 which were formally accepted by the Trust on 7 December 2021.

Our external auditors

One of the Committee's roles is to provide oversight of the performance of our external auditors. We judge KPMG through the quality of their audit findings, management's response and stakeholder feedback. This qualitative assessment, in conjunction with the use of key performance indicators within the contract for services, allows the Committee to be confident that the Trust is receiving high quality services. No decisions are taken by KPMG over the design of internal controls, and they do not perform the role of management as part of any work they undertake. In addition, after each formal meeting, the Committee holds a private discussion with the internal and external auditors on an alternating basis. This is recognised best practice and allows for a frank exchange of views, without any management presence.

In addition to attending the Audit Committee, KPMG attend and report to the Council of Governors their findings for the year and make themselves available for governor workshops and briefings although during 2021–22 those sessions were again impacted by the Covid-19 pandemic. Our auditors have also provided valuable support to the Trust by sharing their thoughts and guidance from across the sector and from the wider financial regulatory frameworks.

Our internal auditors

The appointment of internal auditors is the responsibility of the Committee and the contract for provision of internal audit and counter-fraud services expired on 31 March 2021. As reported last year, the Committee considered the various procurement options bearing in mind discussions amongst Trusts within the Lancashire and South Cumbria ICS region regarding the possibility of creating a region-wide internal audit service, however, at year end no firm plans had materialised. In order to provide the Trust with continuity of services whilst discussions conclude and allow flexibility to participate in any regional arrangements that may emerge, it was decided to examine the options to put in place a short term contract arrangement with MIAA and the Committee agreed to appoint MIAA as its internal auditors for 12 months with effect from 1 April 2021, with an option to extend the contract for a further 12 months.

It is the role of the Committee to provide oversight of MIAA's performance. Our team at MIAA is led by an Engagement Lead along with a dedicated Audit Manager. The internal audit programme is risk-based and is aligned to our strategic risk assessment. The internal audit plans are developed in compliance with national standards and guidance. In addition, MIAA have made themselves available to the Council of Governors for workshops and briefings although, similar to external audit, those sessions have again been impacted during the year by the Covid-19 pandemic. MIAA have supported the Committee and the Trust by sharing best practice from across the sector and delivering valuable sector-wide training to members of the Committee along with other audit Committee members across the North West.

Counter fraud

We have a policy in respect of countering fraud and corruption which includes contact details of the national helpline and a local independent counter fraud officer. The Trust has an accredited anti-fraud specialist provided by MIAA and they deliver the service in line with NHS Counter Fraud Authority's standards. In 2021–22 the anti-fraud specialist has completed the work programme in accordance with the agreed plan.

Audit Committee attendance summary from 1 April 2021 to 31 March 2022

Name of Committee member	A	B	Percentage of meetings attended (%)
Tim Watkinson (Committee Chair)	4	4	100%
Ann Pennell	4	4	100%
Jim Whitaker	4	4	100%
Tricia Whiteside	4	4	100%

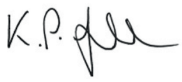
A = maximum number of meetings the member could have attended during 2021–22 | B = actual meetings attended during 2021–22

Audit Committee effectiveness

The Committee undertakes a self-assessment on an annual basis. In April 2021, the Committee undertook a review of its terms of reference, cycle of business and development plan. Committee members participated in a survey of its effectiveness, the results of which were considered by the Committee prior to submission to the Board. The main change during the year was the increase in quoracy to three (previously two) Audit Committee members. I am confident that the Committee has discharged its functions and responsibilities in accordance with its terms of reference, recognising the important role of this Committee to provide assurance to the Board.

Tim Watkinson
Audit Committee Chair
28 June 2022

This Accountability Report is signed on behalf of the Board of Directors by



Kevin McGee OBE
Chief Executive
28 June 2022

Lancashire Teaching Hospitals NHS Foundation Trust

ANNUAL ACCOUNTS

FOR THE YEAR ENDED 31 MARCH 2022

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Lancashire Teaching Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Consolidated Statement of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2022 and of the Group's and Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of, the Group and Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Group's and Trust's business model and analysed how those risks might affect the Group's and Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to meet external expectations.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Group's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards and taking into account possible pressures to meet financial improvement trajectory targets, we perform procedures to address the risk of management override of controls, in particular the risk that Group management may be in a position to make inappropriate accounting entries and the risk of bias in accounting estimates and judgements such as asset valuations and impairments. On this audit we do not believe there is a fraud risk related to revenue recognition due to the temporary NHS funding arrangements that have been in place throughout the financial year and, due to their non-variable nature, we don't believe there to be an incentive to manipulate other operating income streams that are material.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included entries made to unrelated accounts linked to the recognition of expenditure and other unusual journal characteristics.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Evaluating accruals posted as at 31 March 2022 and verifying accruals are appropriate and accurately recorded.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards) and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Group is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Group is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Group is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information.
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion that report has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 87, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Lancashire Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Timothy Cutler
for and on behalf of KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

29 June 2022

Foreword to the accounts

Lancashire Teaching Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2022, have been prepared by Lancashire Teaching Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Kevin McGee OBE**
Job title **Chief Executive**
Date **28 June 2022**

Consolidated Statement of Comprehensive Income

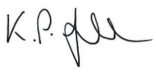
	Note	Group 2021/22 £000	2020/21 £000
Operating income from patient care activities	2	660,105	560,542
Other operating income	2.5	81,199	122,864
Operating expenses	3	(743,461)	(681,537)
Operating (deficit) / surplus from continuing operations		**(2,157)**	**1,869**
Finance income	7	74	63
Finance expenses	8	(226)	(346)
PDC dividends payable		(7,636)	(7,701)
Net finance costs		**(7,788)**	**(7,984)**
Other (losses) / gains	9	(196)	80
Losses arising from transfers by absorption	27	(1,054)	-
Deficit for the year		**(11,195)**	**(6,035)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	4	(9,203)	(4,178)
Revaluations		1,893	398
Total comprehensive expense for the period		**(18,505)**	**(9,815)**
Deficit for the period attributable to:			
Non-controlling interest, and		-	-
Lancashire Teaching Hospitals NHS Foundation Trust		(11,195)	(6,035)
TOTAL		**(11,195)**	**(6,035)**
Total comprehensive income/ (expense) for the period attributable to:			
Lancashire Teaching Hospitals NHS Foundation Trust		(18,505)	(9,815)
TOTAL		**(18,505)**	**(9,815)**

Statements of Financial Position

		Group		Trust	
		31 March 2022	31 March 2021 Restated *	31 March 2022	31 March 2021 Restated *
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	11	7,388	4,415	7,388	4,415
Property, plant and equipment	12	304,394	303,019	304,387	303,019
Receivables	15	6,461	7,024	7,461	8,024
Total non-current assets		**318,243**	**314,458**	**319,236**	**315,458**
Current assets					
Inventories	14	13,876	15,901	12,904	15,088
Receivables	15	35,518	31,388	36,659	29,924
Cash and cash equivalents	16	61,887	59,255	61,340	58,832
Total current assets		**111,281**	**106,544**	**110,903**	**103,844**
Current liabilities					
Trade and other payables	17	(99,855)	(93,893)	(100,470)	(92,193)
Borrowings	19	(2,360)	(4,116)	(2,360)	(4,116)
Provisions	21	(1,808)	(703)	(1,808)	(703)
Other liabilities	18	(16,506)	(13,497)	(16,506)	(13,497)
Total current liabilities		**(120,529)**	**(112,209)**	**(121,144)**	**(110,509)**
Total assets less current liabilities		**308,995**	**308,793**	**308,995**	**308,793**
Non-current liabilities					
Borrowings	19	(4,937)	(7,391)	(4,937)	(7,391)
Provisions	21	(3,805)	(3,069)	(3,805)	(3,069)
Other liabilities	18	(608)	-	-	-
Total non-current liabilities		**(9,350)**	**(10,460)**	**(8,742)**	**(10,460)**
Total assets employed		**299,645**	**298,333**	**300,253**	**298,333**
Financed by					
Public dividend capital		516,713	496,896	516,713	496,896
Revaluation reserve		33,443	41,783	33,443	41,783
Income and expenditure reserve		(250,511)	(240,346)	(250,511)	(240,346)
Total taxpayers' equity		**299,645**	**298,333**	**299,645**	**298,333**

* See Prior Period Adjustments Note 28

The notes on pages 128 to 162 form part of these accounts.



Signed **Kevin McGee OBE**
Chief Executive
Name **28 June 2022**

Consolidated Statement of Changes in Equity for the year ended 31 March 2022

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**496,896**	**41,783**	**(240,346)**	**298,333**
Deficit for the year	-	-	(11,195)	**(11,195)**
Other transfers between reserves	-	(1,030)	1,030	**-**
Impairments	-	(9,203)	-	**(9,203)**
Revaluations	-	1,893	-	**1,893**
Public dividend capital received	19,817	-	-	**19,817**
Taxpayers' and others' equity at 31 March 2022	**516,713**	**33,443**	**(250,511)**	**299,645**

Consolidated Statement of Changes in Equity for the year ended 31 March 2021

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**228,579**	**46,713**	**(235,461)**	**39,831**
Deficit for the year	-	-	(6,035)	**(6,035)**
Other transfers between reserves	-	(1,150)	1,150	**-**
Impairments	-	(4,178)	-	**(4,178)**
Revaluations	-	398	-	**398**
Public dividend capital received	268,317	-	-	**268,317**
Taxpayers' and others' equity at 31 March 2021	**496,896**	**41,783**	**(240,346)**	**298,333**

Consolidated Statement of Changes in Equity for the year ended 31 March 2022

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**496,896**	**41,783**	**(240,346)**	**298,333**
Deficit for the year	-	-	(11,195)	**(11,195)**
Other transfers between reserves	-	(1,030)	1,030	**-**
Impairments	-	(9,203)	-	**(9,203)**
Revaluations	-	1,893	-	**1,893**
Public dividend capital received	19,817	-	-	**19,817**
Taxpayers' and others' equity at 31 March 2022	**516,713**	**33,443**	**(250,511)**	**299,645**

Consolidated Statement of Changes in Equity for the year ended 31 March 2021

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**228,579**	**46,713**	**(235,461)**	**39,831**
Deficit for the year	-	-	(6,035)	**(6,035)**
Other transfers between reserves	-	(1,150)	1,150	**-**
Impairments	-	(4,178)	-	**(4,178)**
Revaluations	-	398	-	**398**
Public dividend capital received	268,317	-	-	**268,317**
Taxpayers' and others' equity at 31 March 2021	**496,896**	**41,783**	**(240,346)**	**298,333**

Statements of Cash Flows

		Group		Trust	
		2021/22	2020/21 Restated *	2021/22	2020/21 Restated *
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating (deficit) / surplus		(2,157)	1,869	(2,157)	1,869
Non-cash income and expense:					
Depreciation and amortisation	3	18,984	16,387	18,984	16,387
Net impairments	4	9,411	11,866	9,411	11,866
Income recognised in respect of capital donations	2.5	(1,639)	(1,724)	(1,639)	(1,724)
(Increase) / decrease in receivables and other assets		(3,550)	6,067	(5,691)	6,531
(Increase) / decrease in inventories		2,025	(1,738)	2,997	(925)
Increase in payables and other liabilities		18,135	34,147	19,173	32,700
Increase / (decrease) in provisions		1,861	(25)	1,861	(25)
Net cash flows from / (used in) operating activities		**43,070**	**66,849**	**42,939**	**66,679**
Cash flows from investing activities					
Interest received		74	63	74	63
Purchase of intangible assets		(4,936)	(1,984)	(4,936)	(1,984)
Purchase of PPE and investment property		(44,852)	(53,294)	(44,845)	(53,294)
Sales of PPE and investment property		48	80	48	80
Receipt of cash donations to purchase assets		1,520	881	1,520	881
Net cash flows from / (used in) investing activities		**(48,146)**	**(54,254)**	**(48,139)**	**(54,254)**
Cash flows from financing activities					
Public dividend capital received		19,817	268,317	19,817	268,317
Movement on loans from DHSC		(3,376)	(219,508)	(3,376)	(219,508)
Movement on other loans		(452)	304	(452)	304
Capital element of finance lease rental payments		(382)	(515)	(382)	(515)
Interest on loans		(222)	(1,010)	(222)	(1,010)
Other interest		-	(1)	-	(1)
Interest paid on finance lease liabilities		(24)	(55)	(24)	(55)
PDC dividend paid		(7,653)	(7,980)	(7,653)	(7,980)
Net cash flows from financing activities		**7,708**	**39,552**	**7,708**	**39,552**
Increase in cash and cash equivalents		**2,632**	**52,147**	**2,508**	**51,977**
Cash and cash equivalents at 1 April - brought forward		**59,255**	**7,108**	**58,832**	**6,855**
Cash and cash equivalents at 31 March	16	**61,887**	**59,255**	**61,340**	**58,832**

Notes to the Accounts

1 Accounting policies and other information

1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Going concern

These accounts have been prepared on a going concern basis which the directors believe to be appropriate for the following reasons.

The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Guidance from the Department of Health and Social care indicates that all NHS bodies will be considered to be going concerns unless there are ongoing discussions at department level regarding the winding up of the activity of the organisation. There are no such conversations regarding this Trust and as such it is regarded as a going concern.

Emergency funding arrangements put into place by the Department of Health and Social Care in response to the COVID-19 pandemic continued in 2021/22. These have had the effect of ensuring that the Trust was able to achieve a small surplus during 2021/22, and the continuation of some of the emergency measures into 2022/23 means the Trust will receive further funding during 2022/23. The receipt of these funds and additional funds to support restoration activities mean that the Trust has been able to set a plan for 2022/23 which is a break-even position which is a significant improvement from the pre-pandemic deficit levels.

It is clear that outside of the pandemic response the Trust remains in a deficit position and will need to work with its partners across the local healthcare system to achieve efficiencies, maximise the use of its assets and sustainable financial balance. The Trust will work with NHS England and NHS Improvement and its stakeholders to achieve this objective.

In addition to the matters referred to above, the Trust has not been informed by NHS England and NHS Improvement that there is any prospect of its dissolution within the next twelve months and it anticipates the continuation of the provision of services in the foreseeable future as evidenced by the inclusion of financial provision for those services in published documents and contracts for services with commissioners.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis.

1.4 Consolidation

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The Trust is corporate trustee of the Lancashire Teaching Hospitals NHS Foundation Trust Charity and the Rosemere Cancer Foundation Charity. The Trust has assessed its relationship to the charitable funds and determined them to be subsidiaries because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable funds and the ability to affect those returns and other benefits through its power over the funds. However the combined charitable funds are not material to the Trust and therefore consolidation is not required.

The Trust is sole owner of Lancashire Hospitals Services (Pharmacy) Limited, a company dispensing prescription drugs to Trust patients. The company has traded throughout the 2021/22 financial year. As sole owner the company therefore constitutes a subsidiary of the Trust and the financial results of the company through the financial year have been consolidated with the Trust to form the Group. The Trust is also the sole owner of Edovation Limited which has not been consolidated due to it being a dormant company.

1.5 Segmental Reporting

An operating segment is a component of the Trust that engages in activities from which it may earn revenues and incur expenses, including revenues and expenses that relate to transactions with any of the the Trust's other components.

The chief operating decision maker for the Trust is the Board of Directors. The Board receives the monthly financial reports for the whole Trust and subsidiary information relating to income and divisional expenses. The board makes decisions based on the effect on the monthly financial statements.

The single segment of Healthcare has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations have been satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

1.7 Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.8 Other Income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract. Other income includes income from car parking and catering which is recognised at the point of receipt of cash consideration.

1.9 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.10 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.11 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

As directed by HM Treasury, the Trust has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets. This approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design, with the same operational value as the existing asset. The modern equivalent may be smaller than the exisitng asset, for example, due to technological advances in plant and machinery or reduced operational use.

The land and buildings of the Trust have been revalued as at 31st March 2022 by Cushman & Wakefield Ltd. The valuation is based on rules issued by RICS, interpreted in accordance with Trust accounting policies and DH guidance. There have been no changes in the estimation techniques used by the valuers since the last valuation, but see note 1.30 for more explanation of this.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of

(i) the impairment charged to operating expenses; and
(ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	80
Plant & machinery	1	15
Transport equipment	6	7
Information technology	1	12
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.12 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS40 or IFRS 5

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell

Amortisation
Intangible assets are amortised over their expected lives in a manner consistent with the consumption of

Useful lives of intangible assets
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are

	Min life Years	Max life Years
Software licences	1	10

1.13 Inventories
Inventories are valued at the lower of cost and net realisable value.

1.14 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments which mature in 3 months or less from the date of acquisition and which are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents balances are recorded at current values.

1.15 Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and Measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.16 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Finance Leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as a lessor

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.17 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021.

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95).

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 22 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.18 Contingencies

Contingent assets are assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control, and are not recognised as assets but are disclosed in the notes to the financial statements where an inflow of economic benefit is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise they are not recognised, but are disclosed unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.20 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation tax

The Trust is a health service body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (S519A(3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare.

1.22 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.23 Foreign exchange

The functional and presentational currency of the trust is sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Any resulting exchange gains or losses are recognised in income or expense in the period in which they arise.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.26 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the trust from another NHS / local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net [gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	43,781
Additional lease obligations recognised for existing operating leases	(43,781)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(10,478)
Additional finance costs on lease liabilities	(362)
Lease rentals no longer charged to operating expenditure	10,676
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(164)**
Estimated increase in capital additions for new leases commencing in 2022/23	**1,085**

1.29 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.30 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

The revaluations of hospitals have been carried out by Cushman & Wakefield, who have applied the modern equivalent asset (MEA) valuation. This approach assumes that the asset would have been replaced with a modern equivalent, not a building of identical design, with the same operational value as the existing asset. The modern equivalent may well be smaller that the existing asset, for example, due to technological advances in plant and machinery or reduced operational use. The application and assesment of the valuation has been informed by Trust management in respect of the estimated requirements of a modern equivalent hospital.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. Outcomes within the next financial year that are different from the assumption around the valuation of our land or PPE could require a material adjustment to the carrying amount of the asset recorded in note 12.

In preparing these accounts the Trust has taken the opportunity to review assumptions that underpin the MEA to account for new ways of working. These assumptions and their impact upon the valuation as at 31st March 2022 were as follows:

Reductions in valuation as a result of:	£'m
50% reduction in administrative areas as a consequence of agile working	3.0
25% reduction in outpatient areas due to outpatient activity taking place on a remote basis	4.8
30% reduction in education and training areas as a consequence of agile approaches to delivery	3.5
Total	**11.3**

2 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6

2.1 Income from patient care activities (by nature)

	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income	566,175	502,278
High cost drugs income from commissioners (excluding pass-through costs)	57,641	40,116
Other NHS clinical income	331	209
All trusts		
Private patient income	387	653
Elective recovery fund	17,033	-
Additional pension contribution central funding*	16,548	15,341
Other clinical income	1,990	1,945
Total income from activities	**660,105**	**560,542**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2021/22 £000	2020/21 £000
NHS England	204,020	195,203
Clinical commissioning groups	453,362	362,532
Department of Health and Social Care	15	19
Other NHS providers	331	209
NHS other	-	-
Local authorities	-	-
Non-NHS: private patients	171	59
Non-NHS: overseas patients (chargeable to patient)	216	595
Injury cost recovery scheme	1,909	1,925
Non NHS: other	81	-
Total income from activities	**660,105**	**560,542**

2.3 Overseas visitors (relating to patients charged directly by the provider)

	2021/22 £000	2020/21 £000
Income recognised this year	216	595
Cash payments received in-year	65	45
Amounts added to provision for impairment of receivables	179	477
Amounts written off in-year	87	605

The above note relates to the treatment of overseas visitors charges directly by the Trust in accordance with Guidance on implementing the overseas regulations 2015 issued by the Department of Health and Social Care.

Amounts written off in-year 2021/22: 63 customers (2020/21: 215 customers)

2.4 Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from

	2021/22 £000	2020/21 £000
Income from services designated as commissioner requested services	657,382	557,735
Income from services not designated as commissioner requested services		
Total	**657,382**	**557,735**

2.5 Other operating income

Other operating income from contracts with customers	2021/22 £000	2020/21 £000
Research and development	2,603	2,004
Education and training	26,303	20,906
Non-patient care services to other bodies	8,710	5,248
Reimbursement and top up funding	21,589	72,333
Other income	18,407	9,841
Other non-contract operating income		
Receipt of capital grants and donations	1,639	1,724
Charitable and other contributions to expenditure	1,948	10,808
Total other operating income	**81,199**	**122,864**

2.6 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22 £000	2020/21 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	7,571	2,579
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

2.7 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	2021/22 £000	2020/21 £000
within one year	16,506	13,497
after one year, not later than five years	608	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**17,114**	**13,497**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from:

(i) contracts with an expected duration of one year or less and,

(ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

3 Operating expenses

	Group		Trust	
	2021/22	2020/21 Restated *	2021/22	2020/21 Restated *
	£000	£000	£000	£000
Staff and executive directors costs (see note 5)	460,014	433,927	459,119	433,139
Supplies and services - clinical (excluding drugs costs)	68,664	61,962	68,664	61,962
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	60,104	51,243	61,032	52,152
Premises	53,440	42,424	53,422	42,367
Clinical negligence	21,369	21,127	21,369	21,127
Purchase of healthcare from non-NHS and non-DHSC bodies	21,094	14,054	21,094	14,054
Depreciation on property, plant and equipment	17,679	15,364	17,679	15,364
Supplies and services - general	13,769	11,666	13,763	11,656
Net impairments	9,411	11,866	9,411	11,866
Transport (including patient travel)	4,088	2,299	4,088	2,299
Establishment	3,630	5,782	3,630	5,782
Other	2,420	2,110	2,356	2,108
Education and training	2,276	886	2,276	886
Legal fees	1,399	925	1,399	918
Amortisation on intangible assets	1,305	1,023	1,305	1,023
Insurance	805	811	777	779
Inventories written down	775	2,614	872	2,614
Movement in credit loss allowance: contract receivables / contract assets	320	280	320	280
Remuneration of non-executive directors	185	177	185	177
Fees payable to the external auditor:				-
Audit services **	150	108	136	95
Consultancy costs	116	19	116	19
Purchase of healthcare from NHS and DHSC bodies	115	-	115	-
Increase in other provisions	100	156	100	156
Internal audit costs	78	118	78	118
Change in provisions discount rate(s)	67	74	67	74
Research and development	47	87	47	87
Redundancy	41	1	41	1
Rentals under operating leases	-	434	-	434
Total	**743,461**	**681,537**	**743,461**	**681,537**

* The classification of 2020/21 expenditure within the above note has been adjusted. There is no overall impact on the total amounts recognised, which remain consistent with the 2020/21 financial statements.

** Total audit services relate soley to statutory external audit. No additional work has been undertaken.

3.1 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2 million (2020/21: £2 million).

4 Impairment of assets (Group)

	2021/22	2020/21
	£000	£000
resulting from:		
Changes in market price	9,411	11,487
Loss as a result of catastrophe	-	379
Total net impairments charged to operating surplus / de	**9,411**	**11,866**
Impairments charged to the revaluation reserve	9,203	4,178
Total net impairments	**18,614**	**16,044**

The impairment was higher in 2021/22 due to the review of the modern equivalent asset.

5 Employee benefits (Group)

	2021/22	2020/21 Restated *
	Total	Total
	£000	£000
Salaries and wages	348,909	331,155
Social security costs	33,762	31,273
Apprenticeship levy	1,737	1,586
Employer's contributions to NHS pensions	54,408	50,463
Pension cost - other	177	176
Temporary staff (including agency)	21,021	19,274
Total gross staff costs	**460,014**	**433,927**
Recoveries in respect of seconded staff	-	-
Total staff costs	**460,014**	**433,927**

* The classification of 2020/21 expenditure within the above note has been adjusted. There is no overall impact on the total amounts recognised, which remain consistent with the 2020/21 financial statements.

Employer's contributions to NHS Pensions includes the costs of the increased contribution rate referred to in note 2.1

5.1 Retirements due to ill-health (Group)

During 2021/22 there were 7 early retirements from the trust agreed on the grounds of ill-health (10 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £634k (£548k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

5.2 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

6 Operating leases (Group)

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	-	434
Total	**-**	**434**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	-	434
Total	**-**	**434**
Future minimum sublease payments to be received	-	-

7 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2021/22 £000	2020/21 £000
Interest on bank accounts	32	-
Other finance income	42	63
Total finance income	**74**	**63**

8 Finance expenditure (Group)

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2021/22 £000	2020/21 Restated* £000
Interest expense:		
Loans from the Department of Health and Social Care	149	217
Other loans	72	88
Finance leases	25	55
Interest on late payment of commercial debt	-	1
Total interest expense	**246**	**361**
Unwinding of discount on provisions	(20)	(15)
Total finance costs	**226**	**346**

* The classification of 2020/21 expenditure within the above note has been adjusted. There is no overall impact on the total amounts recognised, which remain consistent with the 2020/21 financial statements.

8.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2021/22 £000	2020/21 £000
Amounts included within interest payable arising from claims made under this legislation	-	1

9 Other gains / (losses) (Group)

	2021/22 £000	2020/21 £000
Gains on disposal of assets	-	80
Losses on disposal of assets	(196)	-
Total other (losses) / gains	**(196)**	**80**

10 Trust income statement and statement of comprehensive income (Group)

In accordance with Section 408 of the Companies Act 2006, the trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's surplus/(defict) for the period was £11.2 million (2020/21: £6 million). The trust's total comprehensive income/(expense) for the period was £18.5 million (2020/21: £9.8 million).

11.1 Intangible assets - 2021/22 (Group)

	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**18,003**	**13**	**214**	**240**	**18,470**
Transfers by absorption	213	-	(624)	-	**(411)**
Additions	2,898	-	1,791	-	**4,689**
Reclassifications	240	-	-	(240)	**-**
Valuation / gross cost at 31 March 2022	**21,354**	**13**	**1,381**	**-**	**22,748**
Amortisation at 1 April 2021 - brought forward	**14,055**	**-**	**-**	**-**	**14,055**
Provided during the year	1,255	6	44	-	**1,305**
Amortisation at 31 March 2022	**15,310**	**6**	**44**	**-**	**15,360**
Net book value at 31 March 2022	**6,044**	**7**	**1,337**	**-**	**7,388**
Net book value at 1 April 2021	**3,948**	**13**	**214**	**240**	**4,415**

Intangible assets - 2020/21

	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**16,214**	**-**	**-**	**272**	**16,486**
Additions	1,586	13	214	171	**1,984**
Reclassifications	203	-	-	(203)	**-**
Valuation / gross cost at 31 March 2021	**18,003**	**13**	**214**	**240**	**18,470**
Amortisation at 1 April 2020 - as previously stated	**13,032**	**-**	**-**	**-**	**13,032**
Provided during the year	1,023	-	-	-	**1,023**
Amortisation at 31 March 2021	**14,055**	**-**	**-**	**-**	**14,055**
Net book value at 31 March 2021	**3,948**	**13**	**214**	**240**	**4,415**
Net book value at 1 April 2020	**3,182**	**-**	**-**	**272**	**3,454**

12 Property, plant and equipment - 2021/22

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**20,395**	**201,800**	**22,619**	**128,070**	**214**	**54,186**	**1,734**	**429,018**
Transfers by absorption	-	-	-	-	-	(643)	-	**(643)**
Additions	-	5,760	20,011	8,731	-	2,122	38	**36,662**
Impairments	(3,920)	(8,577)	-	-	-	-	-	**(12,497)**
Reversals of impairments	-	2,397	-	-	-	-	-	**2,397**
Revaluations	-	(13,257)	-	-	-	(2,867)	-	**(16,124)**
Reclassifications	-	31,072	(31,072)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(1,156)	-	-	-	**(1,156)**
Valuation/gross cost at 31 March 2022	**16,475**	**219,195**	**11,558**	**135,645**	**214**	**52,798**	**1,772**	**437,657**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**2,570**	**-**	**85,307**	**175**	**36,378**	**1,569**	**125,999**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	7,149	-	7,094	13	3,403	20	**17,679**
Impairments	-	12,204	-	-	-	1,894	-	**14,098**
Reversals of impairments	-	(5,584)	-	-	-	-	-	**(5,584)**
Revaluations	-	(15,150)	-	-	-	(2,867)	-	**(18,017)**
Disposals / derecognition	-	-	-	(912)	-	-	-	**(912)**
Accumulated depreciation at 31 March 2022	**-**	**1,189**	**-**	**91,489**	**188**	**38,808**	**1,589**	**133,263**
Net book value at 31 March 2022	**16,475**	**218,006**	**11,558**	**44,156**	**26**	**13,990**	**183**	**304,394**
Net book value at 1 April 2021	**20,395**	**199,230**	**22,619**	**42,763**	**39**	**17,808**	**165**	**303,019**

12.1 Property, plant and equipment - 2020/21

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**20,395**	**192,989**	**7,888**	**115,239**	**205**	**43,573**	**1,647**	**381,936**
Additions	-	29,355	14,731	13,477	9	10,613	87	**68,272**
Impairments	-	(4,216)	-	-	-	-	-	**(4,216)**
Reversals of impairments	-	38	-	-	-	-	-	**38**
Revaluations	-	(16,366)	-	(583)	-	-	-	**(16,949)**
Disposals / derecognition	-	-	-	(63)	-	-	-	**(63)**
Valuation/gross cost at 31 March 2021	**20,395**	**201,800**	**22,619**	**128,070**	**214**	**54,186**	**1,734**	**429,018**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**2,276**	**-**	**79,027**	**163**	**33,156**	**1,557**	**116,179**
Provided during the year	-	5,571	-	6,547	12	3,222	12	**15,364**
Impairments	-	11,487	-	379	-	-	-	**11,866**
Revaluations	-	(16,764)	-	(583)	-	-	-	**(17,347)**
Disposals / derecognition	-	-	-	(63)	-	-	-	**(63)**
Accumulated depreciation at 31 March 2021	**-**	**2,570**	**-**	**85,307**	**175**	**36,378**	**1,569**	**125,999**
Net book value at 31 March 2021	**20,395**	**199,230**	**22,619**	**42,763**	**39**	**17,808**	**165**	**303,019**
Net book value at 1 April 2020	**20,395**	**190,713**	**7,888**	**36,212**	**42**	**10,417**	**90**	**265,757**

12.1 Property, plant and equipment financing - 2021/22

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	16,475	215,803	11,558	41,383	25	13,637	173	**299,054**
Finance leased	-	100	-	-	-	-	-	**100**
Owned - donated/granted	-	2,103	-	2,773	1	353	10	**5,240**
NBV total at 31 March 2022	**16,475**	**218,006**	**11,558**	**44,156**	**26**	**13,990**	**183**	**304,394**

Property, plant and equipment financing - 2020/21

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	20,395	197,534	22,598	40,086	36	17,455	165	**298,269**
Finance leased	-	292	-	-	-	-	-	**292**
Owned - donated/granted	-	1,404	21	2,677	3	353	-	**4,458**
NBV total at 31 March 2021	**20,395**	**199,230**	**22,619**	**42,763**	**39**	**17,808**	**165**	**303,019**

13.1 Property, plant and equipment - 2021/22

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**20,395**	**201,800**	**22,619**	**128,070**	**214**	**54,186**	**1,734**	**429,018**
Transfers by absorption	-	-	-	-	-	(643)	-	**(643)**
Additions	-	5,760	20,011	8,731	-	2,115	38	**36,655**
Impairments	(3,920)	(8,577)	-	-	-	-	-	**(12,497)**
Reversals of impairments	-	2,397	-	-	-	-	-	**2,397**
Revaluations	-	(13,257)	-	-	-	(2,867)	-	**(16,124)**
Reclassifications	-	31,072	(31,072)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(1,156)	-	-	-	**(1,156)**
Valuation/gross cost at 31 March 2022	**16,475**	**219,195**	**11,558**	**135,645**	**214**	**52,791**	**1,772**	**437,650**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**2,570**	**-**	**85,307**	**175**	**36,378**	**1,569**	**125,999**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	7,149	-	7,094	13	3,403	20	**17,679**
Impairments	-	12,204	-	-	-	1,894	-	**14,098**
Reversals of impairments	-	(5,584)	-	-	-	-	-	**(5,584)**
Revaluations	-	(15,150)	-	-	-	(2,867)	-	**(18,017)**
Reclassifications	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(912)	-	-	-	**(912)**
Accumulated depreciation at 31 March 202	**-**	**1,189**	**-**	**91,489**	**188**	**38,808**	**1,589**	**133,263**
Net book value at 31 March 2022	**16,475**	**218,006**	**11,558**	**44,156**	**26**	**13,983**	**183**	**304,387**
Net book value at 1 April 2021	**20,395**	**199,230**	**22,619**	**42,763**	**39**	**17,808**	**165**	**303,019**

13.2 Property, plant and equipment - 2020/21

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**20,395**	**192,989**	**7,888**	**115,239**	**205**	**43,573**	**1,647**	**381,936**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	29,355	14,731	13,477	9	10,613	87	**68,272**
Impairments	-	(4,216)	-	-	-	-	-	**(4,216)**
Reversals of impairments	-	38	-	-	-	-	-	**38**
Revaluations	-	(16,366)	-	(583)	-	-	-	**(16,949)**
Disposals / derecognition	-	-	-	(63)	-	-	-	**(63)**
Valuation/gross cost at 31 March 2021	**20,395**	**201,800**	**22,619**	**128,070**	**214**	**54,186**	**1,734**	**429,018**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**2,276**	**-**	**79,027**	**163**	**33,156**	**1,557**	**116,179**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,571	-	6,547	12	3,222	12	**15,364**
Impairments	-	11,487	-	379	-	-	-	**11,866**
Revaluations	-	(16,764)	-	(583)	-	-	-	**(17,347)**
Disposals / derecognition	-	-	-	(63)	-	-	-	**(63)**
Accumulated depreciation at 31 March 2021	**-**	**2,570**	**-**	**85,307**	**175**	**36,378**	**1,569**	**125,999**
Net book value at 31 March 2021	**20,395**	**199,230**	**22,619**	**42,763**	**39**	**17,808**	**165**	**303,019**
Net book value at 1 April 2020	**20,395**	**190,713**	**7,888**	**36,212**	**42**	**10,417**	**90**	**265,757**

13.3 Property, plant and equipment financing - 2021/22

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022								
Owned - purchased	16,475	215,803	11,558	41,383	25	13,637	166	**299,047**
Finance leased	-	100	-	-	-	-	-	**100**
Owned - donated / granted	-	2,103	-	2,773	1	353	10	**5,240**
NBV total at 31 March 2022	**16,475**	**218,006**	**11,558**	**44,156**	**26**	**13,990**	**176**	**304,387**

Property, plant and equipment financing - 2020/21

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021								
Owned - purchased	20,395	197,534	22,598	40,086	36	17,455	165	**298,269**
Finance leased	-	292	-	-	-	-	-	**292**
Owned - donated / granted	-	1,404	21	2,677	3	353	-	**4,458**
NBV total at 31 March 2021	**20,395**	**199,230**	**22,619**	**42,763**	**39**	**17,808**	**165**	**303,019**

14 Inventories

	Group		Trust	
	31 March 2022	31 March 2021 Restated*	31 March 2022	31 March 2021 Restated*
	£000	£000	£000	£000
Drugs	4,077	3,375	3,105	2,562
Consumables	9,593	12,411	9,593	12,411
Energy	196	115	196	115
Other	10	-	10	-
Total inventories	**13,876**	**15,901**	**12,904**	**15,088**

* See Prior Period Adjustments Note 28

Inventories recognised in expenses for the year were £80,002k (2020/21: £62,717k). Write-down of inventories recognised as expenses for the year were £775k (2020/21: £2,614k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,573k of items purchased by DHSC (2020/21: £10,048k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

15 Receivables

	Group		Trust	
	2022	2021 Restated*	2022	2021 Restated*
	£000	£000	£000	£000
Current				
Contract receivables	30,405	24,603	32,038	24,598
Contract assets	-	35	-	35
Allowance for impaired contract receivables / assets	(1,892)	(2,565)	(1,892)	(2,565)
Prepayments	2,940	2,768	2,930	2,736
PDC dividend receivable	688	671	688	671
VAT receivable	2,156	3,104	1,674	1,677
Other receivables	1,221	2,772	1,221	2,772
Total current receivables	**35,518**	**31,388**	**36,659**	**29,924**
Non-current				
Contract assets	6,849	7,096	6,849	7,096
Allowance for other impaired receivables	(1,627)	(1,592)	(1,627)	(1,592)
Other receivables	1,239	1,520	2,239	2,520
Total non-current receivables	**6,461**	**7,024**	**7,461**	**8,024**
Of which receivable from NHS and DHSC group bodies:				
Current	25,414	18,675	24,932	17,248
Non-current	1,239	1,520	1,239	1,520

15.1 Allowances for credit losses - 2021/22

	Group receivables £000	Trust receivables £000
Allowances as at 1 Apr 2021 - brought forward	**4,157**	**4,157**
New allowances arising	700	700
Changes in existing allowances	128	128
Reversals of allowances	(508)	(508)
Utilisation of allowances (write offs)	(958)	(958)
Allowances as at 31 Mar 2022	**3,519**	**3,519**

15.2 Allowances for credit losses - 2020/21

	Group receivables £000	Trust receivables £000
Allowances as at 1 Apr 2020 - as previously stated	**4,721**	**4,721**
New allowances arising	1,778	**1,778**
Changes in existing allowances	(97)	**(97)**
Reversals of allowances	(1,401)	**(1,401)**
Utilisation of allowances (write offs)	(844)	**(844)**
Allowances as at 31 Mar 2021	**4,157**	**4,157**

16 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2021/22	2020/21 Restated*	2021/22	2020/21 Restated*
	£000	£000	£000	£000
At 1 April	**59,255**	**7,108**	**58,832**	**6,855**
Net change in year	2,632	52,147	2,508	51,977
At 31 March	**61,887**	**59,255**	**61,340**	**58,832**
Broken down into:				
Cash at commercial banks and in hand	565	439	18	16
Cash with the Government Banking Service	61,322	58,816	61,322	58,816
Total cash and cash equivalents as in SoFP	**61,887**	**59,255**	**61,340**	**58,832**
Total cash and cash equivalents as in SoCF	**61,887**	**59,255**	**61,340**	**58,832**

* See Prior Period Adjustments Note 28

16.1 Third party assets held by the trust (Group)

Lancashire Teaching Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2022 £000	31 March 2021 £000
Bank balances	7	5
Total third party assets	**7**	**5**

17 Trade and other payables

	Group		Trust	
	2022	2021 Restated*	2022	2021 Restated*
	£000	£000	£000	£000
Current				
Trade payables	18,298	17,064	18,316	15,095
Capital payables	18,285	26,841	18,285	26,841
Accruals	46,469	36,091	47,083	36,379
Social security costs	5,357	4,327	5,350	4,318
Other taxes payable	4,847	4,001	4,839	3,992
Other payables	6,599	5,569	6,597	5,568
Total current trade and other payables	**99,855**	**93,893**	**100,470**	**92,193**
Of which payables from NHS and DHSC group bodies:				
Current	6,095	8,578	6,095	8,578
Non-current	-	-	-	-

* See Prior Period Adjustments Note 28

18 Other liabilities

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	16,506	13,497	16,506	13,497
Total other current liabilities	**16,506**	**13,497**	**16,506**	**13,497**
Non-current				
Deferred income: contract liabilities	608	-	608	-
Total other non-current liabilities	**608**	**-**	**608**	**-**

Cancer Alliance funding has been received by the Trust to support staff posts over a 2 year period. A proportion that represents funding for the second year is deferred as non-current and the remainder is included in the current balance.

19 Borrowings

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Loans from DHSC	2,182	3,394	2,182	3,394
Other loans	79	342	79	342
Obligations under finance leases	99	380	99	380
Total current borrowings	**2,360**	**4,116**	**2,360**	**4,116**
Non-current				
Loans from DHSC	4,445	6,611	4,445	6,611
Other loans	492	680	492	680
Obligations under finance leases	-	100	-	100
Total non-current borrowings	**4,937**	**7,391**	**4,937**	**7,391**

19.1 Reconciliation of liabilities arising from financing activities (Group)

2021/22	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**10,005**	**1,022**	**480**	**11,507**
Cash movements:				
Financing cash flows - payments and receipts of principal	(3,376)	(452)	(382)	**(4,210)**
Financing cash flows - payments of interest	(151)	(71)	(24)	**(246)**
Non-cash movements:				
Application of effective interest rate	149	72	25	**246**
Carrying value at 31 March 2022	**6,627**	**571**	**99**	**7,297**

2020/21	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**230,236**	**698**	**996**	**231,930**
Cash movements:				
Financing cash flows - payments and receipts of principal	(219,508)	304	(515)	**(219,719)**
Financing cash flows - payments of interest	(940)	(70)	(55)	**(1,065)**
Non-cash movements:				
Application of effective interest rate	217	89	55	**361**
Other changes	-	1	(1)	**-**
Carrying value at 31 March 2021	**10,005**	**1,022**	**480**	**11,507**

20 Finance leases

20.1 Lancashire Teaching Hospitals NHS Foundation Trust as a lessee (Group)

Obligations under finance leases where the trust is the lessee.

	2022	2021
	£000	£000
Gross lease liabilities	**101**	**506**
of which liabilities are due:		
- not later than one year;	101	406
- later than one year and not later than five years;	-	100
- later than five years.	-	-
Finance charges allocated to future periods	(2)	(26)
Net lease liabilities	**99**	**480**
of which payable:		
- not later than one year;	99	380
- later than one year and not later than five years;	-	100

21 Provisions for liabilities and charges analysis (Group)

Group	Pensions: injury benefits Restated* £000	Legal claims Restated* £000	Other Restated* £000	Total £000
At 1 April 2021	**1,647**	**330**	**1,795**	**3,772**
Transfers by absorption	-	-	-	**-**
Change in the discount rate	67	-	-	**67**
Arising during the year	12	111	2,514	**2,637**
Utilised during the year	(96)	(96)	-	**(192)**
Reclassified to liabilities held in disposal groups	-	-	-	**-**
Reversed unused	(47)	(97)	(507)	**(651)**
Unwinding of discount	(20)	-	-	**(20)**
Movement in charitable fund provisions				**-**
At 31 March 2022	**1,563**	**248**	**3,802**	**5,613**
Expected timing of cash flows:				
- not later than one year;	97	248	1,463	**1,808**
- later than one year and not later than five years;	395	-	48	**443**
- later than five years.	1,071	-	2,291	**3,362**
Total	**1,563**	**248**	**3,802**	**5,613**

* See Prior Period Adjustments Note 28

Clinical negligence liabilities

At 31 March 2022, £464,126k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Lancashire Teaching Hospitals NHS Foundation Trust (31 March 2021: £350,094k).

Permanent injury benefits

Payments are made on a quarterly basis to the NHS Pension Scheme and NHS Injury Benefit Scheme respectively.

Clincians pension tax

Clinicians who were members of the NHS Pensions Scheme and who as a result of work undertaken in the tax year (2019/20) face a tax charge in respect of growth of their NHS pension benefits above their pensions savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme.

The Trust has been required to make a contractually binding commitment to pay them a corresponding amount on retirement, ensuring that they are fully compensated in retirement for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement.

The Trust has created a provision broadly equal to the tax charge owed by clinicians who want to take advantage of the 2019/20 Commitment. This is offset by a receivables balance from NHS England as there has been a commitment by the Government to fund the payments to clinicians as and when they arise.

Dilapidation provisions

The Trust has created a provision for the reinstatement of leased properties (dilapidations). Payments will be made as and when leases expire and agreements are reached with Landlords.

Excess travel provision

The Trust has created a provision to fund the costs involved with displacing staff from their existing work bases to Preston Business Centre. These contractual payments will be made to eligible staff over a period of time in line with the relevant policy.

22 Contingent assets and liabilities (Group)

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(111)	(125)
Gross value of contingent liabilities	**(111)**	**(125)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(111)**	**(125)**

23 Note 23 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	4,433	5,721
Total	**4,433**	**5,721**

The contractual capital commitments represent the outstanding Modular Building project and other projects that were work in progress at the 31st March 2022.

24 Financial instruments

International Financial Reporting Standard 9 requires disclosure of the role which Financial Instruments have had during the period in creating or changing the risks which a body faces in undertaking its activities. Because of the continuing service provider relationship which the Trust has with its Commissioners, and the way in which those Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, Financial Instruments play a much more limited role in creating or changing risk for the Trust than would be typical of listed companies, to which these standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and Financial Assets and Liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's Treasury Management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions, and policies agreed by the Board of Directors. The Trust's treasury activities are also subject to review by Internal Audit.

Liquidity Risk

Net operating costs of the Trust are funded under annual Service Agreements with NHS Commissioners, which are financed from resources voted annually by Parliament. While the Trust is in deficit it is accessing working capital support by means of PDC through DHSC. The Trust largely finances its capital expenditure from internally generated cash, and funds made available by the DHSC. Additional funding by way of loans has been arranged with the Foundation Trust Financing Facility to support major capital developments. The Trust is, therefore, exposed to liquidity risks from the loan funding - however these risks are approved, and comply with Monitor's Risk Assessment Framework.

Currency Risk

The Trust is a domestic organisation with the overwhelming majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations, and therefore has low exposure to currency rate fluctuations..

Interest Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest rate risk.

Credit Risk

The majority of the Trust's Income comes from contracts with other public sector bodies, and therefore the Trust has low exposure to credit risk. The maximum exposure as at 31 March 2022 is within Receivables from customers, as disclosed in the Trade and Other Receivables note to these Accounts.

24.1 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Group		Trust	
	Held at amortised cost	Total book value	Held at amortised cost	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	36,193	**36,193**	38,823	**38,823**
Cash and cash equivalents	61,887	**61,887**	61,340	**61,340**
Total at 31 March 2022	**98,080**	**98,080**	**100,163**	**100,163**

Carrying values of financial assets as at 31 March 2021	Group		Trust	
	Held at amortised cost Restated	Total book value	Held at amortised cost Restated	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	30,641	**30,641**	32,863	**32,863**
Cash and cash equivalents	59,255	**59,255**	58,832	**58,832**
Total at 31 March 2021	**89,896**	**89,896**	**91,695**	**91,695**

24.2 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Group		Trust	
	Held at amortised cost	Total book value	Held at amortised cost	Total book value
	£000	£000	£000	£000
Loans from the Department of Health and Social Care	6,627	**6,627**	6,627	**6,627**
Obligations under finance leases	99	**99**	99	**99**
Other borrowings	571	**571**	571	**571**
Trade and other payables excluding non financial liabilities	89,650	**89,650**	86,796	**86,796**
Total at 31 March 2022	**96,947**	**96,947**	**94,093**	**94,093**

Carrying values of financial liabilities as at 31 March 2021	Group		Trust	
	Held at amortised cost	Total book value	Held at amortised cost	Total book value
	£000	£000	£000	£000
Loans from the Department of Health and Social Care	10,005	**10,005**	10,005	**10,005**
Obligations under finance leases	480	**480**	480	**480**
Other borrowings	1,022	**1,022**	1,022	**1,022**
Trade and other payables excluding non financial liabilities	83,843	**83,843**	83,862	**83,862**
Total at 31 March 2021	**95,350**	**95,350**	**95,369**	**95,369**

24.3 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
In one year or less	93,219	88,500	90,365	88,519
In more than one year but not more than five years	3,698	6,350	3,698	6,350
In more than five years	1,524	1,608	1,524	1,608
Total	**98,441**	**96,458**	**95,587**	**96,477**

25 Losses and special payments (Group)

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases Restated*	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	1,685	141	1,225	755
Stores losses and damage to property	3	343	2	420
Total losses	**1,688**	**484**	**1,227**	**1,175**
Special payments				
Ex-gratia payments	51	171	50	1,442
Total special payments	**51**	**171**	**50**	**1,442**
Total losses and special payments	**1,739**	**655**	**1,277**	**2,617**
Compensation payments received		-		-

* In line with DHSC guidance the figures for 2020/21 have been restated to include backdated overtime corrective payments (a consequence of East of England Ambulance Service NHS Trust v Flowers). The Trust received £1.394m funding which was based on estimates. The final cost was £1.684m. No further losses are reported because payments made on a monthly basis are now classed as contractual payments.

26 Related parties

Lancashire Teaching Hospitals NHS Foundation Trust is a public interest body, a Department of Health and Social Care (parent of the group) Group body, authorised by NHS Improvement, the Independent Regulator for NHS Foundation Trusts. During the year none of the Board members or members of key management staff or parties related to them has undertaken any material transactions with Lancashire Teaching Hospitals NHS Foundation Trust.

26 Related parties (continued)

Council of Governors

The roles and responsibilities of the Council of Governors of the Foundation Trust are carried out in accordance with the Trust's Provider Licence:

The Council has specific powers including:

- appointment and, if appropriate, removal of the Chair and other non-executive Directors
- approval of the appointment of the Chief Executive
- to decide the remuneration and allowances and the other terms and conditions of office of the Chair and other non-executive Directors
- to appoint and, if appropriate, remove the Trust's external auditors
- to appoint or remove any other external auditor
- to receive the annual accounts, annual report and any report on them by the auditor
- to provide their views to the board of directors when the board of directors is preparing the Trust's forward plan
- to hold the non-executive directors individually and collectively to account for the performance of the board of directors
- to represent the interests of the members of the Trust as a whole and of the public
- to approve 'significant transactions' as defined within the constitution
- to approve an application by the Trust to enter into a merger, acquisition, seperation or dissolution
- to decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose
- to approve any proposed increase in private patient income of 5% of total income or more in any financial year
- to approve, along with the Board of Directors, any changes to the Trust's consititution
- to require the attendance of one or more directors at a Council of Governors meeting, for the purpose of obtaining information about the Trust's performance of its functions or the directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or directors' performance).

The Foundation Trust maintains a register of interests for the Board and for members of the Council of Governors.

Of the total of 29 members of the Council of Governors, 6 represent the interests of other organisations who the Trust has identified as key partners in the delivery of healthcare to the population of Preston Chorley and South Ribble.

Members of the Council of Governors, Executive Directors and Non-Executive Directors, or close family members of the same, who have interests in or hold positions with organisations with which the trust has had transactions during the year, are listed below:

	Income	Expenditure	Receivable	Payable	Relationship
	£000	£000	£000	£000	
University of Central Lancashire	47	1,785	23	-	Chairman and Member of Council of Governors
Chorley Borough Council	-	-	-	532	Member of Council of Governors
Lancashire County Council	13	41	7	97	Member of Council of Governors
Preston Council	-	-	-	1,548	Member of Council of Governors
South Ribbe Borough Council	8	-	2	33	Member of Council of Governors
North West Ambulance Service NHS Trust	55	284	-	38	Executive Director
East Lancashire Hospitals NHS Trust	3,847	4,904	2,418	1,573	Non Executive Director
St Helen's and Knowsley Teaching Hospitals NHS Trust	527	75	92	137	Executive Director
Warrington and Halton Hospitals NHS Foundation Trust	81	7	7	5	Executive Director
Health Education England	24,572	176	1,007	1,015	Executive Director

The Trust previously established a wholly owned subsidiary, Lancashire Hospitals Services (Pharmacy) Ltd. Lancashire Hospitals Services (Pharmacy) Ltd took over the outpatient pharmacies accross the Trust on 1 October 2018. Being wholly owned, the Trust has prepared its financial statements on a Group basis, consolidating the results of Lancashire Hospitals Services (Pharmacy) Ltd .

The Trust is Corporate Trustee of two charities which means that the Trust has control over the charities. Both Charities are registered with the Charity Commission and produce a set of annual accounts and an annual report (separate to that of the NHS Foundation Trust) These documents will be available in September 2021, on request from the Finance Department of the Trust. Details of the charities and of material transactions between them and the Trust are detailed below.

Charity	Registered Number	Donations received £000	Receivable £000	Payable £000
Lancashire Teaching Hospitals Charity	1051194	145	87	0
Rosemere Cancer Foundation	1131583	847	55	0

27 Transfers by absorption (Group)

During the year the Trust received PDC capital funding for projects across the ICS. In delivering these projects certain assets were purchased on behalf of other entities and these were transferred to those entities as transfers by absorption on the 31st March 2022. The Trust was also a recipient of assets where other entities purchased assets on behalf of the Trust.

	2021/22	2020/21
	£000	£000
Inward transfers (from)		
East Lancashire Hospitals NHS Trust	322	-
Blackpool Teaching Hospitals NHS Foundation Trust	295	-
Outward transfers (to)		
East Lancashire Hospitals NHS Trust	460	-
Blackpool Teaching Hospitals NHS Foundation Trust	654	-
University Hospitals of Morecambe Bay NHS Foundation Trust	557	-
Net transfers - recognised in the SOCI as a loss due to transfers by absorption	**1,054**	**-**

28 Prior period adjustments

Issues have been identified with the consolidation of the Trust's wholly-owned subsidiary in the prior period, arising from adjustments to ensure the financial statements were consistent with the group consolidation schedules. The prior period numbers within these financial statements have been adjusted to correct for this issue, which results in the following adjustments:

	Group			Trust		
	31 March 2021	31 March 2021	31 March 2021	31 March 2021	31 March 2021	31 March 2021
	Audited	Adjustment	Restated*	Audited	Adjustment	Restated*
	£000	£000	£000	£000	£000	£000
Non Current Receivables	8,024	(1,000)	7,024	9,024	(1,000)	8,024
Inventories	15,088	813	15,901	14,275	813	15,088
Current Receivables	29,924	1,464	31,388	28,460	1,464	29,924
Cash and cash Equivalents	58,832	423	59,255	58,409	423	58,832
Trade and other payables	(92,193)	(1,700)	(93,893)	(90,493)	(1,700)	(92,193)
Net impact on the Statement of Financial Position		**-**			**-**	
(Increase) / decrease in receivables and other assets	6,531	(464)	6,067	6,995	(464)	6,531
(Increase) / decrease in inventories	(925)	(813)	(1,738)	(112)	(813)	(925)
Increase in payables and other liabilities	32,700	1,447	34,147	31,000	1,700	32,700
Net impact on the Statement of Cash Flows		**170**			**423**	

29 Events after the reporting date

Lancashire Teaching Hospitals Foundation Trust (LTH), University Hospitals of Morecambe Bay NHS Foundation Trust, East Lancashire Hospitals NHS Trust, and Blackpool Teaching Hospitals NHS Foundation Trust have all agreed to create a Pathology Collaborative which from, an exact date to be confirmed, brings together the four separate pathology services into a single service. The LTH Trust Board have agreed that LTH would take on the responsibility of host trust for the single service. From the effective date LTH will manage the single service which in accordance with the GAM, IFRS 10 and IFRS 11 will be reported as a joint arrangement in future annual accounts of all four trusts.

If you have any queries regarding this report, or wish to make contact with any of the Directors or Governors, please contact:

Company Secretary
Lancashire Teaching Hospitals NHS Foundation Trust
Royal Preston Hospital, Sharoe Green Lane,
Fulwood, Preston,
PR2 9HT

T: **01772 522010**
E: **Company.Secretary@lthtr.nhs.uk**

For more information about Lancashire Teaching Hospitals NHS Foundation Trust see:

www.lancsteachinghospitals.nhs.uk

@lancshospitals

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Auditor's Annual Report 2021/22

Lancashire Teaching Hospitals NHS Foundation Trust

29 June 2022

Key contacts

Your key contacts in connection with this report are:

Tim Cutler
Partner
Tel: 07789 920497
tim.cutler@kpmg.co.uk

Chris Paisley
Senior Manager
Tel: 07468 367450
christopher.paisley@kpmg.co.uk

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This report is addressed to Lancashire Teaching Hospitals NHS Foundation Trust (the Trust) and has been prepared for the sole use of the Trust. We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Summary

Introduction

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2021-22 audit of Lancashire Teaching Hospitals NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

- **Accounts -** We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).
- **Annual report -** We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.
- **Value for money -** We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.
- **Other reporting -** We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities

Accounts	We issued an unqualified opinion on the Trust's accounts on 29 June 2022. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust. We have provided further details of the key risks we identified and our response on page 4.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the Governance Statement had been prepared in line with the DHSC requirements.
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. We have nothing to report in this regard.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

Accounts audit

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Findings
Valuation of land and buildings Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'. There is a risk the assumptions used to determine the valuation are not accurate.	We identified one unadjusted audit misstatement on this significant risk. This related to the overstatement of the net book value by £2.7m due to capital expenditure being incorrectly duplicated in the valuation of land and buildings. We determined that the judgements made by the external valuers and adopted by the Trust were balanced.
Fraudulent expenditure recognition As the Trust has agreed an outturn total with local NHS partners for its expected financial performance there is a risk that non-pay expenditure may be manipulated in order to report that the control total has been met. We considered there to be a risk over existence and accuracy of non-pay expenditure at the year-end, as there is greater incentive for management to overstate expenditure in 2021-22 by bringing forward expenditure from 2022-23, to mitigate financial pressures in that period.	We identified two items of expenditure included within accrued expenditure at year-end which were recorded in error. The total value of these errors is considered trivial, at £30k, however our sampling software has extrapolated these errors to a total projected overstatement of accrued expenditure in 2021/22 of £1.8m. No adjustment was made to the accounts in respect of these errors as the individual errors found were clearly trivial and the extrapolated error is also not material. We reiterated one recommendation, made in the prior period, relating to management's review and challenge of accruals that are made at the year end.
Management override of controls We are required by auditing standards to recognise the risk that management may use their authority to override the usual control environment.	We did not identify any indication of management override of controls.

Value for money

Introduction

We consider whether there are sufficient arrangements in place for the Trust for each of the elements that make up value for money. Value for money relates to ensuring that resources are used efficiently in order to maximise the outcomes that can be achieved.

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

Further details of our value for money responsibilities can be found in the Audit Code of Practice at Code of Audit Practice (nao.org.uk)

Matters that informed our risk assessment

The table below provides a summary of the external sources of evidence that were utilised in forming our risk assessment as to whether there were significant risks that value for money was not being achieved:

Care Quality Commission rating	Requires improvement (November 2019)
Single Oversight Framework rating	Segment three - Mandated and targeted support:
Governance statement	There were no significant control deficiencies identified in the governance statement.
Head of Internal Audit opinion	The draft Head of Internal Audit Opinion for 2021/22 provides Significant Assurance.

Commentary on arrangements

We have set out on the following pages commentary on how the arrangements in place at the Trust compared to the expected systems that would be in place in the sector.

Summary of findings

We have set out in the table below the outcomes from our procedures against each of the domains of value for money:

Domain	Risk assessment	Summary of arrangements
Financial sustainability	One significant risk identified	No significant weaknesses identified
Governance	No significant risks identified	No significant weaknesses identified
Improving economy, efficiency and effectiveness	No significant risks identified	No significant weaknesses identified

Value for money

Financial sustainability	
Description	**Commentary on arrangements**
This relates to ensuring that the Trust has sufficient arrangements in place to be able to continue to provide its services within the resources available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ How the Trust sets its financial plans to ensure services can continue to be delivered; ▪ How financial performance is monitored and actions identified where it is behind plan; and ▪ How financial risks are identified and actions to manage risks implemented.	The Covid-19 pandemic has continued to have a major impact on the NHS and this is reflected in the financial planning regimes underpinning the 2021/22 financial year. There continues to be a central 'command and control' structure put in place by NHS England / Improvement (NHSE/I) with block payments being determined centrally, rather than being agreed between CCGs and provider Trusts. The funding structure was initially only communicated for the first half of the year (H1), with planning guidance for the second half of the year (H2) being published in late September 2021. NHS organisations continue to be reimbursed with additional funding as required in order to reflect the additional costs incurred as a result of Covid-19. The Trust has continued to operate under Enforcement Undertakings issued by NHS Improvement. The most recent undertakings were agreed in 2018 and were compiled under a very different landscape, prior to the Covid-19 pandemic. However since these were issued, the Trust continued to deliver deficits in 2018/19 and 2019/20 and was reliant on revenue support from DHSC. Reflecting the fact that a surplus of £2.1m in 2020/21 was delivered, but that this was due to additional financial support during the pandemic, NHSI issued the Trust with revised enforcement undertakings in November 2021. These undertakings also reflect that the Trust continues to have a significant underlying deficit for 2022/23 and beyond. They confirm that the Trust will remain in segment 3 in the System Oversight Framework. As part of our risk assessment work, we found that the budget monitoring and control processes were able to identify and incorporate significant pressures into the financial plan to ensure it was achievable and realistic, subject to the gaps in CIP identification covered elsewhere in this section. The initial draft budgets were constructed based on appropriate local and national planning assumptions and we saw evidence of appropriate review and sign-off by the relevant budget holders. Emerging cost pressures were identified through regular meetings at the divisional level before being shared with Executive Directors and incorporated into budget reporting to the Finance and Performance Committee and Trust Board. There is also a separate Overspending Cost Centre Process which identifies the highest overspends and reports them to the relevant Divisional Board, with an action plan for mitigation. Within the risk register, individual risks are marked and described. Each risk has an unmitigated score, a mitigated score and a target score with controls and actions in place to enable the Trust to manage and monitor each specific risk. Our review of the financial plan has confirmed risks have been appropriately considered to date. The Trust presented a financial plan for approval for H1 to Board in March 2021, with a plan for H2 being presented in November 2021 following release of national guidance in late September. The H2 plan assumed a breakeven at year-end, which includes an underlying operating deficit of £96m, with the gap being made up by support funding such as Covid top up funding for H2, Growth Funding and ERF funding. In line with the prior period, the plan assumed delivery of circa 5% efficiency savings. This has been delivered for 2021/22, albeit primarily on a non-recurrent basis at the system level.

Value for money

Financial sustainability (continued)	
Description	**Commentary on arrangements**
This relates to ensuring that the Trust has sufficient arrangements in place to be able to continue to provide its services within the resources available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ How the Trust sets its financial plans to ensure services can continue to be delivered; ▪ How financial performance is monitored and actions identified where it is behind plan; and ▪ How financial risks are identified and actions to manage risks implemented.	Efficiency plans are identified and developed at the Divisional level initially, and once approved by Divisional Board will be then discussed at the Divisional Improvement Forum, attended by Trust Executive Directors. There is an appropriate process in place for Quality Impact Assessment and additional levels of approval by the Quality and Safety Committee for those with a QIA risk score of 15 or more. We found that systems and processes for identifying, monitoring and escalating CIP delivery were designed and implemented effectively during the year. Much of the activity during 2021/22 has focused on CIP identification for 2022/23, with a planning assumption that the Trust will need to deliver 3% efficiencies recurrently (£15.8m). An additional 2% (£10.5m) non-recurrent target is to be delivered via working with the ICB to identify system-wide schemes. The Trust has a planned deficit for 2022/23 of £17.7m. However, this includes the receipt of system funding of £69.2m and assumes full achievement of the 5% CIP target of £26.3m. Therefore the underlying deficit before efficiency and system funding is £113.2m. The Trust's ability to mitigate this is effectively limited to CIP delivery. At the time of completing our risk assessment, the £15.8m target is made up of identified schemes of £10.4m and potential opportunities of £5.4m. However, within the identified schemes, only £0.4m is considered to be low risk, with 83% (£8.7m) still being at the 'hopper' / identification phase (ie. not fully risk-assessed and implemented). The delivery of CIP during 2022/23 presents a greater challenge than in previous years due to a combination of attempting to restore services while continuing to operate in an environment of high Covid-19 infection levels. As a result of the risk assessment we have undertaken, we identified a significant risk around the Trust's value for money arrangements in this area. **Risk assessment conclusion** Based on the risk assessment procedures performed, we have identified a significant risk associated with financial sustainability, specifically linked to the significant underlying deficit and level of unconfirmed CIP schemes for 2022/23. In response to this significant risk, we have undertaken the following procedures: ▪ Understanding and documenting contextual matters relating to the wider Lancashire and South Cumbria system and pressures within the Urgent Care system locally, at the system level and nationally. ▪ Holding discussions with officers to understand the factors impacting on the financial sustainability of the Trust and the underlying deficit for 2022/23. ▪ Reviewing and evaluating the Trust's systems and processes for identifying, challenging, monitoring and reporting on CIP delivery and achievement, at the local, divisional and Trust-wide level. ▪ Evaluating the Trust's financial strategy for 2022/23 and assessing whether this clearly articulates the challenges that exist within he system and the actions the Trust is taking in the areas under its control. ▪ As part of our initial risk assessment we also evaluated and evidenced the implementation of systems and processes for identifying, escalating and monitoring financial risks.

Value for money

Financial sustainability (continued)	
Description	**Commentary on arrangements**
This relates to ensuring that the Trust has sufficient arrangements in place to be able to continue to provide its services within the resources available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ How the Trust sets its financial plans to ensure services can continue to be delivered; ▪ How financial performance is monitored and actions identified where it is behind plan; and ▪ How financial risks are identified and actions to manage risks implemented.	**Risk findings** We have evaluated the Trust's latest financial strategy, which articulates clearly how the Trust is attempting to address the challenges within the Urgent Care system in particular, with reference to publications like Getting It Right First Time and Model Hospital. We are satisfied that the Trust has a robust process for identifying and challenging cost improvements and other efficiencies, including effective processes for impact-assessing these schemes. Reporting to Board and Finance Committee clearly articulate the challenges faced and the actions the Trust is taking to mitigate these challenges as much as is possible. The Trust's activities have been understood in the context of wider issues within Urgent Care, as well as the scale of the financial challenge across the NHS nationally and within the Lancashire and South Cumbria system. We have received high-level data relating to patient flow and the number of beds which the Trust is unable to make available due to downstream blockages in the health and social care system. We have also understood the impact that the economic landscape, namely rising inflation, is having on the ability of the Trust to make efficiencies in the area of procurement. **Conclusion** Based on the findings above we have not identified any significant weaknesses in the Trust's arrangements for ensuring financial sustainability.

Value for money

Governance	
Description	**Commentary on arrangements**
This relates to the arrangements in place for overseeing the Trust's performance, identifying risks to achievement of its objectives and taking key decisions. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ Processes for the identification and management of strategic risks; ▪ Decision making framework for assessing strategic decisions; ▪ Processes for ensuring compliance with laws and regulations; ▪ How controls in key areas are monitored to ensure they are working effectively.	We consider the Trust to have effective processes in place to identify, assess, monitor and manage risk, which is underpinned by a risk management framework and policy. Strategic risks are recorded and identified using the Board Assurance Framework, and any identified risks are appropriately reported to the appropriate governing body and relevant sub-committee. Our review of the risk register found this was sufficiently detailed to effectively manage key risks. Our assessment indicates that the Trust ensures key decisions are appropriately challenged and scrutinised by the executive team through an appropriate Scheme of Delegation and Standing Financial Instructions (SFI's), with escalation to Board as required. The Trust has specific policies in place with regards to fraud and whistleblowing. The Trust also engages a Local Counter Fraud Specialist who produces regular reports that go to Audit and Risk Committee. Additionally, the Trust has a designated Counter Fraud Champion and Freedom to Speak Up Guardian. We note from inquiry with and review of Local Counter Fraud reports in year that there was no indication of any significant weaknesses regarding the governance arrangements in place to prevent and detect fraud. Our assessment indicates that the Trust has processes in place to enable appropriate scrutiny, challenge and transparency on decision making. Business case documentation templates are adhered to for key decisions and these are sufficiently detailed to ensure that those making decisions are doing so in an informed manner. We reviewed a sample of business cases for 2021-22 and found there was evidence of scrutiny and challenge. We have also reviewed the approval of the 2021-22 financial plans by the Board and seen scrutiny and challenge within this approval leading to actions taken to improve the plan before submission to ensure it was realistic and achievable. Financial risks from this plan are also then communicated within the risk register going forward and discussed within Workforce Committee, Audit and Risk Committee and at Board meetings in a timely manner. Our initial assessment indicated there to be appropriate scrutiny and challenge of the budgets and appropriate approval through the budget holders and the Workforce Committee. In order to understand their financial performance against their budget, Divisional budget holders are provided with a monthly finance report which is also reviewed by the relevant Finance Manager. Discussions between Finance Managers and budget holders allowed for challenge and response to adverse variances. There is a separate Overspending Cost Centre Process which identifies the highest overspends and reports them to the relevant Divisional Board, with an action plan for mitigation. We also found processes in place to ensure accurate recording and monitoring of the additional costs associated with Covid-19.

Value for money

Governance (continued)	
Description	**Commentary on arrangements**
This relates to the arrangements in place for overseeing the Trust's performance, identifying risks to achievement of its objectives and taking key decisions. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ Processes for the identification and management of strategic risks; ▪ Decision making framework for assessing strategic decisions; ▪ Processes for ensuring compliance with laws and regulations; ▪ How controls in key areas are monitored to ensure they are working effectively.	Reviews of compliance with laws & regulations, staff code of conduct and the Trust's constitution is completed through Board meetings, Audit and Risk Committee and other governance structures as identified through our testing. We noted that the Trust has up to date policies on the recording of interests, gifts and hospitality. The Trust received a CQC review rating of 'Requires Improvement' at the last review in 2019, which noted a number of improvements since the previous inspection but highlighted areas that continue to require improvement. A CQC action plan was created and monitored at the Safety and Quality Committee where KPMG's assessment indicates that there was sufficient scrutiny over actions to ensure improvements were and continue to be made. We have reviewed overall governance arrangements in place and found appropriate processes are in place and we have not identified any significant weaknesses. **Risk assessment conclusion** Based on the procedures performed we have not identified a significant risk or significant weakness associated with the Trust's governance arrangements.

Value for money

Improving economy, efficiency and effectiveness	
Description	**Commentary on arrangements**
This relates to how the Trust seeks to improve its systems so that it can deliver more for the resources that are available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ The planning and delivery of efficiency plans to achieve savings in how services are delivered; ▪ The use of benchmarking information to identify areas where services could be delivered more effectively; ▪ Monitoring of non-financial performance to assess whether objectives are being achieved; and ▪ Management of partners and subcontractors.	We found appropriate processes in place to ensure the Trust uses information about costs and performance to improve the way they manage and deliver services. A monthly paper is presented to the Trust's Finance and Performance Committee, and the Trust Board, in order to report on financial performance, allowing the Trust to assess the level of value for money being achieved and any actions required. Management also maintains and monitors costs by reviewing the information received from benchmarking through review partnerships and the NHS Reference Costs and Model Hospital initiatives. The outputs of these exercises are fed directly to the Finance and Performance Committee in order to inform cost improvement programmes. The Trust's Board receives a monthly report with an integrated view of performance across the Trust's 'Big Plan' strategic aims. These cover key themes around Workforce, Quality, Activity and Finance. The Trust makes effective use of dashboard through reports to Board and Committees, in order to understand the key issues and improvement areas. This allows the Trust to monitor the performance of services. We noted through our risk assessment that the activities of the ICS/ICB are reported at a number of different forums in order that those charged with governance of the Trust are able to keep abreast of developments at the system level and that the organisation can respond to risks and challenges as they arise. The Trust CEO and Chair also provide updates within their reports to Board with the ICS financial performance also being considered in finance reports. During 21/22 expensive consultation has been undertaken relating to the New Hospitals Programme. This has involved engaging with all the key stakeholder groups in a variety of different ways. As a result of this partnership working, there are a number of tangible examples of service improvements delivered and reported on within the Trust during 2021/22. These include the new Pathology Collaborative and continuous partnership working at the system level to provide mutual support for elective services and long waiting patients, as well as moving of patients within the system in order to respond to demand. A further example is the use of the Nightingale surge hub that has enabled patient flow across the Lancashire & South Cumbria (L&SC) system. To facilitate the translation of Partnership-wide strategies into actions that can be implemented within the Trust, the L&SC ICS have a number of service delivery boards as well as the ICP board, which the Trust's officers interface with regularly and at various different levels. **Risk assessment conclusion** Based on the procedures performed we have not identified a significant risk or significant weakness associated with the arrangements for improving economy, efficiency and effectiveness.

KPMG

Year end report 2021/22

Lancashire Teaching Hospitals NHS Foundation Trust

29 June 2022

I confirm that this is the final version of our ISA 260 Audit Memorandum relating to our audit of the 2021/22 financial statements for Lancashire Teaching Hospitals NHS Foundation Trust. This document was discussed and approved by the Trust's Audit Committee on 16 June 2022.

Timothy Cutler

Partner for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Manchester

29 June 2022

Our audit opinions and conclusions:	
Financial Statements: unqualified	Use of resources: no significant weaknesses identified

Key contacts

Your key contacts in connection with this report are:

Tim Cutler
Partner
Tel: 07789 920497
tim.cutler@kpmg.co.uk

Chris Paisley
Senior Manager
Tel: 07468 367450
christopher.paisley@kpmg.co.uk

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Introduction

To the Audit Committee of Lancashire Teaching Hospitals NHS Foundation Trust

We are pleased to have the opportunity to meet with you on 16 June 2022 to discuss the results of our audit of the consolidated financial statements of Lancashire Teaching Hospitals NHS Foundation Trust (the 'Trust') as at and for the year ended 31 March 2022.

We are providing this report in advance of our meeting to enable you to consider our findings and hence enhance the quality of our discussions. This report should be read in conjunction with our audit plan and strategy report, presented on 20 January 2022, and risk assessment update paper presented on 28 April 2022. We will be pleased to elaborate on the matters covered in this report when we meet.

Our audit is now complete. There have been no significant changes to our audit plan and strategy. Subject to your approval of the financial statements, we expect to be in a position to sign our audit opinion.

We expect to issue an unmodified Auditor's Report on the financial statements and have not identified any significant weaknesses in your arrangements to secure value for money. In addition to this opinion we have prepared our Auditor's Annual Report which contains a narrative summary of our findings to be published on the Trust's website. This is included in the papers for this meeting.

We draw your attention to the important notice on page 4 of this report, which explains:

- The purpose of this report;
- Limitations on work performed; and
- Restrictions on distribution of this report.

Yours sincerely,

Tim Cutler

29 June 2022

How we have delivered audit quality

Audit quality is at the core of everything we do at KPMG and we believe that it is not just about reaching the right opinion, but how we reach that opinion. We consider risks to the quality of our audit in our engagement risk assessment and planning discussions.

We define 'audit quality' as being the outcome when audits are:

– **Executed consistently**, in line with the requirements and intent of **applicable professional standards** within a strong **system of quality controls** and

– All of our related activities are undertaken in an environment of the utmost level of **objectivity**, **independence**, **ethics** and **integrity**.

The National Audit Office (NAO) has issued a document entitled Code of Audit Practice (the Code). This summarises where the responsibilities of auditors begin and end and what is expected from the Trust.

External auditors do not act as a substitute for the Trust's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Important notice

This report is presented under the terms of our audit engagement letter.

— Circulation of this report is restricted.

— The content of this report is based solely on the procedures necessary for our audit.

This report has been prepared for the Audit Committee, in order to communicate matters of interest as required by ISAs (UK), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this report, or for the opinions we have formed in respect of this report.

Purpose of this report

This report has been prepared in connection with our audit of the consolidated financial statements of Lancashire Teaching Hospitals NHS Foundation Trust (the 'Trust'), prepared in accordance with International Financial Reporting Standards ('IFRSs') as adapted by the Group Accounting Manual issued by the Department of Health and Social Care, as at and for the year ended 31 March 2022. This report summarises the key issues identified during our audit but does not repeat matters we have previously communicated to you.

Limitations on work performed

This report is separate from our audit report and does not provide an additional opinion on the Trust's financial statements, nor does it add to or extend or alter our duties and responsibilities as auditors. We have not designed or performed procedures outside those required of us as auditors for the purpose of identifying or communicating any of the matters covered by this report.

The matters reported are based on the knowledge gained as a result of being your auditors. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

Status of our audit

Our audit is now complete.

Restrictions on distribution

The report is provided on the basis that it is only for the information of the Audit Committee of the Trust; that it will not be quoted or referred to, in whole or in part, without our prior written consent; and that we accept no responsibility to any third party in relation to it.

Our audit findings

Significant audit risks

Page 6 - 8

Significant audit risk	Risk change	Our findings
Fraudulent Expenditure Recognition	Stable	No issues or misstatements identified to date.
Land and Buildings Valuation	Stable	No issues or misstatements identified. Overall we consider that assumptions contained in the valuation are balanced.
Management override of controls	Stable	No issues or misstatements identified.

Key accounting estimates

Page 11 - 12

Land and Buildings Valuation	Neutral	Overall we consider that the assumptions underpinning the land and buildings valuation are balanced. See pages 11 and 12 for more details.

Value for money

Page 16 - 17

Under the Code of Audit Practice we are required to report to you if we have identified a significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have nothing to report in this respect. Our Auditor's Annual Report contains our public commentary in regard to this work and is elsewhere on the agenda.

Whole of Government Accounts

We intend to issue an unqualified Group Audit Assurance Certificate to the NAO regarding the Whole of Government Accounts submission, made through the submission of the summarisation schedules to Department of Health and Social Care.

Uncorrected audit misstatements

Page 13

Understatement/(overstatement)

	£m	%
Income	2.7	0.0
Surplus/(deficit)	(1.0)	(5.4)

Number of Control deficiencies

Page 21

Significant control deficiencies	0
Other control deficiencies	0
Prior year control deficiencies remediated	6/7

Other matters

In auditing the accounts of an NHS body auditors must consider whether, in the public interest, they should make a report on any matters coming to their notice in the course of the audit, in order for it to be considered by Trust members or bought to the attention of the public. There are no such matters we wish to bring to your attention.

Audit risks

1 **Expenditure recognition** — Fraud risk related to misstatement of expenditure

Significant audit risk

The risk

As the Trust is set a control total by NHS Improvement for its expected financial performance there is a risk that non-pay expenditure, excluding depreciation, may be manipulated in order to report that the control total has been met.

The setting of a breakeven target can create an incentive for management to either overstate or understate the level of non-pay expenditure compared to that which has been incurred, depending on how challenging the achievement of the target is. We consider this would be most likely to occur through under- or overstating accrued expenditure.

Based on our updated understanding of the Trust's financial performance at the year-end with respect to the 'requirement' to achieve a break-even position for 2021/22, we consider that there is a significant risk of material misstatement due to the **existence** and **accuracy** of expenditure recognised at the year-end, specifically reflected in the Non-NHS accruals captions.

Our response

We performed the following procedures in order to respond to the significant risk identified:

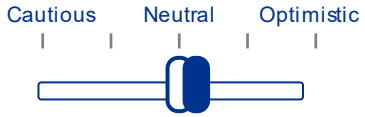
- Assessed the design and implementation of controls for monthly management review of accruals to identify inappropriate or erroneous accruals;
- Inspected a sample of invoices of expenditure, in the period in March 2022, to determine whether expenditure has been recognised in the correct accounting period;
- Selected a sample of year end accruals and inspected evidence of the actual amount paid after year end in order to assess whether the accrual exists / had been accurately recorded;
- Inspected journals posted as part of the year end close procedures that increase the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value can be agreed to supporting evidence;

Our findings

We identified three audit misstatements relating to year-end accrued expenditure, the details of which can be found in Appendix Three of this report. Two of these relate to individual errors arising from our sample which are below our reporting threshold but are projected by our sampling methodology to an extrapolated figure which exceeds our reporting threshold. Collectively these projected misstatements would impact the reported outturn by £3.2m, however as they are projected misstatements it is reasonable for these not to be amended in the financial statements. The third relates to the accrual of costs and associated income in respect of the Nightingale surge hub facility at the Preston site, which does not impact on the reported outturn.

We have not identified any other issues or misstatements as a result of the testing above.

Audit risks



2 Valuation of Property Plant and Equipment

Risk of error relating to misstatement of asset valuations

Significant audit risk

The risk

Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'.

The value of the Trust's land and buildings at 31 March 2022 is £234m, of which £231m were valued as specialised assets at depreciated replacement cost.

The Trust's last full valuation took place as at 31 March 2019, and as such a 'desktop' valuation was commissioned for 2021/22. However due to some changes in MEA assumptions, the approach taken by the valuer is more akin to a full valuation, with rebasing of rebuild costs based on latest BCIS index figures and revisions to obsolescence factors.

Our response

We have performed the following procedures designed to specifically address the significant risk associated with the valuation:

- We critically assessed the independence, objectivity and expertise of Cushman and Wakefield, the valuers used in developing the valuation of the Trust's properties at 31 March 2022. We inspected the instructions issued to the valuers to verify they were appropriate.
- We assessed the accuracy of the data provided to the valuers for the development of the valuation to underlying information, such as floor plans, and to previous valuations.
- We critically assessed the design and implementation of controls in place for management to review the valuation and the appropriateness of assumptions used.
- We challenged key assumptions within the valuation, including the use of relevant indices and assumptions of how a modern equivalent asset would be developed, as part of our judgement.
- We performed inquiries of the valuers in order to verify the methodology that was used in preparing the valuation and whether it was consistent with the requirements of the RICS Red Book and the GAM.
- We agreed the calculations performed of the movements in value of land and buildings and verified that these have been accurately accounted for in line with the requirements of the GAM.
- We assessed whether sufficient disclosure had been provided of the estimation uncertainty associated with the valuation of the Trust's estate.

Our findings

We have one misstatement from our work on this significant risk, in relation to £2.7m of capital expenditure which overstated the net book value following revaluation. We have otherwise determined that the judgements made by your valuers and adopted by you are balanced overall, as outlined on pages 11-12.

Audit risks

3 Management override of controls[a]

Fraud risk related to unpredictable way management override of controls may occur

Significant audit risk

The risk

— Professional standards require us to communicate the fraud risk from management override of controls as significant.

— Management is in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.

— We did not identified any specific additional risks of management override relating to this audit.

Our response

— We evaluated the design and implementation of controls over journal entries and post-closing adjustments.

— We assessed the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates.

— We assessed the appropriateness of the accounting for significant transactions that are outside the component's normal course of business, or are otherwise unusual.

— We assessed the full population of relevant journal entries to identify journals displaying high risk characteristics. We followed up each of these journals in order to assess the appropriateness and accuracy of the transaction posted.

— We assessed the controls in place for the identification of related party relationships and tested the completeness of the related parties identified. We verified that these have been appropriately disclosed within the financial statements.

Our findings

— We identified 14 journal entries and other adjustments meeting our high-risk criteria – our examination did not identify any inappropriate entries.

— We evaluated accounting estimates, including the consideration of assumptions underpinning the valuation of land and buildings and did not identify any indicators of management bias. See pages 11 - 12 for further discussion.

— We did not identify any significant unusual transactions.

Note: (a) Significant risk that professional standards require us to assess in all cases.

Audit risks

4 Revenue recognition

Fraud risk related to misstatement of revenues

Other area of audit focus

The risk

Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.

We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial covenants, rather than broader share based management concerns.

However, due to the block contract nature of much of the Trust's revenue for 2021/22, as well as the disaggregated nature of non-NHS income into multiple immaterial revenue streams, we rebutted this presumed risk for the year ended 31 March 2022. We still regard testing of revenue as an area of audit focus.

Our response

- We agreed commissioner income to the agreed block funding amounts and cash received from commissioners for the largest funding sources/commissioners. We critically assessed the accounting for any variations to the funding levels to ensure they had been recorded correctly under IFRS 15.
- We performed sample testing of invoices for income in the period prior to and following 31 March 2022 to determine whether income was recognised in the correct accounting period, in accordance with the amounts billed to the corresponding parties.
- We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers and confirmed the values they are disclosing within their financial statements to the value of income captured in the financial statements. We sought explanations for any variances over £300,000, and challenged the Trust's assessment of the level of income they are entitled to and receipts that can be collected.
- We agreed additional funding streams received at the end of the year for pension top up to notifications received.
- We performed sample testing of deferred income balances at year end in order to confirm that they had been recorded within the correct accounting period based on the service to be provided.

Our findings

No issues or misstatements identified from the work in relation to this significant risk.

Audit risks

5 IFRS 16 implementation

Risk relating to the accuracy of the Trust's disclosures of the impact of IFRS 16

Other area of audit focus

The risk.

The delayed adoption of IFRS16 has been confirmed as taking place from 1 April 2022. Whilst full implementation is not required in the 2021/22 financial statements the impact of the new standard is required to be included in the accounting policies.

The main source of this risk is that lease terms and lease payments are inappropriately determined. This is a particular risk for arrangements which are not subject to a formal contract such as property agreements with NHS Property Services without an agreed contract or term.

While grandfathering rights are in place it is important that the Trust has completely and accurately identified the leases that it has in place to fully determine the impact of the new standard.

Our response

- We evaluated the Trust's process for reviewing current arrangements and contracts to ascertain whether there is a lease falling within the remit of the standard;
- We tested the completeness and accuracy of the data collected by the Trust and used as part of the preparation of the disclosure note;
- We critically assessed the key decisions made about material contracts such as property leases, such as lease terms where not clear;
- We reviewed the discount rate used in the calculation of the lease liability;
- We reperformed the calculation of the lease liability and right of use asset for a sample of leases;
- We critically assessed the disclosure proposed for compliance with the requirements of the GAM.

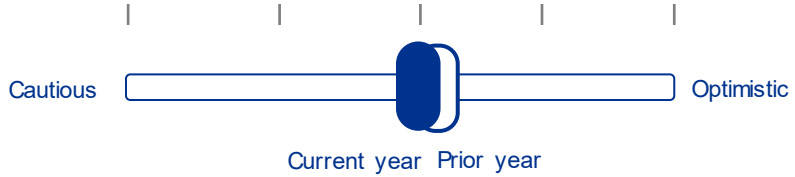
Our findings

No issues or misstatements identified from the work we have completed.

Key accounting estimates - Overview

Our view of management judgement

Our views on management judgments with respect to accounting estimates are based solely on the work performed in the context of our audit of the financial statements as a whole. We express no assurance on individual financial statement captions. Cautious means a smaller asset or bigger liability; optimistic is the reverse.



Asset/liability class	Our view of management judgement	Balance (£m)	YoY change (£m)	Our view of disclosure of judgements & estimates	Further comments
Valuation of property, plant and equipment Movement comprised of (approx.):	Cautious / Neutral / Optimistic	231.4	+14.9	Needs improvement / Neutral / Best practice	**Overall we consider that the assumptions underpinning the land and buildings valuation are balanced. See details of individual components of the valuation below.**
Increase in BCIS rates offset by changes (increases) in obsolescence levels (also includes the effect of CapEx during the year)			+26.3		We have validated the inputs to the valuation including latest BCIS rates and floor areas which are consistent with those used in previous valuations. We have critically assessed changes to functional obsolescence and these have been adequately explained and supported by Cushman and Wakefield.
50% reduction in administrative areas			(3.0)		Supported by evidence of consolidation of existing administrative areas in addition to hybrid working policies now in place. We have requested that your estimates and judgements disclosure is updated to specifically reference this assumption and its impact.

Key accounting estimates - Overview (continued)

Asset/liability class	Our view of management judgement	Balance (£m)	YoY change (£m)	Our view of disclosure of judgements & estimates	Further comments
	Cautious / Neutral / Optimistic			Needs improvement / Neutral / Best practice	
25% reduction in outpatient areas			(4.8)		Supported by evidence of actual increased proportion of outpatient activity taking place on a remote basis compared with pre-pandemic levels, as well as NHS Long Term Plan assumptions around the level of remote consultations which provides assurance over the longevity of these arrangements. We have requested that your estimates and judgements disclosure is updated to specifically reference this assumption and its impact.
30% reduction in education and training areas			(3.5)		Supported by Estates assessment of required space for Education and Training in addition to trend data around number of courses being delivered remotely. The data and evidence supporting this assumption is less specific than for the other new assumptions described above, and therefore we determine that this assumption is at the more optimistic end of the range (while clearly not having a material impact on the valuation). We have requested that your estimates and judgements disclosure is updated to specifically reference this assumption and its impact.

Summary of audit misstatements

Materiality = £11.0m

A summary of the uncorrected audit misstatements is detailed on pages 26 and 27.

The misstatements identified, and their estimated financial impact on the reported outturn, are summarised in the table on the right.

In line with ISA (UK) 450 we request that you correct uncorrected misstatements.

Key comments

- If the uncorrected factual audit misstatements were posted, they would increase the reported deficit by £1m. For our views on management estimates – see pages 11 ad 12 (Key accounting estimates)
- A detailed summary of corrected and uncorrected audit misstatements and omissions and errors in disclosure is included in Appendix 3.

Audit misstatements – Outturn position

	Type	£m
Draft accounts reported deficit position		**(18.5)**
Uncorrected misstatements		
– Accruals testing – projected misstatement	Projected	1.0
– GRNI accruals testing – projected misstatement	Projected	0.7
– Transfers by absorption	Judgemental	0.1
– Impairment of capitalised building costs	Factual	(2.8)
– Surge hub additional costs accrued	Factual	-
Our assessment		**(19.5)**

Group involvement - significant component audits

Involvement in group components

The Group financial statements are made up of the following components:

- Lancashire Teaching Hospitals NHS Foundation Trust
- Lancashire Hospitals Services (Pharmacy) Limited - Subsidiary

As communicated in our audit plan we determined that the parent Trust was the only significant component. We have performed risk assessment procedures over the subsidiary component in order to confirm that there were not material balances within the other entity that could cause a material error and did not identify any exceptions. In order to support our opinion on the consolidated financial statements, we have performed audit testing on the group drug costs expenditure which is then recharged to the subsidiary. We will complete our audit of the rest of the component accounts to a later timescale and will report the findings from this to the Pharmacy Company Board at a later date.

Other matters

Annual report

We have read the contents of the Annual Report (including the Accountability Report, Directors Report, Performance Report and Annual Governance Statement (AGS)) and audited the relevant parts of the Remuneration Report. We are still in the process of checking compliance with the NHS Group Accounting Manual (GAM) issued by Department of Health and Social Care and Foundation Trust Annual Reporting Manual (the ARM). We will complete and report verbally to the Audit Committee on the following procedures:

- Identifying any inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements.
- Identifying any material inconsistencies between the knowledge acquired during our audit and the director's statements. As Directors you confirm that you consider that the annual report and accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.
- Confirming that the parts of the Remuneration Report that are required to be audited were all found to be materially accurate.
- Evaluating whether the AGS is consistent with the financial statements and complies with relevant guidance; and
- Confirming that the report of the Audit Committee included in the Annual Report includes the content expected to be disclosed as set out in the GAM and ARM and was consistent with our knowledge of the work of the Committee during the year.

Whole of Government Accounts

As required by the National Audit Office (NAO) we are required to provide a statement to the NAO on your consolidation schedule. We comply with this by checking that your summarisation schedule is consistent with your annual accounts. We have completed that work and found no matters to report. The Trust was selected for additional procedures this year. We are still in the process of completing this testing but to date have no matters to report.

Independence and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors, which we completed at planning and no further work or matters have arisen since then.

Audit Fees

Our fee for the financial statements audit and Value for Money work was £107,000 plus VAT (£79,108 in 2020/21). Additionally, for 2021/22, we propose additional fees of £10,750 plus VAT in connection with: testing of additional MEAV assumptions in the valuation of land and buildings; additional work around IFRS16 implementation; and relating to the Trust being a sampled component by the NAO for which we need to complete full WGA procedures. Each of these is incremental and additional to the hours spent delivering the prior year audit. We also are charging £13,260 for the audit of the subsidiary company. We have not completed any non-audit work at the Group/Trust during the year.

Value for money

We are required under the Audit Code of Practice to confirm whether we have identified any significant weaknesses in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

In discharging these responsibilities we include a statement within the opinion on your accounts to confirm whether we have identified any significant weaknesses. We also prepare a commentary on your arrangements that is included within our Auditor's Annual Report, which is required to be published on your website alongside your annual report and accounts.

Commentary on arrangements

We have prepared our Auditor's Annual Report and a copy of the report is included within the papers for the Committee alongside this report. The report is required to be published on the Trust's website alongside the publication of the Trust's annual report and financial statements.

Response to risks of significant weaknesses in arrangements to secure value for money

As reported in our risk assessment we noted one risk of a significant weakness in the Trust's arrangements to secure value for money. Our response to this risk is set out on the following page.

Summary of findings

We have set out in the table below the outcomes from our procedures against each of the domains of value for money:

Domain	Risk assessment	Summary of arrangements
Financial sustainability	One significant risk identified	No significant weaknesses identified
Governance	No significant risks identified	No significant weaknesses identified
Improving economy, efficiency and effectiveness	No significant risks identified	No significant weaknesses identified

We identified a significant risk relating to financial sustainability, particularly around the forecast deficit and level of currently unconfirmed CIP schemes for 2022/23. We have set out on the following page the work performed in response to this risk and a summary of our findings.

Value for money - risk of significant weakness in arrangements

Domain - Financial sustainability	
Description of risk	**Our response**
The significant underlying deficit and level of unconfirmed CIP schemes for 2022/23 creates a risk that the entity does not have appropriate value for money arrangements to ensure financial sustainability. In this context, appropriate arrangements relate to those matters that are within the Trust's control and can be reasonable put in place by the Trust as an individual entity.	In response to this significant risk, we have undertaken the following procedures: ▪ Understanding and documenting contextual matters relating to the wider Lancashire and South Cumbria system and pressures within the Urgent Care system locally, at the system level and nationally. ▪ Holding discussions with officers to understand the factors impacting on the financial sustainability of the Trust and the underlying deficit for 2022/23. ▪ Reviewing and evaluating the Trust's systems and processes for identifying, challenging, monitoring and reporting on CIP delivery and achievement, at the local, divisional and Trust-wide level. ▪ Evaluating the Trust's financial strategy for 2022/23 and assessing whether this clearly articulates the challenges that exist within he system and the actions the Trust is taking in the areas under its control. As part of our initial risk assessment we also evaluated and evidenced the implementation of systems and processes for identifying, escalating and monitoring financial risks. **Our findings** At the time of completing our risk assessment, the £15.8m CIP target was made up of identified schemes of £10.4m and potential opportunities of £5.4m. However, within the identified schemes, only £0.4m is considered to be low risk, with 83% (£8.7m) still being at the 'hopper' / identification phase (ie. not fully risk-assessed and implemented). The delivery of CIP during 2022/23 presents a greater challenge than in previous years due to a combination of attempting to restore services while continuing to operate in an environment of high Covid-19 infection levels. We have evaluated the Trust's latest financial strategy, which articulates clearly how the Trust is attempting to address the challenges within the Urgent Care system in particular, with reference to publications like Getting It Right First Time and Model Hospital. We are satisfied that the Trust has a robust process for identifying and challenging cost improvements and other efficiencies, including effective processes for impact-assessing these schemes. Reporting to Board and Finance Committee clearly articulate the challenges faced and the actions the Trust is taking to mitigate these challenges as much as is possible. The Trust's activities have been understood in the context of wider issues within Urgent Care, as well as the scale of the financial challenge across the NHS nationally and within the Lancashire and South Cumbria system. We have received high-level data relating to patient flow and the number of beds which the Trust is unable to make available due to downstream blockages in the health and social care system. We have also understood the impact that the economic landscape, namely rising inflation, is having on the ability of the Trust to make efficiencies in the area of procurement. **Conclusion** Based on the findings above we have not identified any significant weaknesses in the Trust's arrangements.

Appendix

Contents

Appendix One

Required communications with the Audit Committee

Type		Response
Our draft management representation letter		We have requested specific representations relating to new assumptions included within the Modern Equivalent Asset valuation of land and buildings, in addition to those areas normally covered by our standard representation letter for the year ended 31 March 2022.
Adjusted audit differences		Management made some presentational adjustments to the financial statements. The most significant of these in relation to reclassifications of the PPE note are described on slide 27.
Unadjusted audit differences		The aggregated impact on the reported outturn of unadjusted audit differences would be an increase of £1.0m to the reported deficit position. In line with ISA 450 we request that you adjust for these items. However, they will have no effect on the opinion in the auditor's report, individually or in aggregate. See Pages 26 and 27.
Related parties		There were no significant matters that arose during the audit in connection with the entity's related parties.
Other matters warranting attention by the Audit Committee		There were no matters to report arising from the audit that, in our professional judgment, are significant to the oversight of the financial reporting process/summarise any matters to raise to the Committee.
Control deficiencies		We communicate to management in writing, through this report, all deficiencies in internal control over financial reporting of a lesser magnitude than significant deficiencies identified during the audit that had not previously been communicated in writing.
Actual or suspected fraud, noncompliance with laws or regulations or illegal acts		No actual or suspected fraud involving LTH management, employees with significant roles in internal control, or where fraud results in a material misstatement in the financial statements was identified during the audit.
Make a referral to the regulator		If we identify that potential unlawful expenditure might be incurred then we are required to make a referral to your regulator. We have not identified any such matters.
Issue a report in the public interest		We are required to consider if we should issue a public interest report on any matters which come to our attention during the audit. We have not identified any such matters.

Appendix One

Required communications with the Audit Committee

Type		Response
Significant difficulties		No significant difficulties were encountered during the audit.
Modifications to auditor's report		None.
Disagreements with management or scope limitations		The engagement team had no disagreements with management and no scope limitations were imposed by management during the audit.
Other information		No material inconsistencies were identified relating to other information in the annual report, Strategic and Directors' reports. The Annual report is fair, balanced and comprehensive, and complies with the Annual Reporting Manual.
Breaches of independence		No matters to report. The engagement team have complied with relevant ethical requirements regarding independence.
Accounting practices		Over the course of our audit, we have evaluated the appropriateness of the Trust/Groups accounting policies, accounting estimates and financial statement disclosures. In general, we believe these are appropriate.
Significant matters discussed or subject to correspondence with management		No significant matters arising from the audit were discussed, or subject to correspondence, with management.
Certify the audit as complete		We are required to certify the audit as complete when we have fulfilled all of our responsibilities relating to the accounts and use of resources as well as those other matters highlighted above.
Provide a statement to the NAO on your consolidation schedule		We will issue our report to the National Audit Office following the signing of the annual report and accounts.
Provide a summary of significant weakness in arrangements to provide value for money		We are required to report significant weaknesses in arrangements. We have not identified any significant weaknesses.

Appendix Two

Control observations

We have not made any new recommendations as a result of our audit work this year. We have followed up the recommendations from the previous years audit, in summary:

Total number of recommendations	Number of recommendations implemented	Number outstanding (repeated below):
7	6	1

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (June 2022)
Financial Statements				
1	2	**Journals posted by users on behalf of other users** Within our journals sample we identified five instances of journals posted by users on behalf of a different requester. There is a risk that incorrect or inappropriate journals could be posted if users are asked to post journals on behalf of other users. **Recommendation** We recommend the trust provides training for staff and revises standard operating procedures to ensure individuals do not post journals on behalf of other users within the Trust.	The Assistant Finance Director – Financial Services will, in Q2 of 2021/22, introduce revised procedures to ensure that staff do not post journals on behalf of other users.	We did not identify any instances of journals being approved on behalf of others during 2021/22. We are aware that staff have been reminded that they should not do so, therefore we consider that this recommendation has been implemented.
2	2	**Accruals** Our review of the accruals process testing of year end balances identified that journals posting controls are relied on to ensure that the accruals are accurate and appropriate. Our testing identified three instances where expenditure had been accrued but where goods or services had not been received by the Trust. Our testing also identified control deficiencies in the journals posting process. There is a risk that accruals are posted at the year end that result in expenditure being recognised in the wrong accounting period. **Recommendation** We recommend that year end expenditure accruals are reviewed and challenged by management in order to ensure that they are only being made where goods or services have been received before the period end.	The Trust has tasked the Assistant Finance Director – Financial Services with introducing a 'No PO no Pay Policy' within the first half of 2021/22. This will result in all Trust purchases being visible and a report will be created to show all goods received not invoiced at month-end and this will form the basis of month-end and year-end accruals. The Financial Controller will produce a schedule of one-off accounting entries for discussion and approval by the Deputy DOF as part of the month end accounts review meeting.	There are a number of controls through which inappropriate accrual journals would be identified by management, and some assurance over completeness of accruals is gained through monthly and year-end balance sheet and I&E reviews. However, the Trust does not yet have a formal process whereby month- and year-end accruals are reviewed in detail for completeness, existence and accuracy. Therefore we consider that this recommendation is outstanding.

Appendix Two

Control observations (continued)

	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (June 2022)
Financial Statements				
3	2	**Segregation of duties in the processing of journals** Our controls testing around approval and segregation of duties in journal entry processing identified three journal entries that were created and approved / posted by the same individual. In two instances, the individual was an employee of NHS Shared Business Services. For one journal, due to authorisation limits, the journal was approved but then subsequently routed to the original requester for secondary approval due to authorisation limits. At year end we reviewed a complete journals listing to identify whether any other instances occurred and identified an additional two journals without segregation of duties, however these related to reversals of previous accruals. There is a risk where journals are not subject to secondary review by another, more senior, member of staff that inappropriate or erroneous journals are posted to the ledger and this is not detected by the Trust. **Recommendation** We recommend that all journals, including those posted by NHS SBS are subject to segregation of duties and review by senior members of staff. Where this is considered not possible, the finance team should review all journals that have not been subject to segregation of duties in order to satisfy themselves that the journals are accurate and appropriate.	All journals posted are reviewed on a monthly basis by the Senior Financial Account using the A100 Actual Journals Audit History report, and instances where a journal is posted and approved by the same individual are verified as being appropriate. This process is felt to be sufficient to mitigate the risk. SBS have an internal policy ensuring that no individual approves their own journals and are also audited on this point which is referred to in the ISAE3402 report. They use the A100 repot to retrospectively check that the policy has been adhered to. With effect from 1st July 2021 the Assistant Finance Director – Financial Services will sign the A100 reports to evidence that the review has been undertaken.	Recommendation implemented. There is now a process by which all journals without segregation of duties appearing on the A100 report are reviewed retrospectively.

Control observations (continued)

	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (June 2022)
Financial Statements				
4	2	**Impairment review** Our testing of property, plant and equipment balances identified that a formal impairment review had not been completed by management or reviewed by the Board ahead of the year end close down process. Although a desktop valuation has taken place during the year, there is a risk that if an impairment review is not completed, then the valuer could be basing their valuation on inaccurate information or inappropriate instructions. **Recommendation** We recommend that a formal impairment review is completed on an annual basis. The impairment review should document the different factors that have been taken into consideration by management, such as but not limited to, changes in the use of assets, changes to future plans, obsolescence, void buildings and buildings that have required significant maintenance during the year. These outcomes of this review should be formally documented and used to inform any desktop valuation exercises that are completed. We also recommend that the results of the impairment review are presented to the Board.	The Capital Accountant will carry out an impairment review ahead of the year-end and recommend actions to Senior Management ahead of them being presented to the Board/Audit Committee. This process will be implemented ahead of the 2021/22 year-end.	A formal review of impairment indicators has been undertaken for 2021/22. Recommendation implemented.
5	2	**Valuation of land and buildings – enhancement of controls** We observed that management has not documented its review and challenge of the valuation of property, plant and equipment that has been performed by Cushman and Wakefield (C&W). There is a risk that if management do not satisfy themselves with the valuation methodology, the assumptions applied and the accuracy of inputs, errors could exist in the valuation that go undetected that could result in a misstatement being included in the accounts. **Recommendation** We recommend that management formally documents its review and challenge of the valuers methodology, the assumptions used and how they have confirmed input data is complete and accurate.	The capital accountant will document the review and challenge relating to year-end valuations provided by third parties.	Through our work on the valuation of land and buildings, we were able to clearly see that the Trust had been closely involved in the valuation process and had provided appropriate input and challenge to the valuation, which went through a number of iterations as a result. While these review mechanisms do not constitute a Management Review Control in line with International Standards on Auditing, we consider that our recommendation has been implemented.

Appendix Two

Control observations (continued)

	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (June 2022)
Value for Money				
1	2	**CIP identification and monitoring** Despite the suspension of the formal CIP reporting for 2020-21, we observed that other Trusts continued to identify and monitor CIPs throughout the year. Whilst the Trust has demonstrated its ability to manage it resources within the confines of the funding regime, the Trust's formal in in year monitoring of CIPs was very limited. We acknowledge that whilst it is reasonable to not deliver meaningful efficiencies in clinical areas due to the pandemic, we would expect the Trust to continue considering corporate service benchmarking and procurement efficiencies and as part of its formal reporting to the Board and Finance and Performance Committee. The Trust has provided evidence that cost improvement activity has taken place by providing evidence of reporting on Continuous Improvement and details of one of the Trust's ongoing CIP schemes relating to radiology. However, it is unclear whether this activity was part of a wider target or why this activity was specifically prioritised over other savings initiatives. The Trust has agreed a CIP target for 2021-22 as part of the budget setting process. Reimplementing processes for robust monitoring will therefore become increasingly important to demonstrate there is adequate arrangements in place over value for money. **Recommendation** We recommend that Management should ensure CIP savings are clearly identified and that progress is monitored and reported to the Board and Finance and Performance Committee.	The monthly CIP reporting to Finance and Performance Committee will be restarted in 2021/22 – Asst Finance Director – Financial Advice	Our Value for Money risk assessment, and focused work on the financial sustainability domain, has indicated that the Trust had appropriate arrangements during the year for reporting of CIP performance. Recommendation is therefore considered to be implemented.

Appendix Two

Control observations (continued)

	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (June 2022)
Value for Money				
2	2	**NHS costs analysis and use of benchmarking** During 2019-20, the Trust participated in NHS National Costing Exercises that compared the cost of services and identified areas where costs were considered high (high Reference Cost Indexes). In addition, the Trust has obtained corporate benchmarking information from sources such as Model Hospital, in order to identify higher cost areas of service provision. Whilst we are satisfied that these findings were presented and considered by the Board and Finance and Performance Committee during 2020-21, it is unclear what resulting actions were taken during 2020-21 that could contribute to the potential identification of further savings or how these were monitored and reported on to the Board. **Recommendation** Management should ensure they use the national costing exercise, in addition to model hospital data and Getting It Right First Time (GIRFT), to inform the identification of efficiency savings throughout the year. Action plans should be agreed and progress against implementation monitored by the Board and Finance and Performance Committee.	This is included in the Trust's 2021/22 Big Plan targets in Fit for the Future – Director of Service Development	Our Value for Money risk assessment for 2021/22 we have identified areas in which the benchmarking and other publications mentioned have been utilised in particular in developing the Trust's financial strategy which will be monitored in 2022/23 and beyond. We therefore consider that this recommendation has been implemented.

Appendix Three

Audit Differences

Under UK auditing standards (ISA (UK&I) 260) we are required to provide the Audit Committee with a summary of unadjusted audit differences (including disclosure misstatements) identified during the course of our audit, other than those which are 'clearly trivial', which are not reflected in the financial statements. In line with ISA (UK&I) 450 we request that you correct uncorrected misstatements. However, they will have no effect on the opinion in our auditor's report, individually or in aggregate. As communicated previously with the Audit Committee, details of all adjustments greater than £300k are shown below:

Unadjusted audit differences (£'000)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
1	Dr Non-NHS and other WGA Accruals Cr Other Operating Expenses	 (1,058)	1,058	Our sample testing of non-NHS accruals identified one accrual totalling £23k which was a duplicate and was not required to be recognised in 2021/22. This error has been extrapolated by KPMG's sampling methodology and software to a projected misstatement of £1,058k. As the actual error identified is clearly trivial, we would not normally expect for such a matter to be amended in the financial statements, but we report this matter to you as the extrapolated error exceeds our reporting threshold of £300k.
2	Dr Non-NHS and other WGA Accruals Cr Other Operating Expenses	 (725)	725	We separately test the population of accruals for expenditure relating to goods received but not invoiced (GRNI). This testing identified a single error totalling £7k relating to an amount which was 'over-receipted' in error (i.e.. where a greater value is receipted than is subsequently owed as per the supplier invoice), which has been extrapolated by KPMG's sampling methodology and software to a projected misstatement of £725k. As the actual error identified is clearly trivial, we would not normally expect for such a matter to be amended in the financial statements, but we report this matter to you as the extrapolated error exceeds our reporting threshold of £300k.
3	Cr Losses arising from transfers by absorption (SOCI) Dr Loss on disposal of assets Cr Donations/grants of physical assets (Other Operating Income)	(1,121) 1,671 (617)		As set out in the financial statements note 27, the Trust received PDC capital funding for projects across the Lancashire and South Cumbria ICS during 2021/22, which partly involved purchasing equipment on behalf of other NHS bodies. Likewise, those other bodies also purchased some equipment on behalf of the Trust. These asset transfers and the resulting impact on the SOCI have been recognised as transfers by absorption. KPMGs view is that this method is reserved for instances where whole transfers of services have occurred, and that the substance of this arrangement is that assets have been disposed of at a loss (a debit to the SOCI), with some assets donated to the Trust in return (which results in a credit to the SOCI).

Appendix Three

Audit Differences (continued)

Unadjusted audit differences (£'000)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
4	Dr Impairments (SOCI) Cr Property, Plant and Equipment (SOFP)	2,765	(2,765)	Through our reconciliation of the valuation of land and buildings to the financial statements, we noted a sum of £2,765k which was included in the completed Buildings net book value, exceeding the external valuation provided. This related to Capital Expenditure in the year which was taken into account by Cushman and Wakefield in conducting the valuation. Therefore our view is that these capitalised cost ought to be impaired and written off to the SOCI.
5	Dr Non-NHS and other WGA Accruals Cr Operating Expenses Dr Operating income from patient care activities Cr Contract receivables	 (3,362) 3,362 	3,362 (3,362)	The Trust received notification from NHSE/I in March 2022 of additional costs relating to the 'Nightingale' surge hub which were required to be accrued for in 2021/22, with corresponding income also accrued to match these costs. The total additional costs are £3,952k, and the Trust has been able to determine that of this the estimated costs for removal of the surge hub is £590k, with the difference being costs for continued leasing of the facility of £3,362k. Given that the surge hub has been in situ for some months and it is reasonable for costs to be provided for removal, the remainder relates to services not yet received and therefore our view is that the accrued expenditure (and corresponding accrued income) should be removed from the financial statements.
Total		915	(982)	

Under UK auditing standards (ISA UK&I 260) we are required to provide the Audit Committee with a summary of adjusted audit differences (including disclosures) identified during the course of our audit. There have been no adjustments greater than £300k made as a result of audit differences.

We have made a number of disclosure observations which have been amended by management, the most significant of which was the adjustment to reclassify capitalised expenditure within Note 12 of £7,115k from Buildings Excluding Dwellings to Assets Under Construction.

Intra-group error reporting

Further to the misstatements identified above we are required to report any identified errors in the reporting of intra-group balances with other Department of Health and Social Care entities exceeding £300,000 as part of our reporting on the Whole of Government Accounts to the National Audit Office. We have not identified any such errors through our testing.

Appendix Four

Confirmation of Independence

We confirm that, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and that the objectivity of the Partner and audit staff is not impaired.

To the Audit Committee members

Assessment of our objectivity and independence as auditor of Lancashire Teaching Hospitals NHS Foundation Trust

Professional ethical standards require us to provide to you at the completion stage of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the FRC Ethical Standard.

As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity.

Independence and objectivity considerations relating to the provision of non-audit services

Summary of non-audit services

We have not provided any non-audit services to the Trust during 2021/22.

Appendix Four

Confirmation of Independence

We have considered the fees charged by us to the Trust and its affiliates for professional services provided by us during the reporting period. Total fees charged by us can be analysed as follows:

	2021/22	2020/21
	£'000	£'000
Audit of Lancashire Teaching Hospitals NHS Foundation Trust	107	79
Audit of Lancashire Hospitals Services (Pharmacy) Limited	14	13
Additional scope fees (IFRS16, MEAV assumptions, sampled WGA component)	11	-
Total audit	**132**	**92**
Other Assurance Services	-	-
Total non-audit services	-	-
Total Fees	**132**	**92**

Fee ratio

The anticipated ratio of non-audit fees to audit fees for the year at the time of planning is 0: 1. We do not consider that the total non-audit fees create a self-interest threat since the absolute level of fees is not significant to our firm as a whole.

Application of the FRC Ethical Standard 2019

We communicated to you previously the effect of the application of the FRC Ethical Standard 2019. That standard became effective for the first period commencing on or after 15 March 2020, except for the restrictions on non-audit and additional services that became effective immediately at that date, subject to grandfathering provisions.

We confirm that as at 15 March 2020 we were not providing any non-audit or additional services that required to be grandfathered.

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgement, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the Audit and Compliance Committee and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours faithfully

KPMG LLP

Appendix Five

FRC's areas of focus

The areas of focus from the FRC's Annual Review of Corporate Reporting 2020/21, annual letter to CEOs, CFOs and audit committee chairs along with the five thematic reviews issued in 2021 should be considered for reporting in the current financial period. The reports identify where the FRC believes organisations should be improving their reporting. Below is a high level summary of the key topics. We encourage management and those charged with governance to read further on those areas which are significant to the Trust.

Judgements and Estimates	In the current climate it is particularly important for entities to provide as much context as possible for the assumptions and predictions underlying the amounts recognised in the financial statements, including potential sensitivities or ranges of possible outcomes. Trusts should disclose the carrying amounts impacted by estimation uncertainty. Disclosures of key assumptions and sensitivities could be improved. Preparers are encouraged to clearly distinguish between sources of estimation uncertainty with a significant risk of a material adjustment in the following year and other, perhaps longer-term, uncertainties. Significant accounting judgements should be clearly explained along with factors considered.
Revenue	Having raised a considerable number of queries in relation to revenue recognition policies and related disclosure, the FRC strongly encourage preparers to read their thematic report which includes tips and examples of good and inadequate disclosure. Entities should disclose significant judgements made in accounting for revenue. This could include judgements in relation to performance obligations, transaction price and amounts allocated to performance obligations. Disclosures should clearly identify the methods used to estimate any variable consideration.
Statement of Cash Flows	Organisations need robust reviews of the cash flow statement to ensure consistency with other parts of the annual report and to ensure preparation in line with the accounting standard. Errors continue to be identified, including inappropriate classification of cash flows and inappropriate netting. The FRC also challenges organisations on the composition of cash equivalents and on incomplete or incorrect related disclosures. Organisations are reminded that even in the limited cases where borrowings can be included as a component of cash and cash equivalents in the cash flow statement, the IAS 32 'Financial Instruments: Presentation' criteria need to be applied to determine whether they can be presented on a net basis in the balance sheet.
Alternative Performance Measures (APMs)	APMs should not be given undue-prominence. Preparers should avoid statements appearing to provide APMs with more authority than IFRS measures and are reminded that meaningful commentary on the IFRS figures is required. APMs, including ratios, should be appropriately labelled and reconciled to the most directly reconcilable financial statement line item. It should be clear how reconciling items are determined and companies should explain clearly why amounts are excluded from adjusted measures. Adjusting items should include gains as well as losses, where relevant.

Appendix Five

FRC's areas of focus

Strategic Report	The annual report should provide a fair, balanced and comprehensive analysis of the development and performance of the business in the financial year and of its position at the end of the year. In particular companies are encouraged to include discussion of relevant significant matters and performance against key strategic objectives.
Provisions and contingencies	Provisions and contingencies should be clearly explained including the nature of the exposure, the timeframe and the basis for determining the amount. Any significant judgements and relevant assumptions should be disclosed clearly. There should be consistency between information provided in the annual report and accounts. If material provisions are dependent on the future performance of a business expected to be heavily impacted by climate change, this should be disclosed and detail provided on how climate change had been taken into account in the estimate.
Leases	Lessees and lessors are required to disclose information that gives a basis for users to assess the effect of leases on financial position, financial performance and cash flows. This could include information about variable payment features, for example. Judgements should be disclosed. Entity-specific accounting policies should be disclosed for material transactions.
2021/22 priorities for FRC review: - Impact of COVID-19	In addition to the topics summarised above, the FRC have indicated that routine monitoring for the 2021/22 cycle will include a focus on: - judgement and uncertainty in the face of continuing economic and social impact of Covid-19; and - climate-related risks and new disclosures. Disclosure on judgements and assumptions about the future will remain important to users of reports, particularly when considering matters such as going concern and liquidity. Therefore as part of their routine 2021/22 routines, the FRC will continue to consider whether entities: - Explain the significant judgements and estimates made; - Provide meaningful sensitivity analysis or details of a range of possible outcomes; - Describe any significant judgements made in determining whether there is a material uncertainty about their ability to continue as a going concern; and - Ensure that assumptions used in the going concern assessment are compatible with those used elsewhere.

Appendix Six

ISA (UK) 315 Revised: Overview

Summary

ISA (UK) 315 *Identifying and assessing the risks of material misstatement* incorporates significant changes from the previous version of the ISA. These have been introduced to achieve a more rigorous risk identification and assessment process and thereby promote more specificity in the response to the identified risks. The revised ISA is effective for the 2022-23 financial year onwards.

The revised standard expands on concepts in the existing standards but also introduces new risk assessment process requirements – the changes will have a significant impact on our audit methodology and therefore audit approach.

Why have these revisions been made?

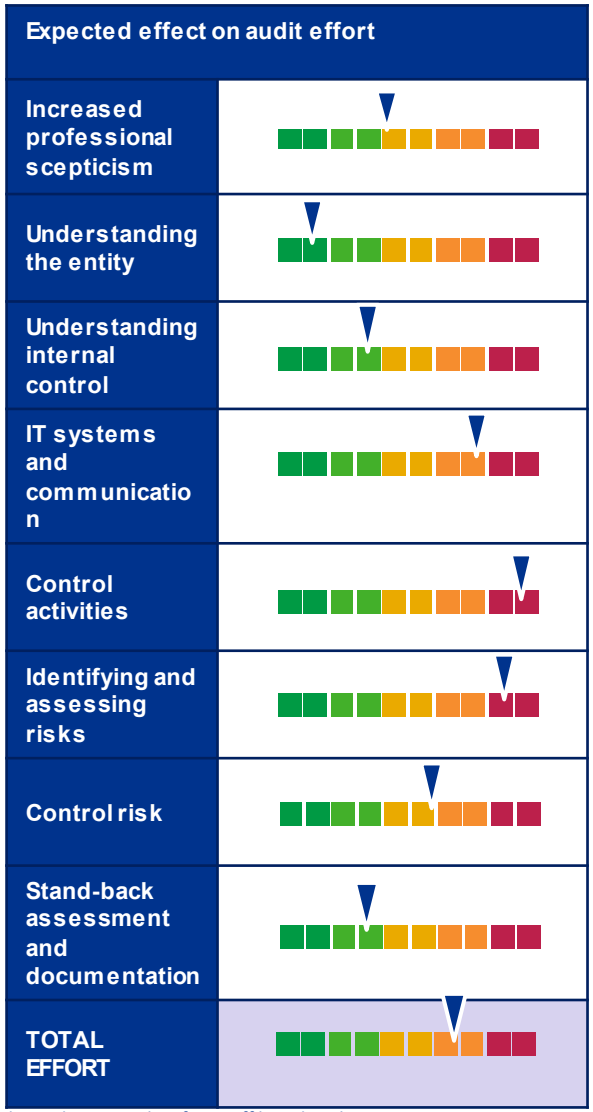
With the changes in the environment, including financial reporting frameworks becoming more complex, technology being used to a greater extent and entities (and their governance structures) becoming more complicated, standard setters recognised that audits need to have a more robust and comprehensive risk identification and assessment mechanism.

The changes are aimed at (i) promoting consistency in effective risk identification and assessment, (ii) modernising the standard by increasing the focus on IT, (iii) enhancing the standard's scalability through a principle based approach, and (iv) focusing auditor attention on exercising professional scepticism throughout risk assessment procedures.

What does this mean for an audit?

To meet the requirements of the new standard, auditors will be required to spend an increased amount of time across the risk assessment process, including more detailed consideration of the IT environment. We expect these changes to result in significantly increased audit effort levels which will, in turn, affect auditor remuneration. This additional effort is a combination of time necessary to perform the enhanced risk assessment procedures and the anticipated need to involve more technical specialists (particularly IT Audit professionals) in our audits.

Given the level of changes to the standard, debate remains ongoing about the extent of impact on application of some paragraphs. Global regulators have committed to providing further clarification in this area in advance of adoption, and there may therefore be some later updates to our initial assessment of relative impact.



Appendix Six

ISA (UK) 315 Revised: Summary of key changes

Area	Impact on audit effort	Summary of changes and impact
Increased professional scepticism		Increased focus on applying professional scepticism – particularly the need for auditors not to bias their approach towards obtaining evidence that is corroborative in nature or excluding contradictory evidence, which requires more independent evidence to be sought. In all cases, there will be enhanced documentation requirements in this area.
Understanding internal control		The previous standard included requirements for understanding components of the entity's system of internal control. The revisions add another step by requiring auditors perform evaluation procedures over these. This may require additional effort to evaluate the entity's processes over risk assessment and monitoring activities over internal control systems to assess their appropriateness to the entity's size and complexity.
IT systems and communication		The requirements introduce an increased focus on understanding the entity's own management of IT. This may entail performing additional risk assessment procedures and taking a broader view across the IT environment, considering more systems and systems in greater depth, than previously. Given the complexity and specialist knowledge required to perform these procedures, increased use of technical IT Audit specialists will be a natural consequence of this revision.
Control activities		The revised standard enhances the way we identify IT applications and aspects of the IT environment that are subject to assessed risks arising from IT. This may result in significant expansion of risk assessment procedures to obtain and evaluate the necessary information. Further, the standard adds new requirements in control testing activities to mandate evaluation of general IT controls that address risks arising from IT associated with significant risks and certain journal entries. For these controls, the auditor is required to evaluate the design and implementation of the individual controls. This could result in a significant change in approach, with more emphasis and effort spent on evaluating control activities. Again, we anticipate integrating more specialised expertise into our audit team to meet the revised requirements.
Identifying and assessing risks		The changes require more detailed assessment of risks at both the financial statement and assertion levels for classes of transactions, account balances and disclosures than previously. Further, the revisions introduce an inherent risk spectrum and new inherent risk assessment factors, each of which the auditor evaluates to assess the level of risk and thereby shape the audit response. This will increase the audit effort needed to evaluate and document the risks of material misstatement.
Control risk		New requirement to assess inherent risk and control risk separately for each risk of material misstatement identified where the auditor plans to test the operating effectiveness of controls. The separation of assessments will require individual attention, increased documentation and is likely to affect sample sizes for substantive procedures.
Stand-back assessment		New requirement to perform a stand-back assessment for material classes of transactions, account balances or disclosures which have not been identified as significant, to assess whether this determination remains appropriate in the context of the overall audit. This will require increased consideration of aggregation risk and introduce additional documentation requirements.

Appendix Six

ISA (UK) 240 Revised: Summary of key changes

Summary and background

ISA (UK) 240 *The auditor's responsibilities relating to fraud in an audit of financial statements* includes revisions introduced to clarify the auditor's obligations with respect to fraud and enhance the quality of audit work performed in this area. The revised ISA (UK) is effective for periods commencing on or after 15 December 2021. Unlike ISA (UK) 315 which mirrors updates in the international ISA, the updated UK fraud standard is not based on international changes by the IAASB.

The impact of the revisions to ISA (UK) 240 is less extensive compared to ISA (UK) 315, but will nevertheless result in changes to our audit approach. The table below summarises the main changes and our initial assessment of their impact.

Area	Summary of changes and impact	Effect on audit effort
Risk assessment procedures and related activities	[1] Increased focus on applying professional scepticism – the key areas affected are: • the need for auditors not to bias their approach towards obtaining evidence that is corroborative in nature or excluding contradictory evidence, • remaining alert for indications of inauthenticity in documents and records, and • investigating inconsistent or implausible responses to inquiries performed. [2] Requirements to perform inquiries with individuals at the entity are expanded to include, amongst others, those who deal with allegations of fraud. [3] Every audit now requires a specific determination as to whether to involve technical specialists (including forensics) to aid in identifying and responding to risks of material misstatement due to fraud. This will result in increased involvement of specialists and an expanded scope of work for these specialists, on audit engagements.	
Internal discussions and challenge	Enhanced requirements for internal discussions among the audit team to identify and assess the risk of fraud in the audit, including a requirement to determine the need for additional meetings to consider the findings from earlier stages of the audit and their impact on our assessment of the risk of fraud.	
Communications with management / TCWG	New requirements for communicating matters related to fraud with management and those charged with governance, in addition to the reporting in our audit reports.	

What does this mean for an audit?

The changes introduce new requirements which will increase audit effort and therefore the audit fee. The additional work is largely the result of investing more time identifying and assessing the risk of fraud during risk assessment and involving specialists to aid with both risk identification and the auditor's response to risk.

KPMG | 150 years supporting the UK

Auditor's Annual Report 2021/22

Lancashire Teaching Hospitals NHS Foundation Trust

29 June 2022

Key contacts

Your key contacts in connection with this report are:

Tim Cutler
Partner
Tel: 07789 920497
tim.cutler@kpmg.co.uk

Chris Paisley
Senior Manager
Tel: 07468 367450
christopher.paisley@kpmg.co.uk

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This report is addressed to Lancashire Teaching Hospitals NHS Foundation Trust (the Trust) and has been prepared for the sole use of the Trust. We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Summary

Introduction

This Auditor's Annual Report provides a summary of the findings and key issues arising from our 2021-22 audit of Lancashire Teaching Hospitals NHS Foundation Trust (the 'Trust'). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:

- **Accounts -** We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).
- **Annual report -** We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.
- **Value for money -** We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust's use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.
- **Other reporting -** We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities

Accounts	We issued an unqualified opinion on the Trust's accounts on 29 June 2022. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust. We have provided further details of the key risks we identified and our response on page 4.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the Governance Statement had been prepared in line with the DHSC requirements.
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. We have nothing to report in this regard.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

Accounts audit

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Risk	Findings
Valuation of land and buildings Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset'. There is a risk the assumptions used to determine the valuation are not accurate.	We identified one unadjusted audit misstatement on this significant risk. This related to the overstatement of the net book value by £2.7m due to capital expenditure being incorrectly duplicated in the valuation of land and buildings. We determined that the judgements made by the external valuers and adopted by the Trust were balanced.
Fraudulent expenditure recognition As the Trust has agreed an outturn total with local NHS partners for its expected financial performance there is a risk that non-pay expenditure may be manipulated in order to report that the control total has been met. We considered there to be a risk over existence and accuracy of non-pay expenditure at the year-end, as there is greater incentive for management to overstate expenditure in 2021-22 by bringing forward expenditure from 2022-23, to mitigate financial pressures in that period.	We identified two items of expenditure included within accrued expenditure at year-end which were recorded in error. The total value of these errors is considered trivial, at £30k, however our sampling software has extrapolated these errors to a total projected overstatement of accrued expenditure in 2021/22 of £1.8m. No adjustment was made to the accounts in respect of these errors as the individual errors found were clearly trivial and the extrapolated error is also not material. We reiterated one recommendation, made in the prior period, relating to management's review and challenge of accruals that are made at the year end.
Management override of controls We are required by auditing standards to recognise the risk that management may use their authority to override the usual control environment.	We did not identify any indication of management override of controls.

Value for money

Introduction

We consider whether there are sufficient arrangements in place for the Trust for each of the elements that make up value for money. Value for money relates to ensuring that resources are used efficiently in order to maximise the outcomes that can be achieved.

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

Further details of our value for money responsibilities can be found in the Audit Code of Practice at Code of Audit Practice (nao.org.uk)

Matters that informed our risk assessment

The table below provides a summary of the external sources of evidence that were utilised in forming our risk assessment as to whether there were significant risks that value for money was not being achieved:

Care Quality Commission rating	Requires improvement (November 2019)
Single Oversight Framework rating	Segment three - Mandated and targeted support:
Governance statement	There were no significant control deficiencies identified in the governance statement.
Head of Internal Audit opinion	The draft Head of Internal Audit Opinion for 2021/22 provides Significant Assurance.

Commentary on arrangements

We have set out on the following pages commentary on how the arrangements in place at the Trust compared to the expected systems that would be in place in the sector.

Summary of findings

We have set out in the table below the outcomes from our procedures against each of the domains of value for money:

Domain	Risk assessment	Summary of arrangements
Financial sustainability	One significant risk identified	No significant weaknesses identified
Governance	No significant risks identified	No significant weaknesses identified
Improving economy, efficiency and effectiveness	No significant risks identified	No significant weaknesses identified

Value for money

Financial sustainability	
Description	**Commentary on arrangements**
This relates to ensuring that the Trust has sufficient arrangements in place to be able to continue to provide its services within the resources available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ How the Trust sets its financial plans to ensure services can continue to be delivered; ▪ How financial performance is monitored and actions identified where it is behind plan; and ▪ How financial risks are identified and actions to manage risks implemented.	The Covid-19 pandemic has continued to have a major impact on the NHS and this is reflected in the financial planning regimes underpinning the 2021/22 financial year. There continues to be a central 'command and control' structure put in place by NHS England / Improvement (NHSE/I) with block payments being determined centrally, rather than being agreed between CCGs and provider Trusts. The funding structure was initially only communicated for the first half of the year (H1), with planning guidance for the second half of the year (H2) being published in late September 2021. NHS organisations continue to be reimbursed with additional funding as required in order to reflect the additional costs incurred as a result of Covid-19. The Trust has continued to operate under Enforcement Undertakings issued by NHS Improvement. The most recent undertakings were agreed in 2018 and were compiled under a very different landscape, prior to the Covid-19 pandemic. However since these were issued, the Trust continued to deliver deficits in 2018/19 and 2019/20 and was reliant on revenue support from DHSC. Reflecting the fact that a surplus of £2.1m in 2020/21 was delivered, but that this was due to additional financial support during the pandemic, NHSI issued the Trust with revised enforcement undertakings in November 2021. These undertakings also reflect that the Trust continues to have a significant underlying deficit for 2022/23 and beyond. They confirm that the Trust will remain in segment 3 in the System Oversight Framework. As part of our risk assessment work, we found that the budget monitoring and control processes were able to identify and incorporate significant pressures into the financial plan to ensure it was achievable and realistic, subject to the gaps in CIP identification covered elsewhere in this section. The initial draft budgets were constructed based on appropriate local and national planning assumptions and we saw evidence of appropriate review and sign-off by the relevant budget holders. Emerging cost pressures were identified through regular meetings at the divisional level before being shared with Executive Directors and incorporated into budget reporting to the Finance and Performance Committee and Trust Board. There is also a separate Overspending Cost Centre Process which identifies the highest overspends and reports them to the relevant Divisional Board, with an action plan for mitigation. Within the risk register, individual risks are marked and described. Each risk has an unmitigated score, a mitigated score and a target score with controls and actions in place to enable the Trust to manage and monitor each specific risk. Our review of the financial plan has confirmed risks have been appropriately considered to date. The Trust presented a financial plan for approval for H1 to Board in March 2021, with a plan for H2 being presented in November 2021 following release of national guidance in late September. The H2 plan assumed a breakeven at year-end, which includes an underlying operating deficit of £96m, with the gap being made up by support funding such as Covid top up funding for H2, Growth Funding and ERF funding. In line with the prior period, the plan assumed delivery of circa 5% efficiency savings. This has been delivered for 2021/22, albeit primarily on a non-recurrent basis at the system level.

Value for money

Financial sustainability (continued)	
Description	**Commentary on arrangements**
This relates to ensuring that the Trust has sufficient arrangements in place to be able to continue to provide its services within the resources available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ How the Trust sets its financial plans to ensure services can continue to be delivered; ▪ How financial performance is monitored and actions identified where it is behind plan; and ▪ How financial risks are identified and actions to manage risks implemented.	Efficiency plans are identified and developed at the Divisional level initially, and once approved by Divisional Board will be then discussed at the Divisional Improvement Forum, attended by Trust Executive Directors. There is an appropriate process in place for Quality Impact Assessment and additional levels of approval by the Quality and Safety Committee for those with a QIA risk score of 15 or more. We found that systems and processes for identifying, monitoring and escalating CIP delivery were designed and implemented effectively during the year. Much of the activity during 2021/22 has focused on CIP identification for 2022/23, with a planning assumption that the Trust will need to deliver 3% efficiencies recurrently (£15.8m). An additional 2% (£10.5m) non-recurrent target is to be delivered via working with the ICB to identify system-wide schemes. The Trust has a planned deficit for 2022/23 of £17.7m. However, this includes the receipt of system funding of £69.2m and assumes full achievement of the 5% CIP target of £26.3m. Therefore the underlying deficit before efficiency and system funding is £113.2m. The Trust's ability to mitigate this is effectively limited to CIP delivery. At the time of completing our risk assessment, the £15.8m target is made up of identified schemes of £10.4m and potential opportunities of £5.4m. However, within the identified schemes, only £0.4m is considered to be low risk, with 83% (£8.7m) still being at the 'hopper' / identification phase (ie. not fully risk-assessed and implemented). The delivery of CIP during 2022/23 presents a greater challenge than in previous years due to a combination of attempting to restore services while continuing to operate in an environment of high Covid-19 infection levels. As a result of the risk assessment we have undertaken, we identified a significant risk around the Trust's value for money arrangements in this area. **Risk assessment conclusion** Based on the risk assessment procedures performed, we have identified a significant risk associated with financial sustainability, specifically linked to the significant underlying deficit and level of unconfirmed CIP schemes for 2022/23. In response to this significant risk, we have undertaken the following procedures: ▪ Understanding and documenting contextual matters relating to the wider Lancashire and South Cumbria system and pressures within the Urgent Care system locally, at the system level and nationally. ▪ Holding discussions with officers to understand the factors impacting on the financial sustainability of the Trust and the underlying deficit for 2022/23. ▪ Reviewing and evaluating the Trust's systems and processes for identifying, challenging, monitoring and reporting on CIP delivery and achievement, at the local, divisional and Trust-wide level. ▪ Evaluating the Trust's financial strategy for 2022/23 and assessing whether this clearly articulates the challenges that exist within he system and the actions the Trust is taking in the areas under its control. ▪ As part of our initial risk assessment we also evaluated and evidenced the implementation of systems and processes for identifying, escalating and monitoring financial risks.

Value for money

Financial sustainability (continued)	
Description	**Commentary on arrangements**
This relates to ensuring that the Trust has sufficient arrangements in place to be able to continue to provide its services within the resources available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ How the Trust sets its financial plans to ensure services can continue to be delivered; ▪ How financial performance is monitored and actions identified where it is behind plan; and ▪ How financial risks are identified and actions to manage risks implemented.	**Risk findings** We have evaluated the Trust's latest financial strategy, which articulates clearly how the Trust is attempting to address the challenges within the Urgent Care system in particular, with reference to publications like Getting It Right First Time and Model Hospital. We are satisfied that the Trust has a robust process for identifying and challenging cost improvements and other efficiencies, including effective processes for impact-assessing these schemes. Reporting to Board and Finance Committee clearly articulate the challenges faced and the actions the Trust is taking to mitigate these challenges as much as is possible. The Trust's activities have been understood in the context of wider issues within Urgent Care, as well as the scale of the financial challenge across the NHS nationally and within the Lancashire and South Cumbria system. We have received high-level data relating to patient flow and the number of beds which the Trust is unable to make available due to downstream blockages in the health and social care system. We have also understood the impact that the economic landscape, namely rising inflation, is having on the ability of the Trust to make efficiencies in the area of procurement. **Conclusion** Based on the findings above we have not identified any significant weaknesses in the Trust's arrangements for ensuring financial sustainability.

Value for money

Governance	
Description	**Commentary on arrangements**
This relates to the arrangements in place for overseeing the Trust's performance, identifying risks to achievement of its objectives and taking key decisions. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ Processes for the identification and management of strategic risks; ▪ Decision making framework for assessing strategic decisions; ▪ Processes for ensuring compliance with laws and regulations; ▪ How controls in key areas are monitored to ensure they are working effectively.	We consider the Trust to have effective processes in place to identify, assess, monitor and manage risk, which is underpinned by a risk management framework and policy. Strategic risks are recorded and identified using the Board Assurance Framework, and any identified risks are appropriately reported to the appropriate governing body and relevant sub-committee. Our review of the risk register found this was sufficiently detailed to effectively manage key risks. Our assessment indicates that the Trust ensures key decisions are appropriately challenged and scrutinised by the executive team through an appropriate Scheme of Delegation and Standing Financial Instructions (SFI's), with escalation to Board as required. The Trust has specific policies in place with regards to fraud and whistleblowing. The Trust also engages a Local Counter Fraud Specialist who produces regular reports that go to Audit and Risk Committee. Additionally, the Trust has a designated Counter Fraud Champion and Freedom to Speak Up Guardian. We note from inquiry with and review of Local Counter Fraud reports in year that there was no indication of any significant weaknesses regarding the governance arrangements in place to prevent and detect fraud. Our assessment indicates that the Trust has processes in place to enable appropriate scrutiny, challenge and transparency on decision making. Business case documentation templates are adhered to for key decisions and these are sufficiently detailed to ensure that those making decisions are doing so in an informed manner. We reviewed a sample of business cases for 2021-22 and found there was evidence of scrutiny and challenge. We have also reviewed the approval of the 2021-22 financial plans by the Board and seen scrutiny and challenge within this approval leading to actions taken to improve the plan before submission to ensure it was realistic and achievable. Financial risks from this plan are also then communicated within the risk register going forward and discussed within Workforce Committee, Audit and Risk Committee and at Board meetings in a timely manner. Our initial assessment indicated there to be appropriate scrutiny and challenge of the budgets and appropriate approval through the budget holders and the Workforce Committee. In order to understand their financial performance against their budget, Divisional budget holders are provided with a monthly finance report which is also reviewed by the relevant Finance Manager. Discussions between Finance Managers and budget holders allowed for challenge and response to adverse variances. There is a separate Overspending Cost Centre Process which identifies the highest overspends and reports them to the relevant Divisional Board, with an action plan for mitigation. We also found processes in place to ensure accurate recording and monitoring of the additional costs associated with Covid-19.

Value for money

Governance (continued)	
Description	**Commentary on arrangements**
This relates to the arrangements in place for overseeing the Trust's performance, identifying risks to achievement of its objectives and taking key decisions. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ Processes for the identification and management of strategic risks; ▪ Decision making framework for assessing strategic decisions; ▪ Processes for ensuring compliance with laws and regulations; ▪ How controls in key areas are monitored to ensure they are working effectively.	Reviews of compliance with laws & regulations, staff code of conduct and the Trust's constitution is completed through Board meetings, Audit and Risk Committee and other governance structures as identified through our testing. We noted that the Trust has up to date policies on the recording of interests, gifts and hospitality. The Trust received a CQC review rating of 'Requires Improvement' at the last review in 2019, which noted a number of improvements since the previous inspection but highlighted areas that continue to require improvement. A CQC action plan was created and monitored at the Safety and Quality Committee where KPMG's assessment indicates that there was sufficient scrutiny over actions to ensure improvements were and continue to be made. We have reviewed overall governance arrangements in place and found appropriate processes are in place and we have not identified any significant weaknesses. **Risk assessment conclusion** Based on the procedures performed we have not identified a significant risk or significant weakness associated with the Trust's governance arrangements.

Value for money

Improving economy, efficiency and effectiveness	
Description	**Commentary on arrangements**
This relates to how the Trust seeks to improve its systems so that it can deliver more for the resources that are available to it. We considered the following areas as part of assessing whether sufficient arrangements were in place: ▪ The planning and delivery of efficiency plans to achieve savings in how services are delivered; ▪ The use of benchmarking information to identify areas where services could be delivered more effectively; ▪ Monitoring of non-financial performance to assess whether objectives are being achieved; and ▪ Management of partners and subcontractors.	We found appropriate processes in place to ensure the Trust uses information about costs and performance to improve the way they manage and deliver services. A monthly paper is presented to the Trust's Finance and Performance Committee, and the Trust Board, in order to report on financial performance, allowing the Trust to assess the level of value for money being achieved and any actions required. Management also maintains and monitors costs by reviewing the information received from benchmarking through review partnerships and the NHS Reference Costs and Model Hospital initiatives. The outputs of these exercises are fed directly to the Finance and Performance Committee in order to inform cost improvement programmes. The Trust's Board receives a monthly report with an integrated view of performance across the Trust's 'Big Plan' strategic aims. These cover key themes around Workforce, Quality, Activity and Finance. The Trust makes effective use of dashboard through reports to Board and Committees, in order to understand the key issues and improvement areas. This allows the Trust to monitor the performance of services. We noted through our risk assessment that the activities of the ICS/ICB are reported at a number of different forums in order that those charged with governance of the Trust are able to keep abreast of developments at the system level and that the organisation can respond to risks and challenges as they arise. The Trust CEO and Chair also provide updates within their reports to Board with the ICS financial performance also being considered in finance reports. During 21/22 expensive consultation has been undertaken relating to the New Hospitals Programme. This has involved engaging with all the key stakeholder groups in a variety of different ways. As a result of this partnership working, there are a number of tangible examples of service improvements delivered and reported on within the Trust during 2021/22. These include the new Pathology Collaborative and continuous partnership working at the system level to provide mutual support for elective services and long waiting patients, as well as moving of patients within the system in order to respond to demand. A further example is the use of the Nightingale surge hub that has enabled patient flow across the Lancashire & South Cumbria (L&SC) system. To facilitate the translation of Partnership-wide strategies into actions that can be implemented within the Trust, the L&SC ICS have a number of service delivery boards as well as the ICP board, which the Trust's officers interface with regularly and at various different levels. **Risk assessment conclusion** Based on the procedures performed we have not identified a significant risk or significant weakness associated with the arrangements for improving economy, efficiency and effectiveness.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Annual Members Meeting 2022							
Report to:	Council of Governors			**Date:**	28 July 2022		
Report of:	Company Secretary			**Prepared by:**	K Brewin		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☒	**For noting**	☐	**For discussion**	☐	**For information**	☐

Executive Summary:

The Trust is required to hold an annual members' meeting within nine months of the end of each financial year.

The following paper outlines the mandated content of the 2022 annual members' meeting, other stipulations that have been considered and the draft programme for the meeting. The contents of the draft programme are commended to the Council for approval.

The Council is asked to:

I. Note the contents of the report.
II. Agree to the annual members' meeting being held virtually.
III. Approve the format of the event.
IV. Approve the proposed topic for the clinical presentation.

Trust Strategic Aims and Ambitions supported by this paper:

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

Previous consideration

Not applicable

1. Introduction

1.1 Being a member of Lancashire Teaching Hospitals NHS Foundation Trust provides the public and staff with the opportunity to participate and get involved with our hospitals. The Trust is required to hold an annual members' meeting within nine months of the end of each financial year.

1.2 During the last two years because of the Covid-19 pandemic the annual members' meeting was held online using MS Teams Live. Over 150 people joined the live meeting in 2020 although fewer numbers were seen in 2021 however both meetings were recorded and uploaded to the Trust website for anyone who did not manage to attend; the link to each recording was also emailed to people upon request.

1.3 From a positive point of view, the meetings had good uptake from attendees when compared to previous in person events as it enabled attendance from individuals across broader constituencies. It was also financially prudent as it made significant savings on the cost of the event such as the venue, refreshments, printing, etc. The disadvantages were not having the usual face-to-face engagement and not everyone had access to digital technology although there were also potential problems with face-to-face meetings as not everyone has access to personal transport or good public transport links and travelling distances to the venue could be restricting factors.

1.4 Given that the situation regarding the pandemic remains uncertain it is proposed that the annual members' meeting on 12 October 2022 follows the same model and format as the previous two years and is held virtually.

2. Content

2.1 The mandated content is as follows:

Requirement	How met
Council of Governors to present: ▪ a report on steps taken to secure that, taken as a whole, the actual membership of the public constituency, patients' constituency and the classes of the staff constituency is representative of those eligible for such membership ▪ progress with the membership strategy ▪ any changes to the membership strategy	Contained within the annual report available on the website and on request to the Company Secretary for a paper copy

Board of Directors to present: ▪ annual report ▪ annual accounts ▪ any report of the financial auditor ▪ any report of any other external auditor of the Trust's affairs ▪ forward planning information for the next financial year	Presentation and copy of annual report available on the Trust website and on request to the Company Secretary for a paper copy
To be included (presenter not stipulated): ▪ results of any elections and announcement of governors appointed ▪ announcement of any Non-Executive Directors appointed	To be included in the presentation

2.2 The mandated content has been provided for within the draft programme which is outlined below:

Item	Time	Encl.	Presenter
Welcome and Introduction	6pm	Verbal	Chair
Annual Review 2021/22	6.10pm	Presentation	Chief Executive
First Q&A Session	6.30pm	Verbal	Board of Directors
Clinical presentation	6.45pm	Presentation	Patient Contribution to Case Notes (PCCN)
Second Q&A Session	7.15pm	Verbal	*To be confirmed*
End of Event	7.30pm	Verbal	Chair

3. Other stipulations to note

3.1 Members' meetings are convened by the Company Secretary by order of the council of governors and must be open to all members of the public as opposed to simply being open to Trust members. The council of governors may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Trust to attend a members' meeting, however it is not proposed that this will be necessary. The event is open to Trust members, stakeholders and the wider public.

3.2 Notice of the meeting is to be given at least 14 days in advance of the meeting in appropriate local media, by notice in the members' newsletter, by notice in the main premises of the Trust and by notice on the Trust's website. To this end, a notice will be placed in the Lancashire Post and Chorley and Leyland Guardian newspapers prior to the meeting. The event will also be publicised on the Trust website and Twitter account and on the network screens located in various areas across both hospital sites.

3.3 The quorum for an annual members' meeting is six members and directors, governors, and employees all count towards this quorum, provided that staff members have not opted-out of membership.

3.4 It is the responsibility of the council of governors, the chair of the meeting (the Trust Chairman) and the Company Secretary to ensure that any issues to be decided are clearly explained and that sufficient information is provided to enable rational discussion to take place. The Company Secretary will ensure that all documentation provided to members is clear, concise, and easy to read.

4. Financial implications

Should support not be provided to the proposal for a virtual annual members' meeting there will be financial implications as described in section 1.3 above.

5. Legal implications

There are no legal implications associated with the contents of this report.

6. Risks

Failure of the Council to fulfil its role and responsibilities could destabilise governance arrangements and impact upon statutory obligations.

7. Impact on stakeholders

There is no impact on stakeholder associated with the contents of this report.

8. Recommendation

8.1 The Council is asked to:

I. Note the content of the report.
II. Agree to the annual members' meeting being held virtually.
III. Approve the format of the event.
IV. Approve the proposed topic for the clinical presentation.

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Council Development Plan update							
Report to:	Council of Governors			**Date:**	28 July 2022		
Report of:	Company Secretary			**Prepared by:**	K Brewin		
Part I	✓			**Part II**			
Purpose of Report							
For approval	☐	**For noting**	☒	**For discussion**	☐	**For information**	☐

Executive Summary:

The purpose of this report is to provide the Council of Governors with an update on the Council Development Plan approved at the Council meeting on 26 October 2021.

It should be noted the Council recognised there were elements of the development plan which could not be progressed until a Company Secretary was in post. However, there were also actions identified that could potentially be delivered and the Council requested an update at each Council of Governors' meeting on progress with actions. The Council has received an update at each meeting since the plan was approved and appendix 1 provides a further update in the RAG-rated column on the status of some of the outstanding actions.

It is recommended that the Council of Governors receive the report and note the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable

1. **Financial implications**

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

2. **Legal implications**

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

3. **Risks**

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

4. **Impact on stakeholders**

   The effective operation of the Council of Governors is a significant component of the Trust's assurance arrangements and the development plan will further enhance working relationships between Governors.

5. **Recommendations**

   It is recommended that the Council of Governors receive the report and note the contents for information.

Appendix 1: Council Development Plan

COUNCIL OF GOVERNORS DEVELOPMENT PLAN **Appendix 1**

THEME	ISSUES	ACTIONS	RESPONSIBLE/LEAD	STATUS
MEMBERSHIP	Lack of diversity amongst membership with some groups under-represented	Review and update of membership strategy. Workshop planned 13th October 2021 to develop strategy.	Karen Swindley	
		Ideas to be written into refreshed strategy	Karen Swindley	
		Strategy to be signed off by Council of Governors	Pav Akhtar	
	Engaging with members has been difficult during covid and acknowledgement that engagement methods may need to change.	Engagement approach to be considered as part of the review of the membership strategy	Karen Swindley	
		Governor engagement plan developed to be approved by Council of Governors	Karen Swindley	
	Recognise that to attract diversity amongst governors, level of commitment and ability to attend events must be balanced and facilitated	Explore use of hybrid meetings in the future	Company Secretary	
	Longstanding issues of governor vacancies for some constituencies	Review of Constitution	Hempsons	Awaiting revised Constitution from Hempsons. Delayed due to national consultation
		Approval of revised constitution by council of governors	Karen Swindley	Plan to take to November Council
ORGANISATION	Difficulty in accessing core information, eg, constitution	Information Management system to be sourced and implemented	Stephen Dobson/Karen Brewin	Paused until new Company Secretary commences in post

	Need to improve the level of administrative support available to governor groups	Review of Corporate Affairs Office to build in appropriate levels of support for governor groups	Karen Swindley	
		Recruitment to new roles	Karen Brewin	
		Allocation of responsibilities	Karen Brewin	
	Lack of workshops over the last 18 months	Workshops dates to be agreed and incorporated into corporate calendar for 2022	Karen Brewin	
		Governors to agree workshop content to allow for appropriate facilitators to be identified and secured to avoid cancellation of events	Governors	List agreed at the Council Workshop on 12 May
	Response to governor queries	Revisit governor process map	Karen Swindley	
		Agree process map	Governors	
		Re-issue process map	Karen Swindley	
GOVERNOR CONTRIBUTION	Differing views of the role and expectations of the governors	Debate and agree minimum contribution to ensure appropriate – COG workshop	Karen Swindley	
		Ensure commitment is clearly laid out to governor candidates	Company secretary	
		Ensure commitment is clear in induction	Company secretary	
		Undertake annual assessment of whether governors are meeting minimum requirements for annual report to council of governors	Company secretary	
		Governor workshop on contributing with confidence	Karen Swindley	
		Implement the governor engagement plan	Karen Brewin	Limitations due to Covid
		360 degree training for governors to contribute to NED appraisals in Q1 2022/23	Karen Swindley	Training delivered on 24 May 2022
	Governors would like to get to know one another better and	Council workshop focused on relationship building	Karen Swindley	

	develop relationships	Recovery roadmap for return to face to face meetings	Karen Swindley	
		Include pen portraits of governors on the new internet site	Naomi Duggan	
		Ensure governor photo boards are maintained up to date	Governor volunteers	
COUNCIL MEETINGS	Insufficient engagement in council meetings and too much focus on information giving	Review process for getting items on the agenda to ensure governors have greater influence on the items discussed	Company Secretary	
		Revisit format of the COG meeting to time agendas to allow for debate	Company Secretary	
		Use COG to garner views on forward looking issues	Company Secretary	
		Include governor queries report on the COG agenda	Company Secretary	
		Standing item on COG agenda for key issues and priorities for the next quarter	Company Secretary	
		Develop a separate corporate calendar for governor events	Company Secretary	

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Quality Account 2021/22			
Report to:	Council of Governors	**Date:**	28 July 2022
Report of:	Nursing, Midwifery and Allied Health Professional Director	**Prepared by:**	S Cullen
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to provide the Council of Governors with the final approved Quality Account for 2021/22. The Quality Account is set out in the prescribed format and contains feedback from the Clinical Commissioning Group and Healthwatch.

The Council of Governors, as part of a planned Development Session on 12 May 2022, contributed towards the content of the annual Quality Account and identified two key priorities for 2022/23. These are as follows:

- Inclusive end of life care and advanced care planning
- Patient experience including PALS and complaints resolution

The feedback from Lancashire County Council Health Scrutiny Committee remains outstanding at this time.

The report was published on 30 June 2022 as per the guidelines.

The Council is asked to note the contents of the 2021/22 Quality Account 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

Safety and Quality Committee (24 June 2022)

Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Quality Account 2021-22

Lancashire Teaching Hospitals NHS Foundation Trust

Excellent care with compassion

@LancsHospitals

Measuring success, keeping it simple

Throughout the Quality Account 2021/22 the following key symbols will be used as an easy reference tool.

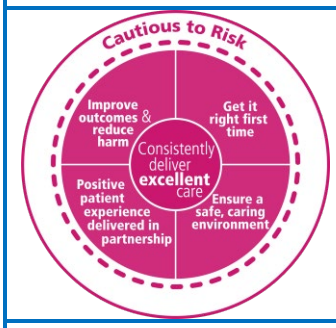
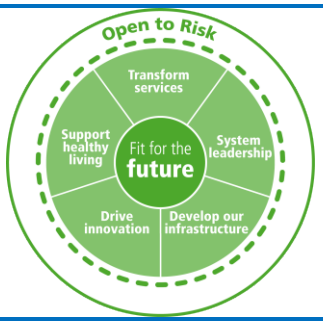
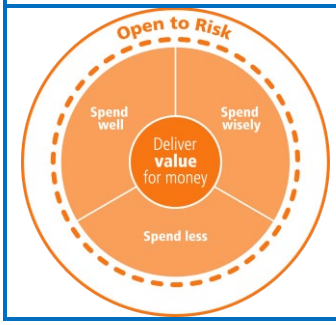
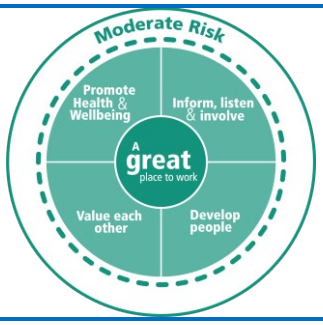
Symbol	Meaning
	The Trust continues to perform well and/or has improved
	The Trust is achieving well in some areas, but further areas require development
	The Trust is not achieving our target however are aware and have improvement projects in place

Key - Our Ambitions

Our Big Plan is our Strategy which aligns to our mission to provide "excellent care with compassion" and is founded on our four ambitions which are:

1. to 'Consistently deliver excellent care'
2. to 'Deliver value for money'
3. be 'Fit for the future'
4. be 'A great place to work'

Each ambition has a symbol which is presented in the key below. These are highlighted throughout our Quality Account to demonstrate how the content relates to *Our Big Plan* and Mission Statement.

Consistently deliver excellent care		Fit for the future	
	Improve outcomes and reduce harm Get it right first time Positive patient experience delivered in partnership Ensure a safe, caring environment		Transform services System leadership Develop our infrastructure Drive innovation Support healthy living
Deliver value for money		**A great place to work**	
	Spend well Spend wisely Spend less		Promote health and wellbeing Inform, listen, and involve Develop people Value each other

PART 1

Chief Executive's Statement

This report provides an overview of the quality of services provided at Lancashire Teaching Hospitals NHS Foundation Trust for the period 1st April 2021 to 31st March 2022.

Over the last twelve months the NHS has continued to face unprecedented challenges in dealing with the impact of the Covid-19 pandemic which has claimed so many lives across the world and within the communities served by our Trust.

As a centre for many specialist services across our region, Lancashire Teaching Hospitals treated many of those critically ill with Covid-19 alongside patients suffering from a range of other conditions requiring life-saving intervention. The Trust put in place vaccination and testing hubs, numerous research studies and trials, developed Covid-19 recovery and rehabilitation resources as part of the national strategy to help mitigate the effects of the virus and set up the Nightingale Surge Hub at Royal Preston Hospital.

Despite the continued effects of the pandemic, the Trust has maintained focus on our mission and our ambitions as set out in our organisational strategy *Our Big Plan* which has a very specific focus on quality. Our year three metrics have been co-developed with our divisional teams and staff across the organisation.

Our Continuous Improvement Strategy reflects approaches for each level of improvement across the organisation and system and incorporates a digital approach to the design and delivery of improvement programmes.

The pandemic has supported strengthened partnership working with local partners, Lancashire and South Cumbria NHS Foundation Trust, Lancashire County Council, third sector partners including our local hospices; Derian House and St. Catherine's Hospice with the Clinical Commissioning Group through a Central Lancashire Integrated Care Partnership and regionally with the Lancashire and South Cumbria Integrated Care System, to change the way the Trust works and provides care and treatment more effectively and efficiently, leading to better outcomes for patients and their families, closer to home. The last 12 months has seen more mutual aid between organisations and a more collaborative approach to the increased waiting lists to ensure that patients across the patch are treated equitably.

Although our financial deficit has increased due to continued growth in demand, rising costs, workforce shortages and the need to make our hospitals Covid-19 secure the Trust has continued to make incremental improvements to our operational efficiency.

The Trust is extremely proud to see that our staff continue to be recognised for their outstanding achievements. The year has seen selfless fundraising activity, national and international recognition for our Covid-19 resource pack to aid patient recovery, accolades in innovation, research, and clinical trials and much, much more.

Our staff have met the challenges described with courage and determination, providing compassionate care to our patients, often at personal cost. The Trust is exceptionally proud of them.

I would therefore like to record my thanks to all our staff, as well as our local partners and local communities for their unwavering dedication and support throughout a period which has been unlike any other experienced since the inception of the NHS.

Together with the support of Trust Directors, I confirm to the best of my knowledge that the following Quality Report complies with the necessary requirements and, indeed, the information in this document is accurate.

KEVIN McGEE OBE
Chief Executive
27th June 2022

PART 2

2.1 Priorities for Improvement

Our Big Plan was developed in partnership with our divisions and aligns the organisation's mission to provide "excellent care with compassion" with our ambitions.

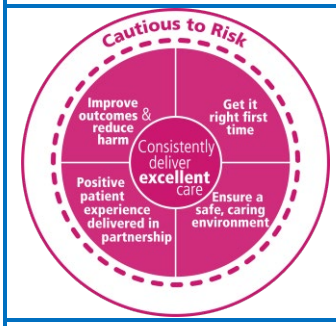
Our values underpin everything we do and support the delivery of our ambitions.

The plan also sets the priorities for improvement and annual performance standards aligned to each of the four ambitions below:

Our values

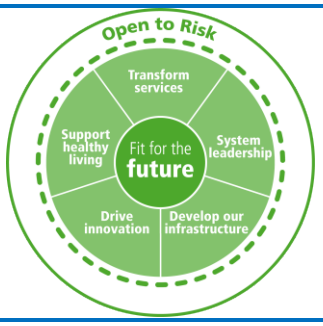
- Being caring and compassionate
- Recognising individuality
- Seeking to involve
- Building team spirit
- Taking personal responsibility

Figure 1 Our Ambitions

<table>
<tr><th colspan="2">Consistently deliver excellent care</th><th colspan="2">Fit for the future</th></tr>
<tr>
<td> 
</td>
<td>Improve outcomes and reduce harm

Get it right first time

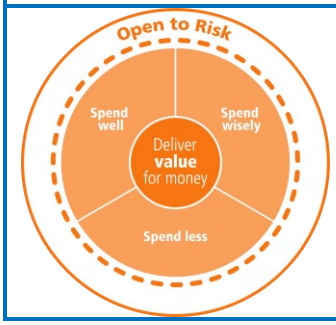
Positive patient experience delivered in partnership

Ensure a safe, caring environment</td>
<td> 
</td>
<td>Transform services

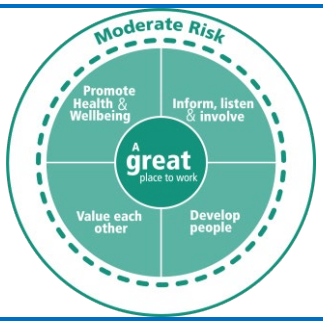
System leadership

Develop our infrastructure

Drive innovation

Support healthy living</td>
</tr>
<tr><th colspan="2">Deliver value for money</th><th colspan="2">A great place to work</th></tr>
<tr>
<td> 
</td>
<td>Spend well

Spend wisely

Spend less</td>
<td> 
</td>
<td>Promote Health and wellbeing

Inform, listen and involve

Develop people

Value each other</td>
</tr>
</table>

Our Big Plan is enabled through the commitments in the *Nursing, Midwifery, Allied Health Professional (AHP) and Care Givers Strategy* as well as those in the *Patient Experience and Involvement Strategy* using the methodology and approach outlined in the *Continuous Improvement Strategy*. This year has seen the launch of the new Clinical Strategy, and this will replace the Nursing, Midwifery and AHP Strategy, coming in 2022/23.

Nursing, Midwifery, AHP and Care Givers strategy commitments

- Continuously strive to improve
- Lead with care and compassion
- Work as a team to improve as much as possible
- Look for diversity and be inclusive
- Nurture a workforce able to meet our local population demands

The Patient Experience and Involvement Strategy commitments

- Deliver a positive experience
- Improve outcomes and reduce harm
- Create a good care environment
- Improve capacity and patient flow

Patient Experience

Our Big Plan and the strategies can be found on our Trust Internet site.

Priorities for Improvement 2021-22

Our Big Plan has committed to delivering a wide range of improvements over a three-year period (2019-22). The following key priorities were identified and reported in 2020-21 and continued into Year 3 (2021-22). Our performance in these priorities for 2021-22 is presented below.

The key for each outcome

Risk	Status
Not Delivered	
Partly Achieved	
Achieved	
Performance impacted by pandemic	
Not applicable due to pandemic	
No Status	

Consistently deliver excellent care

Big Plan key priorities achieved or partially achieved

During 2021-22 there has been positive delivery of a number of Big Plan metrics as follows:

Improve outcomes and prevent harm	
Reduce the number of cardiac arrests by 10%	
Achieve compliance with the 10 safety actions for maternity services	
Develop and test 10 key safety actions for children and young people	
Reduce the number of device related pressure ulcers by 25%. (Deemed partial as achievement based on 156 cases or less. The actual number was 66. Patients with Covid-19 are at increased risk and so the increase of 10 cases versus actual is within tolerance.)	

Get it right first time	
Continue to deliver a Hospital Standardised mortality figure of <100	
Reduce the average length of stay for patient undergoing planned surgery by 3.5 days	
Reduce the number of times patients are moved more than 3 times by 10%	

Reduce the number of patients moved after 22.00hrs by 10%	
Reduce the number of patients re-admitted within 30 days to less than 7.7%	
Reduce the number of operations cancelled for non-clinical reasons to less than 1% of cancellations	
Pre-procedure elective- to reduce the number of days patients spend in hospital prior to planned surgery to 0.25 days or below	
Pre-procedure non-elective- to reduce the number of days patients spend in hospital prior to planned surgery to 0.72 days or below	

Ensure a safe caring environment	
Achieve 75% of silver rated and above departments	
100% participation of each directorate in the annual risk and governance maturity programme. As assessed by external audit	

Promote Health and wellbeing	
To increase staff perception that the organisation takes positive action on health and wellbeing to 36%	
To create outdoor recreational space at both Preston and Chorley hospitals	
To update 5 local staff rest areas	

Areas not delivered as follows

However, 2021-22 continued to be another challenging year due to the pandemic impacting on delivery of a number of Big Plan metrics:

Improve outcomes and prevent harm	
Reduce the number of pressure ulcers by 10% through positive action	

Get it right first time	
Achieve no more than 3% of patients delayed within hospital	
Achieve the 62-day cancer trajectory	
Reduce the number of patients in hospital for longer than 7 days by 20%	
Achieve 90% of patients in ED within 4 hours	
Cancer 28 days from referral to diagnosis	
Reduction in 52-week waiters (target as per NHSI recovery plans)	

Ensure a safe caring environment	
Achieve the annual target for *C. difficile* (trajectory to be below 118 cases)	
Reduce the number of falls by 5%	

Achieve zero Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia (1 reported case September 2021)	

Promote Health and wellbeing	
To reduce short term sickness absence to 1.25%	
To reduce long terms sickness absence to 2.75%	
To reduce overall sickness absence to 4.0%	
To create 5 agile activity based workspaces	
Drive forward zero tolerance with regard to violence and aggression towards staff by reducing the number of incidents by 10%	
Reduce average duration of musculoskeletal (MSK) related absences by 1%	
Reduce average duration of psychological health related absences by 1%	

Priorities for Improvement 2022-23

Our Big Plan priorities for improvement for 2022-23 are as follows:

Consistently deliver excellent care

- Reduce 104 week waits
- Reduce 12 hours Emergency Department
- Reduce delayed Ambulance handovers
- Achieve 62-day cancer target
- Mortality within the expected range for adults, children, and paediatrics
- Reduce by 10% pressure ulcers
- Deliver the C. difficile measure within nationally set trajectory
- 90% patients rating services as good or very good
- 75% clinical areas with silver STAR rating

A great place to work

- Reduce sickness absence to 4%
- Reduce vacancies by a further 5%
- Maintain 90% for appraisals
- Maintain staff engagement

These priorities will be monitored through the Trust's governance and reporting processes, managed through the arrangements described in the relevant strategies and supported by the Continuous Improvement team.

Continuous Improvement and Always Safety First

Continuous Improvement

The Trust has launched its second Continuous Improvement Strategy and the implementation of the delivery of the first year of this Strategy has been delivered throughout the year.

Cohort one of the Lancashire and South Cumbria Flow Coaching Academy has been delivered with the establishment of fourteen Big Rooms; Brain Cancer; Chemotherapy; Deteriorating Patients; Enhanced Care; End of Life; Endoscopy; Ear, Nose and Throat; Gynaecology; Lung Cancer; Nutrition; Respiratory; Transition into Adult Services; Heart Valve Transplant and Vascular Surgery. The four Big Rooms from the initial training in Sheffield are continuing; Colorectal Cancer; Frailty; Inflammatory Bowel Disease, and Sepsis.

A second co-hort is planned for 2022/23 as follows; Cauda Equina Syndrome, DNACPR, Emergency Mental Health, Emergency Theatres, Major Trauma, Neurology (Headache), Pain Management, Pneumonia, Pre-operative & Prehabilitation and Stroke.

The second cohort of the Microsystem Coaching Academy programme has been delivered, though there has been an impact of Covid-19 on the delivery of the programme.

There has been a significant focus throughout the year on building continuous improvement (CI) capability across the organisation through the delivery of the CI building capability strategy in line with the NHS Improvement report and dosing formula for provider organisations for year one of the strategy.

Continuous Improvement support has been provided to a number of the divisions and corporate teams with the design, testing and implementation of improvement priorities in response to specific requests (out with the formal improvement programmes), often in response to organisational pressures. In year, this has included:

- Supporting pharmacy to use a Continuous Improvement methodology to reduce medicines wastage
- Supporting the pain management psychology team to streamline referral processes
- Supporting the patient experience team to drive improvements in patient experience, including participating in the Imperial College and Health Foundation Scale, Spread and Embed Research Project
- Supporting the referral and triage process for the Nightingale Hub to ensure improved flow of patients into the Unit
- Utilising a Continuous Improvement approach to support the adoption of patient initiated follow up
- Testing of the National Rapid Release Policy for ambulance handovers
- Co-ordinating the Lancashire and South Cumbria Together Improvement Weeks in response to operational pressures
- Improvement project in maternity triage assessment unit, and

- A patient flow improvement programme.

Always Safety First

The Always Safety First Improvement programme has been delivered in line with the Always Safety First Strategy (the Trust's response to the National Patient Safety Strategy), facilitating improvement in safety metrics across the organisation.

The Trust Board recognises the benefits of embedding a culture of continuous improvement across our organisation, supporting our staff to design, test, embed and sustain changes that benefit patients and our local population. To achieve a culture of continuous improvement in our patient safety metrics, the Trust developed Always Safety First, our long-term approach to transforming the way services are delivered for the better, utilising a robust improvement methodology. Always Safety First is based on proactive regular review of our safety metrics and safety intelligence to inform our priorities, improvement co-designed with our staff and patients, shared governance, collaborative working across divisions and clinical specialities and learning to improve. Our work is underpinned by a real time safety surveillance system, making our data visible from Ward to Board. Always Safety First is focused on achieving high reliability through standardisation, system redesign and ongoing development of pathways of care, built on a philosophy of continuous improvement led by frontline clinical staff.

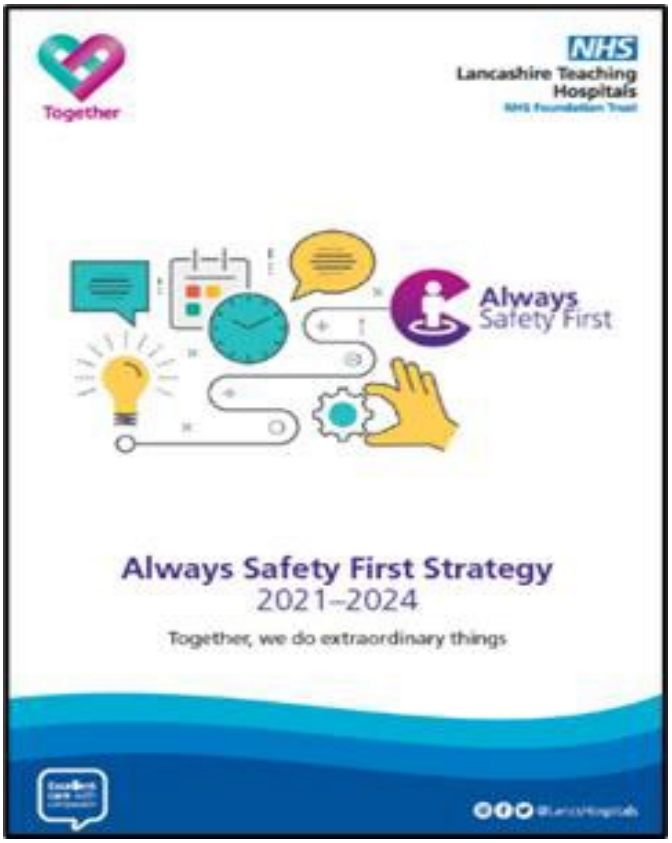
How is our continuous improvement in patient safety, access and patient experience delivered?

In September 2021, the Trust launched its Always Safety First Strategy, which is our Trust response to the NHS National Patient Safety Strategy. This ambitious strategy outlines our plans and aspirations to improve quality of care and safety for our patients, service users and

staff. To support the delivery of this strategy an Always Safety First Group was formed, chaired by our Trust Patient Safety Specialists with representation from a wide group of staff across the organisation. This specialist multidisciplinary group is enabling a culture of continuous improvement and cross system working to build the will to improve safety, making safety everyone's role. By reviewing systematic data from harms, incidents, and our Safety Surveillance System the group is initiating new targeted programme design and delivery to tackle our biggest challenges around safety, including pressure ulcers and medication safety.

The Always Safety First programme is now maturing in its delivery and our teams are building on the learning from the initial launch and facilitation of virtual collaborative learning sessions. At these sessions participating teams are brought together to learn about the improvement interventions to be embedded, share learning and best practice, building improvement capability and actively participating, forming a positive continuous improvement culture.

The trust is now developing an Always Safety First Phase II approach which is focusing much more on the scale and sustainability of our improvements which were developed and tested through our founding Breakthrough Series Collaboratives. This new approach will combine our learning and new improvement methods to deliver rapid testing and development of change solutions, which can then be guided through a formal scale and sustainability process, supported by measurement, communication and governance to ensure our new improved ways of working are embedded.



Risk Maturity

Our organisation has adopted a strategic approach to the management of risk by integrating risk into 'Our Ambitions' so that they link to the strategic objectives of *Our Big Plan* and support the well-led aspect of the CQC requirements. It has also ensured the trust continues to further develop the way risks are managed and support the improvement of safety, effectiveness, and the experience of patients through the way that services are delivered.

Our Board has defined the level of risk appetite for each ambition and a description of what the appetite means is presented below.

Risk Appetite Statement

"The Trust has a low appetite for risk in relation to its strategic aim to **Consistently Deliver Excellent Care**, only being prepared to adopt safe delivery options. However, the Trust has an open appetite for risk in relation to its strategic aims to be **Fit for The Future** and to **Deliver Value for Money**, so that the Trust embraces change and employs innovative approaches to the way services are provided. The Trust has a moderate appetite for risk in its strategic aim to create a **Great Place to Work**, recognising the need for a strong and committed workforce might involve accepting some, but not significant risk."

The Risk Appetite Statement was initially approved by the Trust Board on 5 December 2019; it has been monitored regularly and reconfirmed by the Board on 3 December 2020 and is currently undergoing re-evaluation with the support of the Good Governance Institute.

The **Consistently Deliver Excellent Care** ambition is **cautious to risk**

This means our Board is willing to accept some low risk, whilst maintaining an overall commitment to safe delivery options.

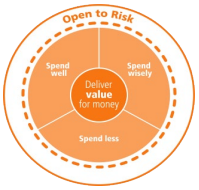
The **Fit for the Future** ambition is **open to risk**

This means our Board is prepared to consider all delivery options, so that the trust embraces change and employs innovative approaches to the way our services are provided, selecting those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

The **Great Place to Work** ambition is **moderate risk**

This means our Board is tending always towards exposure to only modest levels of risk in order to achieve acceptable but possibly unambitious outcomes, recognising the need for a strong and committed workforce might involve accepting some, but not significant risk.

The **Deliver Value for Money** ambition is **open to risk**



This means our Board is prepared to consider all delivery options, so that the trust embraces change and employs innovative approaches to the way services are provided, selecting those with the highest probability of productive outcomes, even when there are elevated levels of associated risk.

To address the Mersey Internal Audit Agency (MIAA) and Care Quality Commission (CQC) feedback, the Trust has taken a number of additional steps to meet the recommendations. These include:

- Integrating the use of the risk appetite and defining the components and nomenclature of the Board Assurance Framework (BAF) throughout the organisation i.e., Strategic Risk Register + Operational Risk Register = BAF, and improve staff understanding of this.
- Use of the BAF in all the Committees of the Board meetings to ensure that there is clarity on actions being undertaken to mitigate risks and that any changes to risks or assurance levels is updated in a timely manner.
- Continued review of the processes for recording, reporting and mitigating risk to ensure that risk registers and the BAF are up to date, in line with the Trust's policy and reflective of the risks and their impact on the Trust.
- Engaging with the Board of Directors using risk information to drive the Board Workshop agenda.
- Ensuring that there is a robust process in place to escalate all risks, including divisional risks, with a rating of 15+ to the Board via the BAF. This is reflected in the Risk Management Strategy.
- Continued re-designing of the Datix Risk Register module to support improvement programmes.
- Re-designing of the Strategic Risk Templates in response to stakeholder feedback.
- Extending the use of dashboards to include themes, risk appetite, heat-maps, trajectory of risk and qualitative narrative on actions and mitigations.
- Implementation of governance dashboards for each division, monitored as part of the accountability framework in divisional improvement forums with specific risk key performance indicators including risk, audit, incident and safeguarding management.
- Enhancing training and support at all levels of the organisation, including a series of Board Workshops throughout the year.
- Enhancing lessons learned from risk management integrated into the learning to improve bulletins.
- Executive Management Group as a forum to discuss risk and share learning from the management of risks cross divisionally with the Executive Team.
- Response to the requirements of the updated NHS England and NHS Improvement Patient Safety Strategy.

During 2020-21, an informal review of divisional quality and governance was undertaken by the Quality Governance Lead from the Nursing Directorate at NHS England/Improvement (NHSE/I). This review highlighted a number of outstanding practices within divisional and speciality arrangements and following the review, NHSE/I asked that the Trust work with them as an exemplar organisation to create some national guidance. In addition, NHSE/I have signposted a number of organisations to our Trust throughout the 2021-22 period and we continue to share our good practice in improving divisional quality and governance with these organisations.

2.2 Statements of Assurance from the Board

This section of the quality account is presented with the numerical referencing required by NHS Improvement; therefore, the numerical referencing in some parts is non-consecutive. It is also presented in places with the narrative which is mandated in the Quality Account regulations which refers to Lancashire Teaching Hospitals NHS Foundation Trust or the Trust.

During 2021-22 the Lancashire Teaching Hospitals NHS Foundation Trust provided and/or sub-contracted forty six relevant health services.

The Lancashire Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in forty six relevant health services.

The income generated by the relevant health services reviewed in 2020-21 represents 100% of the total income generated from the provision of relevant health services by the Lancashire Teaching Hospitals NHS Foundation Trust for 2021-22.

Participation in Clinical Audits

During 2021-22 forty-eight national clinical audits and three national confidential enquiries covered relevant health services that Lancashire Teaching Hospitals NHS Foundation Trust provides.

During that period Lancashire Teaching Hospitals NHS Foundation Trust participated in 96% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. The Trust did not participate in the Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit and the Lancashire Teaching Hospitals NHS Foundation Trust did not participate in one of the workstreams of the National Diabetes Inpatient Audit due to pressures in the services and inability to field the relevant staff to support the audit.

The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2021- 22 are as follows:

Table 1 Audit and Confidential Enquiries - Eligible for Participation[1]

National Clinical Audit	
Project Name	**Provider Organisation**
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)
Chronic Kidney Disease registry	The Renal Association/The UK Renal Registry
Elective Surgery - National PROMs Programme	NHS Digital
Emergency Medicine QIPs	Royal College of Emergency Medicine (RCEM)
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians (RCP)
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	IBD Registry Ltd
Learning Disabilities Mortality Review Programme (LeDeR)	University of Bristol / Norah Fry Centre for Disability Studies
Maternal, Newborn and Infant Clinical Outcome Review Programme	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
National Adult Diabetes Audit	NHS Digital
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Royal College of Physicians (RCP)
National Audit of Breast Cancer in Older People (NABCOP)	Royal College of Surgeons (RCS)
National Audit of Cardiac Rehabilitation (NACR)	University of York
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network
National Audit of Dementia[2]	Royal College of Psychiatrists (RCPsych)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Royal College of Paediatrics and Child Health (RCPCH)
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK
National Cardiac Audit Programme (NCAP)	Barts. Health NHS Trust
National Child Mortality Database	University of Bristol
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCOA)
National Gastro-intestinal Cancer Programme	NHS Digital
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)
National Lung Cancer Audit (NLCA)	Royal College of Physicians (RCP)

National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists (RCOG)
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health (RCPCH)
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health (RCPCH)
National Perinatal Mortality Review Tool	University of Oxford / Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) collaborative
National Prostate Cancer Audit	Royal College of Surgeons (RCS)
National Vascular Registry	Royal College of Surgeons (RCS)
Neurosurgical National Audit Programme	Society of British Neurological Surgeons
Respiratory Audits	British Thoracic Society
Sentinel Stroke National Audit programme (SSNAP)	King's College London
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Society for Acute Medicine (SAM)
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	BURST Collaborative / British Urology Researchers in Surgical Training
The Trauma Audit & Research Network (TARN)	The Trauma Audit & Research Network (TARN)
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust
Urology Audits	British Association of Urological Surgeons (BAUS)

[1] List of national clinical audits as per specification provided by the DH cited on the HQIP website https://www.hqip.org.uk/national-programmes/quality-accounts

2 The National Audit of Dementia did not run and no new date was arranged

The national clinical audits and national confidential enquiries that Lancashire Teaching Hospitals NHS Foundation Trust participated in during 2021-22 are as follows:

Table 2 National Confidential Enquiries

Clinical outcome review programmes / National Confidential Enquiries
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD): Studies collecting data during 2021-22 • Crohn's Disease • Epilepsy • Transition from child to adult services study

Table 2 contd. Audit and Confidential Enquiries - Participated

National Clinical Audit	
Project Name	**Participated**
Case Mix Programme (CMP)	Yes
Child Health Clinical Outcome Review Programme	Yes
Chronic Kidney Disease registry	Yes
Elective Surgery - National Patient Reported Outcome Measures (PROMs) measure Programme	Yes
Emergency Medicine QIPs	Yes
Falls and Fragility Fractures Audit programme (FFFAP)	Yes
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit[3]	No
Learning Disabilities Mortality Review Programme (LeDeR)	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes
Medical and Surgical Clinical Outcome Review Programme	Yes
National Adult Diabetes Audit[4]	Yes
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Yes
National Audit of Breast Cancer in Older People (NABCOP)	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes
National Audit of Care at the End of Life (NACEL)	Yes
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Cardiac Audit Programme (NCAP)	Yes
National Child Mortality Database	Yes
National Comparative Audit of Blood Transfusion programme	Yes
National Emergency Laparotomy Audit (NELA)	Yes
National Gastro-intestinal Cancer Programme	Yes
National Joint Registry (NJR)	Yes
National Lung Cancer Audit (NLCA)	Yes
National Maternity and Perinatal Audit (NMPA)	Yes
National Neonatal Audit Programme	Yes
National Paediatric Diabetes Audit (NPDA)	Yes
National Perinatal Mortality Review Tool	Yes
National Prostate Cancer Audit	Yes
National Vascular Registry	Yes
Neurosurgical National Audit Programme	Yes
Respiratory Audits	Yes
Sentinel Stroke National Audit programme (SSNAP)	Yes
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes
The Trauma Audit & Research Network (TARN)	Yes
UK Cystic Fibrosis Registry	Yes
Urology Audits	Yes

[3] The Trust did not participate in the Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit due to pressures in the Gastroenterology service

[4] Lancashire Teaching Hospitals did not participate in one of the workstreams of the National Diabetes Inpatient Audit

The national clinical audits and national confidential enquires that Lancashire Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2021-2022, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 3 Audit and Confidential Enquiry - Case Submission

Project Name	% Submitted	Actual Number Submitted
Case Mix Programme (CMP)		1453
Child Health Clinical Outcome Review Programme NCEPOD Transition from child to adult services		NYA*
Chronic Kidney Disease registry	100%	168 (Up to 31/01/22)
Elective Surgery - National PROMs Programme		Hips: 236 scanned Knees: 227 scanned
Royal College of Emergency Medicine QIPs Pain in Children Infection Control	 100% >100% >100%	 RPH 56 RPH 128 CDH 267
Falls and Fragility Fractures Audit programme (FFFAP) National Audit of Inpatient Falls National Hip Fracture Database		13 NHFD: 408
Learning Disabilities Mortality Review Programme (LeDeR)		24
Maternal, Newborn and Infant Clinical Outcome Review Programme MBRRACE Perinatal Confidential Enquiry - Stillbirths & neonatal deaths in twin pregnancies MBRRACE-UK: Perinatal Mortality Births MBRRACE UK Saving Lives, Improving Mothers' Care	100%	Requested x 3 audits 3 UTD** UTD
Medical and Surgical Clinical Outcome Review Programme Epilepsy	90%	9
National Adult Diabetes Audits National Diabetes Core Audit National Pregnancy in Diabetes National Diabetes Footcare Audit	100%	18 UTD 47

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) (NACAP) National Paediatric Asthma Audit National Adult Asthma Audit National COPD Audit	100%	RPH 80, CDH 0 CDH= 51, RPH= 81 CDH= 151, RPH= 442
National Audit of Breast Cancer in Older People (NABCOP)		UTD
National Audit of Cardiac Rehabilitation (NACR)	100%	234
National Audit of Care at the End of Life (NACEL)	100% 100%	RPH 54 CDH 24
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)		UTD
National Cardiac Arrest Audit (NCAA)		CDH: 122 RPH: 547
National Cardiac Audit Programme (NCAP) MINAP Heart Failure	 100% 100%	252 216 (CDH) 190 (RPH)
National Child Mortality Database	100%	10
National Comparative Audit of Blood Transfusion programme 2021 National Comparative Audit of NICE Quality Standard QS138		10
National Emergency Laparotomy Audit (NELA)		88
National Gastro-intestinal Cancer Programme National Bowel Cancer Audit (NBOCA) National Oesophago-Gastric Cancer Audit (NOGCA)	 NBOCA: >80% NOGCA: 85-100%	 NBOCA: 205 NOGCA: 175
National Joint Registry (NJR)		RPH: 77 CDH: 305
National Lung Cancer Audit (NLCA)		
National Maternity and Perinatal Audit (NMPA)		UTD
National Neonatal Audit Programme		UTD
National Paediatric Diabetes Audit (NPDA)		UTD
National Perinatal Mortality Review Tool		21 stillbirths & late fetal losses reported. 14 reviews completed & 6 in progress 15 neonatal deaths & post-neonatal deaths reported. 4 reviews completed, 5 reviews in progress & 4

		not supported for review.
National Prostate Cancer Audit (NPCA)		407
National Vascular Registry		Abdominal Aortic Aneurysm: 56 Bypass: 504 Angioplasty: 1103 Amputation: 238 Carotid Endarterectomy: 73
Neurosurgical National Audit Programme		NYA
Respiratory Audits National Outpatient Management of Pulmonary Embolism Smoking Cessation	100% 100%	10 88
Sentinel Stroke National Audit programme (SSNAP)		811
Serious Hazards of Transfusion: UK National Haemovigilance Scheme		24
Society for Acute Medicine's Benchmarking Audit (SAMBA)	100% 100%	RPH 28 CDH 23
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment		UTD
The Trauma Audit & Research Network (TARN)		1004
UK Cystic Fibrosis Registry	100%	20
Urology Audits British Association of Urological Surgeons (BAUS) Snapshot Audits: Cytoreductive Radical Nephrectomy Audit British Association of Urological Surgeons (BAUS) Snapshot Audits: Management of the Lower Ureter in Nephroureterectomy Audit		UTD UTD

*NYA – Not yet available
**UTD (Unable to determine - currently)

The reports of 21 published national clinical audits were reviewed by the provider in 2021-22 and Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Table 4 Audit and Confidential Enquiry – Intended Actions

All Actions are monitored in our *Audit Management and Tracking* (AMaT) system:

Title of Audit	Actions
Case Mix Programme (ICNARC) - 2020-2021	Review re-admissions to identify any areas where the service can improve the discharge and post-discharge pathway. Action completed: Audit of re-admissions within 48hrs (CrCU/QI/2021-22/09) has been instigated.
Falls and Fragility Fractures Audit programme (FFFAP) National Audit of Inpatient Falls	Awaiting an action plan – within the time frame for submission at the time of this report.
MBRRACE-UK: Perinatal Mortality (2019) Births	Align the local Trust guideline with the current North West Coast Fetal Growth Restriction regional guideline to remove inequity in care and potential risk of this to mothers and babies. Action completed: New guideline now published and on intranet page in March 2022. Reinstate GTT screening. Action completed: GTT service now fully re-instated and operational in November 2021. Review and amend guideline 'Hypertension in pregnancy' to clearly state process for sending PEM markers urgently and process for chasing and actioning these blood results. To ensure staff working in antenatal clinic and maternity assessment suite are aware of process. Action partially completed: Awaiting ratification from the trusts Procedural Documentation Ratification Group. Audit compliance with missed appointments guideline. Action completed: Audit undertaken. OBS/SE/2020-21/43: Missed appointments guideline compliance.
National Audit of Breast Cancer in Older Patients (NABCOP)	Implement holistic needs assessment through completion of the NABCOP fitness assessment tool in breast clinic. To be discussed at next operational meeting. Action completed: Implementation of the NABCOP fitness assessment tool discussed and agreed at Breast OPs meeting. ABCOP assessment tool now in use and copies of the assessment tool laminated and displayed in the clinical area to remind clinicians to use this assessment form. To incorporate COVID pandemic changes to practice into the recovery plan. Telephone consultations to become a standard option for older breast cancer patients. To look at remote ways of delivery follow up and care. Action in progress. Continue to work closely with Oncology to deliver new targeted treatments to older breast cancer patients in line with NICE guidance. Action in progress.

National Bowel Cancer Audit (NBOCA) 2021	Awaiting an action plan – within the time frame for submission at the time of this report.
National Cardiac Arrest Audit (NCAA) 2020-2021	Awaiting action plan.
National Emergency Laparotomy Audit (NELA) - 2020 Report (Y7)	To develop relevant documentation in in Quadramed which will help to cover us legally under appropriate consent. Action in progress.
National Joint Registry (NJR) - 2020 Report	To participate in the annual NJR data validation audit to make sure all the relevant case submitted. Action completed: NJR Data Quality audit – data validated for CDH and RPH (ORTH/CA/2021-22/26).
National Oesophago-Gastric Cancer Audit (NOGCA) 2021	No action plan required.
National Perinatal Mortality Review Tool 3rd	To conduct a review of the stillbirth cases for 2018 & 2019. Action completed: Review completed as part of the OBS/CA/2021-22/04: MBRRACE-UK: Perinatal Mortality (2019) Births audit action plan. Produce a local review/report and share findings. Action completed: Produced and shared via the S&Q committee.
National Pregnancy in Diabetes 2020	Continue to educate women in regard to preconception care and contraception as currently offered when women attend their routine Diabetes follow-ups. Action completed: Discussed at MDT and fully implemented. Amend guideline to include obtaining of HbA1c on diagnosis of GDM in line with NICE guidance (Type 1 and 2 data may be useful in monitoring GDM more closely and minimising related risks in relation to HbA1c). Action partially completed: In practice, the service does do this. Guideline to be amended, two other full guideline amendments required with higher priority, this will be done alongside. Contact all GPs to advise the following: Referring women with previous GDM and obesity to weight management programs to reduce the risk of future GDM and type 2 DM. On liaising with the wider MDT, it became evident this is not something available in the local vicinity, however the service continues to share our resources on T2DM 'know your risk', exercise 'moving more' and diet and lifestyle.
National Prostate Cancer Audit (NPCA) 2021	No action plan required.
National Smoking Cessation Audit 2021	Awaiting an action plan – within the time frame for submission at the time of this report.
National Vascular Registry 2021	Awaiting action.
NCABT: 2021 Audit of Patient Blood Management & NICE Guidelines	Awaiting an action plan – within the time frame for submission at the time of this report.

NNAP National Neonatal Audit Programme 2020	Awaiting an action plan – within the time frame for submission at the time of this report.
NPDA National Paediatric Diabetes Audit 2019-2020	MDT meetings to assess patients who have high HbA1c and tailor management accordingly. Action completed: Meetings implemented and fully established. Robust Insulin Dose Adjustments with emphasis on self- management and increase use of technology and pumps. Action completed: Process implemented and fully established – Ongoing process. Recruitment of band 7 Nurse. Action completed: Nurse now appointed into role. Audit of Psychology referral and outcome of support. Action overdue: Overdue action escalated at the Woman and Children Safety & Quality meeting.
SAMBA 2021 (Society for Acute Medicine Benchmarking Audit)	To meet the RCP and SAM standards for post-take by increasing medical recruitment on MAU. Action partially complete: There is task and finish group set up in the directorate with the aim to make the consultant advert more attractive, to attract candidates towards CESR route to CCT, aim to change locum consultants into substantives and utilise Head hunters for recruitments.
Serious Hazards of Transfusion (SHOT) – 2020	To ensure procedures are in place detailing identification, escalation and blood provision in Major Trauma and Major Haemorrhage cases. Action complete: Major Haemorrhage Pathway in place. To provide a platform to share learning from transfusion errors and near miss events across the whole organisation. Action complete: Safety Bulletins used to highlight trends. To provide support wit implementation of effective corrective and preventive actions. Action complete: Regular review by governance team to review relevant actions and to ensure they are in place in DATIX. To ensure procedures are agreed by relevant clinician, are accessible and incorporated in regular training. Action complete: To contact the simulation team to access input for MH cases. To ensure procedures are in place detailing appropriate use of anticoagulant reversal agents without requirement for approval by a consultant haematologist. Action complete: Anticoagulant reversal policy in place. To clarify the approval process with the coagulation leads.
The National Hip Fracture Database (NHFD) 2020	To Improve orthogeriatric cover To continue with recruitment. Finance available. The registrar now meets the orthogeriatric tariff and the service is looking to employ a nurse consultant.

	To improve time to theatre. Action in progress: More capacity needed. Despite Theatres 8 and 10 being used for trauma – as the Trust is the major trauma centre, major trauma and spinal emergencies take priority. To improve physiotherapist assessments/reviews. Action in progress: 7 day physio service.
UK Cystic Fibrosis 2020 Registry Only	No action plan required.

The reports of 356 local clinical audits were reviewed by the provider in 2021-22 and Lancashire Teaching Hospitals NHS Foundation Trust actions to improve the quality of healthcare provided are referenced in table 5.

Table 5 Audit and Confidential Enquiry – Resulting Actions

Audit title	Actions intended/completed
Audit	Clinical outcomes of VR clinics
Action - complete	Introduce an optometrist-led VR clinic in order to reduce waiting times for a VR clinic appointment.
Audit	Small bowel obstruction
Action - complete	Design and implement a small bowel obstruction pathway to standardise management.
Audit	Management of hypocalcaemia post total thyroidectomy
Action - complete	Update the Trust guideline on Post-op Total Thyroidectomy Hypocalcaemia.
Audit	Metastatic Spinal Cord Compression (June - December 2020)
Action - complete	Update the MSCC guidelines in order to reduce the variability of reporting and to emphasize importance of treating IMSCC with same urgency.
Audit	Re-audit of late effects of pelvic radiotherapy
Actions - complete	ALERT-B screening tool to be added to the end of treatment summaries to aid discussion and identify issues sooner All patients to be given self-help Macmillan booklet “Managing the late effects of pelvic radiotherapy” at the end of treatment.
Audit	Initiating a capillary blood glucose monitoring pathway for patients receiving radiotherapy for primary brain tumours taking dexamethasone
Action - complete	To introduce a risk adapted capillary blood glucose (CBG) monitoring strategy for the course of radiotherapy.
Audit	Skin Assessment Compliance (Breast)
Action - complete	ALL patients to receive baseline and weekly skin assessments during radiotherapy.
Audit	Audit on post-operative complications affecting OMFS Head & Neck Cancer patients.
Action - complete	Design and implement template for final clinical entry prior to discharge to comprehensively summarise inpatient episode. (diagnoses, treatment, complications etc.)

Audit	Re-audit of Quality of Extra-Oral Radiographs (2020)
Action - Complete	Develop QA programme with Christie's Medical Physics to highlight any processing, software or mechanical errors before patients are exposed to ionising radiation.
Audit	Audit of Robotic Assisted Laparoscopic Prostatectomy (RALP) operations of 2020
Actions - complete	Work to maintain prostate planning meeting and collaboration between surgeons and radiology and pathology teams to benefit patient outcomes. Improve documentation of functional results – incorporate into the remote PSA FU programme.
Audit	Patient Satisfaction with Information Given for Anaesthesia and Post-operative Care
Actions- complete	Written information on general anaesthesia, spinal anaesthetic, epidural anaesthesia and post-op HDU should be available in Pre-operative Assessment Clinic. QR codes for these patient information leaflets should also be available for patients that prefer easy access to an online source of anaesthetic information. Video explaining role of pre-operative assessment and advice on health and lifestyle choices to be played in waiting room as a source of patient education.
Audit	Post Operative Handover
Action - complete	To create a handover folder on QMED which when completed would contain the key handover information relevant to the ward/CrCu/SECU.
Audit	Re-admission rate to intensive care within 48 hours
Actions – in progress	Review of discharge times for all patients for same time period to see if out of hours discharge is higher in re-admission. Meeting with 'Discharge Group' to Streamline discharge process and ensure pre-discharge reviews, discharge documentation and post-discharge planning are optimised. CrCU Staff to Gain Access to Smart Page App to allow for handover of medical patients to Medical Team (vast majority of re-admissions are medical).
Audit	Metastatic Cord Compression - Review of Practice at a Single Tertiary Centre
Action - complete	Epidural Spinal Cord Compression (ESCC) grading to be recorded with all scans showing Metastatic Cord Compression.
Audit	Neurosurgery Referral Audit 2021
Action - complete	To create Information guidance document.
Audit	Adherence to the Trust antibiotics guidelines in Orthopaedic Surgery
Action - complete	Include the Guidelines and the link to tap on bugs application in the welcome pack for the newcomers to the Trust.
Audit	Improving the Quality of Orthopaedic Departmental Teaching

Actions - complete	Publish a teaching timetable at the commencement of the cycle to improve organisation and planning. Improve communication about the teaching programme amongst the junior team to improve attendance. Improve teaching on areas related to general perioperative care to aid with ward-based clinical scenario management.
Audit	Appropriateness of Prophylactic Anti-D issue in response to Fetal Genotyping results
Action - complete	Increased access for colleagues in both Obstetrics and Gynaecology to fetal genotyping results, so that if patients present with Potentially Sensitising Events, the fetal genotyping result is readily available and therefore, Anti-D Ig is not requested.
Audit	Antibiotics in hand injury
Actions - complete	Ensure adherence to LTHTR local antibiotic guidelines. Keep the night team (RMOs) updated about the audit results and guide them on how to access the LTHTR local antibiotic guidelines
Audit	Compliance with thromboprophylaxis guidelines in plastic surgery department
Action - complete	Monthly rolling audit to be conducted on Venous Thrombo Embolism (VTE). Use the ‘ward round’ function of the Quadramed application. Make laminated prompts to ensure ward round is approached systematically.
Audit	Tourniquet Documentation
Actions - complete	Departmental teaching session. New tourniquet operation notes stickers. Theatre staff teaching session.
Audit	Local anaesthetic toxicity and its treatment in the Plastic Surgery minor op theatre (CBT)
Actions - complete	Display official Association of Anaesthetists of Great Britain and Ireland (AABGI) posters with information on Local anaesthetic (LA) toxicity around the department in the nurse’s station. Include information on LA toxicity in the junior doctor’s handbook Organise departmental teaching on LA toxicity.
Audit	'Hot' report and formal report compliance of Major Trauma CT scans
Actions - complete	Reminding LTHTR radiologists of the 5 minute Verbal Report target time. Addressing the Out of Hours reporting by the Tele-radiology company.
Audit	Breast imaging for male patients: CLBU experience
Actions - complete	Patients with a clinical score of P1-3 should have ultrasound evaluation only, excluding mammography. Mammography should be reserved for patient who have suspicious changes on clinical or sonographic examination.
Audit	Physical Patient Folders on MAU & Ward 23

Actions - complete	Dividers have been added to the folders to create separate sections. Posters have been put on the folder trolleys to instruct staff on how the folders should be organised. Staff have been informed that Do Not Attempt Resuscitation (DNACPR) forms should be at the front of the folder.
Audit	First Fit Advice
Action - complete	A “First Fit” patient information leaflet has been developed for use in the Emergency Department.
Audit	Chest Drain Documentation and Monitoring
Actions - complete	Departmental teaching has been undertaken for doctors to raise awareness of completing the chest drain insertion form and how to access it on Quadramed. Chest drain posters are now available for both pleural effusion and pneumothorax and nurses have been informed that one needs to be put up on the head end of the bed for all patients with a chest drain in-situ. Raised awareness in departmental teaching sessions of the LocSSips chest drain insertion guideline which is available on the intranet.
Audit	Assessing Documentation of Ascitic Paracentesis
Action - complete	Ascitic drain insertion and removal forms are now available on Quadramed.
Audit	Maximal effort cytoreductive surgery for Advanced Ovarian Cancer
Actions – in progress	Link dataset of GynOnc Cancer Patient database with blood bank manager software. Audit of use of anti-microbial order sets on gynaecology ward and develop additional order sets if required. Establish GynOc Clinical Data Science Group to develop prospective data collection for gynaecological cancers and to link with other cancer alliance datasets. Complete gap analysis of current electronic patient record data set to identify additional data fields required in EPR (including digital operation note). Working groups with anaesthetists and pre-operative assessment team to be established. NW and GA have been identified as lead surgeons for advanced ovarian cancer cytoreductive surgery.
Audit	Re-audit Neonatal Jaundice Audit
Actions – in progress	Educational interventions as per recommendation. Education and dissemination - induction information for new starters, jaundice awareness week, e-learning module, audit meeting. Bilirubin Datix review currently being undertaken by nursing colleague. Schedule a re-audit in AMaT for 1 year after educational interventions.

Audit	Re-audit Care & Outcomes of Newly Diagnosed Paediatric Type 1 Diabetes
Actions – in progress	Communicate with local GPs/local schools to ensure they are aware of the key symptoms/need for timely referral. Increased need for clinic capacity & general resources for standards to be sustained. Management to assess this and address the potential deficit. Schedule a re-audit on AMaT ready to be activated when needed for the next audit period.
Audit	Audit of Melatonin for Sleep Disorder in Children with Neurodevelopmental Conditions
Actions – in progress	Discuss with commissioners about a commissioned sleep service. Review the Trust spending on melatonin to identify any potential savings.
Audit	Perineal Trauma - 3rd/4th Degree Tears (Feb-Apr 2021)
Actions - complete	Review of perineal trauma guideline -ref EBG00131 v1.2. Update the LTHTR perineal care bundle if needed using available evidence. Request participation in OASI 2 bundle.
Audit	Saving Babies Lives: audit of babies born with a birth weight less than the 3rd centile
Actions - complete	To review methods of data extraction to enable publication of accurate detection rates. To publish our detection rate to the Saving Babies Lives Dashboard. To include Small for Gestational Age (SGA)/ fetal growth restriction (FGR) data in board report and share with LMS. To continue with ongoing case-note audit of <3rd centile babies not detected antenatally, to identify areas for future improvement (at least 20 cases per year, or all cases if less than 20 occur). To continue with the Induction of labour audit. To share audit findings at consultant meeting. Share findings with Community Midwifery Team where SFH measurements have been missed and that could impact on missed cases. Update Fetal Growth Restriction Detection and Management guideline to align with Saving Babies Lives Version 2.

Clinical Research

Research Recruitment

The number of patients receiving relevant health services provided or sub-contracted by Lancashire Teaching Hospitals NHS Foundation Trust in 2021-22, that were recruited during that period to participate in research approved by a research ethics committee, was 2,646.

Lancashire Teaching Hospitals NHS Foundation Trust has recruited 2,487 patients to the National Institute for Health Research (NIHR) portfolio adopted studies in 2021-22. It granted local confirmation of capacity and capability (formally NHS permission) for 76 new studies to commence during that time. The Trust recruited a further 159 participants to non-portfolio studies. In total, there are currently 204 active research studies recruiting patients at the Trust. Due to the pandemic, and following guidance from the NIHR, the Trust suspended a large number of studies to focus on Covid-19 research. Over the course of the year, studies have been gradually reopened and the Trust currently have 94% of all studies reopened to recruitment. This provides us with a balanced portfolio of Covid-19 and non-Covid studies.

Research Governance

In 2019-20 the Department of Health benchmarks for the set up and delivery of clinical research in the NHS were changed to 62 days for non-commercial and 80 days for commercial studies. These figures are a measure from site selection to first participant recruited. For 2021-22, the metrics have once more been suspended, however Lancashire Teaching Hospitals NHS Foundation Trust have continued to collate this data. Performance has reduced compared to previous years due to study suspensions and restarts meaning that only 48% of studies have opened within the metrics.

Developments and Awards in Research (including Covid-19)

In June 2021, the Research and Development Department received notification that they were the top recruiting site in the UK for the NOVEL study. Since then, the Trust has continued to recruit and has now had 51 patients participating. The trial aims to explore the value of vaccinating women against HPV (human papillomavirus) at the time of local treatment for cervical pre-cancer. The trial is funded by the NIHR in the UK and is also running in a number of European sites as well.

The Trust is also involved in the UK's largest study investigating the best gap between first and second doses for pregnant women (Preg-Cov Study). £7.5m of Government funding has been put into the study and is being led by St George's, University of London. Dr Charlotte Cox is leading on the study locally. This study will provide vital information about which Covid-19 vaccine schedule works best in pregnancy.

The SIREN study has been taking place since early in the pandemic with data feeding directly into Government policy decisions. Health care staff from across the Trust have participated to enable an understanding of antibody response, immunity and vaccine response. The study would not have been possible without the support of Pathology colleagues.

The NIHR Lancashire Clinical Research Facility (LCRF) a collaborative partnership based within the Trust was re-awarded NIHR status with a 33% uplift in funding for 2022-25.

The NIHR LCRF is funded for experimental medicine studies and trials and as part of the evolution through Phase I and First in Human (FiH) trials already achieved the LCRF team has opened a trial with genetically modified organism (GMO) provision with Vaccitech (instrumental in the Oxford/AZ vaccine development). The trial is studying a Human Papillomavirus (hrHPV) Vaccine in women with low grade HPV cervical lesions. This is the

first study of its kind in Lancashire and South Cumbria and the Research and Development Department have already recruited two patients.

The LCRF is also just one of seven centres across the country to take part in a Covid-19 AGILE coronavirus drug testing initiative, recruiting people including staff, friends and family members who are testing positive. The study is currently looking at assessing the effectiveness of a new antiviral medication, Molnupiravir. Molnupiravir has been approved by the MHRA and is now available for use in vulnerable and immunosuppressed patients with Covid-19 in the community. The AGILE clinical trial aims to continue to assess its effectiveness in the wider population. This study has recently been featured on the BBC.

Having never had a successful application for the NIHR Northwest Coast CRN's Scholar scheme, to train new Consultant-level clinicians and NMAHPs as Investigators, the Research and Development Department is delighted to report four successful applications for 2021-22 which is the joint highest in the region. Congratulations to:

- Dr Rob Shorten (Clinician Scientist)
- Dr Katherine Prior (Respiratory Consultant)
- Dr Malabika Ghosh (Occupational Therapist)
- Sarah Edney (Speech and Language Therapist)

The Research and Development Department has also had three NIHR Applied Research Collaborative (ARC) internships awarded this year, building further capability for future home grown studies. In addition to this the Research and Development Department have further developed our collaborative relationship with the University of Central Lancashire to appoint five Honorary Chairs linked to research.

Nichola Verstraelen, Research Matron, completed her 3 years as NIHR 70@70 representative and was asked to lead an NHSE/I project on a research toolkit for the Matron's Handbook. The aim is to support the embedding of research within the clinical environment.

Acting Matron Katrina Rigby was nominated for the Women of the Year Awards, as a guest of Ruth May, Chief Nursing Officer for England. The awards honoured the women of the NHS this year, in recognition of the Year of the Nurse and Midwife 2020.

Commissioning for Quality & Innovation

Due to the Covid-19 pandemic the Commissioning for Quality and Innovation (CQUIN) programme continues to be suspended for this year and as such there is no information or data for the current reporting period.

Registration with the Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust is required to register with the CQC, and it is currently registered and licensed to provide the following services:

- Diagnostic and/or screening services
- Maternity and midwifery services

- Surgical procedures
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Termination of pregnancies
- Treatment of disease, disorder, or injury
- Management of supply of blood and blood derived products
- There are no conditions to this registration

Lancashire Teaching Hospitals NHS Foundation Trust has been delivering a vaccination hub service since the 18th February 2021 at a community venue as part of the response to the Covid-19 pandemic. The vaccination hub is a satellite service of Lancashire Teaching Hospitals and is covered by its existing CQC registration. The service has been set up in conjunction with the Integrated Care System, in line with the National Covid-19 Vaccination Programme. Equipment is supplied directly from the national Covid-19 procurement supplies and is stored at the vaccination hub. Security is available to maintain safekeeping.

Between the 10th June 2021 and 13th June 2021, clinical care of patients for two lanes at the St John's Mass Vaccination Centre was provided by Broadway Pharmacy. From September 2021. the St John's Vaccination Hub extended administration of Covid-19 vaccination to 16 and 17 year olds. This was extended further to cover 12 -15 years who may be clinically vulnerable or may be household contacts of clinically vulnerable individuals in October 2021. This is in line with national protocols and Safeguarding Level 2 and 3 Training and Paediatric Basic Life Support training has been put in place as appropriate for relevant staff. Since September 2021 trust staff from the St John's Mass Vaccination also delivered Covid-19 vaccinations as part of a roving model. The vaccine was delivered in line with the National Standard Operating Procedure for roving and mobile models.

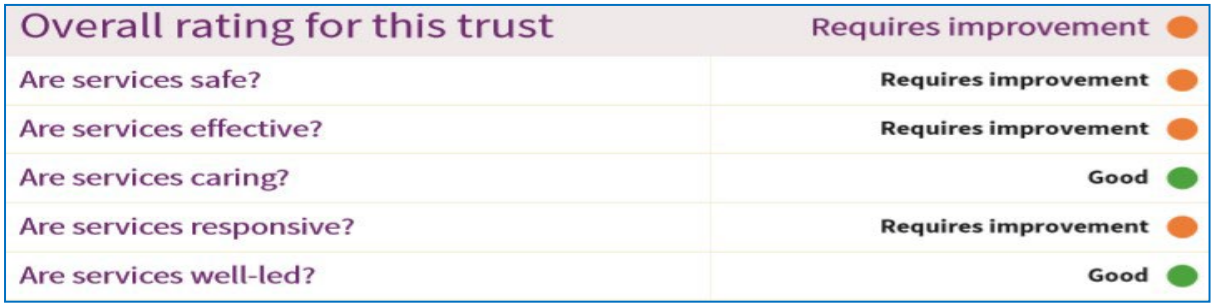
The CQC has not taken enforcement action against Lancashire Teaching Hospitals NHS Foundation Trust during 2021-22.

The CQC have not been routinely inspecting services during the pandemic period and recovery phases, although have been carrying out some focussed inspections based on the level of risk identified. Throughout 2021-22 period the Trust had a number of CQC engagement meetings to discuss Infection, Prevention and Control arrangements, Emergency department through Patient First Framework safety and the Nightingale surge hub as a result of the Covid-19 pandemic as well as more general topics as part of regular reporting to the CQC. Through these meetings, the CQC was pleased to note improvements in hospital onset (nosocomial) infection rates and were assured that robust action plans were in place to ensure safety was maintained through the pandemic.

Lancashire Teaching Hospitals NHS Foundation Trust was last subject to a routine inspection of services between 2 July and 8 August 2019. For completeness of information this was reported in the 2020-21 Quality Account and reiterated in this report as the rating remains applicable. The services inspected in 2019 were Urgent and Emergency Services and Medical Care at Royal Preston Hospital and Chorley and South Ribble Hospital and Surgery and Critical Care at Royal Preston Hospital only.

Overall, the Trust retained a rating of 'requires improvement', with 'good' for caring and a new 'good' for well led. This is a combined rating based on the inspection in specific core services and also based on the number of improvements observed and built on since the previous inspection. Specifically, a rating of good for 'caring' means that people are supported and treated with dignity and respect and are involved as partners in their care and a rating of good for 'well led' means leadership, governance and culture promote the delivery of high quality person-centred care.

Figure 2 Overall CQC Ratings for the Trust



Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Data source: CQC Report

CQC Inspectors also observed an improved position at site level and core service level.

Throughout 2021-22, the Trust has been able to demonstrate ongoing progress in meeting the recommendations from the last inspection through a number of programmes of work, including the *Always Safety First* Programme, a number of Continuous Improvement Programmes, the Governance and Risk Maturity Plan, the Safety Triangulation Accreditation Review Framework as well as our Organisational Development and Equality and Inclusion Strategies.

The Trust continues to maintain established and trusted relationships with the CQC by fostering a transparent relationship, sharing risks and concerns in respect of patient safety and quality as they occur, together with the actions taken or proposed in order to provide assurance that the Board has appropriate oversight of its quality governance and patient safety risks.

Quality of Data

Data Quality and Information governance

It is generally accepted that good quality data is at the heart of identifying the need to improve. It also provides the evidence that there has been improvement in the quality of care delivered as a result of changes that the Trust has made.

Lancashire Teaching Hospitals NHS Foundation Trust submitted records during 2021-22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number, was:

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 99.5% for accident and emergency care

The percentage of records in the published data, which included the patient's valid General Medical Practice code, was:

- 99.6% for admitted patient care
- 99.6% for outpatient care
- 99.5% for accident and emergency care

All data set types are either consistent with or show an improvement compared to 2020-21, all are above the national average for 2021-22.

As part of the Lancashire Teaching Hospitals NHS Foundation Trust annual assessment, the Data Security and Protection Toolkit (DSPT) is reviewed annually and updated to ensure Trust standards are aligned with current best practice. The status for the 2020-21 DSPT is 'standards met'. The 2021-22 submission is not due to be made until June 2022.

Lancashire Teaching Hospitals NHS Foundation Trust was not subject to a Payment by Results audit completed by the Audit Commission during 2021-22 and could not be externally audited by Coding Collaborative partners due to pandemic restrictions. The Trust was subject to an internal Information Governance clinical coding quality assurance audit during 2021-22. Results indicate a high level of coding quality and completeness as follows:

- Primary Diagnosis 96%
- Secondary Diagnosis 88%
- Primary Procedure 94%
- Secondary Procedure 80%

Lancashire Teaching Hospitals NHS Foundation Trust has undertaken the following actions to improve data quality:

- Submission of a bi-annual Data Quality Assurance Report to the Board providing a summary of Data Quality Team activities, an update in relation to Data Quality Risks and compliance in relation to the National Data Quality Assurance Dashboard and Maturity Index.

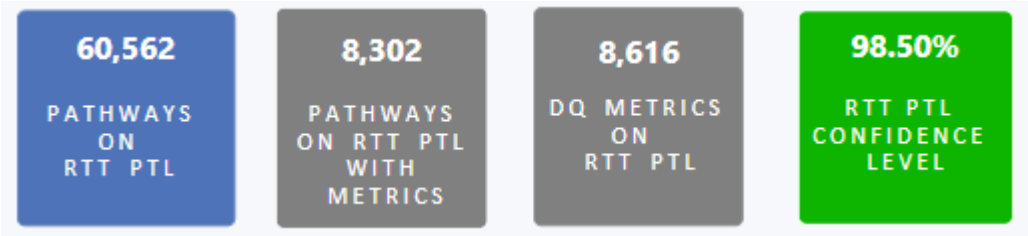
- In terms of the NHS Digital Data Quality Maturity Index the Trust scored the following for the latest position available, above the national average in all datasets.

Table 6 NHS Digital Data Quality

	Overall	Emergency Care Dataset	Admitted Patient Care Dataset	Out-Patient Dataset
National Average	81.8	68.1	91.0	88.3
Lancashire Teaching	91.3	84.8	99.5	99.0

Data source: NHS Digital

- National Waiting List Minimum dataset data quality confidence level of 98.5%, above the national threshold of 95%. Compliance is detailed below:



- Integrated Performance Report aligned to *Our Big Plan* ambitions reflecting the golden thread of reporting from Board to Division and Sub Committee to Specialty and Ward.

- Extended suite of validation reports to increase validation and assurance of the quality of data on the main Patient Administration System (PAS).

- Interactive workshops to ensure engagement with clinical and support staff regarding importance of good data quality and individual responsibility.

Information Governance

The confidentiality and security of information regarding patients, staff and the Trust are maintained through governance and control policies, all of which support current legislation and are reviewed on a regular basis. Personal information is increasingly held electronically within secure IT systems. It is inevitable that in a complex NHS organisation a small number of data security incidents occur. The Trust is diligent in its reporting and investigation of such incidents, in line with statutory, regulatory, and best practice obligations. Any incident involving a breach of personal data is handled under the Trust's risk and control framework, graded and the more serious incidents are reported to the Department of Health and the Information Commissioner's Office (ICO) where appropriate.

The Trust experienced four externally reportable serious incidents in the 2021-22 period, only one of which reached the reporting criteria sent to the ICO. This incident was in relation to an allegation for unauthorised access and full internal onward processes followed. All four incidents were reported using the DSPT.

As part of our annual assessment, the DSPT is reviewed annually and updated to ensure Trust standards are aligned with current best practice. The status for the 2021-22 DSPT is 'standards met'.

The Trust has established a dedicated information risk framework with Information Asset Owners throughout the organisation which is embedded with responsibilities in ensuring information assets are handled and managed appropriately. There are robust and effective systems, procedures, and practices to identify, manage and control information risks. Alongside training and awareness, incident management is part of the risk management framework and is a mechanism for the immediate reporting and investigation of actual or suspected information security breaches and potential vulnerabilities or weaknesses within the organisation. This will ensure compliance in line with the General Data Protection Regulations (GDPR) and Data Protection legislation.

Although the Board of Directors is ultimately responsible for information governance it has delegated responsibility to the Information Governance/Records Committee which is accountable to the Finance and Performance Committee. The Information Governance Committee is chaired by the Medical Director who is also the Caldicott Guardian. The Board appointed Senior Information Risk Owner (SIRO), is the Finance Director.

The Information Governance Management Framework brings together all the statutory requirements, standards, and best practice and in conjunction with the Information Governance Policy, is used to drive continuous improvement in information governance across the organisation. The development of the Information Governance Management Framework is informed by the results from DSPT assessment and by participation in the Information Governance Assurance Framework.

Adult Mortality Reviews and Serious Investigation Data

The trust implemented the nationally recommended approach to Mortality Review (MR) during 2017-18 which was based on the Royal College of Physicians Structure Judgement Review (SJR) model. This has been embedded in practice for the past three years. The SJR mortality model was developed for the review of adult deaths, the outcomes of which are presented below. Neonatal and child deaths are managed through different nationally defined review and reporting processes which are presented separately in the Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths section in this account. The deaths include inpatient and Emergency Department deaths which are reviewed using SJR methodology.

During 2021-22, 1,934 of Lancashire Teaching Hospitals NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 429 in the first quarter
- 459 in the second quarter
- 525 in the third quarter
- 521 in the fourth quarter

Data source: Trust data warehouse

By 30th March 2022, 825* case record reviews and 15** Strategic Executive Information System (StEIS) investigations have been carried out in relation to the 1,934 deaths noted above.

** Q4 data incomplete as March 2022 reviews are still ongoing*

***6 StEIS investigations have been concluded and awaiting Coroner's inquest/inquest outcome: four complete and five ongoing*

The number of deaths in each quarter for which a case record review or StEIS investigation was carried out was:

- 209 in the first quarter (plus four StEIS investigations)
- 211 in the second quarter (plus one StEIS investigation)
- 210 in the third quarter (plus five StEIS investigations)
- 177 in fourth quarter (plus five StEIS investigations)

Data source: Trust MR Database and Datix

1 case representing 0.2% of patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient in relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 0 representing 0%for the second quarter
- 1 representing 0.2% for the third quarter
- 0 representing 0% for the fourth quarter

Data source: Trust MR Database & Datix

These numbers have been calculated using the Structured Judgement Review (SJR) Mortality Review process and the StEIS process. Of the six completed StEIS investigations awaiting HM Coroner's review in 2021-22 it is not possible to determine for all cases if deaths were on balance likely due to problems in care as inquests have been delayed due to the Covid-19 pandemic. It is noted that the new Patient Safety Incident Response Framework from NHS Improvement (NHSI), which is expected to be implemented in 2022 advises that avoidability of death should not form part of the terms of reference for StEIS investigations with that being the remit of HM Coroner.

Learning from the deaths reviewed

The learning from deaths investigation subject to inquest will be shared through our learning to improve process when available. The learning from the four StEIS cases (three falls and one pressure ulcer) for which investigation has been completed and HM Coroner's inquest is not required includes:

- Mental Capacity Assessments to be completed if there are any concerns over the patient's mental capacity.
- Develop action plan to ensure End of Life Care assessments and implementation for 'certain' patients in ED.
- Due to Covid-19 infection prevention and control measures and depleted staffing during the peak of the pandemic, enhanced levels of care were not always able to be carried out to prevent falls.
- Ensure that safety risk assessments such as falls are completed on admission and on transfer.
- Ensure all staff are aware of the post fall protocol – safety message/memo to staff and communicate at staff meetings.
- Ensure that the Age UK 'Staying Steady' leaflet is shared with patients who are at risk of falls so that they can take steps to reduce their risk of falling not only in hospital but also on discharge.
- The need for timely risk assessment and body map completion to aid prevention of pressure ulcers.

- Regular repositioning on alternate side and documentation when this is not possible to aid prevention of pressure ulcers.
- To ensure staff check under and reposition all medical devices regularly as determined in the care plan to aid prevention of pressure ulcers

Actions in relation to the learning from investigations subject to inquest

The learning and actions from investigations subject to inquest will be shared through our learning to improve process when available. The action plans from the completed StEIS investigation are all recorded and monitored through the Trust's Datix system and through the Trust's Safety and Learning Group.

Assessment of the impact of actions from investigations

The assessment of the impact of actions from investigations subject to inquest is shared through our learning to improve process. The assessment of the impact of actions is tested through audit.

2.3 Reporting Core Indicators

Lancashire Teaching Hospitals NHS Foundation Trust performance is measured against a range of patient safety, access and experience indicators identified in the NHSI compliance framework and the acute services contract.

The NHS continued to face significant challenges in 2021-22 and, like all other NHS Trusts across the country, Lancashire Teaching Hospitals NHS Foundation Trust has continued to experience pressures as a result of the Covid-19 pandemic. Performance across the board, both emergency and elective has been impacted with operational pressures and infection prevention control measures experienced through the year resulting in non-compliance in relation to a number of key standards.

Whole health economy system pressures in response to Covid-19 demand resulted in high bed occupancy throughout the year with the need to focus both on Covid-19 non-elective activity and elective recovery as mandated nationally. The number of patients not meeting the criteria to reside rose as Covid-19 outbreaks in community settings increased. This, together with Covid-19 demand as a result of the Omicron variant resulted in significant capacity and demand pressures. Workforce capacity to undertake elective activity was also impacted by Covid-19 related absence throughout December 2021 and January 2022.

A health economy system wide action plan is in place to address the urgent care system and pressures; with identified primary and social care initiatives/schemes delivering a level of sustainability across the health economy. In 2021-22 the Trust took a lead role in bringing together operational delivery of the system wide urgent and emergency care programme, including key transformational work streams identified and prioritised by all system partners. Discharge arrangements reflecting national policy changes brought in as a result of Covid-19 and the provision of community capacity to support are being progressed through these arrangements.

Since the beginning of the Covid-19 pandemic the Trust has put in place a range of measures including;

- Additional medicine bed capacity to meet increased demand
- Re-zoning of our estate to meet Infection, Prevention and Control (IPC) requirements
- Delivery of Same Day Emergency Care (SDECs) moving to a 24/7 model
- Additional ITU surge beds with additional staffing through redeployment
- Implemented digital health to reduce inappropriate admissions to hospital
- Nightingale Surge Hub capacity to support increased demand as a result of the Omicron variant of Covid-19

These actions have helped to support the Trust during these unprecedented times and enabled the Trust to achieve compliance against a range of measures within the risk assessment framework, including one of the national cancer waiting times standards. However, the Trust has failed to achieve its objectives in relation to the 4 Hour A&E target, the 18-week incomplete access target, and the 62-day cancer treatment standard. The significant growth in the number of long waiters in both RTT and cancer pathways has been directly impacted by the Covid-19 pandemic and the need to cease some elective activity during the pandemic peak periods and prioritise only urgent elective activity as part of the elective restoration plan.

Core Indicators: Summary position detailing performance 2021-22 is shown in table 7 below.

Table 7 Core Indicators: Summary position 2021 -22

To note some data is only available up to February 2022 at the time of report writing

Indicator	2020-21	2021-22	Current Period
A&E - 4 hour standard	85.56	78.2	% - Cumulative to end Mar 2022 Position includes both ED and UCC locations.
Cancer - 2 week rule (All Referrals) - New method	88.0	79.2	% - Cumulative to end Feb 2022
Cancer - 2 week rule - Referrals with breast symptoms	52.8	54.9	% - Cumulative to end Feb 2022
Cancer - 31 day target	89.5	87.2	% - Cumulative to end Feb 2022
Cancer - 31 Day Target - Subsequent treatment – Surgery	77.8	72.1	% - Cumulative to end Feb 2022
Cancer - 31 Day Target - Subsequent treatment – Drug	97.9	99.2	% - Cumulative to end Feb 2022
Cancer - 31 Day Target - Subsequent treatment - Radiotherapy	97.7	97.5	% - Cumulative to end Feb 2022
Cancer - 62 day Target	64.0	37.6	% - Cumulative to end Feb 2022
Cancer - 62 Day Target - Referrals from NSS (Summary)	57.3	60.0	% - Cumulative to end Feb 2022
28 day faster diagnosis standard	80.3	72.0	% - Cumulative to end Feb 2022
MRSA	0	1	Cumulative to end Feb 2022
C.difficile Infections	100	114	Cumulative to end Feb 2022

18 weeks - Referral to Treatment - % of Incomplete Pathways < 18 Weeks	54.2	53.7	% - sum of Apr-Feb 2021-22
% of patients waiting over 6 weeks for a diagnostic test	43.12	44.87	% - Cumulative to end Feb 2022

Summary of Performance against Core Indicators

The source of all the data presented in the table below is from ***NHS Digital*** as is the requirement for the Quality Account and is the most current data available for each Performance Indicator presented. All benchmarking data presented is related to Acute (non-specialist) NHS Trusts.

NHS Digital Data availability

For Table 8 Summary Hospital-Level Mortality Indicator (SMHI), Table 9 Readmissions within 30 days of Discharge, Table 13 Clostridioides Difficile Infection and Table 14 Patient Safety Incidents the most recent data available from NHS Digital is for the 2020/21 period.

For Table 10 Responsiveness to Personal Needs and Table 11 Staff Recommendation as a Provider of Care the data is from the National Inpatient Survey 2019/20. The 2020/21 National Inpatient Survey has not yet been published.

For Table 12 Venous Thromboembolism Risk Assessment, NHS Digital VTE data collection and publication was paused to release NHS capacity to support the response to coronavirus (COVID-19). The most up to date data from NHS digital for VTE data is therefore, 2019/20.

Table 8 Summary Hospital-Level Mortality Indicator (SMHI)

Summary Hospital- Level Mortality Indicator (SMHI)	**December 2018-November 2019**	**December 2019-November 2020**	**December 2020-November 2021**
(a) the value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period	**Trust = 0.9702**	**Trust = 0.9671**	**Trust = 0.9593**
	England average = 1.0	England average = 1.0	England average = 1.0
	Low = 0.69	Low = 0.69	Low = 0.71
	High = 1.19	High = 1.18	High = 1.19
	Banding = 2	Banding = 2	Banding = 2
(b) the percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period	**Trust = 53%** England = 36% High = 59% Low = 11%	**Trust = 52%** England = 36% High = 59% Low = 8%	**Trust = 51%** England = 39% High = 64% Low = 11%

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- NHS Digital categorizes NHS Trusts into bands 'higher than expected' (banding=1), 'as expected' (banding=2) or 'lower than expected' (banding=3). The trust remains in band 2 which is within the expected range. The SHMI for the most current data available (Dec 2020 – Nov 2021) is 0.95 which is marginally lower than the previous 12-month period.

- The SHMI data does not include Covid-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were to be included it would affect the accuracy.

Table 9 Readmissions within 30 days of Discharge

The percentage of patients aged: 0 to 15 and 16 or over Readmitted to a hospital which forms part of the Trust within 30 days of being discharged from the Trust during the reporting period	April 2017-March 2018	April 2018-March 2019	April 2019-March 2020	April 2020-March 2021
0-15 years	**Trust = 15.2 (A1)**	**Trust = 15.8 (A1)**	**Trust = 13.5 (A5)**	**Trust = 12.0 (W)**
	England = 11.9 High = 17.0 Low = 1.7	England = 12.5 High = 19.3 Low = 2.0	England = 12.5 High = 18.5 Low = 2.4	England = 11.9 High = 12.1 Low = 11.9
16 years – 74 years	**Trust = 10.9 (B1)**	**Trust = 12.0 (B1)**	**Trust = 11.8 (B1)**	**Trust = 12.4 (B1)**
	England = 12.4 High = 21.0 Low = 2.2	England = 13.0 High = 21.8 Low = 1.2	England = 13.1 High = 19.5 Low = 3.2	England = 14.5 High = 14.5 Low = 14.4
75 years +	**Trust = 16.9 (B1)**	**Trust = 17.8 (W)**	**Trust = 17.6 (B5)**	**Trust = 19.5 (W)**
	England = 18.4 High = 22.5 Low = 6.7	England = 18.7 High = 29.4 Low = 6.1	England = 18.6 High = 31.9 Low = 8.6	England = 19.6 High = 19.7 Low = 19.4

2021/22 not yet released by NHS Digital. As such data is presented 12 months in arears.

Banding key:

B1 = Significantly lower than the national average at the 99.8% level

B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level

W = National average lies within expected variation (95% confidence interval)

A5 = Significantly higher than the national average at the 95% level but not at the 99.8% level

A1 = Significantly higher than the national average at the 99.8% level.

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The NHS Digital readmissions data is now categorised into 0-15 years, 16- 74 years, and 75+ years. The banding has been presented to indicate the Trust performance.

The 0-15 year's readmissions are 0.1% above the England average which shows an improvement from the last reported figure and the Trust remains lower than the highest rate of 12.1.

The Trust re-admissions rate for patients 16-74 & 75+ is either as expected or lower than the average

Table 10 Responsiveness to Personal Needs

	2017-2018	2018-2019	2019-2020
The Trust's responsiveness to the personal needs of its patients during the reporting period	**Trust = 65.9**	**Trust = 66.2**	**Trust = 66.8**
	England = 68.6 High = 85.0 Low = 60.5	England = 67.2 High = 85.0 Low = 58.9	England = 67.1 High = 84.2 Low = 59.5

This indicator value is based on the average score of five questions from the National Inpatient Survey, which measure the experiences of people admitted to NHS Hospitals.

It should be noted that the sampling month for 2021 moved from July to November so the 2020/21 survey results are not comparable to previous years. The 2020/21 National Inpatient Survey has not yet been published.

The Trust is continually aiming to improve being responsive to the personal needs of patients and undertakes the following actions to improve the quality of its services, by

- Continually improving responsiveness to needs through all our patient experience and professional strategies in our pursuit of 'consistently deliver excellent care'.
- By responding to feedback from patients and families through the Friends & Family test as well as national and local surveys.
- The STAR accreditation system drives continuous improvement in our services being responsive to the personal needs of patients.
- Strengthen the connection between equality, inclusion and diversity agenda between patients and staff.
- Delivery of patient contribution to case notes, an innovative patient held record to promote patients as partners in care.

Table 11 Staff Recommendation as a Provider of Care

	2018	2019	2020
Percentage of staff employed by, or under contract to the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends	**Trust = 65.4**	**Trust = 62.6**	**Trust = 69.0**
	England = 71.0 High = 90.4 Low = 39.7	England = 70.5 High = 90.5 Low = 39.8	England = 74.3 High = 91.7 Low = 49.7

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust continues to receive staff feedback through a range of channels including the Staff Survey, Valuing your Voice and through the Trust 'Big Conversations' which has been responded to and this has most likely influenced the 6% improvement between 2019 and 2020.

Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by**;**

Continuing with workforce and organisational development strategy as our people plan for the organisation, implementing staff engagement and continuous improvement programmes. The Trust involves clinical and non-clinical staff in our improvement journey which has been presented in the Continuous Improvement section in this Quality Account.

Table 12 Venous Thromboembolism Risk Assessment

	Q4 2018 -2019	Q3 2019 -2020	Q4 2020-2021
Percentage of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period	**Trust = 95.7%**	**Trust = 97.0%**	NHS Digital VTE data collection and publication paused.
	England = 95.7% High = 100% Low = 74%	England = 95.3% High = 100% Low = 71%	

NHS Digital VTE data collection and publication has been paused to release NHS capacity to support the response to coronavirus (COVID-19).

The trusts VTE risk assessment compliance data is collated and reported to Safety and Quality Committee in an assurance report.

Table 13	***Clostridioides Difficile (C. difficile)*** **Infection**	
The rate per 100000 bed days of cases of *C. Difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period	**2019-20**	**2020-21**
	Trust = 62.9	**Trust = 74.5**
	High = 142.8 Low = 0	High = 140.5 Low = 0

Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Hospital onset *Clostridioides difficile* (C. *difficile*) was higher than the Trust annual objective during 2020-21 according to the NHS Digital data against a trajectory of 118 cases.
- 2020-21 was a challenging year for many Trusts around *C. difficile* with many hospitals seeing significant increases. The trajectory set for Lancashire Teaching Hospitals was based on 2019-20 figure set against the 2018/19 period where a 15% decrease in C. *difficile* cases occurred. This has not been achieved in any other year.
- To mitigate the exceeded trajectory the trust has undertaken the interventions outlined below;

Lancashire Teaching Hospitals NHS Foundation Trust has taken the following actions to reduce *C. difficile*, and so the quality of its services, by:

- Continuing Post Infection Reviews (PIRs) which is a multidisciplinary approach to investigate each hospital onset *C. difficile* case.
- Sharing lessons learned from PIRs and implement quality improvement actions.
- Continuing to focus on antimicrobial prescribing with community partners.
- Continuing to promote best practice around antimicrobial stewardship.
- Continuing to be responsive to the need for isolation.
- Promoting hand hygiene and environmental cleaning.
- Promoting infection prevention and control education Trust wide with the implementation of a robust E-Learning package.
- Promoting clinical revalidation audits and environmental audits

And the following actions:

Fogging of Bays

If the patient is nursed in a bay when C. difficile diagnosed, Fog bay within 7 days of C. difficile positive sample
If there is a period of increased incidence (PII) on a ward, fog all bays and sluice on ward within 7 days of PII being reported

Risk Assessments

If a patient has a type 6/7 stool in a shift, include within the nursing documentation –

- Any non-infectious possible causes (e.g. laxatives)
- A decision as to whether or not sampling is required
- A decision as to whether or not side-room /Redi-room required

Testing & Sampling

ASAP, if testing indicated for type 6/7 stool –

- Send one faecal sample for laboratory culture and
- Immediately transport rectal swab to rapid testing team for rapid intestinal screen

If C. difficile positive on rapid intestinal screen, this may indicate carriage or infection, however, the patient must be isolated.
Patient with chronic diarrhoea should be tested every 5 days in the laboratory

Visual Displays

Create column on ward "white board" –

- "Type 6/7 stools in the past 48 hours" – Yes/No

Review white board at least daily in appropriate ward meetings and ensure documentation of risk assessment and appropriate actions for patients with loose stools, as above

Further information on C. difficile can be found in the Infection Prevention and Control section of this report.

Table 14 Patient Safety Incidents

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death. The 2021 date is being collated and will be included once available.				
	Oct 2017-March 2018	**Oct 2018-March 2019**	**Oct 2019-March 2020**	**Apr 2020-March 2021**
(i) Rate of Patient Safety Incidents per 1000 Bed days	**Trust Number = 6506 Trust Rate = 43.6**	**Trust Number = 7250 Trust Rate = 52.4**	**Trust Number = 7766 Trust Rate = 51.8**	**Trust Number = 14428 Trust Rate = 68.9**
	England – 42.1 All * Trusts Rate High = 69.0 All * Trusts Rate Low = 23.1	England – 45.2 All *Trusts Rate High= 95.9 All *Trust Rate Low = 16.9	England – 49.6 All *Trusts Rate High = 110.2 All *Trusts Low = 15.7	England – 57.3 All *Trusts Rate High = 118.7 All *Trusts Low = 27.2
(ii) % of Above Patient Safety Incidents = Severe/Death **Rate = per 1000 Bed Days**	**Severe harm or death**	**Severe harm or death**	**Severe harm or death**	**Severe harm or death**
	Trust Number = 62 Trust Rate = 0.42 % of all incidents = 0.95%	**Trust Number = 60 Trust Rate = 0.43 % of all incidents = 0.83%**	**Trust Number = 49 Trust Rate = 0.33 % of all incidents = 0.63%**	**Trust Number = 88 Trust Rate = 0.42 % of all incidents = 0.61%**
	England – 0.35% All *Trusts Highest % = 1.54% All *Trusts Lowest % = 0%	England – 0.32% All *Trusts Highest % = 1.82% All *Trusts Lowest % = 0%	England – 0.30% All *Trusts Highest % = 1.29% All *Trusts Lowest % = 0%	England – 0.44% All *Trusts Highest % = 2.80% All *Trusts Lowest % = 0.03%

The Lancashire Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons;

- The Trust continues to improve education regarding the reporting of incidents and near misses, the importance of doing so and the outcome of the learning gleaned from incident reporting.
- Continued improvements to the reporting system to make it easier to report in a timely manner, whilst obtaining essential information.
- Our staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients.
- Incident dashboards and a Governance Dashboard are now in use across the Trust for embedded incident analysis.

The Lancashire Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:
Continued Learning 2 Improve work through the Governance and Continuous Improvement Teams to address areas of concern from Incident trends (Pressure Ulcers, Never Events, and Safeguarding etc.). Develop an automatic Governance Dashboard which is more interactive and more widely accessible to staff for improved incident analysis.
Develop and improve the scope and agenda for Safety & Learning Group to ensure systematic delivery on action plans and the embedded improvements for patient safety result in improved outcomes. This is being built into the Datix system.
Continue to link incident analysis to the risk register and the Trust's Risk Maturity Programme of work. Linking incident and risk intelligence to *Our Big Plan*.

Clinical Standards for Seven Day Hospital Services

A Board Assurance Framework for seven-day hospital clinical services was developed by NHSI in 2018, requiring all Trusts to provide Board level assurance every 6 months, through completion of a standardised template capturing performance against all 10 Clinical Standards. At the onset of the Covid-19 pandemic this requirement was stood down by NHSE/I and the impact of the pandemic on this indicator continued through the period March 2021 to April 2022. Despite the reporting requirement being stood down, the Trust has continued to focus on Our Big Plan metrics during 2021-22 to continuously improve performance and deliver transformation.

In addition, the following actions support improved performance:

- Adjustments to the Emergency Department attendance and admissions processes to safely manage Covid-19 positive and negative patients and ensure timely consultant reviews.

- Adjustments to the bed utilisation across both hospital sites to support cohorting enhanced high care, Covid-19 positive and negative patients.

- Adjustments to the medical, nursing and AHP staffing models across both hospital sites to ensure timely consultant reviews.

- Roll-out of electronic clinical notes across the Trust for inpatients.

- Development of the Clinical Documentation Business Intelligence ('ClinDoc') Application (App) to enable capturing current data relating to key clinical metrics.

- Key performance data from the 'ClinDoc' App is now included in divisional performance information to facilitate discussions between the Divisional Leadership Teams and Executive Team and inform decisions regarding improvement actions.

- Additional functions have been added to 'ClinDoc' to expand the range of clinical standards captured which includes:

    - Daily Consultant Review.
    - Consultant Review within 14 hours of Admission.
    - VTE Risk Assessment.
    - Expected Day of Discharge.
    - Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR).
    - Midday Discharges.

Freedom to Speak Up

In response to the principles and actions described in the review into Mid-Staffordshire Hospitals[1] (2013) and the later review of whistleblowing in the NHS[2] (2015), undertaken by Sir Robert Francis Queens Counsel (QC); the Trust reviewed its processes and systems for inviting, listening, and responding to concerns raised by staff. The Board of Directors oversaw implementation of a range of measures to strengthen systems and processes to enable staff across the Trust to raise concerns and speak up with confidence. These included:

- The appointment of a Freedom to Speak Up (FTSU) Guardian
- Establishment of Board level representation (Executive and Non-Executive Directors) for staff raising concerns
- Establishment of Trust policy
- Quarterly reporting of concerns and learning that comes from them
- Inclusion of importance of raising concerns in new staff induction for all staff including Board members and inclusion in mandatory training

The ability to raise concerns in a safe way is essential as a contribution to the delivery of safe, effective care. The Trust recognises that this ability is also a key element towards a positive staff experience, affecting our ability to retain our staff. Our staff are encouraged to raise any concerns, including those about; patient safety and quality of care; bullying and harassment;

[1] Francis Enquiry 2013

[2] Freedom to Speak Up report 2015

or financial impropriety, to immediate line managers or their line manager's superior as they feel able. Where there are immediate safety concerns, staff are encouraged to report to their line manager and to record this as a patient safety incident in Datix.

Where staff feel that their concern has not been addressed, they can raise their concern with our FTSU Guardian, a FTSU champion or their union representative.

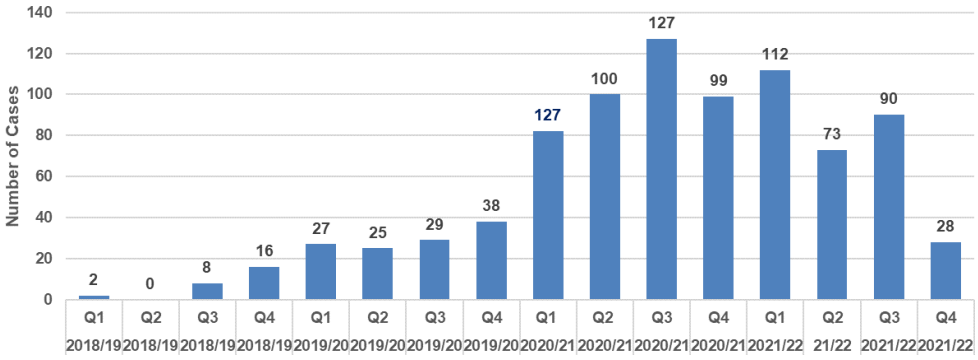
In September 2021, a new FTSU reporting module has been added to our Datix incident reporting system. The module allows staff to share concerns in a safe way that is only visible to the FTSU Guardian. The module has enhanced our record keeping and reporting capabilities and improved access to FTSU support.

During 2021-22 there were 303 contacts with the FTSU service compared with 408 in 2020-21, representing a 26% reduction in activity.

Until quarter 4 of 2021, the number of staff contacting the Freedom to Speak Up team had increased every quarter since quarter 1 in 2018-19. It is likely that several factors have led to the fall in activity in quarter 4 (back to quarter 2 levels), including but probably not limited to: resolved issues associated with car parking permit allocation, improved engagement from managers in resolving concerns, repositioning of responsibility for the valuing your voice intranet page (now managed by the Communications team) and reduced availability due to staff sickness.

Q4 activity represented the lowest level since Q2 in 2019-20 and is almost certainly mainly attributable to reduced team capacity because of staff sickness. Activity levels are expected to increase as staffing levels return to normal in 2021/22.

Figure 3 Quarterly FTSU activity since 2018

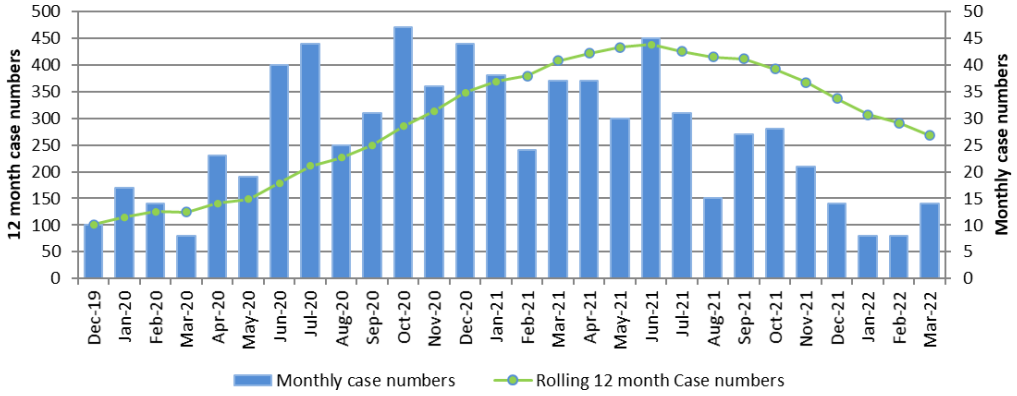


Source: FTSU activity data

Whilst activity is reduced compared to last year, it is expected that the rate of reduction will level off during 2022/23. It should be noted that the National Guardian's office in its annual report on activity for 2020/21[3], reported an average (mean) of 97.6 cases per acute hospital Trust, with an average (mean) 104 cases per annum from medium sized Trusts (5000-10000 staff) - significantly lower than Lancashire Teaching Hospitals activity.

Figure 4 Monthly Freedom to Speak Up Concerns Raised Since 2019

[3] NGO Annual Report 2020/21



Source: FTSU activity data

Our FTSU Guardian will also offer support to any members of staff who suffer detriment as a direct result of raising concerns with the FTSU service. During 2021-22 four staff reported experiencing detriment that they attributed to speaking up. Each was supported in addressing these added concerns. A similar number expressed concern that they may suffer detriment suggesting a need to consider further actions to provide a safe environment. These actions are reflected in FTSU priorities and actions in year one of the Trust FTSU Strategy.

Our FTSU Guardian provides assurance to the Board that the trust is responsive to concerns and meets regularly with our Chief Executive and Chairman to share any concerns, emerging themes, and trends.

Our Trust policy encourages staff to seek internal resolution but also specifically tells staff who wish to raise concerns externally how they can do this in a safe way, providing contact details of organisations they can go to.

The trust recognises that FTSU activity should not be viewed in isolation. The Trust's Raising Concerns Group meets on a quarterly basis and reviews data and intelligence from several sources including workforce and organisational development data, safety incidents, complaints, staff surveys, and safeguarding information. Areas of concern and good practice, along with themes, trends, and actions taken are reported to the Workforce Committee and to the Board of Directors.

The introduction of the Early Resolution policy underpins the Trust's intention to minimise an adversarial approach to the management of conflict and is consistent with FTSU principles.

For 2022-23 seven key priorities have been identified to strengthen and embed Speak Up Listen Up Follow Up across the Trust:

- The Guardian will maintain knowledge, skills, and credibility
- Ensure that staff are aware of arrangements for speaking up, listening up and following up
- Promote protection for those who speak up
- Make available training tools for leaders and for all staff that promote a speak up, listen up, follow up culture
- Make available training tools for leaders that promote a speak up, listen up, follow up culture
- Ensure that the Board of Directors and senior leaders behave in a way that encourages others to speak up

- Promote wider learning across our leadership
- Ensure that external stakeholders are engaged and have access to FTSU information and intelligence

A series of actions to facilitate improvement in the areas above have been identified. Progress against these priorities will be monitored by the Raising Concerns Group and reported to the Workforce Committee and the Board of Directors. However, completion of these and other actions does not represent an end point. The trust recognises that there is more to do to ensure that raising concerns is business as usual for all our staff, and that when they do so they can be confident that those concerns will be heard and, as appropriate, acted upon.

Medical and Dental Workforce Rota Gaps

Our Workforce Department monitor vacant posts and as part of the Guardian of Safe Working requirements provides a quarterly vacancy gap analysis as required in relation to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 Schedule 6 paragraph 11b. The medical vacancies are presented in Table 15 below.

Table 15 Medical and Dental Vacancies

Data is for each post as a whole time equivalent. It does not reflect gaps as a result of long-term sickness, Covid-19 shielding, maternity/adoption leave and working part time.

Grade	Vacant	Filled	Total	Vacancy Rate
Deanery				
FY1	1	53	54	1.85%
FY2	6	55	61	9.84%
ST1-2	7	106	113	6.19%
ST3+	14	140	154	9.09%
Trust				
Junior Clinical Fellow	15	57	72	20.83%
Senior Clinical Fellow	24	71	95	25.26%
SAS	9	77	86	10.47%
Consultant	50	418	468	10.68%
Grand Total	**126**	**977**	**1,103**	11.42%

Source: LTHTR data

Our Medical Workforce team provide reports to specialities and departments to support services fully understanding the medical and dental staffing position. The team use this information to work closely with Clinical Directors and departmental managers to source vacancies and agree recruitment strategies for hard to fill posts. These strategies continue to include:

- Reviewing job descriptions and creation of promotional activity, aligning job descriptions to the new employment brand and elements to make posts more attractive for example rotations and dedicated time for audit, research, and teaching.

- Promoting vacancies through social media, relevant journals, and websites, through the British Medical Journal (BMJ) website and purchase of a number of print credits and support from NHS Creative to improve advertising.
- Continuing to source doctors through international placement agencies. This includes more efficient shortlisting, skype interviews and supporting candidates to transition into the NHS. This has been especially successful during 2021-22 in recruitment to ED middle grade posts and Consultants in Respiratory and Oncology specialities.
- Continuing to source doctors through the Medical Training Initiative in liaison with the Royal Colleges and the Trust has seen success particularly in the Critical Care Unit.
- Implementation of the recruitment and retention premia policy to be applied with hard to fill posts and financially support international candidates with visa costs.
- Implementation of an Associate Consultant post to support retention of existing middle grade doctors by providing career progression.
- Continuing to develop quality job planning to ensure fully reflective of activity.
- Utilising our medical and dental in-house banks to reduce reliance on agency workers, reduce cost and improve quality of care. There are currently approximately 140 medical bank workers working regular shifts.
- Working with the lead employer to improve rotation information to ensure early identification of vacant posts where possible.
- Implementation of a medical intern programme in partnership with the University of Manchester and the University of Mansoura in Egypt. A total of nine Interns were appointed in August 2020 and a further 10 commenced in post in August 2021. These posts filled vacant junior clinical fellow gaps and where required vacant FY2/ST1 posts.
- Exploring a three way electronic systems interface with the lead employer and Health Education England to reduce manual data processing, improve quality and enable gap reporting to whole time equivalent percentage reporting.

PART 3

Review of Quality Performance - Patient Safety

The Trust considers the safety of patients to be our principal priority. To ensure the organisation is a safe place to receive care and treatment and the Trust monitors performance against certain factors and continually aims to reduce and eliminate patient harm where possible.

In 2019-20 the Trust responded to the NHS National Patient Safety Strategy with Lancashire Teaching Hospitals *Always Safety First* programme. During 2021-22 this has continued to be led by the Nursing Midwifery and AHP Director and Medical Director and supported by the Governance, Nursing and Continuous Improvement teams. The programme promotes staff to always consider safety across the organisation and has involved lay representatives from the community to support the programme to provide opportunities to share their ideas. This section of the Quality Account presents indicators relating to patient safety, clinical effectiveness and patient experience as outlined below.

Patient Safety

- The Trust Safety Triangulation Accreditation Review (STAR) programme
- Falls prevention
- Safeguarding Adults
- Safeguarding Children
- Maternity and Neonatal Safety
- Incidents & Never Events
- Duty of Candour

Clinical Effectiveness

- The *Getting it Right First Time* (GIRFT) programme
- Tissue Viability – Pressure Ulcer Incidence and Prevention
- Nutrition for Effective Patient Care
- Medication Incident Monitoring
- Infection Prevention and Control
- Methicillin-resistant Staphylococcus Aureus (MRSA)
- C. difficile
- SARS coronavirus-2 (SARS-CoV-2) – Covid-19
- Mortality Surveillance and Learning from Neonatal, Child and Adult Deaths
- The Medical Examiner Service

Patient Experience

- Patient Surveys
- Friends and Family Test feedback
- Concerns, Complaints and Compliments
- Patient, Family and Public Involvement
- Working Differently for Patients during Covid-19 Pandemic
- Patient Stories
- Staff Survey and Recommendation of Our Care

Safety Triangulation Accreditation Review (STAR)

The Trust designed the STAR Quality Assurance Framework in 2017 with Trust teams to provide an evidence base to demonstrate the standard of care delivery, identify what works well and where further improvements are required. STAR is broken down into two aspects:

- STAR Monthly reviews – 17 audit questions are undertaken by the Matron or Professional Lead for each area.

- STAR Accreditation Visits – an in-depth CQC style audit is undertaken by the Quality Assurance Team with support from staff, governors, and volunteers from across the Trust.

In 2021-22 there are now 124 clinical areas registered for the STAR Quality Assurance Framework. Participants in this safety programme undertake monthly peer review audits using the Trust audit system AMaT. The system hosts the actions required for improvement which are monitored by the ward Matron or professional lead. A performance dashboard is also made available on the Trust Business Intelligence (BI) portal.

STAR visits result in a red, amber, or green score depending on the level of assurance gained and the outcome of the visit will determine the revisit frequency.

Up to the end of March 2022 a total of 123 areas had STAR visits completed and there is only one new area awaiting their first STAR visit. These have resulted in the following scores:

Figure 5 STAR Accreditation Scores

Source: LTHTR data

The Trust currently has 95 areas achieving a silver star or gold star status equating to 77% which achieves our target in *Our Big Plan* of 75% of areas achieving silver or above by the end of March 2022.

In order to achieve a gold star rating our clinical areas must demonstrate consistently that they have met all the standards set for their staff and patients. This means that the team have worked together to:

- Achieve 3 green rated STAR accreditation visits.
- Leaders have supported a peer ward or department to achieve an improvement in their rating.
- There is evidence that staff, learner, and patient feedback is consistently responded to.
- Evidence of high standards of audit practice and environmental cleanliness.
- Evidence that these criteria have been met is to be presented to a panel which would comprise senior nurses, midwives, and allied health professionals. The Trust currently has 29 clinical areas which have successfully maintained three consecutive silver stars and have progressed onto a gold star.

Gold award celebrations were held in July 2021 and March 2022, supported by our Chief Executive, Chairman, Governors, Nursing Midwifery and AHP Director and Deputy along with the Divisional Nurse, Midwifery and AHP Directors. The gold teams presented virtually on their progression to achieving the gold star, with many sharing very honest, inspirational stories. Key themes from the progression of the teams related to:

- Leadership and teamwork
- Sharing and learning from each other
- Networking and collaboration with others
- Listening to staff and patients.

Our gold star teams all showed determination and commitment to act upon feedback and drive improvement to ensure the best possible care for our patients. There are currently 23 areas achieving two consecutive green scores, who currently have silver stars potentially progressing onto a third consecutive green on their next visit and therefore potentially a further 23 gold stars.

15 Step Challenge

As part of the STAR accreditation visit the 15 step challenge is undertaken by a member of the visit team, and there is usually a governor or volunteer who is not familiar with the clinical environment. The 15 step challenge is based on first impressions on entering the clinical environment and how confident the assessor is that the ward or department supports good care. In particular that the area is:

- Welcoming
- Safe

- Caring and involved
- Well organised and calm
- Well led

Areas are given a scoring based on the following:

- A = Very confident
- B = Confident
- C = Not very confident
- D = Not confident at all

If a C or D rating is given for the 15 steps the relevant Matron or professional lead will be responsible for liaising directly with the ward or department manager and the Divisional Nursing or Allied Health Professional (AHP) Director to ensure immediate action on the areas of concern and implement recommendations in the report.

Table 16 15 Step Challenge Results

	A Very confident	B Confident	C Not very confident	D Not confident at all
Trust Overall	88	33	2	0

Source: LTHTR data

In order to continuously improve the STAR Quality Assurance framework and to ensure the process is efficient and meets the priorities for the Trust, the Quality Assurance Team (QAT) undertakes a regular review which incorporates feedback from clinical staff, governors and the CQC key lines of enquiry.

Our Phase 5 review of the STAR accreditation visit, and STAR monthly review standards was finalised in November 2021 with changes effective from January 2022. Our STAR accreditation visits are unannounced and conducted over a longer period of time to capture handovers and safety huddles. Feedback is mainly delivered virtually to the divisional teams, ensuring the Trust is responsive and able to apply any immediate supportive measures and can cascade for a wider response if required. There is ongoing reflection and evaluation of the impact of these changes, with lots of positive feedback received to date.

MIAA undertook a review of the STAR programme in December 2019 which made recommendations for improvement which were to develop a STAR page within our Learning Bank and features within the Learning Bulletin, and the development of an improved electronic dashboard to capture themes and trends. Both have been completed and have been accessible to all staff since December 2020. Learning from STAR is shared each month by the Quality Assurance Matron and team via the divisional Always Safety First meetings. Quarterly STAR newsletters are produced, and a new Hot Topics bulletin was developed during November 2021 to support sharing of good practice and key areas for improvement during safety huddles and handovers.

Falls Prevention

Falls prevention continues to be one of our key priorities for improvement and *Our Big Plan* target is to achieve a year on year 5% reduction in falls.

Falls and falls related injuries are a common and serious problem for people aged 65 and over with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. (NICE, 2013). Falls prevention is a complex challenge due to the large array of influencing factors requiring multifactorial patient assessments and implementation of individualised falls prevention measures. Increased age and frailty, history of falls and cognitive impairment significantly increase the risk of falling and risk of harm from falls.

Falls are one of the most commonly reported incidents affecting inpatients. Although most falls result in no harm or low harm, the consequences to the patient and their relatives/carers can be considerable. The impact may appear minimal; however, the patient can suffer pain, distress, loss of mobility and independence, depression, psychological distress or anxiety, and loss of confidence leading to social isolation. Falls can result in moderate or severe levels of harm including fractures, cerebral haemorrhage, and even result in death. Hip fractures within a hospital setting are associated with poorer outcomes including an increase in mortality. The risk of having an increased level of injury or harm from a fall is difficult to predict but there are a number of known risk factors such as increased age, frailty, osteoporosis, bone metastases, blood clotting disorders, multiple co-morbidities and medications such as anti-coagulants.

Over the past eight years the Trust has implemented several falls prevention initiatives as part of the ongoing falls improvement project work. In this reporting period improvements have included development of a Falls Prevention Champion role for teams to drive improvements in falls prevention within the Divisions. Other falls prevention improvement actions have included:

- Falls Prevention Improvement Collaborative with a cohort of 10 wards, led by the Continuous Improvement team commenced from February to September 2021. The collaborative demonstrated a reduction in falls from an average of 12 falls per week to nine falls per week average.
- Development of a new Intentional Rounding Document, training video and training sessions.
- Development and cascade of a Safety Surveillance System and digital whiteboards for wards to highlight key safety concerns such as falls risk and highlight real-time compliance with risk assessments. These can be used during handovers and huddles.
- Cascade of Age UK Staying Steady patient information leaflet, to provide advice on falls prevention.
- Continuation with the Royal College of Physicians (RCP) National audit of inpatient falls, an ongoing action plan which includes medications reviews, visual assessments, and the provision of mobility aids.
- Learning from falls and falls with severe harm is discussed at Divisional Governance and Always Safety First meetings and at the Safety and Learning Group.
- Falls risk assessments, moving and handling assessments, bedrails assessments and falls prevention care plans are being reviewed as part of risk assessment and care plan

improvement work in collaboration with the Chief Nursing Information Officer, Digital Change team and our Continuous Improvement team.

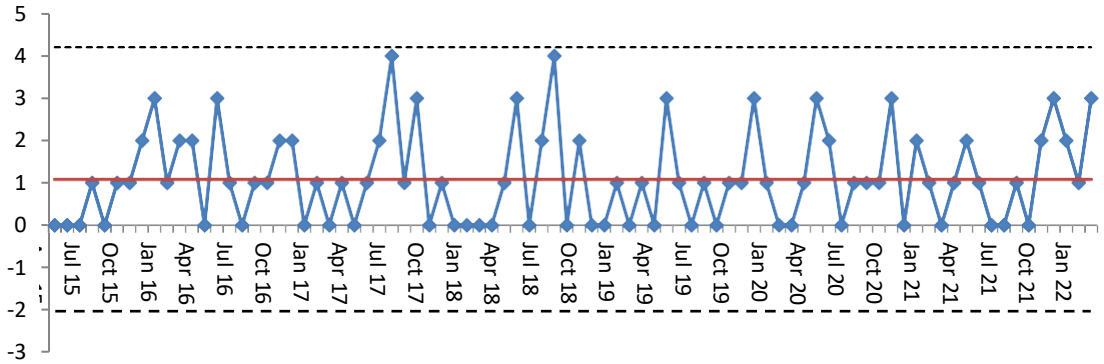
- Falls and falls with harm incidents are included in the monthly nurse staffing report.
- Reviewing of falls with severe or above harm at the Serious Incident (SI) panel at the Clinical Commissioning Group (CCG), which has progressed to be presented in quarterly reports, highlighting learning, themes and trends, and learning from HM Coroner Inquests.

Future improvement plans include:

- Improvement in patient information and evidencing discussions with patient about how to prevent falls.
- Updating the falls prevention e-learning package.

Falls prevention remains one of our key priorities. The end of year falls statistics demonstrate an increase in the overall number of inpatient falls. The total number of falls with major and above harm (severe, death) remained the same; there were 15 inpatient falls resulting in major or above harm.

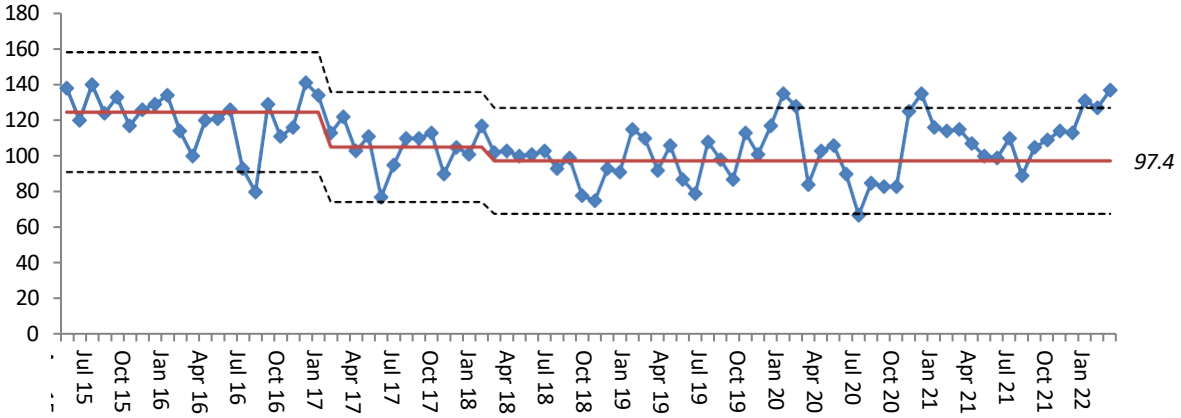
Figure 6 Total Inpatient Falls with Major or Above Harm – April 2015 - March 2022



Source: LTHTR data

The total falls data since April 2015 is presented in Figure 7. Since 2020-21 there has been a 10% increase in the number of inpatient falls with 1,216 inpatient falls during 2020-21 increased to 1,340 inpatient falls in 2021-22.

Figure 7 Total Inpatient Falls April 2015 – March 2022



Source: LTHTR data

The Trust Big Plan falls prevention target for 2021-22 was to achieve a year on year 5% reduction in inpatient falls. This was not achieved during 2021-22, there was an increase of 125 falls compared to the previous year which is an increase of 10% for inpatient falls. It is noteworthy that there has been a substantial increase in our bed-base and inpatient capacity, bed occupancy and acuity during this 12-month period. The Trust is still facing the pressures of the Covid-19 pandemic, with a significant increase in pressure since December 2021. This has impacted upon the timely discharge of many inpatients, and a notable increase in the frailty and dependency of many inpatients. Reduced staffing levels due to sickness and isolation requirements and decrease in patient flow and capacity has further impacted upon the organisation as demonstrated by the continued major incident status. Staff are dealing with the challenges of implementing Infection Prevention and Control (IPC) standards, Personal Protective Equipment (PPE) and cohorting of patients in different environments. Staff availability and human factors are critical elements in the falls reduction strategy.

We continue to prioritise falls prevention as part of our Always Safety First Strategy. The annual falls report and action plan will be shared among the divisions alongside Falls Prevention Champions' training to strengthen knowledge and awareness of falls prevention strategies and support ongoing improvements within clinical teams.

Safeguarding

Lancashire Safeguarding Adult Board (LSAB) and Children's Safeguarding Assurance Partnership (CSAP)

The Trust is well represented across the local safeguarding partnership arrangements including at executive and senior operational level via the Nursing, Midwifery and AHP Director and Head of Safeguarding. The Trust is fully sighted and actively involved in the safeguarding agenda and board priorities for Lancashire and South Cumbria, the board priorities are linked to the activities undertaken within the safeguarding team annual work plan (see Appendix 2). In addition, the named professionals and safeguarding team are active members on a number of subgroups to the Lancashire Safeguarding Adults Board (LSAB) and Children's Safeguarding Assurance Partnership (CSAP). These include:

- Lancashire and South Cumbria Integrated Care System (ICS) Safeguarding Health Executive Group
- ICS Safeguarding System Leaders Business meeting
- Central Locality CSAP Tactical Group
- Lancashire Contextual Safeguarding Operational Group
- Lancashire Neglect Operational Group
- LSAB MCA/DoLS Implementation Group
- LSAB Quality Assurance, Audit and Performance Group
- LSAB Safeguarding Adult Review Group
- Pan-Lancashire Child Death Overview Panel (CDOP) Business meeting
- Pan-Lancashire Sudden Unexpected Death in Childhood (SUDC) Prevention Group

Safeguarding Audit Activity

The annual safeguarding audit activity is directed by the local safeguarding board priorities, CQC 'must do's and should do's', All-Age Section 11 Children Act (1989, 2004) and Care Act (2014) Compliance Audit, CCG Safeguarding Standards Audit and local and national safeguarding practice reviews. Audit activity for 2020/21 includes:

- Trust-wide audit of domestic abuse knowledge amongst staff and management of incidents
- Trust-wide themes and trends audit relating to safeguarding incident management and Section 42 enquiries.
- Trust-wide audit of MCA and DoLS, Least Restrictive Practice and Enhanced Levels of Care knowledge amongst staff and monthly compliance of application.
- Monthly audit in Emergency Department (ED) to monitor quality in completion of child safeguarding checklist.
- Paediatric Assessment Unit (PAU) safeguarding recognition and referral assurance audit
- SAFE Centre audit to improve quality of Children Social Care (CSC) referrals
- Maternity Perinatal Mental Health audit
- Maternity domestic abuse audit regarding routine enquiry and compliance with National Institute for Health and Care Excellence (NICE) Guidance.

Lessons Learnt from Safeguarding Audit Activity

- Trust-wide audit of domestic abuse demonstrated good overall understanding of recognising and responding to victims and their families. Child safeguarding procedures demonstrated 100% compliance giving strong assurance that the 'think family' message is embedded in practice.
- Trust-wide audit activity showed positive results in relation to staff knowledge of MCA and DoLS. This includes improvements in the quantity and quality of MCA and DoLS applications, giving strong assurance patients human rights are protected whilst in our care.
- Good overall assurance is noted within the annual incident management and Section 42 enquiries themes and trends audit. Areas highlighted for growth include adverse discharges, compliance of nursing risk assessments and care planning to support patient

care. Findings from the audit have been cascaded into the Trust's Always Safety First Discharge Programme.

- Good compliance in respect of maternal mental health risk assessments (*Whooley questions) being completed at maternity booking appointments. Implementation of the digital end to end maternity system (Badgernet) will increase compliance at every antenatal contact via an electronic mandatory field.

* Used as a screening tool for major depressive disorder.

- Good assurance that routine enquiry into domestic abuse during pregnancy is being undertaken. The implementation of Badgernet will again increase compliance.

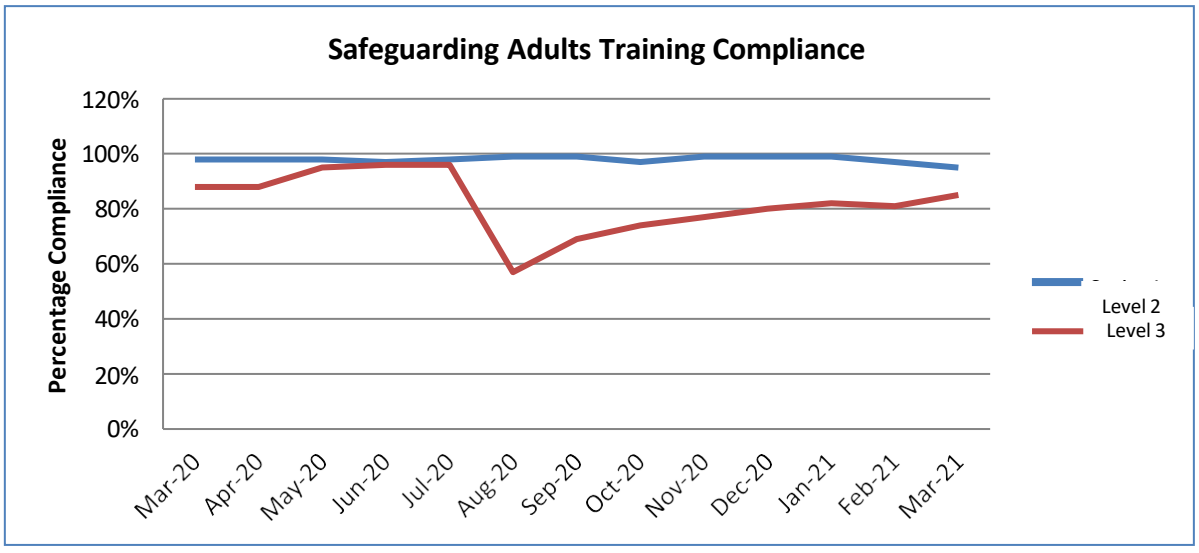
Safeguarding Adults

Our Safeguarding Adults team continues to build upon risk and governance maturity and develop policy and practice and to optimise patient care where safeguarding concerns are realised externally to the organisation.

We operate a safeguarding duty system and the Safeguarding team have a visible presence on wards and departments where required. Our team support staff with a wide range of safeguarding concerns including supporting multi-agency referrals and complex case management with wider system partners. Our Named Nurse for Safeguarding Adults is Chair of the Pan-Lancashire Acute Hospitals Task Force promoting the implementation of Liberty Protection Safeguards and Vice Chair of Lancashire Safeguarding Adults Board Safeguarding Adult Review Group.

Safeguarding adults training has been fully revised in line with the Royal College of Nursing (RCN) competencies framework for health care staff and also the General Medical Council (GMC) adult safeguarding standards. The new Training Needs Analysis implemented in August 2020 has successfully achieved compliance of Adult Levels 1 and 2 training and significant progress has been made with workforce coverage of 84% of adult Level 3 competencies.

Figure 8 Safeguarding Adults Training Compliance

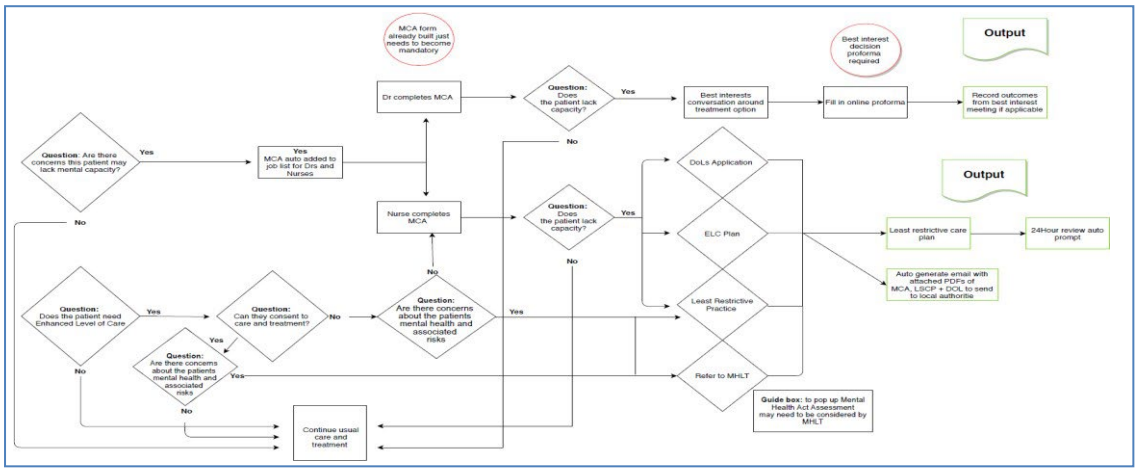


Source: LTHTR data

The Safeguarding leads contribute towards the weekly Safety and Learning Group. During the Covid-19 pandemic the team has supported the Divisions in releasing resource to support safeguarding management of Section 42 investigations, allowing nursing staff to remain free to deliver direct patient care.

The Trust has undertaken a Mental Capacity and Deprivation of Liberty Safeguards project which has successfully produced an electronic patient journey process in Quadramed based on the Process Map in figure 9 below.

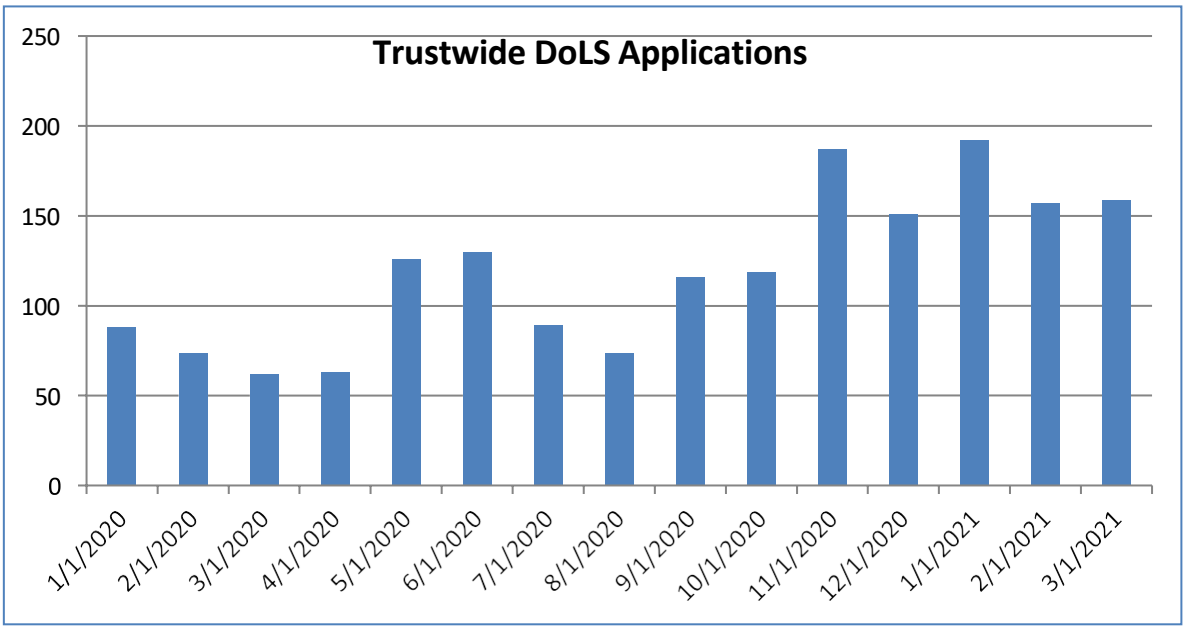
Figure 9 Electronic Patient Journey Process Map



Source: LTHTR data

The new electronic process has improved Deprivation of Liberty (DoLS) applications which are demonstrated through the DoLS application data shown in Figure 10.

Figure 10 DoLS Applications



Source: LTHTR data

During 2021-22 our Safeguarding team have contributed to 13 Safeguarding Adults reviews and four Domestic Homicide reviews, some of these have progressed to a full review, which are still in progress.

The team has contributed to wider organisational work streams in relation to Mental Capacity Act (MCA) and discharge processes, adverse discharge themes and pressure ulcer care. It is expected that these works streams will continue to develop in 2022-23 and that a positive culture of learning from safeguarding processes is embedded.

In order to support all the developments in Adult Safeguarding the trust has successfully recruited a Named Safeguarding Adults Doctor. This will ensure multidisciplinary collaboration in the Safeguarding Adults agenda and enable us to prepare for the impending changes to Liberty Protection Safeguards legislation scheduled to be enacted April 2022.

Safeguarding Children

Our Child Safeguarding team are visible on a daily basis within Paediatrics, Neonates, Maternity and the ED and the trust utilises our BI system to gain an oversight of all children aged 16-17 who have been admitted to an adult ward. The team operates a safeguarding duty system whereby one of the safeguarding practitioners is available to support staff with a wide range of child safeguarding concerns. A child safeguarding risk assessment is undertaken for every child who attends an assessment area, this also includes notification via the National Child Protection Information Sharing system (CP-IS).

During 2021-22 the Trust received approximately 40-73 child safeguarding enquires per month and the Trust make between 9-34 referrals to Children's Social Care each month. The number of enquires and referrals fluctuates each month. However, the Trust consistently sees the greatest number of child safeguarding referrals made following parental attendance under the category of emotional abuse. Our team have close links with the local Multi-Agency Safeguarding Hub (MASH) and wider safeguarding system partners including the local Child Safeguarding Assurance Partnership (CSAP).

In the last 12 months our team has worked alongside our local Child Death Overview Panel (CDOP) and Sudden Unexpected Death in Childhood (SUDC) prevention in implementing a Safer Sleep assessment. The Safer Sleep assessment has been rolled out within the ED, Maternity, Neonates and Paediatrics to ensure that 'every contact counts' and parents/carers repeatedly receive the important messages around Safer Sleep.

Following lessons learned from local and national Child Safeguarding Practice Reviews (CSPR) and child deaths, the trust has again this year been involved in promoting the ICON messages with parents including the creation of a video for Healthier Lancashire and South Cumbria's Better Births.

This work will help to ensure that the Trust embeds lessons learnt following serious incidents by increasing staff knowledge and confidence in providing parents with Safer Sleep and how to cope with crying baby messages. This supports the aim to reduce the number of child deaths and traumatic head injuries in young babies.

Child safeguarding training compliance continues to remain above 90% for level 1-3 training. This training is available as e-learning packages to enable staff to continue to access their essential child safeguarding training whilst face-to-face training has been on hold during the Covid-19 pandemic.

Safeguarding/Mental Health Operational Groups Adult and Child

The Safeguarding/Mental Health Operational Groups are held on a monthly basis reporting directly to the Trust Safeguarding Board via a chair's report. The Safeguarding/Mental Health Operational Groups include representation at a senior level across all divisions and undertake the operational business of the safeguarding/mental health agenda ensuring divisional Matrons and safeguarding leads work together to make improvements and share this agenda. The operational groups ensure delivery of key messages from the wider safeguarding/mental health partnership system and establish divisional ownership to improve practice in relation to both local and national safeguarding practice reviews and developments in safeguarding/ mental health policies/procedures including the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) *Treat as One* for both adult and child

Maternity Safeguarding

Improvements include:

- Membership of the National Maternity Safeguarding network with NHS England, providing a national voice for safeguarding midwives working for or on behalf of maternity service providers.
- Collaborative working with Child Safeguarding Lead for GTD on complex cases including development of pathways promoting the 'think family' message and sharing of training resources.
- Named midwife participation in the development of the pan-Lancashire Concealed and Denied Pregnancy Protocol and revision of the Antenatal care booking appointment guidelines to include the protocol.
- Named midwife participation in the development of the new Lancashire Safeguarding model.
- Named midwife participation in the review of the pan-Lancashire Pre-Birth Protocol.
- Participation in the production of Safer Sleep message videos following publication of national guidance regarding the increased risk of babies/children sleeping 'out of routine'.
- Weekly allocations meeting with Children's Social Care (CSC) managers

- Development of an e-learning package for ICON. Training package shared with partner agencies across Lancashire.
- Development and implementation of the Perinatal Mental Health Pathway leading to a reduction in the length of stay for women with mental health concerns following the birth of their baby.
- Specialist Perinatal Community Mental Health (SPCMHT) Multi-Disciplinary meeting now embedded within Maternity.
- Developments of a pan-Lancashire pathway to ensure substance misuse services adapt a 'think family' approach.
- Female Genital Mutilation Policy updated and incorporated into Trust FGM Guideline and training for Maternity.
- Specialist midwife for perinatal mental health participating in the development and delivery of a new maternal mental health service across Lancashire and South Cumbria.
- Participation in a two-year national research project *Born into Care* which aims to improve professional practice when the Local Authority intervenes in the lives of new-born babies.

Maternity Safety Metrics

Maternity sensitive staffing metrics are displayed on the maternity dashboard each month and alert the team to factors that reflect deficits in staffing levels that may cause potential harm and thus need investigation and prompt action. The metrics collated are triangulated with staffing levels when the maternity dashboard is reviewed at the Divisional Safety and Quality Committee on a monthly basis and detailed in the monthly safe staffing report submitted to the Trust's Safety and Quality Committee.

The dashboard reflects a decrease in training compliance since April 2021 due to sustained and elevated sickness and vacancy levels within the service during this period. The service will continue to prioritise service essential training such as fetal monitoring training and obstetric skills drills until October 2022 when additional recruited staff will commence in post.

There has been a fluctuating trend in the number of births taking place in midwifery-led settings during the past six months with a sustained increased incidence in home birth following the introduction of the Ivy continuity of carer homebirth team. The mean homebirth rate has improved significantly since the introduction of the team in April 2020 with a mean of 3.7% year to date (national mean 2.1%).

The maternity dashboard indicators reflect a challenged service. One to one care in labour compliance rates and supernumerary status of the Delivery Suite Co-ordinator continue to be below the standard and remain an area of ongoing focus however there is no evidence of harm occurring as a result of this. This continues to be monitored on a monthly basis with a detailed recruitment action plan ongoing to address the deficit.

Incidents and Never Events

Incidents

Our incident data has been presented in section 2 of this report with a rationale for the data and actions taken and planned. The levels of harm from incidents in 2021-22 are presented below.

Table 17 Level of Harm Related to Incidents 2021-22

Level of Harm	Number of Incidents Reported
No Harm	21,517
Low Harm	5,702
Moderate Harm	1,081
Severe Harm	64
Death	25
Total	**28,389**

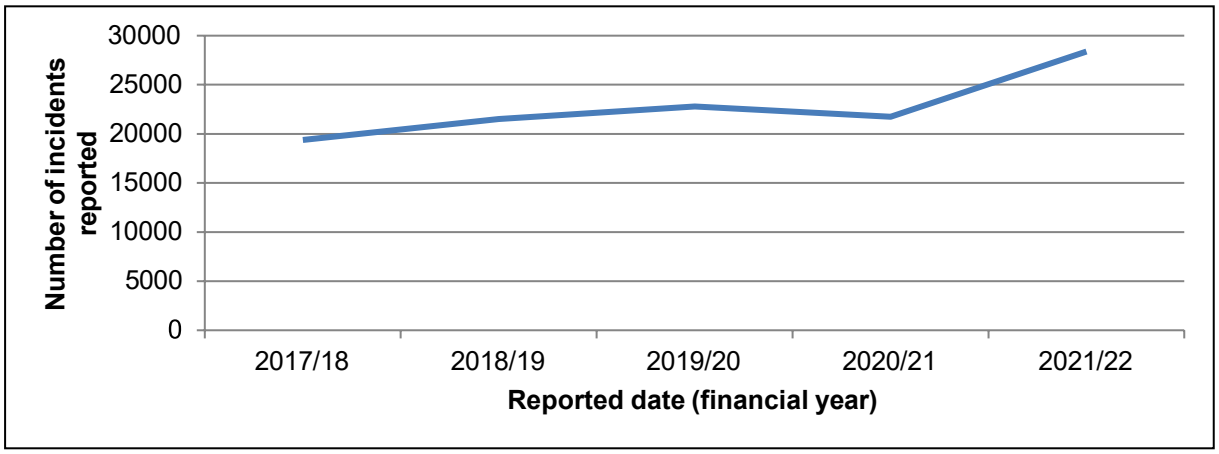
Source: LTHTR Datix data

Our staff are proactively encouraged to report near misses and no harm incidents to enable increased opportunity to identify themes and trends before harm occurs to patients. In order to promote and develop our culture of incident reporting the Trust continues to improve education regarding the reporting of incidents and near misses, the importance of reporting and the learning the trust obtains from incident reporting. More detailed education around the importance of incident reporting and how to report an incident have been included in the Trust's induction programme, along with the Trust's annual training which all staff must complete, from March 2022. The Trust has also continued to make further improvements to our reporting system Datix to make it easier to report appropriate information in a timely manner.

Governance and incident dashboards are in use across our organisation to embed incident reporting and analysis. Work is ongoing for this information to be automated through the Trust's Business Intelligence app and will enable staff to filter governance data all the way to ward level if required. The Trust has also continued to link our incident analysis to our risk register to promote our Risk Maturity programme of work in line with *Our Big Plan*.

Our incident reporting has over successive years continued to improve which is demonstrated in the Figure 11 below.

Figure 11 Incidents Reported 2017-2022



Source: LTHTR Datix data

In 2020-21 there was a decrease in the volume of incidents reported which correlated with a decrease in hospital activity impacted upon by the Covid-19 pandemic. In 2021-22 the number of incidents reported shows a significant increase, correlating with the recovery of hospital activity but also accounting for the significant number of hospital acquired Covid-19 infection incidents reported and a significant number of delayed diagnosis and treatment incidents as a result of the Covid-19 pandemic.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They can lead to serious adverse outcomes and can damage patients' confidence and trust.

During 2021-22 the trust initially reported four Never Events. However, following detail on two of the wrong site surgery cases the Clinical Commissioning group agreed the following actions. A reported Never Event relating to formation of a bowel stoma has now been re-categorised as not a Never Event following presentation at the CCG Serious Incident Panel as the anatomical variations of the patient is an exclusion category for Never Events. Additionally, a case relating to a skin graft has also been deemed as not a Never Event by the CCG attending SLG but awaits formal confirmation of re-categorisation by the CCG Serious Incident Panel scheduled for June 2022.

In conclusion the Never Events reported during 2021-22 is two cases, with one under the category of wrong site surgery and 1 as a wrong implant/prothesis. It is positive to note that there have been no Never Events reported to StEIS in Quarter 4 of 2021/22.

All Never Events are subject to a serious incident review and reported to the local CCGs as well as nationally to StEIS and the National Reporting and Learning System (NRLS). Learning from both systems is shared nationally. All four never events in the reporting period 2021-22 have undergone full investigation and action plans have been developed and are either complete or being monitored

The Trust had an Always Safety First work stream to review actions from all Never Events both for compliance with initial target completion dates and for quality of evidence. Never Events

have been added to our 'Learning to Improve' programme to ensure that actions and learning are embedded over time and participation in a regional learning event has taken place to share learning across organisations.

Duty of Candour

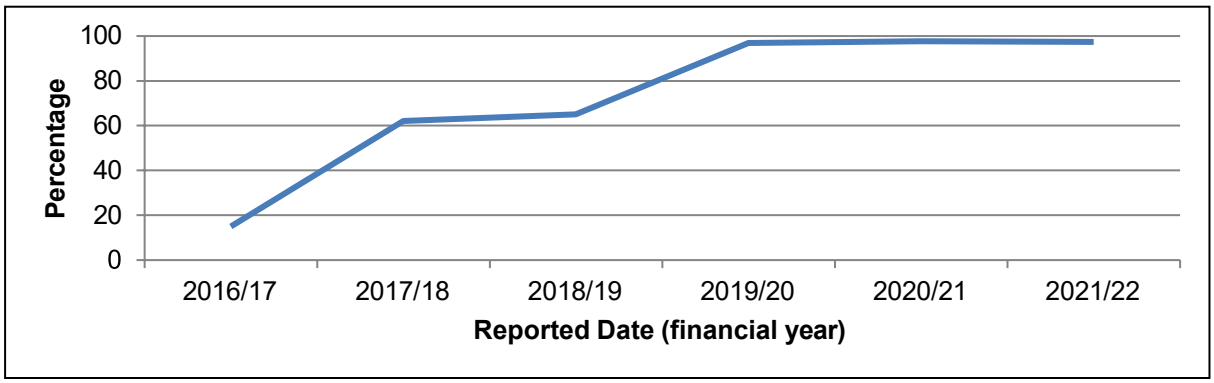
Duty of Candour is a regulation that has been applicable to health service organisations since November 2014 in response to the Francis report (2013) which stated that *"any patient harmed by the provision of health care service is informed of the fact and an appropriate remedy offered regardless of whether a complaint has been made or a question asked"* (Francis 2013).

The investigation of incidents where actual or potential for harm has occurred, is carried out within a culture of openness and transparency with an absolute commitment to explaining and apologising to patients who have suffered harm. This is a key aspect of us delivering excellent care with compassion. The Trust monitors compliance with Duty of Candour on a weekly basis through the Safety and Learning Group.

In the year 2021-22 the Trust identified 873 cases where Duty of Candour was applicable. This is a slight decrease in cases since the previous financial year but is still much higher than historic financial years due to the volume of hospital acquired Covid-19 cases which have required Duty of Candour. Of the 873 cases where Duty of Candour was applicable, 278 of them were probable or definite hospital acquired Covid-19 cases. Of those 873 cases, Duty of Candour has been applied to the patient or next of kin either verbally and/or in writing on 856 occasions (98%). The remaining 17 cases (2%) have documented validated reasons as to why Duty of Candour has not been carried out. Reasons for Duty of Candour not being applied relate to:

- Due to the outcome of the incident, it is deemed inappropriate to have the discussion.
- No known address of the patient or appropriate person.
- Patient is too acutely unwell to receive the letter but will be delivered once the condition improves.
- Patient or appropriate person is untraceable.

Figure 12 Percentage of Cases with DOC Applied (Annual Comparison)

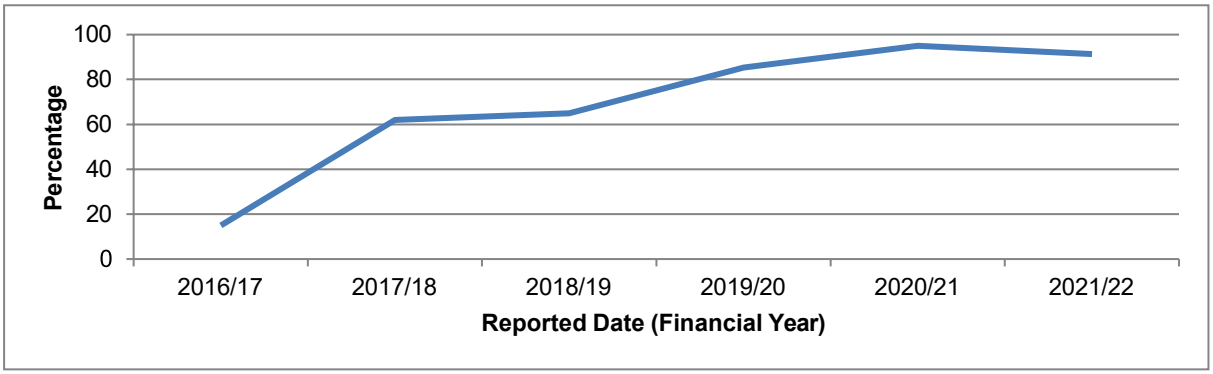


Source: LTHTR Datix data

Of the 856 occasions where Duty of Candour has been undertaken, 782 cases (91.3%) were achieved either verbally or in writing within 10 working days of the incident being reported.

This is a further decrease compared to 2020-21 where 95% of cases had Duty of Candour carried out within 10 working days of the incident being reported. Significant pressures in the hospital during this financial year can be attributed to the decrease in compliance with the 10 working day target as senior clinical staff have not always been available as soon as previously possible to carry out Duty of Candour with patients/next of kin.

Figure 13 Percentage of Cases with DOC Applied in 10 Working Days



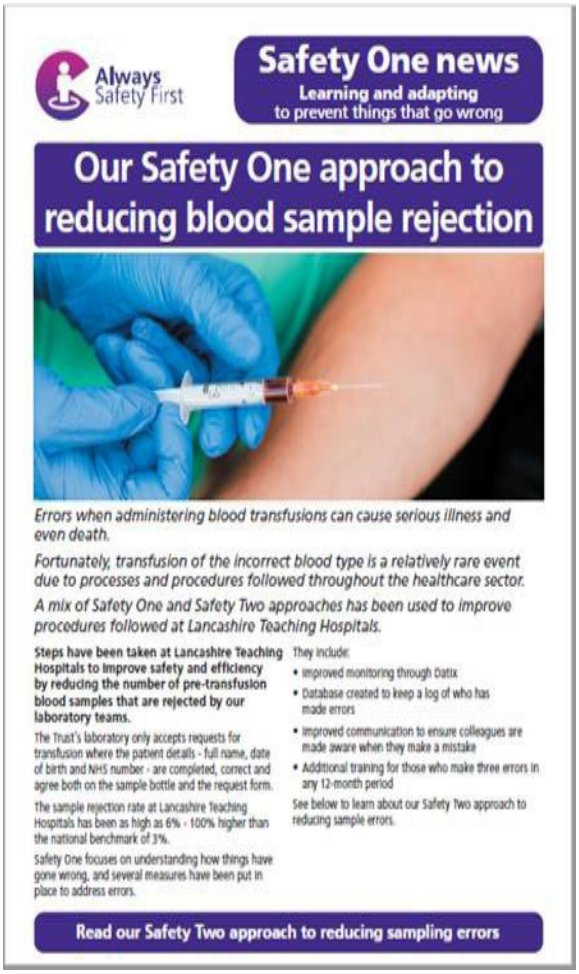
Source: LTHTR Datix data

Figure 13 demonstrates a strong trend of improvement over the last 6 years regarding timely application of Duty of Candour and provides further assurance that the application of Duty of Candour is embedded in our culture and practice. However, it does show the slight decrease in compliance with application of Duty of Candour within 10 working days in the last financial year and the Trust continued to focus on the 9% of cases where the 10 day response rate was not being delivered.

A Learning Organisation

To support the Trust commitment to becoming a learning organisation, a review of the governance structure was undertaken in December 2021 and resulted in the creation of two Associate Director roles within the Corporate Governance team, these are the Associate Director of Safety and Learning and the Associate Director of Risk and Assurance.

Always Safety First bulletins are produced and are framed using a safety 1 and safety 2 approach. These are displayed across the organisation in public areas further enhancing the open approach to learning. In 2021-22 four Always Safety First special bulletins were produced focused on falls, pressure ulcers deteriorating patient and sepsis in response to themed learning from incidents.



Always Safety First

Safety One news

Learning and adapting to prevent things that go wrong

Our Safety One approach to reducing blood sample rejection

Errors when administering blood transfusions can cause serious illness and even death.

Fortunately, transfusion of the incorrect blood type is a relatively rare event due to processes and procedures followed throughout the healthcare sector.

A mix of Safety One and Safety Two approaches has been used to improve procedures followed at Lancashire Teaching Hospitals.

Steps have been taken at Lancashire Teaching Hospitals to improve safety and efficiency by reducing the number of pre-transfusion blood samples that are rejected by our laboratory teams.

The Trust's laboratory only accepts requests for transfusion where the patient details - full name, date of birth and NHS number - are completed, correct and agree both on the sample bottle and the request form.

The sample rejection rate at Lancashire Teaching Hospitals has been as high as 6% - 100% higher than the national benchmark of 3%.

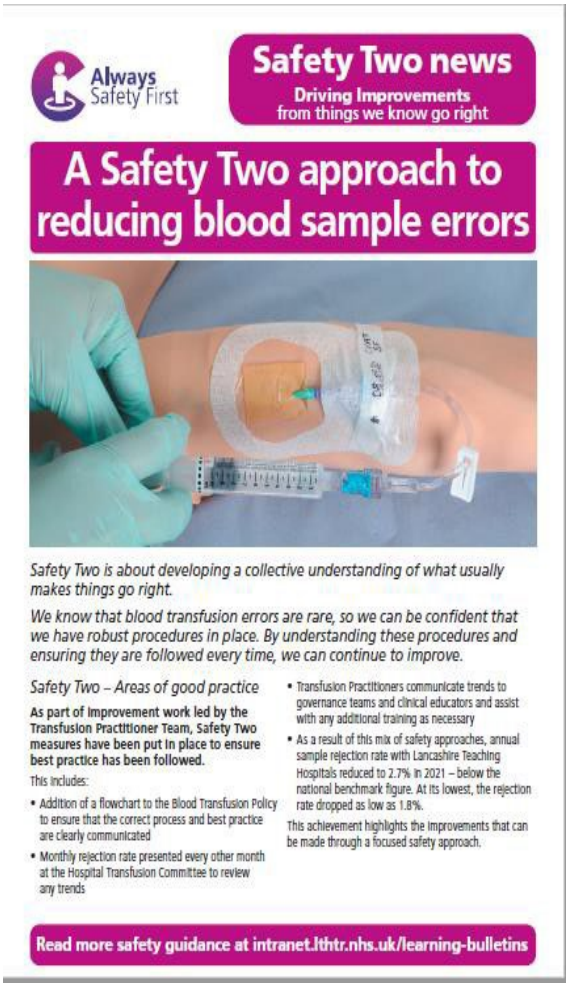
Safety One focuses on understanding how things have gone wrong, and several measures have been put in place to address errors.

They include:

- Improved monitoring through Datix
- Database created to keep a log of who has made errors
- Improved communication to ensure colleagues are made aware when they make a mistake
- Additional training for those who make three errors in any 12-month period

See below to learn about our Safety Two approach to reducing sample errors.

Read our Safety Two approach to reducing sampling errors



Always Safety First

Safety Two news

Driving Improvements from things we know go right

A Safety Two approach to reducing blood sample errors

Safety Two is about developing a collective understanding of what usually makes things go right.

We know that blood transfusion errors are rare, so we can be confident that we have robust procedures in place. By understanding these procedures and ensuring they are followed every time, we can continue to improve.

Safety Two – Areas of good practice

As part of improvement work led by the Transfusion Practitioner Team, Safety Two measures have been put in place to ensure best practice has been followed.

This includes:

- Addition of a flowchart to the Blood Transfusion Policy to ensure that the correct process and best practice are clearly communicated
- Monthly rejection rate presented every other month at the Hospital Transfusion Committee to review any trends
- Transfusion Practitioners communicate trends to governance teams and clinical educators and assist with any additional training as necessary
- As a result of this mix of safety approaches, annual sample rejection rate with Lancashire Teaching Hospitals reduced to 2.7% in 2021 – below the national benchmark figure. At its lowest, the rejection rate dropped as low as 1.8%.

This achievement highlights the improvements that can be made through a focused safety approach.

Read more safety guidance at intranet.lthtr.nhs.uk/learning-bulletins

Review of Quality Performance - Effective Care

The Trust aims to continually provide effective care and treatment by ensuring clinical practice is evidence based against national standards and clinical research. Being involved with national quality and benchmarking programmes including 'Getting it Right First Time (GIRFT)' gives us opportunities to benchmark our services and improve our outcomes. Tissue viability and pressure ulcer prevention, nutritional support, management of medications and infection prevention and control are critical to the effective care and treatment of our patients.

We monitor our mortality benchmarking data to ensure there are no emerging risks and we also learn from the deaths of patients to inform change and improve practice where required. The Medical Examiner Service provides an independent review of the care and treatment of patients who have died in our Trust. Requests from the Medical Examiner to undertake a SJR Mortality Review or Serious Investigation are responded to and learning shared.

The following sections provide details on a number of areas that support the Review of Quality Performance.

Getting it Right First Time

The Getting It Right First Time (GIRFT) programme is helping to improve the quality of care within the NHS by bringing efficiencies and improvements.

The Trust recognises the opportunities that the national GIRFT programme provides and the benefits it will bring to the services provided. This quality improvement programme encompasses a wide range of clinical pathways, and it enables us to benchmark with other similar hospital services and share the learning.

The GIRFT visits to the Trust commenced in 2014 with 25 specialties visited so far, four of which were revisits. A further four specialty visits were scheduled for 2020 however due to the Covid-19 pandemic these were cancelled. The GIRFT programme was temporarily suspended externally and internally over the previous year due to the pandemic and normal services have only recently resumed. The GIRFT lead will be working with teams and the first GIRFT visit since the pandemic has been booked with the cardiac services.

Our Trust lead for GIRFT has a robust monitoring programme which is utilised Trust wide, and it has the capability to link in with our Cost Improvement Plan and Quality Improvement work. Now that visits have been reinvigorated post pandemic all improvement work identified will be captured and linked into the relevant cost improvement and/or continuous improvement programme of work.

Tissue Viability – Pressure Ulcer Incidence and Prevention

Pressure ulcer incidence is used worldwide as an indicator of safety and quality and reducing pressure ulcers has been and continues to be a priority for improvement in the care of our patients.

The root cause of pressure ulcers is multifactorial including having reliable robust systems and processes to ensure care is implemented effectively, enabling timely risk assessment, skin assessment and repositioning. The multiple factors for the development of the pressure ulcers require a multidisciplinary approach for improvement.

We have an established programme of prevention and management of pressure ulceration, which includes training, education, clinical advice, and support for clinical teams facilitated by the Tissue Viability Nurses (TVNs).

Education and audit of pressure relieving equipment is another key role of the TVNs, supported by the Medstrom clinical nurse advisor. Education has resulted in improved recognition of patients who need pressure relieving equipment and the selection available for use. The effective utilisation, management and education of the pressure relieving surfaces is vital for both preventing and treating new hospital acquired pressure ulcers and also the effective care for the most vulnerable patients who are admitted with pressure ulcers.

The impact of the Covid-19 pandemic remains, having a significant impact upon the organisation from reduced staff availability, reduced fill rates, redeployment and challenges of infection prevention and control procedures. All these factors also impact on the potential for

pressure ulcer development. Throughout the Covid-19 pandemic there has been a focus on learning and sharing of good practice.

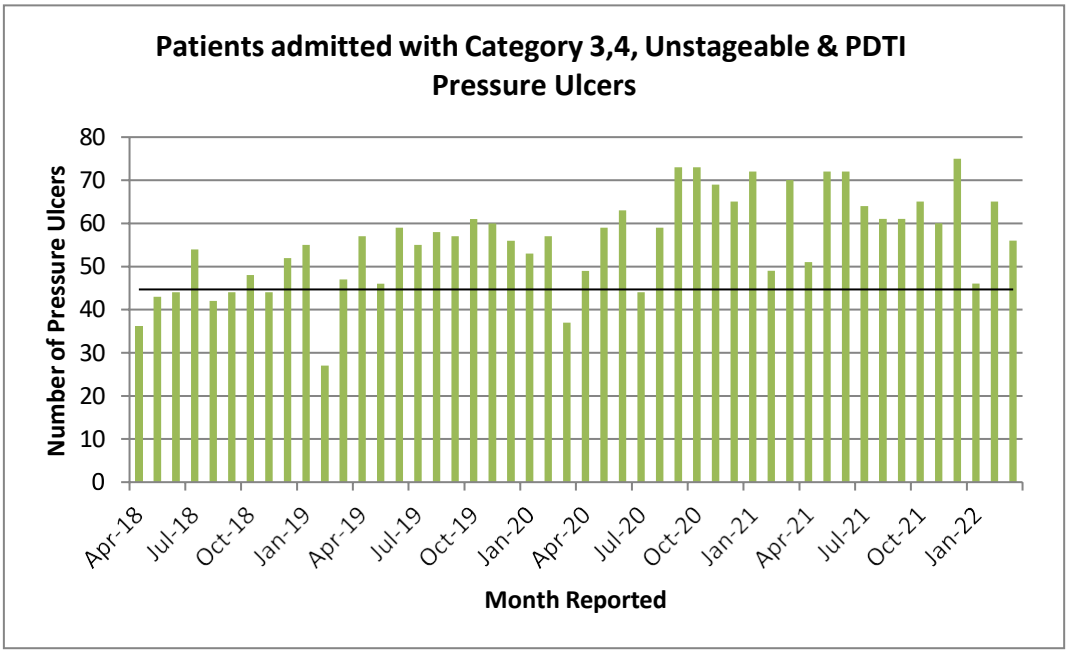
Admissions with High Category Pressure Ulcers

The Trust recognises that there has been an increase in the number of patients admitted with category 3, category 4, potential deep tissue injury (PDTI) and unstageable pressure ulcers (reported as moderate and severe harm) since 2018-19 which is highlighted in Figure 14 below.

Admitted with Category 3, 4 Unstageable and PDTI pressure Ulcers

There have been improvements in the identification and management of these categories of pressure ulcers by using photographs to promote prompt and timely validation of pressure ulcer and assist in the monitoring of pressure ulcer progress over time. Historically only Medical Illustration were able to take photographs in the Trust but over the past two years the TVN team have been taking clinical photos and assisting in the roll out of this across the Trust. This enables wards to photograph any area of concern at the point of care, thus reducing the need for multiple unnecessary dressing changes which would otherwise be required for multiple person reviews. This will also facilitate multispecialty reviews of a concern remotely, potentially reducing the waiting time for a treatment plan.

Figure 14 Patients admitted with Category 3,4, Unstageable & PDTI Pressure Ulcers

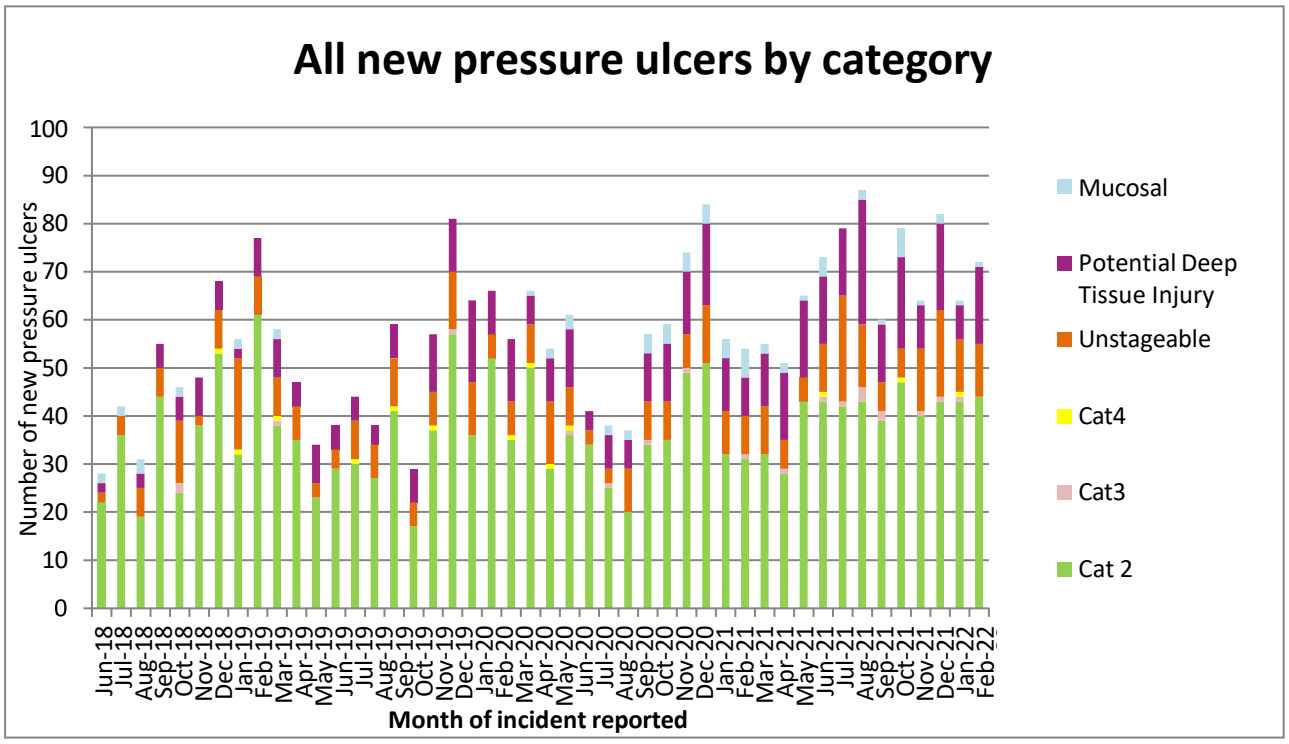


Source: LTHTR data

All New Pressure Ulcers

The Trust acknowledges that there has been an increase in the overall number of patients with pressure ulcers since 2018. The reason for this is multifaceted which includes the complexity and frailty of patients, increase in the number of patients admitted to hospital and the increased bed capacity of the hospital. The bar chart below in Figure 15 highlights the category of harm.

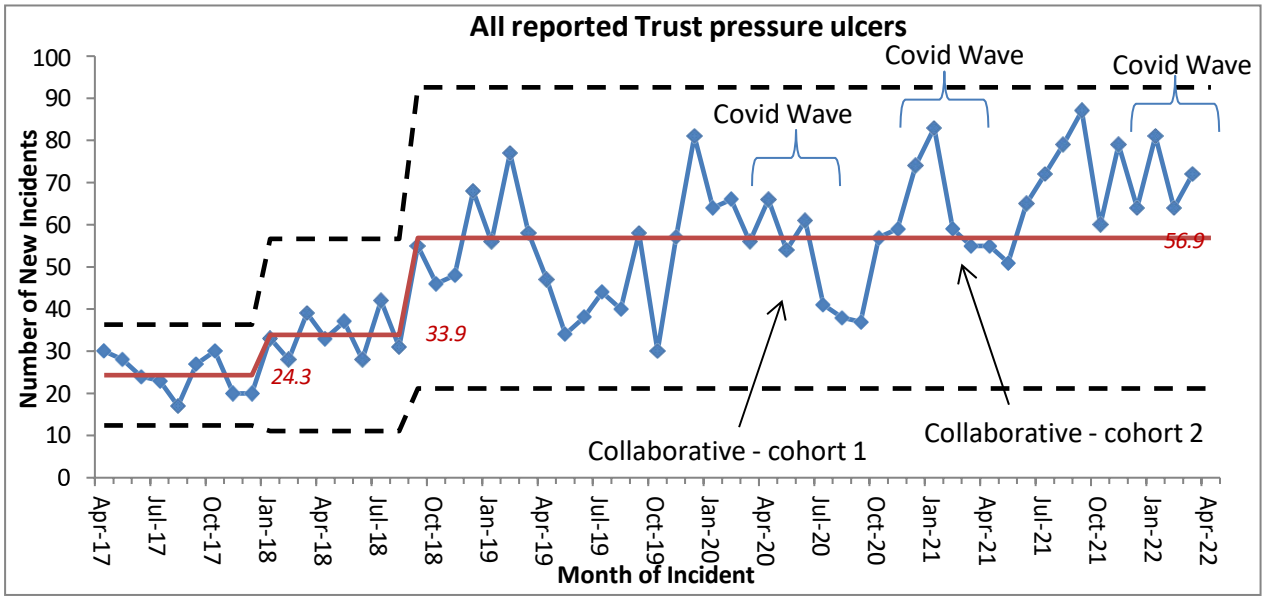
Figure 15 New Pressure Ulcers by Category June 2018 – March 2022



Source: LTHTR data

The Statistical Process Control (SPC) chart in Figure 16 below demonstrates an increase in pressure ulcers over time. A drop in incidents is noted after each cohort of the pressure ulcer collaborative but this is not sustained.

Figure 16 All Pressure Ulcers Statistical Process Control (SPC) Chart



Source: LTHTR data

Medical Device Related Pressure Ulcers

Medical device related pressure ulcers are clearly identified within our incident reporting as outlined in NHSI guidance (2018). This promotes clearer visibility of these types of pressure ulcer and enables further targeted pressure ulcer prevention improvement actions. The key to preventing these pressure ulcers is careful skin assessment under and around any medical devices. Review and improvement of the medical device-related skin assessment processes and documentation has been developed through the pressure ulcer collaborative.

The new 'Essentials of Care' chart was rolled out in all adult inpatient areas in December 2021. This document contains clear sections to be completed every shift to support skin inspections, including under medical devices.

Table 18 Device Related Pressure Ulcers

Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
8	4	5	13	9	10	8	9	13	11	5	8	5	9	13	5	13	6	8	9	8	7	4	5
0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	1	0	1	0	1	0
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	0	0	3	2	0	1	1	0	1	3	1	0	1	1	1	1	1	4	3	0	3
3	1	3	3	1	1	1	1	1	1	0	2	1	4	4	0	2	4	2	2	1	3	3	2
1	2	3	0	2	2	4	4	4	4	3	5	2	2	1	3	0	2	1	5	1	2	1	1
13	8	13	16	12	16	15	14	19	17	8	16	11	17	18	9	17	14	13	17	15	15	9	11

Source: LTHTR data

Learning and Improvement

The Pressure Ulcer Champion role has been reviewed and re-established after the Covid-19 pandemic. This role is to provide cascade training for other members of the ward team and to be the first line source of pressure ulcer prevention knowledge and advice in ward areas. In order to ensure all staff are kept updated with current practice, an e-learning annual update has been developed which will be updated every two years, alternatively there is the availability of face-to-face sessions.

The combination of electronic and written documentation has been identified as an obstacle in providing a holistic overview of patients and their needs on each shift. A review of the electronic Waterlow, skin assessment and wound chart has been undertaken by the TVNs and the development of an electronic care plan has been undertaken. This is due to be launched in June 2022 to standardise and streamline processes with the aim to make it simple, meaningful, and easily accessible to all involved in patient care.

Pressure ulcer improvement strategies also include:

- The Datix system has been updated to ensure inclusion of patients in the pressure ulcer review process in order to improve patient involvement in the investigation and learning process.
- Witness statements to HM Coroner Inquests, providing an overview of the pressure ulcer prevention measures in place.
- Nutritional Big Room, looking at malnutrition screening tool (MUST) and weight compliance to identify patients requiring additional nutritional support.

- Purchase of weighing pad slides in the Trust.
- Close working with ED reviewing equipment and the pressure ulcer review process.
- Pressure ulcer prevention training provision for HM Coroner's Team (2019, 2021).
- Review of any severe harm incident with Divisional governance and senior leader team.
- Weekly in-depth Divisional review.
- Monthly Divisional Always Safety First meetings focusing on shared learning.
- Trust-wide learning included as part of the Always Safety First Learning bulletins.
- Pressure ulcer incidents are highlighted in the monthly nurse staffing report, with a ward breakdown.
- Re-introduction of the TVN link nurse day commenced in April 2022.
- Pressure ulcer prevention training for healthcare assistance on induction.
- Various tissue viability sessions for inter professional learners (IPL) (sessions in all three years of training).
- Student placement development within the tissue viability team (first students April 2022).

Nutrition for Effective Patient Care

The provision of high quality nutritional support is complemented by our 7-day Integrated Nutrition and Communication Service (INCS) who have led and supported a number of key initiatives in previous years, many of which are now well embedded in daily practice. INCS comprises of the Nutrition Nursing Team, Dietetics, Speech and Language Therapy, Central Venous Access team and the Hospital Alcohol Liaison team.

One of our aims continues to be to ensure that patients admitted to the Trust who remain for more than 48 hours (excluding maternity and day-case patients) have a nutritional screening assessment on admission. The assessment is carried out using the Malnutrition Universal Screening Tool 'MUST' developed by the British Association for Parenteral and Enteral Nutrition. The screening tool highlights patients who are already malnourished or at risk of malnourishment and determines the need for referral for a more detailed nutrition assessment by a dietician or an alternative nutritional care plan.

Many patients require artificial feeding using either enteral feeding tubes or intravenous feeding. Our INCS service is designed to assess patients swiftly, make nutritional care plans, including feeding device selection, and undertake appropriate follow up.

The nursing 7-day service provides a rapid access clinic which is an admission avoidance measure and improves quality of care and experience for patients as they have a dedicated telephone helpline to gain this expert advice.

Our Speech and Language Therapy department offer high quality services to patients with communication and swallowing difficulties including complex presentations. Direct access to instrumental swallowing assessments using fiberoptic endoscopes and Video fluoroscopy is available onsite, informing diagnosis, decision-making and provision of appropriate nutrition.

Our Dietetic service provides highly specialist care for a wide group of patients both adults and children. The service offers a variety of specialist clinics including paediatric diabetes,

paediatric ketogenics, adult coeliac and adult renal, as well as providing a comprehensive inpatient service over both hospital sites.

The Trust continues to work alongside the catering services so that services are fully compliant with legislation relating to allergens. There is ongoing work to support the new bulk trolley system and menu development.

During 2021-22 our services key achievements were:

- Being fully compliant with legislation relating to allergens
- Cook/chill trolley system now implemented across both hospital sites
- The implementation of the weekly integrated secondary and primary care nutrition Multidisciplinary Team meetings.
- An established Head and Neck direct access to outpatient Nasogastric Tube (NGT) pathway for community patients.
- The Head of Dietetics has been appointed as a Flow Coach and will be leading the work streams identified as their training progresses. This continues to develop.
- Revised the policies and pathways around improving NGT safety. This has resulted in no NG tune placement Never Events for over 17 months.
- Completion of the Electronic Patient Record (Quadramed) team to refine the electronic documentation of NGT management.
- Approval of a difficult feeding service in SLT for over 2 years.
- Dietetics and SLT services now have electronic inpatient referral systems.
- Appointed a Clinical Service Manager to support governance, business intelligence and performance initiatives.
- Increased SLT and dietetic services within critical care following a CQC should do.
- Recruited to NHSI/E funded child health weight management post

Medication and Incident Monitoring

Medication errors have significant implications on patient safety. In 2018 the Secretary of State commissioned research into the 'Prevalence and Economic Burden of Medication Errors in the NHS in England' from the Policy Research Unit in Economic Evaluation of Health and Care Interventions (EEPRU). This research identified there are an estimated 237 million 'medication errors' per year in the NHS in England, with 66 million of these potentially clinically significant.

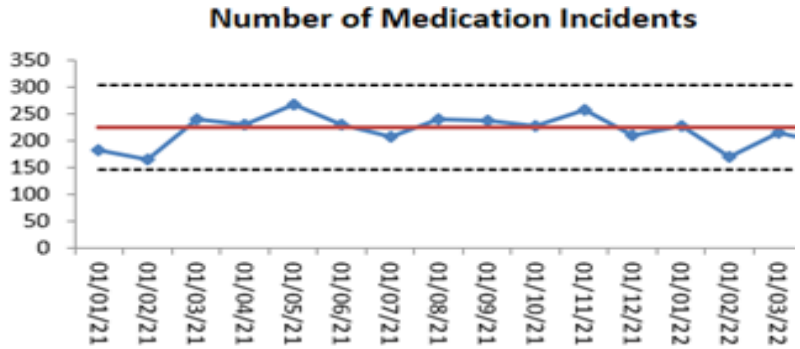
The Trust's Medication Safety team review medication incidents on a monthly basis, monitoring types, trends and rates of errors. This review and analysis supports identification of immediate actions to be taken in response to incidents and also supports long term action plans to address ongoing issues and trends. The team has expanded during 2021-22 with the recruitment to additional posts:

- to increase audit capacity and capability,
- to support the expanding activities relating to Covid-19 vaccines and treatments
- to further strengthen capacity for Pharmacy education and training.

The Pharmacy Medication Safety Team work hard to encourage a positive incident reporting culture which is enabled by our effective reporting system (Datix), supporting medication errors to be reported quickly and ensures thorough and timely investigation. Having a robust medication incident reporting culture is fundamental for the development and sustainability of a learning culture, which is essential for preventing future harm. Incidents reported are predominately incidents causing no harm or near misses and analysis of these help us develop strategies to prevent future harm events.

An initial downturn in incident reporting was seen early in the pandemic. However, after significant campaigning through the Pharmacy Medicines Safety Team the average reporting figures have increased back to our historical mean throughout 2021-22 (average of 227 medication incidents reported each month, which is a 29% increase on 2020-21), which demonstrates a positive culture of reporting.

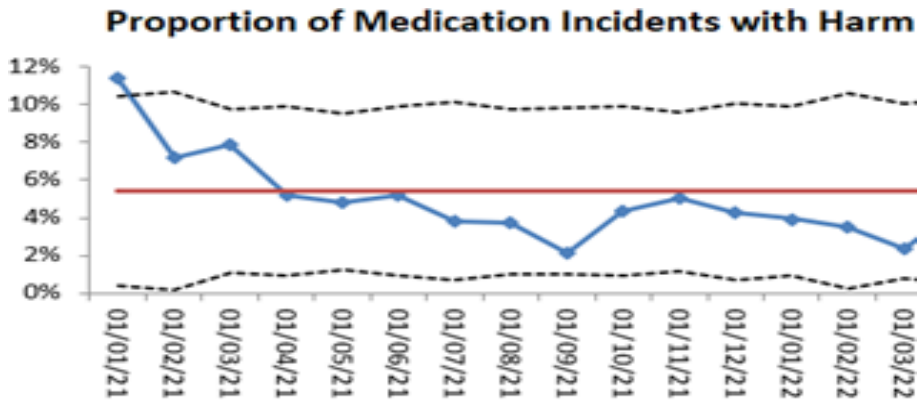
Figure 17 Medication Incidents Reported



Source: LTHTR data

A study conducted by the University of Manchester in 2018 estimated that across the UK 25% of medication errors in hospital lead to harm. Data in the Model Hospital dashboard indicates the hospital national average for medication incidents causing harm is 11%. Throughout 2021-22, the Trust has maintained harm rate at below 6%, with some months being as low as 2% (average 4%).

Figure 18 Medication Incidents Leading to Harm



Source: LTHTR data

Every incident reported at moderate harm or above is subject to a rapid review meeting, led and facilitated by the Divisional Governance team and supported by the Medication Safety Officer. Early impact interventions are identified and disseminated prior to the outcome of formal investigations.

Medication incident themes are shared with the relevant divisional areas in Medication Safety reports presented at Always Safety First meetings along with any shared learnings from significant events in other divisions. The Trust has a network of Medication Safety Champions, supported by the Medications Safety Education Pharmacist. Our champions are link nurses from each clinical area that meet monthly on both hospital sites to share learning from errors, implement change and act as an education forum. Medication Champions and their meetings will be a focus for the Pharmacy Medication Safety team in 2022, integrating allied roles such as cross departmental Oxygen and Medical Gas Champions and the Clinical Educators.

Our monthly performance is also reported to the Medicines Governance Committee which details harm and near miss themes and trends. Following a period of enhanced surveillance of the Covid-19 vaccination services there were no concerning trends identified from incidents relating to the service throughout 2021-22.

All our medication incidents continue to be reported on Datix and are linked the Risk Register on the same system. The Medicines Governance Committee maintain a cycle of business for risk assurance reporting to monitor medication risks, which is in line with the Trust's Risk Maturity agenda.

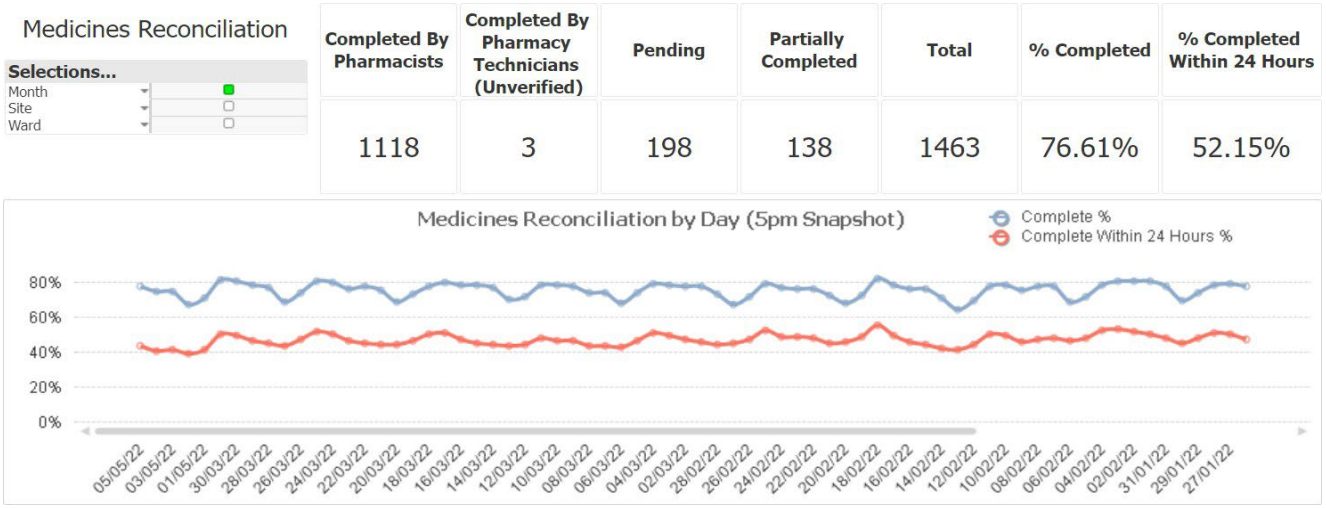
Medicines Reconciliation

Medicines reconciliation is the process by which information on a patient's medication history is collected and verified following admission. The NPSA/NICE guidance directs that this should be completed within 24 hours of admission.

Positively, the organisation has moved away from a manual audit process whereby medicines reconciliation was measured using a quarterly single day point prevalence audit that sampled five patients on each ward (a method developed by the NW Clinical pharmacy forum). Following the implementation of Electronic Prescribing and Medicines Administration (EPMA) system to wards across Royal Preston Hospital a pharmacy dashboard was developed within the Trust's BI portal application. EPMA was also rolled out across the Chorley and South Ribble Hospital site in September 2021, so the electronic data is now available for all inpatients across the Trust. Data is taken from the live EPMA system every 15 minutes to refresh the BI portal, and the data is used in two ways:

- a 'freeze' position is recorded at 5pm every day to build a long-term picture of performance (and replace the manual quarterly audit described above). This includes every patient in an inpatient bed every day; and
- the live data (updated every 15 minutes) is used throughout the day to aid decision making regarding the best deployment of pharmacy staff based on workload pressures.

Figure 19 Daily Medication Reconciliation Quarter 4 2021-22



Source: LTHTR data

In 2021-22, medicines reconciliation was completed within 24 hours of admission for 53.1% of patients (improvement from 46% in 2020-21). On average, 74.8% of all patients in an inpatient bed have a medicines reconciliation completed (improvement from 62% for 2020-21). Factors impacting on performance relating to medicines reconciliation include:

- Significant pharmacy staffing challenges (vacancies and increased staff absences due to Covid-19).
- Significant numbers of additional unfunded beds due to patient flow issues across the system.

Improvement actions are underway to support improvements in performance:

The Pharmacy Clinical and Supply teams undertook a restructure process during 2021-22. A range of activity and staffing data was analysed by the teams to develop a new team structure, bringing about improvements to leadership as well as the deployment of both registered and non-registered pharmacy staff across all clinical areas. The implementation phase of this work had begun at the end of 2021-22.

A Continuous Improvement project was initiated to support continuously reviewing aspects of challenged service delivery and support the introduction of innovative solutions. This project is aligned to support closing the performance gap at weekends.

Prescription Verification

Our pharmacists review and verify prescriptions in the clinical areas, assessing prescribing for dose, legibility, interactions, appropriateness of therapy (including patient characteristics, disease state, laboratory results), formulary compliance and legal requirements. Our EPMA system has enabled this verification to be measured 24 hours a day including every individual prescription via data capture in the BI portal (in a similar manner to medicines reconciliation this has replaced a manual point prevalence audit of a sample of prescriptions).

Average compliance for prescription verification within 24 hours is 48.5%. On average, 79% of all live prescriptions are verified (with a peak of approx. 85%). On a daily basis the live EPMA data is now utilised to target staffing resources to ward areas where the workload is greatest.

The same factors impacting performance apply to both prescription verification and medicines reconciliation, as do the improvement actions.

Antimicrobial Stewardship

The Antimicrobial Stewardship team undertake antimicrobial stewardship audits across all in-patient areas. With the roll-out of EPMA the data collection process is largely automated. All patients in every inpatient ward who are prescribed antimicrobials are included in the audit (an improvement to the small sample included in snapshot paper based audits).

The audit assesses:

- Compliance with documentation of the indication for antibiotics on the prescription
- Compliance with the Trust's antimicrobial guidelines or recommended by Microbiology
- Compliance with the Trust's stop/review date guidance
  - Stop/review date on the initial prescription
  - % Compliance with evidence of stop date or documented review within 72 hours

Table 19 Antimicrobial Stewardship Point Prevalence Audit Results

	N° of patients on antibiotics	N° of antibiotic prescriptions Audited	% Documented Indication on the Prescription	% Compliance with Guidelines	% Compliance with Guidelines or Recommended by Microbiology	% Compliance with stop/review date on the initial prescription	% Compliance with documented review within 72hrs
Division of Medicine	186	237	98%	94%	95%	100%	86%
Division of Surgery	97	123	98%	91%	93%	100%	91%
Division of women and children	22	39	100%	97%	97%	93%	100%
Division of Diagnostic and clinical support	16	24	96%	94%	96%	100%	100%
Trust Wide Q4 2021-22	321	423	98%↑	94%↑	95%↑	97%↓	*90↑
Trust Wide Q3 2021-22	331	432	97%↓	90%↔	92%↑	98%↔	8%↓
Trust Wide Q2 2021-22	310	411	98%↔	90%↑	91%↑	98%↑	23%↑
Trust Wide Q1 2021-22	288	396	98%↑	88%↓	90%↓	95%↓	12%↓

*Assessed using documentation in ward round proforma for this quarter (previous results are based on completion of work queue task). Where multiple antibiotics were listed with one review outcome these prescriptions have been marked as compliant on this occasion.

Source: LTHTR data

Audit results are reported quarterly to the clinical Divisions and specialities, and actions agreed locally to address any shortfall in performance. The table above illustrates the ongoing strong performance throughout the year in relation to:

- Documented indication
- Compliance with guidelines or Microbiology team advice

- Documenting the stop/review date on initial prescription

This strong performance correlates directly to the development and roll out of EPMA where a number of fields have been mandated for completion to ensure key information is included. The one area requiring improvement work during the year was the documented outcome from the antimicrobial reviews. Although an electronic process was in place to support this it was evident early in the year it was not achieving the desired outcome of a documented review that was picked up in the automated audit process (a manual review of the entire medical notes of a small cohort of patients receiving antimicrobials did demonstrate compliance was actually >80%). The Microbiology team worked with clinical and IT colleagues to agree an alternative electronic process for capturing the documented reviews, which was switched on in December 2021. The audit data from the following quarter (quarter 4) captures a much improved performance.

Infection Prevention and Control

MRSA Bacteraemia

Staphylococcus aureus is a bacterium that commonly colonises human skin and mucosa. Most strains of *Staphylococcus aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. *Staphylococcus aureus* bacteria are more resistant. Those resistant to the antibiotic methicillin are termed methicillin-resistant *Staphylococcus aureus* (MRSA). Bacteraemia occurs when bacteria get into the bloodstream.

Infection Prevention and Control continues to be a key priority for the trust and the incidence of MRSA is outlined below:

- In 2018-19 there were zero incidents of hospital onset MRSA bacteraemia and two cases of community onset MRSA.
- In 2019-20 there was one incident of hospital onset MRSA bacteraemia and two cases of community onset MRSA.
- In 2020-21 there has been zero incidents of hospital onset MRSA bacteraemia and zero cases of community onset MRSA.
- In 2021-22 there has been one incident of hospital onset MRSA bacteraemia and two cases of community onset MRSA.

Cases are investigated by a multi-disciplinary team using the national post infection review tool and discussed with the Director of Infection Prevention and Control to identify causes and actions for future prevention. The hospital associated case identified in August 2021 was reviewed and the key contributing factor was a delay in decolonisation.

Clostridioides difficile Infection

Clostridioides difficile (*C. difficile*) is an anaerobic bacterium that is present in the gut. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of infants). In some instances, strains of *C. difficile* can grow to unusually high levels and attack the intestines, causing mild to severe diarrhoea. Patients who are commonly affected are

usually elderly and/or immunocompromised and are often exposed to antibiotics or may have been exposed to *C. difficile*.

The prevention of *C. difficile* infection remains a key priority for our organisation. During 2017-18 there were 60 cases and during 2018-19 there were 51 cases. This was an improving picture in relation to the overall objective of not exceeding 65 cases a year for the organisation during that reporting period. There was then an increase in 2019-20 with 130 cases against an objective of 84 cases.

Due to the Covid-19 pandemic there was no national objective set by NHSI/E for 2020-21. The Trust therefore used the previous year's target to set a local objective of 84. In 2020-21 the Trust saw an improvement in the number of healthcare associated *C. difficile* cases as compared with 2019-20, although it remained higher than the target at 100 cases.

The National objective set by NHSI/E for the year 2021-22 was 118. There was an increase in hospital acquired cases during 2021-22 in comparison to previous years with a total of 132 cases against an objective of 118.

- Hospital Onset Healthcare Associated = 114
- Community Onset Healthcare Associated = 18

From the 114 Hospital onset cases, 83 have already been reviewed to date and there were lapses in care identified for 72 cases: no lapses in care identified in 21 cases and 21 cases are still under review at the time of writing.

The Trust acknowledges that the yearly objective of 118 cases for this reporting period has been exceeded. All our hospital cases are reviewed by an expert group including the Director of Infection Prevention and Control or Associate Deputy Director of Infection Prevention and Control, Infection Prevention and Control Matron, Infection Prevention and Control Nurse, Antimicrobial Pharmacist or Specialist Antimicrobial Technician, Governance representative, Ward Manager, Ward Matron and Consultant in charge of the patient's care.

Our review process facilitates a greater understanding of the individual cause of the *C. difficile* cases to determine whether there were any lapses in the quality of care provided. This is so that the Trust can develop an appropriate plan of action to address any problems identified and to promote learning. A lapse in care is based on the checklist detailed in the national guidance and includes omissions which would not have contributed to the development of *C. difficile* infection. Common themes in terms of lapses in care included:

- A lack of documentation of risk assessment around diarrhoea and need for isolation.
- A lack of documentation of escalation of isolation requirements to site/bed management.
- Sampling delays.
- IPC audits (environment and IPC practice) not reaching required standard.
- Less than optimum bay decontamination after *C. difficile* cases and carriage due to bed pressures/constraints caused by the Covid-19 pandemic (inability to fog areas on occasion).
- Continued use of Laxatives after *C. difficile* diagnosis
- Isolation delays due to limited isolation facilities

During the Covid-19 pandemic, isolation of patients with diarrhoea was more challenging due to access to side rooms associated with the isolation of Covid-19 patients. The Trust also saw a significant increase in broad-spectrum antimicrobial consumption which mirrored the pandemic waves. Antimicrobials are a major risk factor for *C. difficile*.

For the coming year, as the Covid-19 pandemic reduces in intensity, there will be a renewed focus on C. *difficile* and the known actions to reduce incidence. In 2021-22 a *C. difficile* action plan was developed and while there was some success in completing the actions identified, the following interventions are being realised in 2022-23;

- Implementation of the Rapid Intestinal Infection PCR test
- Roll out of whiteboards on wards for view of patients with diarrhoea
- Standardisation of nursing documentation on Quadramed which includes diarrhoea risk assessments
- Review the fogging and cleaning systems in place in regard to the National Cleaning Standards
- Plans to establish processes to allow proactive fogging across the organisation
- Further refine the BI app displaying all patients with diarrhoea across the Trust to identify patients who require risk assessments for testing and isolation.

Focus on learning from lapses in care are triangulated in our Antimicrobial Management Group and Divisional Infection Prevention and Control meetings and the Trust has focused on antimicrobial stewardship, hand hygiene, environmental hygiene and timely isolation of patients with symptoms of diarrhoea. Hospital onset *C. difficile* review is undertaken during the monthly CDI Panel meeting with the CCG, leading to a health-economy-wide approach to learning and reduction.

SARS coronavirus-2 (SARS-CoV-2) – Covid-19

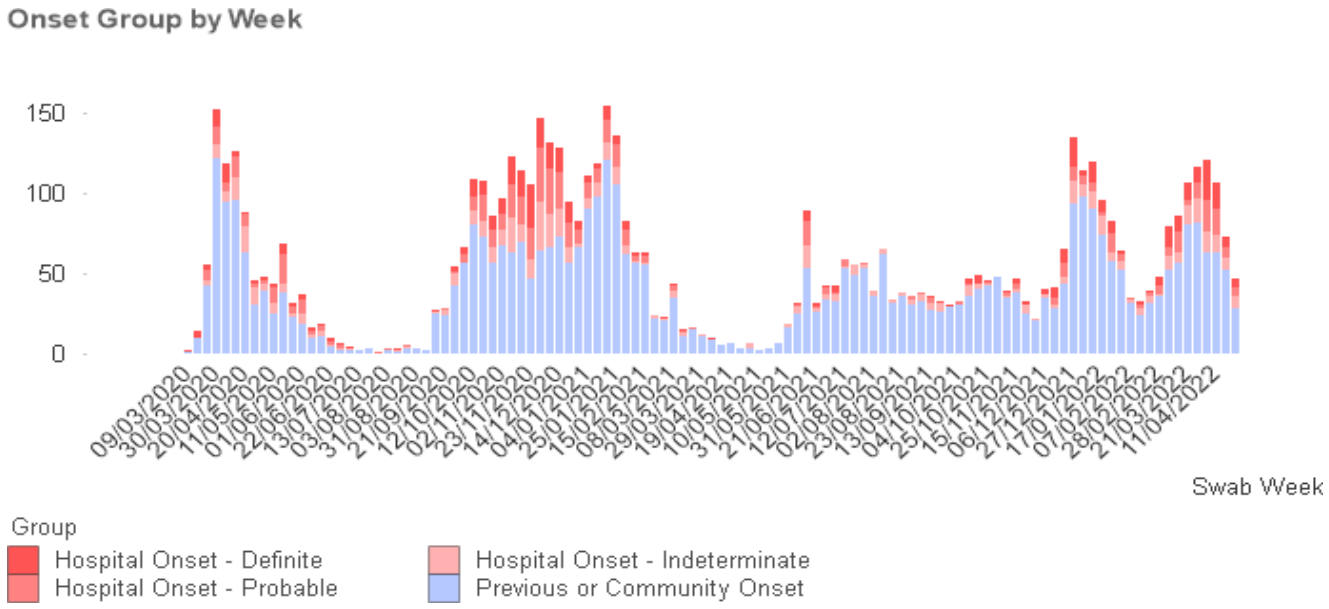
On 31 December 2019, WHO was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel coronavirus SARS coronavirus-2 (SARS-CoV-2) was subsequently identified, and symptoms were flu-like initially and also included a loss or change in the normal sense of taste or smell.

The virus is mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions. Infection control, which, in large part, relies on segregation of infected from non-infected individuals, is incredibly difficult as one third of infected individuals have no symptoms but are still able to transmit the infection to others. The Trust suffered from key disadvantages as compared to other similar Trusts when it comes to preventing nosocomial Covid-19, mainly relating to the estate:

- Only 20% of our beds are in side rooms making it difficult to segregate patients.
- A large number of our hospital bays have virtually no ventilation and Covid-19 spreads more readily in poorly ventilated areas.
- A two-metre separation between bed spaces is not possible in most areas.

During the five waves of the pandemic, our Trust like all Trusts in the NHS unfortunately had some hospital acquired or nosocomial Covid-19 infections. Presented in Figure 20 is a breakdown in the number of hospital onset versus community onset cases by week.

Figure 20 Hospital Onset versus Community Onset C-19 infections



Source: LTHTR data

From April 2021 to March 2022 the Trust continued with the measures introduced in the previous year to reduce nosocomial cases. The key measures are:

- Point of care testing in admission areas, resulting in better streaming of infected versus non-infected patients at the point of entry to the organisation.
- Continued use of rapid confirmatory Covid-19 tests.
- IT driven contact tracing system to identify bay contacts of infected patients in the 48 hours before a positive result.
- Bed re-organisation within the designation of Covid-19 wards.
- A programme of regular testing of all inpatients increasing to three times per week.
- Asymptomatic staff testing by lateral flow tests.
- A communication strategy to improve awareness and compliance with infection control procedures.
- Transparent screens/curtains between patient spaces.
- Use of 'redi-rooms' to isolate patients where side-rooms not available.
- The use of High Efficiency Particulate Absorbing (HEPA) air-purifiers to areas with high risk of transmission.

For the year April 2021 to March 2022 the nosocomial rate stood at 13% which was significantly less than the previous year at a nosocomial rate of 29% despite a higher community prevalence and transmissibility of newer variants in 2021-22.

Table 20 Cases of Covid-19 by Month and Designation April 2020 – March 2021

	HODHA	HOPHA	HOIHA	CO	**Total**
Apr-20	34	37	47	271	0
May-20	20	40	19	88	167
Jun-20	10	16	13	32	71
Jul-20	1	1	3	6	11
Aug-20	1	1	3	6	11
Sep-20	3	1	7	54	65
Oct-20	36	46	44	208	334
Nov-20	77	71	54	215	417
Dec-20	72	97	71	196	436
Jan-21	20	49	34	376	479
Feb-21	10	13	7	166	196
Mar-21	4	3	3	80	90

Source: LTHTR data

Key: **HODHA** = Hospital onset definite healthcare associated
HOPHA – Hospital onset probable healthcare associated
HOIHA - Hospital onset indeterminate healthcare associated
CO - Community onset

Table 21 Cases of Covid-19 by Month and Designation April 2021 – March 2022

	HODHA	HOPHA	HOIHA	CO	**Total**
Apr-21	0	0	0	27	27
May-21	0	0	3	15	18
Jun-21	12	24	19	97	152
Jul-21	6	6	11	173	196
Aug-21	1	2	9	152	164
Sep-21	2	4	14	122	142
Oct-21	7	4	14	129	154
Nov-21	4	7	8	120	139
Dec-21	35	21	22	173	251
Jan-22	32	25	33	291	381
Feb-22	6	7	21	111	145
Mar-22	49	29	38	239	355

Mortality Surveillance and Learning from Deaths

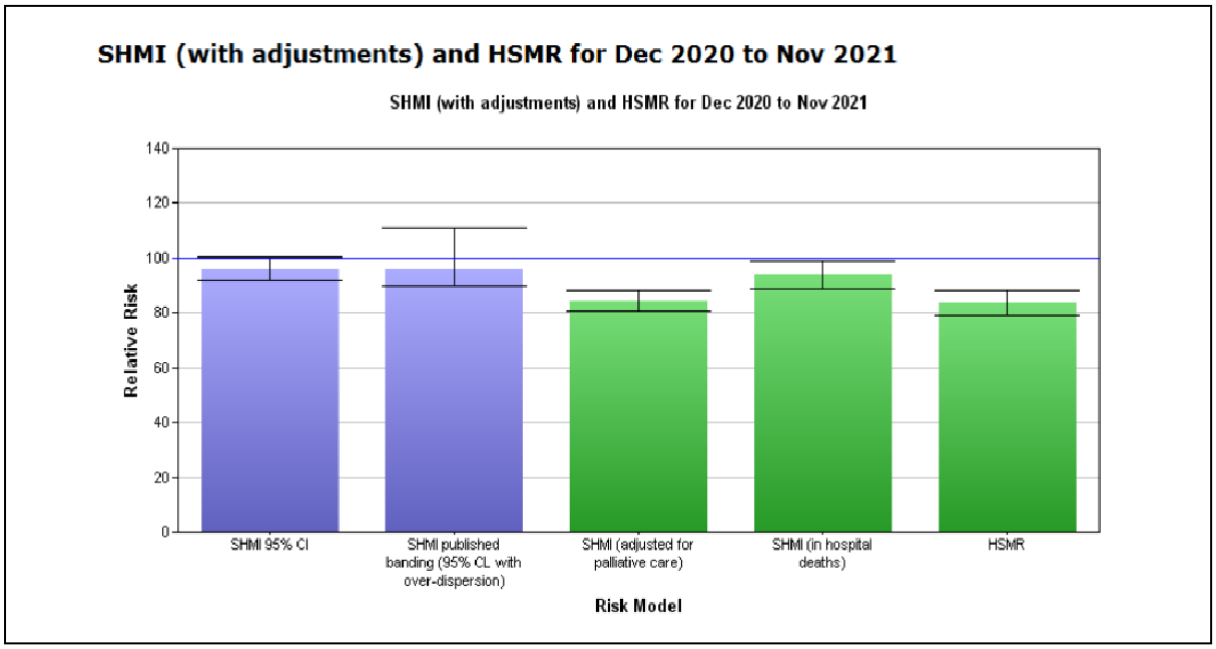
Mortality Surveillance

The trust recognises the importance of mortality rates as a key indicator in promoting confidence in the quality of the care and treatment provided through our services. The mortality data used relates to both the Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Rate (HSMR).

The SHMI measures mortality in patients who die in hospital or within 30 days of discharge from hospital. The SHMI does not take account of palliative care coding, social deprivation, but includes zero length of stay emergency patients and maternal and baby deaths. The SHMI data does not include Covid-19 data because the statistical model was not designed for this kind of pandemic activity and if the data were included it would affect the accuracy.

The SHMI for the most current period available at the time of report writing is for the 12-month period from December 2020 to November 2021, is 0.95 and remains within the expected range, as was the case during the previous reporting period 2019-20. When the SHMI is adjusted for palliative care, it is 0.84 and lower than expected, which is consistent with the reporting period 2019-20.

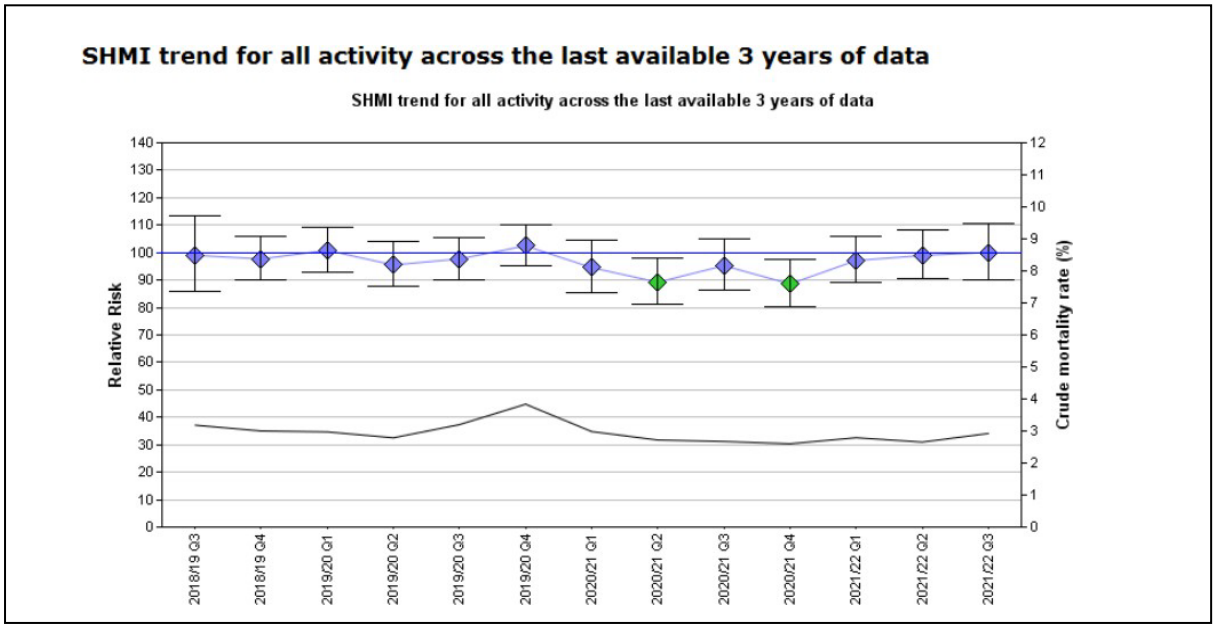
Figure 21 Summary Hospital Mortality Indicator (SHMI) Dec 20 – Nov 21



Source: Dr Foster Intelligence

The SHMI trend for the last 3 years is presented below, it demonstrates a within expected position for most quarters, apart from quarter 2 and quarter 4 of 2020-21, which were both significantly lower than expected.

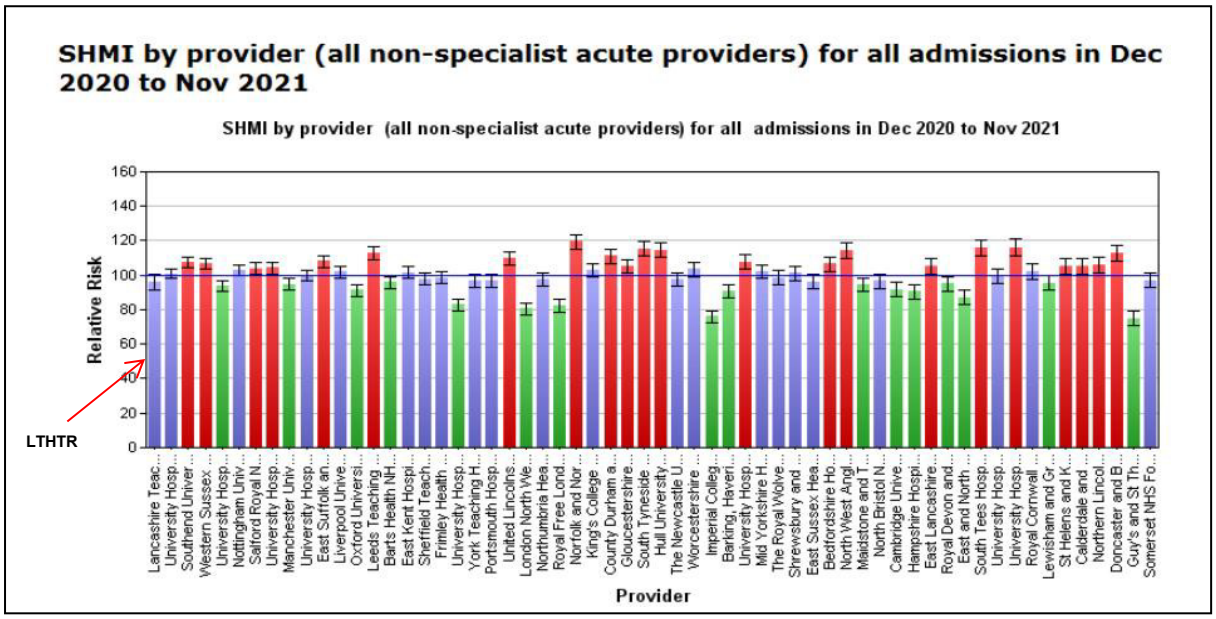
Figure 22 Summary Hospital Mortality Indicator 3 Year Trend



Source: Dr Foster Intelligence

The Trust can compare our SHMI with national peers and this is presented in Figure 23 below, the Trust is the first organisation in the bar chart. Trusts featuring in blue are those within the expected range, green bars are lower than expected and those in red are higher than expected.

Figure 23 Summary Hospital Mortality Indicator Peer Comparison



Source: Dr Foster Intelligence

Hospital Standardised Mortality Rate (HSMR)

In addition to the SHMI the trust monitors mortality rates using the HSMR which is derived from data based on 56 diagnostic groups, which account for approximately 80% of all hospital deaths.

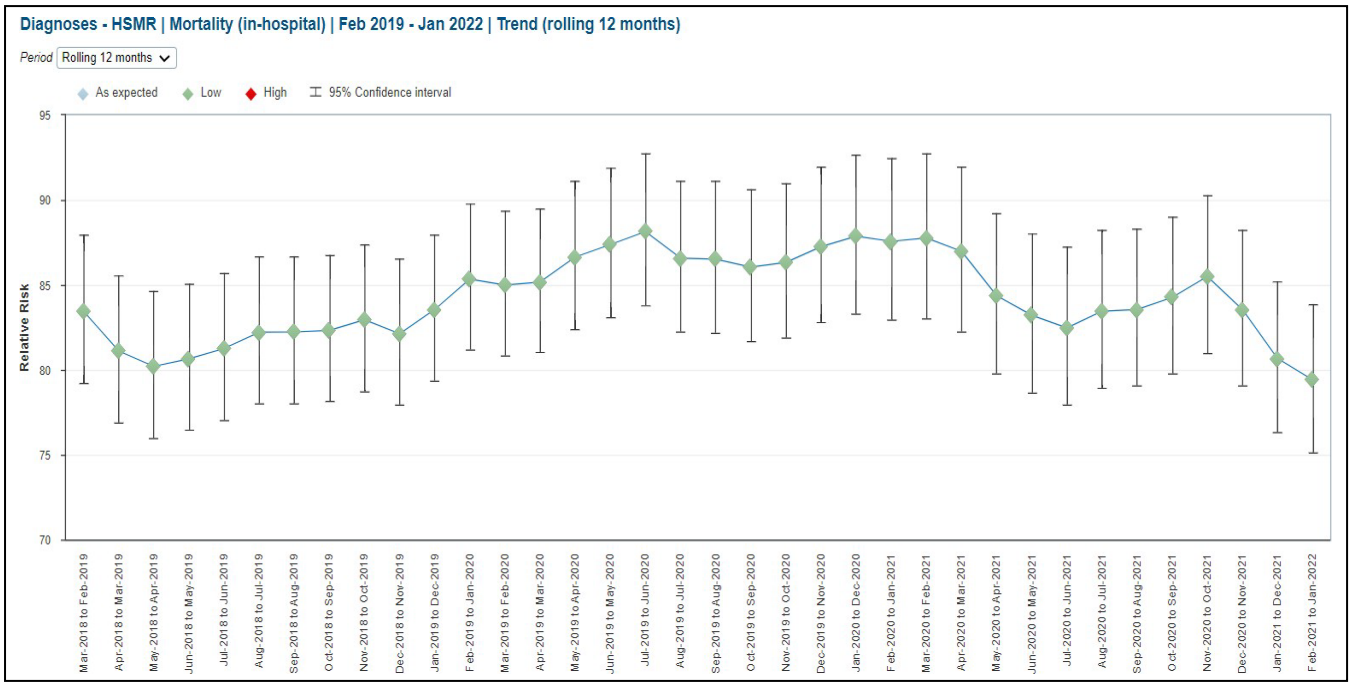
The data is adjusted to include a range of factors that can affect survival rates but that may be outside of our direct control such as age, gender, associated medical conditions and social deprivation. The HSMR is defined as the ratio of observed deaths to expected deaths (based on the sum of the estimated risks of death) multiplied by 100. A rate greater than 100 indicates a higher-than-expected mortality rate, whilst a rate less than 100 indicates either as expected or lower than expected.

The HSMR does not include patients who presented with a primary diagnosis of Covid-19; these are mapped to the viral infections group and included in the Standardised Mortality Ratio, which includes all diagnoses. However, any patients who present with one of the 56 diagnoses within the HSMR basket, who subsequently develop Covid-19, will be included in the HSMR figure.

The most current 12-month HSMR data relates to the period from February 2021 to January 2022, the figure is 79.4 and remains lower than expected. The HSMR for the same period between February 2020 and January 2021 was 87.6 and significantly lower than expected.

Our HSMR trend over the past three years is presented in Figure 24 below and demonstrates the continued HSMR trend of mortality being either 'within expected' or 'lower than expected'.

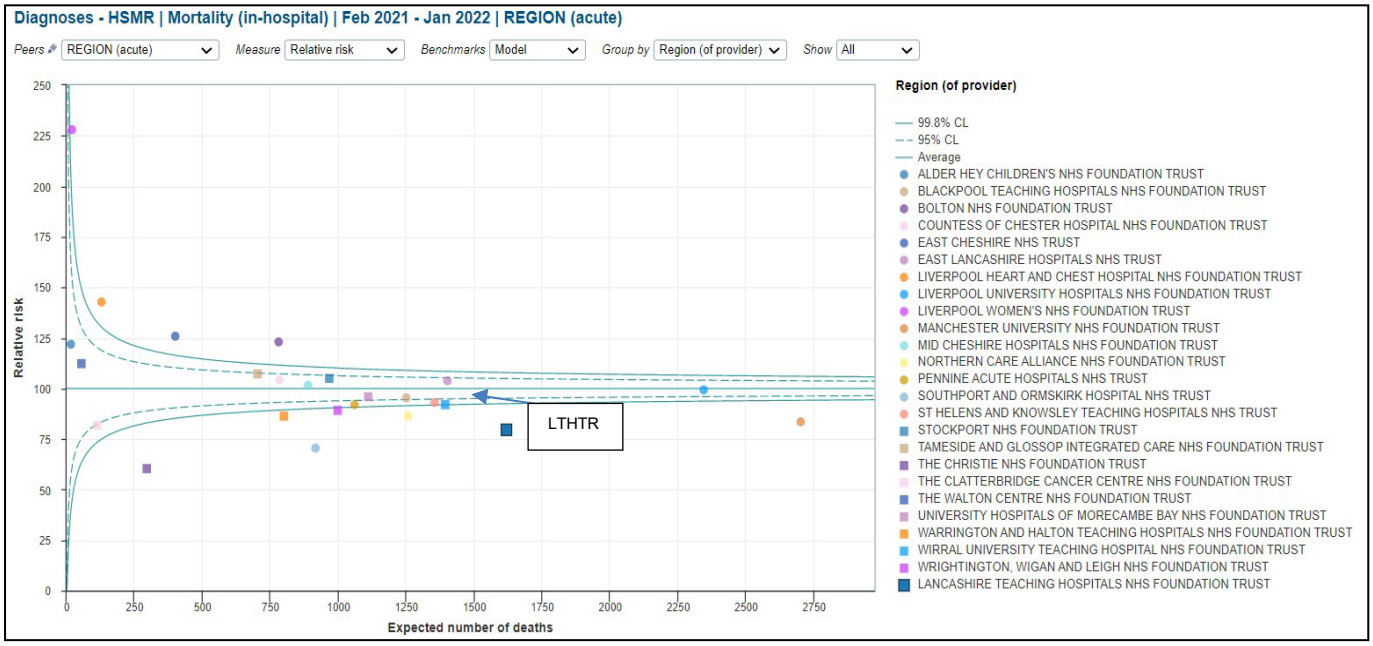
Figure 24 Hospital Standardised Mortality Rate Feb 2019 – Jan 2022



Source: Dr Foster Intelligence

A comparison with other regional acute peers is also presented in the funnel plot in Figure 25 below, which shows the Trust has one of the lowest HSMRs in relation to our regional peers for the most recent data available.

Figure 25 HSMR Regional Acute Peers Benchmark Feb 2021 – Jan 2022

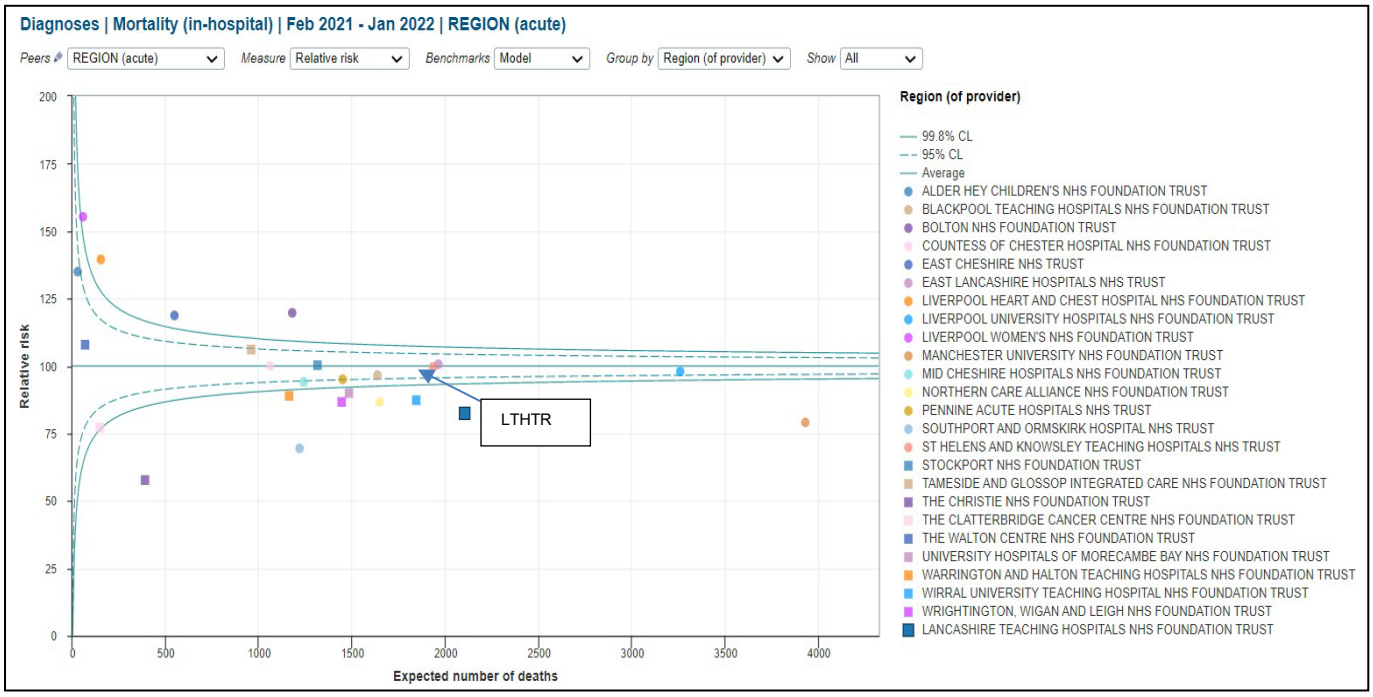


Source: Dr Foster Intelligence

Standardised Mortality Ratio – Relative Risk for All Diagnoses

The Trust also monitors the Standardised Mortality Ratio (SMR) 'Relative Risk' for 'All Diagnoses' and for the period February 2021 to January 2022 this was 82.5, which is lower than expected. The funnel plot in figure 26 below, demonstrates that again the Trust has one of the lowest relative risks compared to our regional acute peers.

Figure 26 SMR Regional Acute Trust Benchmark Feb 2021 – Jan 2022

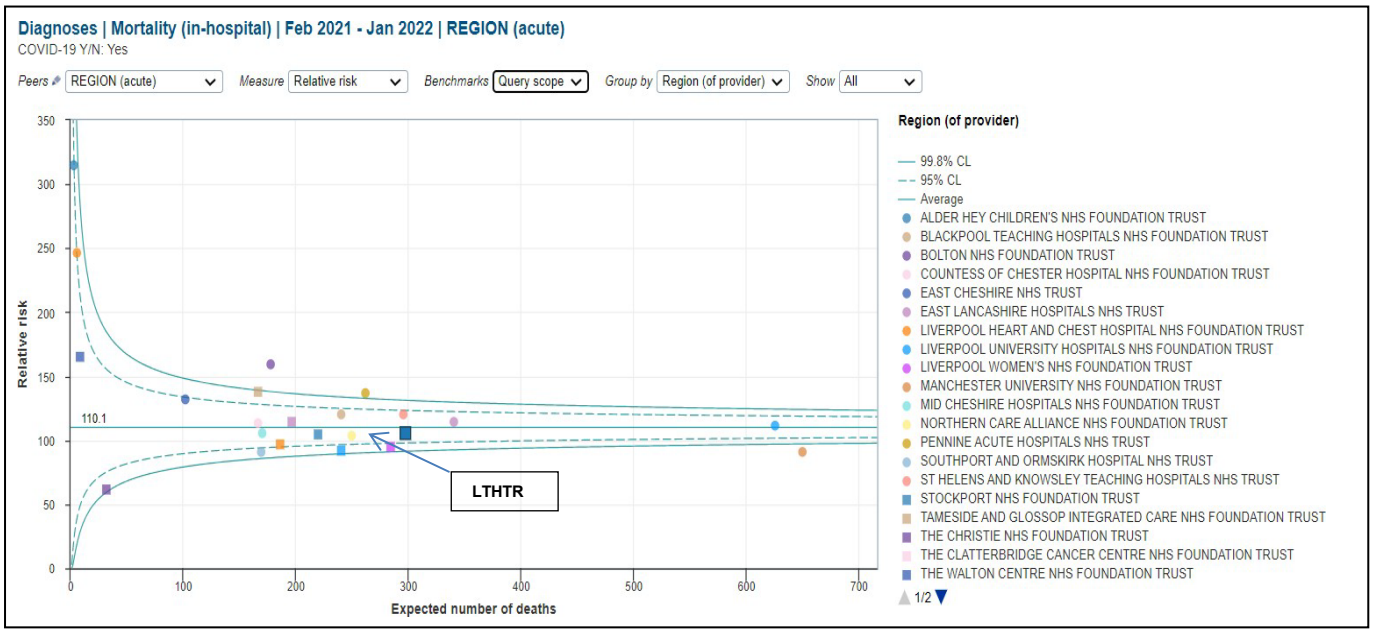


Source: Dr Foster Intelligence

Covid-19 Mortality Data Analysis

When only the Covid-19 data is analysed the average relative risk for the Northwest peer group is above the 100 mark at 110.1. The funnel plot in figure 27 below, demonstrates that the Trust is within the expected range.

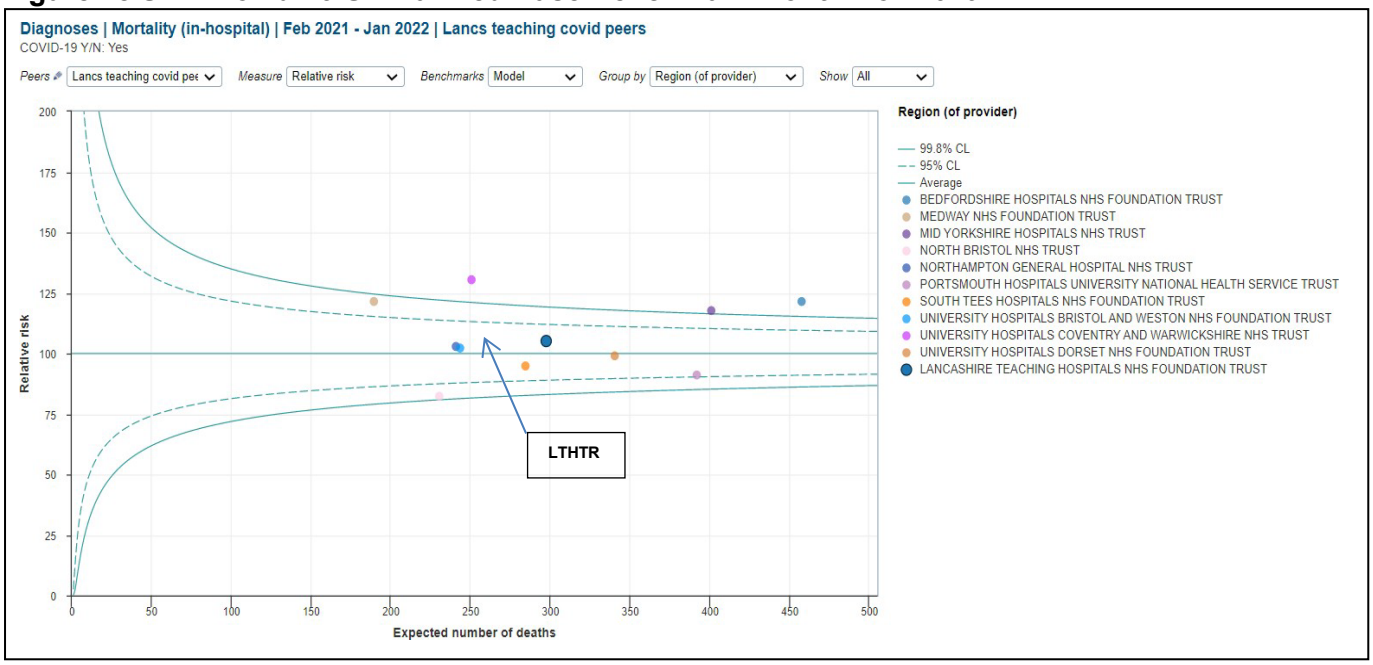
Figure 27 SMR Regional Covid-19 Benchmark Month Nov 2020



Source: Dr Foster Intelligence

The funnel plot in Figure 28 below, compares the SMR with peers who have a similar number of beds and numbers of Covid-19 admissions. The data demonstrates that the Trust was within the expected for their SMR for Covid-19 deaths.

Figure 28 SMR Covid-19 Similar Bed Base Benchmark Month Nov 2020



Source: Dr Foster Intelligence

Covid-19 Patient Deaths

Patients who get Covid-19 whilst in hospital are particularly at risk of death from the infection because hospitalised patients are already unwell and often have significant co-morbidities. Since the start of the Covid-19 pandemic the trust has taken all the protective measures available to ensure our patients and staff have been as safe as possible while in our hospitals. All deaths and those attributed to Covid-19 from April 2020 to March 2021 are presented in the table below. With deaths attributed to Covid-19 between April 2021 and March 2022 at 34.2% of deaths during that period. The Trust is continually improving our safety and protection measures to minimise the impact of Covid-19 within our services. Detail is included in the Infection Prevention and Control section.

Table 22 Deaths and Covid-19 Deaths 2020-2021

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Year to Date
Number of Inpatient deaths (Total)	219	178	132	97	100	96	156	195	226	206	166	130	1901
Number of Inpatient deaths (attributed to Covid)	122	75	34	6	0	6	50	96	126	95	73	20	703
% of Inpatient deaths attributed to Covid	55.7%	42.1%	25.8%	6.2%	0.0%	6.3%	32.1%	49.2%	55.8%	46.1%	44.0%	15.4%	37.0%
Number of ED deaths (Total)	15	6	5	10	18	9	19	20	29	24	13	18	186
Number of ED deaths (attributed to Covid)	2	0	0	0	0	0	1	1	2	3	1	0	10
% of ED deaths attributed to Covid	13.3%	0.0%	0.0%	0.0%	0.0%	0.0%	5.3%	5.0%	6.9%	12.5%	7.7%	0.0%	5.4%
All Deaths (Total)	234	184	137	107	118	105	175	215	255	230	179	148	2087
All Deaths (attributed to Covid)	124	75	34	6	0	6	51	97	128	98	74	20	713
% of All deaths attributed to Covid	53.0%	40.8%	24.8%	5.6%	0.0%	5.7%	29.1%	45.1%	50.2%	42.6%	41.3%	13.5%	34.2%

Source: LTHTR data

Learning from Adult Deaths

A summary of the learning from the Structured Judgement Mortality Reviews (SJRs) is presented below:

These are the key themes that have been identified from primary and secondary SJRs undertaken in 2021-22 and are areas for continual improvement:

- Importance of early decision making and discussion of DNACPR with patients and families
- Importance of appropriate use of Alcohol Withdrawal Guidelines and correct documentation of CIWA scores (CIWA is a tool to measure the level of alcohol withdrawal and informs medication)
- Timely transfer of patients to specialty or higher level of care to avoid issues with transfer of patients who are acutely decompensating
- Education of management plans for intra cranial haemorrhage including observations, A-E assessments and blood pressure targets
- Accurate calculation and documentation of fluid balance
- Confirmation of prognosis from all relevant specialties for patients with active cancer to aid decision making regarding active treatment/palliation
- Patients undergoing active treatment should still have an individualised care plan if likely to pass away during current admission

- Importance of holistic review – in cases where there is false reassurance from an EWS <4 but a single parameter is of concern
- Need for earlier recognition of patients nearing the end of life
- Improved communication with patients and families regarding decisions

It is important to note that areas of good practice are also highlighted at primary and secondary review and key themes were:

- Good quality MDT working
- Nursing care of patients
- Pre-emptive planning and discussions around DNACPR
- Communication and considerations well documented
- Co-morbidities influencing decisions to transition to conservative management and end of life care in a positive way
- Good discussions with family keeping them up to date and explaining the limitations to treatment and risk of deterioration
- Good pre-emptive planning and discussions around DNACPR
- Good end of life care with the family supported and updated including Palliative care involvement
- Timely review and prompt admission to Critical Care.
- Excellent end of life care
- The deaths reviewed of patients with Learning Disabilities had good to excellent care

Learning from Mortality Reviews is shared at Speciality level Morbidity and Mortality and Safety and Quality meetings. The learning outcomes from the SJR reviews are extracted from the electronic SJR tool in our clinical audit system; AMaT. This is collated and key themes are reported into our Divisional and Trust Safety and Quality Committees. Themes for learning are also reported into our Mortality and End of Life Care Committee which highlight excellent practice as well as areas for consideration and action.

Child Deaths

The SMR for children for the 12 month period January 2021 to December 2021 (the most recent period available) is within expected range.

Reporting of child deaths is managed in line with local and national guidance. The Trust offers immediate support to parents and families and the Trust has a bereavement midwife available to support the parents of newborn infants.

All child deaths are reported to the HM Coroner unless the death is expected, and this has previously been agreed with the HM Coroner. The statutory requirements for reporting child deaths to the Child Death Overview Panel (CDOP) are followed with this panel providing an independent multi-disciplinary review with the purpose of identifying lessons and preventing future deaths. In addition to reviewing children who have died in the Trust a case review is undertaken for any children known to the children's services at the Trust for example those transferred to Paediatric Critical Care or children who have died unexpectedly at home.

Neonatal Deaths

All neonatal deaths under 28 days are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). MBRRACE-UK is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths, and infant deaths, including the Confidential Enquiry in Maternal Deaths (CEMD).

In addition, local reviews are undertaken by the neonatal lead Consultant for neonatal death or the Named Doctor for Safeguarding Children. All reviews are shared locally at departmental level and neonatal reviews have been shared at the Lancashire and South Cumbria Neonatal Operational Delivery Network Clinical Effectiveness Group. A summary is also presented to the Trust Mortality and End of Life Committee on a quarterly basis.

A summary of the learning from the child/neonatal deaths is presented below:

- Consider earlier decision to withdraw treatment and commence palliative care.
- Importance of antibiotic stewardship.
- Encourage early trophic feeds (even minimal).
- Explore use of probiotics.
- Continue to enhance support for breast milk expressing.
- Be aware of Hyper-osmolality of milk plus additives.
- Maintain situational awareness.
- Monitor and review growth trends better.

A summary of the learning from the neonatal deaths is presented below:

- Importance of following Sudden Death in Childhood (SUDIC) policy for all unexpected deaths even when explained. Police and Emergency Department have the SUDIC duty rota.
- Ensure staff are aware of the ability to upgrade North West Ambulance Service (NWAS) calls from category 1 to category 2 via direct discussion with the control room clinical lead.
- Consider end of life plan instead of escalation to critical care which would have allowed consideration of home as a place for death (however not possible when child deteriorates quickly).

Perinatal Mortality

The Trust uses the Perinatal Mortality Review Tool (PMRT) to review deaths of babies within defined eligibility criteria. Between April 2021 and March 2022, the Trust has reported 34 deaths that have met the defined threshold for reporting using the PMRT. The tool is used to review the care of all the relevant cases and draft reports are generated for use with families and staff groups to share wider learning. The Trust also shares a summary report of all cases at the Maternity Safety Champions meetings held bi-monthly for review and discussion. Formal assurance is provided in a summary report to the Board following submission of a detailed report to the Trust Safety and Quality Committee containing details of the deaths reviewed and the consequent action plans.

Stillbirths

The incidence of stillbirth remains an area of focus within the maternity service. The maternity dashboard, see Table 23 below, reflects a fluctuation in the reported incidence of stillbirth during the past 12 months. The Trust mean for 2020-21 in March was 4.1/1000 following an increase in cases during the waves of the Covid-19 pandemic.

Table 23 Maternity Dashboard - Incidence of Stillbirths (per 1000 births)

Metric	Red flag		Green flag		Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Stillbirth rate (per 1,000 births)	>	4.2	≤	4.2	5.7	2.9	0.0	5.1	0.0	5.5	12.9	7.5	3.1	6.3	0.0	0.0

The regional maternity dashboard collated by the North West Coast Strategic Clinical Network has previously identified the Trust as an outlier with regard to the incidence of stillbirth between 1 April 2020 to 31 March 2021. In response an in-depth detailed audit and review of 23 of the 24 cases that occurred during the period April 2020 to March 2021 was conducted using a regional audit tool by the multidisciplinary team and a thematic analysis of the results was undertaken. The report was presented to Safety and Quality Committee in August 2021 and recommendations for practice were highlighted. An action plan update and clinical audit schedule were presented to Safety and Quality Committee.

The major themes identified within the audit report related to fetal growth restriction, placental dysfunction, and maternal comorbidities. The audit findings highlighted that service improvements needed to be implemented with regard to aspects of the care pathway relating to the management of fetal growth restriction, hypertensive disorders, missed appointments, the assessment and management of Maternity Triage calls, continuity of carer and carbon monoxide monitoring. The report concluded with 16 recommendations for consideration that have been incorporated into an action plan for ongoing monitoring and visibility.

To provide robust assurance, a clinical audit schedule has been collated to provide ongoing assurance. The Clinical Negligence Scheme for Trusts year 4 work stream also provides ongoing audit, tracking and action planning in relation to the Saving Babies Lives care bundle and carbon monoxide pathway.

Statistical process control analysis

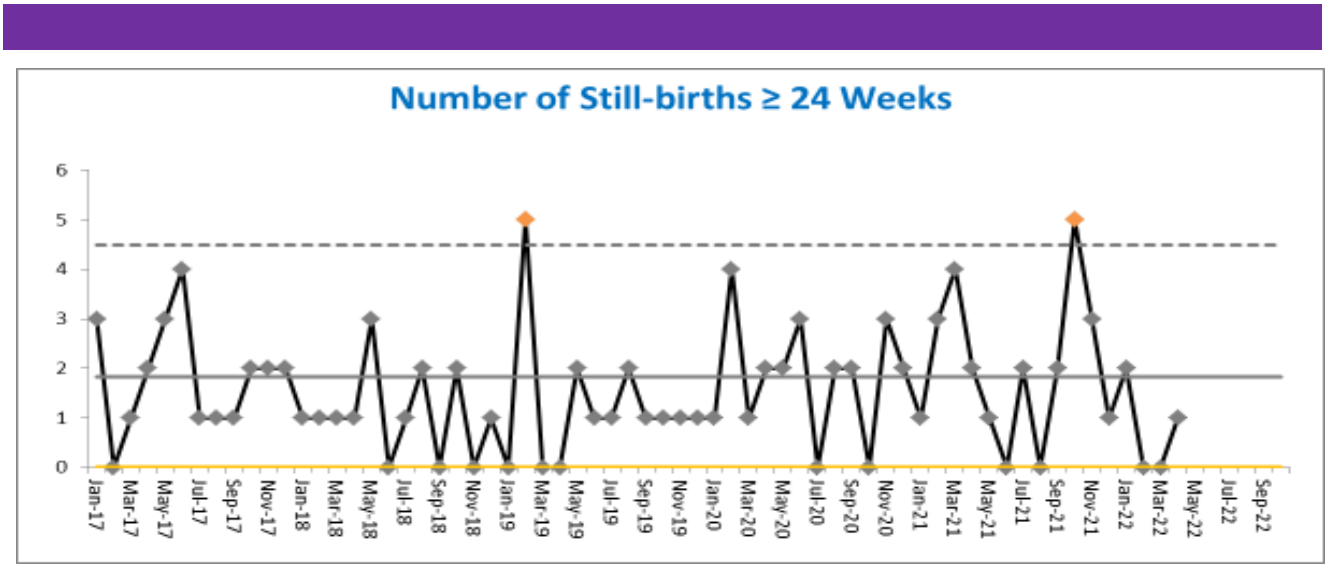
A statistical process control analysis of the stillbirth rate has been undertaken by the Trust quality improvement team (Figure 29) to review the overall trend of stillbirth incidence since January 2017.

On average there are around two stillbirths a month, however the Trust would expect this to range anywhere between zero and four per month within expected variation. There are no signs of sustained change since 2017. Back in February 2019, the Trust had slightly more stillbirths than might be expected but within normal variation, and this was repeated recently in October 2021.

In view of the elevated incidence of stillbirth rate in October 2021 an initial analysis of the cases has been undertaken in response. No immediate themes were identified in the initial

analysis of cases and therefore a detailed review of each case will be undertaken using the Perinatal Mortality Review Tool (PMRT).

Figure 29: Statistical analysis of the rate of stillbirth at the Trust since January 2017



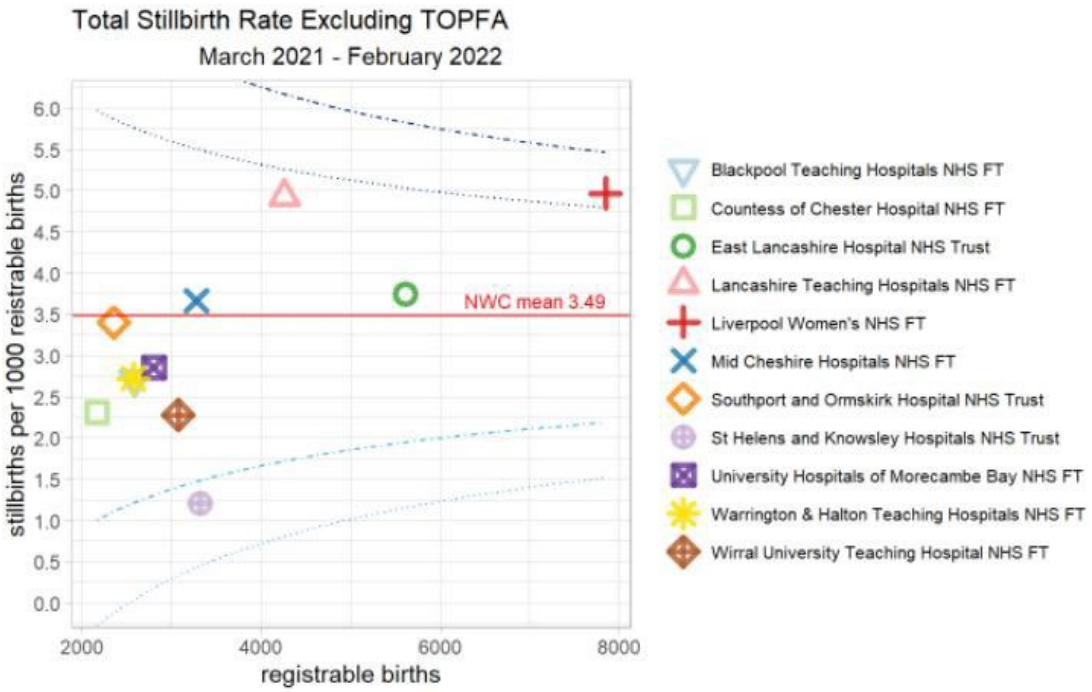
Data source LTHTR.

North West Coast Strategic Clinical Network Dashboard

The current North West Coast dashboard confirms that the incidence of stillbirth within the Trust is now within upper and lower control limits (within warranted variation) parameters when compared to North West Coast Trusts for the period March 2021 to February 2022 (Figure 30 below). To be noted, the overall stillbirth incidence appears to equate with the incidence within the regional comparator Liverpool Women's NHS Trust yet within the tolerance levels of the dashboard parameters.

As the current incidence of stillbirth remains slightly elevated compared to the adjusted rate calculated by MBRRACE the rate will continue to be monitored using the regional dashboard as the action plan collated in response to the outlier review is completed to monitor the impact of the actions undertaken.

Figure 30: North West Coast Strategic Clinical Network Maternity Dashboard – total stillbirth rate excluding termination of pregnancy for fetal abnormality (TOPFA). It should be noted Liverpool Women's is a direct comparator.



Data Source: NWC CN Maternity Dashboard
Missing or incomplete data (months): Countess of Chester Hospital NHS FT (1),
East Lancashire Hospital NHS Trust (1),
St Helens and Knowsley Hospitals NHS Trust (2)

Medical Examiner Service

The Medical Examiner (ME) service was introduced nationally in response to:

- Recommendations in the 2003 Home Office Fundamental Review of Death Certification and Investigation
- The Shipman Enquiry
- Recommendations of Robert Francis in the Investigation into Mid-Staffordshire NHS Foundation Trust
- The Kirkup Review of Deaths at Morecambe Bay Hospitals

The key principles have been to establish a system which provides independent scrutiny of deaths, improved accuracy of death certification, more consistent and appropriate referrals to HM Coroner, reduced rejections of medical certificates by the Registrar and improved focus on the bereaved by responding to and reducing concerns. The MEs are supported by Medical Examiner Officers (MEOs).

The MEs undertake the following tasks:

- Review the last admission episode
- Review the cremation forms
- Review the certified cause of death and discuss with the responsible clinical team if there are queries or causes of concern
- Speak to families and resolve any potential concerns

- Consider potential Coronial cases
- Review all deaths and escalate cases for Primary (SJR) Mortality Review or in cases of concern for a Rapid Incident or Serious Incident Review
- Facilitate early detection of any clinical governance issues through this additional layer of scrutiny into the review of deaths

The MEO under delegated authority scrutinises every death that occurs at both of our hospital sites, discusses any areas of concern the bereaved may raise and ensures that the correct medical certificate of cause of death (MCCD) is issued. Any concerns that require additional support are raised to either the attending doctor or the ME.

Table 24 Medical Examiner Service Performance 2020/21 data with 2021/22 awaited.

	Number	Percentage
Inpatient & ED Deaths	2,087	
ME Reviews of all Deaths	571	27%
MEO Reviews of all Deaths	1,332	64%
ME/MEO Reviews of all Deaths	1,903	91%
ME/MEO Conversations with Bereaved	1,386	66%
Referrals to Coroner	270	13%

Source: LTHTR data

As a result of the Covid-19 pandemic, there has been an increased demand on the MEs to complete the MCCDs and the cremation forms which has impacted on the capacity to undertake the detailed scrutiny of deaths. The MEO has however been able under delegated authority to support the reviews.

The Coroner's Officers hold conversations with the bereaved when the death is referred to HM Coroner and out of hours the families are supported by the General Office team and bereavement service.

The Registration Service has reported a reduction in the number of certificates rejected due to inaccurate or inappropriate causes of death. This rejection would normally result in the family having to seek a new MCCD from the hospital or a referral to HM Coroner's service.

It has also been reported that there has been a significant decrease in inappropriate cases being referred to HM Coroner. ME discussions with attending practitioners have resulted in clarity around the causes of death which has led to less patients being referred due to 'no cause of death identified'. Some cases have been referred to HM Coroner as a direct result of ME scrutiny. These include cases where concerns have been raised by families, substandard care has been identified or more commonly aspects of the events around death have meant that it is necessary to refer.

A second MEO has been recruited which has allowed for more support for the Lead ME and cover for annual leave. The increased capacity has also facilitated scrutiny of cases at Chorley and South Ribble Hospital. The national ME database system was introduced in April 2021 which replaced the current AMAT proformas. Resources have also been secured to start scoping the ME scrutiny of non-acute/community deaths, which it is hoped will result in the recruitment of two additional MEOs.

Review of Quality Performance – Experience of Care

PATIENT EXPERIENCE 2021-22 PERFORMANCE REPORT

Delivering excellent care with compassion relies on positive patient experiences within the organisation. Actively seeking to listen to the experience of patients, staff and families is a fundamental part of learning from lived experience. This year has seen the conclusion of our three year Patient Experience and Involvement Strategy 2018-2021. The next Patient Experience and Involvement Strategy 2022-2025 is being co-produced and will be launched in quarter 2 of 2022. The delivery of the Patient Experience and Involvement Strategy 2021-22 has been underpinned by a fully diverse and inclusive Patient Experience and Involvement Group. The group consists of governors, patient representatives, carers, voluntary sector organisations and staff members and throughout the year has continued to shape and prioritise the focus of improvement work. This group reports directly into the Safety and Quality Committee.

Metrics that are used to determine outcomes relating to experience include.

- Friends and Family Test numeric and narrative responses
- Complaints
- Parliamentary Health Service Ombudsman (PHSO) reviews
- Compliments and Thank You messages
- National patient survey results

A comprehensive Patient Experience and Patient Advice and Liaison Service (PALS) team function in partnership with teams across the organisation and aim to provide a patient focused service supporting improvement in all services in partnership with teams and in a proactive and responsive format.

Experience is tested as part of the STAR quality assurance process and includes a 15 step process involving laypeople (outside of Covid-19 conditions) and governors to speak to patients and test their experience of care. More than 75% of areas are now achieving a silver rated or above STAR outcome. STAR is a core metric of *Our Big Plan* and is measured and monitored in the Safety and Quality Committee and by the Board of Directors.

A number of patient engagement forums are facilitated across the organisation and for patients with protected characteristics, who are more likely to experience adverse outcomes, there are specific focused programmes of work to improve the experience of patients and families. Examples of this work include but are not limited to increasing the multifaith services, increase in the number of induction loops, introduction of patient contribution to case notes, creation of dementia corridors and outside therapeutic areas.

Complaints and Concerns

Table 25 Comparator data for Complaints 2015 to 2022

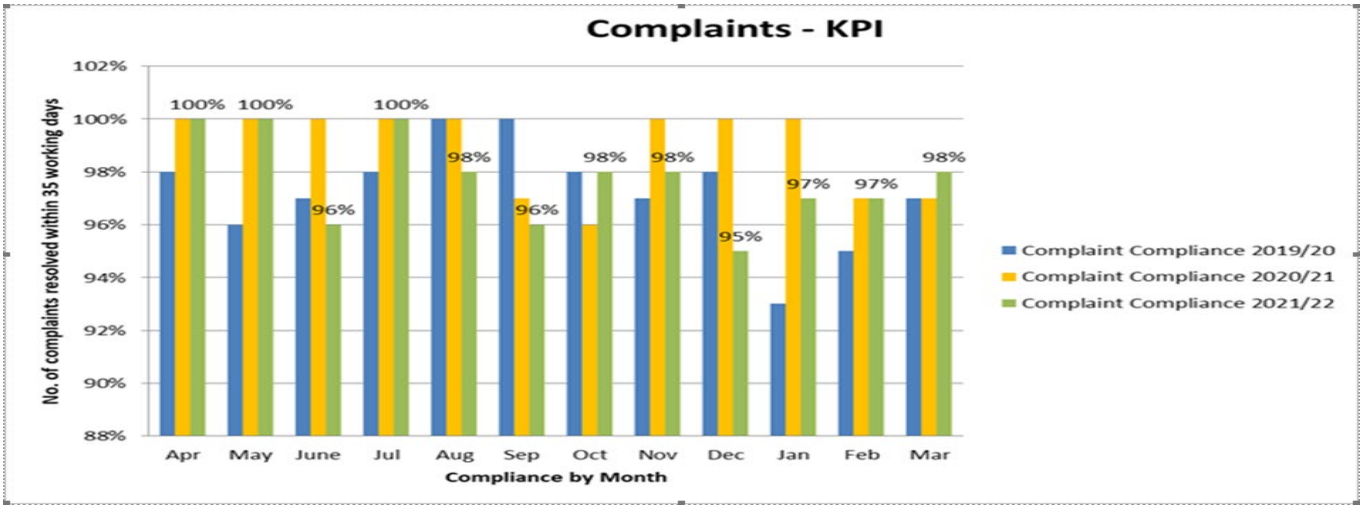
Year	Complaints received	Increase/reduction
2015-16	575	-4
2016-17	595	+2-
2017-18	553	-42
2018-19	710	+157
2019-20	457	-253
2020-21	361	-96
2021-22	580	+219

Source: LTHTR Datix

During 2021-22 the Trust received 580 formal complaints, an increase of 264 (10%) from 2020-21. The impact of the pandemic led to fewer complaints in the previous two years, and it is evident the number of complaints has now stabilised in comparison to the years pre-pandemic. The number of patients raising concerns relating to reduced visiting and extended waits on waiting lists has increased.

Of the 580 complaints received between April 2021 to March 2022, 509 (87.5%) related to care or services provided at the Royal Preston Hospital, 69 (12%) to care or services provided at Chorley and South Ribble Hospital and two (0.5%) to care or services provided by offsite services. In addition to the 580 complaints received, the Patient Experience and PALS team also responded to seven cases which were deemed to be outside of the timescale set out under the NHS Complaints Procedure.

Figure 31 Complaints answered within 35 days (April 2021 to March 2022)



Source: LTHTR Datix

Investigations that were undertaken into the 580 closed complaints concluded that 56 (10%) of the complaints had been upheld. 284 (49.5%) were partly upheld and 165 (28%) had not been upheld. The five (0.5%) remaining records were cases that were withdrawn, and 70 (12%) cases remain open.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 99% of complainants received an acknowledgement within that timescale where complaints were received into the Patient Experience and PALS team.

Second letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the year we received 27 second letters.

A total of 544 formal complaints were closed during the period 1 April 2021 to 31 March 2022 and 98% of complaints were closed within the 35-day timescale. Of note, the organisation is not mandated to respond within 35 days, however the standard set is to ensure that complainants receive timely responses. During 2021-22 the Patient Experience and PALS Team have dealt with a total of 1,749 concerns and 7,347 enquiries.

The implementation of the Governance and Risk Maturity Plan across the organisation has led to the introduction of Datix 2 (the governance reporting system) for patient experience. This will provide opportunities going forward to ensure that there is a more complete understanding of the themes and trends from all concerns, not only complaints.

Complaints by Division

Table 26 Number of Complaints by Division (April 2021 to March 2022)

Division	Number (%)	Division	Number (%)
Medicine	247 (42.5%)	Women and Children's Services	79 (14%)
Surgery	198 (34%)	Diagnostics and Clinical Support	48 (8%)
Estates and Facilities	2 (0.5%)	Corporate Services	46 (1%)

Source: LTHTR Datix

Themes from complaints

Communication is the most common cause for complaints, this has been compounded by the limited access families have experienced in the previous year. Steps have been taken to mitigate this for patients and families including the use of media however the impact has been most significant. The new Always Safety First Strategy includes communication and safety culture as core components of achieving safety and will introduce communication training as part of this. The Big Rooms feature patient stories to ensure the patient is in the room and central to the improvement work and where possible patients themselves will attend and share their experience first hand, increasing the impact of the experience and provide a driver for change and improvement.

Parliamentary Health Service Ombudsman (PHSO)

Complainants have the right to request that the PHSO undertakes an independent review into their complaint in instances where local resolution has not been achieved. Between the period 1 April 2021 to 31 March 2022 there were five cases referred to the PHSO; one was not upheld and four are ongoing. During this period, the PHSO sent final reports for four cases which were opened prior to April 2021 and the outcome of these were that three were not upheld and one was partly upheld. There were a further three cases referred to the PHSO prior to April 2021 which are still under investigation and a final decision is yet to be reached. Also, during this period a further two cases have been referred to the PHSO which are being

actioned through the PHSO's local dispute resolution process: one has been resolved and one is ongoing, and a meeting date is to be arranged.

Compliments

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2021-22 a total of 2,071 compliments and Thank You cards were received by wards, departments and through the Chief Executive's Office.

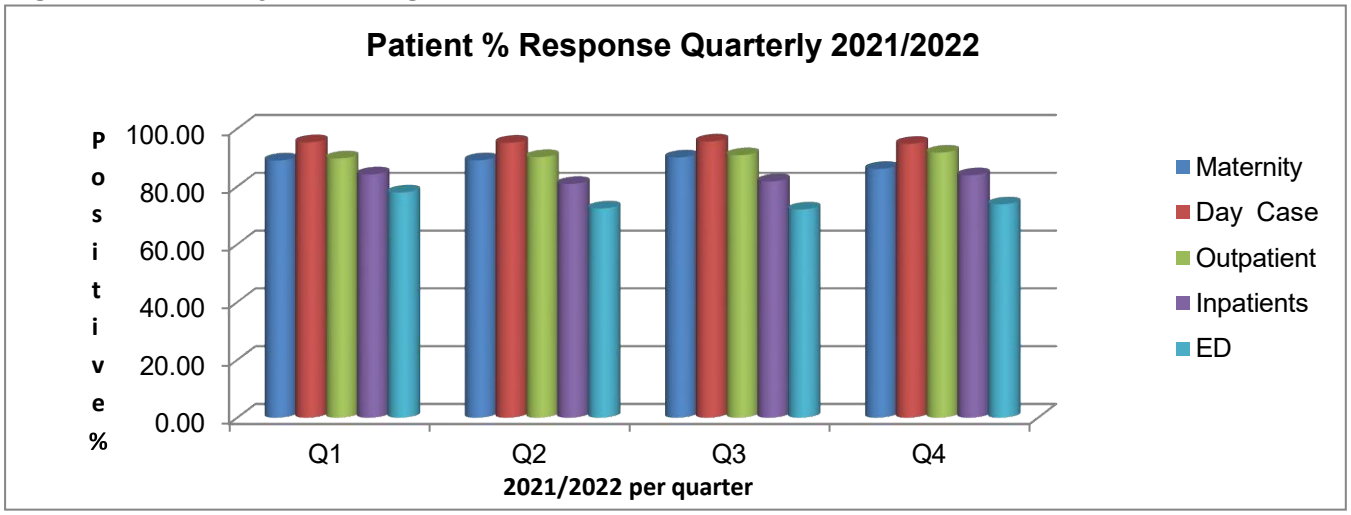
Patient experience feedback

Friends and Family Test (FFT)

The FFT is used as a national measure to identify whether patients would or would not recommend the services of our hospitals to their friends and family. FFT is reported at departmental level, to the Safety and Quality Committee and through to the Board of Directors. The national requirement is to report on the following areas:

- Maternity
- Day Case
- Outpatients
- Inpatients
- Emergency Department

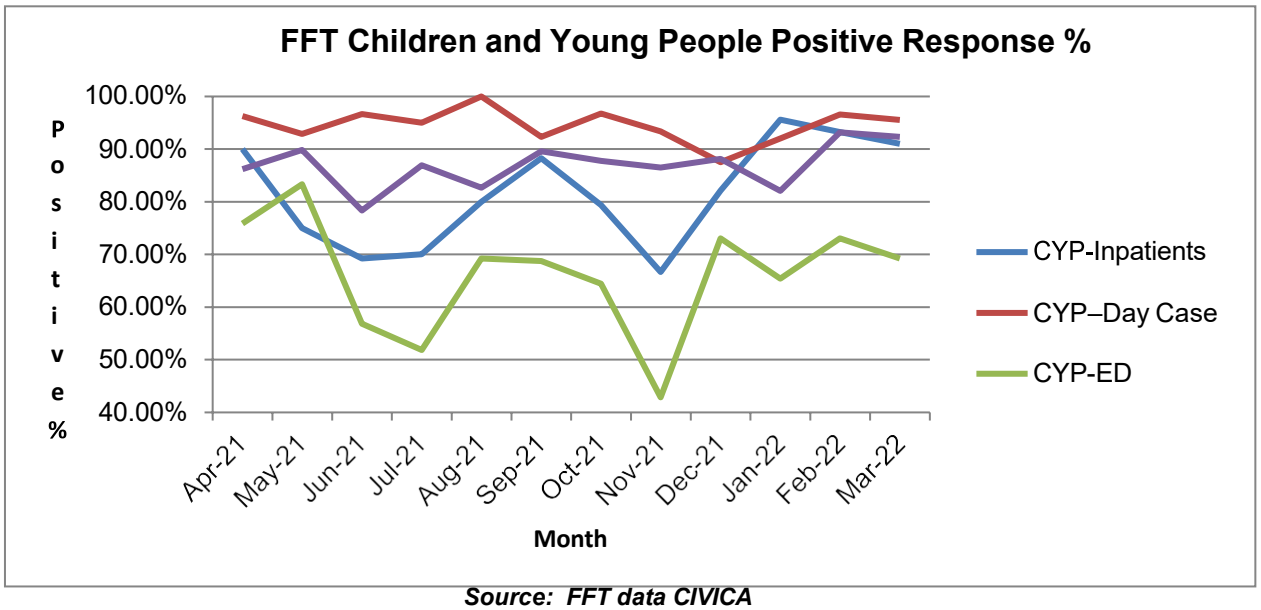
Figure 32 Quarterly percentage of positive responses (FFT)



Source: FFT data CIVICA

Historically, a target of 90% was set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department. Maternity achieved the target in Q3, day-case have consistently achieved in excess of 90% throughout the year, and outpatients have achieved the target for the past three quarters. Inpatients and the Emergency Department remained under the target percentage in all four quarters.

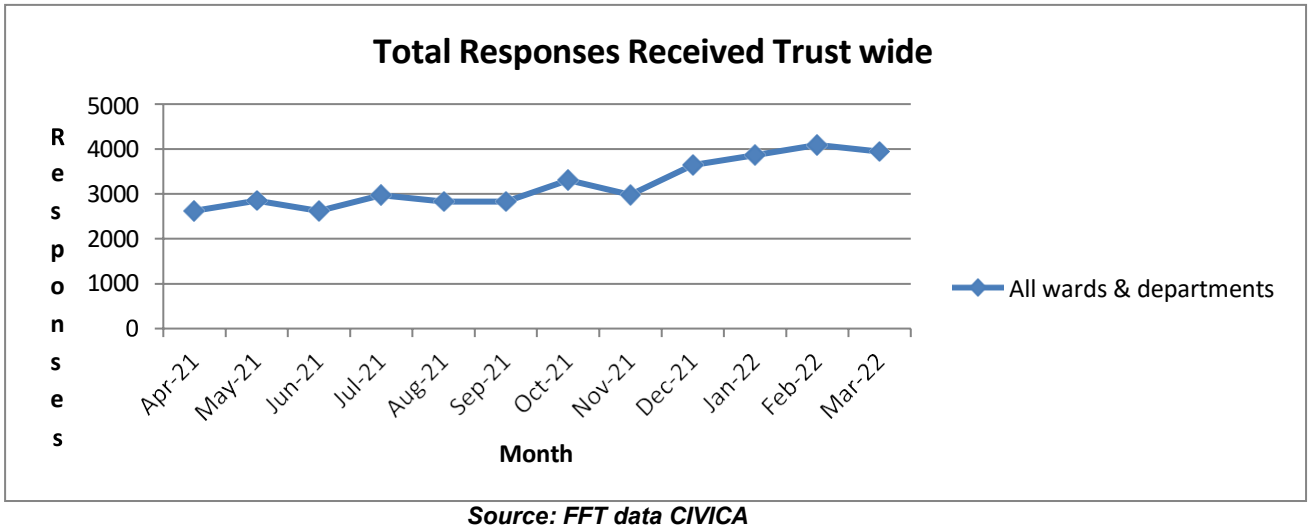
Figure 33 Children and Young People (CYP) quarterly percentage of positive responses (FFT)



Source: FFT data CIVICA

Although not a national requirement, the Trust undertakes surveys in children and young people's services to ensure an equitable approach to measurement of experience. The neonatal service has maintained a positive response rate of 100% throughout the year. Children within the Emergency Department have been adversely affected by increases in demand associated with Respiratory Synctol Virus (RSV). The department has increased in size and staffing numbers to reflect continued growth in demand. This is evaluating more positively alongside increasing the number of written responses provided on site now the Covid-19 restrictions have lifted.

Figure 34 Friends and Family percentage response



Source: FFT data CIVICA

The data above demonstrates an overall increase in responses. The number of responses for FFT has gradually increased over the last 12 months as paper responses and QR codes have been introduced. Since April 2021 to March 2022, the trust received 1,468 surveys completed using the QR codes/online links, 2,829 paper surveys, 3,684 telephone surveys and 36,128 SMS surveys. 30 bespoke surveys have been created in additional to the 15 FFT surveys.

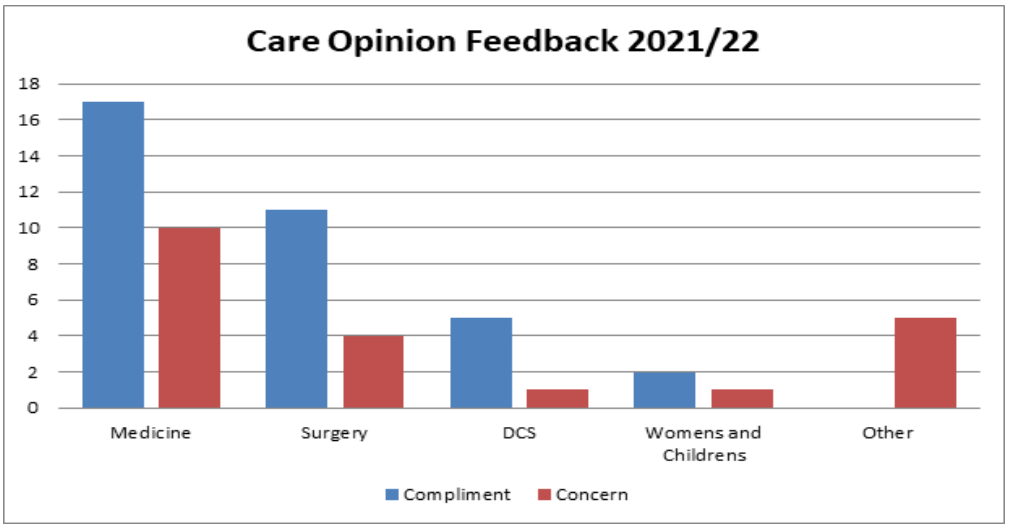
Care Opinion website (www.careopinion.org.uk)

Care Opinion is a place where patients can share their experience of health or care services and help make them better for everyone. It provides patients with the ability to post reviews for both Royal Preston (which includes Preston Business Centre) and Chorley and South Ribble Hospitals.

The Care Opinion website is monitored and responded to on a regular basis by the Patient Experience and PALS Team. All reviews are responded to in order to acknowledge them, provide assurance that their feedback will be shared and provide the Patient Experience and PALS Team contact details for those who wish their concerns to be raised or looked into further. All feedback and compliments are logged on Datix and shared with the relevant divisions and staff. A CCG quarterly quality report is produced from the reviews left on Care Opinion and shared with the Trust Governance team.

It is difficult to establish themes due to the low number of responses provided. During the past financial year, there have been a total of 57 reviews posted on the website consisting of 35 compliments and 22 concerns.

Figure 35 Care Opinion feedback



Health Inequalities

Mental Health, Learning Disabilities, Autism and Dementia

In recognition of the impact mental health, learning disabilities, autism and dementia may have on outcomes, work continues to provide specific focus on experience in these groups, which includes:

Mental Health:

- Development, consultation, and implementation of all age Mental Health Strategy (October 2021-2025) which notes patient experience as a commitment, aims to increase the skills and knowledge of the workforce in delivering patient centred care, and has a future vision for co-production with experts by experience.

- Development of the Children and Young Person Emotional Health and Wellbeing friends and family feedback form, in collaboration with the Paediatric teams.
- Implementation of the Mental Health Risk Tool and e-learning package which emphasises the need for collaboration with patients to understand triggers, helpful strategies, and a risk management plan.
- Continued drive for parallel assessment by the Mental Health Liaison Team (MHLT) and Children and Young People's Mental Health Services (CAMHS), documentation from our mental health services and joint working.

Learning Disability and Autism:

- Continued provision of easy read information (including a PALS leaflet) and social stories for patients – increasing the information shared to discuss care options, for patients to understand their health needs and access healthcare, making adaptions/easy read options to increase the patient's ability to consent and to reduce any anxieties the patient may have in their journey.
- Continued focus on use of the Hospital Passport (as noted as good practice by LeDeR 'Learning from Lives and Deaths – people with a learning disability and autistic people') and within the Special Educational Needs and Disability agenda.
- Identifying, flagging, and ensuring reasonable adjustments to best support patients – working across the Trust with specialist teams.
- Active multidisciplinary team involvement and linking into the CCG where care and treatment reviews and care, education and treatment reviews are indicated.
- Consultation in March 2022 at the Learning Disability Partnership Board (including multi-agency partners and people with a learning disability) into the Trust's proposed Learning Disability and Autism Strategy. With an agreed focus on re-establishing the 'Live Healthier, Live Longer' co-production groups, importance of Hospital Passports recognised and easy read to support decision-making (or Mental Capacity Act and best interest decision-making where capacity is questioned).
- The completion of the fourth year of NHSE/I Learning Disabilities Benchmarking Standards (results of 2021 not yet available, available patient feedback in 2020 – five out of 50 responses, 2019 – 16 out of 50 responses and 2018 – four out of 50 responses) which will guide completion of the Learning Disabilities and Autism Strategy 2022.
- Biannual review of learning disability deaths, specific learning from deaths shared and triangulated with national learning.

Dementia:

- Development, consultation, and implementation of the Dementia Strategy (July 2021-2025)
- Establishment of the Dementia Strategy Task and Finish Groups including people living with dementia, families, carers, governors, patient experience lead and multi-agency partners (for example, Alzheimer's Society and n-compass).
- Development of the Dementia Corridor to raise the profile of dementia, signpost and provide simple activity suggestions.
- Development of single-use activity packs during Covid-19, access to resources on the intranet, purchasing of dementia-friendly activities for the Emergency Departments at

both hospitals and specified medical wards, and the development of reminiscence therapy boxes (yet to be fully implemented in 2022) – with the message that activity maintains cognition and engagement provides a therapeutic environment.

National Patient Survey Results

There are several national surveys carried out across the organisation each year that provide a snapshot in terms of the experiences of patients. All surveys are administered externally by Picker UK and the results are provided once the CQC removes their embargo. The results are then published to ensure transparency of information. The surveys carried out in 2020 for Inpatients, Children and Young People and Maternity have all shown an improved position for the Trust.

National Picker Surveys Summary

The information below provides a narrative on the results of the four National Patient Picker Surveys that have been reported on during 2021-22. These are Maternity, Children and Young people, Inpatient and Urgent and Emergency Care. All areas show an improved position on the previous surveys.

Maternity Survey 2020

Lancashire Teaching Hospitals NHS Foundation Trust is ranked 11th out of the 66 Trusts nationally surveyed by Picker. This is compared to the 2019 survey, where the Trust was ranked 10th out of 63 Trusts surveyed. The response rate to the Maternity survey had a significantly higher response rate (59%) compared to the national average of 54%.

There were no areas identified where the Trust was significantly better than the 2019 survey.

The Trust was significantly worse than the last survey on the following five questions

- Not left alone when worried (during labour and birth) – 81% compared to 91% in 2019
- Treated with kindness and understanding (in hospital after birth) – 95% compared to 100% in 2019
- Had a telephone number for midwives (postnatal) – 94% compared to 99% in 2019
- Received help and advice about feeding their baby (first six weeks after birth) – 91% compared to 100% in 2019
- Received help and advice from health professionals about their baby's health and progress (first six weeks after birth) – 91% compared to 100% in 2019

The Trust was significantly better than the national Picker average on the following five questions

- Given a choice about where postnatal care would take place – 52% compared to 38%
- Given enough information about where to have baby – 89% compared to 78%
- Offered a choice of where to have baby – 92% compared to 80%
- Involved enough in decision to be induced – 93% compared to 83%

- Received support or advice about feeding their baby during evenings, nights, or weekends – 79% compared to 70%

The Trust was significantly worse than the national Picker average on the following five questions

- Received help and advice about feeding their baby (first six weeks after birth) – 81% compared to 86%
- Felt midwives aware of medical history (postnatal) – 72% compared to 73%
- Had a telephone number for midwives (postnatal) – 94% compared to 95%
- Felt midwives or doctor aware of medical history (antenatal) – 82% compared to 83%
- Felt midwives listened (postnatal) – 95% compared to 96%

Overall, the results for our Trust showed:

- 97% treated with respect and dignity (during labour and birth)
- 95% had confidence and trust in staff (during labour and birth)
- 96% involved enough in decisions about their care (during labour and birth)

Key theme summation

It is worth noting that percentage deterioration was around 3% points on the majority of the domains. There were 11 new measures introduced in the latest survey and the Trust performed above Picker average for 2021 on all the measures. Significant performance on the new measures was around providing information during hospital interventions. With a marked improvement on discharge without delay from 59.6% in 2019 to 66.3% in 2021 which is above the Picker average of 63.8%. Good progress regarding supporting patients with mental health interventions and providing information where the Trust performed above Picker average in the newly introduced outcome measure. The Trust performed significantly better in six domains and there were no significant differences in 46 areas as compared to other Trusts.

Children and Young People's Survey 2020

The Trust has seen an increase for the year 2020 in satisfaction of the parents, children and young people surveyed based on the 2018 survey. The Trust is ranked 31st out of the 67 Trusts nationally. This is compared to the 2018 survey, where the Trust was ranked 58th out of 66 Trusts surveyed. Parents rated experience of care as seven out of 10 or more and this is at par with the Picker national average.

The Trust was significantly better than the last survey on the following seven questions

- Parents had new members of staff introduce themselves – 97% compared to 92% in 2018
- Parent felt that Wi-Fi was good enough for child to do what they wanted – 81% compared to 57% in 2018
- Parent kept informed by staff about what was happening – 90% compared to 92% in 2018
- Parent had access to hot drinks facilities in hospital – 84% compared to 74% in 2018

- Parent felt that staff were available when child needed attention – 97% compared to 93% in 2018
- Parent felt hospital room or ward was clean – 99% compared to 96% in 2018
- Child felt hospital was quiet enough to sleep – 86% compared to 68% in 2018

The Trust was significantly worse than the last survey on the following question

- Parents felt that there was not enough for their child to do – 73% compared to 91% in 2018

The Trust was significantly better than the Picker average on the following two questions

- Parent had access to hot drinks facilities in hospital – 84% compared to 78%
- Parent able to prepare food in hospital – 70% compared to 41%

The Trust was significantly worse than the Picker average on the following question

- Parent rated overnight facilities as good or very good – 50% compared to 69%

Overall, the results for our Trust showed:

- 93% parent felt well looked after by staff
- 93% child felt well looked after in hospital
- 94% parent felt staff agreed a plan with them for child's care

Key theme summation

Parents rated experience of care as seven out of 10 or more and this is at par with the Picker national average. This was noted to be an improvement from the previous survey in comparison from 86% to 91.8% in patient experience. The Trust performed significantly better in 21 domains and there was no significant difference in 62 areas as compared to other Trusts. The percentage improvement was around 2% on most of the domains with a 1% deterioration in the domains which had reduced outcomes. Improvement on children feeling the ward was suitable for their age from 92.5% to 97.8% compared to previous survey results. There is a significant deterioration in parents feeling that there are enough therapeutic activities from 90.6% to 73.3% compared to previous survey results. This has moved the organisation below the Picker national average of 79.6%. Domain of therapeutic activities witnessed a significant drop in satisfaction.

Wi-Fi facilities were noted to be 80.8% and above the Picker national average of 69.9%. This is a significant improvement from a percentage score of 57% in the previous Trust survey. Overnight facilities were noted to be below the national Picker average. However, in terms of promoting better sleep, there was a marked improvement from 68.3% to 85.7% compared to the previous survey. This is still below the national Picker average of 87.8%. After care arrangements following discharge were still below the Picker national average although the Trust achieved about 2% increase in most areas under the domain compared to previous survey.

Urgent and Emergency Care Survey 2020

The results demonstrate an improved position for the Emergency Departments compared to the last National Picker survey in 2018. The Trust is ranked 34th out of 66 Trusts nationally. This is compared to the 2018 survey, where the Trust was ranked 47th out of 69 Trusts surveyed. Patients rated experience of care as seven or more out of 10 and this is above the Picker national average.

The Trust was significantly better than the last survey on the following three questions

- Waited under an hour in the ambulance – 97% compared to 89% in 2018
- Waited under an hour in A&E to speak to a doctor/nurse – 90% compared to 82% in 2018
- Staff helped control pain – 90% compared to 84% in 2018

The Trust was significantly worse than the last survey on the following question

- Right amount of information given on condition or treatment – 74% compared to 83% in 2018

The Trust was significantly better than the Picker average on the following five questions

- Understood results of tests – 99% compared to 97%
- Saw the cleaning of surfaces – 82% compared to 74%
- Saw tissues available – 83% compared to 78%
- Did not feel threatened by other patients or visitors – 96% compared to 93%
- Staff discussed transport arrangements before leaving A&E – 61% compared to 50%

The Trust was significantly worse than the Picker average on the following question

- Spent under 12 hours in A&E – 88% compared to 94%

When rated against all 126 Emergency Departments the Trust's overall scores demonstrated 'about the same' therefore comparable to similar organisations.

Overall, the results for our Trust showed:

- 88% rated care as seven or more out of 10
- 97% treated with respect and dignity
- 95% doctors and nurses listened to patients

Key theme summation

Patients rated experience of care as seven or more out of 10 and this is above the Picker national average. This was noted to be an improvement from the previous survey – 80% to 88.2% versus the Picker average score of 85.6%. The Trust performed significantly worse in five domains and there was no significant difference in 38 areas as compared to other Trusts.

The shift on improvement or deteriorated areas was plus or minus 3% in the majority of areas. It is worth noting that there were 16 domains measured in the current survey that were not

indicated in the previous year. The current survey indicated that 90.1% of patients waited under an hour to speak to a nurse/doctor compared to 81.9% from the previous survey. This is above the national Picker average of 86.6%. This is mirrored positively with 96.5% of patients reporting that they waited under an hour in the ambulance compared to 89.2% in the previous survey. This is above the national Picker average of 95.3%.

Right amount of information being given to patients deteriorated from 82.6% to 74.2% with the Picker national average percentage score at 77.5%. A similar percentage drop on patients being given test results before discharge from 82% to 76% which is below the Picker average score of 80.4%. Pain management satisfaction witnessed a percentage improvement from 84.2% to 90.3% which is above the Picker national average. The Trust performed better in all domains on cleanliness compared to the national Picker average, scoring higher in comparison to the previous survey. Patients on the whole reported that they felt safe from other patients and visitors with a score above the national Picker average.

Positive satisfaction was also noted on social distancing as the Trust score was above the national average. Patients scored the Trust low on information provision as compared to the national average on medication, symptoms and after care upon discharge. Patient transport arrangements after discharge were scored above the national average with 61.2% against the Picker national score of 49.6%.

The Trust performed low in comparison to other Trusts on patients waiting under 12 hours in A&E with a score of 87.7% compared with the national Picker average of 94.1%. However, the Trust performed highly on supporting patients whilst waiting, with a score of 65.9% compared to national average of 58.8%. Positive results were also noted in the domain of dignity and respect where the Trust performed above the national average.

Inpatient Survey 2020

The Trust is ranked 61st out of the 71 Trusts surveyed by Picker. This is compared to the 2019 survey where the Trust was ranked 51st out of 77 Trusts surveyed. This year has seen a reduction in satisfaction of the inpatients surveyed based on last year. It is worth noting that some of the benchmarking asked this year was not part of the survey in 2019 survey. Patients rated quality of care as 11% compared to 8.1% from the previous survey; this is below the national average of 13.7% although it was an improvement for the organisation. Experience of care was rated at 80.2% which is a slight drop from the previous survey of 82.8% which remains lower than the national average of 85.3%.

The Trust was significantly better than the last survey on the following two questions

- Nurses answered questions clearly – 97% compared to 94% in 2019
- Given written/printed information about what they should or should not do after leaving hospital – 72% compared to 64% in 2019

There were no areas identified as significantly worse than the 2019 survey. There were no areas identified as significantly better than the Picker average.

The Trust was significantly worse than the Picker average on the following 4 questions:

- Got enough help from staff to eat meals – 77% compared to 85% in 2019
- Staff did not contradict each other about care and treatment – 65% compared to 66% in 2019
- Right amount of information given on condition or treatment – 77% compared to 80% in 2019
- Rated overall experience as seven or more out of 10 – 80% compared to 83% in 2019

Overall, the results for our Trust showed:

- 80% rated experience as seven or more out of 10
- 98% treated with respect or dignity
- 98% had confidence and trust

Key theme summation

The percentage improvement was around plus or minus 2% on the majority of the domains. With a plus or minus 1% deterioration in the domains which had reduced outcomes. Patients rated quality of care as 11% compared to 8.1% from the previous survey: this is below national average of 13.7% although it was an improvement for the organisation. Experience of care was rated at 80.2% which is a slight drop from the previous survey of 82.8% which remains lower than the national average of 85.3%.

There were 17 more domains rated in the current survey where the Trust performed marginally lower than the national average with a percentage gap of about plus or minus two points.

The Trust gained a marginal improvement on dignity, respect, and confidentiality although the organisation scores are still below the national Picker average. Patients rated the Trust the same on the discharge support plan which remains below the national average of 78.4% when compared to year-on-year for the Trust of 74.4%. The survey indicated a below national average score year-on-year on staff contradicting each other on information regarding treatment and care. The Trust continues to make improvements on food satisfaction although it remains below national average at 63.5% compared to the Picker average score of 70.2%. Patients rated the organisation below national average on promoting better sleep. This was mirrored in the rating score on staff providing information on why patients need to move wards at night as it remains below the national average. Staffing numbers were rated as an improvement from the previous year although it remains below the national average.

Table 27 Summation of results

Survey title	Position 2021	Previous position	Number of areas improved comparison to previous survey	Number of areas deteriorated in comparison to previous survey
Maternity	11 out of 66 Trusts	10 out of 63 Trusts	5	35
Children and Young People's Survey 2020	31 out 67 Trusts	58 out of 66 Trusts	41	17
Urgent and Emergency Care Survey 2020	34 out of 66 Trusts	47 out 69 Trusts	11	15

Inpatient Survey 2020	61 out 71 Trusts	51 out 77 Trusts	14	9

National Cancer Patient Experience Survey

The Cancer Patient Experience Survey 2020 is the tenth iteration of the survey first undertaken in 2010. The Cancer Patient Experience Survey 2020 published November 2021 provides analysis of the experiences of care provided for adults aged 16 or over with a confirmed diagnosis of cancer, discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment, in the months of April, May and June 2020. The survey is carried out annually with the previous Cancer Patient Experience Survey undertaken in 2019.

The Cancer Patient Experience Survey 2020 differs from all previous years in that it involved only 55 NHS Trusts as it was voluntary due to the pandemic. As not all NHS Trusts participated in the survey no comparisons to scores nationally are shown. Out of 33,266 people, 19,610 people responded to the survey, yielding a response rate of 59%. The Trust response rate was 59%.

A total of 52 questions were used in the 2020 survey, of these 47 can be compared to questions in 2019. Compared to the 2019 survey rating of 8.9, the Trust has maintained a satisfaction score of 8.9 overall, however, Urology scored 9.4.

The following questions were included in phase one of the Cancer Dashboard developed by Public Health England and NHS England:

- 89% rated overall care as very good/good
- 80% patients definitely involved as much as they wanted in decisions about care
- 93% patients were given the name of a Cancer Nurse Specialist (CNS) who would support them
- 88% patients found it very or quite easy to contact their CNS
- 90% patients always felt they were treated with respect and dignity while in hospital
- 97% patients were told by staff who to contact after leaving hospital

When comparing the results to 2019 the Trust scored significantly higher in four questions:

- Patient given a care plan
- Confidence in ward nurses treating them
- Nearly always enough nurses on duty
- Hospital staff asked the patient what name they preferred to be called by

When comparing the results to 2019 the Trust scored significantly lower in one question:

- Hospital staff told patients they could get free prescriptions

Actions taken to develop services experienced by patients with cancer

- Each multi-disciplinary team to complete annual action plans. Monitoring of the action plans will be through the tumour site operational meetings and the Network Site

Specific Group (NSSG) CNS meetings, overseen by the Trust Lead Cancer Nurse. Any tumour specific actions are added to the Quality Surveillance Work Programme to facilitate change.

- Due to low numbers of responders, local surveys are performed every two years for Sarcoma and Brain to enable monitoring on an ongoing basis.
- Macmillan Right by You manager in post to ensure personalised care in cancer has been rolled out
- All Patients have access to support/CNS at diagnosis.
- Holistic needs assessments are offered to all patients at diagnosis and post treatment.
- Treatment summaries are provided post treatment.
- Patient stratified follow up pathways implemented for Breast, Colorectal and Urology and for all tumour sites by 2024 – plan being developed with the Cancer Alliance.
- Development and expansion of the Macmillan Cancer Information and Support Service, (MCISS) has been completed to improve patient access to information and support and ensure information and support is available to all inpatients and day surgery patients, improving educational and training for staff in these areas. Increased support available for all patients for employment and financial advice provided by the MCISS. This will need to include promotion of free prescriptions for patients.

Summary of actions to improve patient experience

- Recruit and embed Patient Safety Partners in order to provide patients with a voice as part of the Always Safety First programme of work.
- Continually embed Always Safety First Live Patient Feedback and general live feedback initiative
- Sharing of patient lived experience in team meetings
- Quarterly complaints quality review
- Embrace and continually develop Patient Experience and Involvement Group
- Continuously develop and evolve to always incorporate what matters to patients/carers in the STAR Quality Assurance Framework
- Promote co-production via Patient Contribution to Case Notes project
- Participate in the Imperial College project
- Continue progress in supporting women in the maternity division with mental health interventions
- Therapeutic activities review is required in the Children and Young People's division to promote engagement.
- Ensure real-time feedback is gathered and reported upon within all inpatient wards
- Demonstrate change through continuous improvement from the benchmarking of lost property
- Develop a Patient Experience and PALS Newsletter to share feedback and learning
- Develop an e-learning package for leaders to understand the principles of local resolution, concerns, and complaints and what a good response looks like
- Ensure communication of involvement projects is delivered in a structured approach to all Trust staff and accessible to everyone and in all areas
- Extend involvement in the local community and through support groups/forums to learn what patients want and achieve improvements

- Continue to provide forums for patients, carers, and families to learn and act on information
- Focus on projects with diverse communities, appreciating differences with a view to delivering a positive patient experience

MAJOR SERVICE DEVELOPMENTS

Despite the well-documented challenges presented by the Covid-19 pandemic, we continued to implement a number of major service developments during 2021-22. This is testament to the resilience of our hard working and dedicated staff and key partners who have remained committed to improving the care the Trust delivers to our patients and the experience they received. The major service developments during the past year are outlined below.

Surgical Enhanced Care Unit (SECU) at Chorley and South Ribble Hospital

In May 2021, the trust opened the Surgical Enhanced Care Unit (SECU) at Chorley and South Ribble Hospital. It is important to keep surgical patients Covid-19 free and SECU offers an elective 'green stream' for patients whose operations have been postponed due to the pandemic. This means that patients isolate at home before their operation, are tested upon arrival and throughout their stay. The unit comprises four beds and operations focus on orthopaedic patients as well as some other specialities.

The unit provides more optimal levels of monitoring for patients after surgery than would be expected on a postoperative ward but who do not require admission to critical care. SECU patients therefore get enhanced care, whilst postoperative critical care beds are preserved for those who really need them.

New renal services

Our Trust is responsible for providing renal services across Lancashire and South Cumbria. Accessibility and travel times is an important issue for patients and the Trust has therefore focused on providing more local facilities.

In July 2021, the Trust opened the Furness Renal Centre in Ulverston, bringing both haemodialysis treatment and outpatient clinic facilities closer to home for patients. Read more on the Trust website.

Shortly after, in October 2021, the Trust opened the John Sagar Renal Centre in Burnley, named in tribute to East Lancashire gentleman John Sagar, who was the former Chair of the Lancashire and South Cumbria Kidney Patients Association. Read more on the Trust website.

The Trust has also recently partnered with East Lancashire Hospitals NHS Trust to build a new renal dialysis centre on the Royal Blackburn Teaching Hospital site to improve services in East Lancashire. The purpose-built facility will feature 24 dialysis stations as well as clinical facilities. More about the development is available on the Trust website.

Ribblesdale refurbishment

In October 2021, the Trust opened Rosemere Cancer Centre's new 24-bed Ribblesdale Ward at Royal Preston Hospital.

The Ribblesdale Ward is the only inpatient oncology-specific ward in Lancashire and South Cumbria and supports patients with a wide range of clinical needs and end of life care. The ward was transformed after receiving funding of over £1m from the Rosemere Cancer Foundation following its hugely successful 20th anniversary appeal.

The state-of-the-art ward consists of shared and single bedroom spaces for patients being cared for by a specialist cancer team, with additional areas for relatives to visit their loved ones. Nature-inspired interiors will promote a healthy recovery and positive wellbeing through bespoke wood designs that feature back-lit art panels, floor vectors, and skylights that can be tailored to the time of day. More about the development is available on the Trust website.

Chorley and South Ribble Hospital Day Case Theatres

In November 2021, the Trust opened three new day case theatres at Chorley and South Ribble Hospital. The new theatres, which now make nine in total, are a much welcomed addition to the site and will help make inroads for patients who are currently awaiting elective procedures.

The multi-million pound project, developed by construction company Tilbury Douglas, has already welcomed many patients, with many more scheduled for treatment over the coming months.

The theatres will treat patients from across Lancashire and South Cumbria for a range of surgical specialty day case procedures such as Orthopaedic, Plastic Surgery and General Surgery. Read more on the Trust website.

Lancashire Eye Centre

Following a multi-million pound investment, the Trust was delighted to officially open our new Ophthalmology development at Chorley and South Ribble Hospital in December 2021. Known as the Lancashire Eye Centre, this modern technologically advanced facility provides increased capacity to patients across Lancashire and South Cumbria including urgent and emergency clinics, cataract services and all other specialist ophthalmic services including glaucoma, retina, paediatric, neuro-ophthalmic, oculoplastic and cornea.

Lancashire Eye Centre contd.

The three-tier building includes a dedicated outpatient and diagnostic space as well as three additional theatres to provide extra capacity for patients requiring a variety of day case procedures.

The new unit has been designed with the patient experience at the forefront. The various segments of the building are even colour coded to ease patient navigation and improve accessibility for those who need additional support. Read more on the Trust website.

Nightingale Surge Hub Preston

Originally planned to deal with a potential surge in the number of cases of the Omicron variant of Covid-19, it was agreed with NHS England that Preston's Nightingale Surge Hub would open in January 2022 to help alleviate sustained and severe pressures and high bed occupancy across the Lancashire and South Cumbria ICS.

The hub is a high quality and well equipped space, which provides care for low acuity patients awaiting discharge who do not have Covid-19.

With the additional bed base allowing us to free up space within Lancashire's emergency departments and within its hospitals, the use of the facility was extended from the initial three month period until the end of June 2022. Read more on the Trust website.

Covid-19 Vaccination Programme

Following the opening of our original vaccination hub at Royal Preston Hospital on 8 December 2020, our services have expanded to delivering doses from Chorley and South Ribble Hospital and from February 2021, St John's Vaccination Hub in Preston.

Throughout 2021-22, teams from multi-disciplinary divisions across Lancashire Teaching Hospitals have helped to deliver over 100,000 Covid-19 vaccinations from first doses to fourth doses.

Countless staff and volunteers have worked incredibly hard to deliver the service to ensure everyone who wishes to receive a Covid-19 vaccine is able to receive the vaccine at a convenient location.

Staff Survey and Recommendation of Our Care

Improving staff experience continues to be a high priority for us, particularly given the operational challenges the organisation has experienced during the ongoing pressures in relation to the Covid-19 pandemic. The NHS Annual Staff Survey provides us with vital feedback about the experience of our workforce, enabling us to build on what is working well for them, and learn from and address the areas that are causing dissatisfaction. The response rate to the 2021 survey was 45%, which was in line with the national average.

The survey provides us with an overall staff engagement score which is calculated using the results for nine key questions around motivation, advocacy, and involvement. In the 2021 survey our staff engagement score was 6.8 (on a scale of 0 to 10, with 0 being the lowest and 10 being the highest) this is 0.2 points lower than our score in 2020 where the Trust achieved a score of 7.0.

Across the nine questions that measure staff engagement the Trust scored above the national average for five of the nine items, scoring below on the remaining four. The Trust scored at the national average for feelings of involvement, above the national average for motivation, however below the national average for advocacy. Our advocacy score dropped by 0.4 points in 2021 compared with results in 2020.

There are three questions which measure advocacy as detailed in table 28 below:

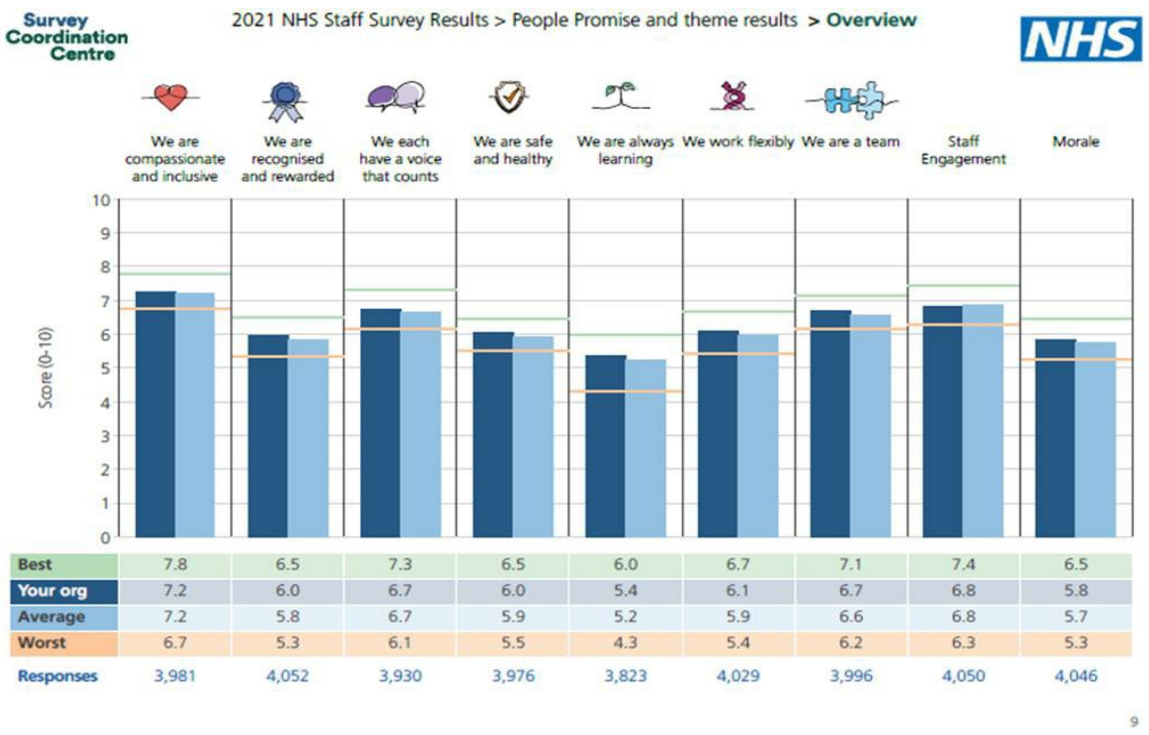
Table 28 NHS Staff Survey – Recommendation of the Trust

ADVOCACY	7.0	⬇ 6.6	6.8
Care of patients/service users is my organisation's top priority.	78.8%	⬇ 72.6%	**75.5%**
I would recommend my organisation as a place to work.	63.6%	⬇ 56.2%	**58.4%**
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	69.1%	⬇ 61.9%	**66.9%**

Source – National Staff Survey

Figure 36 below details the national benchmarking performance, illustrating our performance against each of the elements which make up the NHS People Promise. In summary the Trust has performed at or above the national average for all nine of the people promise elements in 2021: this is the first time the Trust achieved this. Whilst the Trust was not yet reaching the aspiration of being the best in the NHS, the Trust has a positive level of engagement and satisfaction to move forward from.

Figure 36 NHS Staff Survey Results Bar Graph



Source – National Staff Survey

Unlike in previous years, the Trust initiated engagement activities with regards to the themes arising from the NHS National Staff Survey earlier on in the cycle beginning in late February until early April 2022. Organisational Development carried out three rounds of engagement activities with over 550 colleagues sharing their thoughts and ideas. Carrying out these events in quick succession enabled us to demonstrate integrity and responsiveness in the feedback loop, only sharing colleague feedback and inviting colleagues to participate in prioritisation of those areas they had identified as important for us to progress. This engagement was supported through a rolling communications programme, which also sought to align the staff survey to the development of the new Workforce and Organisational Development Strategy and the re-launch of *Our Big Plan*.

To bring about improvement to levels of colleague engagement and their satisfaction with regards to their experience of work, a Staff Survey Action Plan has been developed which is aligned to the Workforce and Organisational Development Strategy 2022-2025. Divisional Action Plans which respond to local staff survey results will also be aligned to the Workforce and Organisational Development Strategy and Our Big Plan Strategy Refresh.

Quality Assurance

Our Quality Account has presented the data, information and assurance required by NHSI. The Trust has provided information related to the statutory core performance indicators and assurance on our data quality. The Trust has presented progress with our key priorities for 2021-22 which were stated in the 2020-21 Quality Account and highlighted new priorities for 2022-23 which align to *Our Big Plan*. The Trust has presented a review of activity in relation

to safety, effective care and patient experience which are aligned to the ambitions and risk appetite of the Trust.

Our Safety and Quality Committee promote a safety and quality culture in which staff are supported and empowered to improve services and care. The Committee provides the Board of Directors with assurance on the patient experience and outcomes of care by:

- Ensuring that adequate structure, processes, and controls are in place to promote safety and excellence in the standards of care and treatment.
- Monitoring performance against agreed safety and quality metrics and ensuring appropriate and effective responses occur when indicated.
- Ensuring compliance with NHSI and relevant CQC standards.

Trust Governors continue to be actively supportive of the Trust's quality improvement activities and continue to play a major part in providing assurance by participating in STAR and other quality assessments as well as attending our Patient Experience Improvement group.

Our Governor involvement in the New Hospitals Programme has been hugely valued and much appreciated by the Trust. Our Governors also continue to offer valuable challenge and assurance as well as contribute to significant environmental improvements for patients through use of their charitable fund.

Our Quality Account for 2021-22 has provided assurance of the performance and ongoing activity which promotes patient safety, effective care, and excellent experience.

Annex 1:

Statements from External Stakeholders

Statement from the Lancashire County Council Health Scrutiny Committee re: Quality Accounts for 2021-22

Feedback outstanding at time of publication.

Healthwatch Lancashire
Response to Lancashire Teaching Hospitals NHS Foundation Trust Quality Accounts Report for 2021-22

Leyland House
Lancashire Business Park
Centurion Way
Leyland
PR26 6TY
Tel: 01524 239103
www.healthwatchlancashire.co.uk

Christine Morris
Associate Director of Safety and Learning
Lancashire Teaching Hospitals NHS Trust
Sharoe Green Lane
Fulwood
Preston
PR2 9HT

Dear Christine,

Healthwatch Lancashire
Response to Lancashire Teaching Hospitals NHS Trust
Quality Account Report for
2021-22

Healthwatch Lancashire is pleased to be able to submit the following considered response to Lancashire Teaching Hospitals NHS Trust Quality Account Report for 2021-22.

Part 1: Chief Executives Statement

We acknowledge that the Pandemic has presented many challenges and note the Trust has strengthened partnership working and adopted a more collaborative approach to effective and efficient acre and treatment.

Part 2:

Recognising that the pandemic has adversely impacted on services, particularly waiting times for appointments and surgery we welcome the priority given to reducing long-term waits. We are also pleased to see the work that has been undertaken to achieve 100% compliance regarding Child Safeguarding procedures and the launch of the Trust's Always Safety First Strategy.

The increase in service provision is also commendable. The opening of the new Furness Renal Centre in Ulverston bringing dialysis treatment closer to home for patients in South Cumbria has been very much welcomed. Our colleagues at Healthwatch Cumbria have received very positive feedback. We know from our own experience that the Surgical Enhanced Care Unit at Chorley and South Ribble Hospital has also been well received.

We welcome the clear presentation of performance regarding the Big Plan priorities for improvement, the comprehensive reporting of the Experience of Care, the specific focus on Mental Health, Learning Disabilities, Autism and Dementia and the actions to improve patient experience.

We would compliment the Trust for the detailed reporting of Freedom to Speak Up and the seven key priorities to strengthen and embed 'Speak Up Listen Up Follow Up' across the Trust.

We believe that the Trust has met the NHS England Requirements and in the view of Healthwatch Lancashire the information in the Report is consistent with our experiences.

Summary

Overall, we would say that this is a well-balanced document, aims and outcomes clearly described and comprehensive actions being taken to further improve patient treatment and care. We welcome these and remain committed to finding ways of supporting the Trust to achieve its aims.

Kerry Prescott

Kerry Prescott

Manager

Healthwatch Lancashire

Chorley and South Ribble and Greater Preston Clinical Commissioning Groups' Response to the Lancashire Teaching Hospitals NHS Foundation Trust Quality Account 2021-22

Chorley and South Ribble Clinical Commissioning Group
Greater Preston Clinical Commissioning Group

Your Reference: LTH Quality Account 21/22
Our Reference: JR/DG/TS LTHQA2122

Contact: Jacquie Ruddick
E-mail: Jacqueline.Ruddick@nhs.net

15 June 2022

Christine Morris
Associate Director of Safety And Learning
Lancashire Teaching Hospitals NHS Trust
Sharoe Green Lane
Fulwood
Preston
PR2 9HT

NHS Chorley and South Ribble CCG
NHS Greater Preston CCG
Chorley House
Lancashire Business Park
Centurion Way
Leyland
Lancashire
PR26 6TT

Dear Christine,

CCG Response to Lancashire Teaching Hospitals NHS Trust Quality Account 2021/22
Greater Preston CCG would like to take this opportunity to comment on the annual Quality Account from Lancashire Teaching Hospitals NHS Foundation Trust. As in previous years, the account has been shared with the CCG's Quality and Performance Committee and will be shared with associate commissioners.

The CCG would like to acknowledge the continued effort that the Trust has made in relation to their response to the challenges of the ongoing COVID-19 pandemic. In particular, we note the courage, dedication and resilience demonstrated by all staff groups in all services provided by the Trust. Their actions and behaviours have supported service users and carers through an incredibly difficult period for the NHS.

The Trust's Care Quality Commission (CQC) overall rating has remained as 'requires improvement' since November 2019. Although paused earlier in the pandemic, the CQC restarted inspections, prioritising NHS Trusts with ratings of 'inadequate' and 'requires improvement'. During 2021/22, the Trust had a number of CQC engagement meetings to discuss Infection Prevention and Control (IPC) arrangements, the Emergency Department and the Nightingale COVID-19 surge hub, as well as more general issues in relation to regular reporting to the CQC. The CCG note the amount of improvement work undertaken by the Trust since the last inspection in 2019 and is keen to see all the CQC's recommendations implemented.

In March 2022, the CQC commenced an urgent care system inspection in Lancashire and South Cumbria, involving the Trust alongside GPs, Northwest Ambulance Service, nursing homes, urgent care, mental health, and acute hospital providers. The CCG looks forward to supporting the system further once the report is published.

In 2021/22, Trust performance in relation to NHS Constitutional targets was adversely impacted by operational pressures and infection prevention control measures due to the pandemic. The need to cease some elective activity in response to peaks in the pandemic and prioritise only urgent elective activity, as part of the elective restoration plan, introduced additional pressures on the Trust. As a consequence, the Trust failed to achieve several key indicators including, the 4-hour A&E target, the 18-week referral to treatment target, the 6-week diagnostic target and key cancer (2-week waits and 62-day treatment) targets. Notably, there has been a significant increase in the number of patients waiting over 52 weeks to start treatment. In response, the Trust has agreed a new process to ensure patients are clinically prioritised for review by utilising artificial intelligence. The CCG is keen to see further improvement work in the coming year, particularly regarding reducing long-term waits and in collaborating and reviewing good practice by other Trusts to achieve this objective.

The CCG would also like to recognise all the challenging work that has been undertaken, especially the launch of the Trust's Always Safety First Strategy, and the Trust's response to the NHS National Patient Safety Strategy. The CCG was also pleased to note other improvement work, including:

- Child safeguarding procedures demonstrated 100% compliance throughout 2021/22, confirming that the 'think family' message is fully embedded in practice.
- The Safer Sleep assessment has been rolled out within ED, Maternity, Neonates and Paediatrics to ensure that 'every contact counts' and that parents and carers repeatedly receive the important messages around Safer Sleep.
- The development and implementation of the Perinatal Mental Health Pathway, reducing the length of stay for women with mental health concerns following the birth of their baby.
- The revision of policies and pathways around improving nasogastric tube insertion safety, which has resulted in no reported nasogastric placement Never Events for over 17 months.

The CCG commends the Trust's commitment to improving the care it delivers to our patients and the experience they received, despite the challenges that the last few years have brought. It is important to acknowledge increased service provision, including:

- The opening of the Surgical Enhanced Care Unit (SECU) at Chorley and South Ribble Hospital.
- The new Furness Renal Centre in Ulverston, began to bring haemodialysis treatment and outpatient clinic facilities closer to home for patients.
- Rosemere Cancer Centre's new 24-bed Ribblesdale Ward at the Royal Preston Hospital. This is the only inpatient oncology-specific ward in Lancashire and South Cumbria and supports patients with a wide range of clinical needs and End of Life care.
- new day case theatres were opened at Chorley and South Ribble Hospital.
- Lancashire Eye Centre opened at Chorley and South Ribble Hospital.

The CCG recognises the improvements that continue to be made under the Trust's value-based 3-year 'Our Big Plan' (2019-22). The CCG note that at the end of March 2022, the Trust has 124 clinical areas taking part in its STAR (Safety Triangulation Accreditation Review) Quality Assurance Framework, with the Trust reporting that 95 areas had achieved a silver star or gold star status, equating to 77% of those registered. The CCG acknowledges the challenges that the Trust have experienced in relation to its falls prevention work and supports the Trust's continued focus on this. The CCG acknowledges there is more work to be done regarding pressure ulcers and looks forward to working with the Trust to see improvements in the coming year. The CCG is pleased to see that a target has been set for the coming year for 90% of patients to rate services as 'good' or 'very good' by the end of March 2022. In addition, the CCG are pleased to see that the Trust have identified seven key priorities to strengthen and embed 'Speak Up, Listen Up, Follow Up' to reinforce staff's ability to speak up in a safe way, within their 'Our Big Plan'.

The CCG notes the improvement made in reducing the Trust's nosocomial (hospital acquired) COVID-19 infection rate from 29% in 2020/21 to 13% in 2021/22 and acknowledges the challenges that the Trust has continued to experience due to its aged estate, including the relatively low number of side rooms, the high number of bays with limited ventilation and restrictive ward layouts. Although it was disappointing to note that the Trust exceeded its annual objective for C. difficile infections by 14, the CCG recognises the impact that the continued pandemic has had in further limiting the opportunities to isolate patients with suspected infection and fully decontaminate wards. The CCG continues to welcome the Trust's focus and determination to actively reduce the number of Healthcare Associated

Infections (HCAIs) and looks forward to engaging in further collaborative improvement work in the coming year.
The CCG acknowledges the good practice of reporting 2 Never Events (wrong site surgery and wrong implant/prothesis). The CCG are pleased to see that Never Events have been added to the Trust's 'Learning to Improve' programme to ensure that actions and learning are embedded. The CCG note that the Trust has also participated in a regional learning event to share learning across organisations and looks forward to further collaborative work to improve patient safety in the future.

The Trust has continued to report patient experience to the CCG and as of March 2022, 70.6% of patients would recommend the Trust for care and treatment within the Emergency Department, with 88.5% for inpatients services. The CCG recognise that high demand and high bed occupancy have severely restricted capacity and flow, frequently leading to long waits in Accident & Emergency (A&E), episodes of Exit Block and a poor patient experience throughout the year. In addition to long waits and reduced staffing, patient satisfaction was also affected by Infection Prevention Control (IPC) restrictions on visiting arrangements around peaks in the pandemic. The CCG look forward to working with the Trust to see improvements on this measure.

The CCG note there was no requirement for providers to submit CQUIN returns in 2021/22 due to the COVID-19 pandemic.

To conclude, 2021-22 has continued to be an exceptionally difficult year for the Trust in terms of the operational and workforce challenges it has experienced due to the ongoing impact of the pandemic. The year ahead will continue to provide new challenges in terms of restoring services to full capacity and addressing the back-log of patients still waiting for treatment. We look forward to working closely with the Trust with the 2022/2023 priorities and further developing our collaborative partnerships to continue to improve the quality of care to our patients.

Yours sincerely

Denis Gizzi

Chief Accountable Officer

Healthcare shaped around you

Dr Sumantra Mukerji– Chair
Denis Gizzi – Chief Officer

Council of Governors of Lancashire Teaching Hospitals NHS Foundation Trust

Quality Account: Feedback from Council of Governors Meeting 12th May 2022

In line with the Trust's commitment to engage and consult with the council of governors at a meeting of 12th May 2022 the Council of Governors were invited to consider and input into the two indicators for inclusion in the 2022/23 Quality Account.

The agreed topics which support putting patients are at the heart of what we do are as follows:

Inclusive end of life care and advanced care planning.

Patient experience including PALS and complaints resolution.

Annex 2:

Statement of directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support data quality for the preparation of the Quality Report.

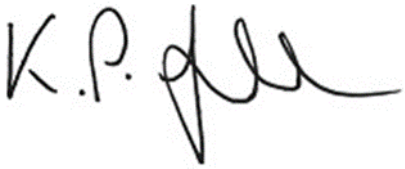
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2021-22 and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2021 to March 2022.
    - Papers relating to quality reported to the Board over the period April 2021 to March 2022.
    - Feedback from commissioners 15/06/2022.
    - Feedback from Healthwatch 15/06/2022.
    - Feedback from Overview and Scrutiny Committee Outstanding at time of publication.
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 is incorporated in the Annual Patient Experience Report 2021-22.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review by MIAA to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's Quality Account manual and supporting guidance as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Professor Ebrahim Adia
Chairman Date: 27th June 2022



Kevin McGee OBE
Chief Executive Date: 27th June 2022

Appendix 1 Maternity specific safety and quality matrix check

Metric	Red flag		Green flag		Apr 21	May 21	June 21	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Marc 22
CNST 10 Key safety actions (Year 4 scheme commenced in August 2021)					**90%**	**100%**	**100%**	**100%**	**60%**	**60%**	**80%**	**80%**	**70%**	**70%**	**70%**	**80%**
Births					343	344	348	372	390	363	389	399	326	318	322	361
Stillbirth rate (per 1,000 births)	>	4.2	≤	4.2	5.8	2.9	0.0	5.4	0.0	5.5	12.9	7.5	3.1	6.3	0	0
Examination of the newborn completed within 72 hours	<	95%	≥	95%	97%	96%	97%	96%	95%	96%	97%	96%	96%	95%	95%	96%
Breastfeeding initiation	<	70%	≥	70%	72%	72%	74%	75%	72%	76%	74%	80%	73%	74%	74%	78%
Births per Funded clinical midwife WTE (Staff in post)	>	28	≤	27	24	23	24	25	26	25	26	27	22	21	24	24
Booked by 9+6	<	50%	≥	50%	45%	43%	58%	61%	53%	51%	45%	47%	46%	21%	47%	43%
Booked by 12+6	<	90%	≥	90%	91%	95%	92%	95%	95%	95%	90%	94%	92%	89%	90%	89%
Women giving birth in a midwife-led setting	<	25%	≥	30%	22%	25%	28%	23%	29%	27%	25%	27%	21%	29%	22%	20%
Home birth	<	1.7%	≥	2.0%	4%	5%	4%	3%	3%	3%	2%	5%	3%	5%	3%	2%
Incidence of severe tears grade 3 and above	≥	3.5%	<	3.5%	5%	3%	3%	2%	7%	2%	2%	1%	2%	1%	3%	4%
One-to-one care in labour in Delivery Suite	<	95%	=	100%	100%	99%	100%	98%	98%	98%	96%	98%	99%	97%	96%	97%
One-to-one care in labour in Preston Birth Centre	<	95%	=	100%	100%	100%	98%	98%	99%	100%	99%	100%	100%	97%	96%	98%
One-to-one care in labour in Chorley Birth Centre	<	95%	=	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%
One-to-one care in labour overall	<	95%	=	100%	100%	99%	99%	98%	99%	98%	96%	99%	99%	99%	97%	97%
Supernumerary status of DS coordinator	<	95%	=	100%	100%	100%	99%	100%	98%	99%	100%	100%	100%	94%	99%	98%
CTG update training	<	90%	≥	90%	92%	91%	93%	94%	95%	97%	85%	85%	85%	92%	88%	87%
Annual competency (K2 Training Package)	<	90%	≥	90%	92%	73%	74%	80%	72%	74%	74%	75%	75%	75%	79%	82%
Antenatal CTG	<	90%	≥	90%	91%	79%	83%	79%	77%	80%	78%	72%	77%	77%	87%	91%
Intrapartum CTG	<	90%	≥	90%	90%	78%	80%	79%	77%	79%	77%	72%	78%	73%	83%	88%
Intrapartum IA	<	90%	≥	90%	91%	81%	80%	80%	77%	82%	80%	72%	78%	74%	85%	92%
GAP/GROW (Growth Assessment Protocol Training)	<	90%	≥	90%	87%	88%	88%	72%	61%	72%	71%	60%	71%	65%	64%	64%

Emergency skills Training (PROMPT – Practical Obstetric Multi-Professional Training)	<	90%	≥	90%	91%	88%	89%	94%	94%	94%	90%	84%	85%	85%	80%	82%
Staff sickness rate					7%	8%	7%	8%	8%	11%	10%	10%	10.%	10%	9%	10%
Incidents of moderate harm and above					0	2	1	1	1	2	0	0	0	2	0	2
HSIB referrals					0	0	0	0	0	2	0	0	0	2**	0	0
Prevention of future deaths regulation 28					0	0	0	0	0	0	0	0	0	0	0	0
Number of Consultant hours on obstetric unit	<70 hrs		=/> 96.5hrs		76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs	76.5 hrs
RCOG obstetric benchmarking compliance						97%	95%	99%	98%	92%	97%	92%	99%	99%	100%	99%
Complaints					3	5	3	3	2	0	3	3	2	6	3	1
Maternal Death					1*	0	0	0	0	1	0	0	0	0	0	0

List of Tables

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Glossary of Abbreviations

A&E	Accident & Emergency
AHP	Allied Health Professionals
AMaT	Audit Management and Tracking System
BAETs	British Association of Endocrine and Thyroid Surgeons
BAME	Black, Asian, and Minority Ethnic
BAPM	British Association of Perinatal Medicine
BAUS	British Association of Urological Surgeons
BFI	Baby Friendly Initiative
BI	Business Intelligence
BSL	British Sign Language
BTS	British Thoracic Society
CCG	Clinical Commissioning Group
CCOT	Critical Care Outreach team
CDH	Chorley District Hospital
CDOP	Child Death Overview Panel
CI	Continuous Improvement
CMP	Case Mix Programme
CNST	Clinical Negligence Scheme for Trusts
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CrCu	Critical Care Unit
CRF	Clinical Research Facility
CS	Caesarean Section
CSAP	Child Safeguarding Assurance Partnership
CSPR	Child Safeguarding Practice Reviews
CTG	Cardiotocograph Traces
CUR	Clinical Utilisation Review
CVC	Central Venous Catheter
DCT	Dental Core Trainees
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DoLs	Deprivation of Liberty Safeguards

dsDNA	Anti-double-stranded Deoxyribonucleic acid
E.Coli	Escherichia coli
ED	Emergency Department
ELC	End of Life Care
EMB	Ethambutol Endometrial Biopsy
ENT	Ear, Nose and Throat
EPMA	Electronic Prescribing and Medicines Administration
EWS	Early Warning Score
FCA	Flow Coaching Academy
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FTSU	Freedom to Speak Up (FTSU) guardian
GIRFT	Getting It Right First Time
GMC	General Medical Council
GP	General Practitioners
HASU	Hyper Acute Stroke Unit
HbA1c	Haemoglobin A1c or Glycated Haemoglobin Test
HDU	High Dependency Unit
HRA	Health Research Authority
HSMR	Hospital Standardised Mortality Ratio
HSPCT	Hospital Specialist Palliative Care Team
HSST	Higher Specialist Scientist Training
HQIP	Healthcare Quality Improvement Partnership
IA	Intermittent auscultation
IBD	Inflammatory Bowel Disease (Programme)
ICP	Intracranial Pressure
ICNARC	Intensive Care National Audit & Research Centre
ICU	Intensive Care Unit
ICS	Intensive Care Society
IG	Information Governance
INCS	Integrated Nutrition and Communication Service
IPC	Infection Prevention Control
LAST	Local Anaesthetic Systemic Toxicity

LeDeR	Learning Disability Mortality Review Programme
MPP	Manual Perineal Protection
LTHTR	Lancashire Teaching Hospitals NHS Foundation Trust
MASH	Multi Agency Safeguarding Hubs
MAU	Medical Assessment Unit
MBRRACE-UK	Mothers and Babies - Reducing Risk through Audits and Confidential Enquiries across the UK
MCA	Mental Capacity Act
MCCDs	Medical Certificate of Cause of Death
MDT	Multidisciplinary Team
ME	Medical Examiner
MEO	Medical Examiner Officer
MINAP	Myocardial Ischaemia National Audit Project
MIAA	Mersey Internal Audit Agency
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MSO	Medications Safety Officer
MSSA	Methicillin-Susceptible Staphylococcus Aureus
MSU	Midstream Specimen of Urine
MUST	Malnutrition Universal Screening Tool
NACAP	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
NACEL	National Audit of Care at the End of Life
NAOGC	National Audit of Oesophago-gastric Cancer
NASH	National Audit of Seizure Management in Hospitals
NBOCA	National Bowel Cancer Audit
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit
NCASRI	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NELA	National Emergency Laparotomy Audit
NHSI	NHS Improvement
NHSE	NHS England

NICE	National Institute for Health and Care Excellence
NJR	National Joint Registry
NRLS	National Reporting and Learning System
NLCA	National Lung Cancer Audit
NMPA	National Maternity and Perinatal Audit
NNAP	National Neonatal Audit Programme
NPDA	National Paediatric Diabetes Audit
NVR	National Vascular Registry
OASI	Obstetric Anal Sphincter Injury
OMFS	Oral and Maxillofacial Surgery
PALS	Patient Advice and Liaison Service
PAS	Patient Administration Systems
PEWS	Paediatric Early Warning Score
PICANET	Paediatric Intensive Care Audit Network
PCCN	Patient Contribution to Case Notes
PCNL	Nephrolithotomy
PDTI	Pulsed Doppler Tissue Imaging
PHSO	Parliamentary and Health Service Ombudsman
PMRT	Perinatal Mortality Review Tool
PQIP	Perioperative Quality Improvement Programme
PROMS	Patient Reported Outcome Measures
QAT	Quality Assurance Team
QIF	Quality Improvement Framework
RAG	Red/Amber/Green
PIR	Provider Information Request
PPH	Postpartum Haemorrhage
PREM	Patient Reported Experience Measure
PROMs	National Patient Reported Outcome Measures programme
RCEM	Royal College of Emergency Medicine
RCN	Royal College of Nursing
RCOA	Royal College of Anaesthetists

RCOG	Royal College of Obstetricians and Gynaecologists
RCOPHTH	Royal College of Ophthalmologists
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
RCPSYCH	Royal College of Psychiatrists
RCS	Royal College of Surgeons
RPH	Royal Preston Hospital
RTOG	Radiation Therapy Oncology Group
SAM	Society for Acute Medicine
SAMBA	Society for Acute Medicine Benchmarking Audit
SDEC	Same Day Emergency Care
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious Hazards of Transfusions
SI	Serious Investigation
SJR	Structured Judgement Review
SLT	Speech and Language Therapy
SOP	Standard Operating Procedures
SPC	Statistical Process Control
SSI	Surgical Site Infection
SSNAP	Sentinel Stroke National Audit Programme
STAR	Safety Triangulation Accreditation Review
StEIS	Strategic Executive Information System
SUS	Secondary User Service
TARN	Trauma Audit and Research Network
TIA	Transient Ischaemic Attack
TBI	Traumatic Brain Injury
UCAM	Urinary Catheter Assessment and Monitoring Form
VBAC	Vaginal Birth After Previous Caesarean
VTE	Venous Thromboembolism

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Governor Opportunities and Activities – May 2022 – July 2022

Report to:	Council of Governors	**Date:**	28 July 2022
Report of:	Governors	**Prepared by:**	J Leeming
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to update the Council of Governors on the opportunities, events and activities Governors have been involved in during May 2022 to July 2022.

The Governor role is to represent the interests of Foundation Trust members, the public and the organisations Appointed Governors represent. The events and engagement opportunities that Governors have been involved in are recorded in the report and attached as appendix 1.

It should also be noted that several of Governors undertake voluntary roles across both hospital sites.

It is recommended that the Council of Governors receive the report and note the contents for information.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

None

1. Background

Governors have an important part to play by listening to the views of the Trust's members, the public and other stakeholders, and representing their interests in the Trust. This means, for example, gathering information about people's experiences to help inform the way the Trust designs, reviews or improves services effectively. Governors also have a role in communicating information from the Trust to members and to the public, such as information about the Trust's plans and performance. Successful engagement calls for an ongoing working relationship between a Foundation Trust and its members and the public, with patients and service users at the heart of this. Governors are supported in their work by other groups of people at the Trust including Executive and Non-Executive Directors and the Corporate Affairs Office.

2. Financial implications

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

3. Legal implications

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

4. Risks

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

5. Impact on stakeholders

Positive engagement with membership is a critical role for the Governors.

6. Recommendations

It is recommended that the Council of Governors receive the report and note the contents for information.

There are a number of regular activities which Governors could be involved in including:

Fabulous Feedback Friday
Held monthly and virtually throughout the Covid-19 pandemic, teams provide an overview of their service at the Trust. Governors are provided with the opportunity to explore, receive insights and have a deeper understanding of the service being presented. The events have a broad reach and include invitations to Governors, Board Members, and a range of senior leaders throughout the Trust.

STAR celebration events
Held three times per year and virtually throughout the Covid-19 pandemic, teams present the peer support activity in which they have been involved as part of the STAR accreditation framework as well as celebrating achievements.

PLACE (Patient Led Assessment of the Care Environment)
The national programme usually takes place annually at each of our hospital sites (Chorley and South Ribble and Royal Preston Hospital). It is an opportunity for Governors to engage with patients and training is provided by the Trust. The programme is being reviewed nationally and further information on the changes is awaited.

Strategic Operating Group (SOG) Debrief
Every Friday between 10am and 12noon a Strategic Operations Group meeting is held during which leaders from across the Trust review existing pressures and make important decisions about our hospitals' current and future operational challenges. Governors along with staff can attend the debrief every Friday afternoon between 2pm and 2.15pm.

The list below does not include Governors' scheduled meetings and workshops.
All activities were held using virtual platforms unless indicated otherwise.

EVENT: excluding scheduled meetings and workshops	**DATE: May – July 2022**
Patient Experience & Involvement Group meeting	3 May 2022
NHP Trust Engagement	5 May 2022
Patient Experience Improvement Group meeting	10 May 2022
Recruitment Roadshow at South Ribble Civic Centre	15 May 2022
Day with catering services	24 May 2022
Patient Letters Working Group	24 May 2022
Day with porter services	25 May 2022
Carers Forum	25 May 2022

Working with the Rapid Response Team	26 May 2022
Car Parking Meeting	26 May 2022
Visit to the modular build (Cuerden Ward)	27 May 2022
Day with porter services	31 May 2022
Working with the Security Team at RPH	1 June 2022
Leyland Festival to engage re NHP and sign up new Trust members	2 June 2022
Staff Ambassador Forum	7 June 2022
Day with security	14 June 2022
Patient Experience & Involvement Group meeting	14 June 2022
South Ribble Civic Centre to engage re NHP and sign up new Trust members	15 June 2022
Patient Issues Car Parking Group	16 June 2022
Patient Experience Improvement Group meeting	21 June 2022
Carers Forum	22 June 2022
NHP Trust Engagement	23 June 2022
Lancashire & South Cumbria Provider Collaborative-Colleague Briefing	29 June 2022
Coffee Catch Up	4 July 2022
NHS Providers Conference	6 July 2022

Governor's focus conference NHS Providers	7 July 2022
Day on Cuerden Ward at Chorley & South Ribble Hospital	11 July 2022
Meeting to discuss the redesign of the PALS office at Chorley	11 July 2022
Meeting to discuss arrangements for Preston Pride on 24th September	12 July 2022
Dementia meeting	13 July 2022
Lancashire & South Cumbria Provider Collaborative-Colleague Briefing	13 July 2022
STAR Visits training session	18 July 2022
Carers Forum	19 July 2022
Patient Experience & Involvement Group Meeting	20 July 2022
NHP Trust Engagement	21 July 2022
Patient Issues Car Parking Group	21 July 2022
STAR Visits training session	22 July 2022
Patient Experience Improvement Group Meeting	26 July 2022

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Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors Report

Governor Issues Report							
Report to:	Council of Governors			**Date:**	28 July 2022		
Report of:	Workforce and Education Director			**Prepared by:**	N Gauld		
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 visibility of the issues and concerns raised by Governors for information.

The agreed process for Governors to raise issues and concerns is through the Senior Executive Assistant (Natalie.gauld@lthtr.nhs.uk). These are then passed to the appropriate manager for investigation and response. A response is then provided to the Governor who raised the issue.

The attached report contains a summary of the issues raised since the last report to the Council and covers the period between May 2022 to date along with details of the responses provided.

It is recommended that the Council 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

Not applicable

Introduction

The purpose of this report is to provide visibility of the issues and concerns raised by Governors for information.

The agreed process for Governors to raise issues and concerns is through the Senior Executive Assistant (Natalie.gauld@lthtr.nhs.uk). These are then passed to the appropriate manager for investigation and response. A response is then provided to the Governor who raised the issue.

The report contains a summary of the issues raised since the last report to the Council and covers the period between May 2022 to date along with details of the responses provided.

1. **Activity report**

During the reporting period, 6 concerns/issues were raised through the governor process map.

All concerns/issues have been closed (within timescales for response).

2 different governors raised concerns.

A summary of the issues raised is provided below:

- 1 concern was raised regarding inclusion of all staff uniforms on our website (eg porters, domestics, volunteers etc). The Marketing Manager within the Comms team has confirmed that the page itself is poorly visited and is a nice to have versus an important page which must be displayed. The team are considering benefit of page versus the time taken to liaise with all Teams within our hospitals and produce content. Once the team have more resource, an update will be given.
- 1 concern was raised following the CEO Monday Message and raised concerns regarding lack of visibility for governors in terms of the staff intranet. The Director for Comms and Engagement has separately addressed this issue with governors and a new intranet is being implemented (October launch) which will enable governors to access information easily. The Comms team are sending relevant information routinely to governors.
- 1 concern was raised regarding a press release from the RCN outlining that research reveals that black and Asian nurses being overlooked for promotion due to structural racism. James Whitaker provided assurance that we have an inclusive leadership development programme which is specifically designed to tackle this issue. The Chairman for the Trust is the exec sponsor for the programme.
- 1 concern was raised regarding staff training and ensuring staff have the right skills to support people with a learning disability and autistic people. It was confirmed that compliance with training specifically looking after vulnerable adults and children is monitored carefully. As the CQC develop their code of practice in line with the legal requirements, the Trust will develop and adapt to ensure we comply.
- 1 concern was raised regarding patients being equal partners in designing of health and social care services and also having a good understanding of their health and the system. The query has also been raised at PEIG and is therefore closed.
- 1 concern was raised regarding ambulances waiting at A&E. The Chief Operating Officer for the Trust provided assurance regarding a join process which has been put in place with ED teams, site and NWAS crews with agreed steps and escalation processes up to Gold and Silver. The Trust has ongoing active plans on our urgent care flows across all partners and risks on ambulance hand overs have mitigations and actions in place.

3. **Financial implications**

There are no financial implications associated with this report.

4. **Legal implications**

There are no legal implications associated with this report.

5. **Risks**

There are no risks associated with this report.

6. **Impact on stakeholders**

There is no impact on stakeholders associated with this report.

7. **Recommendation**

It is recommended that the Council receives the report and notes the contents of this report for information.

Care and Safety Subgroup

24 March 2022 | 1.00pm | Microsoft Teams

PRESENT	DESIGNATION	17/05	15/07	20/09	29/11	17/01	24/03
Janet Miller	Public Governor *(Chair)*	P	P	P	P	P	P
Keith Ackers	Public Governor	P	P	P	A	P	P
Pav Akhtar	Public Governor	A	A	A	A		
Takhsin Akhtar	Public Governor	A	A	A	A		
Rebecca Allcock	Staff Governor	A	P	P	P	A	P
Peter Askew	Public Governor	A	A	P	A	P	
Paul Brooks	Public Governor	P	A	A	P	P	
Anneen Carlisle	Staff Governor	A	A	A	A		
David Cook	Public Governor	P	P	A	P	P	P
Margaret France	Public Governor	P	P	P	P	P	P
Hazel Hammond	Public Governor	A	P	P	A		
Steve Heywood	Public Governor	A	P	P	A	P	P
Trudi Kay	Public Governor *(Deputy Chair)*	P	P	P	P	P	P
Lynne Lynch	Public Governor	P	P	P	P	P	
Shirley Murray	Appointed Governor	A	A	A	P	P	P
Janet Oats	Public Governor	P	A	A	A		
Frank Robinson	Public Governor	P	P	P	P	P	A
Ann Simpson	Public Governor	P	P	P	P	P	
Mike Simpson	Public Governor	P	P	P	A	P	P
Piotr Spadlo	Staff Governor	P	P	A	P	A	A
David Watson	Public Governor	P	P	P	P	P	P
IN ATTENDANCE							
Catherine Arrand-Green	Membership Manager	A	P				
Karen Brewin	Committee Secretary			P	P	P	
Alison Cookson	Patient Experience and Involvement	P	P	A	P	P	A
David Hounslea	Director of Facilities and Services	P	P	A	P	A	A
Christmas Musonza	Associate Director of Patient Quality, Experience and Engagement			P	P	P	P
Geoff Rossington	Non-Executive Director	P	A	P			
Kate Smyth	Non-Executive Director	P	P	P	P	P	P
Karen Swindley	Strategy, Workforce and Education Director	P	P	P	A		
Joanne Wiseman	Corporate Affairs Officer (minutes)					P	P

P – present | **A** – apologies
***Quorum**: 50% of the Subgroup's total membership at the time of the meeting*

Presenters: Janet Young, Deputy Chief Information Officer *and* Vishnu Chandrabalan, Locum Consultant *(for item 13)*
Catherine Silcock, Deputy Director of Nursing, Midwifery & AHP's *(for item 6)*

1. **Chair and quorum**

J Miller noted that due notice of the meeting had been given to each member and that a quorum was present. Accordingly, the Chair declared the meeting duly convened and constituted.

2. **Apologies for absence**

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

3. **Declarations of interest**

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

4. **Minutes of the previous meeting**

The minutes of the previous meeting held on 17 January 2022 were approved as an accurate record.

5. **Matters arising and action log**

The Chair advised that the results from the public Governor elections will be available on Friday 25 March 2022. H Hammond, T Kay and J Oates did not put themselves forward for re-election and the Chair conveyed her gratitude for the work that they have done. The Chair also thanked S Murray for her work as appointed volunteer Governor for the Governing Council and the Care and Safety Subgroup.

A copy of the action log had been circulated with the agenda and it was noted the majority of actions had been completed to time. C Musonza provided an update on the following outstanding action:

Action 1: is now completed. K Smyth advised if any colleagues have further examples of issues, she will contact NWAS so they can investigate.
Action 2: Completed and the terms of reference for the Patient Experience and Involvement Group shared with the Subgroup.
Action 3: a) & b) update not received. c) C Musonza will provide update during his presentation.
Action 4: The Chair informed that the action is completed.
Action 5: K Smyth asked for the action regarding patient letters to be allocated to C Musonza for patient experience.
Action 6: Completed and C Musonza will provide update during presentation.

6. **Patient Experience update**

The Chair welcomed C Silcock who thanked the Chair for the invitation to cover the numerous updates with C Musonza for the following:

- Letters and the working group progress.
- Safety Two meeting.
- Patient experience involvement group.
- Patient experience improvement group.

C Musonza shared the presentation and explained that the report A Cookson circulated with the agenda is in addition to the presentation.

Patient letters – The working group proposed for a representative from each division, representative from patient experience team, I.T. Lead, member of the communication team, Governor representative and patient representative. The working group will obtain

templates and ad Hoc letters from each department to form a standardised letter going forward.

Telephone calls being unanswered for the Blood Clinic – there were concerns that the calls are not being answered and the solution is that the lines are active and the answer phone message informing that the clinic has reverted to a walk-in clinic and details how patients access this is now live. The Trust internet page has also been updated. A request has been made for all hospital letters sent to patients to include the update of the new arrangements regarding bloods appointments and communication has gone to the CCG and to GP's.

The patient strategy – There has been Governor participation in the focus groups and the following commitments were agreed.

- Deliver a positive patient experience.
- Improve outcomes and promote patient safety.
- Create a good care environment that is inclusive of staff and patients.
- Improve the Trust's admission, treatment and discharge pathway.

The draft strategy has been completed for 2022/25 and has been reviewed by Clinical Leads so their contribution has been captured within the strategy. There will be another opportunity for feedback on the strategy before this is finalised and revisions have already been implemented. The next step will be the strategy launch once the document is finalised.

Patient feedback – There are a number of surveys that provide feedback that are taken into consideration. The Trust collects the Friends and Family feedback and has been gathering live feedback with a PALS member of staff based in the Emergency Department. They are currently collating data from around 15 patients per day in that department in both Chorley and Preston.

Patient experience and involvement - Forums have been embedded now as two groups, patient experience involvement group and patient experience improvement group. The patient experience involvement group is centred around discussions regarding the members views and how the organisation can move forward. The patient experience improvement group is a concise meeting centred on projects which will be measured in terms of their improvements. K Smyth provided feedback that having similar names can be confusing and would help if they were different.

Patient feedback Safety Two – A face to face survey was conducted in February 2022 and 383 patients were spoken to on the wards at both Preston and Chorley. Patients were given the opportunity to define what they value for feeling safe rather than just having a clinician's point of view. A Word Cloud was produced to establish the themes and they were: being organised, being efficient, structured ward, staff being present, security being available, caring staff and the ward being clean and tidy.

- 362 patients said they felt safe
- 21 reporting that they did not feel safe.

C Musonza asked if there is anything further they can add for Governors. The Governors have been supporting in the recommencement of the STAR visits and this contribution is extremely helpful for the Trust. There will be a patient safety partner role and C Musonza

is confident this role will help the Trust progress. The ongoing live patient feedback in the Emergency Departments at both Preston and Chorley will continue.

C Silcock added that from the strategy perspective it is hoped that the document will be live and worthwhile as patients are considered from the beginning. C Silcock would like the group to feel assured that this will happen and consider the patient voice regarding safety. The patient safety role will assist this and although the change may not be seen immediately this is the vision of the strategy. The live feedback that the patient provides before leaving the hospital is invaluable as this helps to resolve the issues in real time.

T Kay asked what happens to the Friends and Family feedback as she has seen that the number of completed forms do not appear to be part of the results and some of the boxes are not emptied. C Musonza responded to advise that the feedback is gathered and uploaded and they have been visiting areas that they haven't received any feedback from. They then speak to staff and ward managers to make them aware so changes can be made to resolve issues. The Chair had also noticed a Friends and Family box that hadn't been emptied from the Preston Discharge Lounge. C Silcock agreed that if patients have taken the time to complete the forms, they will need to check the process is being carried out to ensure the information is collated. S Murray also informed that originally around 30 boxes were delivered to various departments so there could be a large number of forms not being logged. C Musonza confirmed that S Iaconianni has spoken to around 6 other Trusts to establish the processes they are following for collating the patient feedback. C Musonza added that some divisions have actions to improve this focus and there have been meetings with Matrons and Ward Managers. C Musonza will also check the data to establish the preference for feedback to be given manually on the paper forms or electronically.

J Miller advised that she recently visited an inpatient at Chorley Hospital and entered by the ATC entrance and went to level 3. On the corridor outside theatres, J Miller found a visitor without a mask so had escorted him to Lancashire Eye Centre to provide a mask. Then another gentleman going up to Rookwood B did not have a mask on so J Miller hoped the ward staff addressed this with him. The patient J Miller was visiting on this occasion provided her with feedback that they do not feel particularly safe during the night as two of the patients opposite, living with dementia, had been shouting out in the night. As she is in a strange environment, being woken up by patients shouting can be quite alarming. J Miller had suggested to the patient that if any side rooms became vacant, she should ask to be moved. C Musonza explained that it is difficult when patients are very poorly and they call out, and the nursing staff can find this challenging for the other patients who are being disturbed. C Silcock agreed that this is a difficult issue to resolve at the Trust, as they do not have enough side rooms and unfortunately this issue is difficult to resolve. J Miller raised this from a patient experience perspective in terms of feedback.

Rookwood A had requested evidence of a lateral flow test result for visiting purposes and as free tests will no longer be available soon, J Miller asked if the hospital will still ask for the test result bearing in mind low-income families. C Silcock informed that the Infection Control framework is currently being updated and they are awaiting this information. This will be in line with the national guidelines and will be the same for all organisations.

J Miller asked how long it is expected until the working group will be up and running regarding the letters. C Musonza will know when the meetings are being held from next week. Complaints and issues with the quality of the communications are not specifically linked to the letters and it has been difficult to compile the data as the complaints have

addressed other concerns. The working group will also cover the content of the text messages.

Action:

- **C Silcock and C Musonza will check that there is a robust process being followed to collect the Friends and Family forms from various areas and is being uploaded to collate the information. C Musonza will also check the data to establish the preference for feedback to be given manually on the paper forms or electronically.**

7. **Estates and Facilities update**

The Chair informed that D Hounslea unfortunately cannot attend today and asked if there were any questions from reading the report circulated with the agenda.

T Kay asked if the new wheelchairs that have been ordered will be suitable for outdoors as all terrain, or just ones to be used inside. T Kay also asked if the wheelchairs could have leg rests at the front for the patients who have had leg surgery. T Kay also advised that the since the Nightingale hub has been situated at the front of the hospital, when you leave the main entrance, you can turn left or right to go back to Sharoe Green Lane. You now have to go through the disabled carpark and there is no footpath or signage and it is not suitable to walk on due to lumps of concrete. There is a steep slope that has no warning for wheelchair users and it drops down to the pavement on Sharoe Green Lane. There is no signage when leaving the hospital to access Sharoe Green Lane and no signage in the car park to exit via the slope. C Musonza confirmed that the plan is to remove the hub from June.

K Smyth also suggested checking if the wheelchairs need to be self-propelled or if someone needs to push the wheelchair. K Smyth also believes that the wheelchair service could provide some accessories and this may include a bracket that can be attached as a leg support. J Miller informed that hospital wheelchairs have been an ongoing issue with different options being implemented. It is also a concern that wheelchairs are removed from our sites and Estates have looked at a form of security. This will require a response from D Hounslea.

The Chair informed the group that Mr Peter Hickey is retiring from the Trust after 40 years' service and he is returning to work on a part-time basis to work on strategic projects.

Action:

- **C Musonza will establish which type of wheelchairs have been purchased and advise the group.**
- **D Hounslea to advise if leg supports for wheelchairs can be ordered and what method of security will be in place for the new wheelchairs.**

8. **Patient experience and Involvement update**

The Chair informed that unfortunately A Cookson is unable to attend today but she had provided a comprehensive report for the group. The Chair asked the group if they had any questions that C Musonza may be able to answer. No questions were raised.

9. **Non-Executive Director update**

K Smyth informed that the new Non-Executive Director is Victoria Crorken. J Miller added that she had received an email from K Swindley who advised that V Crorken has a large work commitment and as the group already has the support of K Smyth it would probably be that V Crorken will not attend the Care and Safety Subgroup.

- There was a meeting yesterday on anchor institutions and social value and was attended by the staff who provide the recruitment for the Trust. They presented on how they engage with people from all walks of life who may like to work at the Trust. This was an excellent presentation and there were other organisations in the meeting, namely Preston and Chorley Council, and they were keen to replicate some of the ideas. This group meets bi-monthly and has an extremely large audience.
- The Trust's Social and Value group meeting monthly which includes work on the green agenda as well as HR, Recruitment and Procurement. With over 10,000 staff and a budget of millions it is agreed that there needs to be as much benefit for the local community as possible.
- K Smyth is now a member of the ICP determinates of the health group and has been to several meetings. K Smyth is involved in preparing the action plan and is meeting the Director of Public Health for Lancashire on a regular basis and is trying to get them to think of the bigger picture as there is only so much that can be done at local level. Central Government needs to be able to look at fuel poverty, food poverty, additional social housing and changing the way for people to gain benefits. K Smyth is hopeful that they can make a difference in the long term.
- K Smyth informed that she has close links with Calderdale and Huddersfield Trust and Ann Pennell and K Smyth attended their Safety and Quality Committee meeting last week. A Pennell and K Smyth were particularly interested on the work being done for patients with dementia and falls. It was noted that the way in which they capture the patient voice in the reports was excellent. A Pennell and K Smyth have also been invited to attend the Safety and Quality meetings at Morecambe Bay and East Lancashire and they will also have the opportunity to attend Lancashire Teaching Hospitals meeting.
- K Smyth has been working with C Musonza and C Silcock on the Patient Experience agenda.
- Nationally, there are 49 members of the Disabled NHS Directors Network and they will be meeting MP Chloe Smith the minister for disabled people on 16 May 2022 and are keen to discuss government policy.
- K Smyth is meeting Amanda Doyle the NHSEI Director for the North West on 8 April to discuss the work that is ongoing.
- K Smyth cannot mute or turn the camera on and off as Teams is not compatible with voice activated software and has met with Microsoft who have taken note of the difficulties that K Smyth and other users face. They will look at solutions for voice commands to make access easier.
- Last week K Smyth interviewed for the Associate Consultant post at the Trust which is to help people who are not currently Consultants and 4 people were offered Associate Consultant positions.
- K Smyth is hoping to be back on site once per month but the number of Covid cases are increasing again so this will continue to be monitored.

The Chair asked K Smyth how the Place-based Public Patient and Care Voice Committee will be formed going forward and if patients will be members or if it will continue with

representatives from Lancashire Council and the Trust. K Smyth advised that there are members from the CCG but is not certain of when any changes will be implemented. C Musonza provided feedback from the two sessions he had attended and that it follows the Integrated Care System in terms of systems and a place to share initiatives and inviting participants to take up roles they may want to do. K Smyth confirmed that there is the Patient Advisory Group at the CCG where patients are involved but is unsure of what will happen once the CCG disbands. K Smyth will write to her contacts to ask for an update on the status of the PPCV and PAG and at what level they will operate at in the future plan.

Action:

- **K Smyth will write to contacts at the CCG to ask for an update on the status of the PPCV and PAG and at what level they will operate at in the future plan and will then advise the group of the information she receives.**

10. **Reflections on the meeting**

M Simpson asked if anyone can be invited to the Patient Experience Involvement and Improvement Groups. J Miller informed that there used to only be a Patient Experience and Involvement Group but this has been changed. The Patient Experience and Involvement Group used to comprise of patients, Governors, volunteers, staff and organisations that support patients like Macmillan, N-Compass, Healthwatch, Galloways etc. When C Musonza joined the Trust, the group was divided into two - the Involvement group and the Improvement group. C Musonza explained that the decision to split the group was due to following the methodology of continuous improvement and engaging with patients, carers and other stakeholders. It required more time to share all of the information and it was not possible to do this under one umbrella. The Improvement group takes on projects identified and recommended from the Involvement group. C Musonza explained that anyone can attend the Involvement group however the focus of the Improvement group, is more dependent on individuals dedicated to projects, data analysis and carrying out continuous improvements. J Miller confirmed that M Simpson can attend the patient experience Involvement group and advised of the other Governors who already attend.

K Ackers asked where the Flow Coaching Academy is placed in the current meetings and also noted that patient experiences for ambulance waiting times is around 4 hours and asked if this topic is included as part of what the Improvement Group could review. C Musonza advised that the ambulance waiting times would need to be taken to the Improvement group as a project. The Improvement group currently have two projects ongoing for lost property and Patients Contribution to Case Notes. K Smyth added that the Safety and Quality Committee also look at long waiting times in the Emergency Department from the point of arriving in an ambulance and this is continually reviewed. The Tissue Viability Nurses have been working with Ambulance staff in using the correct mattresses and the Emergency Department staff to help prevent and care for pressure ulcers. K Smyth also advised K Ackers that waiting times for ambulances arriving after being called probably sits within the remit of the North West Ambulance Service. K Smyth will ask for a representative from North West Ambulance Service to attend and provide the group with an update. M Simpson also reiterated that there is the issue of the 4-hour waiting time from the point that the patient calls for an ambulance until it arrives. K Smyth advised this is for North West Ambulance Service to update on. S Heywood added that both of the issues of delay in patients waiting for the ambulance and then the ambulance

waiting to handover patients need to be resolved for this problem to be completely resolved.

K Smyth advised that the digital strategy was taken to Board and P O'Neill and K Smyth met with S Dobson. There is still some work to be done with how people will manage with a digitalisation system and also for disabled people and how they will be able to work with it. K Smyth wanted J Miller to be aware of this so she can keep monitoring this. J Miller advised that she had discovered a paper produced by Nuffield Department of Primary Care Health Sciences regarding patients and remote consultations. It states remote consultations seem to be less suitable for people who are very young, very old, are very unwell with high-risk conditions, have complex health or wider needs, want or need a physical examination, have difficulty communicating, need supervised check-ups for controlled drugs or do not own technologies like smartphones or lack privacy at home. There appears to be a large group of patients who would not choose to have a remote consultation. J Miller advised that Trish Greenhalgh at Oxford University was involved in this study.

S Heywood asked if like the Membership Group there was a need to re-energise the attendance at the meetings and noted this may change after the elections. J Miller advised that there are quite a few Governors who are not standing for re-election who have not attended today but agreed that some work to re-energise the group would be of benefit.

Action:

- **K Smyth to arrange for a representative of North West Ambulance Service to attend and provide the group with an update on the issue of waiting times for ambulances.**

11. **Request for future meeting topics**

The Chair informed of 7 topics that have already been suggested for 16 May meeting including F Button on waiting lists and K Swindley on staff facilities.

12. **Any other business.**

D Watson asked if the surplus bed frames mentioned could be donated to Ukraine, C Musonza confirmed that the Trust hires beds.

M France informed of the International Aid charity based locally, that has recently had a van stolen. The charity provides great support and have been helping with the situation in Ukraine. J Miller advised that a News report had informed that this was an expensive vehicle that was stolen, so a huge loss for the charity.

T Kay informed that STAR visits have now recommenced. This involves carrying out the 15-step challenge around first impressions of walking into an area and also interviewing 5 patients. This would entail around 3 hours commitment if anyone would like to volunteer to help. J Miller informed that the 15-step challenge can be found on the NHS website. PLACE visits organised by Julie Tonge may be starting again, to be involved new Governors will have to undertake the necessary training.

13. **IM&T: Data Science**

Janet Young, Deputy Chief Information Officer attended the meeting with Vishnu Chandrabalan who is a Consultant Surgeon but also a Lead for Data Science to present the Data Science information.

The link to the presentation is:
http://lthtr-nhsa-2021.surge.sh/?print-pdf#/

V Chandrabalan informed that this is around building a modern infrastructure for collaborative data science, machine learning and artificial intelligence. This will benefit patient care, safety and pathways. Lancashire Teachings Hospitals are a digitally mature organisation and are able to work with academic organisations like Oxford.

For the last 15 years the Trust has used QuadraMed and have been able to collate high quality digital patient data. This data provided insights on patient care, outcomes and where improvements can be made. There are other Trust databases that provide similar data but the problem with having many systems is that they sit in their individual information silo. It can be challenging in having the systems talk to each other and looking at the bigger picture this can be made more effective. The Trust has a view of the patient when they are in hospital but when they return to primary care, they don't see the information that the Trust has for the patient and the Trust does not see the information then collated in the community. The challenge for data science is to have all the information joined together in a unified database.

Using anonymised data, trusted research development work can also be done with research and clinicians in a highly secure manner. This is an opportunity for healthcare professionals to work hand in hand with experts in data analysis within universities. With this is mind the Trust now has a platform within the Microsoft cloud that is being developed.

Three different examples of previous data science projects over the last two years are:

- For cancer pathways, an algorithm was implemented to read the data and identify the high risk patients to schedule them into clinic earlier.
- Diabetic Foot Ulcer Detection using Deep Learning – an image of the foot is taken and this is linked to the other data held for the patient and this model is then being used with the Tissue Viability team for pressure ulcers.
- Named entity recognition on unstructured clinical text for clinical letters – for example if a scan is performed and a critical finding is identified such as a cancer, the current process involves a process of contacting numerous people to get the result to the correct person. The new system will have an alert sent to an inbox which is monitored and therefore avoids this finding going unmonitored.

J Young added that the team work in providing these changes and improvements has been immense. This is helping with communication given to patients. The involvement and scrutiny from clinicians is of massive benefit for patients and some of the large well-known colleges are extremely keen to work with the Trust in this area. J Young informed that the project ensures everyone is included and anyone that is digitally challenged is also considered. K Smyth has also provided support with this project and committed a large amount of her time.

The Chair remarked that this presentation had been informative and advised the patient letters are currently being discussed in the group and issues need resolving. J Miller can see the benefit of the streamlining of the patient data for primary care and ultimately provide the GP with discharge information.

M France added that currently the letter informing the GP of action to be taken needs to be more succinct and this would be a huge improvement. J Young explained that there are other changes being implemented for the ICS so the letters are simplified to assist clinicians in having an overview of the patient in a more user-friendly manner. Dr Elizabeth McPhee is helping to restructure the letter priority order. M Simpson advised that it had been difficult to obtain scan results from one Trust to another and J Young agreed that this is a known historical issue. V Chandrabalan added that they are working on collating scan data for various sites in the ICS but outside of the ICS is more difficult as this is going to be much slower to improve. J Young will provide further updates when she has them.

R Allcock asked if the algorithm is in place now for the colorectal referrals for cancer two week wait patients. V Chandrabalan informed that this is not yet in place for prioritising the more serious patients. However, the other anonymising data for research has been deployed. J Young added that they have been working with Continuous Improvement on the Big Room for Colorectal and Alan Beveridge has built an algorithm for patients he would not categorise in the two week rule based on the information provided in the referral. An analyst has been able to recreate this in QuadraMed and this is now live. It is expected to be rolled out to other specialities for the two week wait patients.

The Chair thanked both V Chandrabalan and J Young for providing the group with the inspirational update.

14. **Date, time and venue of next meeting**

The next meeting of the Care and Safety Subgroup will be held on 16 May 2022 at 10.00am using Microsoft Teams.

Care and Safety Subgroup

16 May 2022 | 10.00am | Microsoft Teams

PRESENT	DESIGNATION	16/05	14/07	19/09	24/11	16/01	23/03
Janet Miller	Public Governor *(Chair)*	P					
Keith Ackers	Public Governor	P					
Paul Wharton-Hardman	Public Governor						
Rebecca Allcock	Staff Governor	P					
Peter Askew	Public Governor	P					
Sheila Brennan	Public Governor	A					
Paul Brooks	Public Governor	P					
Anneen Carlisle	Staff Governor						
David Cook	Public Governor	A					
Kristinna Counsell	Public Governor	P					
Margaret France	Public Governor	P					
Steve Heywood	Public Governor	A					
Lynne Lynch	Public Governor	P					
Frank Robinson	Public Governor	P					
Ann Simpson	Public Governor	A					
Mike Simpson	Public Governor						
Piotr Spadlo	Staff Governor	P					
David Watson	Public Governor	P					
IN ATTENDANCE							
Alison Cookson	Patient Experience and Involvement	P					
David Hounslea	Director of Facilities and Services	P					
Christmas Musonza	Associate Director of Patient Quality, Experience and Engagement	A					
Kate Smyth	Non-Executive Director	P					
Karen Swindley	Strategy, Workforce and Education Director						
Joanne Wiseman	Corporate Affairs Officer (minutes)	P					

P – present | **A** – apologies
***Quorum**: 50% of the Subgroup's total membership at the time of the meeting*

Presenters: Steph Iaconianni Head of Patient Experience and PALS *(item 8)*
Faith Button, Chief Operating Officer *(item 6)*
Rachel O'Brien, Associate Director of Workforce *(item 15)*

1. **Chair and quorum**

J Miller noted that due notice of the meeting had been given to each member and that a quorum was present. Accordingly, the Chair declared the meeting duly convened and constituted.

The Chair advised the group that P Akhtar has now stood down from the Care and Safety Subgroup and resigned his position of Chair at the Membership Subgroup due to increased workload. The Chair welcomed K Counsell to her first meeting as a newly elected Governor.

2. **Apologies for absence**

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

3. **Declarations of interest**

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

4. **Minutes of the previous meeting**

The minutes of the previous meeting held on 24 March 2022 were approved as an accurate record.

5. **Matters arising and action log**

A copy of the action log had been circulated with the agenda and it was noted the majority of actions had been completed to time with the exception of action below:

Action 1b: Estates and facilities update - D Hounslea provided the group with an update on the order of 50 wheelchairs and advised that they are Stryker wheelchairs. D Hounslea indicated that these wheelchairs do have leg supports on them which fold under the seat when not being used. The link below provides information for the Stryker wheelchairs. D Hounslea will check who the contact is with for when the leg support gets stuck as there is a maintenance programme for the wheelchairs. K Counsell asked why the same brand has been re-ordered if they cannot be taken outside. D Hounslea advised there was a further requirement for internal wheelchairs and clarified that these are not for outdoor use due to the ongoing issues of training and risk assessments being required for use outdoors.

Prime TC Transport Chair - Stryker Acute Care - PDF Catalogs | Technical Documentation (medicalexpo.com)

Action:

- **D Hounslea will check who the contact is with for when the leg support gets stuck as there is a maintenance programme for the wheelchairs and send this information on to the group.**

6. **Management of Waiting Lists Update**

F Button the Chief Operating Officer for the Trust attended to provide the group with an update on the waiting lists, advised of the targets in place for the Trust and the actions being undertaken to achieve those targets.

The Trust has a commitment as part of the government target to have no patient waiting over 104 weeks by the end of June. That is a very ambitious target due to the pandemic for the last two years and the day case theatres being out for a significant amount of time and being a cancer and tertiary specialist provider there are a lot of routine patients now waiting over two years. In January there were over 1000 patients and now today there are 777 patients and if not treated by the end of June, they will breach the two year commitment. There is significant focus on achieving the ambitious target of reaching zero by the end of June.

Priorities that come into play, particularly at the Preston site is our tertiary work in cancer which has to take precedent over routine work. The Trust are the provider across the ICS for a number of services, so the clinically urgent patients have to always take priority because they cannot go elsewhere.

Since November 2021 the good news is that at Chorley, the day case theatres have been rebuilt and there is also the Rawcliffe ward which is ring fenced for the day case unit and despite the emergency pressures this has been adhered to. Only G Skailes, F Button and K McGee can authorise using Rawcliffe outside of the day case patients. The emergency pressures you can see across the NHS continue every day and the Emergency Department pass the bed down on a huge amount of patients every single day, as the emergency demand that is competing with the elective cases. However, the Trust does its best not to cancel the electives to try and continue to clear the backlogs. These backlogs are just not good enough and patients have been waiting far too long and the teams are attempting to clear them through several methods at the moment. The Trust is utilising the independent sector to take some low routine work where it can. Unfortunately, there is a lot of clinical work they cannot take and they cannot take children or complex big general anaesthetic cases. The NHS has paid them a contract for their capacity and the Trust are using that and have a really good relationship. Ramsey now come on our site every week and triage patients suitability. Long waiting patients have been contacted to ask if they are willing to go into the independent sector.

The Trust is also using mutual aid which is where it works as an Integrated Care System and in particular asking East Lancs, Blackpool and Morecambe Bay if they could assist with any work because they do not have significant numbers waiting. To put that in context, Lancashire Teaching Hospitals has 777 long waiters and Morecambe Bay have 40 long waiters, Blackpool have around 30 and East Lancs do not have a patient waiting for more than 52 weeks. Therefore, you can see that difference depending on where you live now across Lancashire. This is no one's fault it is just because of the way services are set up, what the Trust provides and Covid. There is commitment in the ICS to work as a group to ensure that patients who are willing to travel, can move patients around. The Trust has already successfully sent quite a few patients to East Lancs and this is the first time in history the NHS between providers have actually managed to do this. It really demonstrates how the collaborative working system starting to change. Unfortunately, they cannot take some of the neurosurgical, colorectal, some of the other cases where there are some long waiters. So again, this is being reviewed outside of the Integrated Care System, for help with this more specialist provision.

The third method is WLI's which is Waiting List Initiative and is the one that we do not like to keep doing, to keep asking staff workforce that is most skilled, to do extra shifts to clear the patients at weekends, evenings using the facilities and using the assets. As you can imagine, in terms of the health and wellbeing of staff, this is a difficult request because you are asking teams to do more and more. This is very much a balancing act of not burning staff out who are committed to clearing the waiting lists but it is also a huge way of delivering more activity for patients at the evenings and weekends. There is also the insourcing outsourcing models with companies who have been established for years and are re-emerging for the demand. They can supply a workforce and they often bring staff on their books to use your facilities at weekends. There is an Endoscopy unit and Diagnostics who also have a bottleneck that are using insourcing and outsourcing.

The internal efficiencies are being reviewed to increase productivity as some were lost due to Covid and with the recent changes to the infection control measures this is allowing

productivity to increase. There are teams helping to get it right first time and challenging what current processes to improve. This is tracked weekly and F Button is chair of a meeting with all the teams, and the Divisional Directors are focused on this. This is of a high priority for the Trust. After 104 week waiters have reduced focus will start to move down to 78 weeks for next March and then down to 52 week waits the year after. This is a long recovery for the NHS and it has to be recognised that Lancashire, Manchester, Leicester, Birmingham and Southampton have the biggest waiting lists which will take time to clear. The other dynamic to clearing waiting lists is financial and the Trust is required to ensure that it has the finances to do this because they are not being done within the core capacity. The Trust also has to ensure it looks after the health and wellbeing of staff and make sure patients are not coming to harm while they are waiting significant amounts of time. Running alongside this G Skailes the Trust Medical Director and S Cullen the Trust Nursing Director have a clinical harm group looking through the lists validating with the clinicians to review patients to ensure that no harm is happening to patients.

K Ackers advised that 104 weeks is a very long time to be waiting. F Button explained that the P Codes are used to prioritise categorisation of patients and that the private sector is being utilised to assist with backlogs.

M France advised that the Trust has an unenviable task of the 777 patient target by the end of June and asked F Button if this is achievable for the next two months. M France asked if there is anything the Governors can do to assist. F Button informed that at the moment there are plans for 88% of those patients for the end of June. There is a risk around a 12% and have a high risk of 8% around 67 of those patients so going out of area for some spine work, some neurosurgical work, plastics, neurology and colorectal. Therefore, the more complex cases still to work on but overall, completely on track and the Trust achieved the April target. Unfortunately, there were impacts due to the recent wave of Covid and staff shortages. Other Trusts have been contacted with the help of the Chief Executive and this is a Government set target. Staff are working incredibly hard to achieve this and it will not be anyone's fault if the target is not achieved therefore a sympathetic understanding is requested.

R Allcock asked why there is such a large difference in the numbers waiting compared to the neighbouring Trusts. F Button explained that Lancashire Teaching Hospital is very different to the neighbouring Trusts. Even before Covid there were very long waits, particularly neurology, neurosurgery and colorectal and that is just the competing demand of being a centre that does almost everything specialist, tertiary and cancer.

7. **Estates and Facilities Update**

The report had been circulated with the agenda and D Hounslea attended the meeting to answer any queries. The Chair opened to questions.

F Robinson asked about the new inpatient ward at Chorley due to be completed at the end of June but thought this had been due in March. D Hounslea explained that the build was going to be a single storey building however part way through the project, additional funds were allocated for a second level to be added. This has an impact to the carparking and staff have the option to use Morrisons car park but unfortunately this has not been used by many members of staff. There is free bus travel to Chorley hospital from Morrisons by anyone using their ID badge. F Robinson provided feedback that there is

limited visitor parking space at Chorley especially around 10.00am and his relatives have experienced this. K Ackers added that there is a lack of 'blue badge' spaces however D Hounslea is not aware of this being an issue.

J Miller asked what the plan is for the area under the Lancashire Eye Centre and D Hounslea was unable to answer but advised K Hatch may be able to help her. D Hounslea confirmed that P Collier's role is going to be recruited to again and currently his workload is being divided amongst colleagues.

Any further queries regarding the report please email J Miller or D Hounslea.

8. **PALS Frequent Complaint Theme**

Stephanie Iaconianni Head of Patient Experience and PALS attended the meeting to provide information around the more frequent complaints and themes. S Iaconianni overheard the mention of car parking and informed that there have been no complaints recently regarding car parking issues.

S Iaconianni explained that there is an increase in complaints around waiting lists and the Trust is working through the backlog of patients. There have been concerns received around visiting and the measures in place for infection control are gradually reducing and visitor numbers are increasing. Complaints have been received around the blood clinic which have now dissipated due to patients being able to walk in rather than ring and book an appointment. However, GP referrals do still have to ring and book an appointment. Some concerns were received regarding the Nightingale hub environment but this will de-commissioned at end of June. Communication is usually the most frequent topic for complaints especially during Covid as it has been difficult for families to stay in touch with their relative in hospital as clinical priorities will take precedent over communicating with families.

L Lynch asked if staff are back in the office at the front of Royal Preston Hospital and S Iaconianni informed that they have been from two weeks ago however there is still social distancing to consider but there are two colleagues each day on the Preston site. Work is ongoing for an office space for the Chorley Hospital. There will soon be 3.5 fulltime staff as PALS advisors and S Iaconianni has requested more support as there is an increase in complaints and concerns being raised. L Lynch provided feedback of patients not being able to reach the PALS team and asked if any improvements can be made for access to the team. S Iaconianni advised that resource is being addressed and live feedback is being obtained from patients in the Emergency Department and on the wards to try and resolve issues before they become a complaint. S Iaconianni is aware of concerns raised on social media and has been working with the Communications team to respond to them and asked for Governors to allow the Communications team the opportunity to respond appropriately. S Iaconianni also asked when Governors are aware of someone not being able to contact PALS to contact her with the details, providing they have given consent, as she is usually available.

K Counsell advised that many people do not like to leave voicemails and asked if there is anywhere to send a text message or leave a message on social media and asked if a link could be set up for people to provide feedback there. S Iaconianni advised that she can look into the option with the Communications team to see if there is a mailbox or messaging system that could be set up. S Iaconianni asked that Governors do not respond directly to people as the Communications team will respond where they are

tagged however please forward details of any complaints that are not tagged to the Trust. S Iaconianni confirmed where complaints are raised about the standard of letters these are recorded, however there is no theme regarding complaints for letters.

K Smyth appreciates the amount of work being undertaken to the standard and content of the responses to the complaints. S Iaconianni informed there is a department audit but there is also going to be an audit undertaken where a cross division review of responses will also take place.

Please direct any further queries to S Iaconianni who will be happy to respond.

Action:

- **S Iaconianni will look into the option with the Communications team to see if there is a mailbox or messaging system that could be set up for people to leave their queries or provide feedback.**

9. **Patient Experience and Involvement update**

The report provided by A Cookson was circulated on the agenda and gave a brief overview of the content of the paper.

A Cookson advised that there is another Deaf awareness session coming up with NCompass on 24 May 2022 and the link to join is on the report. The next Carers Forum is on 25 May 2022 and Governors are also welcome to join.

A Cookson explained that communication is always a challenge and her colleague has shared an idea that A Cookson could link in with clinical practitioners who carry out the staff inductions therefore she is producing a guidebook covering some of the basics to include information on how to book language and BSL interpreters along with other tips on supporting the Deaf community, people with learning difficulties and blind/visually impaired community.

K Counsell asked if there is any way to have all staff, fully aware regarding the information in the booklet as some will not read the information. A Cookson advised that the booklet is circulated to all Managers, Ward Managers and Matrons and is open to any other ideas how to circulate the information further however it cannot be included as mandatory training as previously requested but this is also discussed in the induction.

K Ackers thanked A Cookson for presenting and advised that the booklet sounds like a great idea to provide the information to staff.

10. **Non-Executive Director update**

K Smyth informed that the future is still to be confirmed of the groups discussed in the last meeting, Patient and Public Carers Group and the Patient Advisory Group, which are maintained by the CCG. K Smyth has a meeting with the Chair of the PPCB and will hopefully be able to get more information. K Smyth advised the group of some of her current involvements.

- Working with J Young on the digital strategy as K Smyth has concerns this may discriminate against people who are not familiar with digital systems.

- Do not attempt resuscitation work and K Smyth has written up notes from the patient reference group and also included her own experience of people having had DNACPR's assigned to them without the full process being implemented. K Smyth was invited to speak at the Big Room for End of Life and there is a new Big Room being set up for DNACPR which K Smyth will also attend.
- Working with learning disability colleagues and K Smyth is a lay leader at the Yorkshire and Humber Patient Safety Translational Research Centre and work has been done scoping in the way in which people with learning disabilities are nursed in hospital, which was published in the British Medical Journal. K Smyth has put the Trust's colleagues in touch with the researchers to see what can be learned. The maternity services colleagues are also reviewing this option.
- Involved in working on the patient experience strategy with C Musonza and C Silcock and K Smyth has been able to involve other Non-Executive Directors and provided them with the paperwork.
- Attending the Determinants of Health Board meetings and able to provide input to their action plan and has highlighted the need for more affordable social housing and ensuring people have their maximum income and know what they are entitled to claim. There is also work being undertaken around food and fuel poverty and social value in the area.
- Working with other Directors and colleagues within the Trust on anchor institutions and social value. There is now a monthly internal group which looks at all the different things that the Trust is doing in relation to social value which includes the green strategy, waste strategy and the way in which recruitment is done in the community. J Wood and K Smyth are writing a chapter for a book regarding anchor institutions and social values.
- National work with the Disabled NHS Directors Network. They had planned for Chloe Smith the MP Minister for Disabled to attend the last meeting but unfortunately she had to cancel and will reschedule for later in the year. K Smyth is doing lots of presentations and recently spoke at the Association for Ambulance Service Chief Executives Conference. Last week K Smyth met with Lord Holmes who started this work by writing a report for the Government on the lack of visibility of disabled people in the NHS. There is a lot of work being undertaken in the North West and Amanda Doyle the Regional Director is very keen for the area to lead in the work for equality, diversity and inclusion.

The Chair asked when they can expect the Patient Experience Strategy for review and K Smyth informed that C Silcock is working on finalising this. A Cookson confirmed the strategy will be launched soon.

11. **Terms of Reference Review**

The Chair asked if anyone has any queries to the Terms of Reference that were circulated with the agenda.

The Chair informed that 4.2 refers to a minimum of two Non-Executive Directors and the Associate Director of Quality, Effectiveness and Experience which is C Musonza and Divisional Director of Estates and Facilities shall be in routine attendance. V Crorken is the new Non-Executive Director who has replaced G Rossington however K Swindley advised that her workload is quite large so has asked that the Care and Safety Subgroup proceed with one Non-Executive Director who is K Smyth. It was agreed that 4.2 is amended to state 1 Non-Executive Director. All the subgroup in attendance agree and the Chair asked K Brewin or J Wiseman to proceed with the amendment.

Action:

- **J Wiseman to amend the Terms of Reference for 4.2 to state a minimum of 1 Non-Executive Director.**

12. **Vote for Chair/Deputy Chair**

The Chair advised that the role of Chair and Deputy Chair is for a 12 month period and this is now available for election. The Chair would like to continue in this role and the group thanked the Chair for her work and L Lynch and M France commented that they would like her to continue. No one volunteered to take the role of Deputy Chair so the Chair will email all members to ask if anyone would like the role of Deputy Chair.

Action:

- **The Chair is to advise if anyone responds on email and would like to be the Deputy Chair of the Care and Safety Subgroup for the next 12 months.**

13. **Reflections on the meeting**

The Chair informed that she has received an email to advise that on 15 June 2022 it will be the first National Healthcare Estates and Facilities day which will be held annually. There is a proposal that from now until the 15 June there is an opportunity for Governors to take part in training within the Estates Facilities. Training and uniforms will be provided when required and special requirements can be accommodated. If anyone would like to take part please email J Miller. The areas include both sites and these are Portering, Catering, Catering Retail, General Office, Grounds Team, Linen Team and the Security Team.

14. **Request for future meeting topics**

L Lynch suggested that an informative discussion around projects for Governors with a view of when it is possible to be on site again. The Chair informed that she has provided a list of Governors who volunteered to assist with the STAR audits to C Musonza and advised that no one has had a response back. C Musonza is currently on holiday but A Cookson informed she will link to K. Dickinson today.

A Cookson had previously asked for volunteer Governors who could check the patient information leaflets on wards and advised that there still needs to be a measure of restriction from moving from one ward to another for infection control. IPC will advise once it is safer to be on site. P Brooks informed that he is finding it more relaxed now however still wearing a mask on site. K Counsell asked if the ward iPad could be used and one person attend and review the patient experience information leaflets or ask the Porters if they could do it. The Chair had difficulty understanding how that would work for the patient information leaflets to check expiry dates. P Spadlo advised that would take one person a lot of time to visit all of the areas for both sites. K Counsell advised three Governors could carry this out on each site and make appointments with the wards. A Cookson advised that it may work however many of the audits were carried out without prior notice. The Chair advised that the CQC carry out surprise visits and it is probably the best method for audits. F Robinson is due to be on Leyland ward tomorrow and will have a look at the standard of patient experience information leaflets are there.

K Ackers advised that it is also the notices on the notice boards that are sometimes out of date and the Chair advised that there is a 'posters group' who review the dates on the posters. There is some difficulty when the display cabinets are locked as keys have been lost but when there is a notice out of date she removes them. L Lynch suggested drawing someone's attention to the notice and ask the member of staff to remove them as this is not the role of Governors. The Chair advised of the form that can be completed to raise concerns or notify of issues to the Head of Department.

P Spadlo asked if someone from the Portering Service could attend and advise of their work and also suggested an update on cyber security and what is done to protect the NHS.

L Lynch suggested asking UCLAN who provide the training for nurses at or Bolton School of Nurse Training to provide feedback and advise of any enhancements that could be implemented. K Counsell like to understand more on the hospital policies on disabilities and inclusion, how they are managed and how the Trust are performing. A Cookson informed this covers a very large remit for patients and staff and if there is something specific like Workforce information then they could be contacted or Louisa Graham could attend. K Smyth also knows a lot of information and attends the meetings. The Chair informed that within the pack sent to K Counsell there were the minutes from Equalities, Diversity and Inclusion group included in item 9.

Action:

- **A Cookson will speak to K Dickinson regarding the list of Governors who have volunteered to assist with the STAR audits.**
- **Frank Robinson to check patient leaflets on Leyland Ward**

15. **Staff Facilities Update**

R O'Brien the Associate Director of Workforce attended the meeting on behalf of K Swindley to advise the group of the staff bulletin information and presented the information on the screen. J Wiseman emailed the presentation to all after the meeting.

F Robinson advised that Governors do not have access to the intranet so cannot always access. R O'Brien advised that the bulletins are printed out as a hard copy and added to staff rooms.

P Spadlo advised there is no water dispenser at the X ray and MRI departments at Preston and have limited café facilities in the Rosemere. Out of hours has no provision so asked if they could have access to somewhere closer than the front of the hospital. R O'Brien will feedback to the group who are reviewing facilities. There are 24 water dispensing machines on order for clinical areas so will also look if Xray was on this list. R O'Brien advised that it can be difficult for communal areas as they need to be restocked and P Spadlo advised that the staff reorder the cups and restock the water machines.

The Chair asked if the refurbishment of Charters will result in the restaurant being closed or if this will be done in phases. R O'Brien informed that the plan is not available yet but it is hoped that disruption will be kept to a minimum.

K Counsell asked if the Job Centre is being utilised for the provision of having trainees. R O'Brien advised that Workforce is working with the Job Centre on a number of employability schemes and are generally going well.

R O'Brien advised that in summary, she hopes that everyone can identify that there is some positive progress being made and they have got a number of things planned which will come to fruition in the next few months and it is still very much a work in progress and there is much more improvement needed to be done around this area and she happy to keep the group updated as progress is made. D Hounslea advised that he will check what staff facilities are going to be included in the new modular build at Chorley.

Actions:

- **R O'Brien to check is a water dispenser is on order for the X Ray Department at Preston.**
- **D Hounslea advised that he will check what staff facilities are going to be included in the new modular build at Chorley.**

16. **Any other business.**

K Ackers asked why he can see people smoking on the no smoking sites. The Chair advised that it is the people that choose to ignore the information that is readily available and G Wright will continue to update the group regarding the progress of the CURE Smoking cessation service.

A discussion took place around connection issues using iPads and J Wiseman advised anyone having issues to contact the I.T. department. The Chair informed that there were iPads on order and any Governor who still has not been issued one to email J Wiseman.

17. **Date, time and venue of next meeting**

The next meeting of the Care and Safety Subgroup will be held on 14 July 2022 at 1.00pm using Microsoft Teams.

Membership Subgroup

4 April 2022 | 2.00pm | Microsoft Teams

PRESENT	DESIGNATION	04/04				
Pav Akhtar	Public Governor *(Chair)*	P				
Takhsin Akhtar	Public Governor	A				
Rebecca Allcock	Staff Governor	P				
Sean Barnes	Public Governor	A				
David Cook	Public Governor	A				
Margaret France	Public Governor	P				
Steve Heywood	Public Governor	P				
Lynne Lynch	Public Governor	A				
Janet Miller	Public Governor	P				
Eddie Pope	Appointed Governor	A				
Frank Robinson	Public Governor	P				
Suleman Sarwar	Appointed Governor	A				
Mike Simpson	Public Governor	P				
Piotr Spadlo	Staff Governor *(Deputy Chair)*	P				
David Watson	Public Governor	P				
IN ATTENDANCE						
Naomi Duggan	Director of Communications and Engagement	A				
Adam Sharples	Marketing Manager	P				
Karen Swindley	Strategy, Workforce and Education Director	A				
Tricia Whiteside	Non-Executive Director	P				
Jo Leeming	Corporate Affairs Officer (minutes)	P				

P – present | **A** – apologies
***Quorum**: 50% of the Subgroup's total membership at the time of the meeting*

1. **Chair and quorum**

In the absence of the Chair, P Spadlo noted that due notice of the meeting had been given to each member and that a quorum was present. Accordingly, P Spadlo declared the meeting duly convened and constituted.

2. Apologies for absence

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

3. Declarations of interest

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

4. Minutes of the previous meeting held on 7 February 2022

Slight amendments were made to the minutes.

5. Matters arising and action log

J Miller noted on page 2 of the action log, item 8, N Duggan to feed back to Louise Barker regarding information being emailed to councillor email addresses, it was suggested there are GDPR issues, but Governor email addresses are on the website so cannot see the issue.

6. Membership Strategy action plan

The Chair advised this group has done some great work on the Membership strategy, and at the last meeting we agreed to having a smaller group to draft an action plan. This group went through the plan and put in some draft actions against the strategy objectives and assigned names as a working guide.

There was discussion around the first cohort of actions, and T Whiteside noted we need to consider where Governors are targeting their attention and to look at aligning events with specific interests. J Miller stated we need to think about what makes Governors want to be Governors, and noted the urgency of addressing when Governors are not engaging. S Heywood suggested having a questionnaire for Governors to ask what types of events, etc, they would like to get involved with.

J Miller stated we need to look at the website as Catherine Arrand-Green is still named as the Membership Secretary and it states there are 22,000 members. S Heywood noted last year there was a Governor event in Leyland to meet each other face to face, and we need an event like this again.

J Miller stated she had been asked recently when Governors will be returning to the hospitals to interview patients and staff, but this has raised the question of what perspective people have on the role of a Governor. Also, whilst restrictions have eased, they have not in the hospital setting. T Whiteside stated we need to think about how we induct new Governors into a Covid world, and how existing Governors continue their roles in a Covid world as things will not be changing soon.

T Whiteside suggested having a Governor sponsor for subgroups of actions, which was agreed.

J Miller stated she has been trying to push Leyland Festival as a means of getting Governors out into the community but is struggling to make any progress with support from HR. T Whiteside noted the importance of this and stated she will follow up on this. T Whiteside stated we should be maximising the opportunities from all events like this but questioned if we really understand our demographic and there should be some regular understanding of where we are with the demographic.

P Spadlo advised he is meeting with Jackie Higham, Widening Participation Manager, and her team on 5 May as they will be having some involvement with the membership subgroup going forwards.

M Simpson queried who has taken over from Catherine Arrand-Green, and S Heywood also noted that the Corporate Affairs Team has expanded so it would be good to know who does what, and this needs to be communicated.

M Simpson questioned what is the youth offer to this group around careers, projects, fund raising, and so on.

S Heywood suggested holding a workshop session involving all of the Governors on this action plan.

The plan was updated, and Governor sponsors assigned to each section.

7. Election of new Membership Subgroup Chair

P Akhtar is stepping down as Chair of this group after today and asked for names of those who want to be considered to be Chair. P Spadlo put himself forward, all voted in favour, and he was duly elected. P Spadlo noted they also need to look at who will take up the vice chair position. M Simpson stated would be happy to support as vice chair and all members were in support.

8. Governor elections update

The Chair left the meeting, and the new Chair took over, noting congratulations to the re-elected Governors Mike Simpson, Steve Heywood, Takhsin Akhtar and Peter Askew, and to the newly appointed Governors Kristinna Counsell, Sheila Brennan and Paul Wharton-Hardman new. There is a Governor induction session for them to attend on 8 April.

9. Reflections of the meeting

No comments.

10. Requests for future meeting topics

T Whiteside stated that now that we have the key areas for the strategy, the agendas can be structured around this going forwards.

11. Any other business

J Miller questioned why the agreed hard copy version of the membership strategy is not in the same format as the one on the website as it does not have up to date photos of current Governors. Adam Sharples will look into this.

J Miller queried if members have been sent invites to the coffee catch-ups, A Sharples can send out a reminder today, but it won't reach all members.

P Spadlo will contact the new Governors to see if they want to join this group.

P Spadlo noted we need to look at attendance from Governors at these meetings going forwards.

12. Date, time and venue of next meeting

The next meeting of the Membership Subgroup will be held on 4 April 2022 at 2.00pm using Microsoft Teams.

Chairs, Deputy Chairs and Lead Governor with the Chairman and Chief Executive

4 April 2022 | 10.00am | Microsoft Teams

PRESENT	DESIGNATION	04/04/22	04/07/22	03/10/22	09/01/23
Professor E Adia (Chair)	Chairman	P			
Pav Akhtar	Chair of Membership Subgroup	P			
Steve Heywood	Lead Governor	A			
Kevin McGee	Chief Executive	P			
Janet Miller	Chair, Care and Safety Subgroup	P			
Piotr Spadlo	Deputy Chair, Membership Subgroup	P			
IN ATTENDANCE					
Jo Wiseman *(minutes)*	Corporate Affairs Officer	P			
Karen Swindley	Strategy, Workforce and Education Director	A			
P – present | **A** – apologies					

1. Apologies for absence

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

2. Minutes of the previous meeting

The minutes of the meeting held on 10 January 2022 were agreed as a true and accurate record subject to amendments to minute:

3.0 (b) to amend G Skailes to J Hawker - *Lead Governor Update: New Hospitals Programme* – The Chair informed that this action was for him to discuss with G Skailes around the broader issue of engagement for the New Hospitals Programme and support provided by Health Watch in particular. The Chair informed that there is no update but will raise this with G Skailes.

3. Matters arising and action log

The action log had been circulated with the agenda and the following comments were noted on specific actions:

(a) *Lead Governor Update: New Hospitals Programme* – The Chair informed that this action was for him to discuss with G Skailes around the broader issue of engagement for the New Hospitals Programme and support provided by Health Watch in particular. This action was discussed and agreed completed.

(b) Lead Governor update - K Swindley to discuss relative and patient leaflet content with S Cullen to include IPC reference and why visiting patients is restricted. J Miller advised that although this action has been marked completed as decision taken to enhance signage due to continually changing landscape and information changing

so rapidly, but she did not agree that the signage has been added or updated. K McGee agreed that he would take ownership of this to speak with the teams. Action reopened.

The action log would be updated and, where appropriate, actions marked completed and removed from the active action log.

4. Chairman and Chief Executive update on key issues

K McGee informed that the Trust is under immense pressure and the whole country is experiencing the same issues throughout the emergency services, with ambulance delays due to long waits in the Emergency Departments, and a lack of flow in the system with slow discharges due to issues in the social care market. At the beginning of February there were 27 inpatients with covid and its increase to over 120 over the weekend. The infection rate in Lancashire and South Cumbria is just starting to see a downturn however this will take a couple of weeks to show a reduction in the numbers of hospitalisations. It is expected that the increase this will put the organisation under severe pressure as the elective restoration continues. On a more positive note, the trajectory target for March for the 104 week waits for surgery has been achieved and as long as the program is not compromised by Covid, the Trust remains on target to achieve the end of June target of zero 104 week waits. K McGee advised that he is having some difficult conversations internally with regard to continuing the elective restoration whilst the Trust is under pressure. K McGee expressed that the elective restoration is a priority for the Trust. There are concerns around the increasing cases and the impact to staff sickness rates, which is also affecting other sectors as seen in the press over the weekend regarding the airport delays.

There are 48 patients in the Nightingale hub which is really helping the situation and will be available to the Trust until the end of June, by which time the additional capacity will be available at Chorley. There is hope that the Covid cases will have a sharp decline once they have peaked, which will provide the Trust with more capacity. The National debate taking place is around how we live with Covid, with the consideration of what level of infection prevention control to implement and if this can be relaxed to make risk based decisions. All the risks in terms of what the NHS position currently faces, is being held through the response times with ambulances, or through the Emergency Department of the Trust and if the risks can be managed more effectively through the system in more risk based decisions.

The teams are working extremely hard and well together under pressure. K McGee added that the long term solution for Lancashire Teaching Hospitals is the New Hospitals Program. There are shorter term goals in order to receive capital but the pressure from the emergency route in, is not fit for purpose.

In terms of the wider system things are progressing in regard to the Integrated Care System and Kevin Lavery has now joined as the Chief Executive, who will be someone with a positive impact. There have been some great appointments in terms of the Executive Team and Dr David Levy, Regional Medical Director, has been appointed to the Medical Director for the ICS. Dr D Levy will start to influence discussions and that will be an important appointment because with the New Hospitals Program and the work being done on a joint strategy for Lancashire and South Cumbria.

The other ongoing work is the preparation for next year. The final plans for next year are to be submitted by 19 April 2022. There are difficult targets to deliver and there will be pressure nationally. For Lancashire and South Cumbria, there is still a financial gap so this will also be reviewed, along with the capacity that is required to deliver the services and elective targets. One of the big issues the Trust and other Trusts in the area face, as a system, is the non-recurrent capacity that all have opened to help with the winter pressures and Covid flow. No one will have the funding on the recurrent basis so there will be a plan on how to close that capacity down. This will require, appropriate out of hospital care, by using virtual wards and further improve the discharge processes. In summary, the three big issues currently being managed are the here and now in terms of the operational pressures and elective capacity, the work being undertaken for the clinical strategy and the New Hospitals Program and the planning process for next year.

J Miller asked if there is a confirmed date for the completion of the modular build at Chorley. K McGee advised that it is expected to be commissioned and in use by early July.

P Akhtar asked that due to the increasing Covid infection rate if anyone is recording clusters or performing community testing where clusters can be identified. K McGee informed that he also has concerns regarding the reduction of testing and we could see testing set up again, due to the increase in national infections. Over the coming weeks the Trust will probably see more cases. P Akhtar also informed that the Trust had recently responded to helping a Muslim faith person who sadly passed away on a weekend. P Akhtar advised that the chaplaincy team, Imams and staff in the hospital, worked very well with resolving the issues for the relatives and this was very much appreciated.

J Miller advised that she recently visited an inpatient at Chorley Hospital and on contacting the ward she was advised that she would need to produce a negative result for a lateral flow test. J Miller entered by the ATC entrance and went to level 3. On the corridor outside theatres, J Miller found a visitor without a mask so had escorted him to Lancashire Eye Centre to provide a mask. Then another gentleman going up to Rookwood B did not have a mask on, so J Miller hoped the ward staff addressed this with him. When J Miller entered the ward, no one asked to see her lateral flow test result. K McGee advised that everyone in the hospital, clinical and non-clinical are required to wear a mask so he will speak to the teams to ensure the tests are being produced as evidence and that wearing of masks are still being encouraged. The ward staff should have also asked to check the negative result for visitors entering the ward. J Miller added that one of the Trust volunteer's has recently informed her that they had spoken to a member of staff who did not use the hand gel or put on a mask when entering the hospital at the ATC entrance at Chorley. The member of staff responded to their challenge, advising that Lancashire Teaching Hospitals are the only Trust who still has gel and masks in place and continuing with the Covid rules. The Chair asked for J Miller to email the details to him because that response is not acceptable from staff.

Action:

- **K McGee will speak to the teams to ensure the tests are being produced as evidence and that wearing of masks are still being encouraged.**

5. Draft Council of Governors agendas (part I and part II) – 26 April 2022

The draft Council of Governors agenda's for part I and part II had been circulated with the agenda.

The Chair informed that there will be an update from Professor P O'Neil on the work being undertaken in the Education, Training and Research Committee. K Swindley will provide the update on the Workforce and OD Strategy, followed by J Hawker updating on the New Hospitals Program. There will be three items under the Governance and Compliance.

The Chair asked that the item 9.2 on part I agenda should be a part II item and if J Wiseman could arrange for that to be moved. Governors should be given the opportunity to say no or challenge the appointment however part II would be more suitable. The Chair can then report this at part I Board once the appointment finalised.

The Chair asked colleagues if there are any items still to be added to the agenda. J Miller asked if P Akhtar would still provide an update of the Membership Subgroup as he is standing down. P Akhtar confirmed he will be standing down as Chair of the subgroup however he will provide the update and introduce the new Membership Subgroup Chair they are hoping to appoint in the meeting later on the 4 April.

Action:

- **J Wiseman to request that item 9.2 on the part I agenda is moved across to part II.**

6. Subgroups and Lead Governor updates

(a) ***Care and Safety Subgroup*** *(Janet Miller)*

Janet Miller advised since the last meeting on 10 January 2022, there have been two Care and Safety Subgroup meetings held on the 17 January 2022 and 24 March 2022.

- Gemma Wright provided the update on the developments to date on the CURE no smoking project.
- Karen Hatch and Ange Lewthwaite provided updates on the Outpatient Booking Services, in particular the patient communications. It appears the Trust outsource the majority of the letters and text messaging service to Healthcare Solutions and the remaining 25% of letters are produced in house. At a later meeting it was confirmed that PALS had not recorded any patient concerns regarding communications but to rectify this situation a Datix has now been recorded. The two actions taken by Ange Lewthwaite on 17 January are still to be updated however C Musonza is meeting with J Miller on the 5 April 2022 to hopefully confirm that the working group for patient communications has now met and will provide an update.
- Janet Young attended to provide the Governors with an update regarding data science used by the Trust.
- C Silcock and C Musonza attended the meeting and provided an update on Safety Two, Patient Experience Involvement Group and the Patient Experience Improvement Group.

- Colleagues raised concerns regarding the waiting times for ambulances and the impact of buying lateral flow tests for low income families.
- Outside of the meetings, concerns have been raised regarding:
    - the incident involving a Lingwood security staff member breaking into a locked desk at the ATC entrance at Chorley
    - an abandoned ambulance at Chorley
    - the theft of the ATM machines at Chorley
    - the arrangements for people attending weekend appointments who need to register their blue badges
    - home-made poor quality signage frequently used which partially sighted people cannot read due to the sheen on the laminated paper signage.
    - The way in which relatives raise their concerns on social media
    - At the meeting of Lancashire and South Cumbria Quality and Performance in January, the concern was raised that Preston Royal Hospital are an outlier for the Friends and Family Test
    - J Miller has also noted a number of errors on the Trust website. J Miller has emailed A Sharples to advise of the errors and she will follow this up with a phone call.

(b) ***Membership Subgroup*** *(Pav Akhtar)*

P Akhtar informed last Subgroup meeting on the 7 February 2022 and provided an overview of the issues discussed, with highlights including:

- The Membership strategy has been reviewed during the last year in terms of how the membership can best support the Trust values and ambitions. P Akhtar conveyed his thanks to K Swindley, N Duggan and J Leeming for their work on the strategy. There have been meetings held to form the action plan and that will be reviewed today at the Membership Subgroup meeting with a hope to assign the actions to specific members. P Akhtar gave examples of some of the actions.
- The election of Governors has recently taken place with the appointment of 9 new Governors with some of those as returning Governors. P Akhtar advised that unfortunately, the BAME colleagues are usually in the bottom section of the list due to the alphabetical ordering so possibly moving to anonymised data for candidates without photographs, may be a better option. The vote would then be based on the candidates statement and what they intend to achieve. J Miller added that she had asked K Swindley if the photographs could be removed as there is no reference in the Constitution, to say that they need to be included. K Swindley referred this to Civica who informed that the photographs cannot be omitted as per the Constitution. A representative from Hempsons confirmed that the photographs can be omitted. At this point, the elections were too close for any changes to be enacted.
- A replacement Chair will hopefully be selected today at the Membership Subgroup meeting. The subgroup are working well together and is surrounded with the correct support.

J Miller has been contacted by a number of members, predominately in the Chorley area, regarding the accuracy of the nominees statements. One nominee claimed to be a volunteer vaccinator, without having a medical background. M France, who is a retired GP, could not volunteer as she was no longer a member of any regulatory body. J Miller asked if there are any checks in relation to the candidate information and statements that are provided. J Miller will send the details to the Chair so that he can investigate the matter further.

Action:

- **J Miller will send the details to the Chair who will investigate the accuracy of the candidate information used for the elections.**

(c) ***Lead Governor update*** *(Steve Heywood)*

S Heywood sent apologies for today however the Chair will ensure that S Heywood can provide the update at the Council of Governors meeting.

7. Any other urgent business

(a) CQC Inspection

P Spadlo advised that as a Governor, staff ask him questions and he then has this opportunity to bring to this meeting. P Spadlo has read the last two CQC reports, the last one being in 2019 and the CQC rated with requires improvement'. Chorley improved to be rated 'good'. Chorley urgent care was rated 'good' and staff have asked what actions have been put in place to improve Preston. The Chair informed that there is a comprehensive action plan in place. There was improvement from the 2014 CQC rating and overall, the Trust was rated 'good' for the Well Led section. There were areas that had 'must do's' which have been monitored carefully. There are regular updates at the Board Workshops and MIAA provide assurance that actions are progressed. Urgent care is still challenged and may be an area the Trust will be vulnerable.

(b) Facilities at Chorley Hospital and Royal Preston Hospital

P Spadlo has contacted numerous people regarding the facilities for patients buying tea and coffee at MRI Preston. The café is only open for brief sessions. Patients attend MRI in the evening and some come in for long scans therefore, they have to be sent to the front of the hospital which is around half a mile walk. Patient feedback is that other hospitals have facilities and vending machines. Water machines are being installed as per Rachel O'Brien but there are no hot drinks available and P Spadlo has been unable to progress this. The Chorley site is mostly the same, especially difficult on the weekend.

Action:

- **J Wood to take the action to investigate if there are any plans to improve the café or vending for people visiting Chorley at weekends and for Preston MRI area. P Spadlo is happy to provide more information of the issues.**

(c) Staff Car Park Charges

P Spadlo advised that he has been contacted by staff to query staff car parking charges. The team brief recently informed that the charges would be re-introduced from July. P Spadlo asked if any provision would be made for staff who are working from home and only attend on site one or two days a week as it would not be fair to be charged the whole amount. J Miller added that K Swindley has set up a car park working group with staffside who are looking at parking permits. The Chair informed

that the removal of charges though the pandemic was led by the Government and they are re-introducing the charges nationally. P Akhtar mentioned that there is a Facebook group that was set up during the beginning of the pandemic and local residents offered spaces on their driveways so it may be worth investigating if that option is still in place. J Miller added that the Preston Business Centre always has spaces available for staff and there is a free regular bus service to take them up to the hospital. Patients are also using the Business Centre and they have a mini-bus service to transport them up to the hospital, due to the car park being used for the Nightingale Hub.

Action:

- **J Wiseman to allocate the action to the car park working group that K Swindley set up. K Swindley to advise if any reduction of car park charges will be in place for staff working from home, working on site part-time once the charges are re-introduced in July 2022. Local residents offered spaces on the driveways for staff to use during the pandemic and a Facebook page was set up. Could this option also be reviewed for a short term solution.**

8. Date, time and venue of next meeting

The next meeting will be held on Monday, 4 July 2022 at 10.00am using Microsoft Teams.