NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING

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24 July 2025

10:00 GMT+1 Europe/London

Lecture Hall, Education Centre 3, Chorley & South Ribble Hospital

AGENDA

AGENDA

REFERENCES

Only PDFs are attached

0.0 - Agenda (PI) - Council of Governors - 24 July 25.pdf

Council of Governors

24 July 2025 | 10.00am

Lecture Hall, Education Centre 3, Chorley & South Ribble Hospital

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.00am	Verbal	Information	M Thomas
2.	Apologies for absence	10.01am	Verbal	Information	M Thomas
3.	Declaration of interests	10.02am	Verbal	Information	M Thomas
4.	Minutes of the previous meetings held on 24 April 2025	10.03am	✓	Decision	M Thomas
5.	Matters arising and action log	10.04am	✓	Information	M Thomas
6.	Chairman and Chief Executive's opening remarks	10.05am	Verbal	Information	M Thomas/ S Nicholls
7.	Update on Council Membership, Including Appointment of Local Authority Members	10.20am	✓	Information and Decision	J Foote
8.	Approach to Surge Planning	10.30am	Verbal	Assurance	K Foster-Greenwood
9.	Update from Care and Safety Subgroup	10.40am	Verbal	Information	J Miller
10.	Update from Membership Subgroup	10.50am	Verbal	Information	S Brennan
11.	SAFETY, QUALITY, WORKFORCE AND PERFORMANCE				
11.1	Patient Experience and Involvement Annual Report	11.00am	✓	Assurance	S Morrison
12.	STRATEGY AND PLANNING				
12.1	Board Committee Chairs' Reports	11.20am	✓	Assurance	Non-Executive Directors
12.2	Single Improvement Plan	11.30am	✓	Information	A Brotherton
12.3	NHS 10 Year Plan Update	11.40am	Pres	Information	A Brotherton
13.	GOVERNANCE AND COMPLIANCE				
13.1	Annual Members' Meeting	11.50am	✓	Information	J Foote

№	Item	Time	Encl.	Purpose	Presenter
13.2	Update on Process for the Council Effectiveness Review	12.10pm	✓	Assurance	J Foote
14.	ITEMS FOR INFORMATION (taken as read)				
14.1	Governor opportunities summary		✓		
14.2	Governor issues report		✓		
14.3	**Minutes of Governor Subgroups**: (a) Care and Safety Subgroup – 12 May 2025 (b) Membership Subgroup – 5 June 2025 (c) Chairs, Deputy Chairs and Lead Governor – 1 July 2025		✓ ✓ ✓		
14.4	Date, time and venue of next meeting: *30 October 2025, 10.00am, Lecture Room 1, Education Centre 1 - Royal Preston Hospital*	12.15pm	Verbal	Information	M Thomas
15.	REVIEW OF MEETING PERFORMANCE				
15.1	Discussion on how the meeting in public has been conducted	12.15pm	Verbal	Information	All
16.	RESOLUTION TO REMOVE PRESS AND PUBLIC				
16.1	Resolution to exclude members of the press and public	12.17pm	Verbal	Information	M Thomas

1. CHAIR AND QUORUM

Information Item | M Thomas | 10.00

2. APOLOGIES FOR ABSENCE

Information Item | M Thomas | 10:01

3. DECLARATION OF INTERESTS

Information Item | M Thomas | 10:02

4. MINUTES OF THE PREVIOUS MEETING HELD ON 24 APRIL 2025

Decision Item | M Thomas | 10:03

REFERENCES

Only PDFs are attached

4.0 - Minutes - Council of Governors (part I) MT Approved .pdf

Council of Governors Public Meeting

24 April 2025 | 1.00pm

Lecture Room 1, Education Centre 1, Royal Preston Hospital

Present:

Mike Thomas	Chair
George Bailey	Public Governor
Sheila Brennan	Public Governor
Paul Brooks	Public Governor
Darrell Brooks	Public Governor
Sonia Connell	Staff Governor
Margaret France	Public Governor
Graham Fullarton	Public Governor
Lou Jackson	Appointed Governor
Angela Kos	Public Governor
Janet Miller	Public Governor
Carole Oldcorn	Public Governor
Enid Povey	Public Governor
Christine Pownall	Public Governor
Tom Ramsay	Staff Governor
Frank Robinson	Public Governor
Graham Robinson	Public Governor
Tim Young	Public Governor

In attendance:

Tim Ballard	Non-Executive Director
Nicola Compton	Corporate Affairs Officer (minutes)
StJohn Crean	Non-Executive Director
Karen Deeny	Non-Executive Director
Jennifer Foote MBE	Director of Corporate Affairs
Adrian Leather	Non-Executive Director
Sarah Morrison	Chief Nursing Officer/Deputy Chief Executive
Silas Nicholls	Chief Executive
John Schorah	Non-Executive Director
Tim Wheeler	Non-Executive Director
Jo Wiseman	Corporate Affairs Officer

32/25 Chair and quorum

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

33/25 Apologies for absence

Apologies for absence were received from P Akhtar, T Akhtar and E Pope, and U Patel as a non-executive director.

34/25 Declaration of interests

There were no declarations of interest.

35/25 Minutes of the previous meeting

The minutes of the meeting held on 21 January 2025 and the minutes of the special meetings held on 13 and 25 February 2025 were approved as a true and accurate record subject to the amendment to minor typing errors identified in an email forwarded to the officer supporting the meeting.

36/25 Matters arising and action log

A copy of the action log had been circulated and all actions had been completed.

37/25 Chair and Chief Executive's opening remarks

The Chair opened the meeting by outlining the three current strategic goals. The first goal was to address the national outcome framework level 4 finance, specifically responding to the £70 million deficit. A plan was in place to achieve a balanced budget, despite the immense challenge. The Chair provided assurance that the focus would not be solely on finance but also on maintaining patient experience and quality of care. The second goal was to ensure that Chorley and South Ribble District Hospital (CDH) was recognised by CQC as good/outstanding. The third goal was to improve community relationships, including potential health hubs in the centre of Preston, new pathology and vascular services, and the development of facilities at CDH.

The Chair acknowledged the lack of funding and the difficulties this would pose for colleagues, including anxieties about job security and inevitable job losses. It was emphasised that in the future only those services that were commissioned and received funding could be delivered. Despite these challenges, the Chair expressed confidence in the strength of the executive team and the Board.

The CEO reported on the finalisation of Corporate Objectives within the Single Improvement Plan. The first year focused on stabilisation, while the second year aimed to return to average levels in finance and quality. The third year would concentrate on performance and strengthening the organisation.

The majority of the CQC's mandatory and recommended actions 'must do, should dos' had been met. The year began with tier one status for elective, diagnostic and cancer services, but elective and cancer services had since fallen out of tier one which was positive news. Non-elective activity had increased, but performance held steady.

Despite financial struggles, the target for the 2024-25 year had been achieved with non-recurrent support. Of the £60 million saving's target, £30 million was secured with confidence in meeting the goal, marking significant progress from the previous year.

The CEO highlighted the need to provide tertiary services from Preston and district hospital services from Chorley. Vascular services were confirmed to transfer from East Lancashire to Preston in November, concentrating expertise and supporting the major trauma centre. LTH had been agreed as the host provider for all pathology services for Lancashire and South Cumbria.

The next year would see a complex picture with some staff leaving and others joining or transferring. Closer ties with UCLan as the local university were being pursued, with potential for a new education centre and joint posts or faculty.

During the discussion that followed, the CEO gave further detail on thrombectomy services, including the aspiration to move to a 24/7 service.

In response to a question, the CEO confirmed that where possible previous work was being utilised and relied on to deliver the financial benefits required. Further investment would be needed for estate and infrastructure, with plans to approach NHSE with options for the estate in the absence of any timely new hospital build.

38/25 Update from Chairs of Subgroups

The Chairs of the Care and Safety and Membership Subgroups summarised the topics discussed at recent meetings and the following points were noted:

1. *Care and Safety Subgroup (CaSS)*

It was reported that since the last meeting on 21 January, one meeting had taken place on 13th March. Discussion had centred on the Trust estate, the frailty support service, blue badge parking and Gold Star presentations.

Concerns had been raised about the lack of embedding good initiatives, such as dementia wristbands. Basic issues such as uniform standards and personal appearance were also being addressed, with a focus on improving overall standards.

A concern was raised about the availability and visibility of wheelchairs at Royal Preston. It had been agreed that the wheelchair availability and information staff provided would be addressed.

(b) Public Engagement Subgroup

It was reported that since the last meeting on 21 January, one informal meeting had taken place and the next meeting was scheduled for 5 June. The Deputy Chair provided an update. Some governors attended a health mela event and had signed up new members, but it was felt that more events and efforts were needed to enhance membership.

New governors were encouraged to join the subgroup, highlighting its importance despite not being as prominent as other subgroups.

39/25 Board Committee Chairs' Reports

The non-executive directors introduced themselves and provided an overview of the areas they felt were matters of importance and required focus during their tenure as committee chairs.

1. **Safety and Quality Committee**:

The main issues highlighted from 31 January, 28 February, and 28 March meetings included significant concerns around medical device management, with a high number of

items requiring replacement, and the need for increased scrutiny on capital allocation. Additionally, there were ongoing challenges in maternity services related to tier 2 medical cover and the implementation of Birthrate Plus investment. The reports also emphasised the importance of addressing health inequalities and improving compliance with national standards of cleaning and mandatory training. Despite these challenges, the Committee was assured on the progress made in various areas, including the implementation of Martha's Rule, safe staffing levels, and the management of controlled drugs, demonstrating a commitment to improving safety and quality of care.

2. **Finance and Performance Committee (FPC)**:

Across the January, February, and March 2025 Finance and Performance Committee meetings, the Committee had sought assurance regarding the Trust's financial and operational performance, with particular focus on the challenges surrounding the 2025/26 budget submission, performance trajectories and risk mitigation. In January, risks related to cash flow, delays in planning guidance, and gaps in urgent and emergency care recovery were flagged. By February, focused discussion took place around the deliverability of the 2025/26 plan, with further detail required to support the assurance around required savings and reductions. Nevertheless, assurance had been provided in each meeting around the Trust’s ongoing improvement efforts, positive financial performance trends, and enhanced planning capacity for the year ahead.

3. **Workforce Committee**:

The main issues highlighted from the 14 January and 11 March meetings included ongoing concerns around mandatory training compliance for temporary staffing and the need for investment to ensure successful implementation of rostering programmes. Additionally, the importance of addressing workforce risks identified in the staff survey and triangulating this data with national and ICB positions was emphasised. Despite these challenges, the Committee commended positive outcomes from changes within temporary staffing, cultural leadership initiatives, and efforts to address health inequalities and support community employment.

4. **Audit Committee**:

The Audit Committee was undertaking continuing monitoring of recommendations following the limited assurance findings in the Sickness Absence Internal Audit Report and concerns in respect of the Insourcing LLPs Audit Report and ongoing issues with Single Tender Waivers. Despite these challenges, the Committee acknowledged the positive and proactive responses from executives and management to address these issues, as well as improvements in the oversight and management of outstanding audit recommendations. This demonstrated a commitment to resolving the identified gaps in governance and compliance.

5. **Education, Training and Research Committee**:

The main issues highlighted across the reports from the Education, Training, and Research Committee included the need for a robust financial plan to support the Trust's University Hospital Status ambition, ongoing financial turnaround efforts in the Research and Innovation department, and improvements in core skills compliance. The reports also emphasised the positive progress in research activities, including successful patient recruitment and significant achievements in clinical trials. Additionally, there were noted

improvements in core skills training compliance, with action plans in place to address areas of non-compliance, particularly in resuscitation training. These efforts collectively demonstrated a commitment to financial stability, research excellence, and enhanced training compliance.

6. Charitable Funds Committee

The main issue highlighted was the postponement of benchmarking for Brewin & Dolphin due to capacity issues within the finance team, which faced gaps and a busy year-end period. This had led to the formal extension of Brewin & Dolphin's contract for a year to alleviate pressure on the finance department. Despite this, the report notes positive developments, including securing a £200,000 grant for the NHS Charities Together Young Person Pregnancy Service, successful fundraising campaigns, and significant growth in the charity's budget and financial stability through efficiency measures and an internal restructure.

4025 Single Improvement Plan 2 Year Plan

The update on the Single Improvement Plan outlined the progress made and the remaining challenges. The plan served as a clear guide for staff and patients, reflecting the organisation's needs. To exit National Oversight Framework level 4 and move to level 3, specific criteria had to be met. Metrics were tracked through subcommittees and operational meetings, ensuring a consistent approach from Board to Ward.

In response to a question, it was confirmed that the plan included reducing waiting times. In response to a further enquiry, on whether improvements were being made, the CEO affirmed that the organisation had improved from a declining position, with waiting lists significantly reduced. Although financial challenges remained, the situation had stabilised due to the hard work of staff and executives. The CEO acknowledged areas needing improvement, such as sickness and staff morale.

A suggestion was made to avoid sensitive language, such as tying 'waste' to staff elements. This would be amended in the review.

41/25 Corporate Objectives 2025-26

The Corporate Objectives for 2025-26 had been set by the Board at its meeting in April to enable the completion of strategic priorities for the year. Progress would be reviewed through the Single Improvement Plan (SIP). The Board Assurance Framework (BAF) had identified principal risks and was consistent the Corporate Objectives. This document was crucial as it shaped the priorities for the year, focusing on patients, performance, people, productivity, and partnerships. There were 16 objectives in total, reflecting the size and challenge of the Trust's goals, aiming to balance stretch, hope, and optimism.

Council was informed that the Board measured its effectiveness by assessing its performance against the objectives and thereafter providing assurance to the Council of Governors. It was recognised that Council needed to undertake a form of self-assessment during the year to ensure its effectiveness and provide assurance to Trust members.

42/25 Report of Nominations Committee: Appraisal Outcomes 2024-25

The Chair provided a verbal overview of the annual appraisal process for Non-Executive Directors (NEDs), placing the formal report in wider context. It was explained that all NEDs were required to undergo an annual appraisal, with the outcome reported to Council via the Nominations Committee and then on to NHSE.

The appraisals undertaken in 2025 were compliant with the NHSE leadership competency framework for board members. The role of governors in contributing to the appraisal process would be explored at a future workshop.

Due to the turnover in non-executive directors in 2025 only Tim Ballard and Uzair Patel had received an appraisal, and both these had been reported to the Nominations Committee as a satisfactory outcome.

Objectives for 2025/26 based on the agreed corporate objectives would be set for all current non-executive directors.

43/25 Quality Account 2025/26: Agreement of Safety Priorities

A presentation was delivered on the proposed Quality Account indicators for 2025/26. It was noted that the Trust had achieved significant progress under the existing indicators for 2024/25 'Insight' and 'Involvement' and proposed to retain the same indicators for the forthcoming year:

Indicator 1 Insight: The Trust improves its understanding of the patient experience by listening and gaining real insight by using multiple sources of information, including patient stories, impact statements and patient surveys. This will ensure the patient and family voice is truly "heard", especially of those heard less often.

Indicator 2 Involvement: The involvement of patients, families, carers when they have experienced an incident is meaningful, individualised and they are treated with respect and compassion ensuring leading to genuine and compassionate learning from incidents, especially of those involved less often.

In response to a query, it was explained that Council was consulted on the quality account indicators in advance of the final Quality Account being presented to the Board for approval.

44/25 Governor Procedure and Process Map

The Governor Procedure and Process Map had been updated due to the realignment of functions within the executive administration team and now managed by the Corporate Affairs (CA) team. The mechanism for raising issues was outlined in the report, with a feedback loop to the Council. This process would be added as an appendix to the Governor Handbook.

Council requested the addition of a phone number to be used as an additional contact mechanism in case of an emergency with past examples of where this had proved useful cited. This would be included in the final version of the process map.

45/25 NED Committee Appointments

The report provided the details of the Non-Executive Director membership of committees and other nominated positions at board or stakeholder level for 2025/26 and beyond. A description of the purpose and remit of the roles was included for the information of governors.

The appointments had been made by the Chair under delegated authority, but Council was asked to note that the appointment to the role of Senior Independent Director remained subject to consultation with Council.

Council indicated its agreement with the Chair's decision to appoint Karen Deeny as Senior Independent Director.

46/25 Governor Elections

Council received the outcome of the public and staff elections held in March 2025. Notwithstanding comments made on the poor turnout and the impact this could have on the validity of the appointments it was explained that as returning officer for the elections, the Director of Corporate Affairs was required to ensure that due process had been followed and that the elections were fair and transparent.

47/25 Items for information

The following reports had been circulated with the agenda for information:

(i) Governor Opportunities and Activities Summary
(ii) Appointment of Lead Governor 2025-26
(iii) Appointment of Nominations Committee 2025-26
(iv) Register of Interests
(v) Cycle of Business and Training 2025-26
(vi) Minutes of Governor Subgroups:
- Care and Safety Subgroup – 13 January & 13 March 2025
- Chairs, Deputy Chairs and Lead Governor – 17 December 2024 and 1st April 2025

48/25 Date, time and venue of next meeting

The next meeting of the Council of Governors will be held on 24 July 2025 at 10.00am in Lecture Room 3, Education Centre 3, Chorley District Hospital, Preston Road, Chorley, Lancashire, PR71PP.

49/25 Reflections on how the meeting had been conducted

There were no comments or reflections provided.

5. MATTERS ARISING AND ACTION LOG

Information Item | M Thomas | 10:04

REFERENCES

Only PDFs are attached

5.0 - Action log (part I) - Council of Governors - 24 April 2025.pdf

Action log: Council of Governors (part I) – 24 April 2025

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

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

6. CHAIRMAN AND CHIEF EXECUTIVE'S OPENING REMARKS

Information Item | M Thomas / S Nicholls | 10:05

7. UPDATE ON COUNCIL MEMBERSHIP, INCLUDING APPOINTMENT OF LOCAL AUTHORITY MEMBERS

Decision Item | J Foote | 10.20

Item for Information and Decision

REFERENCES

Only PDFs are attached

7.0 - Update on Council Membership - July 2025.pdf

Council of Governors Report

Update on Council Membership including Appointment of Local Authority Members

Report to:	Council of Governors			**Date:**	9 July 2025		
Report of:	Director of Corporate Affairs			**Prepared by:**	K Lawrenson		
Part I	✓			**Part II**			
For assurance	☐	**For decision**	☒	**For information**	☒		

Executive Summary:

The purpose of this report is to provide the Council of Governors with an update on current Council membership, including recent changes and the appointment of local authority representatives.

Membership Changes

Since the last meeting of the Council of Governors held on 24 April 2025, the following changes have occurred:

- Nigel Garrett, University (Partnership) Governor, has formally tendered his resignation.
- Lesley Purcell, Staff Governor, has stepped away from the role following her departure from the Trust.
- Eddie Pope, the appointed Governor representing Lancashire County Council, was no9 longer eligible to serve following the recent local authority elections.
- Feixia Yu's term has concluded due to non-attendance at the required Council meetings, in accordance with the Constitution of the Trust.

New Appointment

Formal notification has been received from Chorley Council regarding the nomination of Councillor Michelle Brown as their appointed Governor. This nomination is made in replacement of Councillor Alistair Bradley, whose term has now concluded following a period of dedicated service.

No notification has yet been received from Lancashire County Council in respect of the nomination in place of Eddie Pope.

Councillor Suleman Sarwar for Preston City Council will continue in office following reappointment by the Council until May 2026. Councillor Lou Jackson, South Ribble Borough Council, was formally approved at Special Council of Governors meeting in February 2025 and will continue in office until February 2026.

Recommendation

It is recommended that the Council of Governors formally approve the appointment of Councillor Michelle Brown as the appointed Governor representing Chorley Council.

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			

8. APPROACH TO SURGE PLANNING

Other | K Foster-Greenwood | 10.30

Verbal
Item for Assurance

9. UPDATE FROM CARE AND SAFETY SUBGROUP

Information Item | J Miller | 10:40

Verbal

10. UPDATE FROM MEMBERSHIP SUBGROUP

Information Item | S Brennan | 10.50

Verbal

11. SAFETY, QUALITY, WORKFORCE AND PERFORMANCE

11.1 PATIENT EXPERIENCE AND INVOLVEMENT ANNUAL REPORT

Other | S Morrison | 11.00

Item for Assurance

REFERENCES

Only PDFs are attached

11.1 - Patient Experience Annual Report 2025 Council of Governors (1).pdf

Excellent care with compassion

Trust Headquarters

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors

Annual Patient Experience Report and update on Patient Experience Strategy – 2024/2025 (Final Year)

Report to:	Council of Governors	**Date:**	24 July 2025
Report of:	Chief Nursing Officer	**Prepared by:**	J Howles

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

Executive Summary:

The purpose of this annual report is to provide an update to Council of Governors following the presentation of the report to the Safety and Quality Committee on 30th May 2025. The report demonstrates the outcomes associated with the patient experience and involvement strategy 2022 to 2025. The report demonstrates what progress has been achieved over the last 12 months.

The annual report provides assurance on the progress made against the Patient Experience and Involvement Strategy (2022–2025), co-produced with patients, carers, staff, and governors. Now at the end of its third and final year, the strategy has actively guided improvements in patient experience across the Lancashire Teaching Hospitals NHS Foundation Trust.

The strategy has been led by the Patient, Carer Experience and Involvement Group (PCEIG) and integrates with broader Trust strategies such as Equality, Diversity and Inclusion, Mental Health, and the Single Improvement Plan. Its focus has been grouped under three core themes:

1. **Insight** – Strengthening the understanding of patient experiences through tools like the Patient Experience Dashboard and feedback triangulation (e.g., complaints, Friends and Family Test, compliments).
2. **Involvement** – Actively engaging patients and communities, increasing volunteer participation, representation from diverse groups, and inclusion of patient voices in governance and service development.
3. **Improvement** – Delivering tangible changes, such as enhancements in care environments, better interpretation services, more accessible information, and new services like youth workers and improved neonatal care.

Key Achievements and assurances from 2024/2025:

- Patient Experience Dashboard has been developed and is in use
- Patient Experience is a crucial element of the Continuous Improvement (CI) methodology and strategy adopted by the Trust and is included in the training programmes of the Microsystem Coaching Academy (MCA) and the Flow Coaching Academy (FCA).

- Health Inequalities poster presentations at Annual Members meeting
- Commencement of Complaints Review Group with Governors, Patient Safety Partners and Staff
- Friends and Family (FFT) – response rate increase by a further 4.7%
- FFT- Day Case and Outpatient services have consistently exceeded the 90% National target across all four quarters, demonstrating high levels of patient satisfaction and sustained excellence in care delivery.
- FFT- Maternity services met the 90% target in Quarters 1 and 4, indicating periods of strong performance, with a focus on identifying and addressing factors that impacted satisfaction in Quarters 2 and 3.
- FFT- Inpatients, Maternity (in two quarters), and the Emergency Department remained below their respective targets in all four quarters. These areas are under close review, with improvement actions already incorporated into the Trust's Patient Experience Improvement Plan to address patient concerns and drive future performance.
- Increase in Patient Forums whose views represent groups that access our services
- Full role out The Health Foundation Scale coordinated by Imperial College
- 71% Ward/Areas accredited with STAR Gold
- National Picker Cancer patient survey demonstrates improvements
- Sustained positive performance in Maternity National Picker survey
- Increase in compliments by 76%
- Complaints: There has been an 8% reduction in complaints with 325 received as opposed to 355 in the previous year.
- 98% of complaints were acknowledged within the timeframes stipulated by NHS Complaints Regulations.
- 82% of complaints were closed within the Trust standard of 35 days or 60 days for those triaged as more complex.
- 4 cases referred to the Parliamentary and Health Services Ombudsman (PHSO); 3 are ongoing, and 1 was partly upheld
- Development of new services and improved care pathways, especially for patients with additional needs or from underrepresented backgrounds.
- Active involvement of the Trust's Patient Safety Partners and the Maternity and Neonatal Voices Partnership Chair in key committees, ensuring consistent representation of the patient voice at all levels of decision-making.
- 41% increase in early resolution training for PALS and Complaints teams, enhancing our ability to address concerns promptly and compassionately.
- 33% growth in our volunteer workforce, including the successful introduction of the 'Hospital Guide' role, supporting patients and visitors across the Trust.
- Strengthened engagement with the Deaf community, with dedicated representation on the Patient, Carer Experience and Involvement Group, promoting inclusivity and accessibility.
- Reintroduction of 'Our Health Day'—a tailored event supporting patients with learning disabilities, focused on health awareness, empowerment, and accessible care.
- 'CARING' walk rounds led by a diverse team, offering compassionate, person-centred support for patients and families at end of life.
- Patients sharing lived experiences at Community of Practice events and Board of Directors meetings, influencing improvement through powerful first-hand narratives.
- Enhanced interpretation services across acute areas, including Emergency and Maternity Assessment Units, with expanded 3-way calling capabilities and access to additional digital platforms—ensuring language is never a barrier to safe, timely care.
- Development and launch of the 'Patient Experience Portal', shaped by patient feedback, to improve accessibility and engagement with services and feedback tools.
- Patients, Governors, and Patient Safety Partners participated in Patient-Led Assessments of the Care Environment (PLACE), with scores improving since 2023—reflecting enhanced care settings and environments.

- New Acute Medical Unit developed, supporting improved patient flow, timely assessment, and high-quality acute care.
- Baby Friendly Initiative (BFI) Stage 2 accreditation achieved, demonstrating a continued commitment to best practice in infant feeding and parent-infant relationships.
- Targeted improvement in postpartum care for women from Black, Asian, and Minority Ethnic (BAME) backgrounds, particularly in the management of postpartum haemorrhage, addressing health inequalities and improving outcomes.
- Youth workers introduced into Children's Services, providing dedicated support and advocacy for young patients during their hospital experience.
- Reduction in costs associated with lost property, reflecting improved personal belongings management and enhanced patient trust and satisfaction.
- Stoma-friendly bathrooms installed across the Trust, ensuring dignity, comfort, and accessibility for patients with stoma care needs.
- Children's Services at the CDH site received 'Getting It Right First Time' (GIRFT) accreditation, recognising excellence in clinical standards and patient care pathways.
- Trust-wide Learning Disability Plan launched, supported by mandatory Level 1 training for all staff to promote understanding, accessibility, and personalised care.
- Innovative whiteboard systems introduced in outpatient settings, enabling clear identification of patients requiring reasonable adjustments and enhancing tailored communication and support.

The report includes detailed metrics on complaints, concerns, compliments, Friends and Family Test performance, and national survey outcomes. It highlights a reduction in complaints and improvements in timeliness and quality of responses. The report also highlights an improvement in overall response rate across the trust for Friends and Family data but acknowledges ore work around feedback from protected characteristics is required.

The report describes the impact that the Patient Experience and Involvement group that has continued to develop and expand. The impact the group has in ensuring the patient voice heard across the organisation and in particular how each clinical division represents that voice.

It is recommended that Council of Governors receive the report noting its scrutiny at Safety and Quality Committee.

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. **Introduction**

1.1. At Lancashire Teaching Hospitals, our commitment to delivering Excellent Care with Compassion remains central at the heart of everything The Trust aims to do. This annual Patient Experience and Involvement report reflects the voices of patients and their families over the past year, showcasing both the Trusts successes and the areas where continued improvement is necessary. By listening, learning and acting on patient feedback, the Trust is strengthening a culture where inclusion, respect and dignity are fully embedded alongside clinical excellence and safety.

1.2. This report outlines the significant progress made against the objectives of the Patient Experience and Involvement Strategy 2022–2025 (Appendix 1), a strategy developed collaboratively with patients, families, carers, governors, and staff. As the Trust concludes the final year of implementation, this report provided clear assurance to the Safety and Quality Committee of the progress made in delivering on our commitments and driving meaningful change.

1.3. Tangible advancements have been achieved across multiple areas of the strategy. In cases where targets have not yet been fully realised, these will be addressed through the Trust's Single Improvement Plan 2025/26 under the Safety and Quality domain. The report incorporates lived experiences from those who use our services and demonstrates how the strategy has been instrumental in deepening our understanding and enhancing service delivery to meet the holistic needs of our patients.

1.4. The annual report also provides assurance on the Trust's performance against key patient experience and involvement indicators, including complaints, response rates, Friends and Family Test results, patient surveys, and compliments. By ensuring that care is delivered both for and with patients supports the achievement of better outcomes and promotes care that is more efficient, productive, and cost-effective.

1.5. Oversight of the strategy and associated performance measures is maintained by the Patient, Carer Experience and Involvement Group (PCEIG). This group submits a monthly Chair's Escalation Report to the Safety and Quality Committee, ensuring robust governance and transparency.

1.6. A key metric of performance, the volume of complaints received, is detailed in Appendix 2 alongside the most common themes. We are encouraged to report a continued year-on-year reduction, with 325 complaints recorded during this reporting period, down from 355 in the previous year. This decline reflects our ongoing efforts to listen, respond, and improve

2. **Discussion**

1.1. The Patient Experience and Involvement Strategy

The Patient Experience and Involvement strategy has set the tone to listen more and act on patients' experiences. This means really listening to the experience of patients and families when they do and do not go well and using this to learn and improve. We asked patients, relatives, carers, colleagues, governors and patient and partner organisations to contribute to setting the actions in the strategy. We have actively sought the views of patient groups who represent those with protected characteristics and recognise the importance of intersectionality when considering this feedback. The Patient Experience and Involvement strategy has strong links with other Trust strategies including the Equality, Diversity and Inclusion strategy, the Mental Health, Learning Disability Dementia and the Autism strategies and patient experience and involvement will now be incorporated into the developing Single Improvement Plan.

The strategy was divided into 3 sections:

- Insight - improving our understanding of patient experience and involvement by listening and drawing insights from multiple sources of information.

- Involvement - equip patients, colleagues and partners with the skills and opportunities to improve patient experience throughout the whole system.
- Improvement - design and support improvement programmes that deliver effective and sustainable change.

The year 3 outcome measures and progress against them are outlined in Appendix 1 Safety and Quality Committee were asked to note that the strategy has remained a live and dynamic document. Whilst some The annual report highlights outcome measures may be partially achieved, they continue to be monitored and have informed the development of future patient experience work. These efforts are now embedded within the Trust's Single Improvement Plan, ensuring continued alignment with broader quality and safety goals.

1.2. Positive highlights and assurances from 2024/2025:

Appendix 1 offers a comprehensive update on all the components targeted for action in the Year 3 strategy implementation plan, categorised under insight, involvement, and improvement. While the list isn't exhaustive, it highlights the key points and reflects the extensive efforts made to enhance experience over the three-year strategy period.

Insight

- Patient Experience Dashboard successfully developed and implemented, providing real-time insight into patient feedback and trends.
- Patient Experience embedded within the Trust's Continuous Improvement (CI) methodology and featured prominently in the training curricula of both the Microsystem Coaching Academy (MCA) and the Flow Coaching Academy (FCA).
- Health Inequalities addressed through impactful poster presentations showcased at the Annual Members' Meeting, raising awareness and driving inclusion.
- Complaints Review Group established, bringing together Governors, Patient Safety Partners, and staff to strengthen learning and transparency.
- Friends and Family Test (FFT) response rates improved by 4.7%, reflecting enhanced patient engagement.
- Expansion of Patient Forums, with increased participation from groups representing those who access our services, ensuring diverse voices are heard and acted upon.
- Full rollout of The Health Foundation's Improvement Scale, coordinated by Imperial College, providing a structured framework for measuring and accelerating change.
- 71% of wards/areas accredited with STAR Gold, signifying excellence in care, environment, and patient experience.
- National Picker Cancer Patient Survey results demonstrate marked improvement, alongside sustained high performance in the National Maternity Survey.
- 76% increase in recorded compliments, indicating a significant uplift in positive patient feedback.
- Complaints reduced by 8%, with 325 received in the reporting period, compared to 355 in the previous year.
- New services and improved care pathways developed, with a particular focus on patients with additional needs and those from underrepresented communities.

Involvement

- Active involvement of the Trust's Patient Safety Partners and the Maternity and Neonatal Voices Partnership Chair in key committees, ensuring consistent representation of the patient voice at all levels of decision-making.

- 41% increase in early resolution training for PALS and Complaints teams, enhancing our ability to address concerns promptly and compassionately.
- 33% growth in our volunteer workforce, including the successful introduction of the 'Hospital Guide' role, supporting patients and visitors across the Trust.
- Strengthened engagement with the Deaf community, with dedicated representation on the Patient, Carer Experience and Involvement Group, promoting inclusivity and accessibility.
- Reintroduction of 'Our Health Day'—a tailored event supporting patients with learning disabilities, focused on health awareness, empowerment, and accessible care.
- 'CARING' walk rounds led by a diverse team, offering compassionate, person-centred support for patients and families at end of life.
- Patients sharing lived experiences at Community of Practice events and Board of Directors meetings, influencing improvement through powerful first-hand narratives.
- Enhanced interpretation services across acute areas, including Emergency and Maternity Assessment Units, with expanded 3-way calling capabilities and access to additional digital platforms—ensuring language is never a barrier to safe, timely care.
- Development and launch of the 'Patient Experience Portal', shaped by patient feedback, to improve accessibility and engagement with services and feedback tools.

Improvement

- Patients, Governors, and Patient Safety Partners participated in Patient-Led Assessments of the Care Environment (PLACE), with scores improving since 2023—reflecting enhanced care settings and environments.
- New Acute Medical Unit developed, supporting improved patient flow, timely assessment, and high-quality acute care.
- Baby Friendly Initiative (BFI) Stage 2 accreditation achieved, demonstrating a continued commitment to best practice in infant feeding and parent-infant relationships.
- Targeted improvement in postpartum care for women from Black, Asian, and Minority Ethnic (BAME) backgrounds, particularly in the management of postpartum haemorrhage, addressing health inequalities and improving outcomes.
- Youth workers introduced into Children's Services, providing dedicated support and advocacy for young patients during their hospital experience.
- Reduction in costs associated with lost property, reflecting improved personal belongings management and enhanced patient trust and satisfaction.
- Stoma-friendly bathrooms installed across the Trust, ensuring dignity, comfort, and accessibility for patients with stoma care needs.
- Children's Services at the CDH site received 'Getting It Right First Time' (GIRFT) accreditation, recognising excellence in clinical standards and patient care pathways.
- Trust-wide Learning Disability Plan launched, supported by mandatory Level 1 training for all staff to promote understanding, accessibility, and personalised care.
- Innovative whiteboard systems introduced in outpatient settings, enabling clear identification of patients requiring reasonable adjustments and enhancing tailored communication and support.

3. **Patient, Carer Experience and Involvement Group**

3.1 Over the past 12 months, the Patient Experience and Involvement group has continued to develop and expand. The group is well-represented by all divisions, patients, third sector partners, charities, governors, and advocacy groups. The meetings are now divided into two parts: Part A and Part B. Part A focuses on feedback and stories from patients, families, and carers, which are presented and

heard from each division to facilitate learning. The group's name has been changed to be inclusive of the experiences of families and carers and to ensure the carer voice is recognised

3.2 Part B focuses on understanding data and metrics. Quarterly reports from each division provide an overview of all aspects of patient experience across the hospitals.

3.3 Over the past 12 months, a review of the terms of reference and cycle of business has been conducted to clarify expectations for the group, ensuring alignment with the strategy and action plan. The group's aim is to achieve full representation from individuals with protected characteristics. This representation is continually improving, and it is anticipated that within the next 12 months, all protected characteristic groups will be represented.

4. Patient, Carer and Family Feedback

4.1 Complaints and Concerns (Appendix 2)

During the 2024/2025 reporting period, the Trust received 325 formal complaints, representing a reduction of 30 complaints compared to 2023/2024. This equates to a reduction of 8.45%. Complaints performance has been monitored throughout the year, with a notable improvement in timeliness of responses. The proportion of patients receiving a response within the designated 35- or 60-day timeframe has risen from last year with an average compliance rate of 82% across the year.

Whilst there has been a reduction in the complaints received in the organization, some are more complex than previously. The trend in the ratio of complaints to patient contacts over the past three years is detailed in appendix 2 (Table 2.1).

Of the 325 complaints received between April 2024 to March 2025, 257 (79%) related to care or services provided at the Royal Preston Hospital (RPH), 60 (18%) to care or services provided at Chorley and South Ribble Hospital (CDH), 1 (1%) to care or services provided by Preston Business Centre, and 7 (2%) to care and services provided at Finney House Community Healthcare Hub. There were no cases which were deemed to be outside of the 12 months' timescale set out under the NHS Complaints Procedure.

During this financial year there were 307 cases closed. The outcome of this can be broken down into the following outcomes 17 (6%) of the complaints had been upheld. 178 (58%) were partly upheld and 102 (33%) were not upheld. 10 (3%) cases currently remain open at the end of the year.

The NHS Complaints Regulations determine that all complaints should be acknowledged within three working days of receipt. In the current reporting period, 98% of complainants received an acknowledgement within that timescale where complaints were received in to the Patient Experience and PALS team. Whilst 100% of patients receive an acknowledgement via email or verbally on the telephone. The 98% figure is taken from when the case is opened on the Datix Governance system to the time that the case manager contacts the complainant.

Second complaint letters may be received because of dissatisfaction with the initial response or as a result of the complainant having unanswered questions. During the period between April 2024 and March 2025 the Trust received 16 second letters. The team remain focused on resolving complaints first time and learning from receipt of second letters will be embedded into improvements.

During the period 1st April 2024 to 31st March 2025 307 complaints were closed. 82% of complaints received in 2024/25 were closed within the 35-day or 60-day timescale. This is reported to Safety & Quality Committee monthly. Of note the organisation is not mandated to respond within 35 days,

however the standard set is to ensure that complainants receive timely responses to provide better patient experience. The Patient Experience and PALS Team have dealt with a total of 2,058 concerns and 3,302 enquiries. There are 293 cases pending whilst awaiting further information from those who have raised concerns, such as consent and patient details.

4.2 **Complaints and Concerns (Appendix 2)**

While there are many more compliments than complaints, complaints are an important source of feedback. Key complaint themes across all divisions include communication, consent, confidentiality, treatment and procedure, and nursing care. To capture learning from complaints, the complaints review group is now in place and monthly update of complaint themes and presented initially through the Patient Experience and Involvement group and also noted in individual divisional reports to this group. It is crucial to understand divisional challenges and the actions taken to address concerns and complaints.

Diagnostic and Clinical Support: The key themes for this division are communication, treatment/procedure, and nursing care.

Women and Children: The main themes here include communication, treatment/procedure, and staff behavior or attitude.

Medicine: For this division, the themes are communication, treatment/procedure, and nursing care.

Surgery: The primary themes are treatment/procedure, communication, and nursing care.

All divisions regularly present paper report updates to the Patient Carer Experience and Involvement Group (PCEIG) regarding the themes within their divisions and the associated actions for improvements. Many of these align with the findings from the national survey, which have individual action plans in place and are also monitored through PCEIG.

4.3 **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 1st April 2024 to 31st March 2025 there were 4 cases referred to the PHSO; 3 are ongoing, and 1 was partly upheld.

During this period, the PHSO sent final reports for 6 cases which were opened prior to April 2024 and the outcome of these were that 3 were not upheld, 2 were partly upheld, and 1 was upheld.

There is one further case referred to the PHSO prior to April 2024, which is still under investigation by the PHSO, and a final decision is yet to be reached.

4.4 **Compliments**

The Trust receives formal and informal compliments from patients and their families in relation to their experience of care. During 2024/25 a total of 6,831 compliments and thank you cards were received by wards, departments and through the Chief Executive's Office. There has been a 76% increase in the number of compliments received this year. Departments are being encouraged to actively log compliments on the Datix system which has its own module for this purpose. This provides teams with the opportunity to celebrate success locally and as part of their wider teams and

divisions. The results from divisional compliments are now published monthly in the Trust Communications and discussed as part of divisional meetings.

4.5 **Friends and Family Feedback (Appendix 3)**

The Friends and Family Test (FFT) is a national measure used to assess patient experience by determining whether patients would or would not recommend the services provided by the hospitals to their friends and family. The national requirement is to report on the following areas:

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

A target of 90% is set for patients who would recommend services to friends and family in four of the areas, with a target of 85% in the Emergency Department. Maternity has achieved this in Q1 and Q4, Day case and Outpatients have consistently achieved more than 90% in all four quarters, Maternity, Inpatients and the Emergency Department are under the target percentage in all four quarters.

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. Children and Young People using the Urgent and Emergency pathways are reporting less favourable experiences. The day case and outpatient departments are demonstrating positive performance. The neonatal service has maintained a sustained performance of 100%. The data demonstrates an overall increase in responses and an increase in usage of the various methods of collection.

4.6 **Friends and Family response rate**

Expanding the methods used to collect feedback is important if we are to understand what matters to patients. The response rate is an area we set out to improve and the data below demonstrates this has been achieved with a total of 2,937 more valuable pieces of feedback than what was collected in 2023/24. It is not yet possible to view this feedback through the lens of protected characteristics and deprivation however, work is underway with Civica to ensure that gender and ethnicity is added to the Friends and Family questions in all formats.

In the year 2024-2025 there has been a positive increase in the response rates overall of 4.7% in comparison to the previous year. Increases have been realised with paper surveys and short message service (SMS) text surveys. There has been a reduction in the telephone surveys and online surveys which in part may be due to an increase in SMS text surveys and paper preferences for service users. Staff are actively encouraging patients to complete the FFT before leaving the hospital, which in turn supports the increase in paper survey completion.

The Trust continues to provide ongoing training to staff on the use of the CIVICA system and ensure the patient experience boards are kept updated with the "You said, we did" posters and various reports that can be downloaded using the CIVICA system. Managers and leaders are actively seeking to make improvements with the Friends and Family test feedback. To support accountability and transparency, monthly FFT reports are distributed to governance and divisional leads, ensuring that results are reviewed, acted upon, and shared across the organisation.

4.7 **Care Opinion Website**

During the past financial year there have been a total of 198 reviews posted on the Care Opinion website relating to care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust. These have consisted of 124 compliments and 66 concerns and 8 that have provided both concerns and compliments.

4.8 **National In-Patient Surveys**

Maternity Survey 2024

The Maternity survey was based on a sample of inpatients during April and July 2024. A total of 324 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 318 patients were eligible for the survey, of which 103 returned their questionnaire, giving a response rate of 32%. This is a 7% decrease in response rate compared to the 2023 survey. The average response rate for the 56 'Picker' trusts in 2024 was 39%.

A total of 89 questions were used in the 2024 survey, of these 59 questions were asked in the 2024 survey. Compared to the 2023 survey, Lancashire Teaching Hospitals has remained in the same position as the 2023 survey. Overall mothers reported that they rated their experience (96%), they were treated with respect and dignity (during labour and birth) (93%) had confidence and trust in staff (during labour and birth) and (94%) were involved in decisions about their care (during labour and birth).

Urgent and Emergency Care Survey 2024

The survey was based on a sample of inpatients receiving care and treatment between April and July 2024. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1195 patients were eligible for the survey, of which 363 returned their questionnaire, giving a response rate of 30%. This is a 5% increase on responses compared to the 2022 survey. The average response rate for the 64 'Picker' trusts in 2024 was 30%.

A total of 55 questions were used in the 2024 survey, of these 19 questions were comparable and asked in the 2022 survey. Compared to the 2022 survey, Lancashire Teaching Hospitals has not significantly improved in any areas, with 5 areas identified as significantly worse in 2024. Overall urgent and emergency care patients reported that they rated their A&E experience (65%), they were treated with respect and dignity (92%) and had confidence and trust in the doctors and nurses (92%). An action plan is in place to address the areas of deterioration reported in the survey.

Inpatient Survey 2023

The survey was based on a sample of inpatients between July and November 2023. A total of 1250 patients from Lancashire Teaching Hospitals were randomly selected to take part in the survey. 1176 patients were eligible for the survey, of which 470 returned a completed questionnaire, giving a response rate of 40%. This is a 2% increase on the 2022 survey. The average response rate for the 64 'Picker' trusts in 2023 was 43%.

A total of 63 questions were used in the 2023 survey, of these 39 questions were asked in the 2022 survey. Compared to the 2022 survey, Lancashire Teaching Hospitals has significantly improved in 2 areas, with 1 area identified as significantly worse in 2023. Overall adult inpatients reported that they rated their experience 7/10 or more (76%), they were treated with respect and dignity (97%) and had confidence and trust in the doctors (97%).

National Cancer Patient Experience Survey (NCPES)
The 2023 NCPES is the thirteenth iteration of the survey. It has been designed to monitor progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients. The 2023 survey involved 132 NHS Trusts with a response rate of 52%. LTHTR sample size was 1463 with a response rate of 55%.

The expected range charts in the national report show the lowest and highest score received for each question nationally. Trusts whose scores were above the upper limit of the expected range are positive outliers, with a score statistically significantly higher than the national mean. This indicates that the Trust performs better than trusts of the same size and demographics are expected to perform. The opposite is true if the score is below the lower limit of the expected range, these are negative outliers. Scores within the expected range are what would be expected given the Trust's size and demographics.
There were 61 questions in total and LTH scored 8 questions were in the higher-than-expected range with no responses in the lower-than-expected range. LTH has been consistently achieving a score of 8.9 (out of 10) and this was maintained even throughout the pandemic. We have now scored 9 consistently since 2021 and consistently above national average.

National Survey	Date published	Trust position nationally	Comparison to previous survey
Inpatient Survey	August 2024	52 out of 60	
Maternity Survey	December 2024	18 out of 61	
Cancer Survey	July 2024	No rankings but scoring improved	
Urgent and Emergency Care Survey	November 2024	46 out of 55	

5. **Financial Implications**

5.1 Although no direct costs have been attributed to this annual report, it is acknowledged that patient experience is closely linked to improved outcomes and efficiency. Therefore, ensuring a positive patient experience directly contributes to the efficient and productive operation of the organisation.

6. **Legal implications**

None

7. **Risks**

7.1 This paper provides details on Patient Experience data by positive and negative escalation and is aligned to risks identified on the risk register.

8. **Impact on stakeholders**

8.1 Patient experience is the most critical area within the organisation needing improvement, primarily due to issues with flow and communication. Both areas have dedicated strategies and improvement plans designed to address these challenges and associated risk assessments.

9. **Closing year 3 and moving to Single Improvement Plan**

9.1 As the trust transitions to a new single improvement plan, the current patient experience and involvement strategy will conclude. However, the patient experience agenda will remain a key focus, with specific objectives and milestones incorporated into the new plan. There will be a greater emphasis on feedback from patients with protected characteristics and those who are vulnerable, in alignment with the Trust's 'Our Health Plan'.

9.2 Appendix 1 of the review of the current strategy acknowledges that some aspects have not been fully achieved. These elements will either be incorporated into the single improvement plan or will continue to be addressed under the leadership of the Associate Director of Experience and Quality.

10. **Equality, Diversity and Inclusion**

10.1 The Equality, Diversity, and Inclusion strategy is the golden thread woven throughout the Patient Experience and Involvement Strategy. It is crucial that we remain consciously inclusive in all our actions. To achieve true inclusivity and diversity, we must gather extensive information from the voices of patients who we do not hear from, with a particular focus on those with protected characteristics. Utilising Friends and Family feedback, Datix, and PSIRF, and aligning with Our Health Plan, will enable us to truly understand the diverse voices of our patients.

11. **Recommendations**

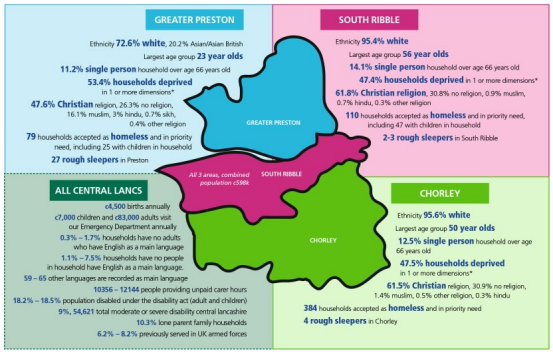
It is recommended that Council of Governors receive the report noting its scrutiny at Safety and Quality Committee.

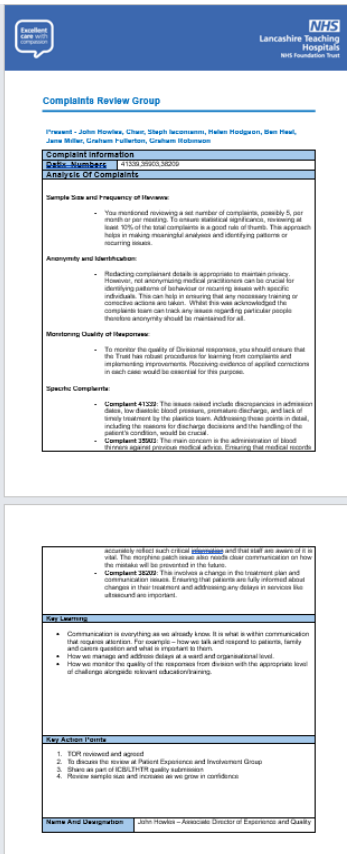
Appendix 1

Appendix 1 The Patient Experience and Involvement Strategy 2022 – 2025

Insight			
Year			
Outcome ***Measurement***		**Completed**	**Update**
Driving Improvement	***Year 1*** We will create a dashboard of patient experience and involvement measures. Initiate key programmes of work and define reporting and monitoring arrangements for programmes of work. The dashboard will triangulate feedback sources e.g. themes from complaints, Friends and Family test, patient surveys to keep focus on our key areas of improvement ***Year 2*** We will use intelligence from the patient experience and involvement committee to inform improvement priorities for the Micro-system Coaching Academy (MCA). ***Year 3*** We will review and refine the approach. We will deliver the improvement programme	Complete	The dashboard is available via the bi portal for all staff. It is part of the overarching governance Dashboard. Image 1 below is an example of the Dashboard that wards and areas can see. The dashboard is discussed and shared at MCA training via Associate Director of Experience and Quality. Thus, enabling all participants has access to data as part of their MCA project. The dashboard allows a snap shot in time for ward areas to review all patient experience data and focus on key themes for their ward or area. Image 1 

	identified at the end of year 2		
Defining key programmes of work	***Year 1*** We will define key improvement (top 5 programmes of work) and initiate Plan-Do-Study-Act (PDSA) cycles on leading patient experience programmes of work. ***Year 2*** We will evaluate outcome of the PDSA methodology, refine and apply to next set of key programmes of work. We will establish a way to capture live feedback that enables services to be more responsive. ***Year 3*** We will design an improvement programme focused on levelling up the clinical areas to the level of the best	Complete	A number of programmes of work have been developed in the last 12 months, some of the key projects have been completed over the are:. • Work with Imperial College London in relation to FFT, which has enabled this to be available across all areas. • Cataract treatments have been brought back into the acute hospital, and developed patient resources including videos and information • Audiology have designed a project to improve appointments • Patient Experience Portal development and rollout • Instigated clinics in the Sahara Centre to help to reduce inequalities. • Improved experience and waiting time for prisoners • Improved outcomes for patients with post-partum haemorrhage from BAME or Ethnic backgrounds • Further Improvements to Gyane Assessment Unit following new build in Gynaecology for women who miscarriage, the development of pictures, wall arts to make the are feel different which ensured that as a trust we listened to service users (through friends and family, complaints) and improved its environment further. We continue to develop programmes through the MCA programmes across the trust. The focus being on patient involvement and diversity of this, ensuring we are wholly inclusive. A member of the Patient Experience and PALS team along with a Volunteer have been gathering live feedback on the wards in relation to boarded or corridor care patients, this has assisted in the principles of local resolution.
Patient experience equality, diversity and inclusion	***Year 1*** We will mandate collection of each protected characteristic to enable the analysis of inequalities and patient experience processes,	Partially completed	We have started to understand the data in regards to health inequalities and commenced work to capture this. The trust has developed 'Our Health Plan'. The trust electronic patient record system does have the ability to capture this information although it is reliant that the areas are 'switched on' in order to gather the data. Work also needs to take place with colleagues asking patients for this information in line with the NHS Accessible Information Standard. The trust internet and intranet has allows for information to be available in many different languages and formats.

	functions and outcomes. We will organise reports within the organisation to enable teams to review data through the eyes of people with protected characteristics developing a road map for year 2. ***Year 2*** Based on year 1 of analysis, we will identify key priorities within each area based on protected characteristic data. We will expand the definition of protected characteristics to include Indices of multiple deprivation analysis. ***Year 3*** We will demonstrate improvements in identified areas of inequalities based on year 1 and 2 analysis and programmes of work.		The CIVICA Friends and Family system reports on the information that we provide and this is how we will realise this objective. It does now have access to patient emotions which gives the ability to review feedback from different ethnic groups. A road map has been developed as part of 'Our Health Plan', which has provided data from across central Lancs, looking at age, sex, deprivation and ethnicity, as seen in image 2 below: Image 2: 
Thematic analysis	***Year 1*** We will carry out a thematic analysis of patient complaints and concerns to be undertaken in each division, using the outcomes to	Complete	A quarterly deep dive is undertaken and presented to the Patient Experience and Involvement group (PEIG). This looks at information from complaints, concerns and enquiries from patients as mapped in the Datix Governance system. A quality patient experience report is produced by each division and presented at PEIG. The feedback allows for new themes which leads to development of further actions, improvements and learning.

	inform areas of focus to improve patient experience. We will use this to understand gap where there may be an under-representation of feedback and consider opportunities for feedback in the patient's journey (for example mental health). ***Year 2*** We will repeat thematic analysis to identify new themes to address, building the findings into the work programme. ***Year 3*** We will repeat thematic analysis to identify new themes to address, building the findings into the work programme.		Complaints Review Group commenced to check quality of responses and pick up any themes  Complaints Review Group Present - John Howles, Chair, Steph Iacomanni, Helen Hodgson, Ben Heal, Jane Miller, Graham Fullerton, Graham Robinson Complaint Information Date Numbers | 41328,39903,38259 Analysis Of Complaints Sample Size and Frequency of Reviews: - You mentioned reviewing a set number of complaints, possibly 5, per month or per meeting. To ensure statistical significance, reviewing at least 10% of the total complaints is a good rule of thumb. This approach helps in making meaningful analyses and identifying patterns or recurring issues. Anonymity and Identification: - Redacting complainant details is appropriate to maintain privacy. However, not anonymizing medical practitioners can be crucial for identifying patterns of behaviour or recurring issues with specific individuals. This can help in ensuring that any necessary training or corrective actions are taken. While this was acknowledged the complaints team can track any issues regarding particular people therefore anonymity should be maintained for all. Monitoring Quality of Responses: - To monitor the quality of Divisional responses, you should ensure that the Trust has robust procedures for learning from complaints and implementing improvements. Receiving evidence of applied corrections in each case would be essential for this purpose. Specific Complaints: - **Complaint 41328**: The issues raised include discrepancies in admission dates, low diastolic blood pressure, premature discharge, and lack of timely treatment by the plastics team. Addressing these points in detail, including the reasons for discharge decisions and the handling of the patient's condition, would be crucial. - **Complaint 25903**: The main concern is the administration of blood thinners against previous medical advice. Ensuring that medical records accurately reflect such critical interactions and that staff are aware of it is vital. The morphine patch issue also needs clear communication on how the mistake will be prevented in the future. - **Complaint 38259**: This involves a change in the treatment plan and communication issues. Ensuring that patients are fully informed about changes in their treatment and addressing any delays in services like ultrasound are important. Key Learning • Communication is everything as we already know. It is what is within communication that requires attention. For example – how we talk and respond to patients, family and carers question and what is important to them. • How we manage and address delays at a ward and organisational level. • How we monitor the quality of the responses from division with the appropriate level of challenge alongside relevant education/training. Key Action Points 1. TOR reviewed and agreed 2. To discuss the review at Patient Experience and Involvement Group 3. Share as part of ICB/LTHTR quality submission 4. Review sample size and increase as we grow in confidence Name And Designation: John Howles – Associate Director of Experience and Quality
Friends and Family feedback	***Year 1*** We will ensure all departments are actively participating in friends and family. We will increase the number of ways that patient can provide feedback including paper and other languages and	Complete	10% increase achieved and with a further 4.7% increase in year 3. The divisions have become more invested in seeking the views of patients and are actively requesting access to the CIVICA Friends and Family (FFT) feedback system. Guides are in place to support department managers and training is available as and when required. There has been a sustained increase in the volume of responses for the FFT feedback with the paper surveys. The SMS text and online surveys provide users with the options to complete in different languages, however to date none of the service users have opted for this. Year 3 has seen a 4.7% increase with the FFT feedback for the year 2024-25. This is an increase of 28% in Friends and Family Responses since 2022/23.

<table>
<tr>
<td></td>
<td>acting upon the responses.

Year 2
We will increase by 10% the volume of feedback from Friends and Family looking at maximising ways to do this and acting upon the responses.

Year3
We will maintain the increase in friends and family feedback acting upon responses.</td>
<td></td>
<td>
<table>
<tr><th>Year</th><th>QR codes/online surveys</th><th>Paper surveys</th><th>Telephone surveys</th><th>SMS text surveys</th><th>Total</th></tr>
<tr><td>2022 - 2023</td><td>2,905</td><td>6,788</td><td>4,421</td><td>37,070</td><td>51,184</td></tr>
<tr><td>2023 - 2024</td><td>3,016</td><td>10,944</td><td>2,112</td><td>46,471</td><td>62,543</td></tr>
<tr><td>2024 - 2025</td><td>973</td><td>13,661</td><td>910</td><td>49,936</td><td>65,480</td></tr>
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<tr>
<td>Patient Experience Culture</td>
<td>Year 1
We will establish baseline measurement of patient experience culture triangulating information from surveys and patient feedback (including information communicated through patient forums).

Year 2
We will agree how to measure culture in relation to patient experience.

Year 3
We will repeat and embed learning from the feedback</td>
<td>Partially completed</td>
<td>Across the trust there has been a number of independent culture reviews and although we have developed a number of tool kits and we continue working with the Organisational Development team to produce a culture dashboard.</td>
</tr>
<tr>
<td>Research</td>
<td>Year 1
We will participate in</td>
<td>Complete</td>
<td>In year one, organised the infrastructure to test this approach, however in the last 12 months, we are developing that all teams have access to the locally developed dashboard. This dashboard is</td>
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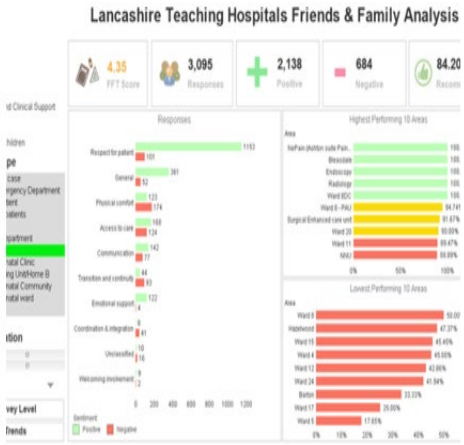
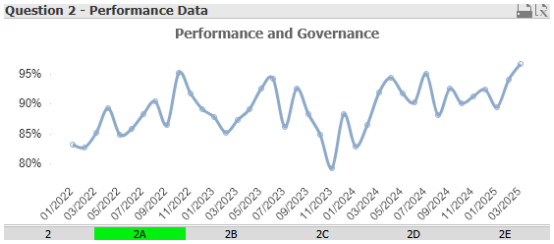
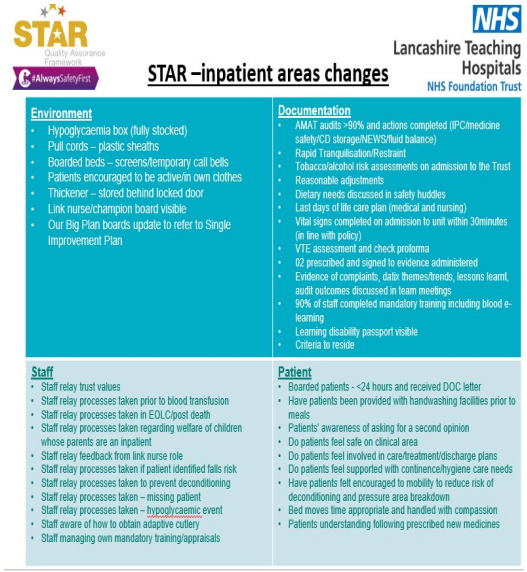
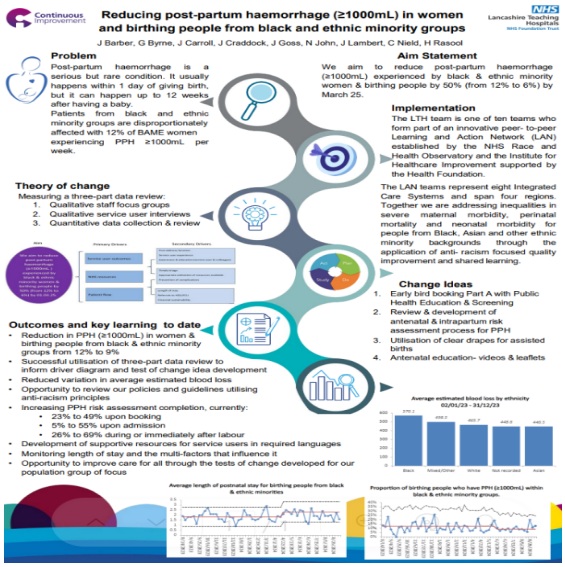
	The Health Foundation 'Scale, Spread and Embed' research project coordinated by Imperial College Healthcare NHS Foundation Trust. As a Phase 1 site, we will collaborate and test the use of natural language processing of free text specifically on patient experience feedback. ***Year 2*** We will continue to participate in the Health Foundation 'Scale, Spread and Embed' research project coordinated by Imperial College Healthcare NHS Foundation Trust. In collaboration with the Phase 1 and 2 sites, refine and innovate to develop intelligence and insights provided by the digital advances testing the approach through continuous improvement methodology.		available on the Business Intelligence (BI) Portal (QlikView) and displays both thematic responses and allows the teams the ability to drill into patient level feedback. This will work in line with the Governance dashboard.  .

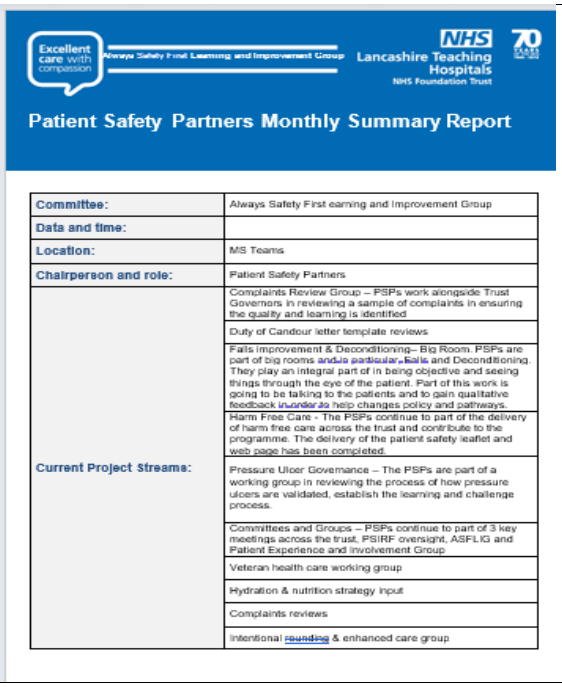
	We will proactively seek to be involved in research relating to patient experience. ***Year 3*** We will repeat and embed learning from the feedback		
National patient experience surveys	***Year 1*** We will ensure that results of each of the national surveys learning to be presented to Patient Experience and Involvement sub-committee and Safety and Learning Group to broaden opportunity to learn and develop action plans in response. ***Year 2*** We will ensure delivery of the actions agreed in response to the National patient experience surveys. **Year 3** We will evaluate the success to date and plan and deliver the work programme for year 3	Complete	All National surveys have been presented to the PECIG and to the Trust Safety and Quality Committee. These reports contain data regarding patient feedback and performance comparted to both local and national trusts. The surveys gives patient feedback on nationally set questions and commissioned by the CQC. It is vital for improvement action plans for each of the departments. The surveys demonstrate: • Cancer Care - Improvements in many metrics • Maternity - Sustained performance • In -patients - Deterioration in patient feedback and comparators • Urgent and Emergency Care – Deterioration in patient feedback and comparators All survey has developed actions plans that are presented at Patient , Carer, Involvement and Experience group monthly.
	Year 1 We will benchmark national survey and Benchmarking Standard responses to peer	Complete	The national Surveys are benchmarked against local and national trusts. This year it has been acknowledged a deteriorated position in both Urgent and emergency care and National Inpatient survey Division have developed Action plan which are monitored through patient, carer experience and involvement group. Focussed assurance held by Associate Director of Quality and Experience

	organisations to learn from what is working well elsewhere and strive to improve the national ranking position. ***Year 2*** We will incorporate learning from peer organisations into Trust action plans and aim to improve the national ranking position. ***Year 3*** We will evaluate actions to date and aim to improve the national ranking position to the next best quartile		within Divisional leads and specialist areas on a bi-weekly to ensure progression. We have reviewed other surveys results and reached out to local and national trusts to enable shared improvements to Urgent and Emergency care.
Improving patient experience communications	***Year 1*** We will link with the communications teams to ensure that key lessons learned from thematic analysis of patient feedback is cascaded across the organisation and externally. ***Year 2*** We will develop sources of communication to ensure that learning is far reaching and evaluate the approach. ***Year 3*** We will re-evaluate lessons learned and modes of	Complete	Associate Director of Patient Experience and Quality meets with the Director of Communications and Engagement monthly, regular updates and learning are added to health matters and other communications updates. Learning from concerns and complaints is published in the governance Learning to Improve bulletins. Increase articles within the trust health matters and social media Presentation at community of practice in relation to Family liaison role and responsibility. Compliments are published monthly in Trust communications to maintain momentum of recording. A 'how to record' video has been produced to assist staff.

	communication to continue to reiterate key messages		
	Year 1 We will link with the Always Safety First Committee to ensure that key patient experience themes related to safety are incorporated into the Always Safety First Bulletin and be physically displayed throughout key public areas of the organisation demonstrating a transparent approach to learning from safety within the organisation. ***Year 2*** We will ensure that learning from Always Safety First will be evident throughout the organisation, with case studies and teams celebrating the successes of the programmes. ***Year 3*** Teams will be supported to gain national recognition for their achievements	Complete	Whilst this group was operational, deep dives were presented to the Always Safety First (ASF) committee quarterly and monthly to the Safety and Learning group. Introduction of PSIRF has enabled a defined role in patient engagement with the family liaison roles. The patients, family involvement in setting terms of reference and presence throughout the reports is improving. The development of PSIRF oversight panel has enabled scrutiny of patient experience data inclusive of complaints, concerns and enquires. Compliments are celebrated monthly in both the trust communication and the Nursing Midwifery, AHP group.
	Year 1 We will ensure that colleague and patient experience feedback is	Complete	The development of Patient Champions across the Trust, most wards and areas have patient experience displays and boards that contain 'You Said, We Did' information based on the results of the FFT feedback. STAR monitors patient experience feedback as part of the accreditation visits.

	displayed in all areas. ***Year 2*** We will evaluate the display of patient experience feedback and improve if and where necessary. ***Year 3*** We will re-evaluate lessons learned and modes of communication to continue to reiterate key messages		STAR monthlies check the 'you said we did' and ask about actions taken. Q2– Performance and governance boards will be updated: 
STAR accreditation	***Year 1*** We will review the patient experience metrics embedded within the STAR process. We will reintroduce Governors to be involved in the STAR accreditation visits to enable real time patient feedback. We will collate themes and trends from patient experience measures to inform opportunities for improvement. Plans will be monitored. ***Year 2*** We will evaluate actions and improvement in response to STAR accreditation	Complete	Patient metrics are reviewed as part of STAR visits, governors have joined the visits. A yearly review of questions has occurred to feedback any themes and is presented at the monthly Nursing, Midwifery and AHP Operational Board (NMAHPB). Star monthly report and Action plan is presented at NMAHP board on a monthly basis 

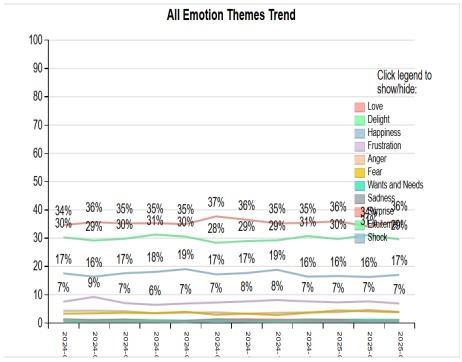
	visits, re-evaluate questions and actions agreed. ***Year 3*** We will continually learn from thematic analysis from STAR accreditation process to inform actions and learning.		
Seldom Heard groups	***Year 1*** We will define those at highest risk and agree the approach to collecting feedback on what matters to the people in these groups. We will seek new ways to collect insights from groups that are less heard. ***Year 2*** A programme of improvement work will be created for these groups to spread learning across the organisation. ***Year 3*** We will build on the new insights and agree year 3 actions with the evolving sources of feedback	Partially completed	Still not achieved the feedback from national surveys or Friends and Family from groups we do not hear often from, links have been forged with some forums and groups and also working with CIVICA to see how we can improve this. To continue to work on improving our data and work alongside the development of 'Our Health Plan' to progress hearing from patients with a protected characteristic. Acknowledging we have made some progress for example work with prisoners and maternity services. 
Equality Quality Impact Assessment	***Year 1*** We will review the policy to ensure EQIA are undertaken in partnership with patients and the results	Partially complete	EQIA process is now well established across the Trust however there is remaining work required to improve the involvement of patients within this process. The recruitment of new Patient Safety Partners (PSP) involved in a number of work streams across the trust which is supporting the voice of the patient.

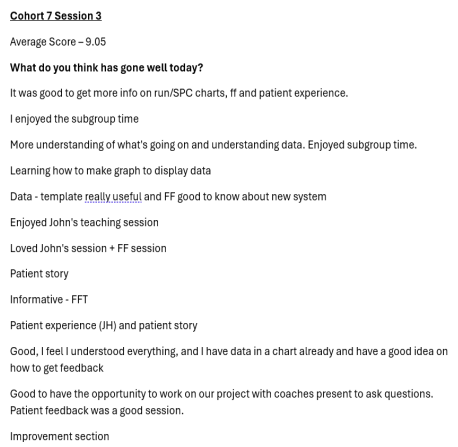
	are meaningful and apply to all change projects. ***Year 2*** We will develop a mechanism for sharing the outputs of EQIA processes to broaden insight in all divisions on patients views and feelings on change proposals. ***Year 3*** We will routinely access patient views and have mechanisms in place in all divisions to do so in an inclusive way.		

Involvement		
Year		
Outcome	**Completed**	**Update**

Measurement			
Patients, carers, families and lay people as partners in safety	***Year 1*** We will align with the Always Safety First strategy and recruit to the role of Patient Safety Partners (PSP) representative of the community we serve. We will ensure that the PSP will reflect the diversity of the community we serve. ***Year 2*** We will take feedback from the PSP to review the Always Safety First year 1 and ensure year 2 reflects the areas that are important to them. **Year 3** We will evaluate the PSP role and identify priorities for delivery in year 3	Complete	PSP have been recruited although at present they are not reflective of the community we serve however there is a planned approach to increase the numbers of these. PSP's are working across a number of groups and have started to have an impact. It should be noted that this role is still in its infancy and development of the role and impact are a work in progress.
	Year 1 The PSP will join the Always Safety First subcommittee and participate in the evaluation of evidence and design of solutions focusing on what matters to patients. We will recruit a senior midwifery advocate. ***Year 2*** We will create a network of advocates and Patient Safety Partners across the organisation to share experiences across specialties. ***Year 3*** We will take the learning from year 1 and 2 and agree year 3 with the Patient safety Partners and senior Midwifery advocate.	Complete	PSP have joined the PSIRF oversight panel, Always Safety First Learning group and PEIG. They are also supporting improvement groups across the trust. Key learning is to ensure the PSP are a true representation of our communities moving forward.
Leadership	***Year 1*** We will define the role of leaders within the organisation in relation to patient experience and involvement and working with patients as partners. ***Year 2*** We will ensure that Leaders at every level of the	Complete	This is developing as we see the role of PSP progressing although this remains in its early stages. Working on how we extrapolate the information and skill mix from annual appraisal. The development of FCA and MCA training across the trust has allowed for a number of staff to develop their leadership skills.

	organisation will have an objective linked to improving patient experience as part of their annual appraisal. ***Year 3*** We will evaluate effectiveness of interventions and activity in year 2 and use to inform year 3 priorities.		
	Year 1 We will commit that all clinical areas will identify patient experience and involvement champions. The champions will continue to work with existing mental health, safeguarding and learning disability champions. ***Year 2*** Representatives from the champions will be present to share their view at the patient experience and involvement group. ***Year 3*** We will evaluate effectiveness of interventions and activity in year 2 and use to inform year 3 priorities.	Complete	Over 170 patient champions across the trust and continue to work across all areas and specialities and attend to share there experiences at the PCEIG. Patient Stories from champions presented PCEIG The effectiveness of the champions is noted with the increase in attendance at the PECIG, the improvements and increase in Friends and Family and the reduction in formal complaints across the trust.
	Year 1 We will increase ward leadership in wards greater than 28 beds in recognition of the challenges of managing large clinical areas. ***Year 2*** We will commit to evaluating the impact on patient experience and involvement that having 2 leaders on large wards has made. Year 3 We will embed the learning from the evaluation once we understand the impact made on experience and involvement having 2 leaders has made	Complete	All large wards have 2 ward managers are in place on them. This is reviewed twice yearly as part of the staffing reviews and Divisional Improvement Frameworks (DIF's). Annual and BI-annual staffing reviews presented at Quality and Safety Committee.
Patient experience and involvement training	***Year 1*** We will agree a training programme and hierarchy of training needs. ***Year 2***	Complete	A blended learning package has been developed for PALS concerns and the need for teams to locally resolve concerns. A complaints handling module was completed this year and aimed at those managers who are required to respond to complaints.

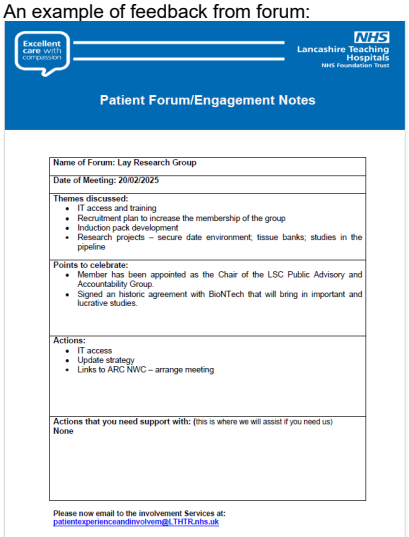
	We will train all clinical and non-clinical department managers as per the training requirements. **Year 3** We will monitor the training plan at departmental level.		A further development is to add the training to the TNAs of teams which is currently being worked through.
	Year 1 We will develop leaders aligned with our Organisational Development programme so that living the values is directly linked to patient experience front and centre in all that we do. ***Year 2*** We will showcase leaders who are creating cultures focussed on patient experience. ***Year 3*** We will continue to showcase leaders who are creating cultures focused on patient experience.	Complete	Work continues in ensuring a focus is given to this a numerous areas, NMC , Civility campaign, patient board stories. External review and internal culture reviews have been presented to Quality and Safety Board. Patient Experience data in relation to emotions is shared at Raising Concerns group 
	Year 1 We will develop a training module for leaders to understand the principles of local resolution, concern and complaints and how to respond. ***Year 2*** We will achieve training for leaders by 50%. We will ensure this training is implemented and evaluated for effectiveness. Year 3 We will further increase training for leaders by 50%. We will continue to embed training and evaluate contribution to improving patient experience during annual appraisal	Partially Achieved	A blended learning package has been developed for PALS concerns and the need for teams to locally resolve concerns. A further module for complaints handling is completed and will be aimed at those managers who are required to respond to complaints. 529 staff completed PALS module 237 staff completed complaints module

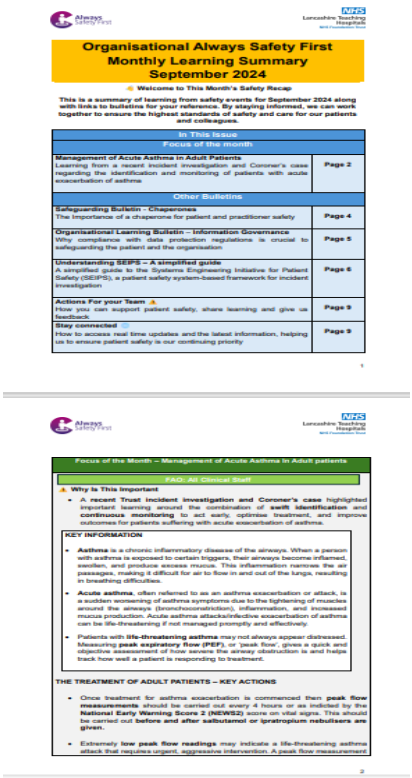
	Year 1 Training in co-design will be identified, this will be delivered through FCA and MCA programmes.. ***Year 2*** All clinical departments will participate in improvement via FCA and MCA and embrace the patient co-design work. ***Year 3*** Evaluate the impact of MCA and FCA participation on patient experience	Complete	Associate Director Quality and Experience attends the MCA to ensure co design is demonstrable. All 8 of MCA ensuring a large number of areas have participated with education regarding patient experience and how they can use this within there projects Feedback from MCA course regarding patient experience session and core to projects. Feedback from one of the cohosts is in image below:  **Cohort 7 Session 3** Average Score – 9.05 **What do you think has gone well today?** It was good to get more info on run/SPC charts, ff and patient experience. I enjoyed the subgroup time More understanding of what's going on and understanding data. Enjoyed subgroup time. Learning how to make graph to display data Data - template really useful and FF good to know about new system Enjoyed John's teaching session Loved John's session + FF session Patient story Informative - FFT Patient experience (JH) and patient story Good, I feel I understood everything, and I have data in a chart already and have a good idea on how to get feedback Good to have the opportunity to work on our project with coaches present to ask questions. Patient feedback was a good session. Improvement section
	Year 1 We will support all staff and students with a booklet about our Involvement services for patients, carers and our community. ***Year 2*** We will increase access to this information ensuring colleagues can access the involvement booklet via clinical practitioners, induction, QR codes and our staff intranet. ***Year 3*** We will maintain and update the Involvement booklet via our Patient Experience and Involvement team.	Complete	Patient Information Group with patients, support staff with all leaflets, posters and QR codes are available. This group provides assurance to the PCEIG in regards to number of leaflets reviewed and the noted feedback for both inpatients and cancer services. All ward communication and involvement booklets updated. As part of the STAR accreditation process it is checked that all ward/areas has accessible information. The trust intranet and internet has improved patient experience information that staff and public have access to including patient stories.
	Year 1 We will develop training sessions that have experts by experience co-delivering the training, to ensure learning from the patient, family or carer.	Partially achieved	The development of community of practice days with all senior nurses and AHP's across the trust has allowed for education and training regarding family liaison by using patients at the centre.

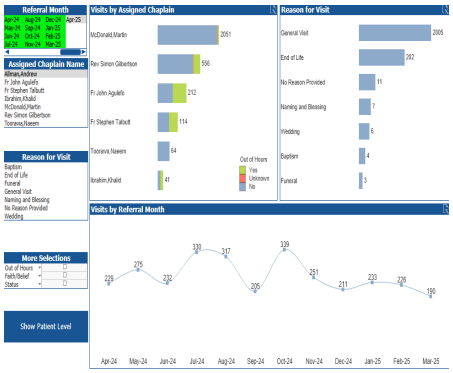
	Year 2 We will continue to develop the training to enhance the skills of our staff to support patients in enhanced levels of care and the use of activity or helpful strategies. ***Year 3*** We will provide training in intersectional approach understanding that no one has just one identity and making sure that one identity e.g. a physical disability is not seen as a stand alone issue.		An example of an agenda below, the richness of the conversation and using patients to support and change practice was palpable. The community of practice has also allowed for senior leaders to role model behaviour, values and show leadership. This does have long term impact on patient experience. **Agenda** Lancashire Teaching Hospitals NHS Foundation Trust **Community of Practice** **Friday 7 February 2025 | 09:30 – 15:00** **Lecture Hall | Health Academy 1 | Royal Preston Hospital** **Topic of the Day: Listening to Patients, Families and Carers** **Arrival 09:00 – 09:15 for a 09:15 start** ****Please register your attendance in Lecture Room 1 – Health Academy 1 – RPH (next to the Lecture Hall)**** **Morning session** 1 – Welcome to the Community of Practice – 09:15 – Sarah Morrison 2 – Icebreaker – 09:25 – Catherine Gregory / Rachel Sansbury 3 – Marina's Story (20 presentation + 20 Q&A) – 09:35 – Michelle Young 4 – Sharing Good Practice (• About Me Boards - Childrens • Pre-op – Reasonable Adjustments) – 10:15 – Angela Mason, Helen Hoyle / Andrea Hardyman **10:45 Coffee break** ****Tea / Coffee will be served in Lecture Room 1**** 5 – Handling Difficult Situations – 11:00 – Kate Holt 6 – Martha's Rule – 11:45 – Sally Fray / Vicky Wilson 7 – What good looks like – Family / Carer / Patient Liaison – 12:00 – John Howles **12:30 Lunch Break** ****Tea / Coffee will be served in Lecture Room 1**** **Afternoon session** 8 – Break out workshops – HA1 (• Meeting Room 2 / Seminar 3 / Seminar 7 / Seminar 8) – 13:00 – Facilitated by DNOs, Deputies, Chief AHPs and Deputy CNOs 9 – Feedback – 14:00 – All 10 – Setting our Commitments to Practice – 14:30 – All **15:00 Close** **Next meeting: Tuesday 1 April 2025**
Volunteer involvement	***Year 1*** We will create a template and single point of contact for volunteers to give feedback on areas that can improve patient experience and involvement. ***Year 2*** We will ensure that this feedback is acted upon and monitored for improvement. ***Year 3*** We will develop the volunteer service via feedback and learning to continue to improve	Complete	Reports and updates are provided to PCEIG on a monthly basis with relevant feedback from volunteers. Volunteers used to gain patient feedback regularly and present at PCEIG Increase year on year for Volunteers: active 2022 196 active 2023 239 active 2024 318 Over the 3 years this is a 62% increase in volunteers within the trust.
	Year 1 We will recruit a core group of volunteers to work with the patient experience team to enhance involvement and promote improvements. We will ensure full representation of the local diverse community to share their views on services and what matters most to them	Complete	Volunteers in PALS, hospital guides and attendance at a number of local diverse events over the last 2 years, i.e. Windrush, Health Mela, LGBTQ+ events. Hospital guides are in place across both sites Increase year on year for Volunteers: active 2022 196 active 2023 239 active 2024 318

	through the Patient Experience Involvement Group and other annual events, such as PRIDE, Windrush etc. ***Year 2*** We will enhance volunteer training to enable them to support patient experience projects. We will use the feedback from each event to make a commitment to improve an area based on the feedback received. ***Year 3*** We will continue to use feedback from patients/carers to explore and develop projects such as 'Navigation guides' using the volunteer service		
Working in partnership	***Year 1*** We will refresh the organisations approach to "Hello my name is". We will ensure that all staff names are visible to patients. ***Year 2*** We will ensure that "Hello my name is" becomes embedded and is assessed via the STAR process. ***Year 3*** We will continue to promote "Hello my name is". We will continue to assess via STAR process.	Complete	Complete and reviewed through STAR accreditation programme. All staff are required to wear name badges that are visible to patients, along with introducing themselves during care interventions.
	Year 1 We will ask all inpatients what matters to them, and bed boards will be completed holistically and specifically based on the patient's preferences. ***Year 2*** We will ensure that this process is embedded using direct feedback and the STAR process. ***Year 3*** We will evaluate the use of bed boards.	Partially achieved	Use of bed boards is inconsistent but work has commenced to change and deliver this across all ward areas. It is noted that within paediatrics they have developed a new about me board that is being tested which incorporates children and family completing themselves alongside the nurse, the feedback is positive so far.

	Year 1 We will engage with external partners and charities e.g. Galloways, Healthwatch, NCompass and our local Partnership Boards, amongst others via the patient experience and involvement group to be fully inclusive and ensure views and experiences are heard. ***Year 2*** We will review membership and continue to check we are fully inclusive and learning. **Year 3** We will continue to review membership of the involvement group and continue to check we are fully inclusive and learning from lived experiences	Complete	All groups represented on the Patient Experience and Involvement group. This will continue to evolve over time to ensure that new community groups are welcomed to attend meetings. Quarterly meeting held with all community partners . Below in the trust cancer centre hosting the Windrush CEO founder : **Trust's Centre for Health Research and Innovation hosts Windrush CEO and founder** Lancashire Teaching Hospitals' Centre for Health Research and Innovation recently hosted a visit from the Windrush CEO and founder, Adrian Murrell, along with Richard Cupid, who is working with them on their "Race to Health" project. One of the centre's goals is to develop an approach that encourages everyone in our community to participate in our research in a way that is inclusive and welcoming, and in late 2024, we visited the local Windrush Initiatives Team in Preston, a well-established organisation which supports Black and Mixed-Race people in Preston and nearby areas. During this meeting, we introduced our Research and Innovation Department while highlighting that ethnic minority groups are underrepresented in the participants we recruit to research studies. In this latest, follow-up meeting, there was a productive, open, and engaging conversation with the team, which brought up several key points, which you can read here. 
	Year 1 We will agree an approach that engages patients in new developments from their inception. We will continue to promote access to healthcare by events such as 'Our Health Day' for people with a learning disability and / or autism. ***Year 2*** We will ensure that patients views are paramount and heard in all change and new developments using a checklist approach. ***Year 3*** We will ensure that no new projects can be agreed unless it is evident that patient's views have been sought as part of the scoping work		The recommence of the Supported Our Health day for people with learning disabilities, this was an enormous success with may areas supporting the event alongside community colleagues The health mela has been represented by many areas from within the trust over the last 2 years it has recommenced. . All new environmental or patient project such as the new DOSSA build and PEP project all come through PCEIG to gain patient opinions
	Year 1 We will ensure that holistic assessment of patients requirements are made and any reasonable adjustment plans are in place where needed. ***Year 2***	Partially achieved	Reasonable adjustment flag now operational on Harris Flex system and associated training provided. Patient Passports are available for all patients and the Forget Me Not document is available for those patients living with dementia. Both of these support the holistic needs of patients and identify additional needs for care and treatment. Data analysis is work still on going

	We will ensure all staff are trained in Reasonable adjustments on internal systems. ***Year 3*** We will ensure use of data from reasonable adjustments for clarity on our communities' diverse needs		
	Year 1 We will work in partnership to promote shared decision making between disabled people and health services, utilising the Kings fund publication Partnering for inclusion. https://www.kingsfund.org.uk/sites/default/files/2022-07/Partnering_for_inclusion_easy_read.pdf ***Year 2*** We will ensure all chairs of Trust patient forums report and feed into the Patient Experience and Involvement Group. ***Year 3*** We will use new approaches developed through partnering for inclusion to hear more from those less well heard and design improvements for specific groups	Complete	A feedback form is completed from all forums and added for information into PCEIG. A note increase in forums and greater representation from community team at PCEIG Quarterly community involvement meeting held which has enabled further links into the community. This has opened opportunities to reach out and visit areas from some groups that have protected characteristic such as disabilities to bridge a greater understanding of their experience. An example of feedback from forum:  Patient Forum/Engagement Notes Name of Forum: Lay Research Group Date of Meeting: 20/02/2025 Themes discussed: • IT access and training • Recruitment plan to increase the membership of the group • Induction pack development • Research projects – secure date environment; tissue banks; studies in the pipeline Points to celebrate: • Member has been appointed as the Chair of the LSC Public Advisory and Accountability Group. • Signed an historic agreement with BioNTech that will bring in important and lucrative studies. Actions: • IT access • Update strategy • Links to ARC NWC – arrange meeting Actions that you need support with: (this is where we will assist if you need us) None Please now email to the involvement Services at: patientexperienceandinvolvem@LTHTR.nhs.uk
	Year 1 We will build on current internal patient forums and connect with external partners to make system changes that affect a large number of people most likely to experience inequalities. ***Year 2*** We will agree priorities as a system and work with partners across Central Lancashire to improve	complete	Our Health Plan is now operational within the trust with agreed priorities across central Lancashire. Key messages are seen in the image below: 1: Give every child the best start in life 2: Promote education and life-long learning 3: Ensure fair employment and good working conditions 4: Secure the minimum income necessary for a healthy life 5: Create healthy and sustainable environments and communities 6: Adopt a social determinants approach to prevention and healthy lifestyles

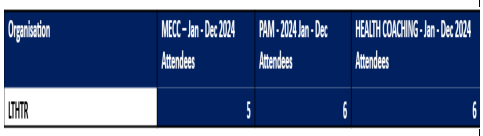
	experiences of those most likely to suffer health inequalities. ***Year 3*** We will encourage collaboration and promotion of projects beneficial to patients and our communities.		
Sharing lived experiences	***Year 1*** We will use narrative, data and lived experience to frame issues and engage towards a shared purpose with staff, patients and carers to improve learning and effect change in team meetings. ***Year 2*** We will have evidence examples of learning from shared lived experiences and provide examples of positive patient experience change as a result ***Year 3*** We will share examples of lived experiences as part of learning bulletins and partnership with patients to improve services	Complete	Patient stories used in a large amount of meetings and we now have a bank on the intranet of stories for staff to see. Development in the Gynae department reconfiguration of the service and estate changed to meet the needs of those ladies who have experienced miscarriage. This was developed as a result of complaints and concerns and co-produced with a family. Patient, care and family involvement has increased and with associated learning bulletins. No greater example than Marinas story.  Organisational Always Safety First Monthly Learning Summary September 2024 Welcome to This Month's Safety Recap This is a summary of learning from safety events for September 2024 along with links to bulletins for your reference. By staying informed, we can work together to ensure the highest standards of safety and care for our patients and colleagues. In This Issue Focus of the month Management of Acute Asthma in Adult Patients — Page 2 Other Bulletins Safeguarding Bulletin - Chaperones — Page 4 Organisational Learning Bulletin – Information Governance — Page 5 Understanding SEIPS – A simplified guide — Page 6 Actions For your Team — Page 9 Stay connected — Page 9 Focus of the Month – Management of Acute Asthma in Adult patients FAO: All Clinical Staff Why is This Important A recent Trust incident investigation and Coroner's case highlighted important learning around the combination of swift identification and continuous monitoring to act early, optimise treatment, and improve outcomes for patients suffering with acute exacerbation of asthma. KEY INFORMATION Asthma is a chronic inflammatory disease of the airways. When a person with asthma is exposed to certain triggers, their airways become inflamed, swollen, and produce excess mucus. This inflammation narrows the air passages, making it difficult for air to flow in and out of the lungs, resulting in breathing difficulties. Acute asthma, often referred to as an asthma exacerbation or attack, is a sudden worsening of asthma symptoms due to the tightening of muscles around the airways (bronchoconstriction), inflammation, and increased mucus production. Acute asthma attacks/infective exacerbation of asthma can be life-threatening if not managed promptly and effectively. Patients with life-threatening asthma may not always appear distressed. Measuring peak expiratory flow (PEF), or 'peak flow', gives a quick and objective assessment of how severe the airway obstruction is and helps track how well a patient is responding to treatment. THE TREATMENT OF ADULT PATIENTS – KEY ACTIONS Once treatment for asthma exacerbation is commenced then peak flow measurements should be carried out every 4 hours or as indicted by the National Early Warning Score 2 (NEWS2) score on vital signs. This should be carried out before and after salbutamol or ipratropium nebulisers are given. Extremely low peak flow readings may indicate a life-threatening asthma attack that requires urgent, aggressive intervention. A peak flow measurement

Engaging with faith leaders	***Year 1*** We will ensure that we listen to what our patients tell us they need in relation to their faith. ***Year 2*** We will continue to ensure representation of all faiths and cultures. Year 3 We will continue to provide information and education support for all staff in the production of guidebooks around culture and faiths	Complete	The Head of Chaplaincy attends Patient Experience and Involvement group and shares relevant patient stories where impacts can be shared. Muslim brethren attend the NMAHP meetings periodically to update in line with the requirements of their faith to raise awareness, for example the requirements of Eid.
	Year 1 We will continue to improve on recognising the needs from patients in all ethnic and religious groups. ***Year 2*** We will use STAR to test the availability of faith resources as agreed in our faith forums. ***Year 3*** We will continue to research and provide staff with support around any additional religious needs that may be required.	Complete	Through the Patient Experience and Involvement group. Food available for a variety of faiths. Supportive and involved with the Rosemere Charity during Eid. STAR covers faith and CARING rounds audit also. 
	Year 1 We will ensure that the bereavement boxes are present on every ward and this is tested as part of STAR. We will acknowledge religious events and ensure that these are treated with respect. ***Year 2*** We will continue to provide and update the Trust Equality Diversity and Inclusion calendar to share relevant religious dates. *Year 3*	Complete	The Trust communications provides updates on religious festivals throughout the year.

	We will enhance our participation in religious events which will be inclusive of more services such as catering and communications		
	Year 1 We will provide the appropriate faith leader (if requested) to work collectively to deliver end of life care. ***Year 2*** When requested cultures and faiths are respectfully recognised and represented during the patient journey. ***Year 3*** Chaplaincy will ensure multi-faith representation is available	Complete	The Chaplaincy team have a list of all faith leaders within the area and can be contacted at any time should their services be required through our switchboard. Chaplaincy take an active part in CARING walk rounds foe EOL. Chaplaincy provide muliti faith support across the trust on a daily basis where required and sup[port patient, families and carers.
Patient Contribution to Case Notes (PCCN), Forget Me Not, Patient Passports	***Year 1*** We will develop and implement a plan to ensure wards and departments are effectively using tools to enhance patient experience whilst in hospital. We will monitor progress via STAR. We will embed these tools in the role of the clinical area patient experience champions. ***Year 2*** We will evidence increased utilisation of the tools, gathering feedback around their effectiveness. Year 3 We will share examples of the contribution these tools have made to improving patient experience and continue to embed	Partially achieved	The Patient Contribution to Case Notes (PCCN) is sporadically used across the Trust although not embedded. Work is scheduled in year 3 of the strategy to deliver and embed this across all areas. More awareness and emphasis to be placed on the use of the Patient Passport and Forget Me Not documents to ensure all areas are maximising the use of this.

Interpreter services	***Year 1*** We will assess the interpreter service provision for the current service needs to ensure current technology, advice and guidance for staff to access on behalf of patients and their carers. ***Year 2*** We will evaluate interpreter service provision to ensure it maintains fit for purpose. ***Year 3*** We will continue to evaluate interpreter service provision. Interpreter services to be commissioned jointly with patients and carers	Complete	Access available and reviewed regularly. Further awareness of Translation and Interpreter services will be carried out and this information will be refreshed periodically to ensure new members to the organisation are aware of what needs to happen when this service is required. Ward and Area visits in place to support knowledge. All patients whom contact acute settings ie AMU, ED can have immediate access to translation via 3 way communication service.
	Year 1 We will increase recruitment of volunteers who can use sign language. ***Year 2*** We will create a database for volunteers who can use sign language. ***Year 3*** We will continue to recruit volunteers who use British sign language to welcome patients before contracted interpreters are sourced	Complete	British Sign Language (BSL) training has been carried out regularly throughout the last 3 years. This training is open to all staff and training is recorded. Guide Dogs UK throughout 2023 and 2024 - We have provided online sighted guidance 1 hour training sessions for all staff, the course advises the most common eye conditions and the barriers faced by people living with sight loss and explains what we can to do to support people coming into our trust, including those with assistance dogs Compass – throughout 2022, 2023 and 2024 - We have provided 'Bridging the Gap' Deaf awareness 1 hour sessions online that provide information for staff on Deaf awareness and basic BSL. This session covers myths and looks at facts on how best we can support our communities who suffer hearing loss right through to cultural Deaf people. This course has also been attended by invite to our local GP service staff and our volunteers at LTHTR. This course has also promoted free basic level 1 British Sign Language courses which staff have gone on to gain a qualification
	Year 1 We will measure feedback and satisfaction with users of interpreting services. ***Year 2*** We will act upon feedback from users of interpreting services. ***Year 3*** We will continue to evaluate and act upon feedback as part of quality assurance meetings with providers.	Complete	Feedback given, reviewed and continued to be used to ensure positive staff and patient experience. Feedback provided via involvement update ate PCEIG. Language Interpreter services We use Face to face, telephone and video calling services with 2 providers The Big Word: overall it has been consistent over the last 2 years, no increase/decrease as such with on average Face to face 194 jobs per month Telephone 141 per month
	Year 1	Complete	No formal complaints have been received regarding translation and interpreter services.

	We will carry out thematic review of any incident / complaints in relation to interpreter services. ***Year 2*** We will ensure an action plan is in place to respond to learning from incidents / complaints regarding interpreter services. ***Year 3*** We will ensure actions are embedded in practice and continue to evaluate		
Bedside handovers	***Year 1*** We will engage with patients to review our process for bedside handovers, updating policy and maintaining confidentiality. We will consider areas that can be used for confidentiality when discussing sensitive matters or when external assessment is being completed (for example mental health). ***Year 2*** We will audit the process via STAR. ***Year 3*** We will review and re-audit the process.	Partially achieved	This remains inconsistent through audited evidence from the STAR accreditation visits. A standardised approach has commenced through the Always Safety First Learning Group (ASFLG)
Transformation programmes	***Year 1*** We will ensure that patients are involved in co-production of transformation projects ensuring that value added components of the programmes is intrinsically linked to patients value added. ***Year 2*** We will ensure that all transformation programmes have evidence of patient involvement. ***Year 3*** We will ensure that all transformation programmes have evidence of patient involvement and co-production.	Complete	Associate Director of Experience and Quality attends all transformation programmes, stories are recorded and patient voice noted in all meetings. Patient involvement with all new strategies, plan etc as presented at all forums and PCEIG EQIA process for all transformation programmes that are led outside of divisions has oversight from Associate Director of Quality and Experience.
Making every contact count	***Year 1***	Partially achieved	Examples of good practice noted in some areas, this is not shared widely.

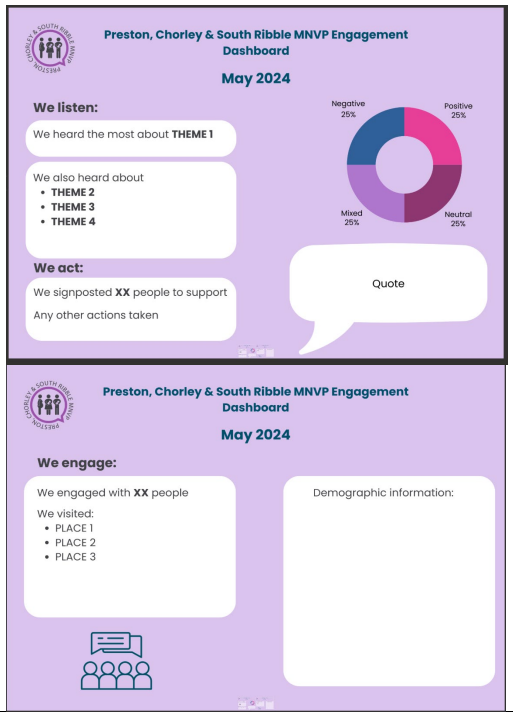
	We will ensure that we take every opportunity to promote healthy lifestyles engaging in opportunities to office advice and guidance around smoking cessation, reducing alcohol intake and promoting healthy lifestyles. ***Year 2*** We will capture health promotion information and discussions on Quadramed. ***Year 3*** We will capture health promotion information and discussions on Quadramed		Ward round document has element s remating to this but remains inconsistent 
Accessible Information Standard	***Year 1*** We will obtain a baseline of current standard that are met and mitigate any gaps creating an action plan towards making health care information accessible to identify, record, flag, share and meet information and communication support needs of patients, service users, carers and patients with a disability, impairment or sensory loss. https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/ ***Year 2*** We will review annually in order to benchmark current position ensuring actions are being progressed and audit under the responsive Key Line of Enquiry to confirm K compliance with the standard. ***Year 3*** We will review annually to benchmark current position ensuring actions are being progressed and audit under the responsive Key Line of Enquiry to confirm compliance with the standard	Complete	The trust internet and intranet meet all accessible standards recommended from a CQC perspective and has been externally reviewed. A indicative tool used by Trusts is Silk Tide's ranking system where we appear at 86% against the A, AA and AAA standards. As a trust we score 2nd highest amongst our ICB partners with LSCFT (92%), ELHT (68%), UHMB (80%), LSC ICB (83%) with Blackpool failing to test. Others in the locality include WWL (72%) and Bolton (61%) and Mersey & WL (69%).
Patient Key Contacts	***Year 1*** We will respond to the feedback from patients with chronic or long term conditions who tell us that they value the role of a key	Complete	An established virtual ward where patients are in their own home and they have a key point of contact for a member of Trust staff to progress their care. CQUIN for decision making in renal and neurology has been completed.

	worker as a point of contact to help navigate and support decision making. We will review what is working well and set this as our standard and benchmark where there are gaps in this provision. ***Year 2*** We will ensure that patients who do not have a key worker are informed of who they should contact and work towards improving this position. ***Year 3*** We will ensure that patients who do not have a key worker are informed of who they should contact and work towards improving this provision.		Introduction of care connexions across the system has supported patients with Key contacts A focussed Discharge action plan developed and supports key patient contacts
Research	***Year 1*** We will continue to raise this profile of involving patients in research by promoting research studies and explaining why involvement in research is important for overall patient experience. ***Year 2*** We will increase the number of patients involved in research and share stories of what this has meant to them and how this has affected their experience. ***Year 3*** We will promote patient experience at research topics for internal degree and masters research topics and share the outcomes	Complete	This is part of the STAR Accreditation process, but we note a couple of research projects: • Work on Postpartum haemorrhage with the BAME community. • Work in neurosurgery regarding spinal surgery and antibiotics Fromer cancer patient who chairs the cancer forum also works in research for the trust and delivers research associated patient stories a to understand the impact and benefits to research.

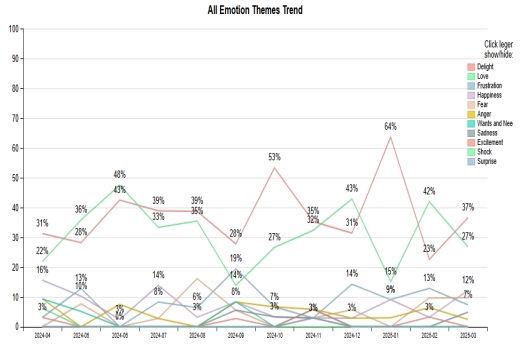
Improvement			
Year 3			
Outcome ***Measurement***		**Completed**	**Update**
Nutrition and hydration and assistance with meals	***Year 1*** We will provide food which is inclusive, tailored to patients needs at the right time, right place and right patient. ***Year 2*** We will measure the quality of provision of catering as a thematic review to establish whether actions taken have led to improvements. ***Year 3*** We will gather feedback and continue to evaluate the effectiveness of actions taken to improve, identifying and responding to new intelligence	Complete	Updated menus are in place including vegan and Halal. The food provision and quality is monitored through the FFT feedback. New digital system foreordering with greater variety for all protected characteristics. Feedback is gained through friends and family test and Facilities present at PCEIG. Further work remains ongoing in relation to food delivery through the Nutritional Steering group
	Year 1 We will celebrate with inclusive food faith events ensuring this is time sensitive when necessary. ***Year 2*** We will improve the rating of food in the national surveys. We will improve the PLACE rating. Year 3 We will improve the rating of food in the national surveys. We will improve the PLACE rating	Partially achieved	National PLACE audit has been carried out this year and feedback provided through the Patient Experience and Involvement group (PEIG). National In-patient survey demonstrated a deteriorated position for food. An associated actin for improvement and work continues through nutrition steering group (FCA big room) PLACE position improved but further work required in certain areas. Food has shown a slight improvement on the previous year 

Organisation Name	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	99.36%	89.01%	90.09%	86.12%	82.32%	97.11%	68.79%	69.60%

	Year 1 We will ask you what you want to order and provide you with information so that you can make the right choice for yourself. We will ensure that patients with special requirements have their needs met e.g. such as patients who have Parkinsons and need to eat with medication. This will be tested through STAR. We will ensure all that require support at meal times, receive this and this is tested through STAR. ***Year 2*** We will increase the availability of reasonable adjustments to support nutrition and hydration. ***Year 3*** We will test the effectiveness of this using experts by experience.	Complete	Digitised menus are now in place and have the functionality to allow more tailored ordering of food. This is monitored through the STAR accreditation visits. Blue trays are available for all patients where additional support with nutrition is needed. Additional needs are identified on the patient behind the bed boards. Increase in availability of food ie Vegan Testing of new foods in relation to menu items iso now in place and staff and patients are used to gain opinions.
Quality Assurance	***Year 1*** We will agree a process to quality assure the responses to complaints and concerns and implement this process. ***Year 2*** We will agree a process to quality assure the responses to	Complete	The Complaints process has been reviewed and the Policy updated to reflect the changes in relation to PSIRF. As well as this the Trust policy now mirrors the Parliamentary and Health Service Ombudsman (PHSO) best practice and this is fully embedded. Reviewed process in place regarding quality to assure and monitor how many 2nd responses letters are written. Regularly weekly complaints meetings with the divisions are in place. A process has been established in the Complaints review group which analyses and tests the quality of responses with minutes shared at PCEIG

	complaints and concerns and implement this process. ***Year 3*** We will agree a process to quality assure the responses to complaints and concerns and implement this process		
Maternity and Neonatal Transformation	***Year 1*** We will ensure that women will not feel alone and will treat them with kindness and respect. This will be measured through the national maternity survey. ***Year 2*** We will utilise national initiatives such as the "15 steps" approach and "Whose Shoes?" to review and improve the care provided and environment it is provided in. ***Year 3*** We will continue to gather feedback and evaluate the effectiveness of actions taken to improve the maternity service	Complete	The National Maternity survey showed sustained performance results. The 15 step challenge is in place a led by the Maternity Voices Partnership lead. Continue to gain friends and family data for All Maternity services . Below is an example of testing an engagement board: 
	Year 1 We will make sure that women have the contact	Complete	A Maternity and Neonates Voices Partnership group is in place. Appointment of Maternity and Neonatal Voices Lead.

	details for their midwife. We will ensure that women are able to make a personalised care and support plan during their pregnancy, for labour and birth and following the birth of their baby. ***Year 2*** We will continue to implement new national directives as they emerge and ensure action plans are shared with the Maternity Voices Partnership. ***Year 3*** We will continue to implement new national directives as they emerge and ensure action plans are shared with the Maternity Voices Partnership.		Badgernet displays contact details of midwife and/ or point of contact. National Directives are discussed and shared at the Maternity and Neonatal Voices meetings. Real focus on Nolan Principles
	Year 1 We will ensure women can access help and advice and advice about feeding their babies during their care journey. ***Year 2*** We will ensure breastfeeding areas will be improved across the organisation and in line with the baby friendly initiative. ***Year 3*** We will increase the number of	Complete	Stage 2 Baby friendly Initiative accreditation achieved Lancashire Teaching Hospitals NHS Foundation Trust **Feedback from The UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative Stage 2 Assessment Report for Maternity Services** Received 21st March 2025.

	breastfeeding areas will increase. We will increase compliance with baby friendly Initiative (BFI) accreditation.		
	Year 1 We will seek to receive feedback in addition to Friends and Family and complaints to understand ways in which our services can improve experience for parents. ***Year 2*** We will continue to co-design service improvements. We will upgrade the provision of birthing pools to ensure water births are accessible for all who choose this as a birthing option. ***Year 3*** We will continue to co-design service improvements	Complete	An increase in the amount of Friends and Family feedback has been realised. It also achieved satisfaction in Q1 and Q4 The division are proactively meeting with people who have raised concerns or made complaints to understand how the service and experiences of parents can be improved. The chart below states the patient emotions fro the last 12 months:  The department as repurposed a room following patient feedback to improve the experience of women needing glucose tolerance testing due to the wait they have for the test.
	Year 1 We will involve parents in the co-production of neonatal services utilising the “neonates” group to facilitate this. ***Year 2*** We will become a neonatal network accredited Family Integrated Care Unit (FiCare).	Complete	Neomates are in place to consult with service users. We achieved Green in Family Integrated care Unit for the region which is the highest accreditation.

	Year 3 We will respond to family feedback and focus on improvement in response to their experience		
	Year 1 We will ensure partners can stay and support women during antenatal periods on the ward. ***Year 2*** We will provide an outdoor space for women in labour that is conducive to the birth process. ***Year 3*** We will identify the next area to improve with our Maternity Voices Partnership.	Not achieved	An outdoor space is not in place at present.
	Year 1 We will improve the facilities and experience for women who experience miscarriage. We will participate and achieve accreditation in standard set to support women who have had a miscarriage. ***Year 2*** We will provide an improved baby memorial area. We will provide 7 day bereavement	Partially achieved	The Gynae assessment unit has undergone a full renovation to improve the experience of patients in the last 18moths. The building works were completed and further art and decals have been supported through the charity to enhance the environment further. A 7 day bereavement service is available and the appointment of a specialised bereavement nurse for woman who miscarriage is now in place again supported by the charity for 2 years The bereavement garden work hasn't commenced to date.

	support services. ***Year 3*** We will improve the facilities further for women who experience miscarriage.		
Children and Young People	***Year 1*** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas. ***Year 2*** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas and monitor. **Year 3** We will ensure that children and young people have therapeutic activities which are fully implemented in clinical areas and monitor	Complete	Therapeutic activities are in place, e.g. sensory, costumes, themes, books, toys. Father Christmas visits annually. Local football and rugby teams visit for stimulation. Play workers in place and with 2 being trained as play specialist working alongside patient experience lead for area have developed many activities to support children whilst in hospital
	Year 1 We will improve overnight facilities to optimise young people and children's outcomes. ***Year 2*** We will improve review feedback on overnight facilities to optimise young people and children's outcomes. ***Year 3*** We will review feedback on	Complete	Estates work carried out to improve the environment in paediatrics. Access to better equipment for sleep is available, New about me board tested for Parents and children together with initial great feedback Improvement plan in place and reported into PCEIG Every patient bed on ward has chairs that converts to beds for parents/families

	overnight facilities to optimise young people and children's outcomes		
	Year 1 We will ensure that age appropriate activities are provided for 16 and 17 year olds being cared for on adult wards. ***Year 2*** We ill ensure that age appropriate activities are provided for 16 and 17 year olds being cared for on adult wards. ***Year 3*** We will ensure that age-appropriate activities are provided for 16 and 17 year olds being cared for on adult wards	complete	All children aged 16/17 are checked on and supported from a Matron as part of their daily checks. A dashboard within BI is in place to give a greater oversight of children in adult wards
	Year 1 We will introduce a parent group to gain feedback and promote co-production in service change. ***Year 2*** We will agree parent priorities to improve and co-design these. ***Year 3*** We will continue to work in partnership exploring the needs of looked after children using social care advocates	Complete	Youth forum in place. Young people form part of the recruitment process which supported the recruitment to a Children youth worker. Work to set up forum in community area of Chorley called Youth zone is also commenced Exploration of community partnership work has also commenced led by the patient experience lead
	Year 1 We will provide a multi-sensory	Partially achieved	Work remains to be completed for Broadoaks site in regard to outdoor space.

	space for children with disabilities at the Broadoaks site. ***Year 2*** We will explore the provision of outdoor play for children on each of our sites. ***Year 3*** We will implement increases in outdoor play provision		
	Year 1 We will introduce the role of patient experience lead for children to provide additional support across all areas. ***Year 2*** We will learn from this and adopt the learning to clinical areas where children are seen in across the organisation. Year 3 We will continue to share the learning from the patient experience lead	Complete	Recruitment to lead and supporting the patients with children is in place and an action plan developed with clear objects to achieve which feeds into PCEIG
	Year 1 We will ensure that children and young people have an appropriate process to raise concerns or make a complaint and we will ensure feedback from the Emotional Health Family and Friends Test is collated and	Partially achieved	Developed a procedure where children and young people feel comfortable to raise concerns or complaints which is user friendly. Has been developed in conjunction with the Youth Forum and divisional leads. Develop further the voices of children through the Friends and Family feedback. 2 play staff completing Play course and then role out of training, compliance with this is not at the required rate expected, Feedback mechanism for friends and family in place via digital version.

	reviewed for learning. We will identify a training plan in relation to play for children's ward and ED. ***Year 2*** We will enact the plan and train 50% of the staff in formal play training. We will roll out the process for children to raise a concern to all clinical areas they are seen in the organisation. ***Year 3*** We will monitor the impact of the improvements through the national patient and parent surveys		 The national Children's survey has recently been released and will be presented at quality and Safety in June.
Estate	***Year 1*** In recognition of the impact that our estate makes on patient experience we commit to a refurbishment plan for three clinical areas each year. *Year 1* • Gordon Hesling Building entrance – introduction of volunteer support space • Mental health facilities in ED for children and adults • Create an alternative to hospitals for patients who do not	Complete	All work completed and further refurbishment planned. Further work completed in: • CDH theatres which support children • New AMU supporting patients experience through acute pathway • Endoscopy room increase , which supports delays in • Hyper acute stroke unit developed procedures to ensure seamless care • New health port commenced to support access to services in community

	meet the criteria to reside ***Year 2*** We will commit to a refurbishment plan for three further clinical areas each year. **Year 3** We will commit to a refurbishment plan for three further clinical areas each year		
Pain management	***Year 1*** We will focus on improving pain management and test the effectiveness of this through STAR. ***Year 2*** We will share learning from areas that manage pain more effectively ***Year 3*** We will see improvements in national audits relating to pain management.	Complete	Work is on-going with the pain team to improve the patient experience through the FCA big room A new Friends and Family feedback questionnaire has been developed. This is also monitored through the STAR accreditation process. Improved position in regards to pain in surveys Patient stories regarding pain management which is supporting patients with long term pain conditions.
End of life care	***Year 1*** We will continue to use the end of life big room to deliver integrated, collaborative palliative and end of life care and improve patient and carer experience and service outcomes based on principles of respect, dignity and compassion. ***Year 2*** We will explore area to be used	Partially achieved	A Big room in place and effective for end of life care EOL rooms being worked on and in place in some areas but remains not all wards or areas have them. From learning from patient feedback from experience in emergency department a quiet room has been developed and used well at Chorley. The trust has a bereavement suite available on the RPH site

	for end of life quiet rooms for families. ***Year 3*** Provide quiet areas for families of patients at end of life and for bereaved families.		
	Year 1 We will define an increased target audience for advanced communication skills training. ***Year 2*** We will achieve the target set once the audience is reviewed. ***Year 3*** We will extend the number of people training in advanced communication skills.	Partially Achieved	The trust has successfully transitioned over to PSIRF and with this came an increase in staff trained in engagement training. A caveat to this is that the trained as nationally required has stalled the improved numbers of this. Over 200 staff trained. The commencement of the community of practice events has enabled role modelling and coaching team in relation to communication and its importance.
	Year 1 We will embed the CARING model as our pledge to patients in last days of life and their loved ones. ***Year 2*** We will monitor and evaluate CARING through the STAR audit. ***Year 3*** We will continue to evaluate the impact of the CARING approach.	complete	CARING in place in now embedded and carried out across the clinical areas, it has been reviewed and now much more diverse. CARING is part of the STAR accreditation visits.
	Year 1 We will recruit families who have had experiences of bereavement to work in partnership to	Complete	Patient stories captured and used at board and also the Patient Experience Involvement group. NACEL audit used to influence STAR and monitored through accreditation visits. Improved position with NACEL audits and STAR reflected changes necessary to improve further.

	improve services. **Year 2** We will use the national NACEL audit to drive the areas we focus on improving. ***Year 3*** We will review and set an improvement goal for each of these in year 3		
	Year 1 We will deliver in partnership a Hospice at Home service to increase the number of patients who are able to die in their preferred place of care. ***Year 2*** We will create the case to formally commission hospice at home pending outcome measures supporting hypothesised benefits. **Year 3** We will deliver in partnership a hospice at home service that meets the need of the local population	Not Achieved	This is not in place at present
	Year 1 We will ensure bereavement services are available to all who experience loss 7 days per week. ***Year 2*** We will ensure bereavement	Complete	Complete and 7 day service in place

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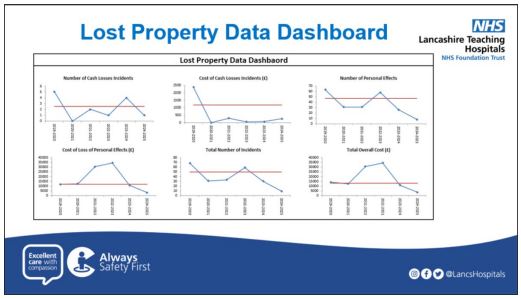
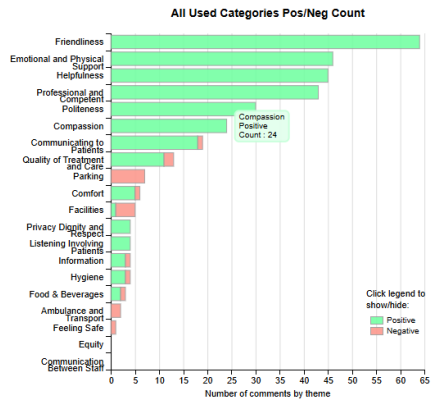
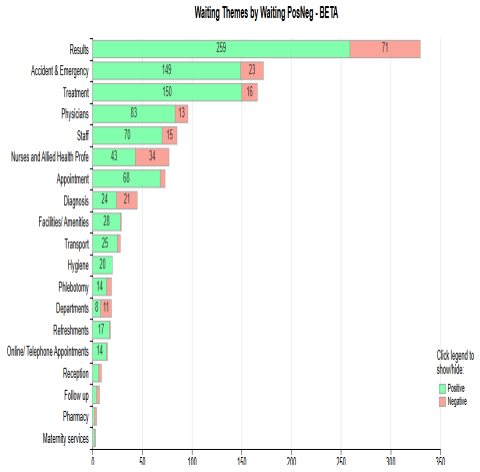
	services are available to all who experience loss 7 days per week. ***Year 3*** We will ensure bereavement services are available to all who experience loss 7 days per week		
Lost property	***Year 1*** We will ensure our processes around patient valuables is robust using patient experiences to build on the procedures we have in place. ***Year 2*** We will ensure our process is established within all areas and test this using STAR. We will investigate when items are lost and share lessons learned to reduce the occurrence of this. ***Year 3*** We will monitor this service regularly and listen to feedback in order to instil confidence from our patients and visitors to the Trust	Complete	Complete and reduce financial spend noted. 
Improve facilities for people while they wait	***Year 1*** We will ensure patients know timescales of any delays in clinical areas. ***Year 2***	Complete	Investment provided in a number of areas for example ward 4. Timescales provided in wating rooms. Friends and family feedback from outpatients 24/25:

	We will ensure details are provided of expected wait times and regularly update this information. ***Year 3*** We will monitor wait times in clinical areas and adapt time slots if data shows continual trends of long waits		 Time scale for appointment delays are published on trust website. Monitor of delays discussed and reviewed at PSRIF Triage and oversight panel
	Year 1 We will provide comfortable and appropriate seating, that meets the needs of those using it in line with reasonable adjustments. This will be tested through STAR. ***Year 2*** We will ensure that areas that experience long waits such as ED will have access to comfortable environments. ***Year 3*** We will continue to listen to feedback from our patients and develop services.	Partially achieved	A review of ED seating underway has been undertaken but no progress to improve this to date, new mattress for trolleys in place. A dedicated Nurse to the waiting room is available 24 hours a day. Upgrade to bathroom facilities has been completed. The Urgent and Care national survey action plan is place to support progress this forward
Improving patient flow	***Year 1*** We will engage in improvement programmes via the Urgent an Emergency Care transformation	Complete	Being monitored in UEC board and SIP boards with clear measures to monitor this although an acceptance of not where it needs to be. A detailed Discharge action plan is in place and system wider recovery plan for operational flow also in place.

	board to improve our patient flow throughout the hospital. This will reduce time patients spend in the ED and assessment units and ensure that patients time in hospital is value added and reduce waiting for services that will progress the pathway of care. We will ensure that discharge is well coordinated and occurs early in the day. ***Year 2*** We will continue to monitor our performance and seek out opportunities to continually improve patient flow, asking patients what matters to them. ***Year 3*** We will monitor our outcome measures and seek new ways to maintain progress		Further work is planned in relation to rapid improvement weeks for patients not meeting the criteria to reside. It must be acknowledge the significant operational pressures from a UEC perspective and impact this has happened in relation to patient experience. Below is the positive and negative emotions of patients in the ED department  As a result of this the trust is working further on supportive comfort action for patients waiting within the UEC pathway
Improve patient experience for those living with dementia	***Year 1*** We will promote understanding of our dementia community. ***Year 2*** We will ensure all staff complete dementia training. ***Year 3*** We will continue to educate staff through e-learning packages	Complete	Information on corridors. Dementia Champions who meet regularly. Dementia education package developed on blended Learning
	Year 1	Complete	Activity boxes on wards and tested through STAR.

<table>
<tr>
<td></td>
<td>We will ensure purple activity boxes are available to all patients and tested through STAR.

Year 2
We will ensure purple activity boxes are available to all patients and updated following patient feedback over the year.

Year 3
We will introduce innovative approaches to managing the experience of patients with dementia.</td>
<td></td>
<td>Dementia Strategy presented to PEIG.
STAR plans updated following feedback.
Commencement of work for patient whom require Enhanced care has begun looking at least restrictive practice and bay nursing.</td>
</tr>
<tr>
<td></td>
<td>Year 1
We will ensure promotion of dementia champions in all clinical areas.

We will ensure this Patient Experience Strategy is in line with the Dementia Strategy and progress monitored in relation to pathways, the Dementia Experience and Empowerment project (DEEP) and co-production with patients living with a dementia and their families and carers.

Year 2
We will continue to promote the</td>
<td>Complete</td>
<td>Monthly catch up’s are in place for dementia champions.

The DOSA building work has engaged with patients living with dementia.

Monthly updates from Dementia lead provided on cycle of business through PCEIG and updates given also at safeguarding board within he cycle of business

Training data reviewed at safeguarding board

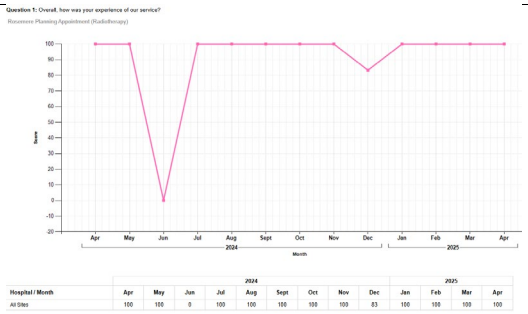
Dementia referrals:
<table>
<tr><th>Year</th><th>Number of ward referrals/clinical contacts</th><th>Notes reviewed-telephone contacts</th></tr>
<tr><td>2025</td><td>23</td><td>452</td></tr>
<tr><td>2024</td><td>110</td><td>2117</td></tr>
<tr><td>2023</td><td>83</td><td>1645</td></tr>
<tr><td>2021</td><td>63</td><td>N/A</td></tr>
</table>
</td>
</tr>
</table>

	use of Forget Me Not passports. We will report progress on the mental health and dementia strategy to the safeguarding board and patient experience group. ***Year 3*** We will report progress on the Mental health and dementia strategy to the safeguarding Board and patient experience group.		
Improve facilities for patients with a physical disability, autism, learning disability, mental health condition	***Year 1*** We will continue to promote the use of the Hospital Passport. ***Year 2*** We will ensure a copy of the passport is taken so we can provide specific individualised care. ***Year 3*** We will provide staff with information and updates on sources available through our Patient experience and Involvement team.	Complete	Hospital passport a regularly used across the trust and uploaded to evolve on the trust EPR system. Request to use the passport are suggested through complaint and concerns responses. An update on new information sources and information is updated and provide to PCEIG
	Year 1 We will ensure all reasonable adjustments are recorded on our systems and test the use of this through STAR.	Partially achieved	The reasonable adjust flag with a clear policy and guidance challenges extrapolating the data remains alongside linking directly with GP records.

	Year 2 We will collate data so future appointments can be adapted to the requirements of the patient. ***Year3*** We will evidence increased use of reasonable adjustment tab on Quadramed		
	Year 1 We will ensure staff liaise with the Learning Disabilities team for specialist advice. ***Year 2*** We will require progress with our partners to agree the next set of actions for blind, visually impaired. ***Year 3*** We will evidence an increased number of MDT care planning forums take place leading to improved person centred care	Complete	The number of patients referred to the learning disability teams has increased by 25% from the previous year Referrals - 23/24 – 314 24/25 - 392
	Year 1 We will continue to provide ward activity boxes for partially sighted or blind communities and test this through STAR. ***Year 2*** We will review progress with our partners to agree the next set of actions for blind, visually impaired. ***Year 3*** We will review progress with our partners to agree the next set of actions for	Complete	Complete and monitored through the STAR accreditation visits. Discussed at the Visual Impairment forum to ensure things are in place and guidance given on a number of project over the last 3 years. VI forum attended the Health Mela and Annual members meeting. The VI forum is in progress of setting out some key objectives for the next 12 months to be considered

	blind, visually impaired		
	Year 1 We will continue to upgrade estate with hearing adjuncts in line with best practice and ensure we work with local groups to test the impact of our focus on hard of hearing or deaf communities. ***Year 2*** We will review progress with our partners to agree the next set of actions for deaf and hard of hearing. Year 3 We will review progress with our partners to agree the next set of actions for deaf and hard of hearing	Partially achieved	Working alongside Ncompas and deafways has enable a clear view on what is required and the experiences of patient whom attend. Representation from both is regularly at PCEIG. Not all estate has appropriate facilities in place for the deaf. Good access to language services to support with sign language is in place.
	Year 1 We will engage in the Learning Disability Partnership board and Autism Partnership Board working alongside experts by experience and our multi-agency partners to re-establish a Health sub group. ***Year 2*** We will implement the national learning disability and autism strategy. Year 3 We will implement the national learning disability and autism strategy	Complete	Strategy developed and in place to support national standards Strategy developed in conjunction with our patients and service users. Our health day recommenced with great feedback

	Year 1 We will ensure promotion of the Learning Disability Champions and Mental Health Champions. We will ensure this Patient Experience Strategy is in line with the Mental Health Strategy, the Learning Disability Plan and Autism Strategy. ***Year 2*** We will monitor this through the safeguarding and patient experience and improvement group. ***Year 3*** We will monitor this through the safeguarding and patient experience and improvement group	Complete	Complete and monitored through the Safeguarding Board and PCEIG.
Cancer care	***Year 1*** We will introduce a patient experience lead in Radiotherapy with a focus on improving the experience for patients attending for radiotherapy and establish a service user group. ***Year 2*** We will evaluate the impact that the patient experience lead in Radiotherapy with a focus on improving the experience for	Complete	This post has been recruited into 95% to 100% consistently positive Friends and Family feedback, largely due to open days prior to treatment.

	patients attending for radiotherapy and establish a service user group. Year 3 We will ensure the patient experience lead is embedded in practice.		 2024 2025 Hospital / Month Apr May Jun Jul Aug Sept Oct Nov Dec Jan Feb Mar Apr All Sites 100 100 0 100 100 100 100 100 83 100 100 100 100
	Year 1 We will establish a cancer patient listening service to gain live feedback from cancer patients and address issues at the time if possible. ***Year 2*** We will explore involvement in addressing the needs and support service users receiving services from different clinical teams e.g. buddying in different services and co-facilitating training with Macmillan Engagement Facilitator to build confidence, skills and knowledge. Year 3 We will involve patients and volunteers to work alongside the Macmillan assistant manager to work with patients in the community and provide care closer to home	Complete	The Macmillan service has delivered service across a number of community service over the last 3 years. The development of clinics inn the Sahara centre screening patient has been successful identifying new cancer • Wok within local Muslim schools regarding taboo topics within the health care • Men's well being checks in the local prison • Breast awareness checks in Asian ladies forums
	Year 1 We will develop a cancer and end of life	Complete	Complete, public and forum members have supported interviews across trust. The chair of cancer forum now works within research within the trust.

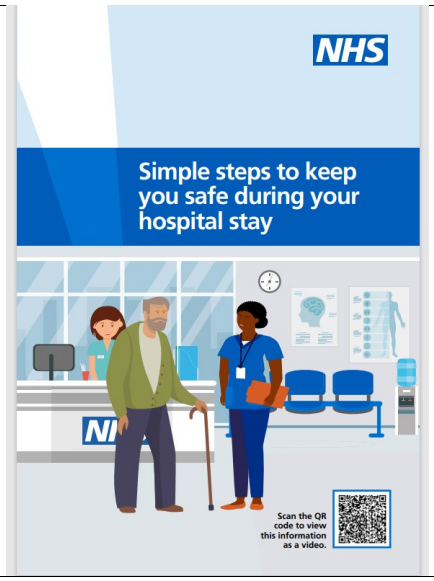
	service user recruitment strategy. ***Year 2*** We will continue service users to be involved with the MPACE project and close working with key Macmillan figures. ***Year 3*** We will explore a partnership approach with the third sector to share volunteer opportunities and collaborative working.		The cancer actively take part in MPACE which has helped increase the diversity of the forum. This was closed down Nov 24. The Macmillan service has delivered service across a number of community service over the last 3 years. The development of clinics inn the Sahara centre screening patient has been successful identifying new cancer Wok within local Muslim schools regarding taboo topics within the health care Men's well being checks in the local prison Breast awareness checks in Asian ladies forums
	Year 1 We will provide HOPE course using service users to facilitate the course in partnership with third sector partners. ***Year 2*** We will continue to implement service user involvement in all cancer interviews. We will continue to deliver and promote the HOPE courses for patients with cancer. ***Year 3*** We will ensure Cancer patient and carers forum increases in membership	Complete	Complete and have worked with GP's to promote HOPE course. Cancer forum number increased over the last 3 years. The Hope course is provided at vine house and runs 4/5 sessions (6week Course) and is full all year round. We have cancer forum members whom are facilitators within this course
	Year 1 We will develop a work programme for the promotion of service user opportunities.	Complete	Complete with board stories presented.

	Year 2 We will increase the diversity of patients and partners. ***Year 3*** We will develop a process for patients as partners to present to the Board of Directors the progress made in this area		
	Year 1 We will develop a virtual forum for patients and carers to link in when they want and to choose which opportunities they wish to be involved in. ***Year 2*** We will continue to recruit service users for the forum and widen recruitment to the forum for diverse range of services users and carers to include BME, LGBTQ, over 75s, working age, disabilities, from all economic backgrounds etc. ***Year 3*** We will deliver on the areas determined as priority areas for each protected characteristic group.	Complete	Ther a number of forums for both staff and patients. The patients have access to carers and staff has access ambassador for as examples. Recruitment and encourage to forum groups are in a place with information on trust internet. We have recruited to forums from a protected characteristics which has enabled links into the community, such as Sahara Centre
	Year 1 We will develop standard operating procedure, to involve service	Complete	Complete and service users involved with recruitment. Improvements within the National Cancer services audits demonstrated.

	users in all interviews for cancer staff. We will develop a training package guide for service users to assist in opportunities they can be involved in. ***Year 2*** We will evaluate the effectiveness of this approach in partnership with patients. ***Year 3*** We will focus on specialities that evaluate less effectively in the national cancer survey		
	Year 1 We will continue service user involvement with the MPACE project and close working with key Macmillan figures. ***Year 2*** We will test the cancer website against the exemplar and agree the next year improvements. **Year 3** We will celebrate achievements and share the positive areas of practice	Complete	The cancer actively take part in MPACE which has helped increase the diversity of the forum. This was closed down Nov 24. We have trust Cancer intranet page which provided up to information, advice and new projects. A newsletter is also provide and updated.

			
	Year 1 We will continue to work with patients in develop the cancer website. ***Year 2*** We will focus on specialities that evaluate less effectively in the national cancer survey. ***Year 3*** We will continue to focus on specialities that evaluate less effectively in the national cancer survey	Partially achieved	Remains under development.
Patient involvement in safe discharge	***Year 1*** We will commence discharge planning from the time patients are admitted to the hospital. ***Year 2***	Complete	Discharge planning commences on admission to clinical area. Commencement of Rapid improvement week focussing patients not meeting the criteria to reside will commence soon.

	We will use discharge improvement work to ensure discharge occurs earlier in the day for patients and families. ***Year3*** We will continue to evidence improvement in this area		
	Year 1 We will ensure that discharge needs are clearly documented and shared with partner organisations where consent is given, this will reduce the need for patients and carers to repeat needs and wishes to achieve safe discharge. ***Year 2*** We will commit that learning from discharge incidents will be shared and actions agreed. ***Year 3*** We will learn from discharge incidents wand this will be shared and actions agreed.		Complete and on DPD, paper provided to Patient Experience and Involvement group. PSIRF triage review incidents relating to discharge as national priority. Patient safety investigations discussed and analysed.
	Year 1 We will review our patient information leaflet and relaunch this, so it is shared with all patients to ensure a safe discharge. ***Year 2*** We will ensure that the use of the patient information	Complete	Complete and monitored through the STAR accreditation process. A new patient safety leaflet has ben produced and shared with patients on admission

	leaflet is tested through STAR. ***Year 3*** We will ensure that use of the patient information leaflet will continue to be monitored.		
	Year 1 We will introduce live feedback on the discharge process, this will be used to drive improvement in this area. Wards will be test on this through STAR. ***Year 2*** We will use feedback to change process or information shared. ***Year 3*** We will build a reporting dashboard that tracks and time stamps discharge process.	Complete	Complete and feedback provided through the Friends and Family data. A dashboard has been created for daily discharges and this can we correlated with relevant friends and family feedback. Discharge summary report presented at PCEIG on a cycle of business
	Year 1 We will continue to plan ahead for discharges and ensure where possible discharge letter and take-home medication is on the ward with the patient the	Partially achieved	The data does not currently demonstrate we are achieving significant change to take home or discharge the day before. This has been raised and discussed at the Carers forum and experiences have been shared and demonstrates a deterioration on national in patient survey. Action plan in place. A review of pharmacy STAR process completed Clinical and Supply transformation project are planning pilot of drug counselling QR codes

	day before their planned discharge. ***Year 2*** We will work closely with carers service to better identify informal carers when planning patient discharges and offer onward referral for carers support and assessment. We will fully embed the "nothing said about me without me" principle for all discharge planning discussions. ***Year 3*** We will evaluate the effectiveness of these interventions through the national patient survey		Continuous improvement activities in place to improve the discharge process including increasing prescribing by pharmacists, ward based dispensing and clinical pharmacy technician validation. Patient counselling for key medicines identified as standard and training module being updated to embed. Quarterly survey of patients being established.
	Year 1 We will implement post discharge follow up calls to a minimum of 50 patients per week (within 48 hrs of discharge) who have had an inpatient stay, this will support ensuring they are safe, identify if any unmet needs were missed prior to discharge and ensure signposted or referred for relevant support. We will also gather feedback around their discharge and	Partially achieved	We are not compliant although through the PCEIG and Involvement group, a planned approach is to be defined. There is evidence of some speciality involvement with follow calls for patients whom are discharged but it remains inconsistent. Stroke services, home first discharge have a process

	what could be improved, ***Year 2*** We will include patient representatives on future improvement workstreams internally and across partner organisation improvement work. We will implement using patient feedback changes and improvements to the process, this will be tested through the national patient survey. **Year 3** We will implement using patient feedback, changes and improvements to the process, this will be tested through the national patient survey		
	Year 1 We will have consistent representation at the care home collaborative to understand discharge impact on care and nursing homes with the aim to improve relationships and trust between organisations building further on the trusted assessor model. ***Year 2*** We will demonstrate a year on year increase in the number of trusted	Partially achieved	We are not compliant although through PCIEG , a planned approach is to be defined. There is evidence of some plans in regards to trusted assessor and relationship building for patients discharges to nursing homes but remains inconsistent The development of care connexions has improved relationship also.

	assessments between the regulated care sector. We will evaluate progress on improving discharges with regulated care settings and agree priorities. ***Year 3*** We will evaluate progress on improving discharges with regulated care settings and agree priorities.		
Essential carer role	***Year 1*** We will introduce the essential carer role into a small number of adult inpatient test sites and evaluate the effectiveness using Plan, Do, Study, Act (PDSA) cycles. ***Year 2*** Following evaluation of the test sites we will role this out to all wards in order to meet patients needs. ***Year 3*** We will embed the principles of the essential carer role as standard practice ***Year 3*** We will embed changes using feedback to promote better Carer experience	Complete	Complete and rolled out with positive feedback.
	Year 1 We will develop an Essential Carer role standard	Complete	Complete and rolled out with positive feedback. Key 3 themes: - Communication between essential carer and team, Understanding limitations of role and parking. All have been updated within policy.

	operating procedure and an information leaflet to support implementation. ***Year 2*** Based on the feedback and learning we will adapt the essential career role so we can achieve the best patient and essential carer experience. ***Year 3*** We will set year 3 priorities based on listening to carers.		
	Year 1 We will continue to support our carers via our carers forum. ***Year 2*** We will share learning from carers forums and use to influence improvement. ***Year 3*** We will set year 3 priorities based on listening to carers.	Complete	
	Year 1 We will consistently ensure we use carers lanyard. ***Year 2*** We will use carers stories and experiences to develop and improve services. ***Year 3*** We will monitor and record Carer feedback, involvement and inclusion in all areas of patient care	Complete	Lanyards available and accessible from General office
	Year 1 We will promote services	Complete	Complete and monitored through the STAR accreditation process.

	available to carers such as Z beds. We will continue to promote our carers charter and test this in practice using STAR. ***Year 2*** We will use our involvement services to educate staff around services available for our carers. ***Year 3*** We will improve facilities for carers to take a break form caring when in the organisation. ***Year 1*** We will ensure carers involvement in all clinical assessments and test this through STAR. We will incorporate Johns Campaign into our way of doing things. ***Year 2*** We will ensure all clinical services recognise carer involvement. ***Year 3*** We will include carer involvement in the newly designed electronic patient record and test this through STAR.	Complete	Carers role has been greater represented across the trust over the last 3 years. The Patient experience Gorup changed its name toa dd Carer in it (PCEIG) Lancashire Carer regular attend the hospital and provide feedback from patient and families. Literature around carer is also provided as team need and particular focussed at discharge. The carers forum regular supports and advises any Clinical changes to parts or development of strategies and plans.
Promote get up get dressed keep moving	***Year 1*** We will encourage	Partially Achieved	Remains constant and is monitored and being developed through the Deconditioning Big Room.

	patients to get up, get dressed and keep moving wherever possible to prevent deconditioning and maximise rehabilitation and experience. We will embed this in practice in 3 wards across the organisation. ***Year 2*** We will share the learning from the pilot sites to role out across all inpatient wards. ***Year 3*** We will embed these principles as our standard.		A key development within falls action plan which is monitored through always safety learning and improvement group.
Promote occupational and purposeful activities for our inpatients	***Year 1*** We will encourage our inpatients to engage in occupational and purposeful activities and when indicated provide suitable resources e.g. activity packs with items such as colouring, paint sets, knitting, cross stitch, cross words, puzzles, poetry, creating writing etc. We will ensure the intranet has accessible resources for staff to download for our patients. We will roll out the newly developed Reminiscence Boxes for use with our patients	Complete	Evidence in specific areas e.g. elderly care and Finney house over the last 3 years. Stroke rehabilitation routinely carry out group activities

	living with dementia. **Year 2** We will review resources and gather feedback from patients and staff. ***Year 3*** We will review resources and gather feedback from patients and staff.		

Appendix 2 – Complaints Data

2.1 Comparator data for Complaints 2022 to 2025

Year	Complaints received	Increase/reduction
2022-23	487	-93
2023-24	355	-132
2024-25	325	-30

Source: LTHTR Datix

2.2 Number of Complaints by Division – April 2024 to March 2025

Division	Number (%)	Division	Number (%)
Medicine	152 (47%)	Women and Children's Services	47 (14%)
Surgery	105 (32%)	Diagnostics and Clinical Support	19 (6%)
Estates and Facilities	1 (0.5%)	Corporate Services	1 (0.5%)

Source: LTHTR Datix

2.3 Trend of ratio of complaints per patient contact 2021 to 2025

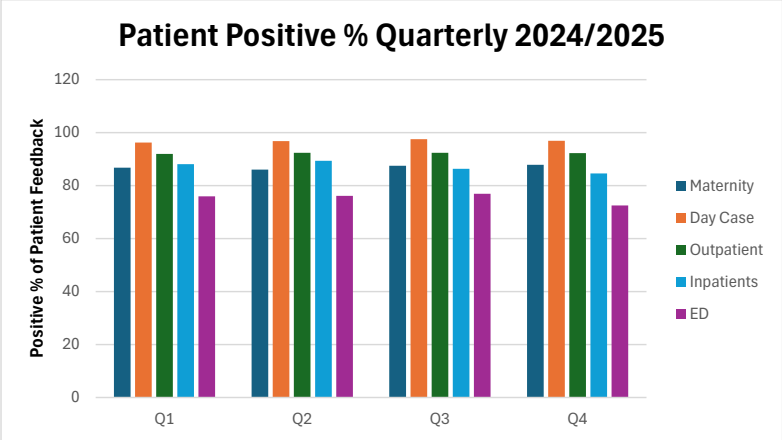
Year	No of complaints	Total episodes (inpatient/outpatient)	Ratio of complaints to patient contacts
2021-22	580	821,526	1:1,416
2022-23	487	849,328	1:1,744
2023-24	355	882,589	1:2,486
2024-25	325	917,962	1:2,825

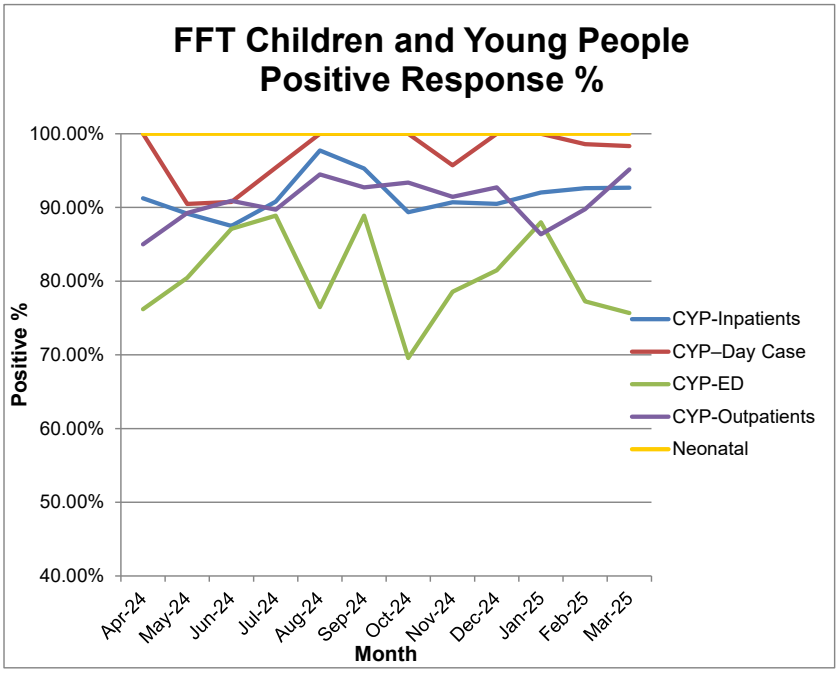
Source: LTHTR Datix

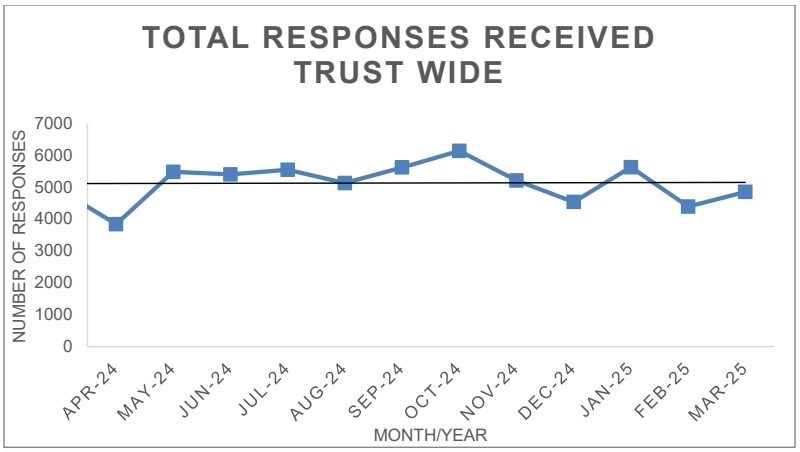
2.4 Top 3 themes from complaints by division:

Division	Themes
Diagnostic and Clinical Support	1. Communication 2. Treatment/procedure 3. Nursing care
Women and Children	1. Communication 2. Treatment/procedure 3. Nursing care
Medicine	1. Communication 2. Treatment/procedure 3. Nursing care
Surgery	1. Treatment/procedure 2. Communication 3. Staff behaviour or attitude

Appendix 3 – Friends and Family Data



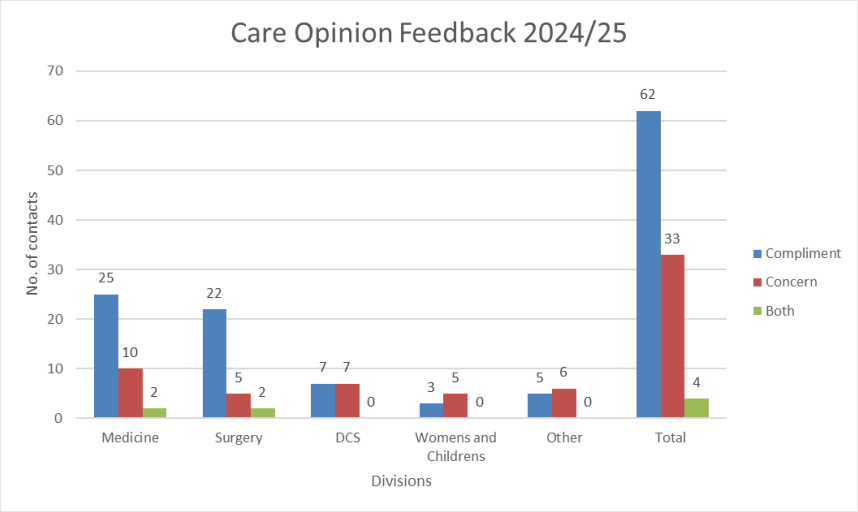




Source: FFT data CIVICA

Year	QR codes/online surveys	Paper surveys	Telephone surveys	SMS text surveys	Total
2022-2023	2,905	6,788	4,421	37,070	51,184
2023-2024	3,016	10,944	2,112	46,471	62,543
2024-2025	973	13,661	910	49,936	65,480

Care Opinion feedback



12. STRATEGY AND PLANNING

12.1 BOARD COMMITTEE CHAIRS' REPORTS

Other | Non-Executive Directors | 11.20

Item for Assurance

REFERENCES

Only PDFs are attached

12.1 - Committee Chairs Reports - Council - 24 July 25.pdf

Board Committee Chairs' Reports

PURPOSE OF THE PAPER:

Council has a statutory responsibility to hold the Board of Directors to account, via the Non-Executive Directors (NEDs), for the performance of the Trust.

This report requires all assurance committee chairs to present to Council. This allows for a greater degree of understanding of the work of Non-Executive Directors committees. The detail contained in the report is not a definitive list of all matters considered, but an assurance provided by the Chairs as NEDs on what they consider to be the matters currently of importance. Sometimes an item may also appear on the agenda for Council as a substantive item (e.g. the Single Improvement Plan). Where this occurs the Committee Chairs will contribute to the debate at that point, rather than duplicating the matter in their own report.

To provide the Council of Governors with assurance that the Board of Directors is ensuring the effective, efficient, and economic provision of services.

ACTION REQUIRED BY THE COUNCIL OF GOVERNORS:

To receive the report and consider the assurance available from this performance assurance report.

Introduction

The NHS Act (2006), as amended, places a duty on the Council of Governors to hold the Board of Directors to account, via the Non-Executive Directors (NEDs), for the performance of the Trust.

Non-Executive Director Assurance

The Board of Directors has in place a Board Assurance Framework (BAF) in which it identifies the key risks to the Trust meeting its strategic objectives.

The oversight and scrutiny of the risks to achieving the strategic objectives, are delegated to Committees of the Board for scrutiny and to gain assurance that the risks are being addressed.

Update from Committee Chairs

This report will continue to ensure that governors are provided with updates from any meetings that have taken place since the last Council meeting.

The narrative below provides an analysis from each of the Trust Committees and sets out the assurance that each Committee of the Board is able to provide to the Council of Governors.

Safety and Quality Committee

Chair: Karen Deeny

NED Analysis:

At meetings held on 25 April, 30 May and 27 June, the Committee reviewed the principal risks assigned to the Committee. These relate to patient experience in urgent and emergency care, Clostridium difficile infection rates, and people experiencing health inequalities. In May, the Committee received the annual Patient Experience Report and an update on the Patient Experience Strategy. The Emergency Departments continue to operate under pressure, an action plan to address feedback in the national survey is in place and a Patient Care Experience and Involvement Group Chairs report is received by the Committee each month. Improvements in infection control have led to a reduction in C. difficile cases to below trajectory; the risk score has been reduced from 20 to16. The nationally set C. difficile trajectory has been received; the Trust currently remains within tolerance for this, with rigorous implementation of the agreed action plan. Continued focus on compliance is required and is monitored at each Committee meeting through the Safety and Quality Dashboard and a Chairs report from the Infection Prevention and Control Committee. The Committee requested greater clarity regarding the Trust's specific contributions to addressing health inequalities and was advised that the population health improvement plan details Trust actions with progress reflected in the Chairs report to the Committee from the Trust Health Inequalities Group.

The Committee received assurance on maternity safety, noting good progress in Clinical Negligence Scheme for Trusts (CNST) standards. Following a tragic maternal death from a very rare condition, the Committee received assurance regarding the rapid incident review process ensuring thorough and sensitive actions were taken. The NED Safety Champion for Maternity and Neonates regularly visits services and feeds back observations, triangulation and areas for improvement.

During May, a fourth Ophthalmology Never Event was reported. An action plan has been implemented, external and internal forensic reviews commissioned with NED support for a site visit and the internal review.

In addition to regular safe staffing reports for nurses, midwives and allied health professionals, in June the Committee received a medical safe staffing report. Unlike nursing, there is no explicit comprehensive national guidance on this and reporting will continue to be refined to support assurance.

The Committee recommended approval of the Annual Patient Experience Report, Infection Prevention and Control Annual Plan, and Patient Safety Incident Report Framework Annual Report to the Board. It also endorsed the establishment of Health and Safety Workstream within the Single Improvement Plan to strengthen the Trust approach.

The May meeting was observed by a colleague from The Good Governance Institute and the June meeting by a representative from the National Recovery Support Team.

Finance and Performance Committee

Chair: John Schorah

NED Analysis:

At meetings held on 22 April and 27 May, the Committee reviewed strategic and operational risks, noting no changes to principal risk scores but highlighting the introduction of a new diagnostic access risk and a proposed shift in productivity risk appetite from ‘open’ to ‘cautious’ in response to financial pressures. Performance in urgent and emergency care showed marginal improvement, though metrics remained below target, with

continued challenges in discharge delays and elective care backlogs. Cancer and diagnostics performance improved, but sustainability concerns were raised due to reliance on temporary capacity.

Financially, the Trust ended 2024/25 in line with forecasts, but began 2025/26 with a £5 million deficit, driven by unidentified savings in the Waste Reduction Programme (WRP). The WRP delivery gap is narrowing but remains at risk due to a steep delivery trajectory with significant cash flow pressures anticipated in Q2. The WRP pipeline expanded, but much remained in early development, prompting calls for over-programming and internal PMO strengthening. At the meeting held on 24 June a significant update was noted regarding principal risk 13, which concerned the cash consequences of the underlying financial position. The risk score had increased due to assumptions around restricted cash support and waste reduction planning, with concerns about cash availability beyond August 2025.

Procurement governance improved with new KPIs and oversight groups, though accountability gaps persist. The Single Improvement Plan (SIP) delivered 14 of 25 exit criteria and was now aligned with strategic priorities. The Green Plan was refreshed to reflect national guidance and would be submitted to the Board. The Committee assured the Board of progress in performance, planning, and governance, while alerting to fragilities in WRP delivery, diagnostic sustainability, and planning risks due to unfunded expectations.

Workforce Committee

Chair: Adrian Leather

NED Analysis:

The Workforce Committee met on 13 May 2025 to review key workforce risks, performance, and strategic developments. The Committee discussed workforce planning capacity, noting ongoing challenges due to long-term sickness and fragile services, particularly in radiotherapy and clinical support roles. While long-term resilience was expected through collaboration with One LSC and automation, short-term risks remained only partially mitigated. Job planning for medical staff was highlighted as a key area for oversight. The integrated performance report showed high vacancy rates and a 12-month sickness absence average of 6.47%, with mental health accounting for nearly 30% of all absences. Psychological wellbeing services were under pressure, with long waits for intensive therapy. Appraisal compliance reached 90.8% overall, but disparities persisted across divisions, particularly in Hosted Services. Concerns were raised about appraisal quality and its impact on staff satisfaction, prompting actions to improve documentation, training, and alignment with corporate goals.

The Committee reviewed the Freedom to Speak Up report, noting a recent increase in concerns raised, attributed to improved reporting mechanisms. Estates and Facilities remained a concern due to low engagement. The National Staff Survey results showed declining satisfaction, with a corporate action plan developed to address issues such as wellbeing, flexible working, and inclusion. The Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) reports were reviewed and recommended for Board approval. Both showed progress in representation and perceptions of equality, though concerns remained around bullying, discrimination, and under-representation in senior roles. The Committee supported ongoing efforts to improve inclusion and suggested further visibility of staff stories and leadership development. Alerts to the Board included short-term workforce planning risks, concerns about the future of psychological wellbeing services under One LSC, and the need for clearer understanding of recruitment risks in specialist areas. Assurance was provided on progress with WRES, WDES, Freedom to Speak Up, and the staff survey action plan.

Audit Committee

Chair: Tim Wheeler

NED Analysis:

The Audit Committee met on 17 April 2025 and reviewed a wide range of assurance, governance, and risk matters. The Committee noted that internal audit progress was on track, with several reviews underway, including mandatory training, PSIRF, and health and safety. The draft Head of Internal Audit Opinion for 2024/25 provided moderate assurance, down from substantial the previous year, reflecting ongoing financial and operational pressures, including the Trust's placement in NHS Oversight Framework Segment 4. The Committee accepted the opinion and acknowledged the need for continued focus on implementing outstanding recommendations, of which 49 remained open. The 2025/26 internal audit plan and counter-fraud programme were approved, with flexibility built in to respond to emerging risks. The external audit plan was also approved, with key risks identified around financial sustainability, procurement, and valuation of assets. The Committee raised concerns about procurement assurance, noting high volumes of single tender waivers and the need for cultural and procedural improvements.

The Committee reviewed the annual report on gifts and hospitality, noting improved compliance with declarations of interest, now at 88%, above the national benchmark. Data quality assurance work highlighted improvements in coding and data capture, particularly in admissions, though outpatient and ED data required further attention. The Committee stressed the importance of accurate data for financial performance and clinical outcomes and acknowledged the role of One LSC in supporting improvements. The Risk Management Policy was endorsed for Board approval, with updates aligning it to the revised Board Assurance Framework and clarifying governance around restricted risks. Alerts to the Board included concerns about procurement practices, unresolved audit arrangements with One LSC, and overdue clinical audit action plans in maternity, obstetrics, and urology. The Committee advised on the need to monitor staff expenditure and evaluate the effectiveness of new risk identification approaches, including cybersecurity. Assurance was provided on data quality improvements and the robustness of the audit and governance processes.

An update on the procurement pathway for external audit services was agreed to deliver the new external audit service by the end of 2025 (as agreed by Council at its meeting in November 2024).

Education, Training and Research Committee

Chair: StJohn Crean

NED Analysis:

The Education, Training and Research Committee met on 8 April 2025 and reviewed key developments across research, training, and governance. The Committee noted promising progress in research and innovation, including encouraging commercial trials (MOLI and LIBREXIA), a new partnership with BioNTech for cancer immunotherapy, and plans to establish a hyperacute stroke research centre. Those initiatives, if successful, support the Trust's ambition to become a leading academic and clinical hub, with financial sustainability being pursued through increased trial activity and reinvestment. In training, compliance improved, with only five non-compliant metrics remaining. However, life support training and medical/dental staff compliance remained areas of concern. A new reporting tool and leadership appointments were helping to address these issues, and an options appraisal was being developed for the Workforce Committee. The Committee also reviewed the 2024 National Education and Training Survey, which showed lower response rates and Trust performance below regional averages, particularly in areas such as bullying, discrimination, and well-being. An action plan was in development, with further triangulation expected in July. Alerts to the Board include ongoing non-compliance in key training areas, while assurances were provided on research progress and improved training oversight.

Charitable Funds Committee

Chair: Tim Ballard

NED Analysis:

At the meeting on 17 June, the Committee was advised that the Lancashire Teaching Hospitals Charity (LTHC) and Baby Beat (BB) reported a strong financial year with income of £732k against a £555k target. April 2025 income aligned with budget expectations. Notable grants included £50k from the Trevor Hemmings Foundation and £25k from the Eric Wright Group, supporting initiatives such as a specialist play scheme and a wellbeing garden. While the charity's financial management was praised, the Committee noted the high proportion of restricted funds and emphasised the need to increase unrestricted income to support operational flexibility.

The Rosemere Cancer Foundation (RCF) exceeded expectations, raising nearly £1.5 million in 2024–25, with April 2025 income above budget. Events such as the Walk in the Dark and upcoming Angkor Wat trek were key contributors.

The Committee approved funding applications for cancer patient accommodation and chemotherapy unit improvements. It was stressed that public relations should accompany funded projects to maintain transparency and donor confidence.

12.2 SINGLE IMPROVEMENT PLAN

Information Item | A Brotherton | 11.30

REFERENCES

Only PDFs are attached

12.2 - Single Improvement Plan Jul-25 v1.1 CoG July 2025.pdf

Council of Governors

SIP 24/25 Review and 25/26 Plan			
Report to:	Council of Governors	**Date:**	24/07/25
Report of:	Chief Strategy & Improvement Officer	**Prepared by:**	K Marshall

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

Executive Summary:

The purpose of this report is to provide an overview of the Single Improvement Plan (SIP) 24/25 delivery and outcomes and review the plans in place for 25/26.

An ambitious improvement plan was created to commence delivery in April 2024. Progress was reported in 2024/25 to the Board, the Improvement and Assurance group (chaired by the ICB in the early part of the year and then by the system financial turnaround director) and the System Improvement Board (chaired by the NHS England Regional team). Part way through the year, the Trust along with two other acute trusts and the ICB entered National Oversight Framework (NOF) Level four. As part of the System Improvement Board, 25 exit criteria were set for the Trust to meet and it was agreed that these 25 measures would be tracked as the outcomes in year one of the SIP delivery.

Overall, 50% of the planned work within the SIP for 24/25 was completed to target date. 41% is ongoing and deliverable but failed to meet target date in year. Part way through the year, the Turnround Director advised that it was necessary to prioritise the financial improvement plan over some elements of the SIP given that there were delays in securing additional PMO support. A decision was therefore taken to delay some elements of the SIP delivery. As the year progressed delivery was also impacted by the need to hold vacancies but assurance has been given that the work is in progress and target delivery has been shifted into early 25/26. 5% remained at risk of not being deliverable and 5% of planned work had not been started. Each portfolio has been reviewed and refreshed and where appropriate this work has been realigned and included in 25/26 plans where the action is still assessed as deliverable, or alternate action plans have been put in place to deliver the required improvement in outcomes.

A review of key performance indicators illustrates whether work delivered has made the shift in intended metrics requiring improvement. Areas that have consistently flagged as failing to meet targets throughout this period are the operational performance measures and workforce measures. A benchmarked review has been carried out in key metrics to assess whether the Trust is an outlier or if comparable to other providers. Broadly, LTH shows a middle position when benchmarked locally and regionally for performance measures with the exception of DM01. Although not yet meeting the target for 4-hour waits LTH has a favourable position compared to the national average value and is ranked 2nd in the Integrated Care Board at the time of reporting. LTH shows a worse position for workforce measures when compared locally and nationally, however sickness rates within LTH has shown early signs of improvement since Jan-25.

The SIP, supported by the revised accountability framework, remain the vehicle for delivery of the Trust's main programmes of work and oversight within the organisation. The criteria remain challenging to deliver within

current resources and with the operational and financial pressures facing the Trust and the wider system. The Executive team and the wider organisation remain focused on the delivery of these and have reviewed and reset plans across portfolios for 2025/2026.

Stakeholder feedback has also been gathered for the approach of the SIP moving forwards. Areas for improvement have been included into 25/26 plans including aligning to the Trust Strategy via the '5P's' and to give visibility through regular communications across the organisation.

It is recommended that the board:

I. Note the delivery position of the SIP 24/25 and benchmarked position against key metrics for 2024/25.
II. Note the alignment of the SIP to planned Trust strategy and the organisational objectives in 2025/26
III. Note 25/26 delivery plans.

Appendices

1. Summary of the SIB Exit Criteria
2. SIP delivery plan 2025/26

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	☒

1. Background

In April 2024, Lancashire Teaching Hospitals developed and implemented a Single Improvement Plan (SIP) with the aim to align and focus improvement efforts across the Organisation in a 3-year strategic plan. The purpose of this update is to provide an overview of 24/25 SIP delivery progress and outcomes. The overall aim of 24/25 SIP was successful stabilisation across key metrics in order to lay the foundation for improvement and transformation. Plans for 25/26 include a focus on areas of continued challenge to deliver outcome improvement alongside financial improvement.

2. Discussion

2.1 2024/2025 Delivery progress position

Overall position at Mar-25 shows delivery progress in charts below by overall plan and by each portfolio.

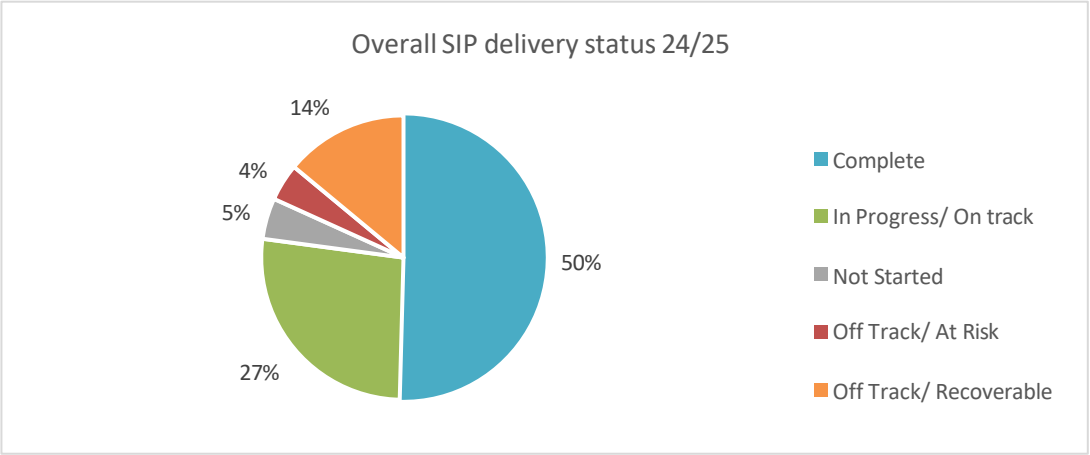


Chart 1: 2425 SIP delivery status

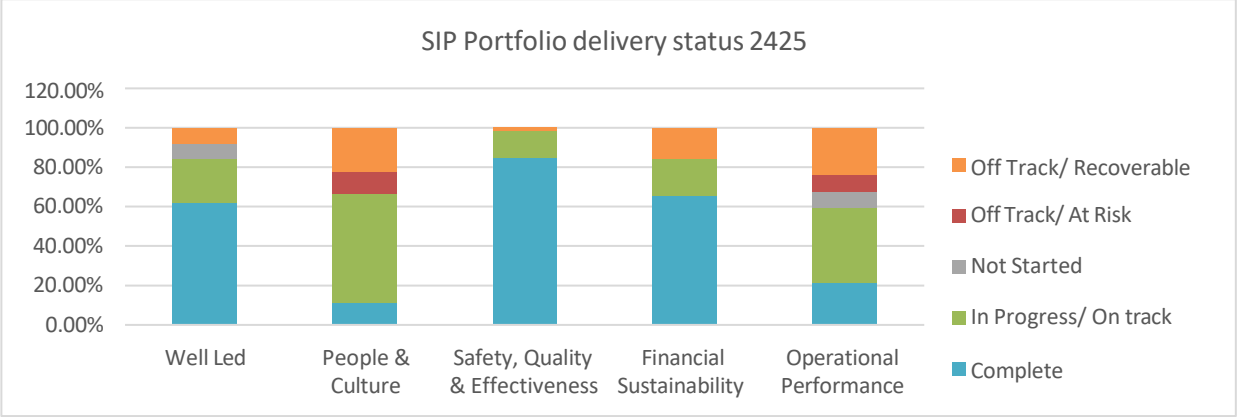


Chart 2: 2425 SIP delivery status by portfolio

At year end 50% of the overall planned milestones were completed to target date, 41% of milestones were still in progress of delivery but had not met the expected delivery date or is ongoing work. As outlined in the Executive summary there was a refocus on prioritising the financial domain of the plan given the enhanced oversight of the Trust's financial position and the lack of programme management resource to deliver the whole of the year one plan. This work has been realigned and included in 25/26 plans. Teams across all portfolios cited the vacancy freeze and reduction in staff capacity as the main driver for not meeting intended delivery dates that were set at the start of 24/25.

5% of planned milestones were left at risk and unable to be delivered within 24/25. Each portfolio has been reviewed and refreshed and where appropriate this work has been realigned and included in 25/26 plans where the action is still assessed as deliverable, or alternate action plans have been put in place to deliver the required improvement in outcomes.

5% of planned milestones were not started within 24/25. The majority of these were due to subsequent actions not yet being complete creating a delay through the planned work. These have been realigned into 25/26 where appropriate.

2.2 2024/2025 Outcomes and KPIs

Detailed metrics are monitored through each SIP portfolio. Fourteen of the initial 25 SIB exit criteria have been met. One criterion is no longer applicable (vacancy rate: this was being achieved prior to the Trust being asked to implement a vacancy freeze). Of the remaining ten metrics, there was recognition at the final SIB meeting that a number of these metrics were going to be very difficult to achieve and it was proposed by the NHS England regional team that an improving position in each metric was required in the short term, rather than achievement of the standard, in line with the current performance and financial challenges across the wider NHS. A summary of the SIB exit criteria and details of which have been achieved in year are presented in Appendix 1.

The overarching aim of successful stabilisation of the Trust is measured by using the System Improvement Board (SIB) exit criteria. Focussing on areas where SIB/SIP criteria has not been fully met or is showing concern in the data a benchmarked review has been carried out to assess if criteria has been achievable in peer, local or other providers nationally. Tables 2 and 3 below show benchmarked position of the key SIP metrics in performance and workforce portfolios. Please note data are not yet available across all metrics for 2024/2025 to provide a fully benchmarked dataset.

Performance metrics	Metric Description	Target Mar-25	Mar-25 Actual	Benchmarked position	
				Ranked position	National average
UEC In Flow	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	78%	69.07%	2nd in ICB	61.4%
Elective (diagnostics)	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	98%	58.21%	4th in ICB	77.6%
Elective (long waits)	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	0	19	2nd in ICB	11
Elective (Cancer)	Improve performance against the headline 62-day standard to 70% by March 2025	70%	56.0%	21st in NW	67.3%

Table 2: Benchmarked operational performance areas of concern

LTH show a 'middle of the pack' position when benchmarked locally and regionally for key performance measures. Although not meeting the target for 4-hour waits LTH has a favourable position compared to the national average value and is ranked 2nd in the ICB. The main exception is DM01 which continues to be challenged, though there is now consistent improvement.

Workforce Metrics	Metric Description	Target FY2425	Latest Actual	Latest Period	Benchmarked position	
					System value	National average
People and Culture	Sickness Absence (% FTE) (annual assessment; in-month reported)	≤ 5.24%	6.53%	M12	NW 6%	5.20%
	Staff Survey: Recommend Trust as place to work (quarterly metric)	≥ 60%	50.99%	Q2	57.20%	62.30%

Table 3: Benchmarked workforce areas of concern

LTH shows a lower benchmarked position when compared locally and nationally, however sickness rates within LTH has shown early improvement since Jan-25.

Across the SIB criteria areas remain challenging to deliver within current resources and with the operational and financial pressures facing the Trust and the wider system. The Executive team and the Board remain focused on the delivery of these, including the metrics across portfolios including:

- Financial sustainability through the delivery of the Financial Recovery Plan and 3-year plan for financial balance.
- Quality improvement plans to deliver of CQC must do action plans.
- Quality improvement plan to minimise C-difficile rates, achieve CNST 6-year compliance and still birth rate in line with expected range.
- Workforce improvements to deliver improvement to turnover and vacancy rates.

2.3 2025/2026 SIP Plans

2.3.1 Year 2 approach

To support development of the SIP for Year 2 feedback has been gathered from various stakeholders including a survey to Trust Board members. Feedback included themes of improved communication and visibility required. For 25/26 the SIP domains have been aligned to the Trust strategy '5 Ps' framework, 'Patients, People, Performance, Productivity and Partnerships'.

Alignment of nomenclature allows work to be visibly aligned and provides clarity for colleagues and other stakeholders how programmes of work thread across the organisation to drive improvement to reach organisational objectives.

2.3.2 Year 2 delivery plans

Throughout each portfolio programme leads have been coached through a review of 24/25 plans to consider what was delivered, what was achieved, what actions supported an outcome improvement and what metrics still need to be improved. 25/26 plans have been developed with a lens of achievability and focus on core actions that will deliver the required improvements within current context of financial limitations and the absolute need to make best use of resources. Full detail of the delivery plans are included in appendix 2. Although the structure of the plan is set for the year it is acknowledged that the plan will need to be relatively agile in order to respond to emerging needs, priorities and national guidance.

2.4 Conclusion

The single improvement plan supported by the revised accountability framework remain the vehicle for delivery and oversight within the organisation. The criteria remain challenging to deliver within current resources and with the operational and financial pressures facing the Trust and the wider system. The Executive team and the wider organisation remain focused on the delivery of these and have reviewed and reset plans across portfolios for 2025/2026.

3 Financial implications

Non-delivery of the plan will directly impact on the Trust's ability to deliver its waste reduction and financial improvement plan in 2025/26. Given the importance of the SIP to the Trust's recovery programme, the CEO continues to chair the monthly SIP Portfolio Board and the progress is reported monthly to the Finance and Performance committee.

4 Legal implications

None

5 Risks

There was a restructure and consultation to create a new PMO. The process is ongoing to fully recruit to the roles required in the new structure to provide a robust function that supports the Organisation's delivery of the SIP including the Waste Reduction and Financial Improvement Programme. There is a risk to be able to successfully continue the monitoring and delivery of the SIP if resource is not appropriately aligned. This will be mitigated through oversight of the allocation of the resource via the SIP Portfolio Board.

6 Impact on stakeholders

The impact and outcomes of delivering the improvement work is to achieve stability of the organisation in year 2 as outlined in our ambition. A number of the metrics are dependent upon collaborative working with key stakeholders and this is a key focus in 2025/26.

It is recommended that the committee:

I. Note the delivery position of the SIP 24/25 and benchmarked position against key metrics for 2024/25.
II. Note the alignment of the SIP to planned Trust strategy and the organisational objectives in 2025/26
III. Note the 25/26 delivery plans.

Appendix 1: Summary of the SIB Exit Criteria

Ref	NOF Improvement criteria / Workstream	Status	Commentary/update	Q4 24/25 Mar	NHS England Evidence definition	Evidence
	Finance					
	Evidence of a short term and long term financial sustainability plan, specifically:					
1.1	Evidence of an agreed medium term financial recovery plan which sets out a trajectory for the Trust to achieve recurrent financial balance over the next 3 years approved by the L&SC system.	**Off Track/ Recoverable**		**No**	Trust Board and L&SC system papers MTFP documentation 2024/25 FRP	FRP report
1.2	Evidence of delivery of the Trust 2024/25 financial recovery plan (FRP) in-year over a minimum 6 month period.	**Off Track/ Recoverable**		**No**	Trust Board and LSC system highlight reports dmeonstrating progress in delivering financial recovery	FRP monthly reports
1.3	Financial governance processes for the FRP that have been approved by the Trust Board.	**Complete**	Completed	**Yes**	Board Papers Financial Governance documentation Independent Use of resources review	Financial Board Report
1.4	Trust demonstrates significant compliance with grip and control checklists and associated measures.	**In Progress/ On track**	211.2.25 -E&Y review completed. 10.3.25 - PWC grip and controlreview completed. 31.4.25 - Next stage review completed and presented to Board and IAG.	**Yes**	Monthly FRP updates report to FPC and SIB Trust weekly reporting of FRP shared with executive directors	I&I intervention feedback
	Performance					
	Evidence of effective systems and processes to support delivery of NHS Constitutional standards specifically:					
2.1	Trust demonstrates sustained improvement over at least 6 months and is not an outlier in Northwest Region, specifically with regard to:				BAF Model Hospital Data Trust IPR	
2.1.1	Cancer 62 and 31 day treatment targets	**Off Track/ Recoverable**	· 62 day March position at 56% vs 70% target.	**No**		IPR Monthly Performance Report
2.1.2	A&E 4 hour treatment	**Off Track/ Recoverable**	· ED 4 hour March position - 69.1% vs 78% target. A slight improvement in performance correlating with high occupancy rates secondary to increase in delays in discharge pathways.	**No**	Model Hospital Data Trust IPR	IPR Monthly Performance Report
2.1.3	Diagnostic wait times	**Off Track/ Recoverable**	· DMO1 March position of 58.2%, an improvement of 0.5% compared to Feb 25.	**No**		IPR Monthly Performance Report
2.1.4	Elective care 65 week waits	**Off Track/ Recoverable**	19 patients>65/52 - all dated.	**No**		IPR Monthly Performance Report
2.2	Trust continues to work as an active member of the Provider Collaborative and participate in system improvement and recovery programmes.	**In Progress/ On track**		**Yes**	Attendance at meetings membership of programme groups	PCB records
	Quality					
	Demonstrable robust systems and process relating to safety & quality, specifically:					
3.1	No new regulatory notices that reflect the current position of the trust. This includes MHRA warning notice, HM Coroner's S28 notices relating to the Trust, HSE, CQC.	**In Progress/ On track**	03.1.25 - None beyond baseline position maintained. **Note:** **i. PFD- Regulation 28 issued 4/10/24 regarding care provided in ED in June 2022.** **ii. CQC investigation regarding maternity case concluded, insufficient evidence, case closed.** **iii MHRA critical finding relating to staffing, agreed in budget setting April 2025 Board.**	**Yes**	Board /committee report	Regulation 28 and action plan
3.2	Regulators are assured that there is a single Trust Improvement Plan with supporting actions that demonstrates sustained improvement, specifically that there is evidence of progress in delivering CQC 'must do' actions in line with planned trajectories for at least 6 months.	**In Progress/ On track**	4 outstanding must do. Trajectory reset for completion 31.7.25.	**Yes**	Trust Board and LSC system papers including - Single Improvement Plan and monthly highlight report to Trust Board and SIB - Monthly CQC reports to trust Board and SIB	SIP Monthly Report
3.3	Robust governance and risk management systems and processes approved by the Trust Board. Specifically:				Trust Safety and Quality committee EQIA process documentation Trust accountability and governance frameowrk - Independent peer review audit findings report and Trust response	
3.3.1	Demonstrate that there is a robust QIA process that supports delivery of the financial recovery plan while maintaining patient safety standards.	**Complete**	Quarterly EQIA reports to Safety and Quality committee. Last report April 2025.	**Yes**		EQIA Report - SQC committee.
3.3.2	Trust accountability and governance framework is agreed and in place.	**Complete**	21.11.24 Accountability Framework refresh complete, reviewed by NHS E and ICB and approved by Board.	**Yes**		Accountability policy
3.4	Demonstrate adherence to the NHS E IPC BAF and provision of a mitigation plan to minimise C. difficile rates	**Complete**	194/199 trajectory. 5 lfewer than trajectory. . Cleaning standards funding agreed in April Board budget setting report.. 50% compliant standards by end og H1, 100% compliance by end of H2.	**Yes**	Trust IPR Tr ust Board reports	IPC BAF and C.difficile improvement plan
3.5	Maternnity - CNST year 6 compliance with still birth rates in line with expected range (compared to peers)	**Complete**	3.10.24 - 10 CNST standards delivered 2024/25 position. Confirmation received from NHS Resolution MIS.	**Yes**		Maternity Neonatal Board Reports
	Workforce					
	Evidence of Workforce stability and demonstrable commitment to developing a culture of safety, compassion and inclusivity with high engagement specifically:					
4.1	Agency spend is within the agreed agency cap for at least 6 months - nursing	**Complete**	Nursing has been compliant for the previous 12 months.	**Yes**	Trust IPR, Workforce and FRP reports Board reports	Workforce Report
4.1.1	Agency spend is within the agreed agency cap for at least 6 months - medical	**Complete**	Medac agency returned to in house provision Oct 25 leading to further WRP.	**Yes**		Workforce Report
4.2	A Trust workforce plan approved by the Board with positive progress in line with planned trajectories	**Complete**	Completed	**Yes**	Workforce Plan documentation Trust Board papers	Workforce submission and Workforce committee report.
4.3	Trust staff engagement and culture plan approved and on track to deliver its objectives.	**Complete**	Quarterly updates provided to workfroce committee.	**Yes**	Staff Engagement & Culture Plan trust People Committee papers	Workfroce committee report
4.4	Medical Engagement Survey undertaken and findings incorporated into staff engagement and culture plan	**Complete**	Engagement being progressed through cultural programme. Michael West seminar held April 2025.	**NA**	Trust People Committee paper Medical Engagement Survey findings report and response	
4.5	Demonstrable improvement in key 'people' metrics across two consecutive quarters specifically: recruitment and retention, sickness, training and development.					TBC
4.5.1	Turnover - maintain annual turnover between 8-11%	**Complete**	The turnover rates remain significantly lower than the 8-11% target.	**Yes**	Trust IPR Trust Board report	Workforce report
4.5.2	Vacancy rate	**Off Track/ Recoverable**	Proposed exclusion given the intention to hold vacancies to deliver headcount reduction.	**No**	Trust IPR Trust Board report	Workforce report
4.5.3	Sickness - reduce in overall sickness absence (Trajectory for improvement required)	**Off Track/ Recoverable**	Reduction in month to 6.53%.	**No**	Trust IPR Trust Board report	workforce report
4.5.4	Appraisal rate	**In Progress/ On track**	Appraisal rate at 89%	**No**	Trust IPR Trust Board report	workforce report
4.5.5	Core skills	**In Progress/ On track**	compliant with the exception of intermediate life support, plan in place to achive compliance by July 26.	**No**	Trust IPR Trust Board report	workforce report

Appendix 2: SIP delivery plan 25/26

Patients | Sarah Morrison, Chief Nursing Officer & Gerry Skailes, Chief Medical Officer

Aim: To improve inpatient care and experience, in particular Sepsis, Clostridium difficile, risk assessment completion, medication safety, maternity, neonatal and children's services whilst reducing health inequalities in our services.

Portfolio and programme deliverables	Target delivery end date
Safe Staffing	
Develop the approach to medical workforce safe staffing reporting	Mar-26
Test methodology in one specialty	Jun-25
Review, agree and standardise multi-professional approach	Sep-25
Trustwide phased rollout	Mar-26
Cycle of business and refresh Safe Staffing policy in place	Jul-25
TNA and compliance monitoring	Jul-25
Scope competencies for B2 and B3 HCSW	Jun-25
Agree HCSW career pathways	Sep-25
Scope academic and vocational pathways for NMAHPs	Sep-25
Develop academic and vocational pathways for NMAHPs	Dec-25
Workforce plan to be in place as determined by CNO	Mar-26
Patient Experience and Involvement	
Complete 5 qualitative (per Quarter) patient experience feedback for patients whom attend with a learning disability, Mental health, dysregulated behaviour. Cases to be presented at PCEIG	Jun-25
Improve the experience for patients in the Emergency Department by the development of comfort packs, about me boards and timely patient information provided for those waiting to be admitted	Jun-25
Increase the National Survey response rate of patients with a protected characteristic to above 5%	Nov-25
25% Increase in volunteers to work across all wards/department whom represent the community we serve to gather feedback from patients	Mar-26
Strengthen ties with local volunteer and community sector organisations to co-deliver services and reach underrepresented groups.	Mar-26
Increase the response rate to Friends and Family by 5% across for those with a protected characteristics	Mar-26
90% of all staff to complete the eLearning module for PALS with 90% of Band 6 and above clinical staff complete Complaints and local resolution training	Mar-26
Ensure 95% compliance that all inpatients view the patient safety video during their hospital stay	Mar-26
Increase the diversity of the Patient Safety Partner role	Mar-26
Improve the experience of in-patients in ensuring they have appropriate completion of intentional rounding, enhanced care and about me boards.	Mar-26
Improve the UEC and In-Patient National Survey overall ranking	Mar-26
Adress the top three themes' across the trust by focusing divisional attention on emerging trends and corresponding actions	Mar-26
Safeguarding	
Design the training required and set a target Training needs analysis.	Jun-25
Deliver training to the agreed year 1 target audience.	Jun-25
Publish revised enhanced care policy to reflect change to Enhanced Therapeutic Observation and Care (ETOC) to take a strengths based approach for people with dementia and/or at risk of falls. With process for	Jun-25
Funding in place for estates works to improve patient environment	Sep-25
Phased implementation plan of patient environment estates improvements using charitable funds to improve patient experiences and feelings of safety	Dec-25
Develop data reporting to show occurrences of chemical and physical restraint disaggregated by gender, minority ethnic groups, learning disability and severe mental illness	Oct-25
Increased oversight of restraint through reporting into DIFs to show restraint by level and annal thematic review of restrictive practices for the Safeguarding Board	Sep-25
Delivery of the actions to meet the recommendations from the External Review of Security	Mar-26
Develop a standardised visible system using the "Reasonable Adjustment Needs" to ensure that clinical staff can see at a glance more vulnerable patients and their additional care needs	Mar-26
Undertake a MDT review using the PSIRF SEIPS approach of areas identified tfollowing a review of he reccomendtaions of the Independent Review Report Reccomedations of GMMH	Mar-26
C.difficile Programme	
Recruitment and training of dometics staff to increase frequency of cleans	Sep-25
Display the clearning frequencies and STAR rating of areas that have the NSOC 2025 implemented	Mar-26
35 areas to be compliant with cleaning standards and displaying frequencies	Sep-25
55 areas to be compliant with cleaning standards and displaying frequencies	Mar-26
Review the joint monitoring audits and ensure they are to NSOC 2025 standards	Jun-25
Implementation and reporting to be included as mandated section in STAR by Q2	Jun-25
Review IPC standards for ED	Jun-25
Set standards for cleaning frequency and sluice fogging in ED	Sep-25
Implement process to consider IPC risks and priorities in CPG	Mar-26
Implement process to consider IPC risks and priorities in minor improvement work programme	Mar-26
Always Safety First	
Prepare draft 2024-2027 Always Safety First taking the learning from the first 3 years of Always safety First.	Jun-25
Develop the draft learning strategy.	Jun-25
Launch Always Safety First strategy	Sep-25
Maternity and Neonatal	
Identify approach to funding birthrate plus and address the gaps identified within the medical workforce for maternity and neonatal services.	Mar-26
Implement the maternal and fetal medicine pathways for women with complex conditions including identification of funding streams and provision for enhance training.	Mar-26
Delivery of the safety and culture improvement programme. Including implementation of the RCOG Escalation toolkit	Mar-26
Full implementation of the optimisation and stabilisation of the very pre-term infant.	Mar-26
Implementation of the national digital MEWS and NEWS tools within WACs phase 1	Mar-26
Implementation of the national digital MEWS and NEWS tools across organisation phase 2	Sep-26
Continue to prioritise the CQC national workstreams associated with maternity triage and induction of labour	Mar-26
Continue to deliver the ongoing actions of the 3-year single delivery plan	Mar-26
Children and Young People	
Review the outcome of the Kendal Bluck Medical staffing review and recommend next steps	Mar-26
Deliery the remaining components of the culture improvement programme.	Mar-26
Formulate approach to collecting feedback from CYP attending ward 8 with mental health presentations	Mar-26
Evidence sustained performance in relation to medication safety	Mar-26
Identified lead for PAU and HDU	Mar-26
Design the improvement plan for SEND	Mar-26
Complete the Ward 8 reception capital programme	Mar-26
Health Inequalities	
Socialise Health Improvement Plan internally and externally	Jun-25
Publish annual report on key health inequalities metrics	Sep-25
Implement health inequality education resources and align to EDI Trust wide, including Board development	Sep-25
Data use into operational BAU - PRG forums	Sep-25
Data use into improvement work - UEC focus and demand management to manage hospital flow	Sep-25
Development of health inequality dashboard - UHMB model	Dec-25
TNA for health inequality and health literacy - linked to EDI	Dec-25
Data links to primary care for LD and SMI	Mar-26
Critical care and enhanced care	
Develop blood competence for CYP and achieve 90% blood culture training compliance	Jul-26
Develop blood competence for Neonatal and achieve 90% blood culture training compliance	Sep-26
Monitor 90% compliance in adult blood culture training.	Mar-26
Sepsis 6 delivered within 1 hour for NEWS > 7 within ED & Inpatient areas	Mar-26
Senior review compliance within NEWS time frames standards	Mar-26
Medication Safety	
Pharmacy Clinical / Supply 7/7 Service	Mar-25
Operational refurbished licenced aseptic unit at LTH	Jun-25
Establish new training pathways and programmes for pharmacists and pharmacy technicians	Sep-25
Achieve VTE standards	Mar-26

People | Neil Pease, Chief People Officer

Aim: To improve colleague experience and create a positive organisational culture. Achieved by effective, supportive, inclusive and performance focussed line management. Aiming to reduce sickness absence, achieve compliance in appraisal and core skills, increase levels of team effectiveness and engagement, resulting in higher levels of colleague satisfaction and retention.

Portfolio and programme deliverables	Target delivery end date
Vacancy Management	
Introduce and embed revised vacancy control process	Jan-25
Redeploy colleagues into vacancies supporting organisational changes aligned to workforce reductions	Apr-25
Improve our data to ensure there is a full oversight of Trust vacancy position	Apr-25
Explore options for expediting band 3 vacancies being filled	Mar-26
Retention	
Refresh and relaunch Stay Conversations to support retention	May-25
Increased reporting and monitoring of retention data and new probationary processes	Jun-25
Target communications and training to areas with low engagement with Probationary and Leavers Conversations	Sep-25
Target workstream and interventions to support retention and recruitment to our HCSW roles	Sep-25
Repeat NHSE Retention Self-Assessment	Nov-25
Sickness Absence Management	
Produce business case for additional clinical psychologist to provide staff mental health support	Feb-25
Finalise and launch new Attendance Management policy	Mar-25
Progress business case and implementation plan for digital sickness absence management system	Mar-25
Address the staffing and capacity issues in the Occupational Health physiotherapy service	Mar-25
Deliver sickness absence reduction plan (detailed action plan with 4 workstreams)	Dec-25
Violence and Aggression	
Undertake self-assessment against new national Violence Prevention & Reduction Standard	Mar-25
Develop toolkit for managers to talk to colleaguesand raise awareness around when to report incidents, the continnum of violence and aggression, and when to call for assistance	Mar-25
Undertake specific analysis around weapons incidents and review actions required	Mar-25
Drive increase in colleagues attending training around how to diffuse and de-escalate incidents, with the impact on incident numbers and types measured in 3 pilot areas	Apr-25
Refocus on ward/departmental violence and aggression risk assessments - to be tested in 3 pilot areas	May-25
Establish regular review meetings with ED team around security strategy and support needed	May-25
Launch incident support toolkit	Jun-25
Engage Safeguarding & Digital colleagues to further review violence marker process	Jun-25
Core Skills Mandatory Training Compliance	
Develop and implement Trustwide reporting tool aligned to CQC core services	Jan-25
Develop CBU and SBU level dashboards for Core Skills, Mandatory Training and Medical Device compliance	Apr-25
Review delivery model for Resus Level 3 ILS and PILS	Apr-25
Implement revised delivery model for Resus Level 3 ILS and PILS	May-25
Develop Core Skills Mandatory Training Policy	Sep-25
Appraisal Compliance	
Review Appraisal Policy	May-25
Refresh and relaunch appraiser training	May-25
Streamline of appraisal templates and develop new supportive guideance	May-25
Align the Objective section to the refreshed Trust strategy	Jun-25
Work with the LMS developer to enable self allocation of appraisal, greater administrative functionality	Jun-25
Increased reporting and monitoring of data held in appraisal to aid compliance, intersectional reporting and localised actions to support quality appraisal conversations	Oct-25
Team and Culture	
Develop corporate level action plan and priorities in response to the 2024 NHS Staff Survey Results	Apr-25
Support Divisional Leadership Teams to align People Plans with Staff Survey Actions	May-25
Develop a new approach to TED Training to increase support for managers and completion numbers	May-25
Launch new starter portal including the full colleague offer (single point access) for colleagues to understand benefits of working at LTH	Jul-25
Develop new approaches to engage colleagues and increase response rate for Staff Survey 2025	Sep-25
Launch new Managers Hub to support managers to have access to all the tools, resources and training they need to support colleague experience	Oct-25
Diversity & Inclusion	
Achieve Bronze level of the NW AntiRacist Framework	Mar-25
Review Recruitment process step by step to identify areas for potential bias and identify mitigating actions to minimise/eradicate	Mar-25
Equality Impact Assessment training reviewed and updated	Apr-25
Launch Cultural Awareness training script (ICB wide project)	Jul-25
Review Trust Values and Leadership in Lancs behaviours, in conjunction with Inclusion forums, to enhance references to inclusive cultural behaviours	Aug-25
Develop and launch Equity Representatives training for leaders/managers to support with workforce processes i.e. Recruitment, Performance or Investigative processes	Aug-25
Evaluate and further develop Supporting Disability/Long Term Conditions agreement and conversations	Sep-25
Develop and Launch Inclusive Language guide	Oct-25
Evaluate Rainbow Badge and Hidden Disability (Sunflower) badge schemes	Dec-25

Performance | Katie Foster-Greenwood, Chief Operating Officer	
Aim: To increase productivity to improve waiting times for elective care, including waits for diagnostic services. To continue improvement of cancer performance to minimise the risk of harm. To develop and improve urgent and emergency care services working with our partners for improved whole system flow.	
Portfolio and programme deliverables	**Target delivery end date**
Urgent and Emergency Care	
Care Connexions	
Implement a call handling function to increase responsive access for referrals and release clinical capacity	Aug-25
Implementation of a clinical triage model to direct referrals into the most appropriate service	Aug-25
Increase acceptance rates of referrals into community hospital avoidance services	Sep-25
Incorporate Hospital @ Home model (previously virtual ward) into Care Connections	May-25
Develop a generalist model for Hospital @ Home, increasing step up activity	Aug-25
Days Kept Away from Home	
Pilot wards agreed for Days Kept Away from Home patient cohorts	Apr-25
Cross organisation data sharing agreements in place to be able to track patients through pathways realtime	Jun-25
Implement ward process change to prevent deconditioning through patient mobility and ending 'pj paralysis'	Jul-25
Cultural change in approach to cross organisational discharge MDT through board and ward rounds daily (LTH/LSCFT/LCC/VCFSE- Age UK)	Jul-25
Implement CHOP model in board rounds	Jul-25
Implement strength based approach conversations with patients in AAU and Brindle	Jul-25
Develop strength based approach training package	Aug-25
Rollout strength based approach competency	Aug-25
Embed strength based conversations through STAR	Dec-25
Diagnostics	
Implement diagnostic stewardship to reduce demand (internal)	Jul-25
Implement diagnostic stewardship to reduce demand (external)	Jul-25
Improve productivity and utilisation in diagnostic modalities	Jul-25
Implement validation processes or strengthen existing processes and utilise PEP+	Jun-25
Complete JAG accreditation actions	Aug-25
CDC optimisation and development	Mar-26
Development of digital transformation schemes, including AI technologies	Mar-26
Outpatient Care	
Implement a clinic 642 Process	Jun-25
Self Check-In – Fully scope the opportunity for operational efficiency by implementing outpatient self check-in and delivering WTE reduction	Oct-25
PEP Plus – Optimisation and timely operational implementation of PEP + maximising the actual and potential breadth of scope to magnify opportunity for productivity and benefits realisation	Nov-25
Develop standardisation of PIFU by default	Dec-25
Develop and implement PSFU	Dec-25
Implement the expansion of the text reminder service	Mar-26
Roll out innovative ways of reduction of DNA eg courtesy calls	Mar-26
Optimise AI solutions for medical scribing to maximise productivity and efficiency for clinical teams in Outpatients	Mar-26
Cancer Care	
Work with cancer alliance to improve diagnostic waiting times and results capacity	Jul-25
Lung health checks to be implemented in January 2025	Aug-25
Bowel screening undertaken within the ICB, to ensure capacity available to support treatment	Jul-25
Implementation of PKB	Dec-25
Breast screening undertaken within the ICB, to ensure capacity available to support treatment	Mar-26
Improve productivity in priority pathways; lower GI ,skin and urological cancers	Mar-26
Ensure at least 80% of Lower GI referrals are accompanied by a FIT result	Mar-26
Ensure teledermatology in Skin has sustainable workforce	Mar-26
Increase GA capacity	Mar-26
Increase ACP capacity to support one stop delivery models of care	Mar-26
To support better recording of staging at MDT	Mar-26
Continuation of pre- hab across Urology, Colo, UGI and palliative	Mar-26
Implement pathways to pre- hab closer to home across all tumour sites	Mar-26
Increase utilisation of PFSU - currently live within 4 tumour sites	Mar-26
Deliver Accend framework across L&SC for CNS, ACP and AHPs delivering cancer services (Accend) across L&SC	Mar-26

Productivity | Craig Carter, Chief Finance Officer	
Aim: To deliver the agreed financial plan for the organisation, including the waste reduction programme, and support ongoing development of a full sustainability plan for the organisation.	
Portfolio and programme deliverables	**Target delivery end date**
Financial Recovery	
External engagement	Jan-25
Resource aligned to identify schemes (PWC)	Jan-25
Benchmarked review and opportunity scoping	Feb-25
Waste reduction schemes identified and costed	Feb-25
Risk rated schemes	Mar-25
Milestones agreed across each scheme	Mar-25
IAG report at 30m schemes	Apr-25
EQIAs approved for schemes	May-25
30m Schemes to go green for delivery	May-25
Waste reduction schemes identified and costed	May-25
Risk rated schemes	May-25
Milestones agreed across each scheme	May-25
IAG report at 60m schemes	May-25
EQIAs approved for schemes	Jun-25
60m Schemes to go green for delivery	Jun-25
Governance, tracking and reporting mechanism in place	Jun-25
Communication plan for delivery progress	Jun-25
Benefits tracking in place	Jun-25
Assurance reporting to committee	Mar-26
60m schemes delivered by end Mar	Mar-26
IAG report at 60m schemes delivered	Mar-26
Scheme development for 26/27	Feb-26
Affordability/budget planning	
Agree Revenue Plan with Board of Directors	May-25
Agree Capital Plan with Board of Directors	May-25
Agree Patient Contract with commissioner	Jun-25
Ensure sign off of individual budgets with Divisions	Apr-25
Move to Working Day 1 Reporting in line with national timetable	Oct-25
Update 3 Year Financial Sustainability Plan	Oct-25
Manage cash to remain within the agreed limit and maximise BPPC	Mar-26
Review and implement balance sheet action plan	Jun-25
Review and implement grip and control actions	Mar-26
Financial Sustainability (OneLSC)	
Align month end financial reporting process with new One LSC process	May-25
Align current Trust monthly financial forecast process to new One LSC process	May-25
Develop divisional financial reporting process as part of One LSC	Jun-25
Procurement & Contracts (OneLSC)	
Review and update ToR for programme of work	May-25
Agree FY25-26 FRP	May-25
Develop FY26-27 FRP	Oct-25
Reporting performance dashboard/KPIs	Jul-25
Develop strategy and solution for contract management within the Organisation	Mar-26
Improve awareness of changes to procurement legislation for budget holders	Mar-26
Ensure procurement are embedded within the WRP Board	Mar-26
Clinical Procurement Advisory Board to be established	Mar-26
Non-pay control group to be reviewed and procurement to take a more active role	Mar-26

Partnerships | Silas Nicholls, Chief Executive Officer & Sarah Morrison, Deputy Chief Executive Officer

Aim: To reduce and manage risks across the organisation, developing a learning and continuous improvement culture focused on working with partners to redesign and deliver our services to meet the needs of our community.

Portfolio and programme deliverables	Target delivery end date
Vision & Strategy	
Develop a Communications Plan	Jun-25
Finalise the Strategy and Implementation plan with Board Approval	Jun-25
Disseminate the Strategy widely	Sep-25
Monitor Implementation year on year	Oct-25
Review supporting strategies and plans	Dec-25
Governance alignment of clinical transformation programmes	Dec-25
Development of clinical strategy	Mar-26
Information Improvement (OneLSC)	
Implementation of clinical insight (new Harris Flex datawarehouse)	Jul-25
Undertake review of Current IPR and DIF metrics (ward to board metrics) Develop a SIP report for SIP board	Sep-25
Complete the transition from Big Plan to SIP in IPR format for 24/25	Sep-25
Implementation of ICD11 coding	Mar-26
Continuous support into Rapid Improvement Events for analytics	Mar-26
Continous support into Operational Transformation programmes (UEC, Outpatients, Diagnostics) and Finance, Workforce and Procurement	Mar-26
Learning & Continuous Improvement	
Develop Lancs Improvement Method (LIM)	Jun-25
Finalise capacity and capability	Jun-25
Expansion of core capability offer - integrate LIM	Sep-25
Continuation of core capability offer - MCA	Mar-26
Develop the RIW Capacity & Capability building programme to support SIP delivery	Mar-26
Support into Key Operational programmes - UEC, Diagnostics, Outpatients	Mar-26
Support development of delivery of the 'improvement element' of the 25-28 ASF strategy'	Mar-26
Support successful delivery or IHI RHO Maternity Programme & AQuA's PSCP Programme	Mar-26
Support successful delivery of Modern Productive Series (Flow and leadership)	Mar-26
Deliver the Enhance FY Junior Doctor programme year 1	Mar-26
Continued integration of CI methods into Organisation Development leadership medical training	Mar-26
Learning strategy development and implementation	Mar-26
Corporate Communications	
Review engagement and communication approach for 2526	Jun-25
Deliver a communications plan for the Single Improvement Plan, including regular updates from exec leads and an intranet accessible version of the plan	Jun-25
Develop a stakeholder management and external relations framework	Sep-25
Providing support to the different workstreams to ensure key messages are delivered from year 1 of the Single Improvement Plan	Mar-26
Regulator Assurance (CQC/NHS E)	
Align the Single Assessment Framework to the Trust Safety Triangulation Accreditation Review (STAR) Quality Assurance Framework	Mar-25
Delivery of all CQC 'Must do' and 'Should do' actions in the QIP	Jun-25
Refresh CQC staff booklet (pre inspection)	Jun-25
Deliver awareness training on the new Single Assessment Framework in line with comms plan	Sep-25
Governance and Risk Maturity	
Develop external visits, accreditations and inspections policy	May-25
Strenthen governance to manage policies and procedures	May-25
Review of Corporate, Clinical, and Divisional Governance Structures and processes	Jun-25
Review Business Planning process to consider any improvements in relation to use of risk assessment and risk management arrangements	Jul-25
Review provision of risk information to functional meetings and establish horizontal risk reporting where gaps exist	Jul-25
Develop a quality governance framework for the Trust	Oct-25
Review of EQuality Impact Assessment (EQIA) process to consider any improvements in relation to use of risk assessment and risk management arrangements.	Oct-25
Demonstrate learning outcomes through implementation of PSIRF	Mar-26
Community Services	
Identify the workforce model required to deliver this programme of work.	Apr-25
Develop a plan of work and priorities for the collaborative steering group	Jun-25
Develop and sign off (LTH and LSCFT) a partnership agreement to support collaborative working ahead of full integration	Jul-25
Seek ICB endorsement for the case for change and timeline for integration	May-25
Develop a plan to integrate adult community dietetics ahead of full commercial transfer of services	Jun-25
Develop the full business case for the transfer of physical health community services from LSCFT to LTH	Dec-25
Complete the commercial transfer of physical health community services from LSCFT to LTH	Mar-26
Establish an approach to system based improvement and reporting	Mar-26
Digital (One LSC)	
Continue to progress the integrated care system single instance Electronic Patient Record using a single instance allowing all Trusts to have access to the complete patient record	Mar-26
Expand the use of robotic process auotmation reducing the admin burden and increasing the ability to capture clinical outcomes from specilaity specific systems into the Trust EPR	Mar-26
Introduce the use of AI ambient listening solution to reduce the admin burden associated with Clinical correspondence, reducing the reliance on digital dication and outsourced typing	Mar-26
Accelerate the use of patient engaged portal to introduce the self booking and reduce DNA	Mar-26
Secure Data Environment	Mar-26
Introduce a stardard process and system to digitise any physical casenotes allowing them to be available within the EPR	Mar-26
Introduce a digital accessibility group within One LSC to support both patients and staff enhancing the safe use of digital systems	Mar-26
Implement a patient self check in system and optimise the use of outpatient clinics through a robust resource booking system which integrates with the Trust EPR	Mar-26
Estates & Facilities	
Refresh of an Estates infrastructure strategy including water safety, call bells, waste, decontamination and medical device sterilisation	Oct-25
Transition Estates & Facilities to OneLSC	Nov-25
Delivery of minority priority backlog work	Mar-26
Monitoring of compliance levels	Mar-26
Delivery of capital programme	Mar-26
Implementation of national standards of cleanliness	Mar-26
24hr domestic and catering model for ED	Mar-26
24hr domestic and catering model for maternity	Mar-26
Review ward based food ordering standardisation of process, quality and procurement	Mar-26
Quality and procurement review of bed contract and equipment	Mar-26
Planning	
LTH Annual Operating Plan agreed	Mar-25
LTH stakeholder engagement	May-25
External stakeholder engagement	Jun-25
Revised LTH planning process agreed	Jun-25
2026/27 planning process commences	Oct-25
2026/27 planning process initial outputs	Dec-25
National Planning guidance	Dec-25
LTH Annual Operating Plan agreed	Mar-26
Education and Training	
Develop a future-focussed Education & Training Strategy aligned with local and national priorities	Dec-25
Establish a robust education governance framework to oversee strategic delivery, quality assurance, regulatory compliance, and measurable impact across all professional groups and training pathways	Mar-26
Strengthen strategic partnerships with higher education institutions to drive curriculum innovation, optimise placement capacity and embed academic excellence	Mar-26
Position LTH as a high quality, accredited Apprenticeship Training Provider, expanding provision to external stakeholders while maintaining compliance, quality, and financial sustainability	Mar-26
Enhance the external profile of LTH as a leader in healthcare education to establish the Trust as a nationally recognised Centre of Excellence for Education and Training	Mar-26
Research & Innovation	
Design and Implement Innovation pipeline - Edovation	Dec-25
Improve access and capacity for radiology	Jun-25
Restructure of clinical team to support agile way of working and prioritising	Jun-25
University Hospital Status Programme (UHS)	
Internal programme group mobilised	Jun-25
Stakeholder mapping and engagement across partners	Jun-25
Decision of University Hospital partner(s)	Sep-25
Decision on themes	Oct-25
Appropriate contracting in place for joint posts	Dec-25
Commence recruitment for posts	Mar-26
Health & Safety	
Refresh the Health and Safety Improvement plan jointly with Workforce and Estates colleauges	May-25
Governance reset for the Health and Safety Governance Group including utilising dashboard, and reporting structure	Jul-25
Refresh the workplace risk assessment procedure and training	Aug-25
Complete self-assessment against NHS HSWPG standards	Sep-25
Strengthen oversight of Estates related Health and Safety Related External Visits and Reporting	Nov-25
Develop cross-organisation governance model for One-LSC transition	Dec-25
Update the Health and Safety Policy to reflect the new assurance framework, dashboard, and reporting structure	Feb-26

12.3 NHS 10 YEAR PLAN UPDATE

Information Item | A Brotherton | 11.40

Presentation

13. GOVERNANCE AND COMPLIANCE

13.1 ANNUAL MEMBERS' MEETING

Information Item | J Foote | 11.50

REFERENCES

Only PDFs are attached

13.1 - CoG AMM report 24.07.25.pdf

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors

Annual Members Meeting 2025

Report to:	Council of Governors	**Date:**	24 July 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	J Foote

Purpose of Report

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

Executive Summary:

The Trust is required to hold a public Annual Meeting open to its members. At this meeting the annual accounts from prior year are presented, together with an overview of the work of the Trust during that same period. The Annual Members Meeting (AMM) should also be the platform at which elected governors are held to account by their electorate for the work they have undertaken as Council.

The meeting must be held within nine months of the end of the financial year and this year the AMM is scheduled for Thursday 25 September from 2pm. The Trust is heavily financially constrained this year. However, the Chair and CEO, having listened to feedback from last year's AMM, have agreed to a prudent commitment of funds to enable an external venue to be used for the event. Lancashire FAs premises at Thurston Road, Leyland have been booked as the venue. In addition, at no cost to the Trust, Active Lancashire will be working in partnership with the Trust on the day to engage with members of the public and support the event under the theme 'health through activity'.

The convening of the AMM is a matter for the Director of Corporate Affairs in the capacity of Company Secretary.

Council is requested to note the arrangements for 2025 and identify appropriate volunteers for Council to present on its behalf at the event.

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 (N/A)

13.2 UPDATE ON PROCESS FOR THE COUNCIL EFFECTIVENESS REVIEW

Other J Foote 12:10

Item for Assurance

REFERENCES

Only PDFs are attached

13.2 - CoG Council effectiveness review 24.07.25.pdf

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Council of Governors

Council Effectiveness Review

Report to:	Council of Governors	**Date:**	24 July 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	J Foote

Purpose of Report

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

Executive Summary:

In October 2023 the Trust engaged Value Circle to undertake an independent review of the effectiveness of Council. During 2024/25 a Task and Finish Group led by the Chief People Officer, Dr Neil Pease was established to consider the recommendations arising from the report and implement them as appropriate.

For the current year it is recommended that Council reviews its own effectiveness based on the following methodology:

- The Senior Independent Director (SID), Dr Karen Deeny, has been meeting with governors individually over the past few months to understand concerns, priorities for the future etc
- The Council workshop on Friday 8 August to be used for the SID and Council collectively to consider the outcome of these discussions to determine collective priorities for the year
- Council to set a series of key performance indicators (KPIs) against which its own effectiveness can be self-assessed
- In March 2026 a session be held for Council to be self-assessed against its pre-agreed KPIs for the year 2025/26
- In March 2026 Council also sets its KPIs for 2026/27
- The two sub-groups of Council agree their in year KPIs at their next meeting and self-assess against these as closely as possible to the end of the financial year 2025/26.

Council is requested to support the methodology and timescale as detailed above.

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	☒

14. ITEMS FOR INFORMATION

14.1 GOVERNOR OPPORTUNITIES SUMMARY

Information Item

REFERENCES

Only PDFs are attached

14.1 - Governor Opportunities and Activities - Apr-July 25.pdf

Council of Governors Report

Governor Opportunities and Activities – April - July 2025

Report to:	Council of Governors	**Date:**	24 July 2024
Report of:	Corporate Affairs Team	**Prepared by:**	K Lawrenson
Part I	✓	**Part II**	

For assurance	☐	**For decision**	☐	**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 April to July 2025.

The governor role is to represent the interests of Foundation Trust members, the public and the organisations the 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 governors also undertake voluntary roles across both our 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

n/a

There are a number of regular activities which Governors could be involved in including:

STAR celebration events
Held three times per year, 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 list below does not include scheduled meetings of Council and workshops.

EVENT: excluding scheduled meetings and workshops	**DATE: 1 May to 1 July 2025**
Carers Forum	28 May 2025 and 25 June 2025
Council Training Session - Safety Triangulation Accreditation System (STAR) quality assurance framework	15 May 2025
Council Training Session – IT systems refresher	22 May 2025
Visit to the new Day of Surgery Admission Unit (DOSA)	23 May 2025
Board of Directors public meeting	3 June 2025
Governor Focus Conference (NHS Providers)	5 June 2025
Focus Group with Good Governance Institute	5 June 2025
Pharmacy Visit	20 June 2025
Governor and Non-Executive Director meeting	1 July 2025

14.2 GOVERNOR ISSUES REPORT

Information Item

REFERENCES

Only PDFs are attached

14.2 - Governor Issues Report.pdf

Council of Governors Report

Governor Issues Report			
Report to:	Council of Governors	**Date:**	24 July 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	K Lawrenson, Corporate Affairs Officer
Part I	✓	**Part II**	

Purpose of Report					
For assurance	☐	**For decision**	☐	**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 Corporate Affairs Team (CorporateAffairs@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, with a summary submitted to Council as part of this report.

During the period April – July 2025 no issues were raised.

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

14.3 MINUTES OF GOVERNOR SUBGROUPS

(a) Care and Safety Subgroup ? 12 May 2025
(b) Membership Subgroup ?5 June 2025
(c) Chairs, Deputy Chairs and Lead Governor ? 1 July 2025

REFERENCES

Only PDFs are attached

14.3a - Minutes CaSS Subgroup 12 May 2025 approved.pdf

14.3b - Minutes - Membership Subgroup - 5 June 2025 approved.pdf

14.3c - Minutes - Chairs Deputy Chairs and Lead Governor - 1 July 2025 approved.pdf

Care and Safety Subgroup

12 May 2025 | 10.00am | Microsoft Teams

Members:

Janet Miller	Public Governor (Chair)
George Bailey	Public Governor
Margaret France	Public Governor
Graham Fullarton	Public Governor
Angela Kos	Public Governor
Carole Oldcorn	Public Governor
Christine Pownall	Public Governor
Frank Robinson	Public Governor
Graham Robinson	Public Governor (Vice Chair)

In Attendance:

Nic Compton	Coporate Affairs Officer
Dr Karen Deeny	Non-Executive Director
Steph Iaconianni	Head of Patient Experience and PALS
Alison McCrudden	Patient Experience and Involvement Lead
Jo Wiseman	Corporate Affairs Officer (*minutes*)

23/25 Chair and quorum

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

24/25 Apologies for absence

Apologies for absence were received from L Jackson, C Howell, E Povey and John Howles.

25/25 Declarations of interest

There were no declarations made by Subgroup members in respect of the business to be transacted during the meeting.

26/25 Minutes of the previous meeting

The minutes of the meeting held on 13 March 2025 were approved as an accurate record.

27/25 Matters arising and action log

The action log was reviewed and updated.

28/25 Estates and Facilities Update

Due to unforeseen operational pressures, no representative was available. It was noted that a discussion had been held at the recent car parking meeting, highlighting the need for better communication regarding the introduction of double red parking lines at CDH

and the changes in the use of blue badges need to be communicated to our patients and visitors before they are implemented. The discontinuation of the shuttle bus was only decided after thorough investigation of how many staff, patients and visitors used it.

29/25 Patient Quality, Experience and Engagement Update

The Head of Patient Experience and PALS provided an overview. This included an update on the work of patient safety partners, including their involvement in complaints review, duty of candour letters and various improvement groups.

Patient Safety Partners were looking at pressure ulcer governance and were involved in the incident reporting method, known as PSIRF oversight. This method included how responses to patients about incidents were managed. They were part of the Always Safety First Learning and Improvement Group and the Patient Experience Carer Involvement Group.

Additionally, they worked with the Veteran Healthcare Working Group and the Hydration and Nutrition Strategy. They were also examining intentional rounding and the Enhanced Care Group. The Patient Safety Partners had participated in staff interviews and had been involved in recruiting several patient-facing roles. They were an integral part of the wider team within the Trust, providing fresh perspectives on various matters. Often, clinical staff might assume they were doing the right thing, but the Patient Safety Partners could offer insights into how patients might react to certain actions.

It was expected that the role would be re-advertised around September 2025. The intention was to look at the diversity of the role and encourage people from different backgrounds to apply. Another query was raised about whether the role had to be a paid position. It was suggested that there might be an incentive for people to apply, however a definitive answer would need to be established outside of the meeting. It was confirmed that this had been raised at a previous council meeting in January 2025 and an action was taken to check.

It was explained that there was a working group who reviewed complaints and responses to ensure their appropriateness. They also examined the process, such as whether to respond to complaints outside the 12-month period. The group decided it was generally not appropriate, except for specific cases like maternity complaints, which might be addressed differently. The group aimed to improve the quality of responses, ensuring they were not defensive and acknowledged mistakes when they occurred. The focus was on resolving issues for patients.

30/25 Patient Experience and Involvement Update

The Patient Experience and Involvement Lead provided an overview of the report.

A question was raised about the mechanisms for communicating the support services offered to people with impairments or disabilities. It was asked whether communication relied on leaflets, the website, or other methods to raise public and patient awareness. It was explained that various forms of communication were used, including leaflets, the Trust website, posters and social media. Different forums were also utilised, such as the SMRC forum. The stoma-friendly toilets project had been advertised through television campaigns, the LEP and leaflets related to different surgeries. Word-of-mouth communication by staff and nurses was emphasised, in addition to written materials and

media. Collaborations with different communities and charities, such as the VI Forum and Guide Dogs UK, were mentioned to share information and gather feedback.
Another question asked was about how to ensure all communities were reached. It was challenging to reach everyone, but efforts were made through various forums, community events and Healthwatch engagements. Feedback from these activities was used to improve communication and outreach.

It was confirmed that there was a patient experience and involvement plan outlined goals for the year and how they would be achieved. Different elements, such as complaints and patient safety partners also fed into this plan.

Concerns were raised about long waiting times for colonoscopy, which should be urgent referrals. It was noted that while elective surgery waiting times were reportedly decreasing, patients often wait for investigations before being added to the surgery list. Each surgical division managed its own waiting lists based on clinical priority and length of wait. It was advised that patients could use the contact numbers provided in appointment letters for enquiries. It was confirmed that COVID-19 had caused greater waiting lists but efforts were being made to address the backlog, including working seven days a week.

31/25 Non-Executive Director Update

Dr Karen Deeny introduced herself as Non-Executive Director and chair of the Safety and Quality Committee. An update was provided on learning from various committees and groups. Meetings had been held with the executive team and other key individuals to discuss plans and collaborations. The focus was on maintaining transparency and ensuring quality and safety remained a key focus.

Three main points were highlighted:

- **Quality, Safety and Experience**: Emphasis was placed on the importance of safety, effectiveness and patient experience. It was noted that patient experience was crucial and should be given equal importance alongside safety and effectiveness.
- **Financial Challenges**: The need to maintain a firm grip on safety, effectiveness, and experience despite financial challenges was stressed. The impact of financial decisions on workforce and safety was discussed, and the importance of connectedness across committees was highlighted.
- **Committee Collaboration**: Collaboration with other committee chairs was emphasised to ensure financial decisions were aligned with performance, workforce and safety needs. Key updates from recent committee meetings included the replacement of medical devices, strengthening of maternity services and addressing health inequalities.

Additional points included the introduction of trajectories to monitor the impact of investments, challenges around mandatory training and updates on safe staffing reviews, particularly in maternity services. Assurance reports had been provided on children's services, safe management of controlled drugs and allied health professional staffing. The importance of equality and quality impact assessments for any service changes or waste reduction initiatives had been highlighted. The Board had approved additional funding to help achieve the national cleaning standards.

Concerns were raised about the overwhelming volume of workflow and the challenge of maintaining a holistic view of improvements year on year. The question was how to ensure that improvements were being made and whether the organisation would meet the CQC standards if reviewed. It was explained that there were different approaches taken to address those concerns. The first approach involved asking the "So What?" question, which helped to evaluate the impact of meeting targets and understanding the difference made by those achievements. The second approach was triangulation, which involved comparing performance data with feedback from people accessing services to ensure consistency between reported data and actual experiences. The third approach was visiting and talking to people, assessing whether the conditions in wards and services matched the data and reports, ensuring a connection between the two. The importance of building stronger connections across different reporting areas, such as finance, workforce, estates and quality, was emphasised to provide assurance.

The discussion also touched on the integrated performance reports, which provide metrics for finance, workforce and safety and quality. These reports use statistical process control to track variations and determine if they are positive or concerning. Triangulating this data with feedback from service users and staff was crucial for a comprehensive understanding. The integrated performance reports that are produced for the Board meeting were recommended as a valuable resource for objective data and tracking progress.

32/25 Reflections on the meeting

None

33/25 Request for future meeting topics and any other business

Future meeting topics - None requested.

A visit to Pharmacy at RPH to view the benefits of the dispensing robot was requested.

A reminder was provided to respond to the DOSA visit invite which had been extended to NED colleagues and all governors.

Date, time, and venue of next meeting
10 July 2025 at 12.30pm using Microsoft Teams.

Membership Subgroup

5 June 2025 | 10.00am | Microsoft Teams

Members:

Sheila Brennan	Chair
George Bailey	Deputy Chair
Sonia Connell	Staff Governor
Janet Miller	Public Governor
Carole Oldcorn	Public Governor
Christine Purcell	Public Governor
Tom Ramsay	Staff Governor
Frank Robinson	Public Governor
Graham Robinson	Public Governor

In attendance:

Karen Lawrenson Corporate Affairs Officer (minutes)

1/25 Chair and quorum

The Chair noted that due notice of the meeting had been given to each member and a quorum was present.

2/25 Apologies for absence

Apologies for absence were received from Dr Karen Deeny, Enid Povey, and Tim Young.

3/25 Declaration of interests

There were no declarations made in respect of the business to be transacted during the meeting.

4/25 Minutes of the previous meeting held on 4 December 2024

The minutes were accepted as a true and accurate record.

5/25 Matters arising and action log

The action log would be updated accordingly.

6/25 Appointment of Deputy Chair

The Chair confirmed that the post of Vice-Chair had now been filled following expressions of interest.

7/25 Events Diary

The Chair reiterated the ongoing need for stronger two-way communication and greater public accountability within the healthcare system.

Previous discussions had addressed budget constraints and the ambition to pursue community-focused activities linked to the new hospital programme. Due to limited support and funding, a do-it-yourself approach was proposed to boost public visibility, particularly through social media. The group were encouraged to identify local events via social media for potential participation, with local sporting and staff diversity events highlighted. While Health Mela stands offering tangible benefits like blood pressure checks were popular, Governor stands at past events had seen limited engagement. The challenge of promoting membership awareness across a large geographical area was noted, with a focus on local events seen as more effective.

Membership engagement at the grassroots level was discussed, with a need to sign up more members and review current data. A comparison between the Civica and Trust databases was requested to ensure membership lists were accurate, and a breakdown of membership demographics was still required. Many staff were unaware of their automatic membership, and turnout for Staff Governor elections was low. A pop-up stand at Trust restaurants for Staff Governors with Public Governor support was suggested. Ideas also included securing a Twitter account for Governors*, using screensavers to raise awareness—especially for night staff—and exploring the inclusion of messages in payslips.

8/25 Reflections on the meeting

A question was raised about the possibility of holding face-to-face meetings. Several attendees expressed a preference for face-to-face meetings, while acknowledging that remote attendance would be available to allow for flexibility.

Date, time, and venue of next meeting:

5 August 2025, 2pm via MS Teams

The meeting concluded at 15.29pm

** this would not be compliant with the Trust's social media policy.*

Chairs, Deputy Chairs and Lead Governor with the Chair and Chief Executive

1 July 2025 | 11.00am | Microsoft Teams

PRESENT

Prof. Mike Thomas	Chair
Prof. Silas Nicholls	Chief Executive Officer
Janet Miller	Lead Governor
Sheila Brennan	Public Governor, Chair Membership Subgroup
Graham Robinson	Public Governor, Deputy Care and Safety Subgroup
George Bailey	Public Governor, Deputy Membership Subgroup

IN ATTENDANCE

Jennifer Foote	Director of Corporate Affairs
Jo Wiseman	Interim Business Manager, Corporate Affairs (minutes)

8/25 Apologies for absence

No apologies had been received for the meeting.

9/25 Minutes of the previous meeting

The minutes of the meeting held on 1 April 2025 were agreed as a true and accurate record. In respect of the appointment of the SID it was explained that a report had been presented to the Council meeting in April for consultation prior to formally appointing to the role, as required by process. However, the comment of the Lead Governor that in her opinion this did not constitute a sufficient involvement by governors was noted for the record.

10/25 Matters arising and action log

The action log was reviewed and would be updated accordingly.

11/25 Chair and Chief Executive update on key issues

It was advised that the Trust had appointed a new Chief Medical Officer, following a robust recruitment process. A handover was expected in the autumn.

Progress was reported on service redesign, including the vascular transfer and pathology service development. Clarification was being sought from the ICB regarding the need for public consultation, which could impact timelines. It was noted that public consultation responsibilities rested with the ICB and relevant scrutiny committees.

Engagement with local councils and voluntary sector partners was ongoing to explore shared estate opportunities and strengthen community links. Discussions were advancing with the University of Central Lancashire to establish an on-site education centre and joint

faculty, supporting the Trust's university teaching hospital status. Development of a service site strategy was underway, focusing initially on Chorley, with plans to enhance surgical and diagnostic services and address parking challenges through a proposed multi-storey facility.

The Trust's financial recovery plan had identified £60 million in-year savings, with full-year effects were projected at £90 million, subject to deliverability. Discussions with commissioners were ongoing regarding a revised payment structure to support urgent and emergency care.

There would be significant national changes, including the planned abolition of Healthwatch, Freedom to Speak Up offices, and Commissioning Support Units. The Trust awaited further detail from NHS England.

A recent CQC review of surgical services at Chorley was reported as highly positive, with commendation for service delivery, equality initiatives and continuous improvement. Minor concerns were noted around administrative and anaesthetic staffing, which were being addressed.

12/25 Draft Council of Governors agendas – 24 July 2025

It was agreed that the title for Item 12.3 - Effectiveness Review, would be amended to reflect the focus of the report on the process, rather than a review of effectiveness per se.

13/25 Subgroups and Lead Governor updates

(a) ***Care and Safety Subgroup*** *(Janet Miller)*

There had been a meeting on 12 May 2025 for Care and Safety Subgroup. Highlights included:

- Concerns were raised at a car parking meeting regarding communication about the shuttle bus discontinuation, double red lines at Chorley, and blue badge access.
- The Head of PALS provided an update on patient quality, experience and engagement. Patient Safety Partners contributed to governance, recruitment, and improvement groups, offering valuable perspectives. The role of Patient Safety Partner was expected to be re-advertised in September 2025, with a focus on increasing diversity. The sub-committee discussed whether the role should remain paid, considering financial constraints.
- The complaints review group advised against responding to complaints older than 12 months and aimed to improve response quality by acknowledging errors and focusing on resolution.
- Efforts to reach diverse communities were ongoing through forums, events, and Healthwatch engagement; feedback informed communication improvements.
- A Patient Experience and Involvement Plan was in place, incorporating complaints and input from Patient Safety Partners.
- Updates were shared from meetings, focusing on transparency, collaboration and maintaining standards in quality, safety, and experience.
- Governors participated in STAR audit training (15 May), a visit to the new DOSA unit (23 May), and a pharmacy visit at Royal Preston (20 June).
- Concerns were noted about PALS staff increasingly working remotely, despite patient preference for face-to-face interaction.

(b) ***Membership Subgroup*** *(Sheila Brennan)*

- There had been one meeting held and a chair and vice chair had been appointed for the membership subgroup.
- The group discussed how to strengthen public engagement within the constraints of current financial pressures. Various ideas were explored, though some were limited by the existing social media policy. It had been agreed that a proposal would be developed for consideration at a future Council of Governors or relevant meeting.

The role of governors in providing a link with the local community following planned changes in the NHSE was highlighted for future discussion, though it was recognised the responsibility for this might shift away from the NHS in future.

(c) ***Lead Governor update*** *(Janet Miller)*

The Lead Governor provided an update. Since the last meeting on 1 April, attendance continued at various monthly forums, including patient and carer experience, staff ambassador, LGBTQ+ and ethnicity groups, dementia strategy and dementia champions meetings.

A meeting was held with representatives from GGI in June, and the Lead Governor reflected on an NHS Providers development session held in July 2024. It was suggested that, while several recommendations were agreed, few had been implemented, including timely report circulation, improved executive summaries, and enhanced governor involvement in agenda setting and joint discussions. The importance of informal dialogue and roundtable formats was highlighted as effective for collaborative working. Governors expressed concern about limited visibility and engagement, particularly with non-executive directors, despite recent site visits.

Volunteer Week and Estates and Facilities Day were noted as missed opportunities for governor involvement. There had been lack of updates regarding the governor working group formed to oversee external auditor appointments.

The Trust's financial challenges and regulatory oversight were recognised as contributing factors to current constraints, but governors emphasised their commitment to supporting the organisation and maintaining their role in representing public interests.

14/25 Other Items

(a) **Subgroups Terms of Reference**
It was agreed for each subgroup to review its Terms of Reference prior to approval by the Council of Governors.

(b) **Engagement Strategy**
A question was asked if the engagement strategy had been updated. It was agreed that the Director of Communications would be asked to make direct contact to provide an update.

(c) **Annual effectiveness reviews**

It was acknowledged that this had been included on the Council agenda.

(d) **Part II Board Agendas**

It was suggested that the CQC's 2023 report stated governors could receive copies of part II Board agenda. It was explained that an update of PII Board business was included in the Chairs report.

(e) **NED Engagement with Governors**

It was acknowledged that a meeting was taking place with NEDs the same afternoon.

Date, time and venue of next meeting

The Chair advised that the next meeting was scheduled for 7 October 2025 at 10.00am via Microsoft Teams.

Meeting closed at 12.01pm

14.4 DATE, TIME AND VENUE OF NEXT MEETING: 30 OCTOBER 2025, 10.00AM, LECTURE ROOM 1, EDUCATION CENTRE 1, ROYAL PRESTON HOSPITAL

Information Item | M Thomas | 12:20

15. REVIEW OF MEETING PERFORMANCE

15.1 DISCUSSION ON HOW THE MEETING IN PUBLIC HAS BEEN CONDUCTED

Information Item | All | 12.15

16. RESOLUTION TO REMOVE PRESS AND PUBLIC

16.1 RESOLUTION TO EXCLUDE MEMBERS OF THE PRESS AND PUBLIC

Information Item | M Thomas | 12.17