NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

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3 June 2025

09:15 GMT+1 Europe/London

Lecture Hall, Education Centre 3, Chorley and South Ribble District Hospital

AGENDA

STAFF STORY FROM HOUSEKEEPING, DISCHARGE LOUNGE.

Information Item | L Yates | 09.15am

AGENDA

REFERENCES

Only PDFs are attached

Agenda - Board (part I) - 3 June 25 .pdf

Board of Directors

3 June 2025 | 09.15am | Lecture Hall, Education Centre 3, Chorley and South Ribble District Hospital

Agenda

At 09.15am, there will be a **staff story from Housekeeping, Discharge Lounge.**

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	9:30am	Verbal	Information	M Thomas
2.	Apologies for absence	9:31am	Verbal	Information	M Thomas
3.	Declaration of interests	9:32am	Verbal	Information	M Thomas
4.	Minutes of the meeting held on 3 April 2025	9:33am	✓	Decision	M Thomas
5.	Matters arising and action log update	9:34am	✓	Decision	M Thomas
6.	Chair's opening remarks and report	9:35am	✓	Information	M Thomas
7.	Chief Executive's report	9:40am	✓	Information	S Nicholls
8.	Board Assurance Framework	9:50am	✓	Assurance	S Regan
9.	**CONSISTENTLY DELIVER EXCELLENT CARE** (SAFETY AND QUALITY)				
9.1	Safety and Quality Committee Chair's Report – *following 3 reports are also recommended for approval confirmation*	10.00am	✓	Assurance	K Deeny
9.2*	Infection prevention and control annual report	10.10am	✓	Decision	C Gregory
9.3*	Patient Experience annual report	10.20am	✓	Decision	C Gregory
9.4*	PSIRF annual report	10.30am	✓	Decision	H Ugradar
9.5	Quality Account	10:40am	Pres	Consultation	C Gregory
10.	**GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH)**				
10.1	Workforce Committee Chair's Report	10.50am	✓	Assurance	K Deeny
10.2*	(a) Workforce Race Equality Standard (WRES) Report 2025 (b) Workforce Disability Equality Standard (WDES) Report 2025 ***Full reports in ancillary pack.**	11.00am	✓	Decision	L Graham
10.3	Education, Training and Research Committee Chair's Report	11.05am	✓	Assurance	A Brotherton

№	Item	Time	Encl.	Purpose	Presenter
11.	**DELIVER VALUE FOR MONEY** (FINANCE AND PERFORMANCE)				
11.1	Integrated Performance Report as at 30 April 2025 including Finance update and Single Improvement Plan *(considered by appropriate Committees of the Board)*	11.15am	✓	Assurance	K Foster-Greenwood/ C Gregory/ N Pease/ C Carter
11.2	Finance and Performance Committee Chair's Report	11.40pm	✓	Assurance	J Schorah
12.	**RISK, GOVERNANCE AND COMPLIANCE**				
12.1	Audit Committee Chair's Report	12.00pm	✓	Assurance	T Wheeler
12.2*	Risk Management Policy ***Full report in ancillary pack**	12.05pm	✓	Decision	T Wheeler
12.3	Raising Concerns at Work (including Whistleblowing and Freedom to Speak Up) annual report	12.10pm	✓	Assurance	N Pease
12.4	Board Visibility 2025/26	12:20pm	✓	Decision	J Foote
13.	**ITEMS FOR INFORMATION**				
13.1	Fit and Proper Persons' Test/Completion of Director Appraisals – Annual Report		✓		
13.2*	Maternity and neonatal services update ***Full report in ancillary pack**		✓		
13.3	Date, time and venue of next meeting: *7 August 2025, 9:15am, Lecture Room 1, EC1, Royal Preston Hospital*	12:25pm	Verbal	Information	M Thomas

1. CHAIR AND QUORUM

Information Item | M Thomas | 09.30am

2. APOLOGIES FOR ABSENCE

Information Item | M Thomas | 09.31am

3. DECLARATION OF INTERESTS

Information Item | M Thomas | 09.32am

4. MINUTES OF THE PREVIOUS MEETING HELD ON 3 APRIL 2025

Decision Item | M Thomas | 09.33am

REFERENCES

Only PDFs are attached

04.0 - Minutes - Board (Part I) - 3 April 25 - approved.pdf

Board of Directors

3 April 2025 | 9.30am
Lecture Room 3, Education Centre 1, Royal Preston Hospital

Part I

Present:

Professor M Thomas	Chair
Dr T Ballard	Non-Executive Director
Professor S Crean	Non-Executive Director
Dr K Deeny	Non-Executive Director
Ms K Foster-Greenwood	Chief Operating Officer
Mr A Leather	Non-Executive Director
Mrs S Morrison	Chief Nursing Officer
Professor S Nicholls	Chief Executive Officer
Mr U Patel	Non-Executive Director
Mr J Schorah	Non-Executive Director
Dr G Skailes	Chief Medical Director
Mr D Stonehouse	Interim Chief Finance Officer
Professor T Wheeler	Non-Executive Director

In attendance:

Mrs E Ashton	Divisional Nursing & Midwifery Director
Mrs A Brotherton	Director of Continuous Improvement
Mrs J Foote	Director of Corporate Affairs
Ms L Graham	Deputy Chief People Officer
Mr K Pringle	Turnaround Director
Mr S Regan	Associate Director of Risk and Assurance
Mr A Sharples	Head of Communications and Engagement
Mrs J Wiseman	Corporate Affairs Officer (minutes)

Governors observing:	George Bailey, Sonia Connell, Janet Miller, Carole Oldcorn, Enid Povey, Tim Young.
Presenters of the patient story:	Louise Gracie, Sarah Ogden, Jennifer Redfern, Rachel Woods

Prior to the meeting the Board received the following presentation: Patient Story, Living with a Laryngectomy – Oncology, Head and Neck, Surgery Division.

Representatives from the Surgery Division presented a video of their patient who had a laryngectomy, (removal of the larynx). The procedure involved major surgery to suture the trachea to the neck, forming a stoma, which then became the patient's permanent and irreversible airway. The patient received care in hospital wards and departments within the trust that were not familiar with laryngectomees, making her feel vulnerable and concerned for her safety. She raised these concerns with the head and neck specialist teams, who, along with the clinical educator and specialist speech and language therapists, recognised the need to prioritise learning, training and education, as this was not an isolated incident. Consequently, a Standard Operating Procedure was established in 2024.

A training package had been implemented for cohorted areas providing care to patients with tracheostomies, including Ward 3, the Enhanced High Care Ward, Ward 23, Neuro High Care, and Critical Care. With the patient's permission, her story was filmed and shared with the Board of Directors. A specialist clinical educator delivered airway training in the Emergency Department and Critical Care, with plans to extend this training to other departments. An altered airway eLearning package was to become a role-specific skill in specialist areas. Continued education and awareness of the Standard Operating Procedure were also planned. A laryngectomy worklist and a reasonable adjustments tab were added to Flex to track and alert staff about patients with altered airways. Clinical competency development through SIM sessions was ongoing, with training videos planned. A "trolley dash" was demonstrated to raise awareness among all staff in the Emergency Department and Critical Care about the care needs to prevent medical emergencies.

Concerns were raised regarding the specialist skillset of temporary or agency staff, and it was noted that an airway-trained member of nursing staff was always on duty. As part of the safety huddle at the beginning of each shift, all staff were informed of any patients with altered airways.

Reasonable adjustments in the work list had recently been rolled out and were still a work in progress. Monitoring the training involved tracking the number of people targeted in training sessions. Family results and patient experience data were collected throughout the trust, with a report detailing patient experiences, particularly those with altered airways. Incident reports from recent years showed a pattern of patients being housed in areas without proper training or equipment. The aim was to reduce incidents over the next two years.

The Board requested that their thanks be conveyed to the patient for sharing her patient experience, which helped improve services for patients.

53/25 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.

54/25 Apologies for absence

Apologies for absence were received from Mrs N Duggan and Mr N Pease.

55/25 Declaration of interests

Non-Executive Dr T Ballard declared an interest in that he was a CQC GP representative. The interest was noted with no requirement to leave the meeting.

56/25 Minutes of the previous meeting

The minutes of the meeting held on 6 February 2025 were approved as a true and accurate record.

57/25 Matters arising and action log

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

58/25 Chair's report

The report provided a summary of work and activities undertaken during February and March 2025 by the Trust Chair including a resumé of the items discussed in the part II Board meeting in February.

Noting the challenges ahead, there was a renewed emphasis placed on the Board of Directors working collaboratively as a unitary Board. Within the separate roles and responsibilities, Non-Executive Directors focused on governance, patient safety, quality of care and financial management strategy. The executive colleagues were responsible for operational aspects, with a clear separation of roles. Decisions were to be undertaken collectively, with a challenging two years ahead. The information executives provided were to help the Board be evidence led to ensure there could be data-driven joint decisions and resource utilisation for patient focus. There needed to be key focus on being a specialist tertiary provider for patient care aiming to serve the population. Chorley and South Ribble Hospital had the potential to be regarded as a good to outstanding District General Hospital. The Trust had a strategy to work as a system to provide the best patient care, within the financial capacity.

59/25 Chief Executive's report

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

NHS Changes - During the recent weeks there had been a significant amount of change within the NHS. Colleagues were sensitive to those experiencing the reduction and revised structures of the joint NHSE/DHSC workforce.

Operational and Financial Pressures - It was announced that the cap on additional income from grants would help address the current shortfall against the elective recovery standards. While this financial upside was welcomed, it was emphasised that the focus must remain on cost reduction rather than relying on trading out of difficult situations. Sensible service decisions were being made and consequences had to be managed. Progress was being made in the financial recovery plan, although it was not yet at the desired level. Rigorous standards were being set for programme initiations and project plans, which, while increasing confidence, also took longer to implement. Feedback from regulators both regionally and nationally was positive, but it was noted that the situation could easily fluctuate.

Finney House Community Healthcare Hub – The phased closure had been a difficult but necessary decision to help get finances back on track. Thanks were extended to colleagues who had worked in the Finney House Community Healthcare Hub facility, acknowledging the complexity of the decisions involved. The professionalism of Staff Side during this period was highlighted.

The report also highlighted some of the ongoing projects and continued improvement work. Over the coming weeks the executive team planned increased focus on staff engagement and Board visibility across the Trust. In May, the Trust would launch the micro improvement methodology, connecting the transformation team's improvement efforts to the business-as-usual activities.

The single pathology programme was highlighted as an exemplar of what needed to be done across the system. It was noted that there was non-executive oversight and assurance framework set around this programme, which exemplified how costs could be

decreased across the system while delivering better care. The importance of robust communication channels across all levels of the organisation was emphasised, particularly in engaging with a challenging agenda. Regular staff briefings and a leadership programme by the senior leadership team had been established, though gaps remained in optimising engagement. Plans included structuring consultant involvement and maintaining contact with Staff Side representatives.

A question was raised to understand if colleagues had been involved in the development of the Lancashire Economic Plan, and although health was not included in the title it was assumed to be an enabler across all areas. It was suggested that ambitious trusts in the region, in financial special measures, faced the danger of repetition and conflict over the same issues that impacted NHS funds. In response to a query assurance was provided that each of the Trusts' CEO's met as part of the Provider Collaborative Board and there had been a required change to the way colleagues worked together. Benefits were already being identified in the new approach with the new pharmacy collaboration being an exemplar of this model.

The number of positive initiatives, programmes and funding bids were noted. A question was asked how visible the results of the intensive impact were, or when projects were not delivering. It was explained that the primary source for tracking was through the single improvement plan and the Integrated Performance Report.

60/25 Board Assurance Framework

This was the second update of the Board Assurance Framework to the Board of Directors since it had been revised in December 2024.

It was noted that the BAF identified the principal risks that threatened the delivery of the corporate objectives. Since the last update, the score for the principal risk related to patient experience and the urgent emergency care (UEC) pathway, had been reviewed and increased to 15. The increase in likelihood took account of the increase in operational pressure, the reduced number of escalation areas available to support patients and the closure of wards. There had been discussions at both of the last Board and Safety and Quality Committee meetings regarding the safety elements of this principal risk. It had concluded that, whilst in this new phase of this framework, the safety elements of the UEC pathway risks were considered in principal risk 5, which reported to the Finance and Performance Committee. All of the principal risks had been reviewed by the relevant assurance committees in advance of this Board meeting.

It was explained that the actions from the historic strategic risks, from the previous Board Assurance Framework, had been tracked through the assurance committees. The majority of them had either transitioned into actions in the new principal risk approach or had been completely stepped down. One outstanding action aligned to the Education, Training, and Research Committee that related to research elements, reported to the Board of Directors until completed.

In terms of operational high risk, there were no operational high risks escalating towards the Board. The Corporate Objectives for 2025/26 would be considered in later agenda item. They would be reviewed with potential new risks and revisions to the Board Assurance Framework at a Board Workshop in May 2025 alongside the annual review of risk appetite and tolerance.

The Board RESOLVED to approve the updates in the Board Assurance Framework and ongoing action plans for the historic strategic risks.

61/25 2025/2026 Planning Submission

The report outlined the latest position of the Trust's 2025/26 planning submissions. The priorities and operational planning guidance, along with revenue finance and contracting guidance, had been published on 30th January 2025. These focused on improving access to timely care for patients, increasing productivity, and delivering services within allocated budgets. The Trust had committed to compliance in six of the eight indicators by March 2026. The remaining two indicators reflected significant challenges in balancing the financial envelope, increased demand, waste reduction programmes, and committing to compliance in other areas. Although the full details were yet unknown the timeframe issue for planning would persist due to information not being made available until June 2025. In line with other organisations nationally, work on the plan would continue.

A discussion was held around the performance measures in the table within the paper. Particular attention was being paid to the DM01 position which was mentioned in a series of sub metrics. This was a key focus for the Trust which remained in the lowest performance range.

There were challenging targets in RTT and ambitious aspirations in terms of bed reductions linked to the UEC. These targets involved many moving parts. Regarding the Elective Recovery Fund (ERF), the plan was to calculate the required activity and income to deliver all constitutional standards, which could then be presented to the ICB. A concern was raised around the workforce plan to understand the commitment to ensuring that safe and effective patient care was not compromised. The mechanism for managing the workforce plan while maintaining quality was discussed. The development of schemes involved rapid improvement weeks with substantial support from divisions to encourage ideas around quality and performance improvements. Safety and quality were monitored closely, with any variations being scrutinised.

The reduction in agency spend was noted and a question was asked if the redundancy costs were included in the waste reduction plan. It was clarified that no redundancy costs had been factored into the plan yet, and the current management through natural turnover, redeployment and the vacancy freeze had helped with the cost reductions. The funding of any further headcount reductions had been raised both locally and with HM Treasury. It was expected that this would be an ongoing discussion.

Assurance was sought regarding cost reduction to understand the lens being applied, such as the use of technology or activities outside of contract. The response confirmed that any changes in service provision was subject to the equality, quality impact assessment process which would continue. A programme of work from One LSC was expected to provide information around automation and AI, although this was not expected to provide financial benefit for the current financial year.

The Board RESOLVED to ratify the assurance statements and approved the plans outlined in the 2025/26 Planning Submission.

62/25 Financial Planning 2025/26

The report provided an update on the latest 2025-26 draft financial plan for Lancashire Teaching Hospital Foundation Trust. It set out the expectations and assumptions reflected in the Trust's plan and highlighted ongoing work to finalise the plan. The paper reported a £5m plan deficit after assuming high risk mitigations could be delivered in year and included a waste reduction programme target (WRP) of £60m and deficit support funding of £30m. The plan reflected the latest expectation following the IAG meeting on the 25 March 2025. A discussion was held around the key highlights of the report.

It was highlighted that within the cost pressures were maternity staffing as part of the CNST Maternity Incentive Scheme to maintain the standard of care and the required investment for the national cleaning standards compliance. The planning around the business case for the required investment for the drainage issue had commenced.

At the end of the financial year, it was noted that there was a £20 million deficit in the EBITDA which was projected to increase. It was explained there were various elements to this which included the starting point of the new financial year taking the deficit into account. It was noted that some of the historic decisions that had been right at the time had to be reviewed to adapt to the change in planning issues.

The Board RESOLVED to:

1. **approve the draft revenue budget of a net deficit position of £5m, including a WRP target of £60m and deficit support funding of £30m.**
2. **approve the capital programme of £20.149m recognising the need to update post ICB confirmation of the Trust share from the Critical Infrastructure Risk (CIR) allocation.**

63/25 Corporate Objectives 2025/26

The report contained the proposed corporate objectives for 2025/26. The Trust five-year strategy was currently being updated following the announcement that the New Hospital Programme had been delayed. The draft strategy focused on 5Ps: Patients, Performance, People, Productivity and Partnership. The corporate objectives for 2025/26 had been aligned to these and would be set as personal objectives for members of the Executive team. This would then inform the objective setting in appraisals for the senior leadership team and would be cascaded throughout the organisation. The objectives had been aligned to the organisation's risks and ambition for the Year 2 delivery of the Single Improvement Plan.

It was anticipated that financial balance would be achieved within the year. The alignment of improvement resources and methods were focused on delivering against the quadruple aim, with a refreshed focus on finance. Close collaboration with the finance teams would be essential to calculate the benefits accurately.

A discussion was held around the 5Ps and a question asked why profitability had been excluded. The nature of the trust as a public benefit corporation was explained in that there was focus on the delivery of national priorities, particularly productivity, as determined ultimately by the Department for Health and Social Care. Rather than aiming to achieve profitability as an outcome in itself, the Trust was required to deliver financial sustainability as one of the triple aims of the NHS.

It was suggested that a cross-cutting objective on progress would help to identify the status of delivery. The annual staff appraisal process was explained and it was noted that the objectives were localised to their area of work. This annual process was overseen by the Workforce Committee.

The Board RESOLVED to approve the corporate objectives to be adopted for 2025/26.

64/25 Workforce Committee Chair's report

The Chair's report from the Workforce Committee provided an overview of items discussed at the meetings on 11 March 2025 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The main point highlighted focussed on the plans to respond to the staff sickness rate. There had also been discussions undertaken that recognised the unacceptable violence and aggression towards staff and how that could be supported.

65/25 Staff Survey Report

The report had been discussed at the Workforce Committee in March and detailed the national benchmark position. Sadly, the position for the Trust had deteriorated over the last 12 months after five years of improvement, with significant deterioration in areas that included staff engagement and morale and recommending the organisation as a place to work and receive care. Despite this, the Trust had retained a similar position to the national average in compassionate and inclusive approaches, recognition and reward and flexible working. The Trust remained above the national average for teamwork. The finalised corporate action plan was due to be presented in May, to address each element of the people promises. Enhanced organisational development interventions would be offered to the 50 lowest performing teams. The divisions would then develop their own people plans, alongside the corporate plan. For smaller teams with a response rate under 11, it was recommended that the team undertake an engagement and development tool known as the TED tool which enabled colleagues to have a voice at the front line.

Concerns around the staff survey were recognised and it was agreed that the work on staff engagement and improvement methodology would address the fundamental issues. The executive team would drive the staff engagement with the Deputy Chief Executive Officer leading the new way of working. Assurance was provided that this was reflected in the discussions held at the Workforce Committee.

66/25 Ethnicity Pay Gap Report

This was the first time an ethnicity pay gap report had been generated, in line with NHSE high impact actions. Although there was no obligation to publish the report, it was considered best practice and in the spirit of transparency. The report summarised that 70% of the workforce was white, with 28% from Black, Asian or Minority Ethnic (BME) backgrounds. It found that BME colleagues occupied 19% of the lowest paid roles and 28% of the highest paid roles. BME colleagues earned 13% more per hour than white colleagues. Given this information, no immediate action was required, but further analysis was suggested to explore potential disparities by profession and band. It was

agreed that further analysis would be progressed through the Workforce Committee later in the year.

The Board RESOLVED to approve the report for publication on the Trust Website.

67/25 Education, Training and Research Committee Chair's report

The Chair's report from the Education, Training and Research Committee provided an overview of items discussed at the meeting on 11 February 2025.

Colleagues noted detailed discussions about the review of core skills training, the quality assurance report from postgraduate medical education alongside updates on research and innovation. The Committee had acknowledged the strength of research across the organisation but focused on the need for the research department to achieve financial balance. Progress in core skills improvement was noted, though further improvement was needed. A discussion had been held about the potential impact of financial challenges within research on the Trust's aspiration to achieve University Hospital status. Funding cuts from the United Kingdom Research and Innovation (UKRI) were affecting projects, with an assumption that they would resume, albeit at a reduced scale. This had significant implications for the Trust's research capabilities. Efforts were being made to seek clarity on when funding would be reactivated, with updates expected next month.

68/25 Safety and Quality Committee Chair's report

The Chair's report from the Safety and Quality Committee provided an overview of items discussed at the meetings on 31 January and 28 February 2025 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

Key points discussed had included the backlog and maintenance costs of medical devices, with assurances given that a programme was in place to manage clinical risk and replacement times. The Board noted that the amount allocated for capital medical equipment had increased from £300,000 to £1.7 million.

Tier 2 medical cover for maternity had been ratified and resolved, removing it from the Board's concerns. The importance of cleaning and investment for the necessary areas had been emphasised. The introduction of Martha's Rule was discussed, and the Committee had agreed that this was known as "call for concern" which was embedded within the organisation. The importance of not only collecting data on calls but also seeking feedback from families and staff was highlighted. The Committee was assured that the uptake of Martha's Rule was manageable and that the system was working well.

69/25 Nurse Safe Staffing Review

The report provided detailed findings of the Lancashire Teaching Hospitals NHS Foundation Trust 2024/25 annual nursing and midwifery safe staffing review. A high level overview was presented that explained a triangulated view of data, performance metrics, workforce, people management, and experience.

Following the reviews, areas requiring additional oversight had been identified and addressed in line with the accountability framework. Monthly reports on safe staffing and

patient outcomes were in place, with an external review by NHS England confirming compliance with National Quality Board recommendations. Fill rates were mostly above 95%, with improvements noted in areas where alternative support staff were positioned.

There was a positive correlation between improved patient safety and quality metrics in areas with better recruitment and retention. Focus on leadership quality and execution continued throughout the year. The review had highlighted the need for increased attention on HCA vacancy rates and the pathway between Band 2 and Band 3, with progress made through apprenticeships. Enhanced therapeutic observation for patients requiring additional care was driving overspend, alongside sickness and both were areas of focus within the waste reduction programme.

The reduction in headroom contributed £445,000 to the organisation, with available staffing resources used to meet staffing needs, producing a further contribution of £599,000. The Chief Nursing Officer and Chief Medical Officer had confirmed satisfaction with the outcome.

The correlation between staff morale and relationships that led to better outcomes for patients was noted. A discussion was held around the regional nurse training and career development, noting a reduction in turnover for registered nurses. Ensuring colleagues had the ability and aptitude to function effectively from day one, helped them to feel safe within their practice.

70/25 Integrated Performance Report as of the end of February 2025

The integrated performance report as of the end of February 2025 provided an overview of key performance indicators.

(a) ***Operational Performance Summary*** – February saw continued pressure, with performance deteriorating compared to January and falling below target. The Trust was below the latest national average of 73.4% and ranked 14th best performing in the NW Region for Jan 25. Ambulance handover times had worsened, but there was a slight reduction in patients with a 12-hour length of stay or more. During February there were 54 beds consistently occupied by those ready to go home or to another setting. Significant data points over two months highlighted the need for close monitoring for the patients who did not meet the criteria to reside. Care connections aimed to prevent avoidable hospital attendances by providing care at home, improving emergency department flow. The programme, described as "days kept away from home," was based on learning from other organisations and involved partnerships with local authorities and community teams. This would help alleviate cost pressures and reduce the time people waited to be discharged home, along with associated harms.

On the planned care side, there had been an increase in patients waiting 52 weeks from referral to treatment, closely monitored due to winter pressures and sickness rates. The number of patients waiting 65 weeks and above remained small, with efforts to eliminate this entirely. January data showed the 62-day cancer performance slightly below the national average, but the faster diagnostic standard was above average. Significant work had been undertaken at specific tumour group levels to balance diagnostic performance. Pressures in urgent care, RTT, and cancer were aligned, with cancer performance remaining critical.

Diagnostic performance improved by 8% in February, reaching 57.7%, though still far from the national target of 95%. Challenges included national recruitment problems, capital expenditure, and increasing demand. Despite these challenges, this was the best diagnostic performance since July 2023. The journey from being in the lowest reported cohorts for cancer and RTT to improved performance was noted, with continued focus on pushing forward.

(b) ***Consistently Deliver Excellent Care*** – From a safety and quality perspective, it was noted that while staffing rates for registered nurses had reduced, they remained at 95% and above, reflecting some of the bed closures. The stable positions were maintained around pressure ulcers and complaints. Progress on CQC "must do" and "should do" actions was noted, with 94% of "should do" actions and 78% of "could do" actions completed. The Safety and Quality Committee received bi-annual reports on the CQC actions. The Board requested that these updates now be received on a quarterly basis.

The organisation was under trajectory for the Clostridium Difficile standard with 5 fewer cases than 2024. The STAR standards had progressively reduced over several months due to mandated fundamental standards, limiting teams' ability to achieve green unless these were met. Some areas showed improvement, but challenges remained in more difficult areas and recovery was expected within the next quarter. HSMSR mortality rates remained stable and maternity had achieved full compliance of the 10 CNST standards.

(c) ***Great Place to Work –*** Sickness remained high at 7.47%, with a very marginal reduction since January. Turnover remained stable, and vacancy rates were above target, which was anticipated due to actions supporting financial control measures. Violence and aggression incidents reduced to below 80 for the first time since April 2024. Core skills compliance remained above 90%. However, appraisal rates dropped to 89.6%, slightly below the compliance level. Further deterioration in staff engagement was reported in the national quarterly Pulse survey.

(d) ***Deliver Value for Money*** - The Trust had formally submitted its revised year end forecast of a £36.3m deficit. The ongoing challenges on the run rate around the variable pay were highlighted.

Assurance was sought around the programme of work to reduce the criteria to reside from 54. The plan was in development and included consolidating patients ready to go home on a small number of wards and targeting cultural change programmes. It was agreed that the Finance and Performance Committee would monitor the progress.

The Board noted that the outpatient, diagnostic and UEC improvement plans were part of the formal programme of works within the waste reduction programme. These plans included detailed actions with monthly targets and highlight reports. The Board agreed that future reports should avoid qualitative statements and focus on measurable targets.

A concern was raised regarding patients to understand how they maintained their levels of independence while waiting to move to a more appropriate place. It was explained that the "days kept away from home" programme aimed to prevent deconditioning and facilitate lower care support on discharge. By consolidating a small number of wards, upskilling could then be achieved and improvements maintained or evidenced. This included helping patients to the best possible level physically and in terms of self-

managing their medications. Additionally, there was an increase in therapy staff to support these initiatives, which should help achieve the targets and improve patient outcomes.

A discussion was held around the did not attend (DNA) rates which were a significant issue, heavily featured in the waste reduction programme for outpatients. It was advised that recently, the focus had been on changing and applying the access policy more effectively, supported by MIAA reviews. There was a need for further work on the digital infrastructure to address the drivers behind DNA rates. Efforts were being made to develop a patient engagement portal and text reminder processes in collaboration with the Lancashire and South Cumbria system. These initiatives aimed to improve productivity and contribute to the financial values of the waste reduction programme.

A concern was raised around the timescale to resolve the capacity issues in the psychological well-being service. It was noted that a business case was set for discussion at the next executive meeting, aiming to address the waiting list. If the business case was approved, recruitment was expected to begin within the next three months.

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

71/25 Finance and Performance Committee Chair's report

The Chair's report from the Finance and Performance Committee provided an overview of items discussed at the meetings on 28 January, 25 February and 25 March 2025 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

One of the key issues was understanding what was applied last year and what had changed this year. The main assurance was from the rigour around the improvement plans. It was crucial to mention that PwC was supporting the IAG processes. The Trust had also engaged a separate PwC team for support the necessary work.

72/25 Charitable Funds Committee Chair's Report

The Chair's report from the Charitable Funds Committee provided an overview of items discussed at the meeting on 28 March 2025 based on the 3As methodology (Alert, Advise, Assure) including, where appropriate, items recommended for approval by the Board.

The Charitable Funds Committee reported strong performance, with all areas exceeding expectations. Highlights included a 5-year-old's fundraising bike ride and positive grants awarded to the GI cancer database and complementary therapy for cancer care.

73/25 Appointment of Directors to LHS Ltd

Following the transition of outpatient contracts to LHS Ltd, the Board of the company would now be expanded to include directors from the three partner trusts. Under the Articles of Association for the company the appointment of directors was a reserved matter for the board of LTH.

The Board RESOLVED that the following be appointed as directors of LHS Ltd:

Uzair Patel, LTH (chair)
Arif Patel, ELHT
Dr Sarah Hauxwell, UHMB
Janet Barnsley, BTH

74/25 LTH Board: appointment to internal positions and membership of committees

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.

The Board was asked to consider and endorse the decisions of the Chair for the appointments to committees and other roles, noting that the appointment to the role of Senior Independent Director remained subject to consultation with Council at its meeting on 24 April 2025.

The Board RESOLVED to endorse the decisions of the Chair for the appointments of NED membership of committees and other roles.

75/25 Midwifery Safe Staffing Review

The Safety and Quality Committee had scrutinised and endorsed the first annual maternity staffing review of 2025. The report detailed workforce strategies and monitoring to ensure safe staffing, using the perinatal quality surveillance dashboard (PQSD) to triangulate workforce information, patient experience, and clinical effectiveness. It was explained that Birthrate Plus was used for independent assessment of midwifery and support worker staffing. The 2022 assessment advised an uplift in staffing, accepted by the Trust Board and implemented in phases. The first phase was included in the early 2024 budget, and the second phase, involving an uplift of 6.86 whole-time equivalent midwives, was anticipated this year. The next assessment was planned for later this year.

A review from NHS England in February provided positive feedback on partnership working, co-design of services with the Maternity Neonatal Voices Partnership, and service improvement. The service hosted the final event for the Race Health Observatory work, with positive feedback from the Chief Midwife for England. The service remained stable but continued to experience pressures due to high acuity, staffing vacancies, and sickness. Robust oversight and monitoring arrangements were in place.

The discussion focused on the approval of 6.86 whole-time equivalent registered midwives for extra capacity. Questions were raised about the source of the £400,000 funding, as there was no additional income associated with the maternity tariff, which was fixed irrespective of complexity. The increasing caesarean section rate was noted as a challenge. Investment that had been agreed was to reduce induction of labour delays, with a direct cause and effect observed. It was emphasised that spending on midwifery should be balanced by reductions elsewhere. The importance of prioritising staffing due to the clear link between maternity staffing and outcomes was highlighted. The national CNST costs were noted to be significantly higher due to historical maternity issues, making financial sense in the long run despite not being in the direct funding

envelope. The complexity of reducing the deficit while improving and scaling services was acknowledged as a significant challenge.

The Board RESOLVED to approve the safe staffing review and phase 2 of Birthrate plus investment as part of the 2024/25 financial plan.

76/25 Items for information

The following reports were received and noted for information:

(a) Data Quality Assurance Report
(b) Use of Common Seal
(c) Governor Election Report
(d) Cycle of Business 2025/6
(e) Use of Delegated Authority – Public Sector Decarbonisation Grant Funding

77/25 Date, time and venue of next meeting

The next meeting of the Board of Directors will be held on Tuesday, 3 June 2025 at 9.15am in Lecture Hall, Education Centre 3, Chorley and South Ribble Hospital.

The meeting closed at 12.35pm

5. MATTERS ARISING AND ACTION LOG UPDATE

Decision Item | M Thomas | 09.34am

REFERENCES

Only PDFs are attached

05.0 - Action log - Board (part I) - 3 April 25.pdf

Action log: Board of Directors (part I) – 3 April 2025

No Outstanding Actions

COMPLETED ACTIONS *(for information)*

№	Min. ref.	Meeting date	Action and narrative	Owner	Deadline	Update
1.	66/25	3 Apr 2025	***Ethnicity Pay Gap Report -*** further analysis was suggested to explore potential disparities by profession and band. It was agreed that further analysis would be progressed through the Workforce Committee later in the year.	CPO	3 Jun 2025	**Completed** **Update for 3 Jun 2025:** added to the Workforce Committee Cycle of Business
2.	70/25	3 Apr 2025	***Integrated Performance Report –*** ***a.*** Request that the Safety and Quality Committee continue to receive progress updates on the CQC action plan on a quarterly basis rather than bi-annual. ***b.*** It was agreed that the Finance and Performance Committee would monitor the progress on the programme of work to reduce the criteria to reside from 54.	CNO COO	3 Jun 2025 3 Jun 2025	**Completed** **Update for 3 Jun 2025** – **a.** Safety and Quality Committee cycle of business updated to include quarterly CQC updates. **b.** Finance and Performance have updates scheduled on the Cycle of Business.

6. CHAIR'S OPENING REMARKS AND REPORT

Information Item | M Thomas | 09.35am

REFERENCES

Only PDFs are attached

06.0 - Chairs Report - 03.06.25.pdf

Board of Directors Report

Chair's Report			
Report to:	Board Of Directors – Part 1	**Date:**	03.06.2025
Report of:	Chair	**Prepared by:**	Mike Thomas, Chair
Part I	√	**Part II**	

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Chair's Report

1. **Introduction**
   The purpose of this report is to provide an overview of the work and activities undertaken during April and May 2025.

2. The Trust continues to be extremely busy however I would like to take the opportunity to thank all our teams for the outstanding dedication and compassion they continue to show in delivering high-quality patient care. Every act of kindness, teamwork and clinical excellence makes a real difference to the lives of our patients and their families.

3. **NOF4**
   The trust continues to be fully engaged with the requirements of the Recovery Support Programme and the board thanks all colleagues for their commitment to tackling the financial deficit and their understanding that difficult decisions have to be made during this challenging period.

4. **External Visitors**
   St Laurence Chorley Wellness Hub
   I attended a special event at St Laurence's Church on the 23rd April to celebrate the Anniversary of the Emergency Food Parcel service and met with Father Neil Kelley and colleagues to see the services provided at the Wellness Hub, which include Food bank, debt support and mindfulness activies for the local community.

5. **Chair's Update – Summary of Key Items from Private Board (3 April 2025)**
   - **Waste Reduction Programme (WRP)**

     The Trust had submitted schemes to the IAG with work continuing to deliver against these by the end of Q1. A rolling programme with quarterly targets was agreed, with NHSE and PwC providing oversight. A workforce review process was submitted, with EQIA processes in place. Strategic alignment with system priorities, including frailty and community services, remained under discussion.

   - **Service Alignment**

     The Board received an update on aligning services with future commissioning intentions, with further detail to follow in the April workshop.

   - **MRI Business Cases**

     Two MRI-related business cases were approved by the Chair under delegated authority in March, following review by the Planning Advisory Group and Trust Management Board. These were ratified by the Board.

   - **Microsoft Licensing**

     The Board approved the renewal of Microsoft licensing for July 2025–June 2026. Work continued to reduce enterprise app usage and transition to web-based tools, with clinical compatibility under review.

6. Chair's attendance at meetings

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

Date	Activity
April 2025	
1st	Chairs, Deputy Chair & Lead Governor Meeting
2nd	Managing Director, One LSC
2nd	Greater Manchester Chairs meeting
3rd	Board Meeting
4th	Sir L Hoyle, MP and Chief Executive
7th	Trust Chairs Meeting – Greater Manchester & East Cheshire
8th	NW System Leaders
8th	1:1 Director of Corporate Affairs
9th	Chief Executive Appraisal
9th	NHW Trustees
9th	1:1 Director of Communications & Engagement
10th	Provider Chairs Meeting
10th	Provider Collaboration Board
11th	1:1 Non-Executive Director
15th	Media Interview
15th	1:1 NWAS Chair
15th	Non-Executive Monthly Meeting
16th	1:1 Deputy Chief Executive
16th	1:1 PWC Update
16th	1:1 Non-Executive Directors
17th	1:1 Turnaround Director

17th	1:1 Lead Governor
17th	Joint Board and Governor Development Session
18th	1:1 meetings with Non-Executive Directors
23rd	Leadership Academy, University of Central Lancashire
23rd	Visit to Wellness Hub 2nd Anniversary Event
24th	Appointments, Remuneration and Terms of Employment Committee (ARTE)
29th	Introduction – Interim Director of Finance
29th	1:1 Chief Executive
29th	1:1 Non-Executive Director
May 2025	
1st	LTH Improvement & Assurance Group (IAG)
6th	1:1 Non-Executive Director
6th	Board Workshop
7th	1:1 Chief Executive
8th	1:1 Non-Executive Director
8th	Provider Collaboration Board
13th	Provider Chairs Discussion
13th	1:1 Non-Executive Director
15th	1:1 Managing Director, Provider Collaborative
15th	Council of Governors Training Session
16th	RSP Board Entry Pre-meet
20th	1:1 Non-Executive Director
20th	1:1 Lead Governor
20th	Non-Executive Director Monthly Meeting
20th	1:1 RSP Entry Discussion

20th	1:1 Non-Executive Director
21st	Chairs and Chief Executive's meeting
21st	LSC System RSP Board to Board Entry Meeting
22nd	1:1 Managing Director, One LSC
22nd	1:1 Non-Executive Director
22nd	1:1 Lead CEO, Provider Collaborative

7. Financial implications

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

8. Legal implications

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

9. Risks

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

10. Impact on stakeholders

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

11. Recommendations

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

7. CHIEF EXECUTIVE'S REPORT

Information Item | S Nicholls | 09.40am

REFERENCES

Only PDFs are attached

07.0 - CEO Board report - Board of Directors -May 2025.pdf

Excellent care with compassion

NHS Lancashire Teaching Hospitals NHS Foundation Trust

Board of Directors

Chief Executive's Report

Report to:	Board of Directors	**Date:**	3 June 2025
Report of:	Chief Executive	**Prepared by:**	N Duggan
Part I	✓	**Part II**	

Purpose of Report

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

Executive Summary:

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

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

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Not applicable

1. CHIEF EXECUTIVE'S REPORT

Government statement on NHS Pay Award for 2025/26

On 22nd May, the Secretary of State for Health and Social Care accepted the independent Pay Review Bodies' headline pay recommendations for NHS staff.

The specific details of what the pay award means for different colleague groups can be found using the following links

- Agenda for change staff: https://www.gov.uk/government/publications/nhs-pay-awards-2025-to-2026-agenda-for-change-staff
- Resident doctors: https://www.gov.uk/government/publications/nhs-pay-awards-2025-to-2026-resident-doctors
- Other doctors and dentists: https://www.gov.uk/government/publications/nhs-pay-awards-2025-to-2026-doctors-and-dentists

Work to update ESR will now begin to reflect the announcement.

NHS delivered over 100,000 more treatments for patients in March, despite rise in demand

The NHS delivered over 100,000 more treatments in March compared to the same month last year, with a quarter of a million fewer waiting longer than 18 weeks for care.

New data published in May also showed that NHS staff have carried out over 1.5 million treatments in just one month, and 3.6 million additional appointments since July 2024.

Despite increased demand, the NHS is continuing to make progress in reducing the number of waits over 18, 52 and 65 weeks respectively. The growth, which is attributed to the Elective care reform plan, is in addition to almost 1.8 million new referrals to the waiting list in March – an increase of 124,000 compared to the same month last year – showing that despite greater demand typical of this time of year, the NHS is delivering activity at a greater rate than last year.

As set out in the Plan for Change, the NHS and the government have set out ambitious measures to return to the 92% 18-week standard by March 2029, with this latest data showing 59.8% waiting less than 18 weeks – the highest proportion since August 2022. Despite the overall backlog growing by 18,751 to 7.42 million, staff delivered over 4.5 million treatments in the first 3 months of 2025.

British Medical Association to ballot resident doctors

On Tuesday 27th May the BMA began balloting its resident doctors which, if returned with a "yes" vote, would provide a mandate for industrial action lasting from July 2025 to January 2026. Resident doctors have previously taken part in 11 strikes between 2023 – 2024.

A trade union ballot requires a turnout of 50% of those eligible to vote in order to be considered to have support for industrial action. A vote for action results in a mandate that lasts for six months. The ballot will close on 7 July.

Tim Kibasi appointed NHS England director of strategy

NHS England has confirmed the appointment Tim Kibasi as its new Executive Director of Strategy.

Mr Kibasi has been an adviser in the Department of Health and Social Care (DHSC) since February, with a key role in writing the 10-year health plan. His career spans the private, public and not-for-profit sectors and until recently a career in biotechnology.

To take up the position, Mr Kibasi leaves his role as the Chair of Central and North West London NHS Foundation Trust (CNWL), Central London Community Healthcare NHS Trust (CLCH) and West London NHS Trust (WLT).

Update on Financial Plans and Service Developments

As outlined at previous Board meetings, we have been targeting savings of £60 million within this financial year. At the last Board meeting, we had identified around half of that amount, and thanks to focused work from many teams across the organisation we are now at £47 million identified savings – albeit with varying levels of risk – which represents significant progress. The full year effect of these schemes would represent a recurrent value of £65.6m.

Of course, identifying a plan and delivering it are two different things. Now that we have the planning phase well established, our focus is shifting firmly towards delivery.

We have been very clear that we would need to make some difficult decisions to get our finances back on track, which means that we simply cannot continue to fund services that we are not paid to provide.

One such unfunded service is the inter-site shuttle bus service between Royal Preston Hospital (RPH) and Chorley and South Ribble Hospital (CDH) which costs around £200,000 to operate. The service was put in place for a very particular set of circumstances relating to contractual changes of work base and was the right thing to do at the time. It was also there to act as an option for colleagues who require transport for their day-to-day activity.

Audits found that usage was largely limited, although the decision was not reached lightly or without significant consideration about the impact on colleagues and the small numbers of members of the public who were able to use the service for a modest fee during off-peak hours. Other options, including the service provider charging passengers, reducing the service or running the service ourselves, were considered but the route wasn't considered profitable by the operator, possibly because there is already a regular public bus service in place along this route. The service ceased to operate on 31 May 2025.

There are several important service developments coming up this year that will further strengthen the Trusts role as a prominent tertiary service provider.

- **Vascular Services**

  Discussions have been taking place over many years about how we can collaborate more closely to transform clinical services for our patients.

  Teams from Lancashire Teaching Hospitals (LTH) and East Lancashire Hospitals NHS Trust (ELHT) have developed a detailed business case proposing a unified vascular service and arterial centre, with LTH as the lead provider. This was endorsed by the Provider Collaborative Board on 10 April and shortly afterwards by the Vascular Board.

  In mid-April we wrote to colleagues to inform them that under the proposal, inpatient and emergency vascular care for Lancashire and South Cumbria would be centralised at the LTH site (which already serves patients from all the other provider Trusts, with the exception of ELHT). A single clinical team will work collaboratively, delivering outpatient and daycase services across Lancashire, South Cumbria and Wigan sites.

  This model will enable us to provide an affordable and sustainable specialist network, focusing our expertise in a single centre of excellence for Lancashire and South Cumbria whilst ensuring that everything that can be done locally remains at each individual Trust for the convenience of patients.

  Engagement with patient groups has been undertaken over the last 18 months and there is strong support for this network approach.

Additional bed and theatre capacity at the LTH site has already been identified and a detailed implementation plan is being developed, with the intention to deliver this at pace.

Plans are subject to appropriate engagement with colleagues and the formalities of a strict due diligence process, as well as agreement from Trust Boards and NHS England. We are in discussions with the Lancashire Overview and Scrutiny Committee about appropriate ongoing public engagement and will also be discussing this with the Clinical Senate.

- **Single Pathology Service**

  In November 2024, the decision to move forward towards establishing a single, unified Pathology service across Lancashire and South Cumbria was endorsed by both the Provider Collaborative and the Integrated Care Boards.

  Since then, significant progress has been made in several key areas, including the deployment of a Laboratory Information Management System (LIMS), advancements in digital pathology, and the procurement of pan-pathology equipment.

  On 6th May, we wrote to Pathology colleagues across the system to inform them that following an application process, LTH has now been confirmed as the host Trust.

  In partnership with all Trusts across the network, we will take on responsibility for the delivery of pathology services. To facilitate this transition, we will be following the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) process, with the aim of forming a single team providing a unified service by Autumn 2025.

  Throughout this period, we remain committed to engaging with staff and key stakeholders, including staff side representatives and have established a series of roadshows which have, to date, been well attended.

We are also reviewing several other services, including Stroke services, Head and Neck services and Neurology services. Our focus is on identifying the most clinically sustainable models for delivering these services.

Changes to the Executive team

Dr Gerry Skailes will be retiring from the Trust this autumn after a remarkable 27 years at Lancashire Teaching Hospitals, seven of which have been in her current role as Chief Medical Officer. Gerry is much-loved at the Trust, and a respected leader across the wider health and care system. I will miss her calm pragmatism, organisational knowledge and experience. She has continued to see oncology patients throughout her time as CMO and has remained very much in touch with what matters to the people we serve. She has been a great advocate for ensuring that the needs of patients remain at the heart of our decision making - something that remains so important given the financial challenges we are facing across the NHS.

While Gerry will be taking a well-earned retirement, our Chief Nursing Officer, Sarah Morrison has been fulfilling the role of interim Deputy Chief Executive for some time now. I've really enjoyed working with Sarah in the role - she provides a very important clinical voice into our decision-making so I am very pleased she has agreed to carry out the role on a substantive basis.

I extend a warm welcome to Craig Carter, who joined us on 1 May 2025 as Acting Chief Finance Officer. Craig has an excellent reputation and has been released on secondment from his current role as Interim Chief Financial Officer at the Northern Care Alliance NHS Trust, to work with us as we face another challenging year in 2025/26.

Last but not least, Chief People Officer Neil Pease is to take on the CPO role at ELHT alongside his role with us. This will be on a six-month pilot basis with the aim of sharing learning – and management costs - across both Trusts.

New members of Council of Governors welcomed to the Trust

I was delighted to be able to welcome the new members of the Trust's Council of Governors in March – some of whom attended our Public Board in April.

I recently attended Council to address their questions and reflect on the vital role governors undertake in acting as a voice for our community. We then embarked on a tour of the hospital's facilities alongside Deputy Chief Nursing Officer, Catherine Gregory.

The governors come from a wide range of backgrounds and experience and are all excited at the challenge and opportunity becoming a governor presents.

The report of voting in the Governor Election has been published on the Trust website, with full details of the governors elected here.

Non-Emergency Patient Transport Services update

During April, we wrote to colleagues to inform them that from 1st May the Trust no longer holds contracts for private non-emergency Patient Transport Services (PTS).

NHS Lancashire and South Cumbria Integrated Care Board (ICB) commission a long established patient transport service from North West Ambulance Service (NWAS) and the Trust continues to use this on a daily basis.

Traditionally, the Trust had also picked up the cost of providing additional private services, however, as this is not funded, the contracts were not renewed when they ran out at the end of April.

With any change like this it takes a little while for the new processes to become embedded, and the ICB have stepped in to arrange additional transport on a case-by-case basis as appropriate.

National, Regional and Local Recognition

- **Trust mark significant milestone after performing 1,000th robotic-assisted prostatectomy**

The Trust celebrated a major milestone in April, completing the 1,000th prostatectomy using the cutting-edge da Vinci Xi robotic-assisted system at Chorley and South Ribble Hospital. Back in May 2017, we were the first hospital in the North of England - and only the third in the UK - to receive the da Vinci Xi surgical system, thanks to the hard work and enterprise of a few consultants, the vision of the Trust's Executive team, and the Rosemere Cancer Foundation, which contributed £1.25 million to the project.

In 2020, a second da Vinci Xi robotic system was installed in the Chorley Elective Surgical Hub, and that year the team surpassed 1,000 robotic-assisted cases, with landmark procedures including the first robotic-assisted upper gastrointestinal robotic tract surgery in the North West. Robotic-assisted surgery with the da Vinci system has significantly improved outcomes for patients, enabling surgeons to perform highly complex procedures with greater precision, faster recovery times, and enhanced long-term results.

James Goggin of Preston was the 1,000th patient to undergo a robotic-assisted prostatectomy at the Trust, and was very complimentary about the procedure, performed by Consultant Michal Smolski. James and Michal, as well as our surgical practitioner Pradip Javle who performed the first robotic prostatectomy at LTH, spoke to BBC Radio Lancashire's Graham Liver about the achievement, which you can listen to from 08:12:28 - 08:18:18 here.

You can read the full piece on the Trust website.

- **Celebrating our Midwives, Nurses and ODPs**

In May we celebrated our fabulous Midwives, Nurses and Operating Department Practitioners (ODPs). May 5 was International Day of the Midwife, which has been celebrated annually since 1992, to help raise awareness about the profession. Some of our Trust midwives took to social media (watch) to talk about the privileges that they personally experience delivering bundles of joy across the region, as we marked the enormous contribution midwives make.

May 12 was International Nurses Day, marked every year on Florence Nightingale's birthday - an opportunity to celebrate the incredible work that our nurses do every day in our communities, and thank them for their unwavering commitment to patient care and the difference they make to people's lives every day. Again, on social media, some of our nurses speak about their journeys and what they love about their roles.

And May 14 was National ODP Day, celebrating the 80th anniversary of the profession. Some of our ODPs explain their varied roles and what they love about what they do, raising awareness of their profession, and recognising the commitment and contribution ODPs make within healthcare.

- **Latest round of Gold STAR awards are handed out in March / May**

Over the last few months, 15 thoroughly-deserved Gold STAR awards were handed out by the Trust at special celebration events.

In late March, it was the turn of Ward 23, Coronary Care RPH, Neurophysiology, Cardiorespiratory RPH, Ward 21 and the Central Lancashire Breast Unit CDH to receive their awards, before a second event saw Rookwood B (CDH), Lancashire Eye Centre OP (CDH), Ward 11, Ward 12, Ribblesdale and Ward 2b mark their success.

Then towards the end of May, there was an emotional Gold STAR Award presentation at the Finney House Community Healthcare Hub, with the 'step-down' Buttercup Unit and Meadow Unit rehab facility both achieving their gold STAR standard. Both wards are currently in the process of being stepped down due to the closure of Finney House.

The Acute Frailty Unit at Royal Preston Hospital, located next to the Emergency Department, also celebrated their journey to gold.

The STAR quality assurance framework, incorporating STAR monthly reviews and STAR accreditation visits, began in 2017, and there are currently 122 clinical areas included within STAR.

The Trust has achieved and exceeded our big plan ambition of 75% silver and above, with 85% of areas currently rated silver and above.

Congratulations to all our Gold STAR award winners and special thanks to all those who worked at our Community Health Hub for the high quality service that they have provided to so many patients and for their professionalism during the closure of this facility.

- **Deputy Lieutenant of Lancashire thanks Trust staff after life-altering fall**

It was a pleasure to welcome a VIP visitor in Charles Hadcock, Deputy Lieutenant of Lancashire, who returned to Ward 16 at Royal Preston Hospital to show his appreciation for the care he received after experiencing a life-altering fall. During his visit, he also met the Trust chaplaincy team and Professor Mike Thomas, Chair of the Trust.

The Deputy Lieutenant was rushed to Royal Preston Hospital in October 2024, after breaking his tibia, fibula and ankle, where he spent 18 days on the trauma ward. His injuries required complex surgery, lasting four and a half hours and resulting in extensive metalwork in his leg, and while his recovery has been slow, he continues to make progress under the expert guidance of hospital staff.

As if the ordeal with his leg wasn't challenging enough, he later required another procedure, having his gallbladder removed at Chorley and South Ribble District Hospital in January.

While his injury has been described as life-changing, possibly requiring him to walk with a stick or crutches, his connection with the Specialist Mobility and Rehabilitation Centre (SMRC) run by the Trust has been an ongoing part of his life, having been a patient there since moving to Lancashire 25 years ago. Read the full story on our website.

- **Trust well-represented at Preston Health Mela**

The Trust was well represented at the National Forum for Health and Wellbeing's 24th annual Health Mela at the University of Central Lancashire's (UCLan) Foster Building in Preston in April.

The Health Mela had approximately 60 health related stalls from the NHS, voluntary and charitable organisations – including the LTH Research Team, LTH Neuroscience Research Team, Immunology, Smokefree team, LTH Governors (pictured – Janet Miller) and the Macmillan Cancer Information Centre.

Blood tests were carried out by members of the Blood Drop team from the Trust, under the leadership of Dr Martin Myers, Bank Biomedical Scientist Shahid Kaleem and Penny Hemingway. Professor Satyan Rajbhandari, Consultant Physician, led the entire team.

Emmy Walmsley, senior engagement lead from Healthwatch Lancashire, and Denise Wilkinson, chair of Visual Impairment (VI) Forum, were also present.

Nearly 1,700 visitors took advantage of the information, advice and opportunity to seek further information so that they could take control of their health.

- **Professor Birtle hosts Bladder Cancer Clinic on Breakfast on BBC Radio Lancashire**

Professor Alison Birtle, consultant oncologist with the Trust, hosted an on-air clinic for Bladder Cancer Awareness Month on Breakfast on BBC Radio Lancashire on 21 May, which you can hear here from 2:11:15 to 2:30:25. Professor Birtle is a regular guest on the show, and joined Graham, along with Urology Specialist Nurse Stephanie Yates Dougherty, Uro-Oncology CNS, to help raise awareness, on the back of a successful live prostate cancer clinic on the show back in January.

Around 10,000 people are diagnosed with bladder cancer each year in the UK, and it is more prevalent with those aged between 50 and 70 with most new cases being diagnosed in people aged 60 and above.

- **Listen To What Your Body Is Telling You**

Nick Wood, Consultant Gynaecological Oncologist with the Trust, was interviewed by ITV Granada Reports in April for North West Cancer Research's latest campaign 'Listen to What Your Body Is Telling You'. The campaign highlights the most common symptoms of ovarian cancer, urging people to take notice and consult their doctor.

In the North West, ovarian cancer incidence rates are 17% higher than the national average, according to the latest data. Across the region, Cumbria's rates are 41% higher than the national benchmark, while Merseyside is 26%; Lancashire is 23%; Cheshire's 19%; and Greater Manchester is 10% above the average.

You can watch the item here.

- **Trust's Centre for Health Research and Innovation hosts Windrush CEO and founder**

It was an honour for our Centre for Health Research and Innovation to host 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. In late 2024, we visited the local Windrush Initiatives Team in Preston, where we introduced our Research and Innovation Department.

In this latest, follow-up meeting, there was a productive, open, and engaging conversation with the team, which brought up several concerns and barriers that might stop people from participating in research, and it was agreed to meet with Adrian and his team again to work on addressing these issues.

- **Terry paves the way for Radiography Apprenticeships at the Trust**

Congratulations to Terry Laing, who is the first person from the Trust to complete a pioneering degree apprenticeship scheme in partnership with Sheffield Hallam University for aspiring therapeutic radiographers.

Terry initially studied as a distance learner with Sheffield Hallam and earned an assistant practitioner post with the Trust before gaining valuable experience with Macmillan. When his secondment ended, the apprenticeship provided the perfect chance to complete his degree while continuing to earn a salary.

Thanks to his previous experience, Terry entered as a second-year apprentice rather than starting from scratch, one of seven students in his cohort. Unlike traditional university routes, apprentices spend more time working directly with patients and staff, gaining practical experience with the latest radiotherapy techniques.

He also used the programme as a platform to improve services, with a research project focused on bladder cancer treatment identifying a gap in provision at the Trust. A carbogen nicotinamide treatment recommended by NICE was not available, but with backing from the education team, oncologists, and advanced radiographers, he led a cost analysis and secured funding from the Rosemere Cancer Foundation to bring the treatment to patients. Read the full story on our website.

- **Theatre Practitioner Sharon's passion for making hockey more accessible**

The enthusiasm of Sharon Bolton is clear to see for all who meet her. By day, she is a skilled and dedicated Theatre Practitioner at the Trust, serving as Team Leader in Gynaecology Theatres. By night and at weekends, she's an award-winning hockey coach, nurturing the next generation of talent across Lancashire.

Sharon has worked in the Trust since 2006, with her current role seeing her support colorectal, gynae-oncology and obstetric surgeries in the Sharoe Green Unit. Off shift, you can find her on the hockey pitch – coaching, mentoring, and inspiring young athletes across the county.

In 2023, she received a Highly Commended Coach of the Year award at the Active Lancashire Awards, presented by former England goalkeeper Rachel Brown-Finnis at Ewood Park, on the back of eight years as Head Junior Coach at Preston Hockey Club, where she dedicated countless volunteer hours to creating opportunities for children from all backgrounds to get involved in hockey. Then, in September last year, she stepped back from that role to become Lancashire Girls' County Head Coach and Administrator, where one of her proudest achievements was devising and launching the Red Rose Raiders Programme – a pioneering initiative aimed at supporting talented young athletes who narrowly missed out on county selection. Read the full story on our website.

- **A record night for Rosemere Cancer Foundation's Walk in the Dark**

A big thank you to our local communities who came together in April to take part in the annual Walk in the Dark event which has so far raised an incredible £55,000 for the Rosemere Cancer Foundation.

Well in excess of 500 adults, children and dogs – the highest ever number in the event's 17-year history - set out from Chorley and South Ribble Hospital to the beat of Preston's Worldwise Samba Drummers Band to follow the A6 for just over 11 miles to the Royal Preston Hospital, where they were greeted with medals and a well-earned jacket potato supper!

Dan Hill, chief officer of Rosemere Cancer Foundation and head of charities for the Trust said: "We can't thank all our walkers, marshals and sponsors enough for making this year's Walk in the Dark the best ever."

2. RECOMMENDATIONS

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

8. BOARD ASSURANCE FRAMEWORK

Other | S Regan | 09.50am

for Assurance

REFERENCES

Only PDFs are attached

08.0 - BAF Risk Paper - June 2025 - Final.pdf

Board of Directors Report

Board Assurance Framework (BAF) Risk Report							
Report to:	Board of Directors			**Date:**	3 June 2025		
Report of:	Associate Director of Risk & Assurance			**Prepared by:**	K Clay		
Part I	✓			**Part II**			
Purpose of Report							
For assurance	☐	**For decision**	☒		**For information**		☐

Executive Summary:

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

This paper provides the Board of Directors with an update on the historic strategic risks that may compromise the achievement of the Trust's high level strategic objectives that were in place prior to December 2024, along with updates in relation to Principal Risks under the revised Board Assurance Framework following implementation in December 2024. The paper also includes an update on 2025/26 following the approval of new Corporate Objectives and a review of the Risk Appetite, Tolerances and the Risk Appetite Statement.

Principal Risks

The BAF in Appendix 1 identifies the Principal Risks that threaten the delivery of the corporate objectives. Due to scheduling of committees, the Principal Risks detailed in Appendix 1 are those that have been presented to Committees of the Board, or reviewed in preparation for the next Committee at the time of writing this paper. Updates since the last Board of Directors meeting:

- The current score for Principal Risk 2 (PR2) related to 'Higher than trajectory rates of clostridioides difficile (*C.Difficile*) Infection' was reviewed and the score decreased from 20 to 16 in May 2025 in light of improvements made in 2024/25 resulting in the Trust's final number of cases for the year being below the trajectory by 7.
- The target score for Principal Risk 4 (timely access to planned and cancer care) has been amended from 3 to 4 following review with the Chief Operating Officer.
- The BAF has been refreshed to include the 2025/26 Strategic & Corporate Objectives.
- Target Control dates have been added following feedback from the Board to outline planned timescales for when improvements may be seen in the Principal Risk.
- Assurances are now categorised by Level 1, 2 and 3 following recommendations from Mersey Internal Audit Agency (MIAA).

Review of Corporate Objectives for 2025/26

The Corporate Objectives for 2025/26 were approved by the Board of Directors in April 2025. The Principal Risks have been reviewed alongside the updated corporate objectives, and any potential new risks or revisions to the

Board Assurance Framework were discussed at a Board Workshop on 6 May 2025. The following proposals were made:

- Principal Risk 7 (Experience of under-represented staff groups) to include wider staff experience and a focus on improved advocacy scores.
- Principal Risk 11 (failure to meet the financial plan 2024/25) to be reworded to reflect the new financial year as the risk to delivery of the 2025/26 Corporate Objective remains.
- Principal Risk 12 (Cash consequences of the Trust's underlying financial position) to potentially be stood down from the "Principal Risk" status, however the new Chief Finance Officer wishes to retain this risk as a Principal Risk until NHS England's intentions regarding cash are clarified as there may be changes announced relating to cash support.
- Principal Risk 13 (Ability to access required Capital), to be updated to reflect the ageing estate.
- Principal Risk 16 (Strategy), to be updated to reflect the reconfiguration of services in line with 2025/26 new Corporate Objectives.
- A new Principal Risk to be developed in relation to Timely access to diagnostic investigations. The proposed risk is linked to 'Corporate Objective 8 - To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory'.

The proposed changes are included in Appendix 1 with the exception of the changes to Principal Risk 7 as the timing of the Workforce Committee and the Board Workshop meant that this was not possible, this will be updated in advance of the next Workforce Committee meeting and Board in August 2025. In addition, the proposed new Principal Risk is included in draft at Appendix 3. Following Board consideration of the proposals, the numbering of the Principal Risks will be refreshed and updated to reflect the 2025/26 financial year.

Historic Strategic Risks

Following the transition to the new Board Assurance Framework in December 2024, it was agreed that the actions from the previous strategic risks would be monitored until their conclusion. Appendix 2 provides an update on the only remaining action that was being monitored against the historic Strategic Risk 'to drive innovation through world class Education, Training and Research'. The action remains outstanding. However, this action can be monitored within Principal Risk 15 (Research capacity and capability to enable progress towards University Hospital status) and as such, this has been transferred over.

There are no further actions to monitor from historic strategic risks and this update will no longer be provided to the Board of Directors in future meetings.

Operational High Risks for Escalation/De-escalation

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

Review of Risk Appetite and Tolerance for 2025/26

The Risk Appetite and Tolerances were set by the Board of Directors in December 2024 following implementation of the revised Board Assurance Framework (BAF). A review of this is undertaken at least annually, and there was a planned review of this in a Board Workshop on 6 May 2025. Changes were proposed in relation to the Risk Appetite for the 'Productivity' Strategic Objective to be changed from 'Open' to 'Cautious' recognising the changes in the financial operating framework, regulator interventions and the Trust's current objectives relating to this area.

It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.
ii. Note and approve the updates to the action plan for the historic Strategic Risks

iii. Note and approve the newly identified Principal Risk relating to Timely Access to Diagnostics for oversight at Finance & Performance Committee.
iv. Note and approve the Risk Appetite, Risk Tolerance and Revised Risk Appetite Statement.

Appendix 1 – Board Assurance Framework
Appendix 2 – Action Plan against Historic Strategic Risks
Appendix 3 – Draft new Principal Risk relating to timely access to diagnostic investigations.
Appendix 4 – Risk Appetite scale and matrix
Appendix 5 – Comparison of the Trust's current and proposed Risk Appetite and rationale
Appendix 6 – Comparison of the Trust's current and proposed Risk Tolerance and rationale

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Committees of the Board in line with cycles of business

1. Background

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

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

1.3 The paper also includes an update on 2025/26 following the approval of new Corporate Objectives and a review of the Risk Appetite, Tolerances and the Risk Appetite Statement.

2. Current Board Assurance Framework

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

2.2 It should be noted due to scheduling of Committees, the Principal Risks detailed in Appendix 1 are those that have been presented to Committees of the Board or reviewed in preparation for the next Committee at the time of writing this paper. Updates since the last Board of Directors meeting include:

- The current score for Principal Risk 2 (PR2) related to 'Higher than trajectory rates of clostridioides difficile (C.*Difficile*) Infection' was reviewed and the score decreased from 20 to 16 in May 2025 in light of improvements made in 2024/25 resulting in the Trust's final number of cases for the year being below the trajectory by 7.
- The target score for Principal Risk 4 (timely access to planned and cancer care) has been amended from 3 to 4 following review with the Chief Operating Officer.
- Target Control dates have been added following feedback from the Board to outline planned timescales for when improvements may be seen in the Principal Risk.
- Assurances are now categorised by Level 1, 2 and 3 following recommendations from Mersey Internal Audit Agency (MIAA).

3. Review of Corporate Objectives for 2025/26

3.1 The Corporate Objectives for 2025/26 were approved by the Board of Directors in April 2025. The Principal Risks have been reviewed alongside the updated corporate objectives, and any potential new risks or revisions to the Board Assurance Framework were discussed at a Board Workshop on 6 May 2025. The following proposals were made:

- Principal Risk 7 (Experience of under-represented staff groups) to include wider staff experience and a focus on improved advocacy scores.
- Principal Risk 11 (failure to meet the financial plan 2024/25) to be reworded to reflect the new financial year as the risk to delivery of the 2025/26 Corporate Objective remains.
- Principal Risk 12 (Cash consequences of the Trust's underlying financial position) to potentially be stood down from the "Principal Risk" status, however the new Chief Finance Officer wishes to retain this risk as a Principal Risk until NHS England's intentions regarding cash are clarified as there may be changes announced relating to cash support.
- Principal Risk 13 (Ability to access required Capital), to be updated to reflect the ageing estate.

- Principal Risk 16 (Strategy), to be updated to reflect the reconfiguration of services in line with 2025/26 new Corporate Objectives.
- A new Principal Risk to be developed in relation to Timely access to diagnostic investigations. The proposed risk is linked to 'Corporate Objective 8 - To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory'.

3.2 The proposed changes are included in Appendix 1 with the exception of the changes to Principal Risk 7 as the timing of the Workforce Committee and the Board Workshop meant that this was not possible, this will be updated in advance of the next Workforce Committee meeting and Board in August 2025.

3.3 A draft of the new Principal Risk has been developed for approval to be added to the Principal Risks for oversight at Finance & Performance Committee (Timely access to diagnostic investigations). The content of the draft Principal Risk is included at Appendix 3 for review and approval.

3.4 Following Board consideration of the proposals, the numbering of the Principal Risks will be refreshed and updated to reflect the 2025/26 financial year.

4. Ongoing Action Plans against Historic Strategic Risks

4.1 Following the transition to the new Board Assurance Framework in December 2024, it was agreed that the actions from the previous strategic risks would be monitored until their conclusion.

4.2 Appendix 2 provides an update on the only remaining action that was being monitored against the historic Strategic Risk 'to drive innovation through world class Education, Training and Research'. The action remains outstanding. However, this action can be monitored within Principal Risk 15 (Research capacity and capability to enable progress towards University Hospital status) and as such, this has been transferred over.

4.3 There are no further actions to monitor from historic strategic risks and this update will no longer be provided to the Board of Directors in future meetings.

5. Operational High Risks for Escalation/De-escalation

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

6. Review of Risk Appetite and Tolerance for 2025/26

6.1 The Risk Appetite and Tolerances were set by the Board of Directors in December 2024 following implementation of the revised Board Assurance Framework (BAF). A review of this is undertaken at least annually, and there was a planned review of this in a Board Workshop on 6 May 2025. A copy of the Risk Appetite scale and matrix used is included at Appendix 4.

6.2 Changes were proposed in relation to the Risk Appetite for the 'Productivity' Strategic Objective to be changed from 'Open' to 'Cautious' recognising the changes in the financial operating framework, regulator interventions and the Trust's current objectives relating to this area.

6.3 A detailed comparison of the Trust's current Risk Appetite and rationale, and the proposed Risk Tolerance and rationale are included at Appendix 5 and 6 respectively.

6.4 The proposed Risk Appetite and Tolerances aligned to the Strategic Objectives, identified as the '5 Ps' with rationale are shown in Table 1 and Table 2 for consideration of adoption by the Board of Directors.

Table 1 – Summarises the Trust's Strategic Objectives and their proposed risk appetite

Strategic Objectives (the 5 Ps)	**Risk Appetite**	**Rationale**
Patients Deliver excellent care	Cautious	Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. The Trust recognises that there may be an adverse impact on other Strategic Objectives but we prefer safe delivery options for patients with a low degree of residual risk, and we aim to work to regulatory standards.
Performance Deliver timely, effective care		
People To be a great place to work	Open	We are willing to accept some risk where there is a potential to improve recruitment, retention and employees' personal development.
Productivity Deliver value for money	Cautious	We are committed to working within our statutory financial duties and will accept risks that may result in limited financial impacts or losses on the basis that there are clear and justifiable opportunities to enhance patient care and outcomes.
Partnership To be fit for the future	Seek	We are willing to consider all possible solutions to providing sustainable healthcare for local communities, while maintaining a low tolerance for risks to quality or patient safety.

Table 2 – Summarises the Trust's current Strategic Objectives and their associated risk tolerance

Strategic Objectives (the 5 Ps)	**Risk Tolerance**	**Rationale**
Patients Deliver excellent care	1-6	We are not willing to tolerate moderate (or worse) harm, however there will always remain a small possibility of adverse outcomes despite the fullest range of safety measures being put in place.
Performance Deliver timely, effective care		
People To be a great place to work	4-8	Whilst recognising that the need to meet unprecedented demand for services and to make significant changes will impact on our workforce, the safety and wellbeing of staff is a priority, and we are guided by our shared values.
Productivity Deliver value for money	8-12	Acute trusts face considerable financial and operational changes which are heavily influenced by external factors outside of our direct control. Transformational changes needed to meet this challenge inevitably carry a degree of risk.
Partnership To be fit for the future	8-12	To transform our services, develop our infrastructure and mature system leadership arrangements we will need to consider all possible solutions to drive innovation and therefore tolerate some degree of risk.

6.5 In light of the proposed changes, an updated risk appetite statement is included below and it is recommended that the Board of Directors adopt this.

> Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. However, to **deliver excellent care for Patients,** our **Performance** needs to support the delivery of **timely, effective care** and we recognise that, in pursuit of these overriding objectives, we may need to take other types of risk which impact on different organisational objectives. Overall, our risk appetite in relation to **Patients** and **Performance** is cautious – we prefer safe delivery options with a low degree of residual risk, and we work to regulatory standards.
>
> We have an open appetite for those risks which we need to take in pursuit of our commitment to being **a Great Place to Work** for our **People.** By being open to risk, we mean that we are willing to consider all potential delivery options which provide an acceptable level of reward to our organisation, its staff and those who it serves. We tolerate some risk in relation to this aim when making changes intended to benefit patients and services. However, in recognising the need for a strong and committed workforce with the right skills and knowledge, this tolerance does not extend to risks which compromise the safety of our **People**, or undermine our Trust values.
>
> We have a cautious appetite for risks in relation to **Productivity, to Deliver Value for Money**. As a Trust, we are committed to working within our statutory financial duties, regulatory undertakings, and our own financial procedures. We will accept risks that may result in limited financial impacts or losses, on the basis that there are clear and justifiable opportunities to enhance patient care and outcomes.
>
> We seek to be **Fit for the Future** through our commitment to working in **Partnership** with organisations in the local health and social care system to make current services sustainable and develop new ones. In pursuit of these aims, we will, where necessary, seek risk - meaning that we are eager to be innovative and will seek options offering higher rewards and benefits, recognising the inherent business risks.

6.6 Upon finalising the Board Risk Appetite, Tolerance and Risk Appetite Statement, the Strategic Decision Support tool will be updated and cascaded through the organisation to support colleagues in the application of this in practice, and when making decisions.

7. Financial implications

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

8. Legal implications

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

9. Risks

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

10. Impact on stakeholders

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

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

11. Recommendations

11.1 It is recommended that Board of Directors:

i. Note and approve the updates to the BAF.
ii. Note and approve the updates to the action plan for the historic Strategic Risks
iii. Note and approve the newly identified Principal Risk relating to Timely Access to Diagnostics for oversight at Finance & Performance Committee.
iv. Note and approve the Risk Appetite, Risk Tolerance and Revised Risk Appetite Statement.

Lancashire Teaching Hospitals
NHS Foundation Trust

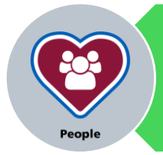
Board Assurance Framework

2025/26

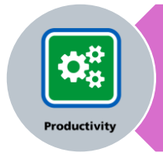
Board of Directors – June 2025

Patients – deliver excellent care

Performance – deliver timely, effective care



People – be a great place to work



Productivity – delivery value for money

Partnership – be fit for the future

Excellent care with compassion

Always Safety First

@LancsHospitals

How the Board Assurance Framework fits in

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

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

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

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

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

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

Understanding the Board Assurance Framework

Risk Rating Matrix (Likelihood x Consequence)

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

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

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

Our strategic approach at a glance

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

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

Our values
- Caring & Compassionate
- Building Team Spirit
- Seeking to Involve
- Recognising Individuality
- Taking Personal Responsibility

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

Lancashire & South Cumbria New Hospitals Programme

Strategic framework
- **The 5 Ps**
- **P**atients
- **P**eople
- **P**artnership
- **P**roductivity
- **P**erformance

Enabling strategies

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

Single Improvement Plan

Partnerships | People | Patients | Productivity | Performance

Strategic Objectives

Patients – deliver excellent care

Improve outcomes, reduce harm and deliver a positive patient experience

Performance – deliver timely, effective care

Deliver agreed trajectories in clinical performance

People – be a great place to work

Create an inclusive culture with leaders at every level leading colleague engagement

Productivity – deliver value for money

Deliver the agreed financial plan including waste reduction programme, maximising use of resources

Partnership – be fit for the future

Be an active system partner leading to the delivery of the system clinical strategy, university hospital status and fulfils our anchor and green plan ambitions

2025/26 Corporate Objectives

Patients
- Improve outcomes and prevent harm
- Deliver a positive patient experience
- Develop new ways of working across the system that lead to more effective patient interventions and pathways.
- To deliver good tertiary services to the population of Lancashire and South Cumbria and District General Hospital Services to the population of Central Lancashire

Performance
- To minimise the risk of harm to patients through the continued delivery of our cancer recovery plan
- To minimise the risk of harm to patients through the delivery of our elective recovery plan
- To improve the responsiveness of urgent and emergency care
- To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory

People
- To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy
- To strive to improve experience at work by actively listening to our people, and turning understanding into positive action
- To be consciously inclusive in everything we do.
- To build a positive culture, demonstrating our values in action through increased colleague engagement across the organisation.
- To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.

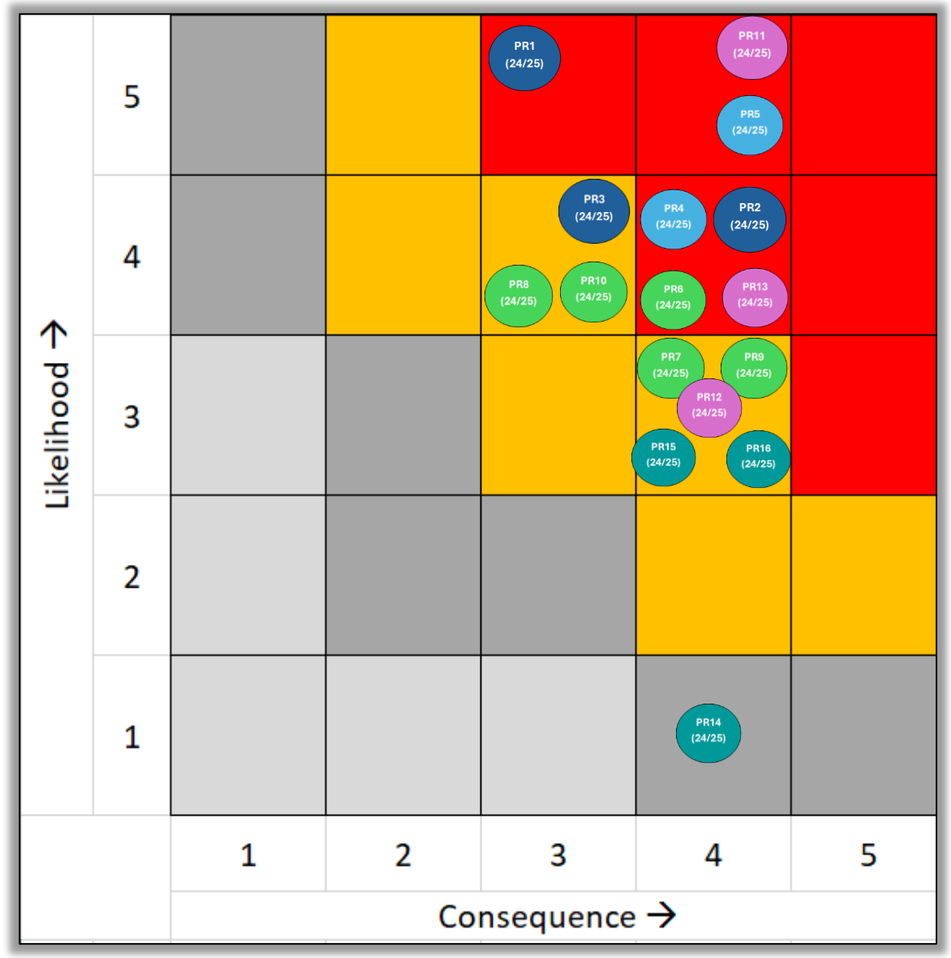
Productivity
- To provide value for money services by spending less, spending well and spending wisely
- To deliver sustained improvement evidenced through the single improvement plan
- Improve our underlying productivity and efficiency
- To develop a clinical services strategy for the organisation

Partnership
- To develop and deliver our strategic plans to support the transitions outlined in the new NHS Plan:hospital to community; treatment to prevention; analogue to digital.
- Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.
- To make progress towards our ambition to be a University Teaching Hospital
- Working with partners, create a single pathology service

Principal Risk Management

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

Ref	Principal Risk	Exec Lead	5Ps	Reporting Committee	Risk Appetite	Risk Tolerance	Current score	Direction of score since last report
PR1 (24/25)	Patient experience within the urgent and emergency care pathway	CNO	Patients	SQC	Cautious	1-6	15	→
PR2 (24/25)	Higher than trajectory rates of clostridioides difficile (C.*difficile*) Infection	CNO	Patients	SQC	Cautious	1-6	16	↓
PR3 (24/25)	People experiencing Health inequalities	CNO	Patients	SQC	Cautious	1-6	12	→
PR4 (24/25)	Timely access to planned and cancer care	COO	Performance	FPC	Cautious	1-6	16	→
PR5 (24/25)	Timely access to urgent and emergency care	COO	Performance	FPC	Cautious	1-6	20	→
PR6 (24/25)	Reliance on temporary medical workforce	CMO	People	WFC	Open	4-8	16	→
PR7 (24/25)	Experience of under-represented staff groups	CPO	People	WFC	Open	4-8	12	→
PR8 (24/25)	Sub-optimal experience of Resident Doctors	CPO	People	ETR	Open	4-8	12	→
PR9 (24/25)	Failure to effectively manage staff absence and achieve Trust and National target rates	CPO	People	WFC	Open	4-8	12	→
PR10 (24/25)	Compliance with Core Skills Training & Appraisals	CPO	People	ETR	Open	4-8	12	→
PR11 (24/25)	Failure to meet the financial plan 2024/25	CFO	Productivity	FPC	Open	8-12	20	→
PR12 (24/25)	Cash consequences of the Trust's underlying financial position	CFO	Productivity	FPC	Open	8-12	12	→
PR13 (24/25)	Ability to access required Capital	CFO	Productivity	FPC	Open	8-12	16	→
PR14 (24/25)	Readiness for the New Hospital Programme	CFO	Partnership	NHP	Seek	8-12	4	CONTROLLED
PR15 (24/25)	Research capacity and capability to enable progress towards University Hospital status	DIRI & CMO	Partnership	ETR	Seek	8-12	12	→
PR16 (24/25)	Implementing the long term strategy for the Trust	DIRI & CMO	Partnership	FPC	Seek	8-12	12	→



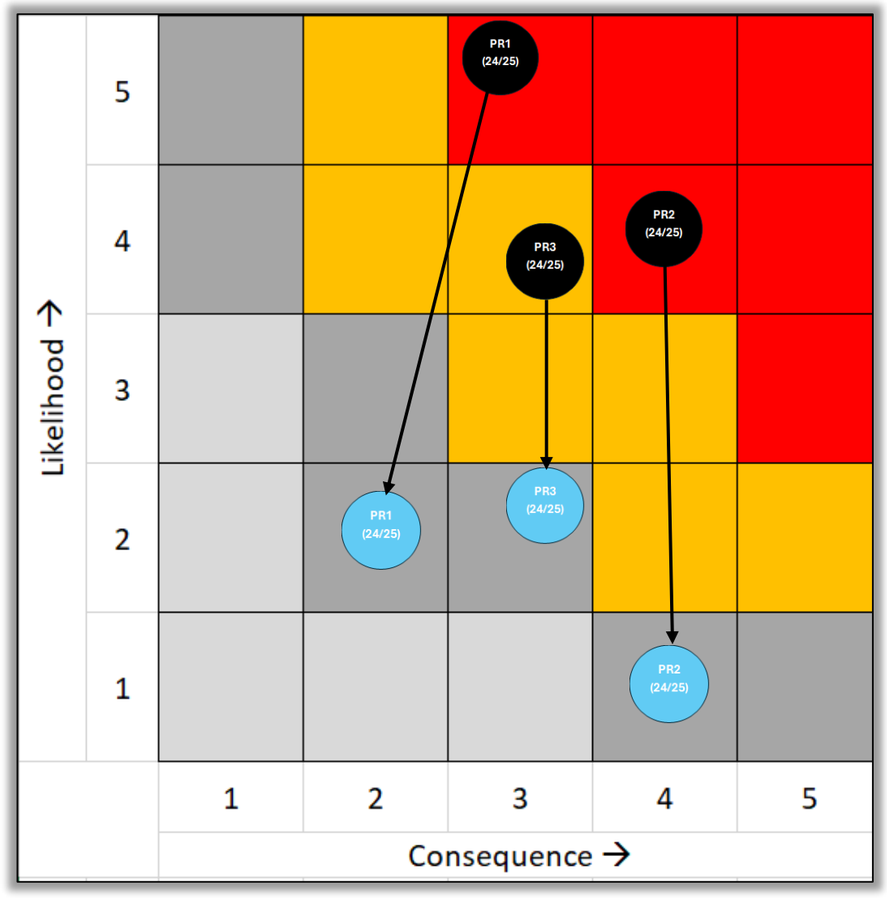
Key- Dark Blue = Patients, Light Blue = Performance, Green = People, Pink = Productivity, Turquoise - Partnership

Patients: Deliver excellent care

Monitored through Safety & Quality Committee

The following 2025/26 corporate objectives are aligned to the **Patients** strategic objective:

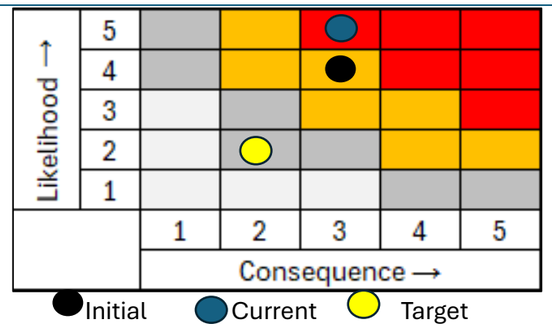
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO1	Improve outcomes and prevent harm	• Design a new medical model for UEC pathways. • Improvement to meet the average time to see a clinician in ED standard • Internal professional standards will be met by each specialty • Develop approach to medical staffing assurance. • Deliver medicines safety and optimisation programme • Lead delivery of CQC action plan • Continued implementation of PSIRF & demonstrate maturity in the approach to learning. • Implement the Always Safety First and learning strategy 2025-2028 • Deliver agreed C.difficile improvement actions • Deliver 10 CNST maternity neonatal safety actions • Deliver annual safe staffing requirements • Deliver the Health Improvement Plan: Our plan to reduce health inequalities	Risk identified
CO2	Deliver a positive patient experience	• Improve the experience of inpatients, improve position in ED and children and maintain positive position in cancer and maternity surveys • Implements a change in culture in UEC pathways focussing on preventing deconditioning and reducing 'days kept away from home' and in elective services ' days worrying'.	Risk identified
CO3	To develop new ways of working across the system that lead to more effective patient interventions and pathways.	To deliver more services to patients outside of hospital: • Lead the approach to community transformation • Develop & deliver the community transformation plan • Establish new ways of working with primary care to promote partnership approach to transformation • Clinically lead the transformation of patient pathways	Risk identified
CO4	To deliver good tertiary services to the population of Lancashire and South Cumbria and District General Hospital Services to the population of Central Lancashire	• Progress the Integrated Care Board and Provider Collaborative Board clinical services programme for vascular, urology, haematology and head and neck. • Progress in tertiary services peer review compliance. • Develop an approach to frailty and end of life care that meets the needs of the local population.	Risk identified



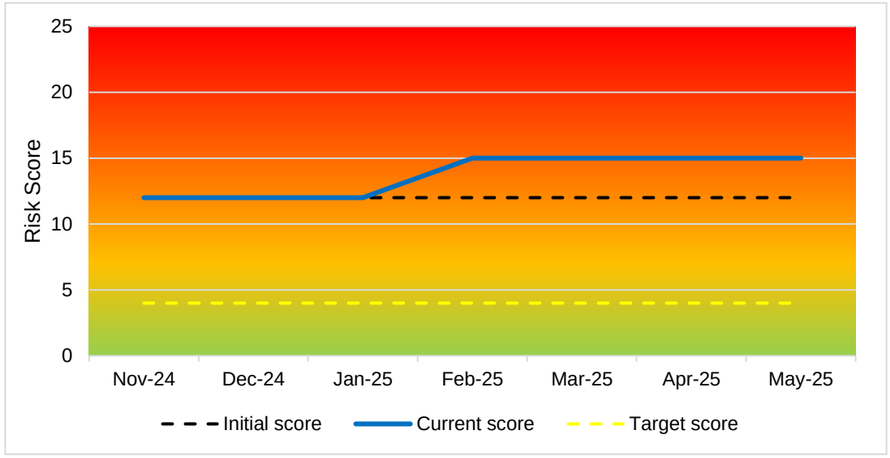
Heat map key: Black = current score, Blue = target score

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

Principal risk 1 (24/25) (ID 2102)	Risk Title:	Patient experience within the urgent and emergency care pathway		
	Risk Description:	There is a risk that patient experience within the urgent and emergency care pathway may be negatively impacted due to high service demand, long waiting times and overcrowding, affecting the ability to deliver care and communication in line with expectations. This could result in reduced patient satisfaction, increased complaints, poor staff experience, regulatory intervention, and potential reputational damage to the Trust.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	05/12/24	Date of last review	21/05/25	
		Target control date	31/08/25	



Risk Score Tracker



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

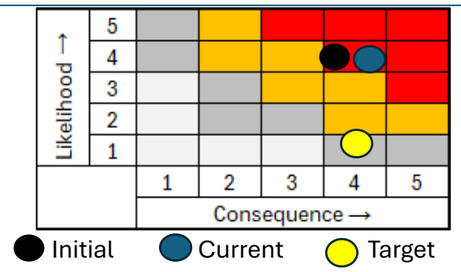
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Patient experience and Involvement Strategy. • Patient Experience & Involvement Group. • Single Improvement Plan related to patient experience. • National OPEL Framework. • L&SC daily Gold Command meetings. • Escalation Plan (including Full Capacity Protocol, Bed Escalation and Extreme Escalation). • Urgent & Emergency Care Delivery Board. • Urgent & Emergency Care Picker Survey Action Plan. • Discharge Improvement Plan.	• Community demand for primary and UEC services. • Alternatives to Emergency Care. • Ageing estate and environment. • Sub-optimal escalation areas. • Being cared for in areas that are waiting areas / not traditional bed spaces. • Financial constraints. • Unpredictability of patient acuity. • Gap in the required number of beds. • Patients cared for outside of designated bed spaces.	<u>Level 1 Assurance</u> • Complaints and concerns – approx. less than 1% versus attendances. • ED dashboard provides monthly overview of safety, quality and performance metrics in ED. • Improved position at CDH in relation to time to triage, average time to see a clinician. • STAR patient experience has some areas of positive performance. <u>Level 2 Assurance</u> • Patient Experience & Involvement Group reports to Safety & Quality Committee • Urgent and Emergency Care Picker Survey reported to Safety & Quality Committee. <u>Level 3 Assurance</u> • Friends & Family Test – some areas of positive assurance.	• Time to see a clinician at RPH consistently exceeds the 60 min average target. • Urgent and Emergency Care Picker Survey identified areas for improvement. • Friends and Family Test – gaps related to communication, waiting times and overall experience.

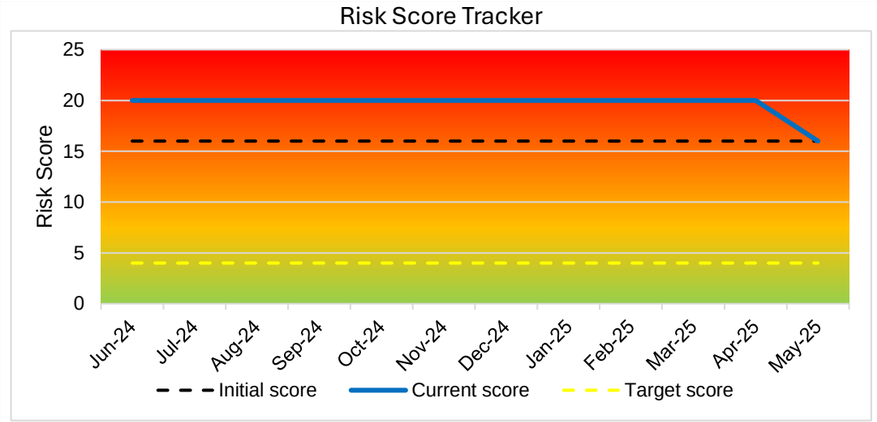
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Specialist review of models of care in Emergency and acute medicine requested through NHS England to ensure models in place reflect best practice.	G. Skailes	~~30.04.25~~ 30.06.25		May 2025: Specialist has been on site and has met with the acute medical team, but is yet to share the findings. An initial review meeting with the Medicine Divisional Management Team is to be scheduled in the first instance, after which an update to SQC can be provided. Due date extended to accommodate this feedback from the specialist.
Review the approach to managing nurse staffing within the escalated ED.	C. Gregory	30.06.25		Aim to increased regular orientated staff in the ED and reduce reliance on agency and bank staff to improve experience.
Delivery of Urgent & Emergency Care Picker Survey Action Plan	A. Booth	~~30.03.25~~ 31.08.25		Mar 2025: Refreshed approach to patient experience in ED underway. Recognising over occupied levels within the department are presenting limitations in how patients experience extended waits. Patient experience plan in development for 2025/26.

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

Principal risk 2 (24/25) (ID 1157)	Risk Title:	Higher than trajectory rates of Clostridioides difficile (C.*difficile*) Infection		
	Risk Description:	There is a risk that there will be higher than trajectory rates of patients contracting C.*difficile* infection. The reasons for this are multifactorial and present a risk of increased mortality and morbidity, longer length of stay, poor patient experience, regulatory action, and reputational impact.		
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Nursing Officer	5Ts status	Treat	
Date risk opened	09/06/21	Date of last review	19/05/25	
		Target control date	31/03/26	





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

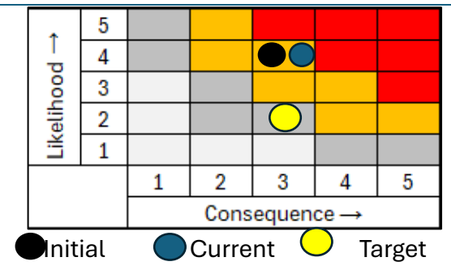
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Annual IPC Plan in place approved by IPCC and Trust Board. • Updated IPC Policy approved at January 25 IPC committee. • Director for IPC and Matron for IPC in place. • Mandatory annual IPC e-learning core skills for all staff. • Antimicrobial pharmacist in post to drive improvements in antimicrobial usage and stewardship. • National cleaning standards in place on 15 wards, with remaining wards completing IPC audits and ward daily cleaning check lists. • Enhanced cleaning/fogging in place as required. • Sporicidal cleaning product (capable of killing C. difficile spores) is in place for general ward environmental cleaning • Ward whiteboard provides visibility of patients who present an infection risk to prompt timely action. • Isolation Room Dashboard ensures visibility of infection status in single rooms, ensuring rooms are used correctly and efficiently. • A rapid gastrointestinal test is available for exclusion of infection in diarrhoeal patients to aid rapid diagnosis. • Operational IPC meetings across Divisions. • Weekly virtual C.*difficile* ward round to support review and prevention, predominantly with relapses.	• Patient non-concordance with medical advice. • High prevalence nationally and community onset cases identified upon attendance at the hospital which creates an increased risk to others. • Non-adherence to antimicrobial guidelines in some cases. • Some staff demonstrate non-compliance with IPC advice and policy. • Isolation facilities insufficient to meet IPC needs across all infections, exacerbated by operational pressures in ED. • Ageing estate impacting upon IPC controls. • Lack of funding to support improvements to ageing estate. • A high number of blockages in the single stack sewage system leading to backflow of infectious waste into clinical areas. • A high frequency of macerator blockages and down-time leading to higher risk disposal methods of infectious waste • Lack of decant facilities to allow for thorough environmental decontamination. • Insufficient space for appropriate separation and storage of clean and dirty items on clinical areas • Lack of funding for the implementation of the domestic services elements of the National Cleaning Standards 2021 beyond the 15 high risk areas where this has been implemented. • Delays in recruiting to domestic services vacancies due to vacancy controls in place.	<u>Level 1 Assurance</u> • IPC Dashboard triangulating process measures with outcome data. • Fogging compliance data available • Hospital acquired infection are reported on Datix. Themes and trends are monitored to identify learning. • Incident oversight in PSIRF triage meetings and regular MDT reviews under PSIRF for high prevalence wards. • For 2024/25, the final number of cases was below the trajectory by seven cases. • IPC BAF report reviewed and shared at IPCC for assurance. • IPC monthly revalidation audits including hand hygiene, commodes, environmental checks and mattress checks. <u>Level 2 Assurance</u> • Monthly reporting into S&Q Committee, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. <u>Level 3 Assurance</u> • Monthly IPC committee includes internal stakeholders and system partners from the ICB, UKHSA and LCC. • ICB & NHSE IPC Collaborative meetings.	• Inconsistent audits on National Cleaning Standards – only 15 wards compliant. • Trust / NHS England – UKHSA Review of wards that do not have national cleaning standards in place show that this gap could be contributing to an increase in infection rates.

Risk Treatment

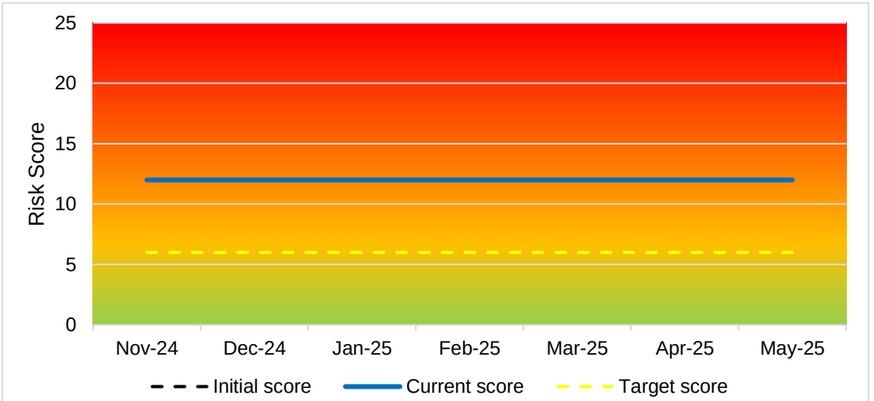
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Enrolled as sentinel site with UKHSA to support genotyping where cases are identified, which will inform further Trust controls/assurances	S Marsh	30.04.25	28.04.25	May 25: Samples for genotyping sent to UKHSA lab each month and commenced in April 2025. Action completed.
Implement the national cleaning standards phase 2 of 3.	C Gregory/J Ashley	31.10.25		Phased implementation agreed for a further 50% implementation by October 2025.
Continue to implement the C.difficile improvement plan monitoring effectiveness through infection prevention and control committee	C Gregory	31.03.26		Mar 2025: Focus on cleaning standard implementation has commenced. Increase assurance reporting implementing with divisions focused on areas that contribute to C.difficile prevention.
Implement the national cleaning standards phase 3 of 3.	C Gregory/J Ashley	31.03.26		Full implementation planned by 31.3.26.
Review of new IPC Board Assurance Framework version 5 released April 2026 by NHS England.	C. Gregory/D. Orr	30.06.25	21.05.25	May 25: Review completed and included in the annual report

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

Principal risk 3 (24/25) (ID 2103)	Risk Title:	People experiencing Health inequalities	
	Risk Description:	There is a risk that the Trust will be unable to effectively address health inequalities because of disparities in access to healthcare services, social determinants of health (such as socioeconomic status, education, and housing conditions), commissioning arrangements, and unequal distribution of resources across communities. This could result in poorer health outcomes for disadvantaged groups, increased pressure on acute and emergency services, reduced patient satisfaction, potential reputational damage for the Trust, non-compliance with regulatory standards and missed opportunities for improving population health. The Trust is part of a wider system approach to health improvement and will work with partners to affect this, recognising the limitations of single services in affecting outcomes in a material way for people.	
Committee	Safety & Quality	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Nursing Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	21/05/25
		Target control date	31/03/26



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire & South Cumbria Integrated Care Partnership Health and Wellbeing Strategy. • LTH Health Improvement Plan, developed in conjunction with L&SC system partners. • Health Inequalities Group. • Health Inequalities Patient Tracking List (PTL) Group. • Health literacy group relating to communication with patients. • Specific improvement programmes for adults and children (e.g. High intensity user service, prisoner referral to treatment and ED navigator role in partnership with Lancashire Violence Reduction Network).	• Commissioning arrangements are led by the ICB. • The Trust has no Public Health Consultant. • Anchor institute plan is under review to link to other plans. • Anchor institute group to be established.	<u>Level 1 Assurance</u> [None detailed] <u>Level 2 Assurance</u> • Monthly chairs reporting to Safety & Quality Committee • Bi-annual update on Health inequalities to Safety & Quality Committee. <u>Level 3 Assurance</u> • Annual compliance NHS statement on information on Health Inequalities – data does not suggest there are barriers for patients from areas of lower deprivation to accessing elective care services. • Quarterly Report to ICB on Health Inequalities.	• Annual compliance NHS statement on information on Health Inequalities – challenges around the completeness and accuracy of ethnicity data captured, with around 7% of patient's ethnicity either unknown or not stated for Central Lancashire. • Inability to access primary care data that would allow improved data quality on high risk groups such as patients with a learning disability, serious mental health and/or physical disability.

Risk Treatment

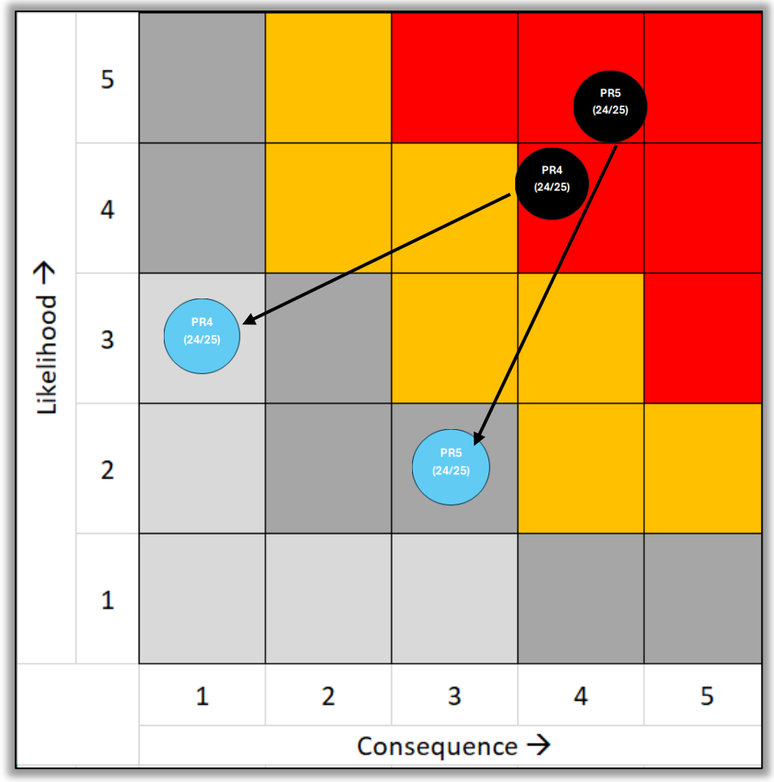
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Finalise Anchor Institute Plan	N. Pease	~~31.03.25~~ 30.06.25		Mar 2025: The drafting of the plan has been delayed due to vacancies and absence and the date has been extended
Support case to approve the data sharing agreements between primary and secondary care.	S. Dobson	30.06.25		Mar 2025: The intention to enable this remains. CNO requested support of ICB CMO regarding required funds to enable this.
Identify approach to driving health inequalities reduction through each portfolio of the single improvement plan	S. Morrison	30.06.25		Mar 2025: New action reflecting the need to build into business as usual the understanding and tracking
Delivery of the Trust's Health Improvement Plan through the three main strategic drivers 1. Awareness 2. Culture 3. Prevention	S. Morrison	31.03.26		Mar 2025: Plan on a page approved through health inequalities group to enable communications plan to commence. The Safety and Quality committee will receive a twice yearly update on progress against the agreed actions within the health improvement plan evidencing the Trusts contribution towards this.

Performance: Deliver timely, effective care

Monitored through Finance & Performance Committee

The following 2025/26 corporate objectives are aligned to the **Performance** strategic objective:

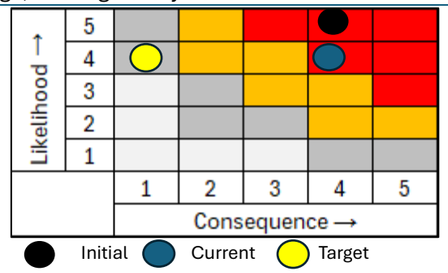
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO5	To minimise the risk of harm to patients through the continued delivery of our cancer recovery plan	• Delivery of more elective care to further improve performance against cancer waiting times standards. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage demand effectively. • Deliver specialty and divisional improvement trajectory.	Risk identified
CO6	To minimise the risk of harm to patients through the delivery of our elective recovery plan	• Delivery of more elective care to improve performance against elective waiting times standards. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage demand effectively. • Deliver specialty and divisional improvement trajectory.	Risk identified
CO7	To improve the responsiveness of urgent and emergency care	• Working with partners, we will continue reforms to urgent and emergency care to deliver safe, high-quality care. • Specific focus on preventing inappropriate attendance at Eds. • The ED and assessment units will be designed to deliver timely assessment, treatment and discharge. • Same Day Emergency Care and virtual wards will increase in use.	Risk identified
CO8	To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory	• Delivery of the plan to improve diagnostic performance. • Working in partnership with providers across L&SC to maximise our collective assets and ensure equity of access. • Work with locality partners to manage access to diagnostics and improvement collaboratively, learning from Cheshire and Merseyside. • Deliver specialty and divisional improvement trajectory.	Risk identified



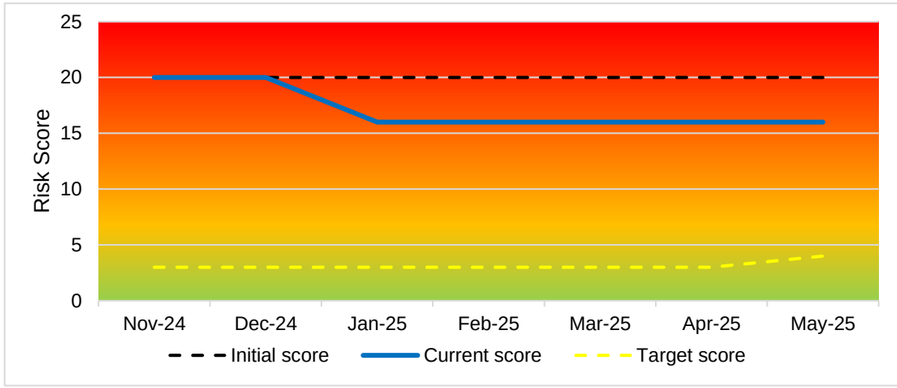
Heat map key: Black = current score, Blue = target score

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

Principal risk 4 (24/25) (ID 1125)	Risk Title:	Timely access to planned and cancer care	
	Risk Description:	There is a risk that there will be insufficient capacity to ensure timely access to planned and cancer care. This is because of backlogs that continue to be seen from the COVID period, surges in demand, shortfalls in capacity, the impact of industrial action, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely access to planned and cancer care, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	19/05/21	Date of last review	19/05/25
		Target control date	31/03/26



Risk Score Tracker



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

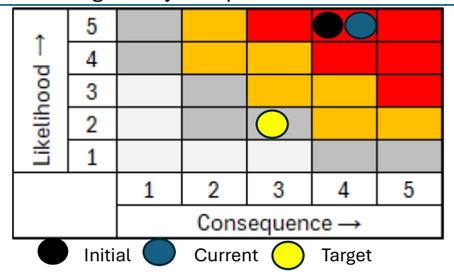
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• 25/26 Annual activity & Performance plans have been outlined to seek to deliver reduction in long waiting RTT targets. Plans include monthly trajectories and associated action plans. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority (P2 – P6) of those patients to support scheduling the most clinically urgent. • PEP+ (Patient Engagement Portal) and AI functionality to support validation of the waiting list and digital letters to support the process. The frequency of validation is monitored via Divisional and organisational performance forums. • Weekly monitoring of cancer patient tracking lists (PTLs) to reduce any delays with tumour specific action plans in place. • Weekly Performance Recovery Group established to track performance and delivery of actions linked to improvement trajectories. • A report for P2 patients waiting over 5 weeks is in place for Divisions to plan their elective capacity. • 6-4-2 protocols in place to drive optimal use of theatre capacity. • Forecasting of potential breaches for Divisions to proactively focus on patients for review and listing, focusing on month-end 52 week+ risks as part of the performance recovery group. • Theatre efficiency programme in place, monitored through the Elective Transformation Programme and up to the Elective Transformation Board and some parts already implemented • Monitoring of benchmarking data via Model Hospital and GIRFT to drive productivity improvements.	• Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes • Inability to fully validate waiting lists regularly due to digital and workforce shortfalls. • Lack of standardised SOPs for validation. • Shortfalls in funding to support the required capacity to deliver the elective restoration plan (ERF cap). • National pension rules for clinicians means there is limited appetite for working additional hours. • Restricted admin capacity to backfill short notice procedure cancellations. • Limitations within the EPR (Flex Harris) system resulting in increased human administrative burden and increased risk of human error leading to data quality issues and potential patient treatment delays • Lack of community capacity with the closure of Community Healthcare Hub resulting in high bed occupancy and increasing the risk of capacity related elective and cancer cancellations	<u>Level 1 Assurance</u> • Live PTL performance report and Validation reports. • Harm reviews process in place for >65 week and cancer pathway patients. <u>Level 2 Assurance</u> • Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • DMO1 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Delays in concluding some harm reviews. • Data sets lack inequalities data visibility to assess the risk to poorer outcomes between patient groups on PTLs. • Inability to assess the risk for patients on surveillance pathways. • Limitations of EPR (Flex Harris) to link patient pathways which may result in ineffective performance management and reporting.

Risk Treatment

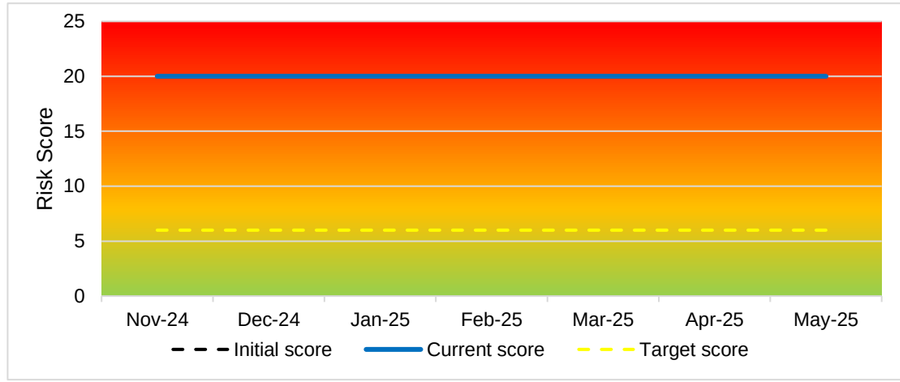
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Agree process and timetable for Model Service reviews to triangulate capacity and demand (C&D), benchmarking data and job planning	A Brotherton	31.05.25	30.04.25	May 2025: The first service review is underway (Trauma and Orthopaedics) and the programme of work for the year has been developed. As a result, the action is marked complete.
Strengthen the data quality of opera reporting.	D Hudson	~~30.04.25~~ 01.07.25		May 25 - Part of the DQ assurance work identified that when generating a pended visit via Opera, the visit was being generated on the incorrect site, necessitating a transfer from one site to the other post admission. Roll out of the long term fix by Harris Flex was expected in February 2025. The roll carries has the phase 1 & 2 improvements for the Interfacility transfer process, this does include the ability to schedule on a pending visit. The roll has been delayed twice due to a significant issue with a function within the EPMA, this delay has had a further impact on the Interfacility Transfer roll out. Work continues by Harris Flex, who provide weekly updates to the Trust via IT team governance calls. Due date extended due to these continued issues.
Scoping & mobilisation of 6-4-2 process for Outpatients	K Foster-Greenwood	31.07.25		May 25: Pilot Control Room has been established to test a 6-4-2 principle for Outpatient productivity for a small number of specialities and following evaluation will roll out further in June and July 25.
Review of validation processes across L&SC to agree standardisation	L Walsh	31.07.25		Apr 25: New action identified
Review of booking, scheduling and administrative resource benchmarking options	K Foster-Greenwood	31.03.26		Apr 25: New action identified

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

Principal risk 5 (24/25) (ID 2104)	Risk Title:	Timely access to urgent and emergency care	
	Risk Description:	There is a risk that patients may experience delays in timely access to urgent and emergency care because of high demand, insufficient out of hospital provision for patients who do not meet the criteria to reside in hospital, limited bed availability, workforce shortages, and delays in patient flow throughout the hospital and community. This could result in longer waiting times, compromised patient safety and experience, increased clinical risk, poorer health outcomes, and potential breaches of national performance targets, impacting the Trust's reputation and regulatory compliance.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6
Director	Chief Operating Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	19/05/25
		Target control date	31/03/26



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Clinical triage processes are established. • OPEL and internal Site Pressure Score Framework and protocols are in place • L&SC daily Gold Command meetings. • Escalation and Surge Plans defined and in place. • Ambulatory and admission avoidance pathways established. • Same Day Emergency Care facilities in place. • Urgent care service provided by a third party co-located on both CDH and RPH sites. • Single Improvement Plan and Board established to track improvement delivery. • Central Lancs system wide UEC & Community Improvement Plan focusing on Hospital @ Home pathways and capacity and Days Kept Away from Home established. • Site Pressure Management processes, meetings and associated action cards established. • Clinical discharge team management of all patients classified as Days Kept Away from Home. • Virtual Ward capacity to support admission avoidance and early step down from hospital. • Care connections coordination function in place to link hospital and community provisions. • Continuous Flow Model is established to drive timely flow. • Ward & Board round process standardisation programme established.	• Insufficient flow within the hospital bed base to prevent ED overcrowding. • Out of hospital provision is insufficient to meet the demand. • The environment and estate is sub-optimal.	<u>Level 1 Assurance</u> • ED Safety Surveillance dashboard monitors live metrics to assess risks of patient harm. <u>Level 2 Assurance</u> • Urgent & Emergency Care and Community Transformation Board provides monthly monitoring of all improvement actions across the system. • Emergency Department Dashboard to Safety & Quality Committee • Finance and Performance Committee. <u>Level 3 Assurance</u> [None detailed]	• High bed occupancy levels (above 92%). • Time to triage and first senior review are not meeting Trust targets. • Performance for the 4 hour wait times and 12 hour total wait time in the department, are not meeting the Trust targets. • Ambulance turnaround times are not meeting the Trust targets.

Risk Treatment

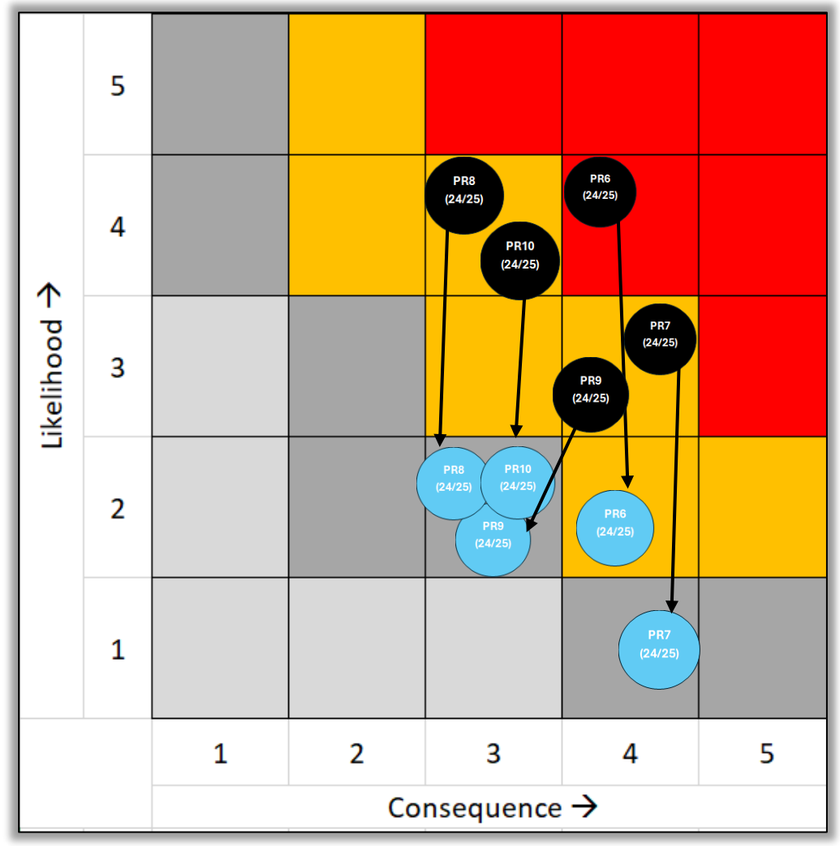
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Expand the volume of Same Day Emergency Care (SDEC) activity.	G Skailes	31.03.25	31.03.25	Apr 2025: Continue to achieve target for proportion of patients seen through SDEC pathways. Further pathways continue to be developed
Implement a Continuous Flow Model.	S. Morrison	31.03.25	31.03.25	Apr 2025: Continuous Flow has recommenced in line with the plan.
Roll out testing of revised Board and Ward round standards	S. Morrison	31.03.25	31.03.25	Apr 2025: Completed. Action can now be closed.
External support to ensure acute medical model is in line with best practice.	S. Morrison	~~31.05.25~~ 30.06.25		May 25: Specialist has been on site and has met with the acute medical team but is yet to share the findings. An initial review meeting with the Medicine Divisional Management Team is to be scheduled in the first instance, after which an update to SQC can be provided. Due date extended to accommodate this feedback from the specialist
Review and analyse 24/25 winter plan effectiveness in preparation for 25/26 plan development	K Foster-Greenwood	30.06.25		May 2025: Plans in place for deadline to be met for Winter Plan review.
Completion of planned expansion of the surgical assessment unit (SAU).	K. Foster-Greenwood	31.07.25		May 2025: Plans currently in place for move in to DOSA on 9th June 2025 and SAU on 16th June 2025, dependent on building schedules and completion.
Surge planning to be concluded re Winter period 25/26	K. Foster-Greenwood	01.09.25		Apr 25: New action identified
Conclude and evaluate Ward & Board round standardisation	R Sansbury	31.03.26		Apr 25: New action identified

People: Be a Great Place to Work

Monitored through Workforce Committee & Education, Training & Research Committee

The following 2025/26 corporate objectives are aligned to the **People** strategic objective:

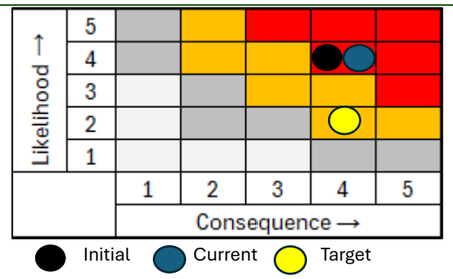
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO9	To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy	• To deliver a workforce plan that responds to commissioning intentions and the communities we serve. • Achieve the headcount reduction needed to ensure successful delivery of the waste reduction workforce plan whilst maintaining safety.	Risks identified
CO10	To strive to improve experience at work by actively listening to our people, and turning understanding into positive action	• To ensure staff choose to stay and work in Lancashire Teaching Hospitals and they are healthy at work. • Delivery of the People Plan. • To progress staff advocacy scores relating to provision of care. • To deliver the sexual safety charter within the organisation.	Risks identified
CO11	To be consciously inclusive in everything we do	• To ensure staff are equipped with the skills to create inclusive cultures that deliver inclusive care. • Deliver the Equality Diversity and Inclusion strategy. • To demonstrate we are an Anti-Racist Organisation.	Risks identified
CO12	To build a positive culture, demonstrating our values in action through increased colleague engagement across the organisation.	• Leaders at all levels recognise their contribution to creating a culture where colleagues feel, ○ Together we are one team ○ Together we can create your future ○ Together we make extraordinary things happen • We will all strive to demonstrate our 'shared responsibilities' in the way we interact with one another.	No risk identified
CO13	To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.	• To enhance the governance and leadership within the Board of Directors through the provision of a Board development programme. • To invest in the development of the senior leadership team within the organisation. • To support the development of leaders at department level through the delivery of leadership training and education.	Risks identified



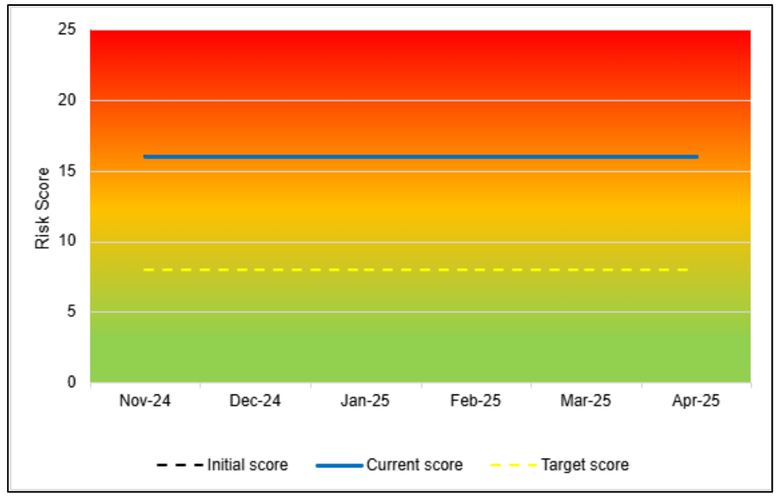
Heat map key: Black = current score, Blue = target score

Strategic Objective: People	**Corporate Objective:** To right size the workforce to support the delivery of safe, affordable and sustainable services, aligned with the Trust's strategy	Overall Assurance Level	Medium

Principal risk 6 (24/25) (ID 2105)	Risk Title:	Reliance on temporary medical workforce		
	Risk Description:	There is a risk that there may be insufficient numbers of medical staff across the Trust. This is due to increasing capacity and demand, and an inability to recruit to vacancies in some specialities. This could result in a reliance on temporary medical staff, lack of continuity of care, patients not receiving treatment in a timely way, poor outcomes, patient harm, lack of detailed organisational knowledge of processes, poor patient and staff experience, staff working extra hours and an impact on wellbeing, financial impact of enhanced payment rates, regulatory enforcement, legal action and reputational impact.		
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief Medical Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	22/04/25	
		Target control date	31/08/25	



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Medical and Dental Job Planning Policy. • Medical Annual Leave policy in place. • Job plans in place for Consultants and Speciality Doctors. Agreed annually as a prospective plan. • Daily Management System in place to aid understanding of temporary workforce in a timely manner. • Processes for changes in job plans where this occurs in-year. • Healthroster system used to manage rotas. • Medical bank in place. • On-call system in place outside of normal working hours (built into job plans). • Non-medical roles for certain specialities to reduce the need for medical input (i.e. Advanced Nurse Practitioners, Consultant AHP roles, physician associates). • Enhanced grip and control measures for the use of temporary medical and agency staff.	• Inconsistent capacity and demand modelling across specialities. • Healthroster not fully aligned to job plans and when job plans are changed. • Operational capacity and technical ability to monitor 42-week productivity against job plans. • Vacancies in hard to recruit specialities can cause long gaps. • Understanding of speciality-by-speciality minimum safe staffing levels. • Sufficient resource to deliver transformational medical staffing projects. • Monitoring of actioning of Medical Annual Leave policy. • Retrospective additions of bank/agency shifts can be misleading for the Daily Management System	<u>Level 1 Assurance</u> • Monthly processes in place to review opportunities based on pay activity. • Monitoring of patients seen by a clinician within 14 hours of admission. • Monitoring of patients seen by a clinician following initial assessment. <u>Level 2 Assurance</u> • Annual Job plan report to Workforce Committee. <u>Level 3 Assurance</u> [None detailed]	• Delays in patients accessing senior medical reviews consistently in all specialties • Inability to articulate the required medical staffing model. • Inability to report on safe staffing levels in relation to medical staffing in response to CQC must do • Absence of robust 42-week monitoring of activity between Healthroster and L2P job plan software. • Requirement to strengthen consistency between ledger and vacancies.

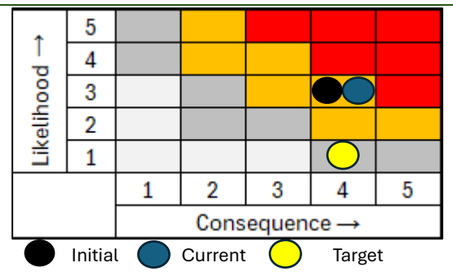
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review Job Plan Internal Audit outcome when finalised	G. Skailes	31.03.25	31.03.25	Apr 2025: Audit outcome was substantial assurance. Action completed.
To determine priorities and number of service reviews that will be completed in the Model Service Programme for 25/26	A. Brotherton	30.04.25	30.04.25	May 2025: The first service review is underway (Trauma and Orthopaedics) and the programme of work for the year has been developed. As a result, the action is marked complete.
Agree an approach to determining minimum safe staffing levels	G. Skailes	~~31.03.25~~ 30.06.25		May 2025: Deputy CMO identified as lead. Position report and proposed approach under development for presentation to Safety and Quality committee in June 25. Date revised to reflect this.
Implement actions following ICB Job Plan Programme	G. Skailes	31.03.25	31.03.25	May 2025: Deputy CMO advised that there are no actions from the ICB job plan programme and this action has been marked complete as a result.
Development of 42-week productivity tool	G. Skailes	~~30.04.25~~ 30.06.25		May 2025: Further work is required in relation to the 42 week productivity and an update on this can be included in the position report to be developed for Safety and Quality committee in June 25. Date revised to reflect this.

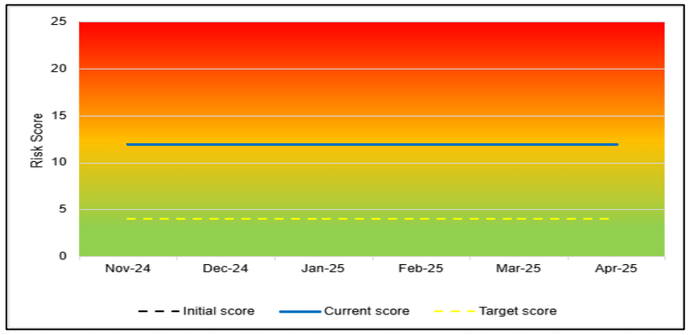
Strategic Objective: People	**Corporate Objective:** To be consciously inclusive in everything we do	Overall Assurance Level	Medium

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

Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8
Director	Chief People Officer	5Ts status	Treat
Date risk opened	05/12/2024	Date of last review	22/04/25
		Target control date	31/08/25



Risk Score Tracker



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

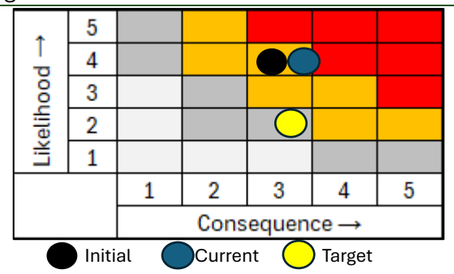
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Equality, Diversity and Inclusion Policy. • Equality, Diversity and Inclusion Strategy. • Single Improvement Plan. • Equality, Diversity and Inclusion mandatory training. • Supporting Disability in the Workplace policy and agreement. • Trans and non-binary policy. • Equality Impact Assessment policy. • NHSE 8 High Impact Actions. • NHS People Promise. • Culture programme, including Zero Tolerance campaigns. • Freedom to Speak Up Policy, Process and Champions. • Employee Relations policies and processes. • Trust Values/Best Version of Us/Leadership in Lancs frameworks. • Core People Management Skills programme. • EDI resources/education/toolkits • Leaders/All Colleague briefings • Staff ambassador forums for colleagues with protected characteristics.	• No equivalent national Workforce Equality Standard for LGBTQ+ colleagues. • ESR Declaration rates for colleagues with a long-term condition or disability. • EQIA process/lack of challenge in respect of EIA findings. • Gaps in localised application of inclusive management practices and in addressing poor behaviours which are not inclusive. • Awaiting mandates and directives following the High Court ruling with regards to protected characteristics of sex in April 2025.	<u>Level 1 Assurance</u> • Equality Diversity and Inclusion Annual Report <u>Level 2 Assurance</u> • Equality, Diversity and Inclusion Strategy Group. • L&SC ICS ED&I Group. • Equality, Diversity and Inclusion Strategy monitoring. • Workforce Committee. <u>Level 3 Assurance</u> • Internal Audit review of ED&I in 2023/24 – Substantial Assurance. • Some positive areas identified in the Workforce Race Equality Standards (WRES). • Some positive areas identified in the Workforce Disability Equality Standards (WDES). • North West Anti-Racist Framework. • EDS2022 • North West ED&I Assurance template	• Challenges in ability to drill down into the data from a minority group/divisional basis due to low numbers and confidentiality • Areas for improvement identified in the Workforce Race Equality Standards (WRES). • Areas for improvement identified in the Workforce Disability Equality Standards (WDES). • WRES/WDES report only completed on an annual basis • Ethnicity Pay Gap/Disability Pay Gap • Ability to take meaningful actions which impact the Gender Pay Gap with Agenda for Change (AfC) • EDS2022 – areas for improvement identified

Risk Treatment

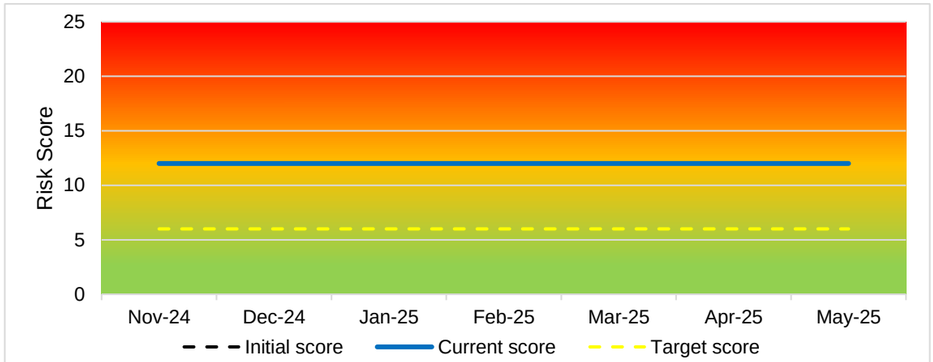
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Reducing the % of colleagues who have not declared disability status on ESR (annual measure)	M. Davis / R. Smith	~~31.03.25~~ 30.05.25		Apr 2025: Improvement seen in statistics gathered in 2024 compared to 2024. Reports expected to be presented at Workforce Committee in May 2025.
Increase level of satisfaction for NHS Staff Survey People Promise element "We are compassionate and inclusive"	M. Davis	31.03.25	28.02.25	Apr 2025: Score remained at 7.3 in 2024, the same as in 2023 and equalling the National Picker average.
Reducing variation in experience around bullying and harassment for disabled vs non-disabled colleagues	M. Davis / R. Smith	31.03.25	28.02.25	Apr 2025: 2024 figures show a slight deterioration in relation to bullying & harassment from the public compared to the previous year. 2024 figures have improved in relation to bullying & harassment from managers. 2024 figures for colleagues with a disability have slightly deteriorated in relation to bullying & harassment from colleagues and for colleagues with no disability the figures have improved. A new action has been identified related to the Living with Disability forum.
Reducing variation in experience around discrimination for minority ethnic vs white colleagues	M. Davis	31.03.25	28.02.25	Apr 2025: 2024 data shows the variation has reduced. A new action has been identified related to the Ethnicity Forum
Increasing the diversity of colleagues in band 8a and above as per WRES/WDES annual report	M. Davis	31.07.25		Apr 2025: Reports expected to be presented at Workforce Committee in May 2025.
Work to be undertaken in conjunction with the Living with Disability forum to understand more about bullying and harassment	M Davis	31.07.25		Apr 2025: New action identified.
Work to be undertaken in conjunction with the Ethnicity forum to understand more about discrimination statistics	M Davis	31.07.25		Apr 2025: New action identified.

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

Principal risk 8 (24/25) (ID 2111)	Risk Title:	Sub-optimal experience of Resident Doctors		
	Risk Description:	There is a risk that resident doctors experience of working at the Trust may not always be positive. This is because of operational pressures and working practices. This could result in poor staff experience, grievances, absence, a reduced level of medical staff, inability to recruit, patient safety incidents, regulatory intervention and reputational damage.		
Committee	Education, Training and Research Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	15/05/25	
		Target control date	31/08/25	



Risk Score Tracker



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

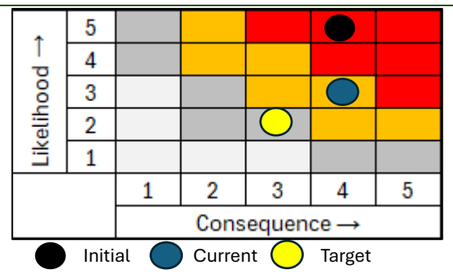
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Resident doctor Single Improvement Plan. • Workforce and OD Strategy. • Education and Training Strategy. • Divisional education contracts. • NHS Education Contract. • Medical Workforce team.	• Lack of national guidance on "Improving the working lives of doctors in training". • National requirement to take an NHS Staff Survey approach to the GMC National Training Survey. • StatMand training currently under review for all staff groups including resident doctors. • Requirement to work with Lead Employer who holds employment responsibilities for resident doctors. • Time restriction of Lead Medical Education officer to progress the resident doctor agenda. There is a need to identify an accountable officer for responsibility of improving the working lives of doctors	<u>Level 1 Assurance</u> • Resident doctor forum. • Divisional Workforce Committee. • Raising Concerns Group. • Enhancing Doctors working lives action and assurance group. <u>Level 2 Assurance</u> • Education, Training and Research Committee. • Workforce Committee. <u>Level 3 Assurance</u> • NHSE Monitoring the Learning Environment quarterly meetings. • GMC National Training Survey (NTS). • National Education and Training Survey. • Annual Internal Placement Experience. • De-escalation of concerns monitored via NHSE Intensive Support Framework (category ISF 1).	• Gap in triangulation of GMC National Training Survey into Raising Concerns, Exception Reporting and NHS Staff Survey Reporting • GMC National Training Survey 2024 results indicated that Trust performance is marginally below the national average in 14 out of 18 themes. • A number of areas of Post Graduate Medical Education are currently being monitored within the NHSE Intensive Support Framework, these include: 1) Senior Support for Foundation Doctors and Acting Beyond Competencies at CDH (ISF 1) 2) Efficient handover with clear allocation of roles (ISF 1) 3) GMC NTS 2024 Results showed Neurology RPH, Radiology RPH, Clinical Oncology RPH and Obstetrics and Gynaecology RPH in ISF 1. • Lack of NHS Staff Survey level of analysis and corporate level action plan for GMC national training survey and National Education and Training Survey for resident doctors, with insufficient triangulation of themes and organisational and specialty level.

Risk Treatment

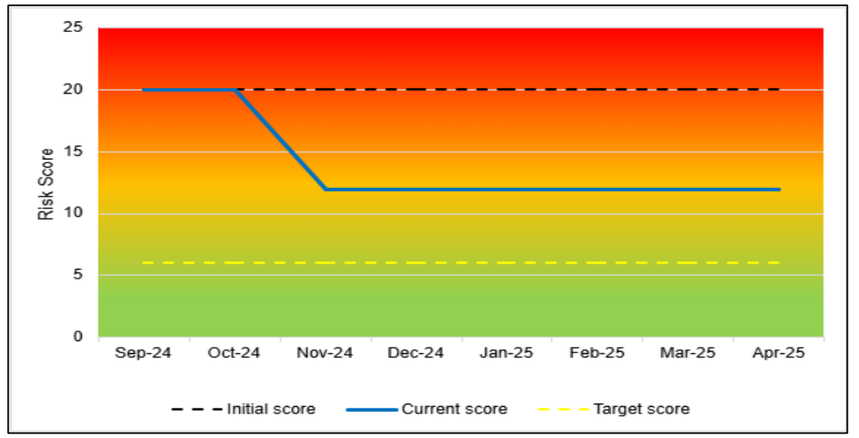
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review Education and Training Strategy	L. O'Brien	~~30.06.25~~ 31.08.25		May 2025: A strategy update will be presented to ETR in August 2025, with delays due to Trust Strategy delays, the expectation of a 10-year plan from NHSE being published in the coming months which will impact on Trust Education and Training Strategy and as part of the revised 25-26 Cycle of Business for ETR. Due date extended.
Implement education portfolio changes to provide dedicated support to Medical Education	L. O'Brien	~~30.06.25~~ 30.09.25		May 25: Due to unforeseen workforce related challenges, this work has been delayed. New expected implementation date is September 2025.
Implement 2025/26 education and training sub-committee structure	L. O'Brien	30.06.25	21.05.25	May 25: The new sub-committee structure with strengthened reporting through relevant Divisional workforce committees was presented to ETR and commenced in April 2025.
Develop escalation protocols and guidance to provide senior support for foundation doctors and residents acting beyond competencies	~~A Sykes~~ M Brady	31.07.25		May 25: Action re-aligned to M Brady who is overseeing this work
Undertake review of the handover template from RPH to test utility at CDH	~~A Sykes~~ H Bhaskar	31.07.25		May 25: Action re-aligned to H Bhaskar who is overseeing this work
Receipt and review of GMC Survey results to understand assurance around controls in place – expected end of July 2025	L. O'Brien	31.08.25		

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

Principal risk 9 (24/25) (ID 499)	Risk Title:	Failure to effectively manage staff absence and achieve Trust and National target rates		
	Risk Description:	There is a risk that failure to effectively manage staff absence due to ineffective systems or processes, or managerial capability will compromise our ability to deliver safe staffing levels and continuity of care. It could also result in increased costs associated with temporary staffing, the Trust being unable to achieve Trust or National targets and could impact on staff morale.		
Committee	Workforce Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	10/02/14	Date of last review	22/04/25	
		Target control date	31/10/25	



Risk Score Tracker



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

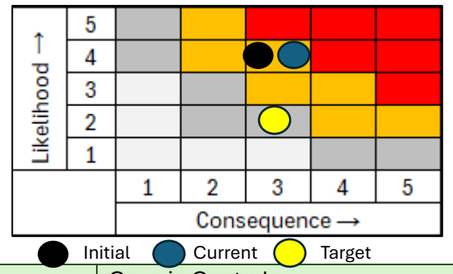
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Sickness Absence Policy in place. • Core People Management Skills training in place. • Monthly reports to Divisions - check & challenge. • Accountability Framework in place which has recently been refreshed. • Toolkits and templates for Managers. • "What Good Looks Like" for Managers. • Live data & reports in Health Roster. • Workforce Advisor Support in place (although at an insufficient level) • Health & Wellbeing Strategy in place. • Workforce & Organisational Development Strategy in place. • Operational processes in place Divisionally to look at staffing levels. • Dashboards in rosters to see safe staffing levels. • Rostering guidance and support in place.	• Gaps in localised management practices. • Lack of one complete absence record affecting ability to demonstrate policy compliance. • Insufficient capacity within the Workforce team to support absence management as proactively as possible. • Lack of localised risk assessments/stress risk assessments/moving & handling risk assessments. • Lack of triangulated data to support prediction/notice of warning signs for sickness absence. • Insufficient capacity within the psychological wellbeing service. • Development of mechanisms to prevent additional work/shifts which are counterintuitive to sickness absence position.	<u>Level 1 Assurance</u> • Divisional Workforce Committees. • Sickness absence reports are produced on a monthly basis which enables trend analysis of absence rates at cost centre level. These are reported through divisional workforce committees. • The Workforce team have undertaken local audits of absence management practice e.g. Return To Work Interview compliance. <u>Level 2 Assurance</u> • Workforce Committee. • Divisional Improvement Forums review absence levels. <u>Level 3 Assurance</u> [None detailed]	• Currently a manual process to monitor compliance with absence management policy and processes. • Inability to achieve the 4% target. • Internal audit of sickness absence management practices, (October 2024) provided limited assurance.

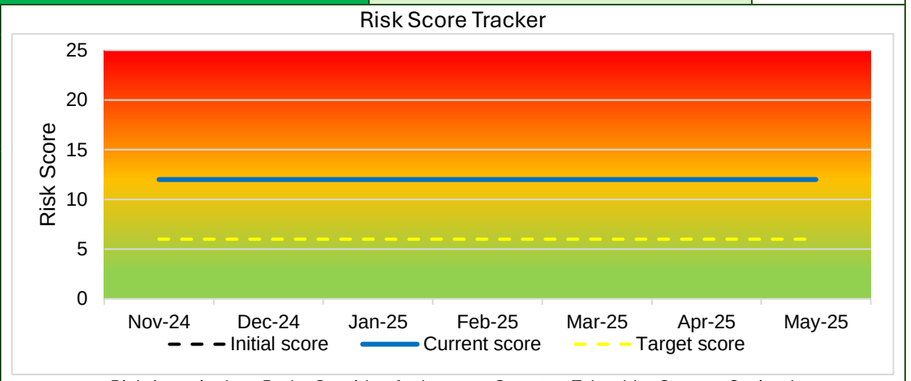
Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Progress and evaluate outreach calling	R O'Brien	31.01.25	31.01.25	Jan 25: Action completed by the end of January 2025.
Develop business case for additional psychologist	R. O'Brien	31.03.25	31.03.25	May 25: business case completed and presented at Trust Management Board in March 2025.
Review of the Sickness Absence Policy	R. O'Brien	31.03.25	31.03.25	May 25: Policy presented to Policy Ratification Group in April, discussed at All Colleague Team Brief in May 2025 and due to be published.
Pilot Empactis as a digital absence management system	R. O'Brien	~~30.04.25~~ 31.07.25		May 25: Business case approved and provider discussions ongoing in relation to implementation. Due date extended to July 2025 as a result.
Deliver absence reduction 'plan on a page' against 4 key workstreams	R. O'Brien	30.06.25		May 25: All actions are progressing and being overseen by an established task and finish group and monitored through the Waste Reduction Programme. Barriers to expediting progress are the shortfalls in Workforce Advisory resource for the scale of the sickness absence caseload and the capacity challenges in the psychological wellbeing service and occupational health physiotherapy. An updated "plan on a page" will be presented at the next Trust Management Board.

Strategic Objective: People	**Corporate Objective:** To develop leaders at every level of the organisation with the skills and behaviours that are able to provide compassionate leadership.	Overall Assurance Level	Medium

Principal risk 10 (24/25) (ID 2041)	Risk Title:	Compliance with Core Skills Training & Appraisals		
	Risk Description:	There is a risk that staff may not have received the core skills training required for their role or had an appraisal in the Trust-defined timeframes. This is due to unavailability of staff, time and capacity. This could result in staff not having up to competencies, patient safety incidents, poor patient experience, poor staff experience, regulatory action, claims and complaints.		
Committee	Education, Training & Research Committee	Risk Appetite and Tolerance	Open 4-8	
Director	Chief People Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	15/05/25	
		Target control date	31/07/25	





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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Core skills training framework (CSTF). • Training needs analysis. • Corporate Induction process. • Local Induction process. • Appraisal Policy. • Appraisal Policy for Medical and Dental colleagues. • Accountability Framework. • Self-service e-learning and appraisal platform. • Regular review of target audiences with Clinical Educators and Divisional leadership. • Training Compliance and Assurance Sub-Committee govern any proposed changes to Core Skills topics. • Monthly emails to staff to show compliance with training and appraisals and any areas that are due to expire. • Weekly reminder to staff who are out of date with Core Skills training. • 'Super red' tool produced to support the divisions in identifying staff who have more than 1 super red topic. • Monthly meetings take place between Training Performance and Compliance and Divisional Nursing Directors to review target audiences and complete approval for sign off of any changes. • Training reports map directly to CQC core services, by professional group.	• Gaps in localised application of appraisal policy and processes. • Nationally set Core Skills training framework. • National review of Core Skills Training Framework (CSTF), which is reviewing statutory and mandatory training across all Trusts, with a plan to produce a national StatMand framework in 2025. This could increase / change the requirements for delivery of training nationally and the governance processes.	<u>Level1 Assurance</u> • Training & Appraisal Compliance report - produced monthly and sent to divisional and corporate leaders. • Regular provisions and/or presentation of compliance including Core Skills training report to Divisional Workforce Committees. <u>Level 2 Assurance</u> • Reports to Training, Compliance and Assurance sub-committee. • Training and Appraisal reports to Divisional Improvement Forums. • Bi-monthly Education Training and Research committee reports to escalate gaps and assurances in plans to rectify. • Annual Appraisal Strategic Update report to Workforce Committee. <u>Level 3 Assurance</u> • Integrated Board Performance Report. • NHS Staff Survey Results	• The Trust is currently non-compliant with specific mandatory (core skills training framework) & essential training subjects as reported to ETR Committee.

Risk Treatment

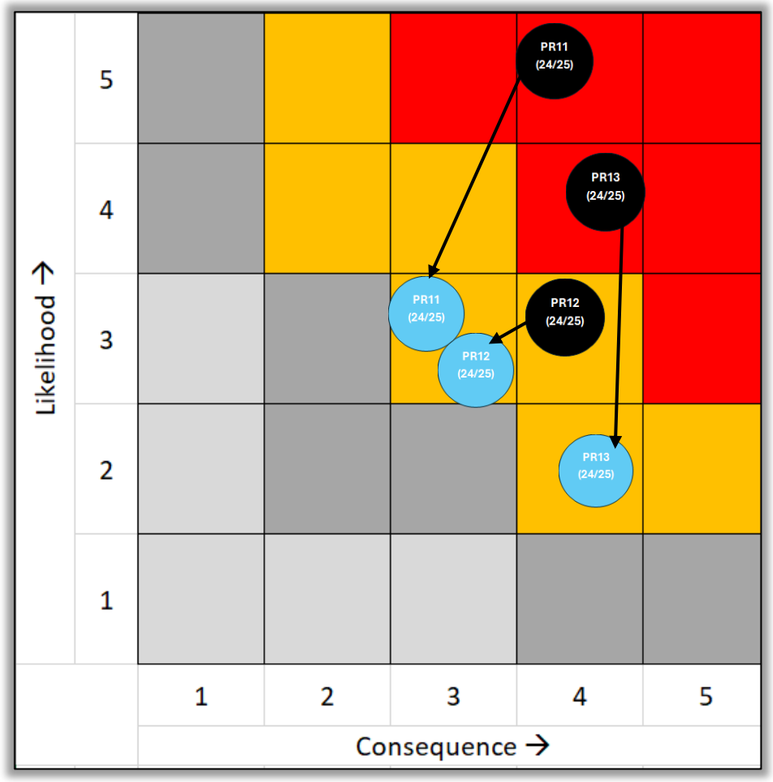
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Divisional Mandatory Training compliance action plan – for each Division	Divisional Leads	31.05.25		Mar 2025: Surgery complete and being monitored. All Divisional actions yet to be finalised, due date extended
Review Mandatory Training Policy	L. O'Brien	~~30.06.25~~ 30.09.25		May 25: A recent MIAA audit recommended the development of a Mandatory Training Policy with target implementation date set at September 2025.
Reviewing processes including guidance provided on how to complete appraisals, reviewing appraisal forms, monitoring and QA processes and developing intranet information hub.	L. Graham	30.06.25		Mar 2025: The appraisal templates have now been reviewed and new guidance drafted for the team members bands 2- 6 appraisal process. The next stage by end of April 2025 will be to follow the same process for Leaders appraisals. A new 'centralised close' standard operating procedure has been developed and has been implemented for the last 3 months. This process is now deployed as standard on a monthly basis. The quality assurance process has been reviewed and decision made to cease as it delivered limited impact. In its place will be increased appraisal data analysis provided to Divisional Workforce Committees on a bi annual basis, this will include assessments of overall appraisal compliance, appraisal ratings, talent management ratings, number of objectives and objective completion, personal development themes and completion this will enable richer discussions and targeted action to be taken. This action has not yet been implemented, work has stalled due to vacancies in Organisational Development team. Due date extended to allow for remaining sub-actions to be completed.

Productivity: Deliver value for money

Monitored through Finance & Performance Committee

The following 2025/26 corporate objectives are aligned to the **Productivity** strategic objective

Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO14	To provide value for money services by spending less, spending well and spending wisely	• To evidence improved value for money and delivery of the financial recovery programme • To design services that are affordable and deliver within the budget. • Commit to make the best use of finance and colleague contribution.	Risks identified
CO15	To deliver sustained improvement evidenced through the single improvement plan	• To deliver against the plan and demonstrate improved outcomes for the organisation • Launch the Lancs Improvement Method	No risk identified
CO16	Improve our underlying productivity and efficiency	• To maximise our productivity through the deliver of the Waste Reduction Programme, Single Improvement Plan and other transformation plans	No risk identified
CO17	To develop a clinical services strategy for the organisation	• To develop safe, innovative, sustainable and affordable clinical models for the future	No risk identified

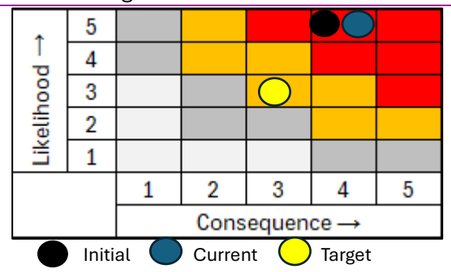


Heat map key: Black = current score, Blue = target score

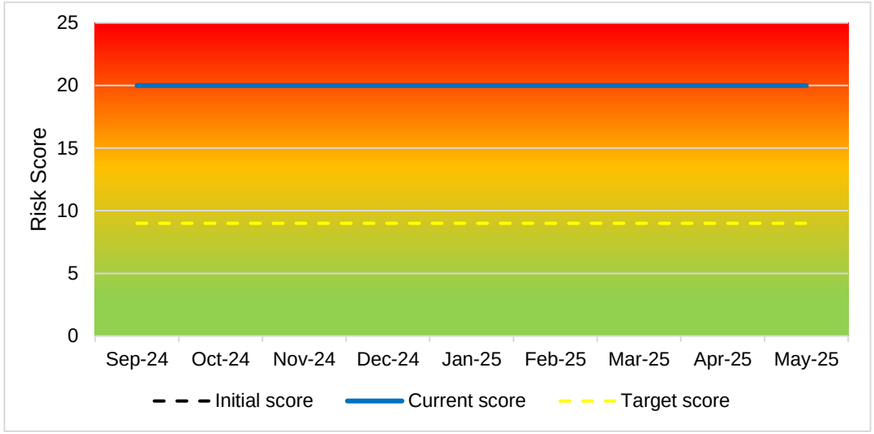
Strategic Objective: Productivity	**Corporate Objective:** Provide value for money services by spending less, spending well and spending wisely	Overall Assurance Level	Low

Principal risk 11 (24/25) (ID 1557)	Risk Title:	Failure to meet the financial plan in 2025/26
	Risk Description:	There is a risk that the Trust may not deliver the financial plan for 2025/26. This is because of factors such as under-delivery of planned efficiency savings, inability to reduce some operational costs, rising operational demand, and insufficient external funding for some services. This could result in a significant financial deficit, reduced resources for patient care, challenges in maintaining service delivery, insufficient income to cover operational costs, inability to exit NHS Oversight Framework (NOF) level 4, further regulatory intervention, impact on staff experience, and reputational damage.

Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	03/06/24	Date of last review	19/05/25
		Target control date	31/03/26



Risk Score Tracker



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

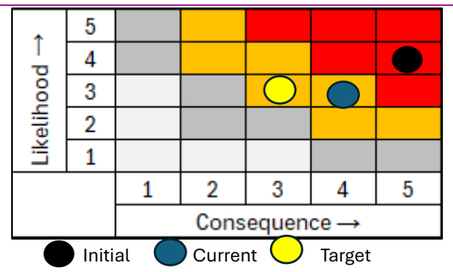
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Financial plan set at the start of the year - common assumptions and principles agreed collaboratively within the ICS. • Financial plan triangulated with activity and workforce plans. • The Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation are in place to support controlling expenditure. • Budgets set at the start of the financial year and agreed with budget holders, risks identified and rated to enable the Board of Directors to approve the budgets. • There are a suite of pay controls for filling vacancies and using agencies. • Processes are in place to ensure waste reduction programme (WRP) schemes that are delivered are transacted through the ledger. • There are a range of grip and control measures in place for managing discretionary expenditure. • There is a no PO no pay system in place for managing non pay expenditure.	• Inability to fully develop and manage services within commissioned resources and in line with commissioning processes due to increasing demand and evolving complexity of patient needs. • The savings programme alongside additional control measures is currently failing to deliver the required level of financial improvement. NHSE are supportive of using additional advisory support to maximise delivery in the current financial year and develop plans for 25/26. • PMO to support the divisions to deliver the WRP is being finalised with external support. • Operational pressures limiting management capacity.	<u>Level 1 Assurance</u> • Ledger reconciliations - on the integrity of the financial data. • Variance and trend analysis - on the integrity of the financial data. <u>Level 2 Assurance</u> • Risks identified monthly to Finance and Performance committee. • Internal Audit - on the integrity of financial systems - through Audit Committee. <u>Level 3 Assurance</u> • Financial plan monitored monthly to; budget holders, DIF, F&P committee, externally through provider finance returns (PFR) monthly returns and system improvement board assurance meetings. • External Audit - on the financial accounts - through Audit Committee. • Collaborative working in ICS - integrity of financial data.	• There is insufficient understanding of the plan to address productivity shortfalls. • WRP schemes are not fully developed for 2025/26 schemes. • Development of the transformation agenda is required to support delivery of the WRP. • Action plans in response to External grip and control and External financial governance reports – planned to be presented to Finance & Performance Committee. • The Trust did not deliver the identified financial plan for 2024/25. The deterioration of forecast in-year resulted the Trust being escalated to national oversight framework (NOF) level 4 and being enrolled in the recovery support programme (RSP). • External grip and control review identified some areas to strengthen. • External financial governance review identified some areas to strengthen.

Risk Treatment

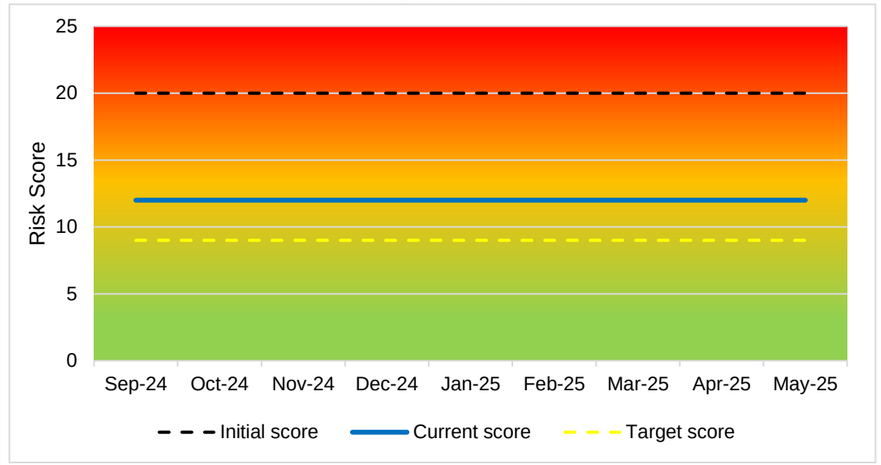
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Robust development of the Waste Recovery Programme for 25/26	D. Stonehouse/ A. Brotherton	31.03.25	31.03.25	Apr 2025: Complete. Plan presented to Finance & Performance Committee in March 2025, with work continuing as per IAG agreed timescales.
Business Case to review/finalise the recurring resources needed for Trust project management office.	A. Brotherton	31.05.25		May 2025: Business case approved, consultation due to be finalised at the end of May and the new PMO formed (minus vacancies in the team) from June 2025.
External support obtained until end of Quarter 1 to further develop schemes and support programme management capacity	C. Carter	30.06.25		Apr 2025: New action – support will be utilised to enhance the capacity to fully develop and realise the schemes requires to deliver the waste reduction programme.

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

Principal risk 12 (24/25) (ID 802)	Risk Title:	Cash consequences of the Trust's underlying financial position	
	Risk Description:	There is a risk that the Trust may face cash flow challenges because of its underlying financial position, including recurring deficits, delayed delivery of financial recovery savings, or insufficient income to cover operational costs. This could result in a cash shortfall and therefore, an inability to meet financial obligations, impact on service delivery, delays in payments to suppliers, restricted investment in essential services and infrastructure, and potential further regulatory intervention or reputational damage.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	06/06/24	Date of last review	19/05/25
		Target control date	30/06/25



Risk Score Tracker



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

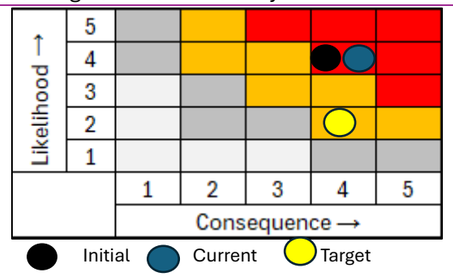
Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Cash Management committee in place. • Annual cash plan in place. • Committee approved cash management policy on prioritisation of supplier payments. • Monthly cash flow forecasting. • Management of working capital balances. • Review of capital programme and timing of expenditure. • Engaging with affected suppliers. • Internal escalation process for urgent cash issues. • NHSE process for requesting cash support. • Additional NHSE process to draw down emergency cash if necessary. • Regular review of cash position and forecasts. • Financial services team resourced for cash management and forecasts.	• Levels of understanding of the cash consequences of not using the established ordering processes. • Access to cash support is subject to external approval.	<u>Level 1 Assurance</u> • Monitoring and reporting performance against 30-day deadline for payments. <u>Level 2 Assurance</u> • Internal Audit reporting through Audit Committee. • Monthly reporting of position including KPIs to Finance & Performance Committee. <u>Level 3 Assurance</u> [None detailed]	• Forecasting generally highlights potential shortfalls in cash availability. However, some invoices can be delayed in being received. • Drop in performance against 30-day deadline for payments.

Risk Treatment

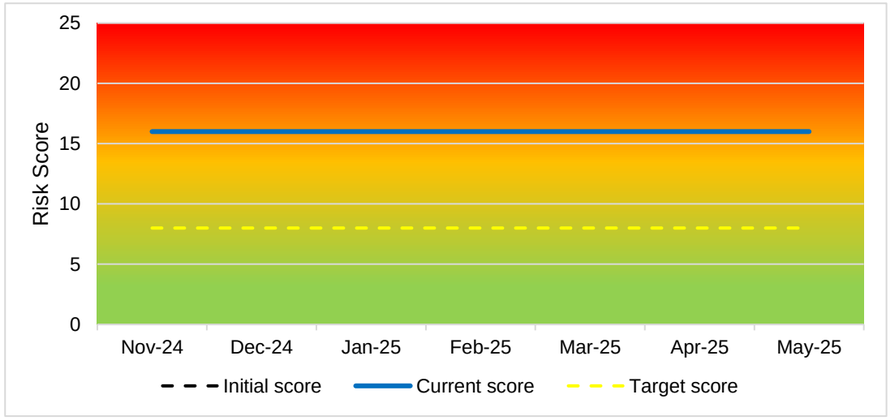
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Timely submissions to NHSE for cash support with Board of Director approval	C. McGourty	~~31.03.25~~ 30.06.25		Apr 25: This risk is currently being reviewed in the context of the final plan submission. The Trust expects to have in a revised framework for cash support. Based on the current expected receipts profile of deficit support funding, the Trust is not expected to need any further cash support before June 2025.

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

Principal risk 13 (24/25) (ID 2106)	Risk Title:	Ability to access required Capital to support an ageing estate	
	Risk Description:	There is a risk that there may be insufficient internally generated capital to support all priority areas of the Trust's ageing estate. This is because of valuation decisions which determine capital funding allocations, the Trust's underlying financial position, competing priorities across the healthcare system, and delays in approvals for capital investment projects. This could result in an inability to progress critical infrastructure maintenance, inability to renew essential existing equipment, potentially impacting service delivery, patient safety, and long-term sustainability.	
Committee	Finance & Performance	Risk Appetite and Tolerance	Open 8-12
Director	Chief Finance Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	19/05/25
		Target control date	31/03/26



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Trust planning framework. • A balanced Capital Plan for 2025/26 has been agreed. • Capital Planning Forum review and determine risk-based approach and recommendations. • Capital Plan agreed by Executive Team & Trust Board. • Backlog maintenance programme developed from 6 facet survey outcome, undertaken annually. • Medical Equipment Group with clinical input to support risk assessment and prioritisation. • IT provided with a budget from Capital Planning forum. • Contingency budget identified at the start of the financial year. • Emergency capital funding process for extreme situations. • Identification of national funding 'bid opportunities'. • Standing financial instructions. • Standing Orders. • Scheme of Reservation and Delegation.	• Externally set capital allocation. • External capital bid opportunities have short timeframes and ability to fully cost this is limited by operational capacity. • Impact of inflation in terms of project costs and timescales. • Ageing estate and inability to comply with latest statutory guidance. • Estates Strategy not finalised. • Approach to IT allocations requires review. • Inability to replace medical equipment as required.	<u>Level 1 Assurance</u> • Asset register in place to support oversight of medical equipment. <u>Level 2 Assurance</u> • Medical Device report to Safety & Quality Committee. • Capital update to Finance & Performance Committee. <u>Level 3 Assurance</u> • 6 facet survey and independent annual report which details the scope and level of the situation. • Estates Returns Information Collection (ERIC) returns to support benchmarking.	• Significant backlog maintenance. • Tracking of project overruns and underspend. • Governance around contract change notices. • Data for ERIC returns is delayed in being released via Model Hospital (2 financial years behind).

Risk Treatment

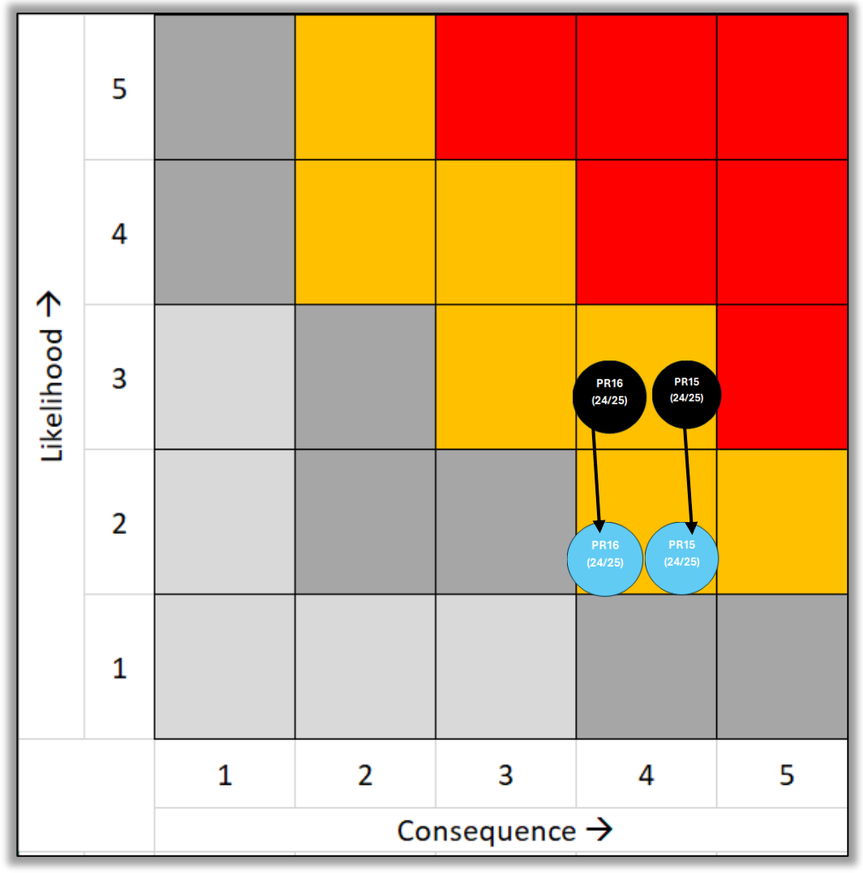
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Review and improve governance of contract change notices	S. Ashworth	13.06.25	08.05.25	May 25: Action has now been completed.
Develop Estates Strategy	C. Howell	~~30.04.25~~ 30.07.25		Apr 2025: There has been a pause to this to reflect on next steps following the NHP delay, which was announced on 20.01.25. Clinical Strategy will require some re-writing alongside the Estates Strategy. Current estimated timeframe for review of Trust position following the NHP delay announcement is April 2025, with estimated re-write of the Estates Strategy by Autumn 2025, but nothing yet confirmed. Deadline adjusted to end of July 2025 with a view for further update at that time.
Review approach to management and reporting of project spend at Capital Planning Forum	C. Carter	31.07.25		
Review and propose alternative options for capital funding allocations	B. Patel	31.03.26	31.03.25	Apr 25: This has been completed for 2025/26 and the available capital has been rebalanced and takes into account some external funding that the Trust has been successful in obtaining.

Partnership: Be Fit for the Future

Monitored as indicated through the relevant Committee of the Board

The following 2025/26 corporate objectives are aligned to the **Partnership** strategic objective:

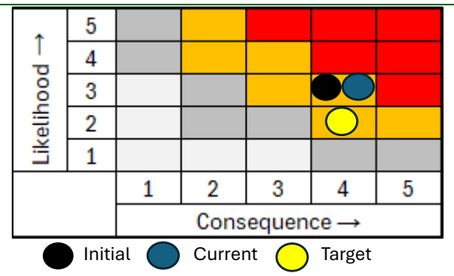
Ref.	Purpose of the objective	Scope and Focus of the Objective	Status
CO18	To develop and deliver our strategic plans to support the transitions outlined in the new NHS Plan:hospital to community; treatment to prevention; analogue to digital.	• Develop and launch the Trust strategy in collaboration with partners. • Develop the capital plans to support the transition. • Develop a digital programme to support the workforce reduction. • Communicate plans with internal and external stakeholders.	No risks identified
CO19	Developing a sustainable future: to develop effective partnerships across L&SC which maximise population health and support services that are clinically and financially sustainable.	• Deliver plans for OneLSC and develop and implement agreed clinical service strategies/plans. • As an Anchor Institution, work with partners to improve population health, supporting development of a thriving local economy and reducing health inequalities. • Reduction in demand through development of Neighbourhood Health with specific focus on frailty and end of life management in central Lancashire.	Risk identified
CO20	To make progress towards our ambition to be a University Teaching Hospital	• Work towards achieving University Hospital status • Continue to shape an education, learning and innovative culture	Risk identified
CO21	Working with partners, create a single pathology service	• To develop and implement the detailed plan for a single pathology service. • Work up the Capital Business Case for a single Pathology hub.	No risks identified



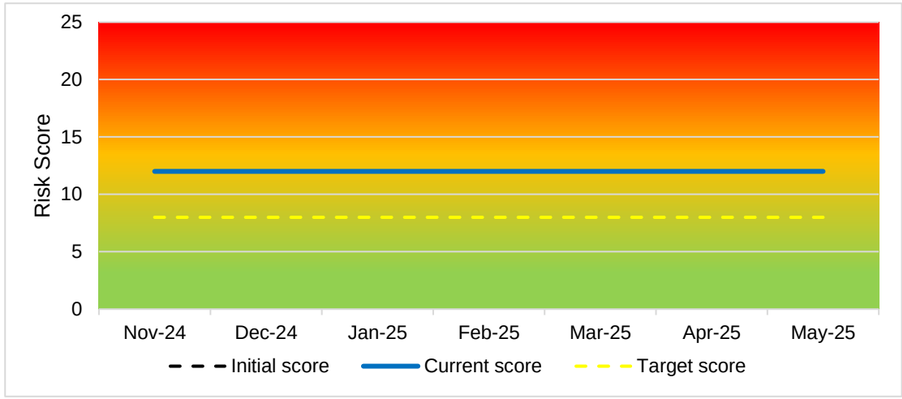
Heat map key: Black = current score, Blue = target score

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

Principal risk 15 (24/25) (ID 2113)	Risk Title:	Research capacity and capability to enable progress towards University Hospital status		
	Risk Description:	There is a risk that the research capacity and capability of the Trust may be insufficient to support the longer-term objectives of becoming a University Teaching Hospital. This is because of limitations of the Trust and potential partners in relation to funding, workforce constraints, lack of dedicated research time for clinical staff, lack of established clinical academics in L&SC and the need for an enhanced infrastructure to support research activities. This could result in missed opportunities for innovation and improvement in patient care, difficulty attracting and retaining talented research staff, an inability to advance the Trust's reputation as a leader in research and clinical excellence and the income generation associated with University Hospital opportunities.		
Committee	Education, Training & Research	Risk Appetite and Tolerance	Seek 9-12	
Director	Director of Improvement, Research and Innovation, and Chief Medical Officer	5Ts status	Treat	
Date risk opened	05/12/2024	Date of last review	21/05/25	
		Target control date	31/12/25	



Risk Score Tracker



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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Fixed National Institute of Health & Care Research (NIHR) Income. • Research & Innovation Strategy (2022-25). • Some protected job-planned time for clinical research activity. • Quarterly Research Collaborative meetings with the 2 main LSC universities to develop research opportunities. • Some joint appointments with university partners.	• Historical and current overspend of research budget. • Funding available to increase capacity and capability. • Ability to engage medical colleagues in in different academic specialities to support advances in research in those areas. • Strategy and appetite of universities to invest in clinical or other academic roles to be based at the Trust.	<u>Level 1 Assurance</u> [None detailed] <u>Level 2 Assurance</u> • Bi-annual Research & Innovation Strategy update. • Research & Innovation Committee. • Education, Training & Research Committee. <u>Level 3 Assurance</u> • Integral role in ICS R&I Collaborative.	• Income generation plan for financial recovery plan is behind trajectory. • Initial project plan to develop partnerships not currently agreed and therefore progress is not able to be reported to R&I Committee and ETR Committee. • Universities are experiencing similar budget constraints and so may lack ability to invest in these areas.

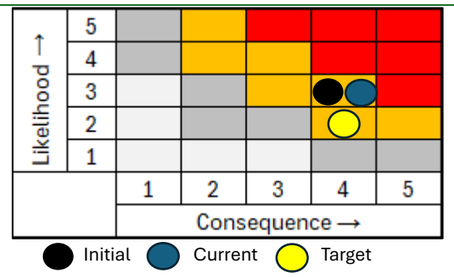
Risk Treatment

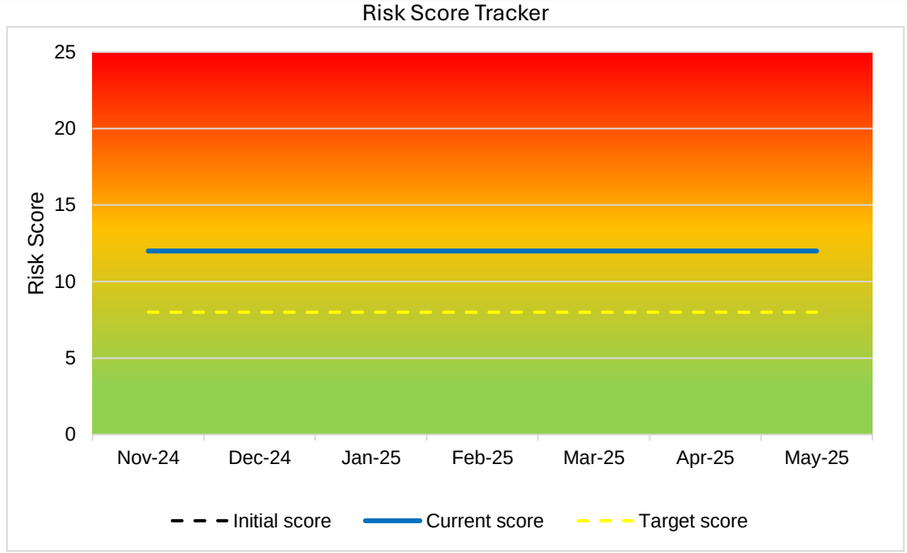
<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Formulate a clear project plan to develop partnerships with potential University partners to explore UH status. This will include plans to engage the clinical teams in the specialities to support these to come to fruition.	P. Brown/ G. Skailes	~~31.05.25~~ 31.08.25		May 25: The first project meeting for this has only been agreed for 06.06.25 with a clear project plan still in aspiration. This is largely due to financial pressures, budget and time availability. The due date as thus been extended.
Delivery of the Income recovery plan for R&I	P. Brown	31.03.25	31.03.25	May 25: 3x PIDs with EQIAs have been delivered to corporate DIF and are in operation: external income, General Commercial Income and Drug Delivery saving are all detailed.
Have Research roles in place within 2 Divisions	P. Brown	~~01.07.25~~ 01.10.25		Action transferred from strategic risk May 25. Research & Innovation has begun a restructure to allow greater flexibility in clinical teams and in which divisional alignment is central, initially to Medicine and Surgery – this is yet to be confirmed. Further work is required with Workforce colleagues thus the change to due date to 01/10/25, by which time it should be confirmed if it is realistic for some or all Divisions to appoint a lead on one PA.

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

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

Committee	Finance & Performance	Risk Appetite and Tolerance	Seek 9-12
Director	Director of Improvement, Research and Innovation/Chief Medical Officer	5Ts status	Treat
Date risk opened	05/12/24	Date of last review	20/05/25
		Target control date	31/03/26





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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Lancashire and South Cumbria (L&SC) Integrated Care System (ICS) joint NHS forward plan and Clinical Blueprint • System Improvement Board • Three-year Single Improvement Plan • Trust's Annual Corporate Objectives • Provider Collaborative Board Joint Committee (PCB JC) • Place based working • Trust development/integration plans with LSCFT	• L&SC Clinical Blueprint has been developed but we are not yet at the stage where we have a detailed, agreed implementation plan. • Discussions with external partners regarding greater service/pathway integration still need further development and may be impacted by the discussions/plans with respect to the L&SC Clinical Blueprint. • Trust long term strategy not yet finalised • Draft ICB Commissioning intentions have been shared but more discussion needed to agree the implications for the Trust. • The 2024 Darzi Review has given a clear indication of the issues to be addressed in the NHS, and some indication of the likely actions needed, but the new long term NHS strategy will not be released until 2025/26. • System based working is still evolving/improving e.g. the PCB Governance reset is underway but has not been fully implemented and Place based working is still developing.	<u>Level 1 Assurance</u> • Trust Board workshops/seminars <u>Level 2 Assurance</u> • Finance & Performance Committee system updates • Trust Board discussions/papers <u>Level 3 Assurance</u> [None detailed]	• Finalised Trust long term strategy

Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Finalise implementation plan for the LSC Clinical Blueprint	ICB / PCBJC	31.03.25	31.03.25	Apr 2025: The work is being taken forward through the PCB Clinical Portfolio Board, which has been established to respond to elements of the clinical blueprint and will be delivered through partnership working.
Agree the implementation plan for the ICB 2025/26 Commissioning Intentions	ICFO / A. Brotherton	31.03.25	31.03.25	Apr 2025: Work is underway as part of the system financial enhanced oversight and the Once LSC Finance programme of work which is being led externally. Work is progressing as per annual planning.
Agree final Trust long term strategy	A. Brotherton	~~30.06.25~~ 30.09.25		May 2025: This has been delayed to due to the Trust being placed into NHS Oversight Framework segment 4 and has been extended to Q2 of 2025/26 with the aim of finalising for the Board of Directors in October 2025.

Appendix 2 – Ongoing Action Plans against Historic Strategic Risks

Ongoing Action Plan against historic Strategic Risk to drive innovation through world class Education, Training and Research

Action Number	Action details	Action Owner	Due Date	Done Date	RAG	Link to Gap In	Gap
ETR 007	Have Research roles in place within 2 Divisions – Suggested Medicine and Women's and Children's Divisions	Deputy Director of Research & Innovation	~~01.07.25~~ 01.10.25		Included within Principal Risk 15	Control	• Lack of research leads embedded in divisions.

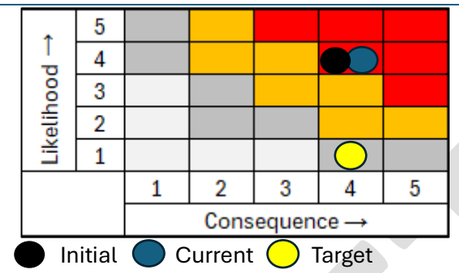
Summary of Updates – May 2025

- Action ETR 007: Research & Innovation has begun a restructure to allow greater flexibility in clinical teams and in which divisional alignment is central, initially to Medicine and Surgery – this is yet to be confirmed. Further work is required with Workforce colleagues thus the change to due date to 01/10/25, by which time it should be confirmed if it is realistic for some or all Divisions to appoint a lead on one PA. This action has now been transferred into Principal Risk 15 for monitoring

Appendix 3 – Draft new Principal Risk

Strategic Objective: Performance	**Corporate Objective:** To minimise the risk of harm to patients through the continued delivery of our DM01 recovery plan in line with trajectory	Overall Assurance Level	Medium

Principal risk # TBC (25/26) (ID 2188)	Risk Title:	Timely access to diagnostic investigations		
	Risk Description:	There is a risk of delays in the completion of diagnostic investigations linked to cancer and elective pathways of care due to high levels of demand, shortfalls in capacity, and financial restrictions limiting the ability to utilise external capacity. This could result in patient harms associated with a delay in timely diagnosis, poorer patient outcomes, inability to meet national constitutional standards, claims, poor patient experience, reputational damage, and regulatory action.		
Committee	Finance & Performance	Risk Appetite and Tolerance	Cautious 1-6	
Director	Chief Operating Officer	5Ts status	Treat	
Date risk opened	NEW	Date of last review	19/05/25	
		Target Control date	31/03/26	



Risk Score Tracker

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

Controls	Gaps in Controls	Assurances	Gaps in Assurances
• Diagnostic Improvement Group has been established to monitor progress of all improvement trajectories, support demand management, the use of technology and monitor productivity. • All Diagnostic modalities have undertaken a capacity and demand analysis and set improvement trajectories. • Clear identification of clinical priorities via the use of national clinical prioritisation codes. This enables the trust to understand the clinical priority using 'D codes' to support scheduling the most clinically urgent. • Diagnostic waiting validation processes are in place to ensure all capacity is effectively used. • Additional capacity has been commissioned for M1-6 25/26. • Weekly monitoring of cancer PTLs to reduce any delays is in place supported by a day zero PTL approach with tumour specific action plans in place. ICB support and performance monitoring re Cancer waiting times is delivered via the Tier 1 performance framework and meetings are held fortnightly. • Weekly Chief Operating Officer monitoring forum for core diagnostic modalities. • Weekly Performance Recovery Group established to monitor performance.	• Lack of capacity to deliver comprehensive diagnostic waiting list validation. • Funding to support additional capacity ceases in M6 25/26. • Lack of triangulation between capacity and demand gaps, benchmarking data and job planning processes. • Physical estate and capital equipment constraints limit available capacity. • Limited influence re external (primary care) demand management.	<u>Level 1 Assurance</u> • Live PTL performance report. • Validation reports. • Datix incident reporting of any treatment delay related harms – review via SI/PSIRF processes with shared learning reports. • Benchmarking data – model hospital, GIRFT, etc <u>Level 2 Assurance.</u> • Oversight in Divisional Improvement Forums, Performance Review Group and F&P Committee. • Benchmarking data analysis – model hospital, GIRFT, etc. <u>Level 3 Assurance</u> • DMO1 improvement plan and trajectory in place monitored through NHS England oversight arrangements.	• Data sets lack inequalities data visibility to assess the risk of poorer outcomes between patient groups on PTLs • Datix incident reporting to assess harms of treatment delays is retrospective

Risk Treatment

<u>Action</u>	<u>Action Owner</u>	<u>Due Date</u>	<u>Done Date</u>	<u>Action Progress Update</u>
Complete the build and mobilisation of additional endoscopy space	K Foster Greenwood	31.10.25		
Establish a Demand Management forum with L&SC ICB	K Foster Greenwood	30.06.25		
Review internal demand utilisation benchmarking data and agree actions	K Foster Greenwood	30.06.25		
Review options to increase capacity via skill mix changes for Urological diagnostic tests	K Foster Greenwood	31.07.25		
Review options to introduce Diagnostic utilisation into Control Room	K Foster Greenwood	30.06.25		

Risk Appetite Scale

Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust
Seek	Eager to be innovative and to choose options offering higher rewards, despite inherent business risk
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
Cautious	Preference for safe delivery options which have a low degree of residual risk and only a limited reward potential
Minimal	Preference for very safe delivery options which have a low degree of inherent risk and only a limited reward potential
None	Avoidance of risks is a key organisational objective

*Created in conjunction with Good Governance Improvement (GGI)

Risk Matrix

Lancashire Teaching Hospitals
NHS Foundation Trust

Risk Rating Matrix (Likelihood x Consequence)

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

Derived from National Patient Safety Agency Risk Matrix

Appendix 5 – Current and Proposed Risk Appetite

Lancashire Teaching Hospitals NHS Foundation Trust

- Recommend:
  - Risk Appetite for the 'Productivity' Strategic Objective to be changed from 'Open' to 'Cautious' recognising the changes in the financial operating framework, regulator interventions and the Trust's current objectives relating to this area.
  - Retain the same risk appetite for the remaining Strategic Objectives.
  - Risk appetite statement is updated in line with these revisions.

Strategic Objectives (5 P's)	Current Risk Appetite	Current Rationale	Proposed Risk Appetite	Proposed Rationale
Patients - deliver excellent care **Performance** – deliver timely, effective care	**Cautious**	Providing safe and effective care for patients is paramount and so we have a low tolerance of risks which would adversely affect the quality and safety of clinical care. The Trust recognises that there may be an adverse impact on other Strategic Objectives, but we prefer safe delivery options for patients with a low degree of residual risk, and we aim to work to regulatory standards.	**Cautious**	No change
People - be a great place to work	**Open**	We are willing to accept some risk where there is a potential to improve recruitment, retention and employees' personal development.	**Open**	No change
Productivity - deliver value for money	**Open**	We are willing to accept quantifiable and well-controlled financial risk where there are tangible benefits and opportunities to restore financial balance, e.g. invest to save programmes.	**Cautious**	We are committed to working within our statutory financial duties and will accept risks that may result in limited financial impacts or losses on the basis that there are clear and justifiable opportunities to enhance patient care and outcomes.
Partnership – be fit for the future	**Seek**	We are willing to consider all possible solutions to providing sustainable healthcare for local communities, while maintaining a low tolerance for risks to quality or patient safety.	**Seek**	No change

9. CONSISTENTLY DELIVER EXCELLENT CARE (SAFETY AND QUALITY)

9.1 SAFETY AND QUALITY COMMITTEE CHAIR'S REPORT

Other | K Deeny | 10.00am

For Assurance

REFERENCES

Only PDFs are attached

09.1 - Chair's Report - Safety and Quality Committee - 28 March & 25 April 2025.pdf

Chair's Report to Board		
Chair: Non-Executive Director Dr Karen Deeny	Safety and Quality Committee	
Date: 28 March & 25 April 2025	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Consistently Deliver Excellent Care	→	• Annual Maternity Staffing Report • The Infection prevention and control annual report, the Patient Experience annual report and the PSIRF annual report will be considered for Board approval on 30 May 2025.

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	**An overview of the findings and response to the Medicines and Healthcare Product Regulatory Agency (MHRA) re-inspection of the Blood Banks at Royal Preston Hospital and Chorley Hospital was presented. This was in relation to compliance with the Blood Safety and Quality Regulations following the initial inspection on 9 February 2023. The Committee noted the outcome of the MHRA inspection major findings and cost implications to address the associated risks. This would be considered by Board in April.** **The Committee received an update on a never event in Ophthalmology where a cataract operation was performed on the incorrect eye. No harm occurred, but process and safety barriers failed. This was reported externally, and a patient safety investigation was underway. Immediate safety actions were taken, and audits continued in clinic and theatre settings.** **The Committee endorsed the safe staffing review and recommended to the Board that phase 2 Birthrate plus investment should be approved as part of the 2024/25 financial plan.**
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**In relation to the principal risk aligned to the Committee: People experiencing health inequalities. The Trust faces challenges in addressing health inequalities due to social determinants of health. While other risks are more controllable, clear steps are needed for this issue. Enacting the Health Improvement Plan and regularly reviewing data were crucial. The Trust must identify realistic changes it can achieve and include specific drivers and outcomes in future risk reviews for better direction and accountability.** **Clostridium Difficile rates ended the year under the Trust tolerance at 192 cases against the national tolerance of 199 cases. The improvements to achieve cleaning standards compliance correlated with reduced Clostridium Difficile cases. Continued focus was ongoing with the aim to further reduce infection rates.**

	The risk score for Hospital Sterilisation and Decontamination Unit (HDSU) sterile processes had been increased and the Committee was assured of the mitigations that had been put in place. There were now daily divisional meetings with HSDU and the issues had been escalated with executive oversight. **A review of the assurance routes into committees was requested to consider the triangulation between each assurance committees.** **The trajectories for the delivery of must-do's and should-do's recommended by the Care Quality Commission (CQC), were noted and accepted by the Committee.** **The Committee requested clear focus on timeframes for delivery, where proposed in reports.**
ASSURE **Assurance received; Matters of positive note.**	**The committee received assurance reports relating to:** **Annual Maternity Staffing Report** **Children and Young People Staffing** **Medical Device Assurance** **Controlled Drugs Improvement Framework** **CQC Investigation Outcome** **MHRA Inspection Outcome** **The reports provided an overview of areas of strength and areas that required continued focus.** **Children and Young People report provided the Committee with clear visibility on the care provision for children and young people within the organisation.** **The Committee received a copy of the Self-Assessment and Designated Body Controlled Drug Accountable Officer (CDAO) Improvement Framework. The responses to the self-assessment tool, along with the details relating to performance against standards and improvement actions captured in the quarterly CDAO Assurance Report and bi-annual Safety and Quality Committee Medicines Management Report provide good assurance of the safe management of controlled drugs in the Trust.** **The first annual maternity staffing review of 2025 provided details of the workforce strategies taken and the scrutiny and monitoring that had been applied to ensure all aspects of safe staffing had been duly considered. The perinatal quality surveillance dashboard (PQSD) was included and triangulated workforce information, patient experience and clinical effectiveness indicators to provide assurance of safe staffing levels. The review feedback from NHS England and external observations with regard to the maternity services also provided the Committee with detailed information and assurance.**

	The Committee confirmed its assurance of the system, process and policy of Equality Quality Impact Assessment management within the organisation. The Bi-annual Allied Health Professionals staffing report provided assurance of the workforce safeguards within AHP services.

Safety and Quality Committee

28 March 2025 | 12.30pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	12.30pm	Verbal	Information	K Deeny
2.	Apologies for absence	12.31pm	Verbal	Information	K Deeny
3.	Declaration of interests	12.32pm	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 28 February 2025	12.33pm	✓	Decision	K Deeny
5.	Matters arising and action log	12.35pm	✓	Decision	K Deeny
6.	Strategic Risk Register	12.45pm	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	12.55pm	✓	Assurance	C Gregory
7.2	Annual Maternity Staffing Report	1.05pm	✓	Assurance	J Lambert
7.3	Children and Young People Report	1.15pm	✓	Assurance	S Morrison
7.4	Controlled Drugs Improvement Framework	1.25pm	✓	Assurance	G Price
8.	GOVERNANCE AND COMPLIANCE				
8.1	CQC Investigation Outcome – Ref 77860 & 2022/6919	1.35pm	✓	Assurance	S Morrison
8.2	MHRA Inspection Outcome	1.45pm	✓	Assurance	R Dineley
8.3	Strategic risk register review	1.55pm	Verbal	Decision	K Deeny
8.4	Items to alert, advise or assure the Board.	2.00pm	Verbal	Information	K Deeny
8.5	Reflections on the meeting and adherence to the Board Compact	2.05pm	✓	Assurance	K Deeny
9.	ITEMS FOR INFORMATION				
9.1	Committee Cycle of Business		✓		
9.2	Exception report from Divisional Improvement Forums		✓		

№	Item	Time	Encl.	Purpose	Presenter
9.3	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group		✓		
9.4	Date, time and venue of next meeting: *25 April 2025, 11.00am, Microsoft Teams*	2.10pm	Verbal	Information	K Deeny

Safety and Quality Committee

25 April 2025 | 11.00am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	11.00am	Verbal	Information	K Deeny
2.	Apologies for absence	11.01am	Verbal	Information	K Deeny
3.	Declaration of interests	11.02am	Verbal	Information	K Deeny
4.	Minutes of the previous meeting held on 28 March 2025	11.03am	✓	Decision	K Deeny
5.	Matters arising and action log	11.05am	✓	Decision	K Deeny
6.	Strategic Risk Register	11.15am	✓	Assurance	S Regan
7.	QUALITY AND PERFORMANCE				
7.1	Safety and Quality Dashboard	11.25am	✓	Assurance	C Gregory
7.2	Bi-annual update of AHP Staffing Report	11.35am	✓	Assurance	C Granato
7.3	CQC Quarterly Update	11.45am	✓	Assurance	S Regan
8.	GOVERNANCE AND COMPLIANCE				
8.1	Equality & Quality Impact Assessment Report	12.00pm	✓	Assurance	S Morrison
8.2	Strategic risk register review	12.15pm	Verbal	Decision	K Deeny
8.3	Items to alert, advise or assure the Board.	12.20pm	Verbal	Information	K Deeny
8.4	Reflections on the meeting	12.25pm	Verbal	Assurance	K Deeny
9.	ITEMS FOR INFORMATION (matters to be raised by exception)				
9.1	**Chairs' reports from feeder groups**: a) Infection, Prevention and Control Committee b) Safeguarding Board c) PSIRF Oversight Group d) Medicines Governance Committee e) Patient Experience and Involvement f) Health Inequalities Group		✓		

№	Item	Time	Encl.	Purpose	Presenter
	g) Mortality and End of Life Care Committee h) Health and Safety Governance				
9.2	Date, time and venue of next meeting: *30 May 2025, 11.00am, Microsoft Teams*	12.30pm	Verbal	Information	K Deeny

9.2 *INFECTION PREVENTION AND CONTROL ANNUAL REPORT

Decision Item | C Gregory | 10.10am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack.

REFERENCES

Only PDFs are attached

09.2 - IPC Annual Report 2024-25 FINAL (002) Main Board.pdf

Board of Directors Report

Infection Prevention and Control (IPC) Annual Report 2024/2025						
Report to:	Board of Directors		**Date:**	3rd June 2025		
Report of:	Chief Nursing Officer		**Prepared by:**	Director of Infection Prevention and Control (DIPC) Dr D Orr IPC Matron S Marsh		
Part I	✓		**Part II**			
Purpose of Report						
For assurance		**For decision**	☒	**For information**	☐	

Executive Summary:

The purpose of this Annual report is to provide an overview of the progress made against the Infection Prevention and Control plan for 2024/2025 and assure the Board of Directors on the Trust's performance against key areas of Infection Prevention and Control (IPC).

Throughout the 2024/2025 period, there were high levels of community transmission of Norovirus and Influenza with subsequent spread in hospitals. This led to sustained operational pressures on the National Health Service (NHS).

In 2024/2025 the summary points of the IPC speciality include:

- There is stable leadership of IPC practice with Dr David Orr holding the position of Director of Infection Prevention and Control (DIPC), Dr Robert Shorten being appointed as the associate DIPC in December 2024, and Sarah Marsh providing Nursing Leadership as the Infection Prevention and Control Matron
- There were 0 hospital acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteraemia case.
- The *Clostridioides difficile (C. difficile*/CDI) objective was achieved, with 192 cases reported— 7 below the allocated trajectory by NHS England of 199. This marks the first time the trajectory has been met since 2019/2020, but it does follow an increase in the objective that was set from 2023/2024 of 132 cases. Overall, there has been a reduction in cases as 2023/2024 resulted in 203 cases. Nevertheless, *C. difficile* continues to present a significant risk to the organisation and incidence rates remain the second highest in the Northwest with a rate per 1000 bed days of 62.3. Hence, it is a principle risk under the new Trust Board Assurance Framework (BAF).
- The Objective for Gram - Negative Bacteraemia was exceeded by 10 cases with 109 cases out of an objective of 99.
- The Influenza season was sustained over 3 months from November 2024 to January 2025 which reflected the National picture.

- Norovirus - The year 2024/2025 saw a very high number of Confirmed Norovirus Outbreaks across the Trust and these had a significant operational impact. However, this matched the current National picture with increased spread of the new variant of Norovirus (GII.17)
- The introduction and implementation of the Patient Safety Incident Response Framework (PSIRF) focussing on system learning and advocating that time should be spent on value added improvement actions rather than investigating individual incidents that draw a conclusion of no new learning.
- The National Standards of Healthcare Cleanliness (2025) have not been fully implemented across all clinical areas within the Trust. Currently 15 wards are compliant within the existing resource of domestic services. Further roll out required further investment and a Business Case was produced that has now been approved by the Board of Directors. A phasing implementation plan for all other high and very high-risk areas will be implemented during the 2025/2026 period.
- There is increased assurance of IPC and cleaning processes via STAR.
- The IPC Team are working with Estates to improve completion of remedial work requests that have an IPC impact.
- All Divisions are achieving their target of over 90% compliance with IPC Mandatory training, and this is consistent throughout the year.
- The Trust has remained >90% compliant with documented indication on the drug chart and documented review within 72hrs for the full year. Compliance with Antimicrobial choice in line with guidelines or recommended by Microbiology was also >90% for the most quarters whilst in Q3 it was 85%.
- Water Safety – The Trust Water Safety Plan remains in place, and this supports the capital development programme. Hydrop, who provide the Trust's Authorising Engineer for Water have updated the Trust Water Safety Plan in line with new/revised guidance. The Authorising Engineer conducted the water safety audit 10th and 11th September 2024 in line with Health Technical Memoranda (HTM) 04. Overall, the audit outcome is positive considering the ageing Estate, and an action plan has been implemented to progress the identified improvement work. In 2024 /2025 the targeted augmented care areas were reviewed with the DIPC and Infection Prevention Control Matron to ensure the testing regimen is aligned with the clinical services being provided.
- Throughout the reporting period, the Sterile Services department demonstrated diligence in maintaining compliance with the HTM01-01 standards and ISO 13485:2016 Quality Management System. Staffing within the Estates Team is recognised as a risk with a score of 12 and has impacted on the frequency of water safety group meetings and reports. This requires improvement in 2025/26.
- Ventilation – The Estates services department continue to implement the relevant guidance within HTM 03 to control the risk of airborne particulate transmission despite challenges due to vacancies within the team and the trust financial position. The Estates team also continue to engage and independent authorising engineers to ensure new mechanical ventilation systems comply with new HTM guidance as well as identifying priorities for the 2025/26 backlog capital programme.
- Decontamination - The Trust decontamination lead has limited capacity to fulfil all the requirements of the role. Reports are provided on a quarterly basis to IPCC for assurance. This represents a risk for the Trust and discussions are underway to mitigate gaps and this will be added to the risk register.
- Waste - The Trust is in the process of implementing the colour coding for clinical waste across our sites. This follows good practice. A new clinical waste contract has been negotiated working with other Trusts in the local Integrated Care Board (ICB), providing Lancashire Teaching Hospitals with some cost savings. The IPC Continue to support the waste manager by attending monthly waste management meetings and continue to contribute to waste management initiatives.
- Research – Primel Study - In October/November 2024, the IPC team led in the implementation of a research study investigating a new hand hygiene product – Primel® Active Hand Coating (PAHC).

The report contains an update on the actions delivered in the 2024/25 IPC plan, the majority of which were completed but where a delay has occurred the reason for this is given alongside the plan for how this is being addressed. This closes the IPC plan for 2024/25 and presents the 2025/2026 IPC plan for approval.

It is recommended that subject to any review from the Safety and Quality Committee on 30th May 2025, the report be recommended for approval by the Board of Directors:

I. The Board of Directors note the contents of the Annual report and confirm that it is assured of progress against the 2024/2025 Annual Plan (Appendix 1).
II. Approve the IPC Annual Plan 2025/2026 (Appendix 2).

Please see the ancillary pack for the full report along with the below appendices.

Appendix 1 – IPC 2024/25 Annual plan
Appendix 2 – IPC 2025/26 Annual plan
Appendix 3 – *C. difficile* Improvement plan
Appendix 4 – Infection, Prevention and Control Structure
Appendix 5 – Community of Practice Agenda October 2024

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

Infection Prevention and Control Committee
Safety and Quality Committee

9.3 *PATIENT EXPERIENCE ANNUAL REPORT

Decision Item | C Gregory | 10.20am

*Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

09.3 - Patient Experience Annual Report 2025 Final reportv2 Main Board.pdf

Board of Directors Report

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

Report to:	Board of Directors	**Date:**	30th May 2025
Report of:	Chief Nursing Officer	**Prepared by:**	J Howles
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this annual report is to provide an update and assurance to Board of Directors on 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:

- **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).
- **Involvement** – Actively engaging patients and communities, increasing volunteer participation, representation from diverse groups, and inclusion of patient voices in governance and service development.
- **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 rollout of The Health Foundation's patient experience improvement scale, a research project led and coordinated by Imperial College which provides a structured framework for measuring and accelerating change over time.
- The developing focus on health inequalities saw a showcase as part of last year's Annual General Members' (AGM) Meeting, with the aim of raising awareness and driving engagement on this important topic.
- 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.

Those partially achieved objectives within the Patient Experience and Involvement strategy that have been identified as priorities for ongoing development within the single improvement plan include:

- Enhancing the collection and analysis of data related to equality, diversity, and inclusion to better inform service delivery and accessibility.
- Increasing training uptake in relation to the PALS and complaints handling processes to ensure consistent, empathetic, and effective resolution of concerns.
- Strengthening feedback mechanisms to ensure the voices of seldom-heard groups and individuals with protected characteristics are more effectively captured and acted upon.
- Advancing the development of personalised care pathways to better meet the individual needs and preferences of our service users.

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 how each clinical division represents that voice.

It is recommended that subject to any review from the Safety and Quality Committee on 30th May, the report be recommended for approval by the Board of Directors:

- The Board of Directors note the contents of this paper and the attached action plan.

Please see the ancillary pack for the full report along with the below appendices.

- Appendix 1 – The Patient Experience and Involvement Strategy 2022 – 2025
- Appendix 2 – Complaints Data
- Appendix 3 – Friends and Family Data

Trust Strategic Aims and Ambitions supported by this Paper:

Aims		Ambitions	
To provide outstanding and sustainable healthcare to our local communities	☒	Consistently Deliver Excellent Care	☒

To offer a range of high quality specialised services to patients in Lancashire and South Cumbria	☐	Great Place To Work	☒
To drive health innovation through world class education, teaching and research	☐	Deliver Value for Money	☒
		Fit For The Future	☐

Previous consideration

Safety and Quality Committee

9.4 *PSIRF ANNUAL REPORT

Decision Item | H Ugradar | 10.30am

* Exec summary only as part of board papers pack. Detailed report to be included in a separate ancillary pack

REFERENCES

Only PDFs are attached

09.4 - PSIRF Annual Report 2024-2025.pdf

Board of Directors

PSRIF Update and Annual Report of Incidents

Report to:	Board of Directors	**Date:**	30th May 2025
Report of:	Chief Nursing Officer	**Prepared by:**	H Hodgson/H.Ugradar
Part I	☑	**Part II**	

Purpose of Report

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

Executive Summary:

This purpose of this paper is to provide an annual update on the implementation of the Patient Safety Incident Response Framework (PSIRF) and an overview of incidents reported to the Strategic Executive Information System (StEIS) between 1st April 2024 and 31st March 2025.

Implementation of PSIRF

Throughout 2024/25, the Trust has successfully transitioned from the Serious Incident Framework (SIF) to PSIRF, embedding a comprehensive policy and implementation plan supported by a strengthened governance structure. This includes a two-tier incident triage system, with a weekly triage meeting and a weekly executive-led oversight meeting with learning triangulated in the monthly Always Safety First Learning and Improvement Group meeting. These structures ensure timely review, escalation, and learning from patient safety events.

The Trust is also awaiting the outcome of the PSIRF MIAA (Mersey Internal Audit Agency) review, which is expected to be positive and will provide further external assurance on the robustness of PSIRF implementation.

Incident Reporting Overview

In 2024/25, a total of 19 incidents were reported to StEIS, compared to 89 incidents in 2023/24. This reduction reflects the shift in reporting criteria under PSIRF, which now prioritises national and local priorities over harm level alone.

Of the incidents reported:

- 6 were classified as deaths thought more likely than not due to problems in care. This includes all cases where a patient sadly passed away and where acts or omissions in care were a contributory factor, or where the death was unexpected and required further investigation.

- 3 were Never Events, consistent with the number reported in 2023/24. All occurred within the Surgical Division and were categorised as Wrong Site Surgery (two wrong site anaesthetic injections and one wrong side eye injection), each resulting in low harm.
- 5 met the Maternity and Neonatal Safety Investigations (MNSI) criteria.
- 5 were aligned with the Trust's local priorities (3 under delayed recognition of a deteriorating patient, 1 under prescribing or administration error or near miss of anticoagulation medication, 1 under Adverse Discharge due to gaps in communication or misinformation)

During the reporting period of 2024/25, there have been 4 cases reported to StEIS which are also subject to a claim, 2 cases which have been subject to a formal complaint and 5 cases with the outcome of Death reported within this year are also subject to inquest.

Positive Trends in Reporting Culture
Incident reporting rates reached 4.2% of total activity in Q4 2024/25, compared to a long-term average of 3.8% from Q1 2020/21. This increase reflects a growing culture of transparency and learning. Trends are reviewed weekly through the weekly executive led Patient Safety Oversight Panel (PSOP) and formally reported through the quarterly PSIRF report. Learning bulletins are regularly issued in response to incidents.

Strengthening Safety Infrastructure
The Trust has transitioned its Datix system to the Learning From Patient Safety Events (LFPSE) system, which will eventually replace StEIS as the national platform for incident reporting. This transition is designed to improve the accuracy and depth of safety data available nationally. The Trust is preparing to upgrade to LFPSE version 6.0, aligning with national standards and enhancing analytical capabilities.

Due to the national transition from the NRLS to LFPSE, benchmarking against national incident reporting data remains limited. However, the Trust continues to monitor trends internally and adapt its systems accordingly. Datix has also been enhanced with tools for C. difficile and Pressure Ulcer reviews, and >90% of staff have completed Levels 1 and 2 of the NHS Patient Safety Syllabus.

Embedding Organisational Learning
The Trust has hosted a series of Community of Practice events, themed around insights from PSOP and incident reviews. Topics have included infection, prevention and control, listening to patients, leadership and safety culture, learning disabilities and autism.

Learning is also triangulated through monthly leadership patient safety visits, which provide real-time insights from clinical areas. Focus areas have included recognising and escalating care for the deteriorating patient, managing safety in areas with boarded beds, pressure ulcer prevention and the Purpose T tool, reasonable adjustments for patients with dementia, learning disabilities, and autism, VTE risk assessments, fluid balance management, theatre safety checks World Health Organisation (WHO) checklist compliance)

Learning bulletins are produced and feature throughout the organisation alongside sharing learning from incidents via clinical reference groups and weekly leadership forums, which are translated into key messages that are available to share easily with teams through department forums. The Trust quality assurance programme, STAR, is updated biannually to reflect the learning from incidents where it is recognised positive practice in areas can lead to improved outcomes for staff or patients.

Patient Engagement
The Trust remains committed to placing patients, families, and carers at the centre of its safety and learning processes. To support this, the Trust launched its new Being Open Policy (which includes Duty of Candour and PSIRF Engagement). The Trust also continues to embrace the national Patient Safety Partner (PSP) model, appointing three PSPs in November 2023 who are working to ensure that patient perspectives are embedded in decision-making, risk identification, and improvement planning

Real-Time Learning and Staff Support
The Trust continues to see high numbers of After Action Reviews (AARs), a trend consistent with other NHS trusts. While AARs remain valuable for structured reflection, the Trust is promoting greater use of SWARMs - rapid, team-based huddles conducted immediately after an incident. SWARMs support quicker learning, reduce reliance on governance teams, and empower frontline staff.

Recognising the emotional impact of incidents, and the success of early training in debriefing, the Trust plans to strengthen staff debrief training and support, ensuring staff feel heard, supported, and valued throughout the incident response process.

Monitoring Learning Responses
The Trust is actively monitoring the timely completion of learning responses to the PSIRF Oversight Panel. Further refinement of reporting is underway, with plans to incorporate updated KPIs into the Business Intelligence (BI) Portal Governance Dashboards. These dashboards will provide data to the Divisional Improvement Forums (DIF) and the quarterly PSIRF reports to the Trust Safety and Quality Committee going forward.

Looking Ahead: Priorities for 2025/26
In 2025/26, the Trust will carry out a full review of the PSIRF plan and workforce requirements, in line with the original implementation strategy. The Single Improvement Plan has a programme of work focused on Always Safety First (Safety and Learning) and is underpinned by the Always Safety First strategy which is currently under review having concluded its first three years. The new strategy will be launched in September 2025, coinciding with World Patient Safety Day. Additional planned priorities include:

- Comprehensive review of the PSIRF Local Priorities to ensure they remain aligned with the organisation's overarching safety profile and developing new processes in the Datix system, including a falls review tool, to support better analysis of themes and trends.
- Creating a tailored in-house training programme to build PSIRF capability and sustainability.
- Ensuring consistent and meaningful reporting against local safety priorities to the Safety and Quality Committee.
- Integrating key performance indicators into governance dashboards to monitor the timeliness of learning responses.
- Improving how learning responses are tracked and monitored.
- Exploring enhancements in Datix to help governance teams identify patterns and generate useful insights.
- Strengthening systems for tracking safety actions.
- Launching post-incident engagement surveys to gather feedback from patients and families involved in investigations.
- Placing greater emphasis on measuring and demonstrating the impact of safety improvements on patient outcomes.
- Increasing the use of thematic and multidisciplinary reviews.
- Including health inequalities in patient safety reporting and analysis.

- Supporting patients and staff who have experienced safety events.

Summary

During 2024/25, the Trust made significant strides in embedding PSIRF across the organisation by strengthening systems for incident response, enhancing staff training and engagement, and fostering a culture of openness and continuous improvement.

The focus for 2025/26 will include deepening the integration PSIRF into everyday practice and enhancing learning systems, reflecting our ongoing dedication to creating a safer, more transparent, and continuously improving healthcare environment:

It is recommended that the Board of Directors:

i. **Receive the updates on the implementation of PSIRF and confirm they are assured on the management of incidents.**

The full report is included in the ancillary pack.

Appendix 1 – Incident Analysis – Charts and Tables

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

Safety and Quality Committee – May 2025 (and previous updates through quarterly PSIRF reports).

9.5 QUALITY ACCOUNT

Other | C Gregory | 10.40am

Presentation
for consultation

10. GREAT PLACE TO WORK (WORKFORCE, EDUCATION AND RESEARCH)

10.1 WORKFORCE COMMITTEE CHAIR'S REPORT

Other | K Deeny | 10.50am

For Assurance

REFERENCES

Only PDFs are attached

10.1 - WFC Chairs Report 13 May 25.pdf

Chair's Report to Board		
Chair: Adrian Leather	**Workforce Committee**	
Date(s): 13 May 2025	**Agenda attached for information**	✓

Strategic Risks	trend	Items Recommended for approval
People: Be a Great Place to Work – current score 16	→	**Workforce Disability Equality Standard (WDES) Return** **Workforce Racial Equality Standard (WRES) Return**

ALERT

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

- With regards to workforce planning capacity, in the long term, there would be resilience through the relationship with One LSC and digitisation and AI. However, for this financial year, there was a risk which was only partly mitigated by planned actions.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- A medium-term solution was in progress to improve access to psychological support, with a current trainee recruited into a preceptorship role however it would be up to six months before they could start practising as a psychologist but could work under supervision. Job plans were under review to maximise clinical activity, and some services were being stepped down to prioritise reducing the waiting list. Additional counselling hours were being explored, though any impact was expected to take around three months.

  The Trust maintained a long-standing collaboration with Wigan Wrightington and Leigh for occupational health services, and entry into the One LSC shared model was deferred due to concerns over financial viability and the strength of the current arrangement. The psychological well-being service, operating independently and akin to a resilience hub, offered a level of support not matched by other regional trusts. Concerns were raised that integration into the One LSC model could dilute or eliminate existing services, particularly given high usage and waiting lists. It was also noted that exiting the current arrangement would require a year's notice and that the One LSC model lacked access to occupational health physicians.

- Efforts to achieve bronze in the anti-racist framework were ongoing, but the limited capacity within the EDI team was a hindering factor. Further proposals would be received in that regard.
- The Committee noted the broader context of fragile services, including radiotherapy, and the need for a clearer understanding of associated recruitment and retention risks. While recruitment risks had historically centred on medical posts, current concerns were increasingly focused on roles in clinical science, engineering, and other specialist areas, particularly within diagnostics and clinical support.
- The Committee noted the relevance of job planning, particularly for medical staff, in relation to Principal Risk 6 and its impact on the use and retention of locums. It was clarified that responsibility for monitoring job planning would sit with the Workforce Committee going forward, following recommendations from a recent MIAA audit.

ASSURE

Assurance received; Matters of positive note.

- Good assurance had been received around WRES and WDES, Freedom to Speak Up and the action plan in place following the staff survey results.

Workforce Committee

13 May 2025 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	a) Chair and quorum b) Temporary recording of meeting	1.00pm	Verbal	Information	A Leather
2.	Apologies for absence	1.01pm	Verbal	Information	A Leather
3.	Declaration of interests	1.02pm	Verbal	Information	A Leather
4.	Minutes of the previous meeting held on 11 March 2025.	1.03pm	✓	Decision	A Leather
5.	Matters arising and action log • FPC Referral	1.05pm	✓ ✓	Decision	A Leather
6.	Strategic Risk Register	1.10pm	✓	Assurance	S Regan
7. PERFORMANCE					
7.1	Workforce and organisational development integrated performance report review	1.20pm	✓	Information	K Downey
8. TO BE WELL LED					
8.1	Annual Appraisal Update	1.30pm	✓	Assurance	L Graham
9. TO CREATE A POSITIVE ORGANISATIONAL CULTURE					
9.1	Bi-annual Freedom to Speak Up Report	1.40pm	✓	Assurance	K Holt
10. TO ENGAGE, RETAIN, REWARD AND RECOGNISE					
10.1	Staff Survey Report and action plan	1.50pm	✓	Assurance	L Graham
11. GOVERNANCE AND COMPLIANCE					
11.1	Workforce Disability Equality Standard (WDES) Return	2.00pm	✓	Decision	L Graham
11.2	Workforce Racial Equality Standard (WRES) Return	2.20pm	✓	Decision	L Graham
11.3	Strategic Risk Register Review	2.40pm	Verbal	Decision	A Leather

№	Item	Time	Encl.	Purpose	Presenter
11.4	Items to alert, assure, advise to the board or items or referral to/from other committees	2.45pm	Verbal	Information	A Leather
11.5	Reflections on the meeting	2.50pm	Verbal	Assurance	A Leather
12.	ITEMS FOR INFORMATION				
12.1	Review Cycle of Business		✓		
12.2	Chairs' Reports from Feeder Groups/Workstreams a) Temporary Staffing Group b) Raising Concerns Group		✓		
12.3	Date, time, and venue of next meeting: *8 July 2025, 1.00pm via Microsoft Teams*	2.50pm	Verbal	Information	A Leather

10.2 *(A)?WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT 2025 AND *(B) WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORT 2025

Decision Item | L Graham | 11.00am

*Full reports in ancillary pack.

10.3 EDUCATION, TRAINING AND RESEARCH COMMITTEE CHAIR'S REPORT

Other | A Brotherton | 11.05am

For Assurance

REFERENCES

Only PDFs are attached

10.3 - ETR Chairs Report 8 April.pdf

Chair's Report to Board		
Chair: Prof StJohn Crean	Education Training and Research Committee	
Date(s): 8 April 2025	Agendas attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	trend	Items Recommended for approval
People and Partnership	→ 12	**None.**

ALERT

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

- Non-compliance with mandatory training in the following areas:
  - Medical and Dental core skills compliance
  - Resus Level 3 for Immediate Life Support and Resus Level 3 Paediatric Immediate Life Support
  - Resus Level 4 - Advanced Life Support and Advanced Paediatric Life Support
  - Safeguarding Children in Medicine Division

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- Potential for reporting of core skills training to transfer across to Workforce Committee.
- Improvements in training compliance following the introduction of the new compliance reporting tool with increased oversight and reporting.

ASSURE

Assurance received; Matters of positive note.

- Positive progress being made in relation to NETs survey.
- Continued support for research activity alongside successful collaboration with BioNtech.

Education, Training and Research Committee

8 April 2025 | 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	(a) Chair and quorum (b) Temporary meeting recording	1.00pm	Verbal	Information	Chair
2.	Apologies for absence	1.01pm	Verbal	Information	Chair
3.	Declaration of interests	1.02pm	Verbal	Information	Chair
4.	Minutes of the previous meeting held on 11 February 2025	1.03pm	✓	Decision	Chair
5.	Matters arising and action log	1.05pm	✓	Decision	Chair
6.	STRATEGY AND PLANNING				
6.1	Research Annual Showcase	1.10pm	✓	Information	P Brown
7.	PERFORMANCE				
7.1	Core Skills Training Report	1.35pm	✓	Assurance	L O'Brien
7.2	Quality Assurance Report	1.45pm	✓	Assurance	L O'Brien
8.	GOVERNANCE AND COMPLIANCE				
8.1	Feeder Groups Terms of Reference	1.55pm	✓	Decision	L O'Brien
8.2	Strategic Risk Register	2.05pm	✓	Assurance	S Regan
8.3	Items to alert, assure, advise to the board or items or referral to/from other committees	2.15pm	Verbal	Information	Chair
8.4	Reflections on the meeting	2.20pm	Verbal	Information	Chair
9.	ITEMS FOR INFORMATION				
9.1	Review Cycle of Business	2.25pm	✓	Information	Chair
9.2	Date, time, and venue of next meeting: 10 June 2025, 1pm via MS Teams	2.30pm	Verbal	Information	Chair

11. DELIVER VALUE FOR MONEY (FINANCE AND PERFORMANCE)

11.1 INTEGRATED PERFORMANCE REPORT

Other | Executive Team | 11.15am

including Finance update and Single Improvement Plan
Item for assurance

REFERENCES

Only PDFs are attached

11.1 - Integrated Performance Report as at 30 April 2025.pdf

Board of Directors Report

Integrated Performance Report			
Report to:	Board of Directors	**Date:**	3rd June 2025
Report of:	Executive Team	**Prepared by:**	Executive Directors
Part I	✓	**Part II**	

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

Executive Summary:

The purpose of this report is to provide the committee with an update on the Trust's performance as at the end of April 2025, unless otherwise stated.

Performance

UEC: Performance against the national 4-hour access standard was above the April 2025 Operational Plan trajectory for the month, with an improvement in performance of 1.5% compared to March 2025. This is the second month of improved 4 hour performance (all types) however the Trust is below the latest national average of 75.0% (Mar 25) and is ranked 16th out of 45 sites in the NW Region for March 25 (all types).

Performance remains below the required target for ambulance handover. However, April 25 performance has seen a continued marked improvement in all handover targets (15 min, 30 min and 60 min) versus last month with an improvement of over 6% in patients handed over from NWAS within 60 minutes, although performance remains considerably below target. The percentage of patients with an ED LOS of 12 hours+ increased marginally in April versus the previous month and was 5% higher than the picture in April 2024. The April 25 level of 12 hour+ ED LOS was 87 above the 24/25 monthly average. This remains a key area of focus within the UEC Improvement Plan and links closely to hospital bed occupancy and the number of patients who are classified as 'No criteria to reside' (NCTR).

The number of patients within this NCTR cohort remained very high in April, although the proportion of patients that did not meet criteria to reside decreased to 13.9%, a further reduction of 1.3% compared to March 25. Immediate actions are being undertaken supported by a 25/26 Days Kept Away from Home transformation programme. This will seek to significantly reduce the number and days patients spend away from home without clinical rationale. Metrics to support this initiative are currently in development.

Consequences of high bed occupancy above the target level in recent months had resulted in an increase in the number of patients 'boarded' in non-bed spaces. The April position saw a third month of decrease with boarding numbers recorded at an average of 14 boarded patients in the month, down from 20 in March 25. The number of escalation beds occupied decreased further from 12 in March to 6 in April. Actions to mitigate this focus on improving ward and board round processes with a Rapid Improvement week planned towards the end of February, increasing the use of Same Day Emergency Care (SDEC) facilities (April has seen the third month of increasing SDEC activity with performance recorded at 41%), the re-introduction of continuous flow, improved discharge processes and mobilisation of the new AMU model of care.

Elective Recovery: March has seen an increase in the number of over 52-week waiters with 1642 reported in Apr 25 versus 1372 in Mar 25, an increase of 270. The number of patients waiting 65 weeks at the end of April reduced to 17, compared to 19 breaches at month end Mar 25, these were due to capacity shortfalls. Comparison of the latest NW region position indicates that the Trust is currently 12th out of all acute and specialist trusts and 6th out of acute Trusts in terms of the overall number in the 65-week cohort with ongoing reductions each week. Close monitoring of long waiting RTT clock stops is ongoing.

Cancer: Whilst the Faster Diagnostic standard performance is below the operational plan for April 25 this is an unvalidated position and is anticipated to achieve the increased target with a strong performance evident over the past 12 months. The 31-day target remains unvalidated however has seen an improved performance since last month and is anticipated to achieve the target of 86%. There remains pressure within 62-day performance with compliance for April 25 (49.4%) being below trajectory however this remains an unvalidated position and is expected to improve once validation is complete however is predicted to be below target because of shortfalls in capacity and some pathways experiencing late tertiary referrals. Based on typical periods of validation this is likely to increase by ~5%. Waiting list performance however does show a continued reduction in the number of patients over 62 days awaiting treatment.

Key areas of focus pertain to surgical capacity linked to theatre space and anaesthetic workforce shortfalls and oncology capacity. Oncology referrals have seen a ~13% increase versus last year with national workforce pressures making recruitment very challenging. Work is ongoing at a regional level to improve capacity and productivity.

Diagnostics: Performance against the Diagnostic access standard (DM01) improved further in April 25 (fourth month of improvement) to 63.2%, an improvement of 5% compared to March 25 however performance remains significantly under the national 95% target. Pressures persist in several modalities (CT, Echo, Audiology, Endoscopy and sleep) with modality level improvement plans in place with weekly monitoring of progress via Performance recovery group. Actions focus on demand management, improvements in productivity, optimal waiting list management and recruitment into vacant posts.

Patients

Safe Staffing requirements
Nurse and Midwifery safe staffing reporting continues on a monthly basis through the safety and quality committee. The adult inpatient areas remain in a positive position with RN staff fill rates achieving 96% and HCA achieving 104%. The maternity fill rate position for registered midwives (RM) achieved 93% in month. The maternity support worker fill rate has improved from previous months now at 91%. Sickness and vacancy rates are affecting fill rates with temporary staff used to maintain safe staffing levels.

Patient Experience and Involvement
The number of complaints per 1000 beds days continues to demonstrate a sustained reduction. This positive trend reflects an increased focus on achieving local resolution for patients and their families, enabling concerns to be addressed promptly and effectively at the point of care. Improving patient experience remains a key focus. Targeted efforts are underway as part of the Urgent and Emergency Care (UEC) improvement plans and enhancements to inpatient pathways. Insight from the national inpatient and ED surveys have provided specific areas of focus and feedback from patients, informing immediate and longer-term actions. It is acknowledged that the UEC pathway has significant impact on the overall experience of patients, families and staff and as such remains a key priority within the Trusts patient experience improvement plan.

Clostridioides difficile (C. difficile/CDI)
The *Clostridioides difficile (C. difficile*/CDI) objective was achieved, with 192 cases reported— 7 below the allocated trajectory by NHS England of 199. This marks the first time the trajectory has been met since 2019/2020, but it does follow an increase in the objective that was set from 2023/2024 of 132 cases. Overall, there has been a reduction in cases as 2023/2024 resulted in 203 cases. Nevertheless, *C. difficile* continues to present a significant risk to the organisation and incidence rates remain the second highest in the Northwest with a rate per 1000 bed days of 62.3. Hence, it is a principle risk under the new Trust Board Assurance Framework (BAF).

STAR accreditation
The STAR accreditation standards continue to exceed the internally set target, providing assurance of sustained performance across the organisation. The Star accreditation process has recently been refreshed to incorporate new mandatory standards that align with historically underperforming areas. While this adjustment was predicted to temporarily impact outcomes within STAR negatively, particularly in higher-risk areas such as wards, theatres and ED, it was a deliberate strategy to drive targeted improvement. Signs of recovery can now be seen in the data, indicating that the new standards are beginning to have the desired effect. To strengthen oversight and further mitigate risk, the Trust level reporting has been disaggregated to clearly differentiate performance in higher risk ward, ED and theatres. This enhanced visibility supports more focussed quality improvement efforts and targeted support where needed. Overall, the STAR accreditation framework remains and robust and responsive tool for quality assurance.

Hospital Standardised Mortality Ration (HSMR) and Standardised Mortality Rate (SMR)
Mortality metrics remain stable and within expected parameters. There were two stillbirths in April (both cases were terminations of pregnancy due to foetal anomaly). This followed a two-month period with 0 occurrences. Statistical Process Control (SPC) chart analysis shows no significant variation or emerging patterns of concern. The 12-month mean average (May 24-April 25) stillbirth rate is 2.8 per 1000 which is lower than the national average of 3.9 per 1000 births. Assurance has been received that the previously identified data quality issue in internal reporting has now been addressed. This note will remain until the data is corrected; this is anticipated by the end of Q1.

Pressure Ulcers
The Trust continues to monitor the incidence of pressure ulcers as a key indicator of care quality. Pressure ulcer data is now benchmarked against the average number of pressure ulcers reported over the past year. Current rates remain stable and within upper and lower control limits, indicating consistency in performance over time. Pressure ulcers are considered as a proxy for the standard of care delivered and as such, remain a priority area for clinical teams. A targeted improvement plan is in place with the dual aim of reducing overall incidence and the severity (category) of pressure ulcers reflecting the significant negative impact to patient outcomes and experience that occurs when a pressure ulcer is acquired in hospital. Whilst the number of pressure ulcers over time has remained within normal variation, there has been a reduction in harm level and this reinforces the importance of sustained focus on preventative measures. This work continues to be a priority for the clinical teams.

Maternity
The Board approved the submission to declare full compliance with the 10 CNST standards in February 2025.

Boarding
The practice of placing patients in non-designated bed spaces across both adult inpatient wards and in the Emergency Department (ED) is referred to as boarding, This, remains a current necessary short-term measure to maintain patient safety within ED and reflects wider systemic pressures within the Urgent and Emergency Care (UEC) system and it is not planned to be a long-term solution. Boarding is a symptom of capacity constraints. To address this there is a programme of work ongoing to focus on alternative pathways of care, working with partners to ensure suitable capacity is created to meet the demand identified within community and internally, to implement a continuous flow model which is designed to improve the timeliness and coordination of patient transfers, ultimately enhancing the quality and continuity of care. Boarding within adult inpatient wards has reduced for the third consecutive month with an average of 14 patients per day but there has been a slight increase in boarding within ED during April with a daily average of 21.

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

At the end of April 2025, of the 'Must Do's' included in the 2023/2024 CQC Quality Improvement Plan (QIP), 78% of Must do actions are delivered. 3 (17%) remain 'amber-red'. 1 (6%) action remains amber-green. There are no actions currently assessed as 'Red' i.e. not expected to deliver at any point in time.

At the end of April 2025, of the 'Should Do's' included in the 2023/2024 CQC QIP, 97% of should do actions are delivered. 1 (3%) should do actions remain 'amber-green'. There are no actions currently assessed as 'Red' i.e. not expected to deliver at any point in time.

People

Sickness absence increased in month 1, and in response a range of new measures have been introduced. These include:

- launch of the new Attendance Management on 12 May, with increased focus on early intervention
- restrictions on working additional hours following sickness absence to support wellbeing during recovery
- senior case review of all long-term absence cases > 6 months

In addition, a Rapid Improvement Event is being planned with divisional teams, and procurement of the digital absence management system has advanced, enabling implementation planning with the supplier.

Violence and aggression incidents have risen over the last 2 months, with some particularly challenging incidents in the Emergency Department. The security team have implemented 24-hour cover in Emergency Department and have planned monthly review sessions with the clinical team to review incidents and identify further support needed. Closer liaison with the police has also been progressed.

Core skills mandatory training compliance and appraisal completion have both improved since Month 11, with further measures being explored to ensure improvement continues.

As anticipated the vacancy rate remains high due to vacancy control measures, although a number of essential posts have recently been filled through redeployment or been advertised. Month 1 turnover was significantly lower than the previous month.

Productivity

Income and Expenditure
The Trust submitted the final financial plan to NHSE at the end of April. For 2025/26 the Trust has a break-even plan which is reliant on a recurrent waste reduction programme of £60m and non-recurrent deficit support funding of £30m.

At the end of April 2025 the Trust has a deficit of £5m against a planned deficit of £2.8m.

The adverse variance to plan of £2.2m is mainly as a consequence of the shortfall in delivery of the Waste Reduction Programme. The Trust has not yet identified the full £60m programme and the unidentified element was included in the plan in 12ths in accordance with NHSE policy.

The Trust has operational pressures in:

- the acute medical pathways reflected in overspends in medical and nursing pay budgets
- sickness remains higher than in operational budgets resulting in nursing pay overspends

Capital Position
Capital expenditure in April at £0.2m is marginally below plan.

Cash Position
The Trust has not required cash support in April and does not forecast a requirement in Q1. Forecasts suggest that cash support from DHSC will be required in Q2 of 2025/26 and an approval to access such support will be sought from the Board of Directors in line with DHSC timescales.

However, it should be noted that it is highly unlikely that revenue support will be approved by DHSC.

Waste Reduction Programme
The Trust's objective to reach financial balance on a recurrent basis by the end of the three-year period (2026-27) will require delivery of an ambitious and very challenging financial recovery plan. The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure.

At the end of April the Trust has delivered £4.2m of the £60m target. The delivery in month was £0.5m against a plan of £2.7m. The Trust has identified £35m of the £60m programme 58%.

Use of Resources
The Trust was notified on 4 February that it has now been put in Segment 4.

Segment 4 is where there is actual or suspected breach of the NHS provider licence with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support.

Segment 4 means the Trust will receive mandated intensive support delivered through the Recovery Support Programme.

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

Previous consideration

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

The Best Version of Us
Our Culture Counts @LTH

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Integrated Performance Report

June 2025 Trust Board meeting with performance to April 2025


Partnerships


People


Patients


Productivity


Performance

Excellent care with compassion

Always Safety First

@LancsHospitals

Contents

Key to Metric Variation, Assurance Icons & Dashboard Headers

Lancashire Teaching Hospitals NHS Foundation Trust

Key to Metric Variance and Assurance Icons

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

Key to Metric SPC Chart and Variance and Assurance Icons

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

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

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

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

Report heading explanation

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

A flag is generated for metrics that are calculated as requring

The latest month target or threshold.

Data to the end of.

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

The name of the Metric

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

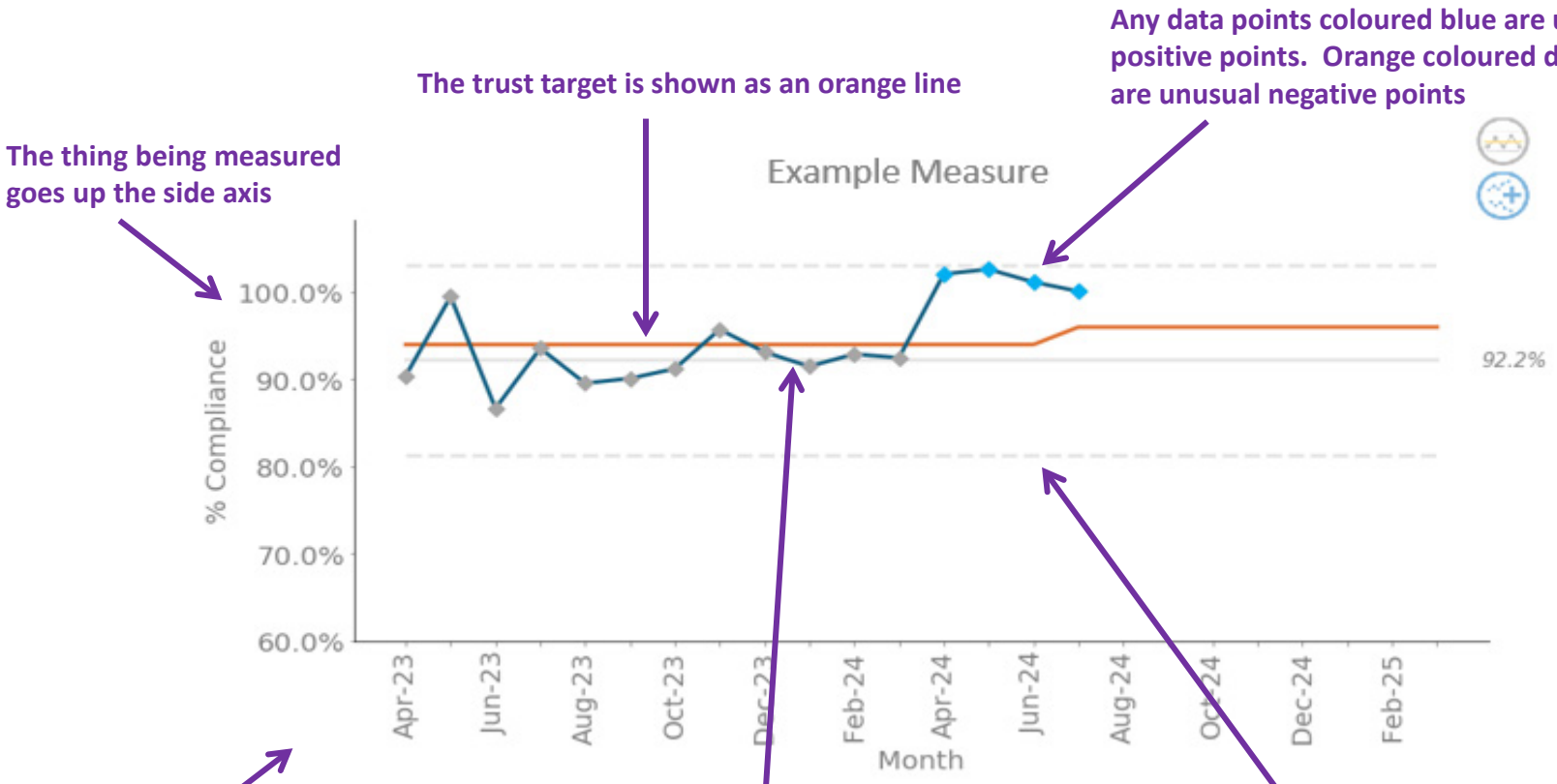
This March 2025 target

The current month actual performance.

How to read Statistical Process Control charts (SPC)

Lancashire Teaching Hospitals NHS Foundation Trust

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



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

SPC KPI Metric Grid

Lancashire Teaching Hospitals NHS Foundation Trust

Variation \ Assurance	Will consistently fail target within expected variation	Could both pass or fail target within expected variation	Will consistently pass target within expected variation
Recent concerning pattern in the data	- Staff Survey: Recommend Trust as place to work - Sickness Absence (% FTE) - Reduce not meeting criteria to reside to 5% - Percentage of patients waiting less than 18 weeks - 31 Day Cancer Standard	- Vacancies (% FTE) - Staffing Fill Rate - Maternity Support Worker - Compliance with 60 minute ambulance turnaround time target - Maximum wait of 12 hours as Total Time in Department	
Normal variation - no recent change	- Percentage of UEC (Type 1 & 3) patients seen within 4 hours - Bed occupancy to 90%	- Number of violence and aggression incidents toward staff - Staffing Fill Rate - Health Care Assistant - Staffing Fill Rate - Registered Midwife - Complaints per 1000 bed days - C. diff perf against national trajectory - no more than 199 Hospital Acquired cases - Pressure Ulcers per 1000 beds days (Category 2 and above) actions - Perinatal - Number of Stillbirths - 85% theatre utilisation - aggregate - Capped - Cancer Faster Diagnosis Performance - RTT - 52 week Waiters	- Turnover (% FTE) - Staffing Fill Rate - Registered Nurse - STAR Accreditation all trust (Silver and Above)
Recent positive pattern in the data	- Number of boarded patients - Percentage of patients that receive a diagnostic test within six weeks - RTT - 65 Week Waiters	- Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety	

Non SPC Metrics flagged as a concern

% of must do's from QIP 2023/24 assessed as Green (i.e. delivered)

% of should do's from QIP 2023/24 assessed as Green (i.e. delivered)

I&E - Plan V Actual variance

WRP schemes delivery

Non SPC Metrics

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

People
Patients
Productivity
Performance

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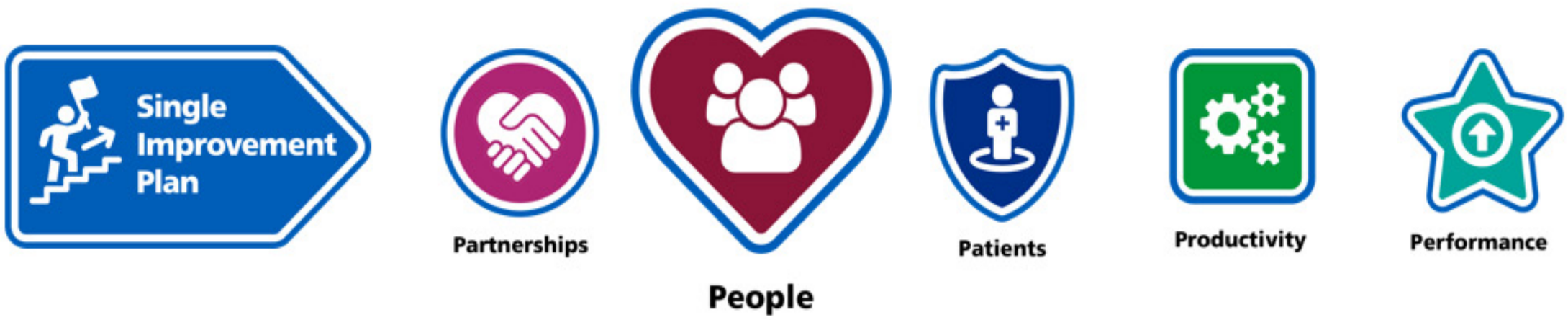
People



People

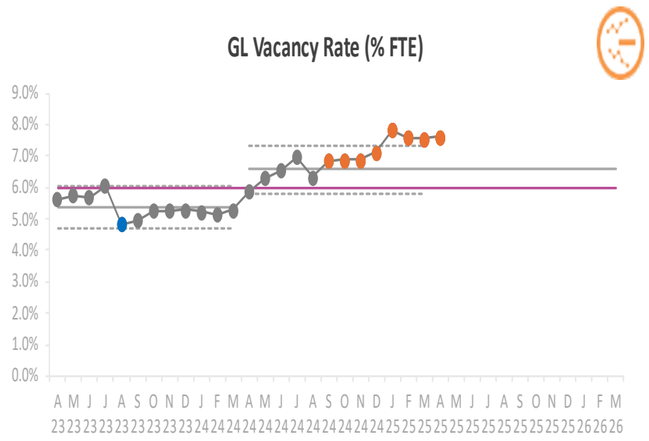
Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		FY2526 Target Assurance	Latest Actual Variation	Target			Latest Actual	Latest Period
				Concern	FY2526	Latest Month Target		
People and Culture	Vacancies (% FTE) (source: General Ledger)				≤ 6%		7.61%	M01
	Turnover (% FTE) (annual assessment; ESR in-month reported)				≤ 10%		0.56%	M01
	Sickness Absence (% FTE) (annual assessment; in-month reported)				≤ 5.24%		6.74%	M01
	Number of violence and aggression incidents toward staff (annual assessment; in-month reported)				996		138	M01
	Core Skills Mandatory Training compliance (% modules) (module compliance reported)				≥ 90%		95.72%	M01
	Appraisal compliance (% HC)				≥ 90%		90.52%	M01
	Staff Survey: Recommend Trust as place to work (quarterly metric)				≥ 60%		42.10%	Q4

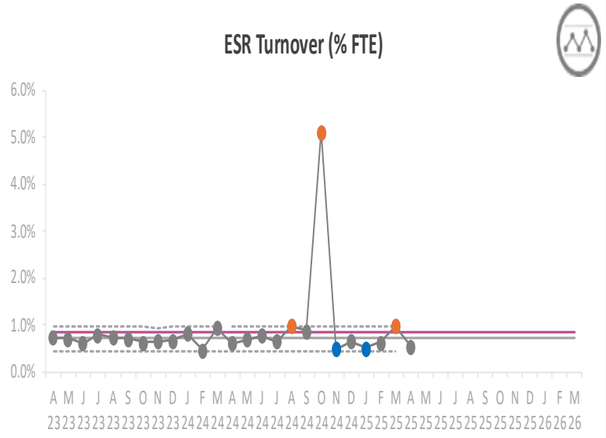
People - Workforce Assurance 1

Single Improvement Plan | Partnerships | People | Patients | Productivity | Performance

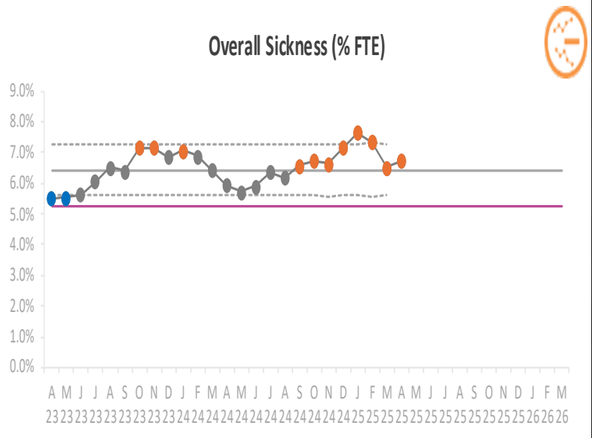
NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest
7.61%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≤ 6%
Target Achievement
Could both pass or fail target within expected variation



Latest
0.56%
Variance Type
Normal variation - no recent change
Mar 26 Target
≤ 10%
Target Achievement
Will consistently pass target within expected variation



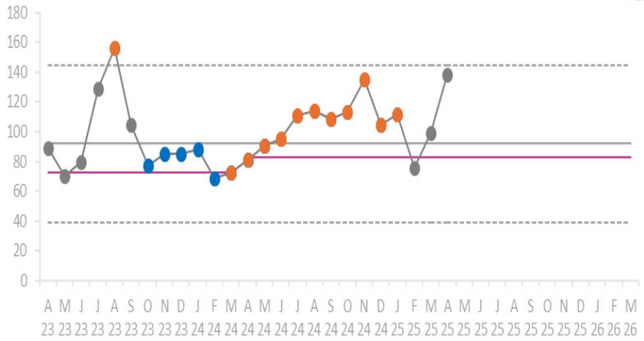
Latest
6.74%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≤ 5.24%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Vacancies (% FTE)	Vacancy rate remains high due to vacancy control measures, however over 100 wte posts have been filled through redeployment in the last month, and a number of essential posts have been released for external advert	Divisional management teams reviewing all long-standing vacancies enabling cleansing of establishments Strategies to address Band 3 Healthcare Support Worker gaps being jointly developed by nursing, education and workforce teams Vacancy control process updated to include defined times for holding posts for redeployment and internal/external advertising All posts currently held for redeployment under review	Vacancy rate monitored through Board reporting, Workforce Committee and Divisional Improvement Forums Safe staffing levels monitored daily in clinical areas New People Operations Group to include a focus on resourcing EQIA process utilised to support vacancy control decision-making
Turnover (% FTE)	In-month turnover significantly reduced in M1 and is below target.	Leaver and exit interview data continues to be monitored to identify any patterns or themes of concern. Any issues are escalated to HRBP colleagues and themes/trends discussed through the Monthly Recruitment and Retention Group and Divisional Workforce Committees. New Stay Conversations launched via corporate forms with guidance communicated through Monthly Managers Update Sessions. Some initial uptake has been seen - further work required to embed across Trust. New starter Forums planning underway for delivery in July to understand colleague experience during onboarding/first year.	Annual retention strategy update report provided to Workforce Committee. Delivery of retention strategic action plan at corporate level, working with Divisions, Departments and Teams to support improvement in hot spot areas. 6 monthly retention updates provided to Divisions.
Sickness Absence (% FTE)	Sickness absence increased in M1, following a reduction over the preceding 2 months. Long-term absence continues to account for over two-thirds of the overall absence rate and is therefore the primary focus. Approximately 30% of all sickness absence us due to mental health.	New Attendance Management policy published 12 May and launch event held for managers Procurement of digital absence management system has advanced enabling implementation planning to commence in detail To support colleague wellbeing, new restrictions around working additional hours following sickness absence will be introduced in June Occupational Health physiotherapy gaps soon to be resolved following successful recruitment of 1 post-holder with a 2nd post due to be offered Agreement to recruit a further fixed term psychologist to address capacity gaps and enable proactive work to be progressed	Twice yearly assurance reports to Workforce Committee Actions resulting from the MIAA Sickness Absence Management audit monitored through Audit Committee 'Failure to manage sickness absence management effectively' is a Principal Risk and subject to monthly risk management review Fortnightly sickness absence task and finish group in place to monitor actions of the sickness absence reduction plan Paper to May TMB outlined actions completed, ongoing or newly developed

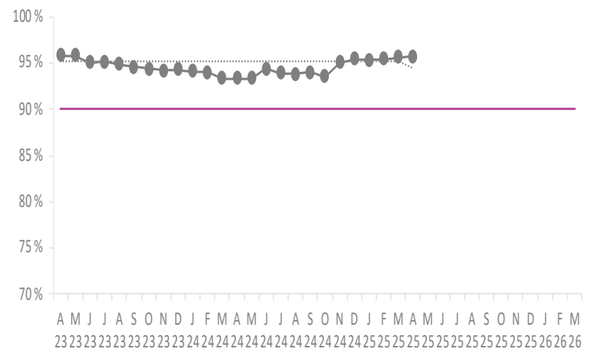
People - Workforce Assurance 2

Single Improvement Plan | Partnerships | People | Patients | Productivity | Performance

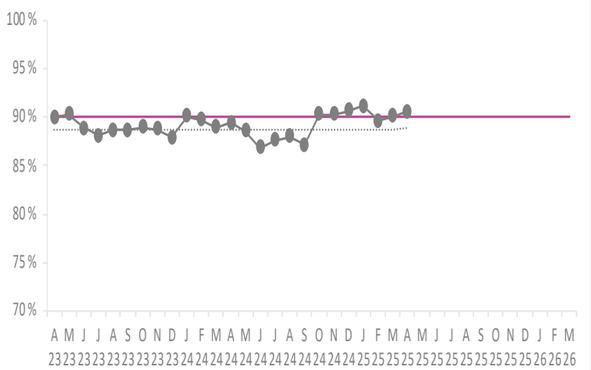
NHS Lancashire Teaching Hospitals NHS Foundation Trust



Latest
138
Variance Type
Normal variation - no recent change
Mar 26 Target
NA
Target Achievement
Could both pass or fail target within expected variation



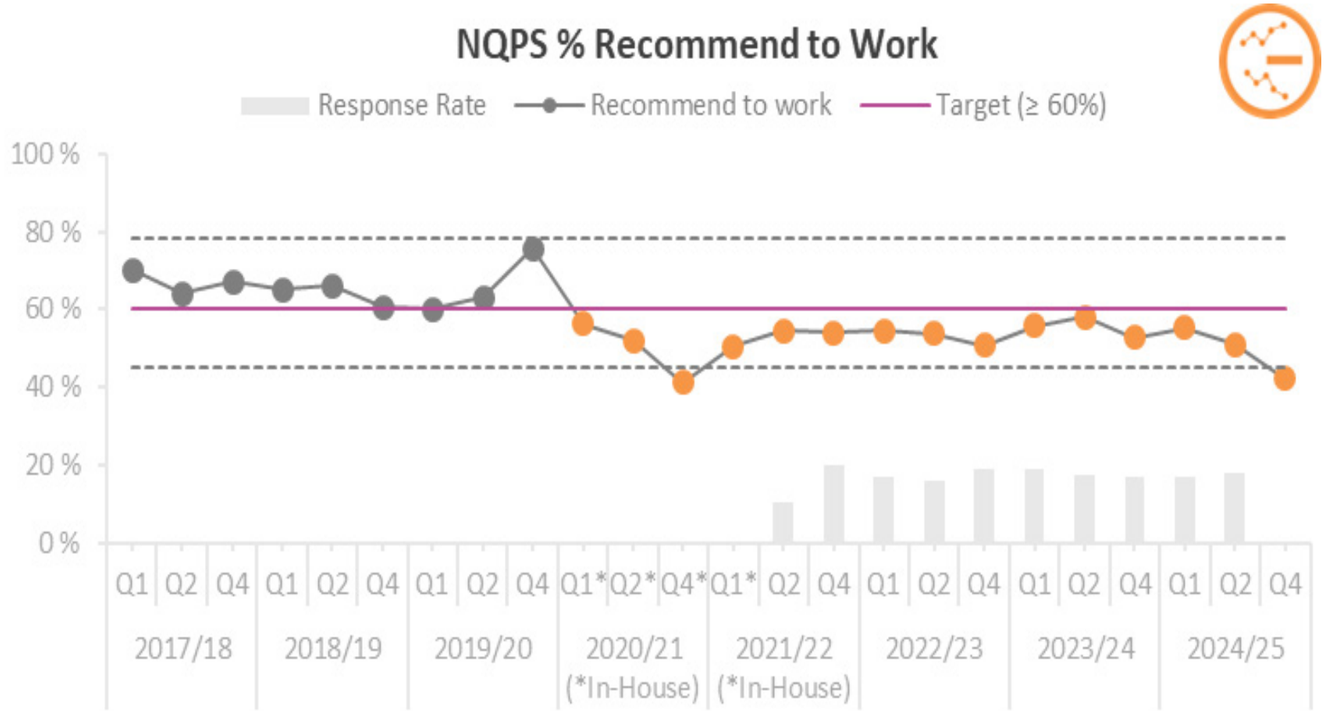
Latest
95.72%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement



Latest
90.52%
Variance Type
Mar 26 Target
≥ 90%
Target Achievement

Metric	Summary	Action	Assurance
Number of violence and aggression incidents toward staff	Incidents have increased over the last 2 months, and there have been some particularly challenging incidents in Emergency Department	Monthly meetings established for Emergency Department with clinical, security and workforce representatives to review actions and learning from recent incidents Security presence increased in ED with the aim of 24/7 cover, and an assessment of all other security measures underway Liaison between Resilience leads and police recently strengthened Violence and aggression risk assessment for wards/departments reviewed by Big Room and will be relaunched in June Violence marker process being reviewed through the Big Room with Safeguarding involvement, with a particular process on how accessible information is to the clinical teams	Twice-yearly deep dive reports around incidents and actions to Workforce Committee Incident data reviewed through Health & Safety Governance Group
Core Skills Mandatory Training compliance (% modules)	Overall Trustwide Core Skills and Mandatory training compliance is 95.72%. Three metrics have not achieved compliance (Resuscitation Level 3 ILS, NILS and PILS).	Targeted intervention and focus has taken place for Resuscitation training, including a review of the Training Needs Analysis. Training provision has been increased and there is enhanced levels of scrutiny and reporting at divisional and professional level.	High levels of engagement at divisional level and targeted intervention by the Resuscitation team is positively impacting Level 3 compliance figures and this will be reflected in the Trustwide reports in May.
Appraisal compliance (% HC)	Appraisal compliance was 90.52% in April which is above the target of 90%. Areas with the lowest compliance include Hosted Services (64%) and Estates and Facilities Management (67%)	All Divisions and Department have received Appraisal compliance data via Workforce Business Partner and Education Compliance Teams, asking to develop plans to achieve 90%. Trust wide communications have been sent to all colleagues with regards to the Standard Operating Procedures which are now being deployed with regards to centralised close when Appraisal target dates have passed however appraisal not closed in a 4 week time period.	Annual Appraisal Update presented to Workforce Committee in May 2025. Divisional Performance metrics shared in Divisional Workforce Committees and Divisional Improvement Forums.

People - Workforce Assurance 3



Latest
42.1%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
≥ 60%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Staff Survey: Recommend Trust as place to work	**Please note: This is a quarterly metric; therefore, there is no update this month. The data remains unchanged from that reported in April's PC Assurance Dashboard** April: There has been a further drop in levels of colleague engagement in the Quarter 4 National Quarterly Pulse results (NQPS), in Q2 it was 51%, in Q3 49.4%, through to the most recent Q4 at 42.1%. There is a significant deterioration in levels of satisfaction and engagement. The Q4 data reflects the themes identified in the full NHS Staff Survey Results for 2024.	A corporate-level action plan, developed in response to the NHS Staff Satisfaction Survey, was presented in May and approved by the Workforce Committee. The plan focuses on addressing areas of dissatisfaction that are contributing to lower levels of colleague engagement, as reflected in the Quarter 4 (Feb 2025) National Quarterly Pulse Survey data. Survey results have been shared through multiple forums. All Divisions, Departments, and Managers have been asked to review their local results and develop targeted action plans to drive improvement. A comprehensive communication plan is in place, with weekly updates and targeted interventions currently being delivered across a range of workstreams.	Workforce Committee reports detailing the programme of work in response to NHS Staff Survey data and national benchmarking. Delivery of the corporate action plan progressed through collaboration with relevant teams and leads addressing priorities/themes. Divisional action plans are scheduled for monthly review through Divisional Workforce Committees - frequency and depth of reporting varies across Divisions. Enhanced team support activity is ongoing in targeted areas of concern, with progress tracked and reviewed through Organisational Development operational meetings.

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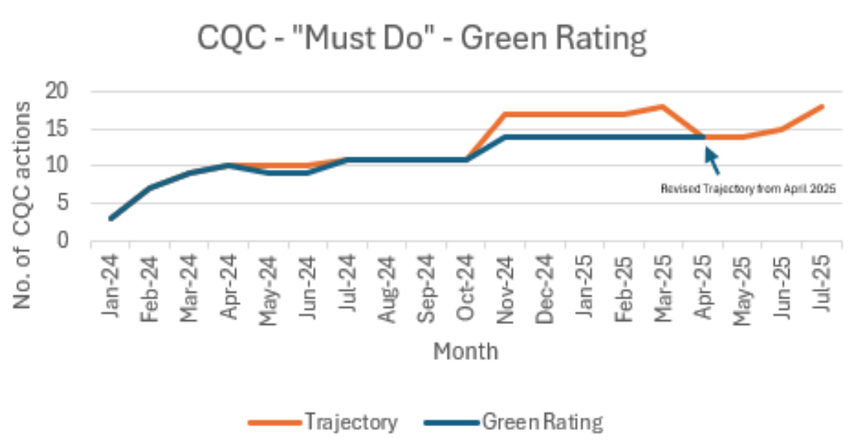
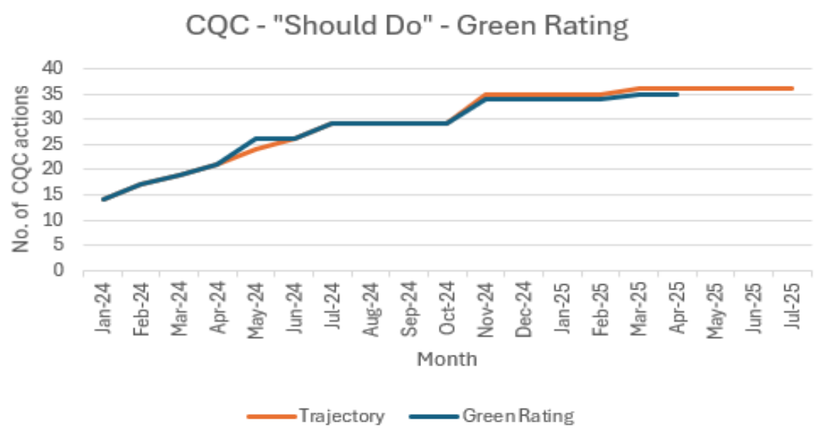
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target			Latest Month Actual	Latest Month
				Concern	Mar-26	Latest Month Target		
CQC	% of must do's from QIP 2023 assessed as Green (i.e. delivered)				18	14	14	Apr-25
	% of should do's from QIP 2023 assessed as Green (i.e. delivered)				36	36	35	Apr-25
Deliver Annual Safe Staffing Requirements	Staffing Fill Rate - Registered Nurse				95%	95.0%	96.2%	Apr-25
	Staffing Fill Rate - Health Care Assistant				95%	95.0%	103.6%	Apr-25
	Staffing Fill Rate - Registered Midwife				95%	95.0%	93.2%	Apr-25
	Staffing Fill Rate - Maternity Support Worker				95%	95.0%	90.5%	Apr-25
Patient Experience and Involvement	Complaints per 1000 bed days				1.40	1.40	0.90	Apr-25
	STAR Accreditation all trust (Silver and Above)				75%	75.0%	85.0%	Apr-25
C Difficile Improvement	C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases				17	17	9	Apr-25
Always Safety First	Hospital Standardised Mortality Ratio (56 Basket – Adult)	As Expected					85.4	Dec-24
	Standardised Mortality Rate (All Diagnoses – Adult)	As Expected					89.5	Dec-24
	Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected					89.3	Dec-24
	Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected					102.9	Dec-24
	Pressure Ulcers per 1000 bed days (Category 2 and above)				3.48	3.02	3.43	Apr-25
Maternity	Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions				100%	100%	100%	Apr-25
	Perinatal - Number of Stillbirths				0	0	2	Apr-25

Patients - CQC Assurance



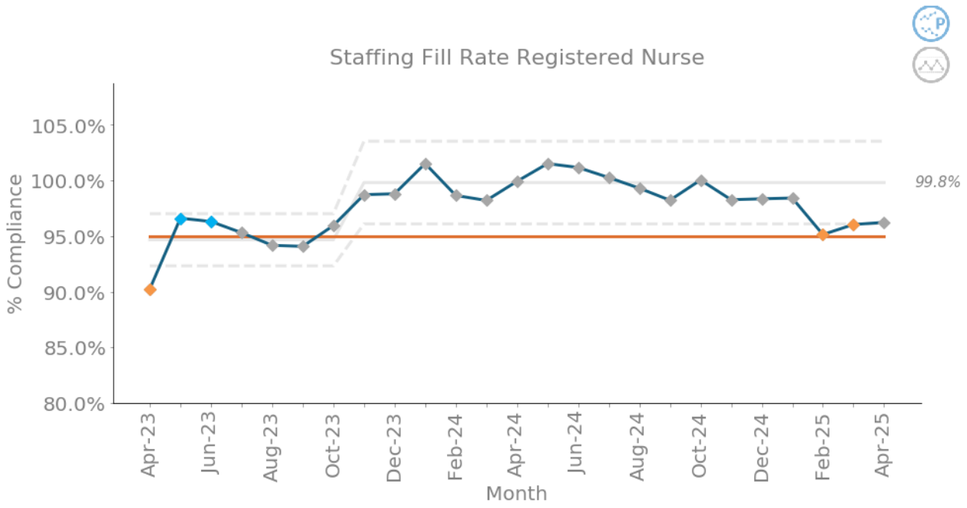
Latest
14
Month Target
14
July-25 Target
18



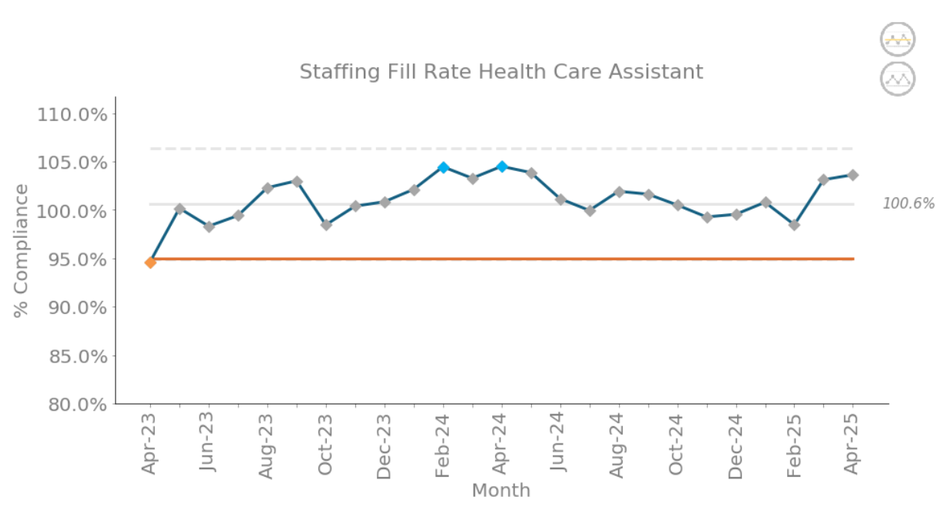
Latest
35
Month Target
36
July-25 Target
36

Metric	Summary	Action	Assurance
CQC - "Must do" (Number with Green rating)	At the end of April 2025, of the 'Must Do's' included in the 2023/2024 CQC Quality Improvement Plan (QIP), 78% of Must do actions are delivered. 3 (17%) remain 'amber-red' . 1 (6%) action remains amber-green. There are no actions currently assessed as 'Red' i.e. not expected to deliver at any point in time.	1. Rates of appraisal and training: Compliance continues to be monitored monthly. In April 2025 amendments were made to the frequency of the resuscitation practical training for immediate life support (ILS) and paediatric immediate life support (PILS), this has impacted training compliance. The three 'Must Do' actions in relation to training for Medical and Dental staff for specific core metrics in urgent and emergency care and medicine remain undelivered. At the end of April 2025, for UEC, medical staff were compliant in 6 of the 20-core skills metrics, whilst nursing staff were compliant in 16 of the 24-core skills metrics. For the medicine RPH nursing staff group, resuscitation and sepsis training demonstrated compliance in 4 out of 6 metrics with 94% compliance achieved for sepsis training, and 99% for adult and paediatric basic life support. For nursing staff within medicine a compliance of 75% was reported for level 4 advanced life support training (ALS) demonstrating an improvement from 23% compliance at the time of the inspection. However, for Medical and Dental staff working within Medicine RPH, there was a 25% decrease in ALS training with compliance reported at 47%, less than the 68% compliance reported at the time of the inspection. Steps have been taken to ensure the TNA is correct and ensure course availability for colleagues. An interim assessment to prove competency has also been developed to allow a 1 year extension to existing qualification for those who have previously sat level 4 resus courses (ALS and APLS), on the proviso that they complete a full course within the year. Those that do not pass this assessment will need to resit the course in full as soon as possible. 2. Fluid balance and vital signs monitoring: Paper documentation continues to be used for both fluid balance and vital signs monitoring in UEC. The monthly NEWS audit for the end of April 2025 demonstrated static performance with an overall compliance of 72.2%. The fluid balance management audit reflected a decline in performance with a month end compliance of 71.2% for April 2025. From May 2025 weekly audits of NEWS and fluid balance compliance have been commenced.	From the 18 'Must Do' recommendations, 14 have been assessed as delivered and the themes of the 4 outstanding 'Must Do' recommendations are related to medical staff training compliance in urgent and emergency care and medicine, and documentation specifically in relation to fluid balance and vital signs.
CQC - "Should do" (Number with Green rating)	At the end of April 2025, of the 'Should Do's' included in the 2023/2024 CQC QIP, 97% of should do actions are delivered. 1 (3%) should do action remains 'amber-green'. There are no actions currently assessed as 'Red' i.e. not expected to deliver at any point in time	1. For timely medical review when not receiving care on the correct medical ward, data quality issues persist with the ClinDoc daily senior review report. Changes made to the ward round proforma in November 2024 caused the form to crash intermittently. The use of the form reduced by 63.5% between November 2024 and April 2025 with a loss of reporting mechanisms and data quality within ClinDoc. A fix for the error was provided in April 2025 however, the fix has unfortunately created another error in the ClinDoc viewer. Whilst work continues to address the issues, a manual audit commenced at the end of April 2025. The early findings of the manual audit reflect positively and the results will be reported upon the conclusion of the first full months audit.	From the 36 'Should Do' recommendations, 35 have been assessed as delivered. The remaining 'Should Do' recommendation relates to timely medical review when not being provided care and treatment on the correct medical speciality ward .

Patients - Deliver Annual Safe Staffing Requirements Assurance



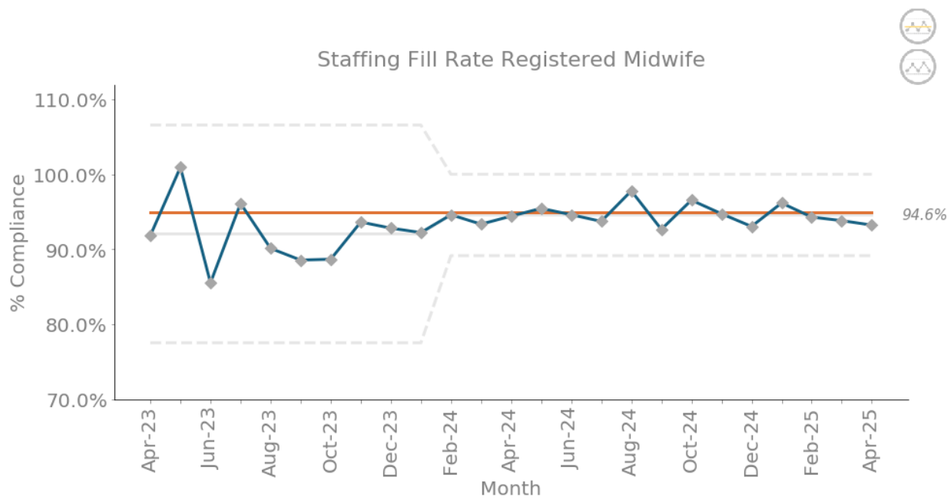
Latest
96.23%
Variance Type
Recent concerning pattern in the data
Mar-26 Target
95%
Target Achievement
Will consistently pass target within expected variation



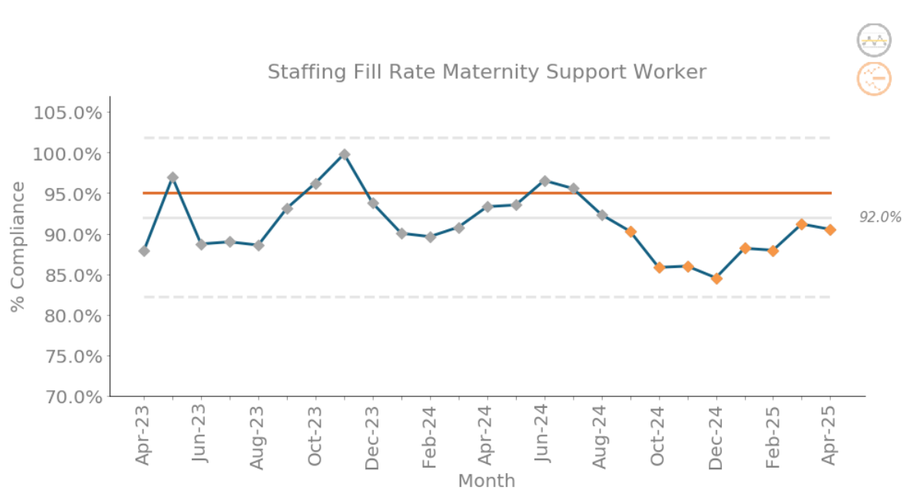
Latest
103.63%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Nurse	The RN staffing fill rate for inpatient wards in April was 96%. Chorley District Hospital (CDH) RN fill rate for April was 101%, with Royal Preston Hospital (RPH) RN fill rate being 95%. The need for bank support remains to ensure safety is maintained, with a limited number of areas still requiring agency support. The implementation of strengthened approval processes for bank and agency is in place to ensure that as a Trust we are maximising the use of our resourced while maintaining safety for our patients and staff. Redeployment of staff due to organisational change is being undertaken.	1. Ward managers work clinically as part of the clinical establishment with Matrons, if required, to support patient care. 2. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders as an interim measure following the introduction of strengthened approval processes for bank and agency. 3. Embedding of Care Hours per Patient Day (CHPPD) ward level SPC charts to allow monitoring of deployment, to be used as part of the monthly triangulated view of staffing. 4. Service need and review of elective surgical services at CDH.	1. Overall fill rate on average is between 112.4% and 85.7%. All clinical areas are showing a stable fill rate position. The Surgical ward staffing needs fluctuate depending, no concerns have been noted relating to safety and quality of care with a planned review across elective services to be undertaken. 2. Daily operational staffing meetings led by matrons, assess and respond to changes in pressure and demand based on acuity and dependency, Red flags and professional judgement. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triangulated through a quarterly serious incident/PSIRF report.
Staffing Fill Rate Health Care Assistant	The HCA staffing fill rate for inpatient wards in April was 104%. Chorley District Hospital (CDH) fill rate for April was 100%, with Royal Preston Hospital (RPH) HCA fill rate being 104%. The need for bank support remains to ensure safety is maintained. The implementation of strengthened approval processes for bank is in place to ensure that as a Trust we are maximising the use of our resourced while maintaining safety for our patients and staff.	1. Weekly roster efficiency reviews undertaken by the Divisional Nurse Leaders as an interim measure following the introduction of strengthened approval processes for bank use. 2. A review of Band 2 and Band 3 roles is being undertaken inline with national role guidance. 3. Introduction of apprentiships into vacancies has commenced in the inpatient wards. 4. Redeployment of staff into vacancies through organisational change and ward closers. 5. Embedding of Care Hours per Patient Day (CHPPD) ward level SPC charts to allow monitoring of deployment, to be used as part of the monthly triangulated view of staffing.	

Patients - Deliver Annual Safe Staffing Requirements Assurance



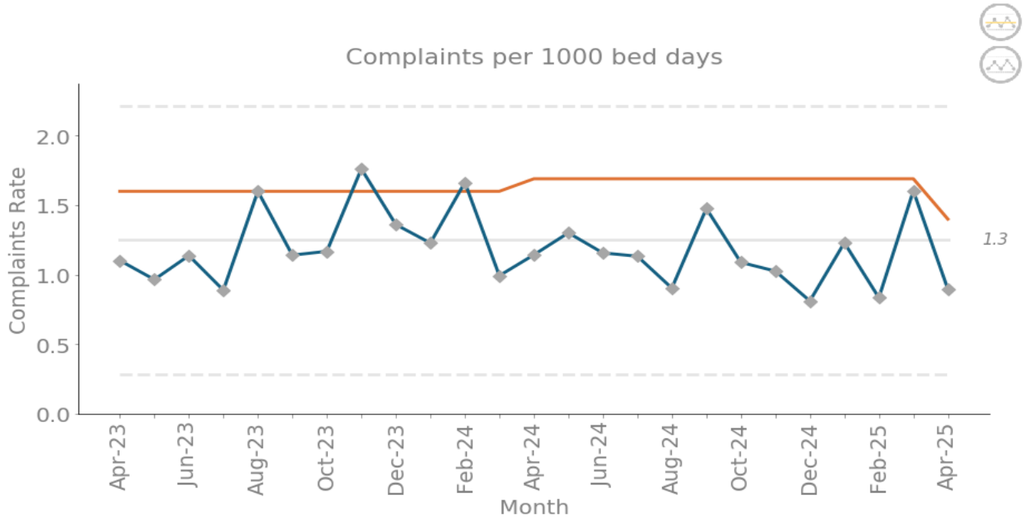
Latest
93.23%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation



Latest
90.52%
Variance Type
Recent concerning pattern in the data
Mar-26 Target
95%
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Staffing Fill Rate Registered Midwife	The fill rates for Registered Midwives in April 2025 demonstrate a stable position overall. The midwifery vacancy is 10.99 WTE which are currently in the VCP process. Protracted approval processes associated with the financial recovery plan contine to affect recruitment timelines. Vacancies continue to result in bank and agency spend associated with Delivery Suite, Maternity A and B and Maternity Assessment Suite. The implementation of the strengthened approval and oversight processes for bank and agency approval continues to be utilised to ensure that the service is maximising efficient use of resources whilst continuing to prioritise safe care. A reduction in agency spend can been seen on the perinatal dashboard, however there is an increase in bank spend.	1. Daily Safety Huddles led by matrons respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Ward managers work clinically in addition to the 80/20 split when required during periods of high activity or reduced staffing. 3. Weekly roster efficiency reviews to ensure appropriate use of bank and agency. 4. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory.	1. Fill rates for registered midwives overall have been stable across day and night shift patterns. 2. The Safety and Quality committee review fill rate and minimum RM levels by area on a monthly basis. 3. Approval and sign off of all agency shifts undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 4. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 5. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report. 6. Redflag reporting is monitored to identify areas where additional input can be provided to manage the risk.
Staffing Fill Rate Maternity Support Worker	Fill rates for MSW's is below target. Continuing long term sickness on maternity A (3.5 WTE) which equates to 66% of the unregistered establishment continued into April 2025. This is being managed in line with the Trust Policy. However, to maintain safe staffing levels, there continues to be a requirement to use bank to backfill shifts. The implementation of the strengthened approval and oversight processes for bank and agency approval continues to be utilised to ensure that the service is maximising efficient use of resources whilst continuing to prioritise safe care. However, there is a continued requirement to use bank to backfill unfilled shifts. There is a current vacancy of 4.61 WTE for Band 2 and Band 3 MSWs. Recruitement is ongoing using redeployment.	1. Daily Safety Huddles led by matrons who respond to changes in pressure and demand based on acuity to move staff around the service as required. 2. Weekly roster efficiency reviews to ensure appropriate use of bank. 4. Ongoing recruitment to fill all vacancies which are tracked using a local trajectory 5. Sickness management procedures reviewed by Workforce BP to ensure appropriate management. 6. Night shifts are prioritsed to ensure periods when less additional support can be accessed are staffed appropriately.	1. The Safety and Quality committee review fill rate and minimum safe staffing levels by area on a monthly basis. 2.. Approval and oversight sight of rosters is undertaken by the Deputy/ Divisional Midwifery and Nursing Director. 3. Biannual safe staffing procedures are in place in line with National Quality Board guidance. 4.. Weekly PSIRF oversight panel reviews incident harm levels, this is triagulated througha quarterley serious incident/PSIRF report. 5. Redflag reporting is monitored to identify areas where additional input can be provided to manage the risk.

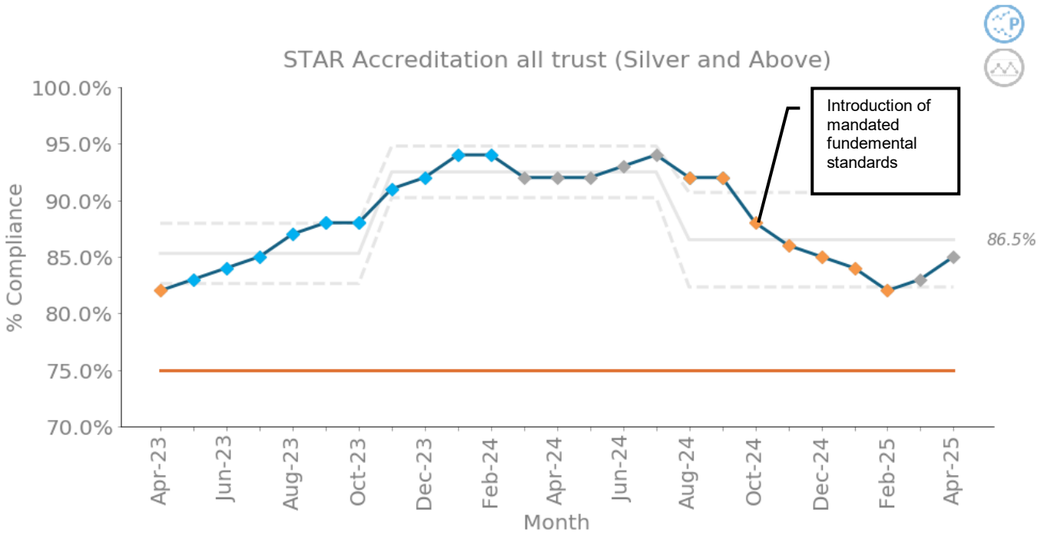
Patients - Patient Experience and Involvement Assurance



Latest
0.90
Variance Type
Normal variation - no recent change
Mar-26 Target
1.40
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Complaints per 1000 bed days	The number of complaints per 1000 beds days continues to demonstrate a sustained reduction. This positive trend reflects an increased focus on achieving local resolution for patients and their families, enabling concerns to be addressed promptly and effectively at the point of care. Improving patient experience remains a key focus. Targeted efforts are underway as part of the Urgent and Emergency Care (UEC) improvement plans and enhancements to inpatient pathways. Insight from the national inpatient and ED surveys have provided specific areas of focus and feedback from patients, informing immediate and longer-term actions. It is acknowledged that the UEC pathway has significant impact on the overall experience of patients, families and staff and as such remains a key priority within the Trusts patient experience improvement plan. The top themes from complaints relate to communication, delays in treatment, delays in procedures and delays in appointments. The continued focus on delivery of the trust Single Improvement incorporates the ongoing patient experience plan. The continued delivery of actions in response to feedback within the national inpatient survey, urgent emergency care, cancer care and maternity.	1. Continue to deliver the Patient Experience Plan 2. Continue to deliver the Patient Safety Incident Response Framework with a focus on family liaison roles 3. Monitor actions in relation to National picker Surveys . 4. To deliver the PALS and local early resolution training. 5. Continue to progress the complaints review group using patient safety partners and governors	1. Annual patient experience reports to Safety and Quality committee. 2. Friends and family monthly reporting in place for all departments. 3. Inclusion of patient experience in STAR. 4. Chief Nursing Officer reviews all complaints and signs off responses. 5. Monitor picker survey action plans through Patient, Carer, Experience and Involvement Group.

Patients - Quality Assurance (Accreditation)

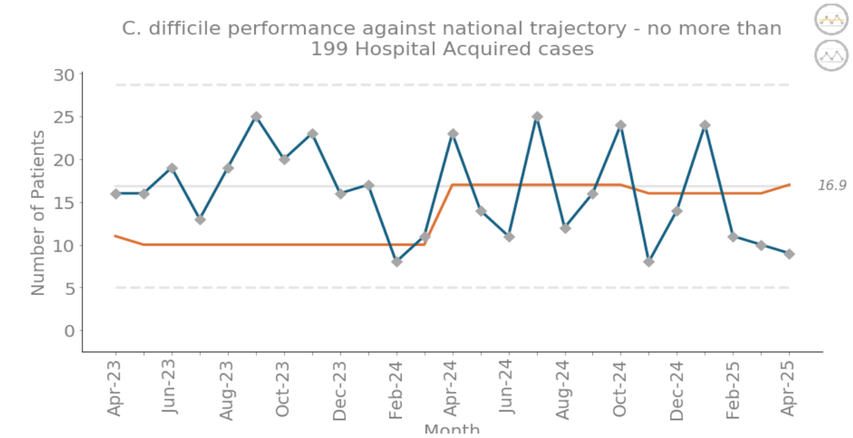


Latest
85.0%
Variance Type
Normal variation - no recent change
Mar-26 Target
75.00%
Target Achievement
Will consistently pass target within expected variation

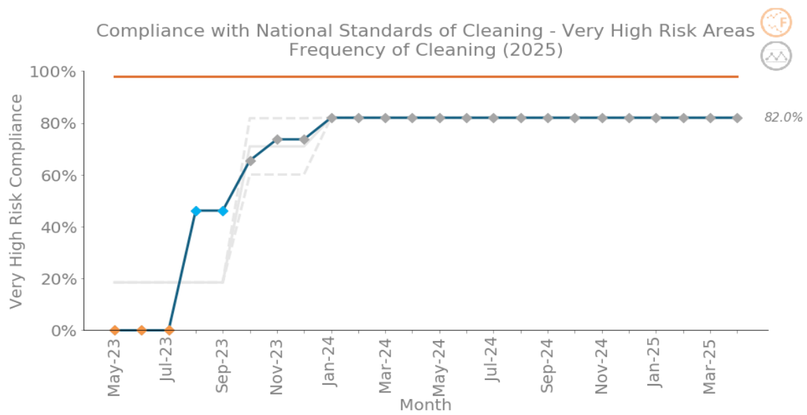
Metric	Summary	Action	Assurance
STAR Accreditation all trust (Silver and Above)	There are 122 clinical areas registered for the STAR Quality Assurance Framework, of which all 122 have received STAR accreditation visits. There are no clinical areas with a red star rating , 18 areas with an amber rating and 104 areas rated green. This results in 22 bronze stars, 19 silver stars and 85 gold stars. There are 85% of areas rated silver or above. During April, there were 0 clinical areas with a reduced STAR rating. There were 2 clinical areas who each achieved their third silver stars allowing them to apply for gold star status, with other areas maintaining their current STAR rating. Themes requiring improvement include documentation of deteriorating patients, fluid balance management, risk assessments, assessment and delivery of enhanced levels of care, mandatory training and IPC. Themes during April flagged issues with patient experience due to boarding and overcrowding in ED and assessment areas, staff feedback due to capacity and staffing pressures and provision of essentials of care. There were 77 % of wards, ED and theatres scoring silver and above for STAR accreditation visits.	1. Any standards which are not achieved require an improvement action which is monitored within division through divisional assurance processes and via STAR monthly reviews and STAR accreditation visits. 2. The monthly STAR report includes trustwide and divisional STAR data and highlights good practice, areas for improvement, themes for learning and an overarching STAR improvement action plan, which is cascaded and discussed through the divisional always safety first meetings, the always safety first learning and improvement group and estates and facilities partnership board. The STAR report now includes CQC (2023) action plan standards. 3. STAR accreditation visits are scheduled depending on star rating, areas with a bronze star rating are reassessed within 3 months. 4. The safety visits in March and April were selected from data within STAR and covered ensuring the environment is safe, documenting within the electronic patient records, Venousthrombus embolism risk assessments and how to improve the overall experience.	1. The STAR report is shared within the divisional leadership teams, good practice is shared and celebrated and actions are developed where improvement is required. 2. Ward/Department Managers, Matrons and Professional Leads provide assurance that actions are completed and monitored for effectiveness through their 1:1 with Matrons and Divisional Nurse Directors. 3. The AMaT system supports STAR audit data management and oversight and management of improvement actions. 4. There is a Business Intelligence (BI) STAR page available to enable data triangulation.

Patients - C Difficile Improvement Programme Assurance

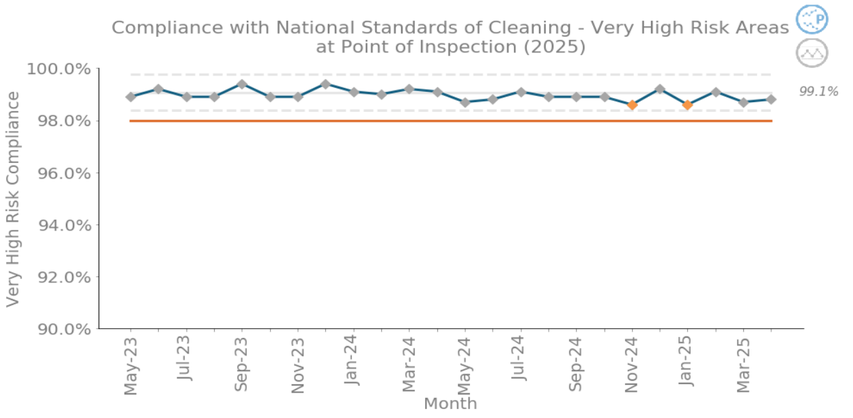
Lancashire Teaching Hospitals NHS Foundation Trust



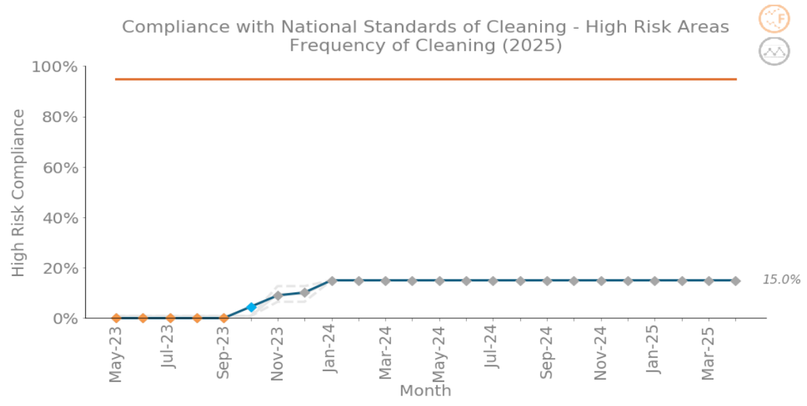
Latest
9
Variance Type
Normal variation - no recent change
Mar-26 Target
16
Target Achievement
Could both pass or fail target within expected variation



Latest
82.00%
Variance Type
Normal variation - no recent change
Mar-26 Target
98%
Target Achievement
Will consistently fail target within expected variation



Latest
98.80%
Variance Type
Normal variation - no recent change
Mar-26 Target
98.00%
Target Achievement
Will consistently pass target within expected variation



Latest
15.00%
Variance Type
Normal variation - no recent change
Mar-26 Target
95%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
C. difficile performance against national trajectory - no more than 199 Hospital Acquired cases	The increase in C.difficile is a recognised high risk and forms part of the principle risks for the organisation. For 2024/2025 there were 192 Clostridium Difficile (CDI) cases against a National objective of 199 cases, 7 cases below the national objective. During April 2025 there have been a total of 9 CDI cases continuing the trend below the objective. The Trust national objective for 2025/2026 is expected later in the year. The focused work on CDI reduction and the improvement plan continues to be monitored through the Infection Control Committee and Estate and Clinical Partnership Board. The National Standards of Healthcare Cleanliness (2025) for frequency of cleaning is now visible and monitored through the dashboard alongside the quality checks of those areas not yet achieving the frequency of cleaning standards.	1. Implementation of the approved business case to be compliant in high risk areas with National Standards of Healthcare Cleanliness (2025). 2. Continued focus on IPC in practice through STAR monthly and accreditation processes. 3. Continue to monitor key performance assurance indicators through IPC committee.	1. IPC BAF report reviewed and shared at IPCC for assurance. 2. IPC Dashboard. 3. IPC monthly revalidation audits such as Hand Hygiene, Commodes, Environmental checks and Mattress checks. 4. Monthly reporting into S&Q, IPCC and Divisional IPC meetings, along with bi-monthly reporting into H&S Committee. 5. STAR encompasses IPC audits and cleaning checklist compliance, with all audit information available within AMAT. 6. NHS England review of IPC assurances.

Patients - Always Safety First Assurance

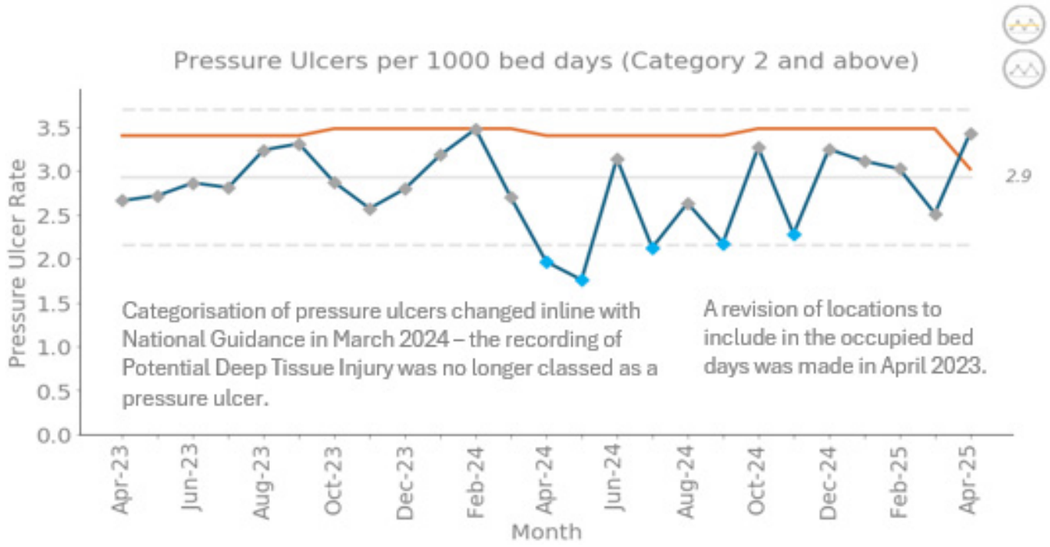
Lancashire Teaching Hospitals NHS Foundation Trust

	Achievement	Position	Month
Hospital Standardised Mortality Ratio (56 Basket – Adult)	As Expected	85.4	December 2024
Standardised Mortality Rate (All Diagnoses – Adult)	As Expected	89.5	December 2024
Standardised Mortality Rate (Child <1 day -17 Years) (All Diagnoses)	As Expected	89.3	December 2024
Standardised Mortality Rate (Neonatal <1 day -28 days) (All Diagnoses)	As Expected	102.9	December 2024

* SOURCE DATA: Telstra (Dr Foster)

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

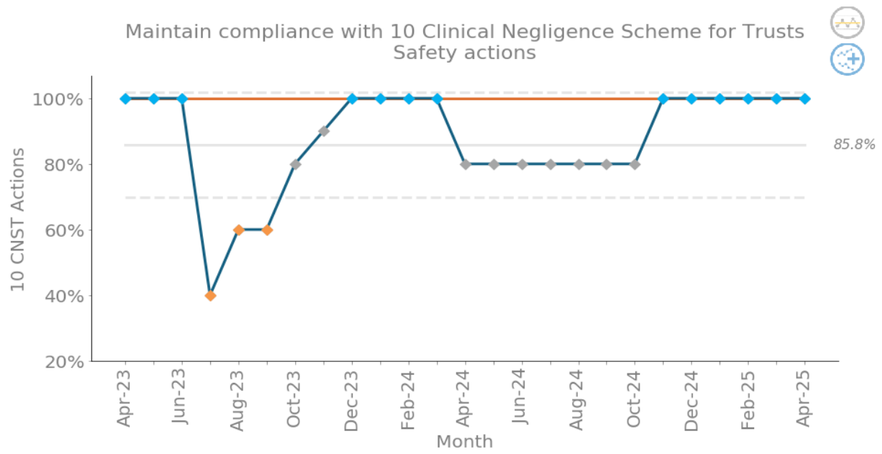
Patients - Always Safety First Assurance



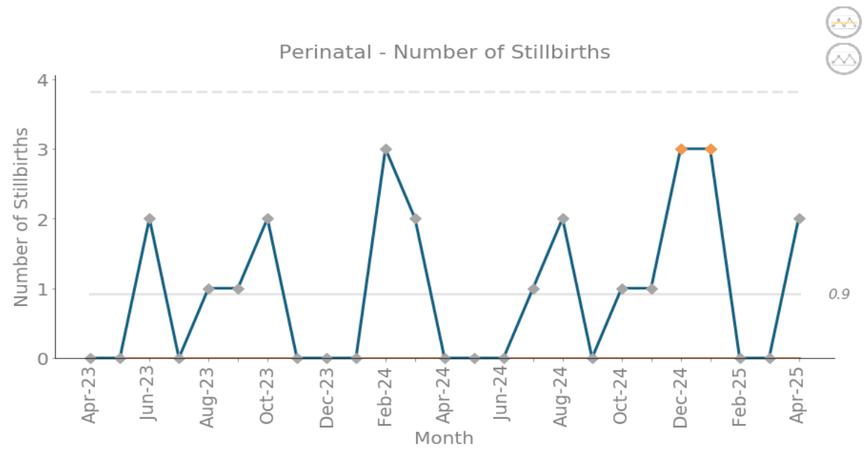
Latest
3.43
Variance Type
Normal variation - no recent change
Mar-26 Target
3.48
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Pressure Ulcers per 1000 bed days (Category 2 and above)	Pressure ulcers are considered a proxy of care delivery. The target line has been set to reflect the average numbers of incidents over the previous 3 years, this has been adjusted from April 2025 to represents the average number of pressure ulcers in the previous year. Following the National changes in March 2024, pressure ulcer incidents have remained below the target. A continued focus on the care interventions that reduce the likelihood of pressure ulcers continues. This work will remain a priority.	1. Organisational pressure ulcer improvement plan lead by the Deputy Chief Nursing Officer 2. Continued focus on Operational Performance Single Improvement plan. 3. STAR quality assurance fundamental standards includes intentional rounding which is linked to pressure relief treatment. 4. Education and awareness of pressure ulcer prevention continues.	1. Always Safety First strategy reporting twice yearly to safety and quality committee. 2. Always Safety First committees at divisional level responsible for overseeing the implementation of the codesigned pressure ulcer improvement programme. 3. Monitoring of pressure ulcer incidence continues to be recognised as a priority metric.

Patients - Maternity Assurance



Latest
100.0%
Variance Type
Recent positive pattern in the data
Mar-26 Target
100.00%
Target Achievement
Could both pass or fail target within expected variation



Latest
2
Variance Type
Normal variation - no recent change
Mar-26 Target
0
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
Maintain compliance with 10 Clinical Negligence Scheme for Trusts Safety actions	The new Year 7 CNST standards have been published and although safety bundles and monitoring are continuous, new elements are included in the updated matrix. As per the year 6 maternity incentive scheme, the Integrated Care Board (ICB) /Local Maternity and Neonatal System (LMNS) assurance visits will be undertaken throughout the reporting period and the compliance to each standard will be updated accordingly. The service is currently on track will 9 of the standards with only 1 standard currently at risk. This relates to standard 7 and MNVP attendance at Perinatal Mortality Review Tool meetings (PMRT). The capacity for the MNVP lead to attend is limited due to the commissioning agreement with the LMNS.	1. Delivery of the Maternity Neonatal Improvement plan and Trust Single Improvement plan.	1. Continue to monitor MIS standards via the maternity and Neonatal Safety Report to safety and quality committee. 2. ICB Local Maternity Neonatal System validation of CNST delivery of standards.
Perinatal - Number of Stillbirths	There has been an increase in stillbirths in the month of April 2025, however this is not statistically significant, and both cases were Terminations of Pregnancy due to Fetal Anomaly (TOPFA). The 12-month average mean (May 24-April 25) still birth rate is 2.8 per 1000 and 3.2 per 1000 cumulatively since March 2023. These are both lower when compared against the national average of 3.9 per 1000.	1. Implementation of the 10 CNST maternity neonatal safety standards.	1. Monthly dashboard analysis shared via the maternity and neonatal safety report to safety and quality committee. 2. Peer comparison data included within the reporting 3. National embrace reporting provides overview of national themes to ensure learning is understood nationally. 4. ICB Local Maternity Neonatal System validation of CNST delivery of standards.

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Productivity

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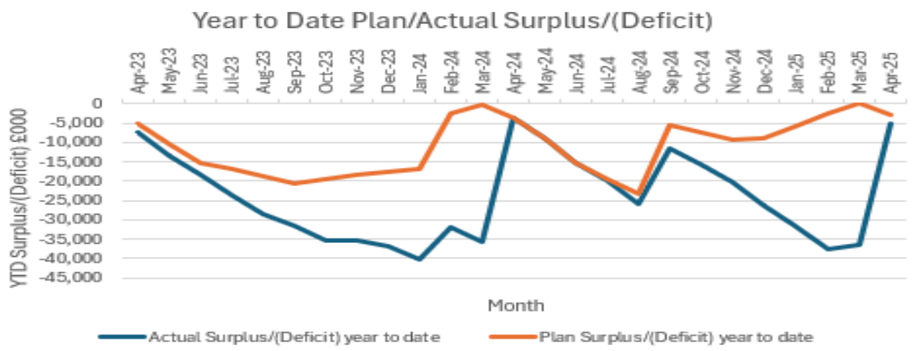
Productivity

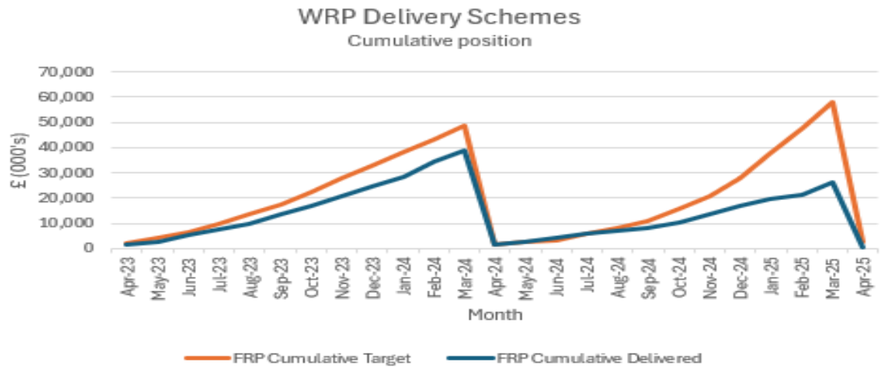
Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target (£ 000's) Concern	Mar-26	Latest YTD Target	Latest YTD Actual (£ 000's)	Latest Month
Finance	I&E - Plan v Actual variance					-2760	-5027	Apr-25
	WRP schemes delivery				60000	2721	512	Apr-25

Productivity - Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



Latest YTD Actual (,000s)
-5,027
Latest YTD Target (,000s)
-2,760
March 26 YTD Target (,000s)
-



Latest YTD Actual (,000s)
512
Latest YTD Target (,000s)
2,721
March 26 YTD Target (,000s)
60,000

Metric	Summary	Action	Assurance
I&E - Plan v Actual variance	The Trust submitted the final financial plan to NHSE at the end of April. For 2025/26 the Trust has a break-even plan which is reliant on a recurrent waste reduction programme of £60m and non-recurrent deficit support funding of £30m. At the end of April 2025 the Trust has a deficit of £5m against a planned deficit of £2.8m. The adverse variance to plan of £2.2m is mainly as a consequence of the shortfall in delivery of the Waste Reduction Programme. The Trust has not yet identified the full £60m programme and the unidentified element was included in the plan in 12ths in accordance with NHSE policy. The Trust has operational pressures in: - the acute medical pathways reflected in overspends in medical and nursing pay budgets - sickness remains higher than in operational budgets resulting in nursing pay overspends	The Trust has appointed a Turnaround Director to work with senior leaders to re-assess the current waste reduction programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting for 2025/26 has taken place. The Trust is working with the ICB on the urgent and emergency pathway system pressures which is one of the main operational pressures that the Trust faces. The system is now receiving enhanced support from the System improvement Director and NHSE as part of the recovery support programme. A focus on grip and control activities continues. The Trust has commissioned further external support in Q1 to support specific financial recovery plan workstreams and 2025/26 waste recovery programme development. Divisions will need to recover their financial performance by delivering improvements in their current run rates e.g. maximising grip around temporary pay, review of vacancies and continuing to develop savings schemes for 2025/26.	Turnaround Director Working with ICB on UEC Pathway I&E Interventions and control measures ICB System Improvement Director Review Mandated national support from PWC
WRP schemes delivery	The Trust's objective to reach financial balance on a recurrent basis by the end of the three-year period (2026-27) will require delivery of an ambitious and very challenging financial recovery plan. The Trust's 2025/26 waste reduction target is £60m, 7% of operating expenditure. At the end of April the Trust has delivered £4.2m of the £60m target. The delivery in month was £0.5m against a plan of £2.7m. The Trust has identified £35m of the £60m programme 58%.	The Trust has a Turnaround Director to work with senior leaders to re-assess the current programme position and deep dive into short, medium and long-term opportunities. A re-set of the programme structure, governance and reporting has taken place for 2025/26. The Trust has additional external support to help with the delivery of the programme. Support has been commissioned for procurement, contract management and other specific workstreams. The Trust is building up its own project management office structure to have a sustainable solution moving forward.	Turnaround Director Waste reduction programme board chaired by CEO ICB System Improvement Director Review External support for procurement and other specific workstreams. Implementation of PMO

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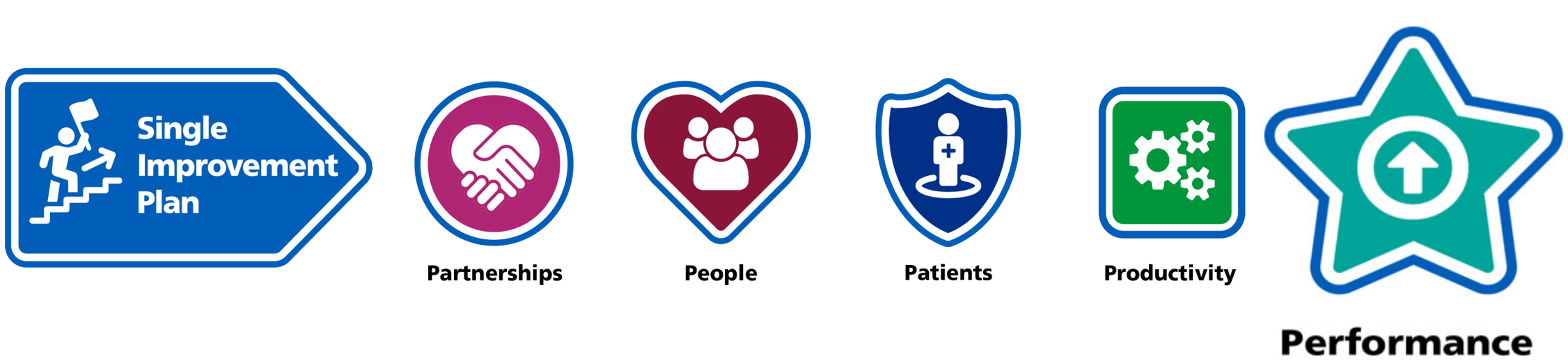
Performance



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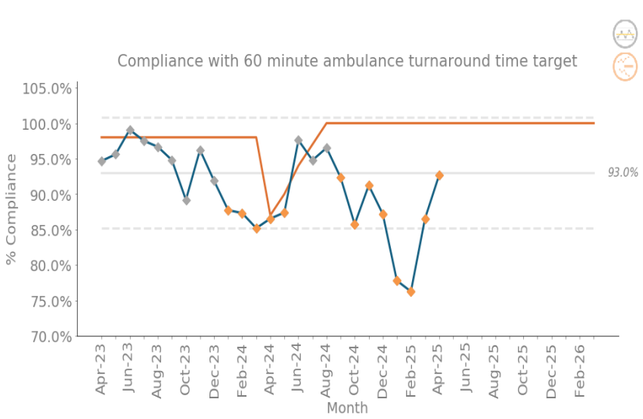
Performance

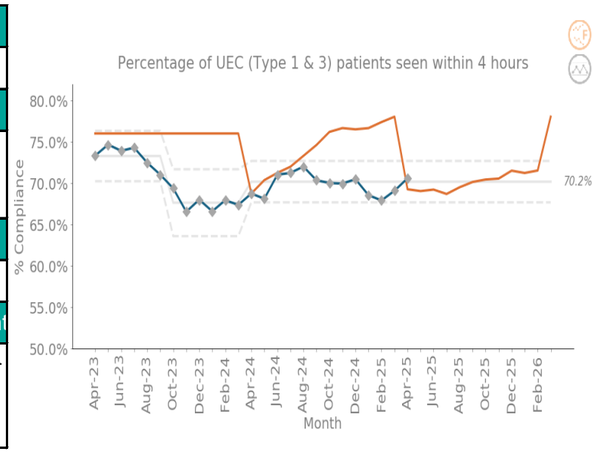
Lancashire Teaching Hospitals NHS Foundation Trust

Metric Description		Assurance @ Mar-26	Variation to Latest Actual	Target Concern	Target Mar-26	Target Latest Month Target	Latest Month Actual	Latest Month
UEC In Flow	Compliance with 60 minute ambulance turnaround time target				100%	100%	92.6%	Apr-25
	Percentage of UEC (Type 1 & 3) patients seen within 4 hours				78%	69.3%	70.6%	Apr-25
	Maximum wait of 12 hours as Total Time in Department				8%	14.1%	10.7%	Apr-25
UEC Flow	Bed occupancy to 90%				90%	90.0%	94.4%	Apr-25
	Number of boarded patients				0	0	14	Apr-25
UEC Outflow/Community Collaborative	Reduce not meeting criteria to reside to 5%				5%	5%	13.9%	Apr-25
Elective (diagnostics)	Percentage of patients that receive a diagnostic test within six weeks				69%	57.0%	63.2%	Apr-25
Elective (long waits)	Percentage of patients waiting less than 18 weeks				64.8%	63.3%	54.8%	Apr-25
	RTT - 52 week Waiters				1304	1467	1642	Apr-25
	RTT - 65 Week Waiters				0	0	17	Apr-25
Elective (theatre utilisation)	85% theatre utilisation - aggregate - Capped				84.6%	84.6%	83.4%	Apr-25
Elective (Cancer)	31 Day Cancer Standard				96%	85.6%	87.4%	Apr-25
	Cancer 62-day performance				75%	58.0%	49.4%	Apr-25
	Cancer Faster Diagnosis Performance				80%	80.0%	77.8%	Apr-25

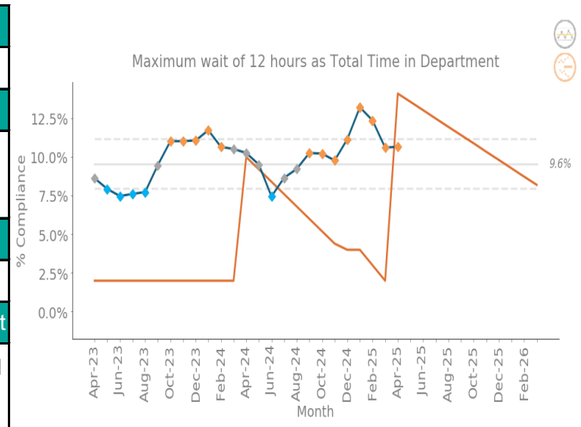
Performance - UEC Assurance



Latest
92.6%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
100%
Target Achievement
Could both pass or fail target within expected variation



Latest
70.58%
Variance Type
Normal variation - no recent change
Mar 26 Target
78.02%
Target Achievement
Will consistently fail the target within expected variation

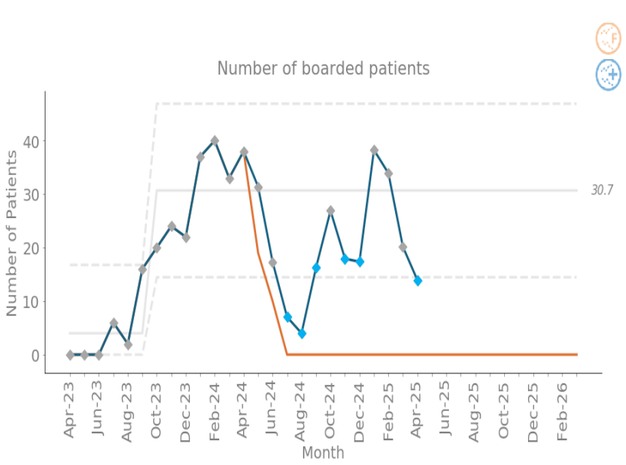


Latest
10.66%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
8.20%
Target Achievement
Could both pass or fail target within expected variation

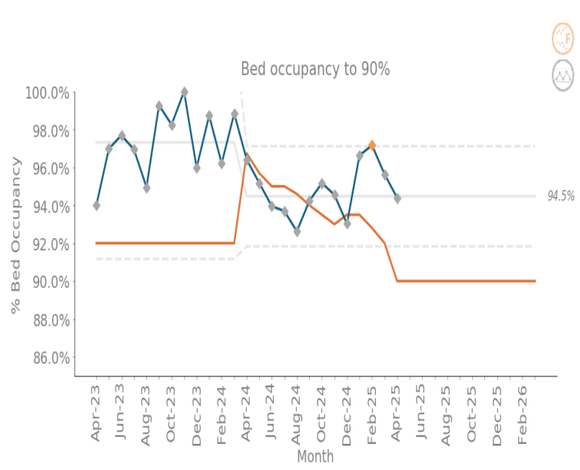
Metric	Summary	Action	Assurance
Compliance with 60 minute ambulance turnaround time target	In April 25 424 patients waited between 30-60 minutes to be handed over from NWAS to the Trust, a decrease of 25 from last month. 308 patients waited over 60 minute to be handed over from NWAS to the Trust in April 25, a decrease of 142 compared to March and continuing the downward trend in long wait handovers. Over 92% of patients were handed over within 60 minutes, an improvement of 6.6% compared to March 25. Performance could both pass or fail target within expected variation	Ambulance handover delays remain a high priority, and a local improvement collaborative is in place with key actions focusing on increasing NWAS to SDEC pathways. This accompanied with the improvement actions focusing on reducing LOS and NMC2R which will reduce ED Overcrowding and support more timely handover and attendance and admission avoidance actions is aimed to see improvements in the remainder of Q4.The ambulance handover position for April 25 further demonstrates the impact of that collaborative improvement work.	Monitoring of ambulance demand is undertaken via the weekly Ambulance handover group. Comparison to both the national and regional performance positions for April 25 indicates that the Trust is now above the national performance position of 90.43% for 60 minute handovers and above the NW performance position of 91.53%.
Percentage of UEC (Type 1 & 3) patients seen within 4 hours	Performance against the national 4 hour access standard improved further in April 2025. The performance improvement was 1.5% compared to March. April experienced a slightly higher rate of attendance compared to March with on average 10 more patients attending per day during the month.	The UEC Improvement programme is focusing on measures to reduce the wait to be seen time, improving response times for patents referred to specialities and seeking to maximise referrals into SDEC. Targets have been set for each of these critical measures and is monitored via the UEC Improvement Board monthly. SDEC activity has increased and exceeded the target in April (41.07%).	The average time to triage in April decreased further to 22 minutes with time to treatment at 160 minutes. Both show a further downward trend in April. Comparison of 4 hour performance to the latest published national benchmarks indicates that the Trust is below the national average for March 25 of 75.0% and was ranked 16th out of Trusts in the NW Region for March 25.
Maximum of 12 Hours Total time in ED	The number of patients waiting over 12 hours (admitted and non-admitted) in ED increased marginally in April to 10.66%, a increase of 0.06% compared to March. This follows a period of deteriorating performance to Jan 2025. The position shows a concerning pattern in the data and could pass or fail the year end target.	The UEC improvement programme is focusing on reducing length of stay via improving board and ward round standards and driving down the days patients spend in hospital when they no longer require inpatient care.	Overall Bed Occupancy is at 94.4%, with a range from 93% - 97% in the last 12 months. The level of boarded patients decreased further in April at an average of 14 patients per day. Comparison within Model Health System indicates the Trust is above the provider median and within Quartile 3.

Performance - UEC Assurance

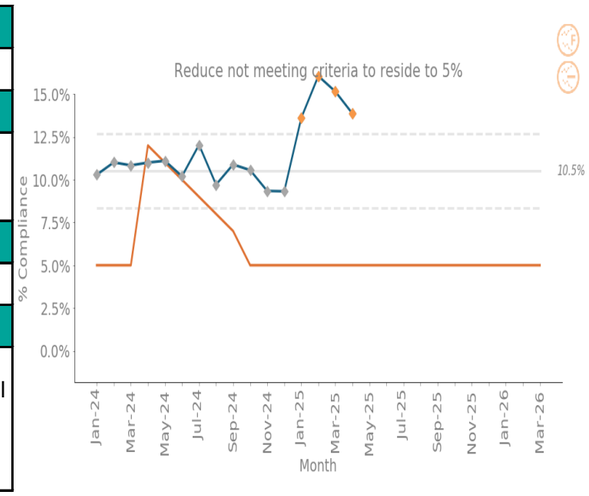
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
14
Variance Type
Recent positive pattern in the data
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation



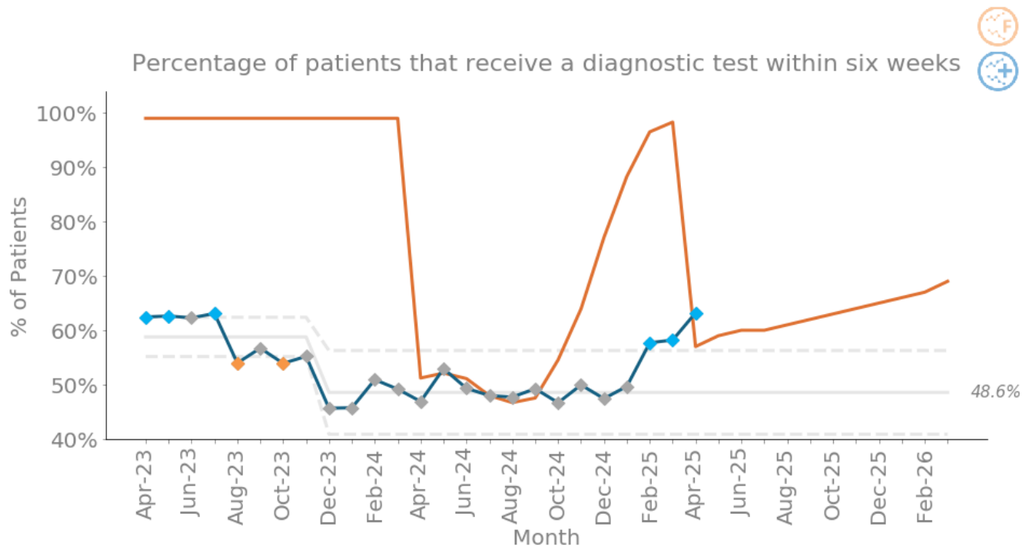
Latest
94.40%
Variance Type
Normal variation - no recent change
Mar 26 Target
90.00%
Target Achievement
Will consistently fail target within expected variation



Latest
13.9%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
5%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Number of Boarded Patients	On average 14 patients were boarded each day across both sites during April with 418 associated bed days. This is a further improvement compared with the March position. These are predominantly medical patients requiring admission to an acute medical ward. There is a recent positive pattern in the data, but will consistently fail the target.	A focus on maximising use of the discharge lounge to reduce the need for boarding. The Medical Division has re-introduced Continuous Flow Model WC 17th March 2025.	Incident levels of harm are monitored on a monthly basis alongside patient feedback. UEC and In-patient survey feedback does reflect patient concerns regarding the practice of boarding. This is also reflected within the staff survey.
Bed Occupancy 92%	The position for April shows a continued improvement with the occupancy rate at 94.4%. This follows a period of reducing occupancy during the Oct-Dec period. Analysis indicates a recent concerning pattern in the data. The data shows normal variation and will consistently fail the target.	The 24/25 UEC Improvement plan continue to be tracked against its ambitions to reduce avoidable admissions and reduce LOS. A significant change to the 25/26 UEC plan has been proposed and supported by the L&SC ICB and Central Lancashire UEC Delivery Board. Plans to further scope and mobilise the 25/26 programme is underway at pace. LTH has closed a 24 bedded ward in line with its Financial Recovery Plan at the end of Feb 25.	Assurance via the Urgent Care Improvement Board and Urgent Care Improvement Plan
Reduce NMC2R to 5%	The number of patients in our hospitals that do not meet the nationally defined clinical criteria to reside for inpatient care in acute hospitals (NMCTR) decreased further in April (13.9% = daily average of 104 patients). Compared to the March position this is a decrease of 1.3%. The variance shows a recent concerning pattern in the data.	A Multi Agency Discharge Event (MADE) was held WC 24 Feb 25 and identified key themes which will support the reduction in discharge delays. Immediate actions are being undertaken supported by a 25/26 Days Kept Away from Home transformation programme. This will seek to significantly reduce the number and days patients spend away from home without clinical rationale. Additional metrics in relation to Days Kept Away From Home are currently being developed.	Monitoring of NMC2R data is undertaken via the Central Lancs Urgent Care Delivery Board

Performance - Elective Care Assurance

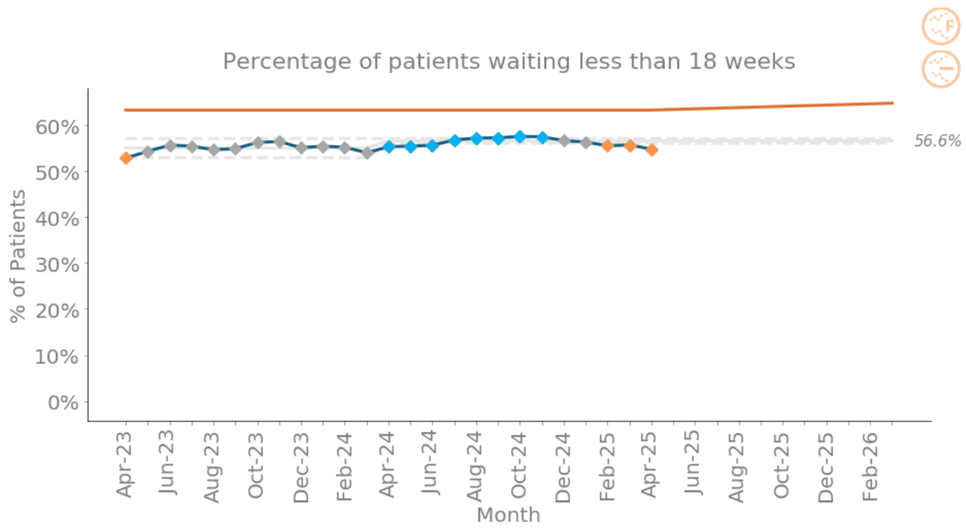


Latest
63.2%
Variance Type
Recent positive pattern in the data
Mar 26 Target
69.0%
Target Achievement
Will consistently fail the target within expected variation

Metric	Summary	Action	Assurance
Percentage of patients that receive a diagnostic test within six weeks	Diagnostics under 6 week performance was 63.2% in April compared to the March position of 58.2%, a 5% improvement on the March position. Urgent and cancer patients are prioritised and seen within 2 weeks. Performance shows a recent positive pattern in the data but is expected to consistently fail the target.	The highest contributors of the backlog at modality level for the DM01 position are NOUS, endoscopy and echocardiography. Mutual aid has been requested for echocardiology. A rapid improvement week has been held WC 13/01/25 to support productivity improvements and reduce process barriers to support improved utilisation of the available endoscopy capacity. Actions and progress are being tracked weekly in a COO led PTL management meeting and monthly within the Diagnostic Improvement Group. Performance improvements have been achieved in NOUS, Echo and Gastroscopy during April 25.	The areas of focus are capacity optimisation, productivity, transformation and system working. Review of the latest published data (Feb 25) indicates that LTH is the worst performing NHS Trust in the NW region, worst performing Trust in the ICB and significantly below the national average of 82.5%.

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust

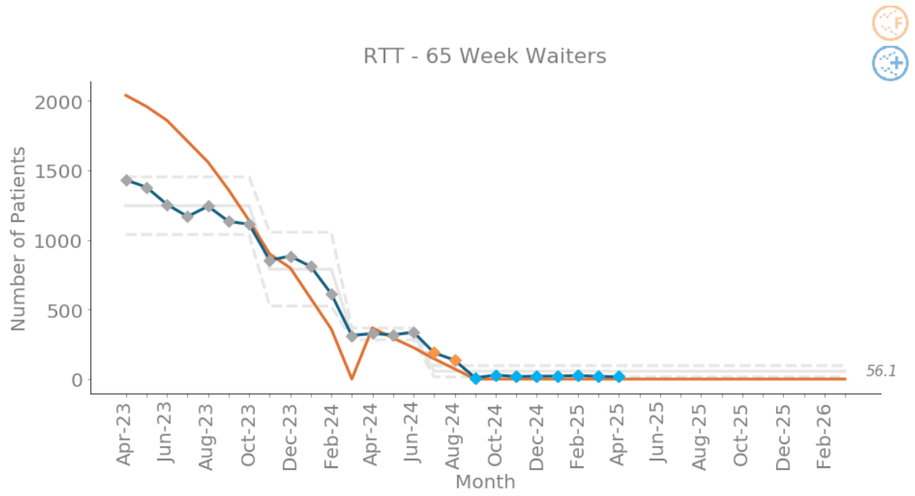


Latest
54.8%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
64.8%
Target Achievement
Will consistently fail the target within expected variation

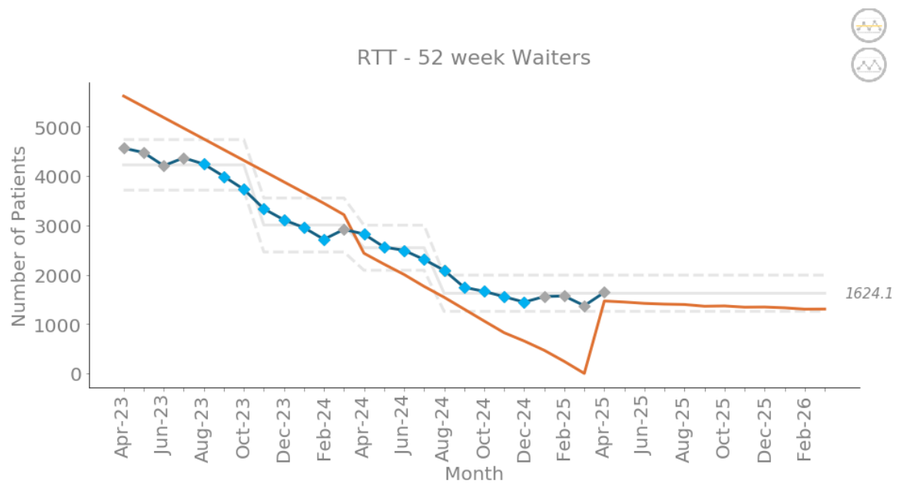
Metric	Summary	Action	Assurance
Percentage of patients waiting less than 18 weeks	The proportion of patients waiting less than 18 weeks on an RTT pathway has shown a consistent position throughout 2024/25. The Operational Plan 2025/26 year end target has been set at 65%. The April 25 position is not yet finalised but is expected to be consistent with previous months.	Performance is monitored at Divisional level via the Elective Performance Review Group where Issues and risks.	Comparison to the latest national performance position (Feb 25) indicates that the Trust is below the national position of 59.3% waiting under 18 weeks'

Performance - Elective Care Assurance

Lancashire Teaching Hospitals NHS Foundation Trust



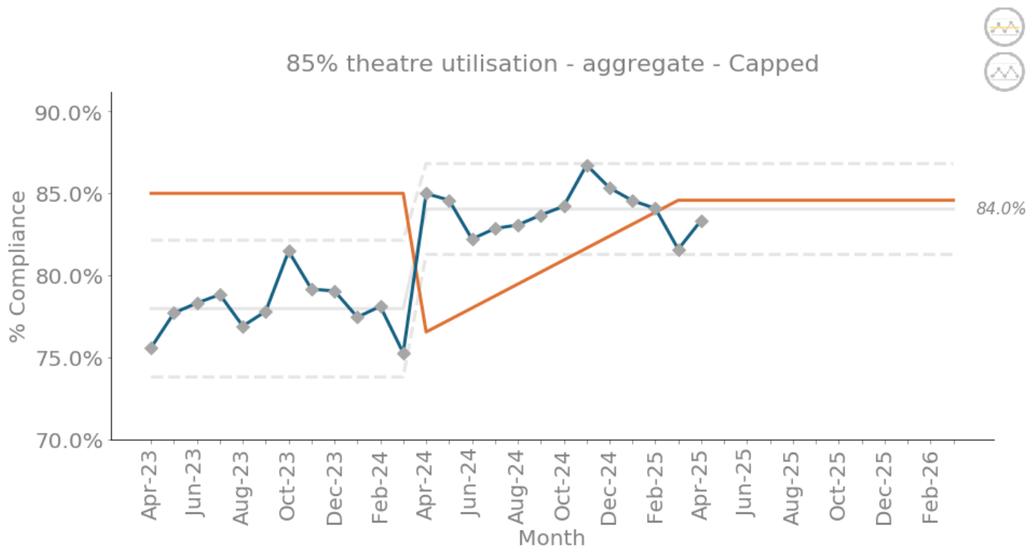
Latest
17
Variance Type
Recent positive pattern in the data
Mar 26 Target
0
Target Achievement
Will consistently fail the target within expected variation



Latest
1642
Variance Type
Normal variation - no recent change
Mar 26 Target
1304
Target Achievement
Could both pass or fail target within expected variation

Metric	Summary	Action	Assurance
RTT - 65 Week Waiters	The downward trend in over 65 week waiters remained consistent with previous months achieving a position of 17 due to capacity shortfalls, equipment issues and on the day patient cancellations. There is a recent positive pattern in the data, however analysis would suggest that the target may be consistently failed.	There is a process in place to ensure daily assurance of progress with >65 week waits prioritising and ensuring the sustained elimination of >78 week waits. Issues and risks are reviewed at the Elective Performance Review Group.	Monitoring of all premium cost activity is ongoing. Capacity & Demand modelling analysis is being concluded in line with the 25/26 annual planning process. Comparison to the latest NW region position indicates that the Trust is currently 12th out of all acute and specialist trusts and 6th out of acute Trusts in terms of the number in the 65 week waiter cohort.
RTT - 52 week Waiters	The over 52 week waiter position in April was 1642, an increase of 270 compared to the March position of 1372. There is a no recent change in the data, however the target could be passed or failed within normal variation.	Capacity & Demand modelling is to be undertaken for all specialities and sub specialities. Focus on DNA reduction, PIFU and theatre utilisation is ongoing to maximise capacity.	Local monitoring of all speciality RTT clock stop/performance is undertaken via fortnightly Performance Recovery Group

Performance - Theatre Utilisation

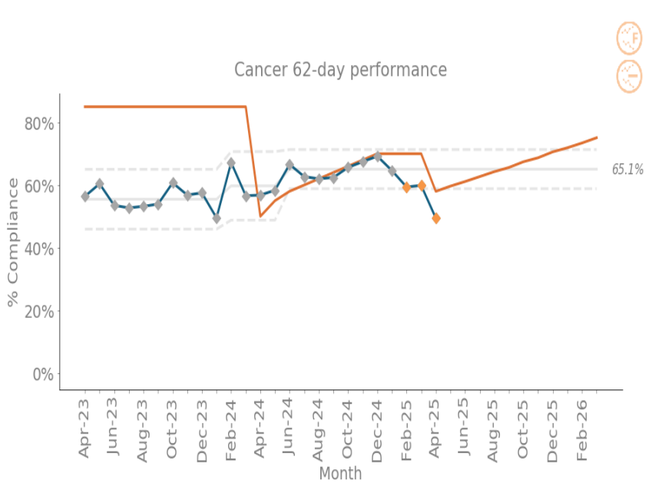


Latest
83.4%
Variance Type
Normal variation - no recent change
Mar 26 Target
84.6%
Target Achievement
Could both pass or fail target within expected variation

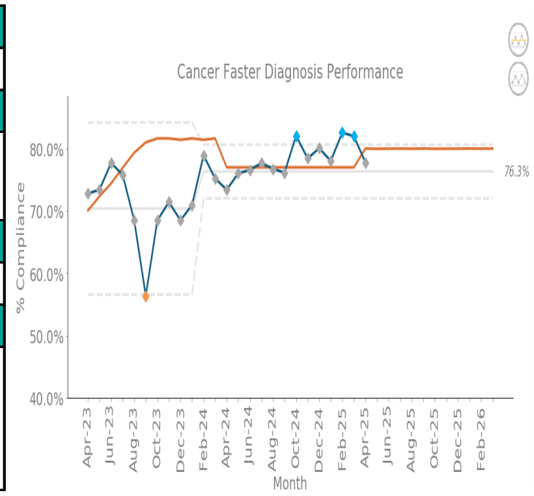
Metric	Summary	Action	Assurance
85% theatre utilisation - aggregate - Capped	Performance throughout 24/25 has been positive with regards theatre utilisation however a deterioration has been noted in March and April due to pressures within the HSDU provision.	An assessment of process within HSDU has been undertaken by the Continuous Improvement team with benchmarking via other similar units. Further improvement plans are in development with close monitoring of performance metrics.	Improvements in theatre utilisation are monitored through the Divisional Improvement Forums with a focus on capped and uncapped utilisation rates, levels of cancellations, late starts and early finishes. Theatre data is also submitted to Model Health for national analysis.

Performance - Cancer Assurance

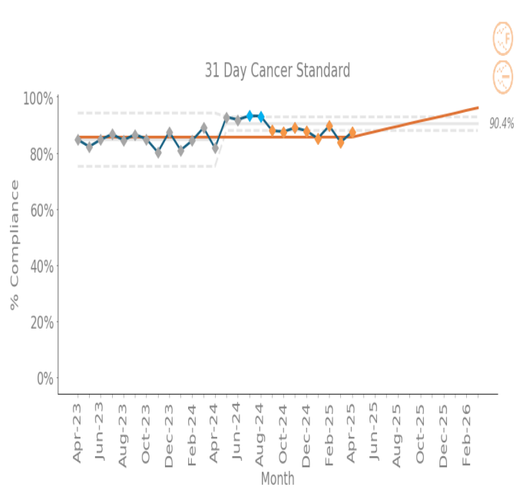
Lancashire Teaching Hospitals NHS Foundation Trust



Latest
49.4%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
75.1%
Target Achievement
Will consistently fail target within expected variation



Latest
77.8%
Variance Type
Normal variation - no recent change
Mar 26 Target
80%
Target Achievement
Could both pass or fail target within expected variation



Latest
87.4%
Variance Type
Recent concerning pattern in the data
Mar 26 Target
96.0%
Target Achievement
Will consistently fail target within expected variation

Metric	Summary	Action	Assurance
Cancer 62-day performance	Performance to the end of April 25 (currently unvalidated and expected to meet the target) is below last month, and below the monthly operational plan target of 58%. Analysis shows a recent concerning pattern in the data and will consistently fail the target.	Whilst Cancer performance is improving there are a small number of tumour groups with the greatest collective contribution to current performance challenges, these are Colorectal, Lung and Urology. All tumour sites have improvement plans to achieve performance targets.	The Trust is currently below the latest national average performance of 66.9% (Feb 25). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group
Cancer Faster Diagnosis Performance	Faster Diagnostic Standard performance has been strong throughout 24/25 and following month end validation is anticipated to be above target.		
31 Day Cancer Standard	Performance to the end of April 25 (currently unvalidated and expected to meet the target) is above last month, and below the monthly operational plan target of 86%. Analysis shows a recent concerning pattern in the data and will consistently fail the target.		The Trust is currently below the latest national average performance of 91.8% (Feb 25). Close monitoring of cancer PTLs are undertaken at fortnightly Performance Recovery Group

11.2 FINANCE AND PERFORMANCE COMMITTEE CHAIR'S REPORT

Other | J Schorah | 11.40am

Item for assurance

REFERENCES

Only PDFs are attached

11.2 - FPC - Chair report - 22 April 25.pdf

Chair's Report to Board		
Chair: J Schorah	Committee: Finance and Performance	
Date(s):22 April 2025	Agenda attached for information	✓

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Strategic Risks	Trend	Items Recommended for approval
Deliver Value for Money – 20 Fit for the Future - 15	⇨	None

ALERT

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

- **Performance Assurance Report**: Despite some good incremental progress and hard work from colleagues, the Trust's UEC metrics were falling further behind its North West provider peers, which was a concern.
- **Waste Reduction Programme**: There were still many moving parts and it would be a challenge to have the plan completed by the end of May *
- **Procurement**: The challenges highlighted in the Grip and Control Update report included several key areas that required significant improvement and restructuring to enhance control and efficiency.
- **Annual Plan:** The plan was very ambitious, especially considering there was no growth factored into it.

ADVISE

Areas requiring on-going monitoring; Limited assurance received.

- **Risk Register:** The dial had not moved on any of the principal risks
- **Financial Plan:** The Trust had delivered the savings promised, although it was based on the previous month's estimates
- **Workforce Risks:** The need to resize the organisation and address high levels of sickness, particularly long-term sickness was recognised.

ASSURE

Assurance received; Matters of positive notes

- **Trading Accounts**: The accounts were in surplus and contributed positively to the plan
- **Grip and Control**: There was plenty of assurance in this area, although procurement and budget management needed more work
- **Governance and Planning**: There was good governance and rigour in the process and planning for the waste reduction programme
- **Performance Improvements**: Marginal improvements were noted, particularly in 12-hour performance and productivity

*FPC meeting took place on 22nd April, 2 weeks before the Board workshop on 6th May - considerable progress had been on the WRP in the intervening two weeks.

Finance and Performance Committee

22 April 2025 1.00pm | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	1.00pm	Verbal	Information	J Schorah
2.	Apologies for absence	1.01pm	Verbal	Information	J Schorah
3.	Declaration of interests	1.02pm	Verbal	Information	J Schorah
4.	Minutes of the previous meeting held on 25th March 2025	1.03pm	✓	Decision	J Schorah
5.	Matters arising and action log	1.05pm	✓	Decision	J Schorah
6.	Strategic Risk Register	1.15pm	✓	Decision	D Stonehouse
7.	OPERATIONAL PERFORMANCE				
7.1	Performance Assurance Progress Report [including Finney House Update]	1.25pm	✓	Assurance	K Foster-Greenwood
8.	FINANCIAL PERFORMANCE				
8.1	Month 12 Financial Position	1.40pm	✓	Assurance	D Stonehouse
8.2	Waste Reduction Programme Development Progress Update and Benchmarking Opportunities	1.50pm	✓	Assurance	D Stonehouse
8.3	Trading Accounts	2.20pm	✓	Assurance	C McGourty
8.4	Grip & Control	2.25pm	✓	Assurance	D Stonehouse
8.5	One LSC Procurement update (incorporating supplier scores)	2.35pm		Assurance	J Collins
9.	STRATEGY & PLANNING				
9.1	Planning Controls inc. SIP progress & external dependencies	2.45pm	✓	Assurance	A Brotherton
9.2	Annual plan, forward plan preparation & 3-year trajectory (Year 1 Annual Plan)	3.00pm	✓	Assurance	I Ward
10.	GOVERNANCE AND COMPLIANCE				
10.1	Items to Alert, Advise or Assure Board	3.15pm	Verbal	Information	J Schorah

№	Item	Time	Encl.	Purpose	Presenter
10.2	Reflections on the meeting	3.20pm	Verbal	Information	J Schorah
11.	ITEMS FOR INFORMATION				
11.1	Contract Performance		✓		
11.2	Chair's Reports/Minutes: (a) EPRR (b) Digital & Health Informatics Divisional Board (c) ELFS Management Committee (d) CSESC Minutes (e) LHS Ltd Minutes		✓ ✓ ✓ ✓ ✓		
11.3	Date, time, and venue of next meeting: *27 May 2025, 1.00pm, Microsoft Teams*	3.30pm	Verbal	Discussion	J Schorah

12. RISK, GOVERNANCE AND COMPLIANCE

12.1 AUDIT COMMITTEE CHAIR'S REPORT

Other | T Wheeler | 12.00pm

For Assurance

REFERENCES

Only PDFs are attached

12.1 - Audit - Chair report - 17 April 2025.pdf

Chair's Report to Board		
Chair: T Wheeler	Committee: Audit	
Date(s): 17 April 2025	Agenda attached for information	✓

Strategic Risks	trend	Items Recommended for approval
N/A		Risk Management Policy

ALERT **Areas of concern; Matters requiring urgent attention; Insufficient assurance received.**	**Procurement:** The Committee expressed concerns about the level of assurance regarding procurement processes. The number of derogations from established procurement procedures needed to be reduced. Specific objectives with timelines for monitoring and a cultural shift to signal that excessive derogations are unacceptable were recommended. **One LSC Audit and Assurance Arrangements:** The audit and assurance arrangements with One LSC were noted as unresolved. The Committee requested a further paper outlining timelines and milestones for resolving this position by the next meeting. **Clinical Audit Programme:** Concerns were raised about the clinical audit programme update, particularly regarding overdue action plans for maternity, obstetrics, and urology, and mixed performance data for stroke. The committee emphasised the need for thorough scrutiny and oversight by the Safety and Quality Committee. It was recommended that reports to the audit committee include an executive summary indicating prior scrutiny by assurance committees.
ADVISE **Areas requiring on-going monitoring; Limited assurance received.**	**Staff Expenditure:** The Committee highlighted the importance of controlling staff expenditure by monitoring agency and bank costs, reviewing core establishment, and addressing issues of recruitment, retention, and sickness absence. The Trust's sickness absence rate was noted to be higher than comparable trusts, representing a potential saving. **Risk Identification:** Evaluating the effectiveness of the new approach to risk identification was identified as a key area. The Committee suggested looking more closely at cybersecurity, considering recent national guidance.
ASSURE **Assurance received; Matters of positive note.**	**Data Quality**: The importance of accurate data capture for clinical research and patient outcomes was underscored. The Committee acknowledged the significant work being done to improve data quality and coding, generating additional income and preparing for future changes in payment models.

Lancashire Teaching Hospitals NHS
NHS Foundation Trust

Audit Committee

17 April 2025 | 10.30am | Microsoft Teams

Agenda

№	Item	Time	Encl.	Purpose	Presenter
1.	Chair and quorum	10.30am	Verbal	Information	T Wheeler
2.	Apologies for absence	10.31am	Verbal	Information	T Wheeler
3.	Declaration of interests	10.32am	Verbal	Information	T Wheeler
4.	Minutes of the previous meeting held on 16 January 2025	10.33am	✓	Decision	T Wheeler
5.	Matters arising and action log	10.34am	✓	Decision	T Wheeler
6. INTERNAL AUDIT					
6.1	Internal Audit Progress Report inc. update on items of limited assurance	10.40pm	✓	Assurance	MIAA
6.2	Combined Internal Audit and Counter-Fraud Follow-Up Summary Report (inc. previous investigations)		✓	Assurance	MIAA
6.3	Draft Head of Internal Audit Opinion	11.00am	✓	Assurance	MIAA
6.4	Internal Audit Plan and Fees inc. Anti-Fraud & One LSC	11.10am	✓	Assurance	MIAA
7. EXTERNAL AUDIT					
7.1	External Audit Plan for 2024/25 including VFM Risk Assessment	11.25am	✓	Information	KPMG
8. GOVERNANCE AND RISK					
8.1	Update on annual report and accounts process	11.35am	✓	Assurance	B Patel

№	Item	Time	Encl.	Purpose	Presenter
8.2	Single Tender Waiver Report	11.45am	✓	Assurance	B Patel/M Doyle
8.3	Annual Report on Gifts & Hospitality/Code of Business Conduct Compliance	11.55am	✓	Assurance	J Foote
8.4	Data Quality Assurance inc. Grant Thornton Review	12.05pm	✓	Assurance	S Dobson
8.5	Risk Management Policy	12.15pm	✓	Decision	S Regan
8.6	Items to alert, advise and assure the Board	12.25pm	Verbal	Information	T Wheeler
8.7	Reflections on the meeting	12.30pm	Verbal	Information	T Wheeler
9. ITEMS FOR INFORMATION (issues raised by exception)					
9.1	Strategic Risk Report		✓		
9.2	Clinical Audit Programme Update		✓		
9.3	Review of Cycle of Business		✓		
9.4	Internal Audit Charter		✓		
9.5	Counter-Fraud a) Anti-Fraud Annual Report 2024-25 b) Anti-Fraud Workplan for 2025-26		✓ ✓		
	Date, time and venue of next meeting: *24 June 2025, 9.30am, Microsoft Teams*	12.35pm	Verbal	Information	T Wheeler

12.2 *RISK MANAGEMENT POLICY

Decision Item | T Wheeler | 12.05pm

*Full report in ancillary pack?

12.3 RAISING CONCERNS AT WORK (INCLUDING WHISTLEBLOWING AND FREEDOM TO SPEAK UP) ANNUAL REPORT

Other | N Pease | 12.10pm

Item for Assurance

REFERENCES

Only PDFs are attached

12.3 - Biannual WFC FTSU Report May 2025 Final.pdf

Board of Directors

Freedom to Speak Up Biannual Report			
Report to:	Workforce Committee	**Date:**	3rd June 2025
Report of:	Chief People Officer	**Prepared by:**	K Holt

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

Executive Summary:

The purpose of this report is to provide an update on:

1. Freedom to Speak up (FTSU) activity during the last 6 months covering October 2024 – March 2025
2. The delivery of actions as described in the strategic Freedom to Speak Up Action Plan
3. Further planned actions to support the ongoing development of the service and improvement to the organisation's culture of speaking up

The number of concerns being raised by colleagues to the FTSU service has stabilised over recent months. Whilst this could be viewed as positive, it is also worth noting that this remains at a reduced rate of reporting of concerns when compared to 12 months ago – a reduction of 56.7%, and in comparison to the trends reported by the National Guardian's Office which continues to state that the rate of concerns is increasing nationally.

The rate at which colleagues are raising concerns anonymously has declined slightly, which is a positive indicator, and may be because of enhanced and clearer messaging on the limitations in effectively responding to anonymous concerns.

Divisional reporting rates remain in line with the previous period, with the larger divisions (Surgery & Medicine) continuing to report higher concerns. Activity is lower across Women's and Children's (W&C), Diagnostics and Clinical Support (DCS) and Estates and Facilities (E&F), with specific staff groups such as Maintenance and Midwifery continuing to follow similar low reporting trends as noted previously. There has however been a positive increase in Medical and Dental colleagues utilising the service to raise concerns.

This year's NHS Staff Survey Results indicate that overall colleague perceptions on the value of and encouragement for speaking up have declined, although in some sections these have remained stable and in line with national benchmarks (e.g. reporting of physical violence, bullying/harassment, and clinical concerns). The division of W&C's scores most highly regarding colleague perceptions, and E&F significantly lower. The NHS Staff Survey feedback has been used to identify teams where there are more and less positive perceptions around speaking up and plans underway to engage with these services to explore this further. The FTSU feedback form is now able to collate valuable insights from colleagues on their experiences of speaking up.

Despite enhanced processes around following up after concerns being resolved, there continues to be a very low rate of cases that are being reopened, suggesting that appropriate action and resolution has been achieved in most concerns.

There has been a slight shift in the themes of concerns being reported over the last 12 months. Notable examples include:

- Reduction in health and wellbeing concerns, and concerns relating to bullying and harassment behaviours from managers
- Increase in concerns on bullying and harassment behaviour from peers, poor leadership, unfair treatment/bias/breach of policy and lack of involvement and consultation

Despite FTSU workforce capacity issues, there has been achievement and progression of several priorities noted in the previous report, all aimed at enhancing the delivery of the service and improving the culture of speaking up across the organisation. Further actions are planned over the coming weeks, with particular focus on re-engagement and enhancing the role of the FTSU Champion Network and finalising the Raising Concerns at Work Policy and Process, which now includes additional guidance on whistleblowing and the Public Interest Disclosure Act.

It is recommended that the Board of Directors

Receives and notes the report.

Trust Strategic Aims and Ambitions supported by this Paper:

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

Previous consideration

Workforce Committee – 13th May 2025

BACKGROUND

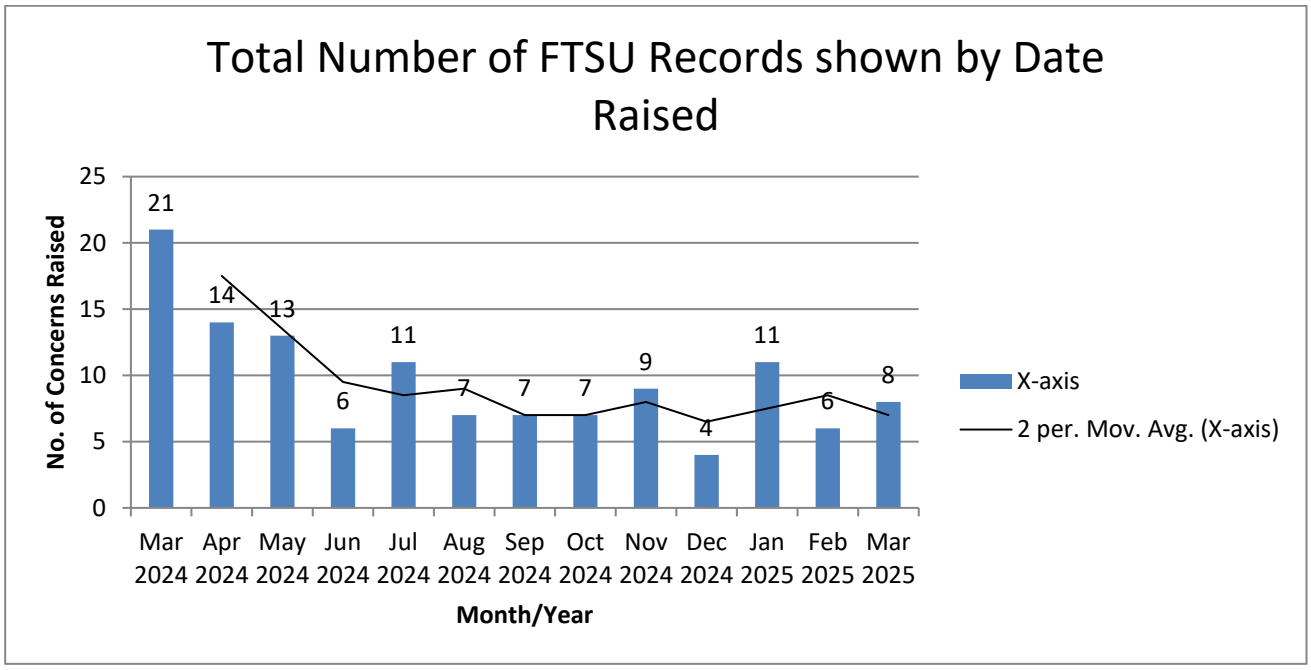
This report provides an update on our current position in relation to our Freedom to Speak Up (FTSU) service and activity during the last 6 months. It also includes reference to perceptions of colleagues around speaking up and a summary of actions taken in response to strategic objectives described in the last report and planned actions for the coming year.

PART 1: FREEDOM TO SPEAK UP ACTIVITY

From analysing the data over the medium and long term and, in comparison with similar reporting periods from previous years, it is evident that the reporting rate of concerns being raised via the Freedom to Speak Up Service has stabilised over the last 6 months.

a) Organisational Activity

Over the last 12 months, the average number of concerns raised per month has reduced although it is noteworthy that this has stabilised over the last 6 months and remains consistent at 7.5 per month.



Over the last 6 months (October 2024 – March 2025), a total of 45 concerns have been raised across the organisation. For the same period last year (October 2023 – March 2024), the number of concerns raised was 104. This represents a reduction of 56.7%.

This trend was similarly noted in the last WFC report (where a reduction of 22% was reported) and remains significant as the most recent information from the National Guardian's Office (which collates data from organisations across the country) states that the national picture for 2023/2024 is that the number of colleagues raising FTSU concerns has increased by 27.6% increase from the previous year. More recent national data (for 2024/2025) will be available soon and further analysis against this national trend will be undertaken at this point.

The previous report noted that potential contributing factors to an overall reduction in the reporting rate over the last 12 months included:

- Improved organisational culture in respect of listening and responding and the achievement of efforts to make speaking up business as usual.
- Reduction in the capacity of the FTSU service.

Whilst these factors may remain it is also worth noting that there has been a stable trend over last 6 months around reporting of concerns through the FTSU service. This could be attributed to several factors:

- If previous concerns have been resolved satisfactorily, colleagues might feel more confident that their issues will be addressed without needing to raise new concerns. Further information on the low rate of reopened concerns is available below.
- Adjustments in how concerns are reported or categorised could lead to a more stable number of reported issues. An example of this is where the FTSU service no longer records concerns linked to car parking – these are immediately signposted to the Car Park Helpdesk for action and resolution.
- Broader external factors, such as changes in the healthcare environment might influence the number of concerns raised. In reference to LTH, this may include reference to increased colleague understanding of political, financial and workforce pressures that are impacting both our own organisation and others across the local and national landscape.

b) Divisional Activity

Over the last 6 months, the two largest Divisions (Surgery and Medicine) generated the greatest number of concerns. This aligns with the previous trend for the previous 12 months as indicated below.

Division	No. of concerns raised April 2023 – March 2024	No. of concerns raised April 2024 – March 2025
W&Cs	18	5
Surgery	55	32
Medicine	36	32
E&F	15	7
DCS	27	13
Corporate	26	13
Total	**177**	**102**

The Divisional Management Team (Divisional Director, Medical Lead, Nursing Lead and Workforce Business Partners) continue to be provided with monthly reports on the nature, distribution and themes of concerns to enable learning and improvement. These are provided in advance of their monthly Divisional Improvement Forums to ensure this information can be referred to as appropriate in these meetings. They are also made aware of when 3 or more concerns have been raised from within a particular service/SBU within the last 12 months to encourage consideration and further discussions on potential risks or issues arising from these areas.

c) Reopened Concerns

The FTSU service continues to conduct a follow up process where colleagues who have previously contacted the service are contacted three months after their concern has been closed to support them in raising concerns to the service again if they feel it's appropriate to do so.

From the period of October 2024 – March 2025, a total of 83 colleagues have been contacted through this process, and this has not resulted in any concerns being formally reopened. This continues to suggest that a significant number of those who have raised concerns feel these have been resolved appropriately.

PART 2: PERCEPTIONS OF SPEAKING UP

a) Organisational Perceptions

Data from our 2024 NHS Staff Survey results suggest that there has been a recent decline in the way our staff feel about speaking up and raising concerns in comparison to the 2023 NHS Staff Survey Results. This does reflect the national trend. In previous years, we have seen increases in satisfaction across numerous speaking up related questions, however this year this has reduced significantly as displayed in the table below, for example, Q25f now sits 3.8% below the national benchmark and is a 5.9% reduction on the previous year's score for the Trust.

Question No.	Description	Organisational Score 2022	Organisational Score 2023	Organisational Score 2024	National Avg. 2024
Q25e	Feel safe to speak up about anything that concerns me in this organisation.	62.5%	62.8%	58.5%	60.5%
Q25f	Feel organisation would address any concerns I raise.	48.0%	50.1%	44.2%	48.0%

There are however positive comparative scores and trends relating to other areas of concern, such as violence bullying and harassment, and clinical concerns as indicated below. Our organisational scores here indicate that we largely sit in line with or slightly above the national benchmark.

Question No.	Description	Organisational Score 2022	Organisational Score 2023	Organisational Score 2024	National Avg. 2024
Q13d	Last experience of physical violence reported.	73.6%	74.1%	72.5%	71.4%
Q14d	Last experience of bullying, harassment or abuse reported.	52.5%	51.5%	52.6%	52.5%
Q19b	Encouraged to report errors, near misses & incidents.	86.6%	87.6%	86.0%	86.0%
Q20a	Would feel secure raising concerns about unsafe clinical practise.	69.7%	70.6%	70.1%	70.0%
Q20b	Would feel confident that organisation would address concerns about unsafe clinical practice.	55.4%	56.2%	53.2%	55.1%

b) Divisional Perceptions

From reviewing colleague feedback via the NHS Staff Survey 2024 by division, it is noted that there are differences in perceptions based on these areas. The scores noted in green indicate the highest scoring divisions, and those noted in red are the lowest. The data below suggests that the division of W&Cs scores most positively in comparison to other divisions. Surgery, Medicine, DCS and Corporate Services have a range of scores around colleague's perceptions of speaking up, and E&F score lowest across most areas. These trends remain very similar to those reported last year.

Question No.	Description	W&Cs	Surgery	Medicine	E&F	DCS	Corporate
Q9h	Immediate manager cares about my concerns.	71.3%	**72.6%**	**71.1%**	**49.8%**	72.3%	**72.6%**
Q9i	Immediate manager helps me with problems I face.	65.4%	**69.6%**	**64.6%**	**48.3%**	69.0%	**69.9%**

Q25e	Feel safe to speak up about anything that concerns me in this organisation.	**63.4%**	59.2%	**53.6%**	**46.4%**	60.5%	60.7%
Q25f	Feel organisation would address any concerns I raise.	**63.4%**	59.2%	**53.6%**	**46.4%**	60.5%	**60.7%**
Q13d	Last experience of physical violence reported.	**54.2%**	72.8%	**79.9%**	71.4%	**59.5%**	**84.6%**
Q14d	Last experience of bullying, harassment or abuse reported.	**49.0%**	**49.9%**	**57.8%**	*	**51.5%**	51.4%
Q19b	Encouraged to report errors, near misses & incidents.	**91.3%**	87.9%	85%	**69%**	88.5%	**83.7%**
Q20a	Would feel secure raising concerns about unsafe clinical practise.	**78.9%**	**73.3%**	72.4%	**51.3%**	72.1%	**62.8%**
Q20b	Would feel confident that organisation would address concerns about unsafe clinical practice.	**59.3%**	**55.3%**	**51.2%**	**39.2%**	53.9%	52.3%

c) Team Perceptions

In conjunction with wider staff survey team level analysis, it has been identified that there are several teams where colleagues' perceptions of speaking up are significantly low. It is planned for these teams to be contacted directly with an offer of support to enable them to review this further and start to consider what actions or areas for improvement could be identified to support positive change. These teams include:

- Preston/receipt Sample in – Pathology Team (T36227)
- Medical Records (CDH) (T37407)
- Anaesthetics Medical (T35301)
- Neurology Management (T35763)
- Orthopaedics Fracture Clinic (CDH) (T35112)
- Clinical Biochemistry (T36224)

It is also useful to note teams where these scores are particularly high. It is planned that these teams will also be contacted to explore opportunities for learning and positive practise which can then be shared more widely.

- Elderly Rookwood B (CDH) (T35434)
- Renal Dialysis Unit (CDH) (T35860)
- Neurosurgery Ward 2A (RPH) (T35751)
- Gynaecology Specialist Nurses (RPH) (T36021)
- Oncology Medical (T35900)

d) Individual Perceptions

Through implementation of a refreshed process for gaining feedback from colleagues who have raised concerns through the FTSU service, it is now possible to provide further analysis on this. All colleagues are invited to submit their views through an online form, and to date a total of four have been completed. The table below shares the findings from these and will continue to be reviewed as more information is generated. From the limited data received, it demonstrates that there has generally been a positive experience of speaking up through the service, although there are opportunities for improvement around timeliness of response/resolution, which may then positively impact overall satisfaction and confidence scores.

Question	Feedback
How easy was it to find information about how to raise a concern via FTSU?	75% Very Easy 25% Easy 0% Neutral 0% Difficult 0% Very Difficult
How did you first contact the FTSU team? (Select all that apply)	In-person meeting 0% Phone call 25% Email 100% Online form (DATIX) 0% Other 0%
How clear and understandable was the information provided about the process?	Very clear 50% Clear 0% Neutral 50% Unclear 0% Very unclear 0%
Please use the space below to describe your experience of raising your concern in more detail.	• *It was a long-drawn-out process and I found it frustrating that progress was very slow. I am grateful we have this service, but it felt that I was always pushing the issue to move on.* • *I raised a concern. Was given helpful steps to take and information. However, the problem isn't resolved and won't be as the Trust won't spend money to rectify this particular problem.* • *I was pleased with how quickly I was contacted after raising my concern. When [FTSU Guardian] needed more information, I genuinely felt believed and that my concern was valid..I didn't feel like I'd wasted anyone's time by reporting. There were issues on the day with teams but [FTSU Guardian] quickly contacted me and we did the meeting over the phone. The follow up was good. I was given feedback about my concerns and I was happy with what had been put in place. Very good experience and would recommend others to use this valuable service.*
To what extent did you feel supported by the FTSU team during the process?	Completely 50% A lot 25% A little25% Not at all 0%
Did the FTSU team communicate with you regularly throughout the process?	Yes 75% No 25%
How satisfied were you with the timeliness of the response to your concern?	Very satisfied 50% Satisfied 25% Neutral 0% Dissatisfied 25% Very dissatisfied 0%

How satisfied were you with how your concern was handled overall?	Very satisfied50% Satisfied 0% Neutral 25% Dissatisfied 25% Very dissatisfied 0%
Did you experience any negative repercussions as a result of raising your concern?	Yes 25% No 75%
Do you feel confident about raising a concern again if necessary?	Yes 50% No 50%
Please use the space below to describe your experience of the support you received and your personal experience of raising a concern in more detail.	• *I felt supported by the staff at Freedom to speak' but not with the process of investigating* • *I appreciate no one has a magic wand and certain issues that pertain to the poor state of the Trusts infrastructure and it's an old building. So I will again dread each summer in our department, powerless to change the high temperature in our department that makes patients and staff feel unwell.* • *Reassurance was given and I was asked if I needed further support. I didn't as I was raising a concern around a colleague I didn't directly work with.*
What improvements would you suggest for the Freedom to Speak Up service?	• *Just be straight with people and don't offer hope that something can be done to improve a situation when in fact nothing can or will be done.*

In addition to the above, there is some reference to colleague's experience of "speaking up" and "raising concerns" identified in the free-text comments of the 2024 staff survey. This specifically refers to the comments of a small number (less than 10 colleagues) however is useful to reference here as it indicates that some feel unsupported, bullied, and discriminated against when raising concerns, leading to a culture of fear and reluctance to speak up.

- **Toxic Culture**: Colleagues describe a toxic management culture where risks are dismissed and those who raise concerns are seen as problems. Negative behaviours and resistance to different thinking are prevalent.
- **Bullying and Retaliation**: Staff who speak up are bullied directly and indirectly, leading to a culture of fear and reluctance to raise concerns.
- **Discrimination**: There are reports of covert racism and discrimination, particularly against international nurses, with punitive measures taken against those who speak up.
- **Confidentiality Issues**: Concerns raised are not kept confidential, leading to widespread knowledge of issues and further reluctance to speak up.
- **Micromanagement**: Staff are micromanaged by inexperienced managers and not involved in decisions affecting their daily tasks.
- **Incident Handling**: Where concerns are handled poorly, this can cause causing embarrassment and distress among staff.

PART 3: SPEAKING UP THEMES

a) Themes of Concerns

(In providing details of the themes of concerns, it is beneficial to review this over a 12-month period to ensure a representative sample for analysis.)

Over the past year there has been notable shifts in the themes of concerns reported through our FTSU service. These are detailed in the table below.

	Overall Concerns %	Last 12 months %	Change (+/-)
Adverse impact on Health and well being	48.1%	41.7%	-7.1%
Bullying and harassment – peer	9.3%	12.6%	+3.3%
Bullying and harassment-manager	12.3%	5.8%	-6.5%
Car Parking	5.5%	5.8%	+0.3%
Change in working conditions	7.2%	8.7%	+1.5%
Discrimination – age	0.2%	1%	+0.8%
Discrimination – disability	3.2%	5.8%	+2.6%
Discrimination – gender	0.8%	1%	+0.2%
Discrimination – race	2.5%	6.8%	+4.3%
Discrimination - sexuality	0.3%	0%	-0.3%
Environmental concern	4.7%	4.9%	+0.2%
Fraud/dishonesty	2.5%	2.9%	+0.4%
Lack of involvement/consultation	6%	13.6%	+7.6%
Lack of response from manager	17.8%	22.3%	-4.5%
Patient safety risk	22.3%	16.5%	-5.8%
Poor attitude and behaviour – manager	19.5%	18.4%	-1.1%
Poor attitude and behaviour – peer	14.3%	27.1%	+12.8%
Poor communication	9.7%	15.5%	+5.8%
Poor leadership	13.3%	22.3%	+9%
Professional concerns	20.3%	26.2%	+5.9%
Public safety risk	1%	0%	-1%
Transport	0.7%	1.9%	+1.2%
Unfair treatment/bias/breach of policy	28.2%	36.8%	+8.6%
Unsafe practice – individual	3.2%	1.9%	-1.3%
Unsafe practice – infection control	1.5%	1%	-0.5%
Unsafe practice – non-clinical	1.2%	2.9%	+1.7%
Unsafe practice – patient flow/bed management	1.3%	3.9%	+2.6%
Unsafe practice - Workwear compliance	0.5%	0%	-0.5%
Unsafe practice- clinical	5.3%	7.8%	+2.5%
Unsafe staffing levels	7%	3.9%	-3.1%
Unwanted, inappropriate and/or harmful sexual behaviours	*	5.8%	*

(Note – this was a new category added in 2024)			
Worker safety risk	12.3%	17.5%	+5.2%

These changes reflect evolving dynamics within our workplace and highlight areas where we need to focus our efforts to ensure a supportive and safe environment for all colleagues here at LTH:

- **Adverse Impact on Health and Well-being**: Reports of concerns related to health and well-being have decreased from 48.1% to 41.7% (-7.1%). This reduction suggests improvements in workplace conditions and support systems, although continued vigilance is necessary to maintain and further enhance staff well-being.
- **Bullying and Harassment**: There has been a mixed trend in bullying and harassment reports. Peer-related bullying and harassment have increased from 9.3% to 12.6% (+3.3%), indicating a need for stronger peer support and conflict resolution mechanisms. Conversely, manager-related bullying and harassment have significantly decreased from 12.3% to 5.8% (-6.5%), suggesting progress in managerial effectiveness and leadership training.
- **Discrimination**: Reports of discrimination have shown varied changes. Discrimination based on race has notably increased from 2.5% to 6.8% (+4.3%), highlighting need for targeted interventions and diversity training. Discrimination based on disability has also risen from 3.2% to 5.8% (+2.6%), while age and gender discrimination have seen smaller increases. These trends underscore the importance of fostering an inclusive and equitable workplace.
- **Communication and Leadership**: Concerns about poor communication have risen from 9.7% to 15.5% (+5.8%), and poor leadership reports have increased from 13.3% to 22.3% (+9%). These changes indicate a need for enhanced communication strategies and leadership development programs to ensure clear, effective, and supportive interactions across all levels of the organisation.
- **Professional and Safety Concerns**: Reports of professional concerns have increased from 20.3% to 26.2% (+5.9%), reflecting ongoing challenges in professional conduct and standards. Patient safety risk concerns have decreased from 22.3% to 16.5% (-5.8%), suggesting improvements in patient care practices, although continued focus on safety protocols is essential.
- **Unfair Treatment and Bias**: Reports of unfair treatment, bias, and breach of policy have risen from 28.2% to 36.8% (+8.6%). This significant increase calls for continued review of policies and practices to ensure fairness and equity in all aspects of employment.
- **Worker Safety**: Concerns about worker safety have increased from 12.3% to 17.5% (+5.2%), indicating a need for enhanced safety measures and support systems to protect staff from harm.
- **New Category - Unwanted Sexual Behaviours**: The introduction of this new category in 2024 has resulted in 5.8% of reports, highlighting the importance of addressing and preventing inappropriate and harmful sexual behaviours in the workplace.

b) Anonymous Concerns

Our levels of anonymous reporting have decreased over the last 6 months, as indicated by the data below.

	April 2023 – Sept 2024	**Oct 2024 – March 2025**
% of concerns raised anonymously	15.6%	13.3%

This represents a positive shift on previous data trends where LTH had noted a slight increase in the rate of anonymous reporting. The service is continuing to focus its messaging on the limitations around anonymous reporting. For example, those who complete the online contact form are informed of the following:

"Please provide as much information here as you feel comfortable with, however you can choose to remain anonymous if you wish. We will action and respond to anonymous concerns as best we can, however please be aware that this does mean we will be unable to contact you to discuss your concerns further, provide you with any updates or offer you ongoing support. There may also be limitations in how much your concern can be investigated or responded to. If you do provide your contact details, the FTSU Team can keep these confidential throughout the process if you'd prefer."

To date, there have not been any anonymous concerns raised through this pathway. The small number) that have been received are through DATIX or alias email addresses (6 anonymous concerns out of a total of 45 concern overall).

c) Concerns By Professional Group

Clinical staff continue to raise the most concerns. Over the last 6 months Registered Nurses, HCAs and AHPs collectively raised 40% of concerns. It is positive to note that there has been an increase in the proportion of concerns raised from Medical and Dental colleagues. Low reporting trends have continued from Midwives, Students and Maintenance colleagues. This data continues to signify the need for FTSU to continue to focus on visibility, accessibility and demonstrating value across these staff groups to ensure that they reach out and use the service appropriately.

Professional Group	Number of concerns	% of Overall Concerns
Administration and Clerical	4	8.8%
Allied Health Professional	6	13.3%
Corporate Services	0	0%
Healthcare Assistant	6	13.3%
Maintenance/Ancillary Staff	3	6.7%
Medical and Dental Professional	7	15.2%
Midwife	0	0%
Registered Nurse	6	13.3%
Student	0	0%

PART 4: PRIORITIES AND ACTIONS FOR THE FREEDOM TO SPEAK UP SERVICE

In the previous report, there were four key areas identified for focus to support continuous improvement of the FTSU service. The information below provides an update on each of these areas, with further details included in the FTSU Action Plan which is available in Appendix 1.

a) Raising Awareness and Increasing FTSU Activity

There has been a rebrand and refresh of the FTSU service communications for colleagues. New posters have been designed, approved, and distributed to support colleagues to understand the importance of raising concern, and how they can contact the service for support (see Appendix 2). The intranet page has also been updated with this information as well as additional information on appropriate pathways for raising concerns. Awareness sessions have been delivered to leaders, for example through learning and development programmes and regular colleague engagement sessions (e.g. Clinical Director Development Programme, NMAHP Weekly Leaders sessions, Leaders Forum, Managers Update Sessions). A new animation video is in development, expected to be completed in the coming weeks.

The Raising Concerns at Work Policy and Process is currently being reviewed and awaiting further comments and feedback before ratification and publication. Enhanced information on whistleblowing and the Public Interest Disclosure Act, as well as protecting staff from detriment have been included in the new policy. Once finalised, this will be published, and colleagues will be signposted as appropriate.

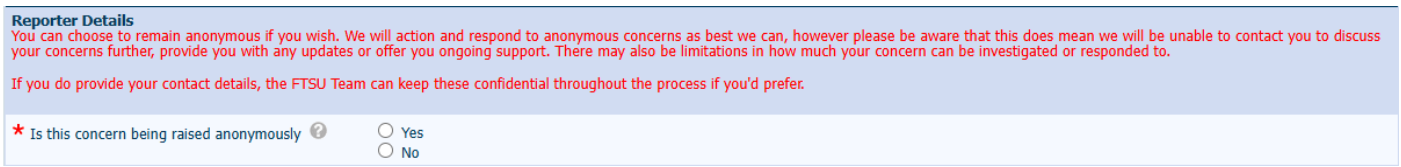
b) Providing focussed support for speaking up (divisions and staff groups)

As previously noted in this report, there are actions planned to outreach into teams where staff survey data indicates that colleague's perceptions around speaking up are low. In addition to this, there has been work undertaken to re-engage the FTSU Champion Network. A new role description has been developed and shared (Appendix 3), and training sessions scheduled to support champions to have a thorough understanding of their role. Colleagues working in what might be viewed as areas of high risk (e.g. Maternity, ED) have been recruited as champions, as well as representatives from the Medical Trainee group where there was previously no-one identified. The refreshed Champion Database has greater representation across the divisions and staff groups. Quarterly network meetings will be scheduled to support appropriate triangulation of intelligence/themes, as well as a resource pack for reference and support in the delivery of these roles.

c) Improving the processes for anonymous reporting

An online form for raising concerns is now fully operational and accessible from any device through both an online-link and scannable QR code. This means that colleagues can now raise a concern without having to be logged into a trust device. The FTSU inbox receives an automated update daily which provides details on whether any new concerns have been raised. As already detailed in this report, this form provides additional guidance to colleagues who wish to raise a concern anonymously.

In relation to the DATIX form, this has been updated so that when colleagues are asked to provide their details as the reporter, they are also provided with the following guidance (which is the same as the online form):



Where colleagues raise concerns anonymously via email, the FTSU service will continue to promote positive interactions and information sharing to enable concerns to be raised in an appropriate way. The quote below provides a recent example of this messaging for information:

"I recognise that sharing your identity is not something you wish to do and can support this. However, to progress this and share the information appropriately there is more information that is required here."

d) Implement a new process for gathering feedback from colleagues who have used the FTSU service to raise a concern

The process for gathering feedback from colleagues on their experience of raising a concern is now included as standard as part of the three month follow up process. This means we are now able to present data on how colleagues have experienced the service and take any necessary action to address emerging themes. This data is also requested as part of the quarterly returns for the National Guardian's Office. We are therefore now able to provide the necessary assurances externally.

FINANCIAL IMPLICATIONS

None

LEGAL IMPLICATIONS

There are no legal implications associated with this report. However, Trust arrangements for raising and responding to concerns are referenced in the standard NHS contract; are subject to review by the Care Quality Commission (CQC) as part of the Well-led domain; and are monitoring by the National Guardians Office (NGO), which is sponsored by the CQC and NHS England (NHSE). Failure to address concerns being raised within the organisation could result in external concerns being raised including legal action such as employment tribunals or because of safety concerns not being appropriately resolved.

RISKS

Whilst actions are underway to address this, it is evident that the current FTSU workforce capacity issues have had a negative impact on the delivery of the wider actions linked to enhance the speak up culture across LTH. There is a real opportunity and need for improvement here as evidenced through the NHS Staff Survey feedback. Reporting rates are shared with the National Guardian's Office, and it is evident that our lower rate of concerns sits in direct comparison to their data trends. Risks associated with speaking up incidents are owned and managed by the relevant Divisions and reviewed as appropriate through the bi-monthly Raising Concerns Meeting.

RECOMMENDATIONS

It is recommended that the Board of Directors:
Receives and notes the report.

APPENDIX 1 - FREEDOM TO SPEAK UP – ACTION PLAN 2025

Theme/Aim	Actions	Update/RAG	Timescale for Delivery
Rebrand and Refresh	Posters	New design approved and payment progressed. Posters have arrived and been delivered arranged through post room and direct distribution to leaders and teams. To continue ad hoc on request.	Completed March 2025
	Intranet	Page has been refreshed with new branding, additional information on raising concern processes/pathways and how to access the FTSU service. Awaiting confirmation of champion contacts and then further update to be completed.	On track for completion by July 2025
	Awareness Sessions	Update and refresher session delivered to NMAHP leaders group on 5.2.25. Outreach activity to be completed upon receipt of Staff Survey data.	On track for completion by May 2025
	Video	Initial meeting with Blended Learning completed. Video script drafted and new imagery shared to support with video development. Timescale for completion approx. 3 months (May 2025).	On track for completion by May 2025
	Accessibility (online form)	Developed using JISK and links shared on posters and intranet. Now fully operational.	Completed March 2025
FTSU Champion Support	Distribution List	Initial review taken place and communications sent to gain commitment to the role going forwards on 18.2.25. New database of contacts established and communication channels in place. Training planned for May/June 2025. To continue to build as required.	Completed April 2025
	Role Description	New description developed using new branding and incorporating more links to wider culture/EDI/colleague experience. Included in communications to distribution list on 18.2.25.	Completed April 2025
	Quarterly Network Meetings	Not yet started. To be scheduled following completion of initial training sessions.	Commence in August 2025
	Triangulation of intelligence	Not yet started. To be included as a standing agenda item for the quarterly network meeting.	Commence in August 2025
	Resource Pack	In development.	On track for completion by June 2025
	Staff Survey Outreach	Teams have been identified. To take place during final two weeks of April 2025.	On track for completion by May 2025

	Representation	Initial review demonstrates good/equal representation across divisions. New representation now establish for Medial Trainee and Maternity services. Further outreach to EDI groups, and other areas of concern based on staff survey trend data once received.	On track for completion by May 2025
Resourcing (FTSU Guardian)	Banding	Completed and approved at B7.	Completed April 2025
	EQIA	Completed and approved.	Completed December 2024
	VCP	Approved.	Completed January 2025
	Recruitment	Currently out to advert: • advert closes - Fri 23rd May • shortlisting - Tues 27th May • interviews - Thurs 12th June	On track for completion by August 2025
Policy & Processes	Whistleblowing Definitions	Discussed and included within new Policy with additional guidance provided to support colleagues and responders.	Completed March 2025
	Protecting Staff from Detriment	As above	Completed March 2025
	Sexual Safety Assurance Framework	Initial review completed and working group re-established to review and allocate actions required to address gaps (e.g. policy, training, EDI, anonymous reporting).	On track for completion by September 2025
	1LSC Processes	Interaction with other organisations is low, therefore requested an update on 12.2.25. Responded to say there is a HRD's meeting where it will be discussed on 24.2.25 however this did not take place. Issues escalated to CPO.	Ongoing – requires confirmation before Nov 2025.
	Policy	Draft developed and currently awaiting comments throughout April 2025. Scheduled for review at JNCC end of May 2025.	On track for completion June 2025
	Strategic alignment with cultural programme of work	Awaiting confirmation from Neil Pease and Silas Nicholls on agreement to move FTSU strategy under "To Create a Positive Organisational Culture"/Our People Plan.	On track for completion by September 2025

APPENDIX 2 – FREEDOM TO SPEAK UP POSTER

Freedom to Speak Up Champion: Role Description

This information sheet explains the role of the FTSU Champion in relation to supporting colleagues in raising their concerns at work.

Background to the role of FTSU Champion

We want to create a culture of openness and ensure our colleagues feel able safe to speak up if something is concerning them.

In February 2015 the Freedom to Speak Up review was published by Sir Robert Francis to give guidance as to how NHS organisations should deal with concerns raised by staff. The aim of the review had been to provide advice and recommendations to ensure that NHS staff in England feel safe to raise concerns, are confident that they will be listened to and the concerns will be acted upon. Following this review, Lancashire Teaching Hospitals established a Freedom to Speak up (FTSU) Team. The purpose of the FTSU Team is to help and support staff with any concerns about what is happening at work; it can be absolutely anything, such as a potential risk to patients, professional misconduct or financial malpractice.

Our **network of Freedom to Speak Up Champions** exists to help create a culture of openness within our organisation where all staff are actively encouraged and enabled to speak up safely. Our FTSU Champions are a valuable point of contact for individuals who require advice, to inform them of the options available, and to direct individuals to the support available. They also act as role models for creating an open, honest and transparent culture which values speaking up.

What does the FTSU Champion role involve?

FTSU Champions will become part of the FTSU Team who are responsible for supporting staff in raising concerns. This role is a voluntary role and is undertaken in addition to any existing role in the trust. Our FTSU Champions are responsible for:

- Promoting a culture where speaking up is recognised and valued.
- Being available and accessible to colleagues who may have a concern.
- Providing information to colleagues on how they can access advice and support when raising their concerns and signposting sources of support and guidance as appropriate.
- Taking immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised.
- Ensure that any safety issues raised are addressed and feedback is given to the colleague who raised it in line with confidentiality agreements
-

NOTE: FTSU champions DO NOT investigate concerns or manage cases personally.

What are the benefits of being a FTSU Champion?

Becoming an FTSU Champion offers both personal and professional rewards and contributes to a safer, fairer, and more open workplace culture and environment. It is a **rewarding and influential role** that drives change, **support colleagues**, and enhances **skills and career prospects.**

1. Making a Positive Impact

- Helps create a culture of openness, trust, and safety.
- Contributes to improving patient care, colleague experience and wellbeing.
- Supports colleagues in having their voices heard and concerns addressed.

2. Developing Key Skills

- Enhances communication, active listening, and problem-solving abilities.
- Builds confidence in handling sensitive issues and supporting colleagues.
- Strengthens leadership and advocacy skills.

3. Expanding Career Opportunities

- Develops experience in staff engagement, governance, and cultural change.
- Provides opportunities for training, networking, and collaboration with senior leaders, HR, and regulatory bodies.
- Enhances career progression into leadership, HR/OD, or patient safety roles.

4. Strengthening Teamwork and Relationships

- Builds stronger connections across departments and staff groups.
- Encourages a supportive and inclusive working environment.
- Promotes cross-team collaboration to address concerns effectively.

5. Advocating for Equity, Diversity, and Inclusion (EDI)

- Helps reduce barriers for underrepresented staff to speak up.
- Supports the organisation's commitment to fairness and inclusion.
- Drives positive cultural change that benefits all colleagues.

6. Personal Fulfilment and Job Satisfaction

- Provides a sense of purpose and achievement in making a difference.
- Fosters pride in promoting a just and accountable workplace.
- Creates a stronger, safer, and more ethical organisation.

Who can be a FTSU Champion?

Any member of staff who meets the skills/attitudes criteria below, and who has agreement from their line manager to undertake the role.

How will a FTSU Champion be supported?

FTSU Champions will be provided with initial training specific to the role and consistent with national guidance. There will also be quarterly FTSU Champion Network Meetings for them to attend, discuss and escalate themes from speaking up activity, and request further advice and support. Additional 1-1 supervision can be provided by the FTSU Guardian or Head of Culture and FTSU for individuals who request it. There is also executive and non-executive director support with appropriate escalation and review of themes of concerns. The National Guardian's Office can also be contacted for independent advice, and further information on FTSU related topics.

What skills are required to be a FTSU Champion?

A FTSU Champion plays a crucial role in supporting a culture of openness and ensuring that staff feel safe and empowered to raise concerns. To be effective in this role, an individual needs a combination of interpersonal, communication, and problem-solving skills, along with a strong commitment to patient safety, fairness, and staff wellbeing.

1. Active Listening and Empathy

- Ability to listen without judgment and make colleagues feel heard.
- Showing compassion and understanding when colleagues raise concerns.

- Recognising and validating colleague's emotions, especially in distressing situations.

2. Strong Communication Skills

- Explaining the Speak Up process clearly and concisely.
- Adjusting communication styles to support diverse staff groups (e.g., using plain language, being culturally aware).
- Encouraging open and honest conversations while maintaining confidentiality.

3. Confidentiality and Discretion

- Handling sensitive information professionally and securely.
- Maintaining trust by respecting the privacy of those raising concerns.
- Ensuring disclosures are only shared on a need-to-know basis.

4. Impartiality and Objectivity

- Avoiding bias and ensuring a fair, non-judgmental approach.
- Supporting all staff equally, regardless of seniority or background.
- Ensuring concerns are escalated appropriately, without personal influence.

5. Problem-Solving and Critical Thinking

- Assessing concerns and guiding colleagues on appropriate next steps.
- Helping identify potential solutions while maintaining independence.
- Recognising when issues need urgent escalation or further support.

6. Psychological Safety and Advocacy

- Creating a safe environment where colleagues feel comfortable speaking up.
- Championing a just and fair culture, preventing blame and retaliation.
- Encouraging leaders to act on concerns and fostering continuous improvement.

7. Resilience and Emotional Intelligence

- Managing emotionally charged situations while remaining calm.
- Recognising and managing personal biases and emotions.
- Coping with challenging conversations and maintaining professionalism.

8. Awareness of Policies and Legal Protections

- Basic understanding Freedom to Speak Up policies, NHS guidelines, and whistleblowing laws (e.g., Public Interest Disclosure Act).
- Being familiar with internal reporting procedures and escalation pathways.
- Providing accurate guidance on available support services.

9. Collaboration and Relationship-Building

- Working effectively with Freedom to Speak Up Guardians, HR/OD, trade unions, and senior leaders.
- Building trusting relationships with colleagues across the organisation.
- Promoting teamwork and collective responsibility for speaking up.

10. Commitment to Equity, Diversity, and Inclusion (EDI)

- Understanding how EDI barriers impact speaking up.
- Supporting marginalised groups in raising concerns safely.
- Advocating for an inclusive, fair, and respectful workplace.

What are the time commitments required to be an FTSU Champion?

It is important that colleagues wishing to be a FTSU Champion have discussed this with their line manager in the first instance. Line managers will be requested to release the champions for the sessions indicated below, as well as sufficient time as required to provide support to colleagues raising concerns.

- Attending one-off induction training session (approximately 1-2 hours)
- Attending quarterly FTSU Champion Network Meetings (approximately 1-2 hour every 3 months)

12.4 BOARD VISIBILITY 2025/26

Decision Item | J Foote | 12.20pm

REFERENCES

Only PDFs are attached

12.4 - Board Safety and Experience Programme - June 2025.pdf

Board of Directors Report

Board Safety and Experience Programme					
Report to:	Board of Directors	**Date:**	3 June 2025		
Report of:	Chair	**Prepared by:**	S Morrison/J Foote		
Part I	✓	**Part II**			
Purpose of Report					
For assurance		**For decision**	X	**For information**	

Executive Summary:

The purpose of the report is to review the approach to the Board Safety and Experience programme for 2024/25 and set out the plan for 2025/26.

The Board visibility safety and experience programme to date has provided structured visits to departments that have led to discussions at Board level where triangulation has then taken place and an increased focus on important topics. Feedback from divisional teams and leaders indicates that teams would find it helpful to have a closer connection with the Board and therefore a change in approach will take place in 2025/26 that aligns the Board to divisions, providing the opportunity to build relationships and undertake visits of areas with the aim of strengthening the level of triangulation and assurance provided through committees of the Board. Monthly safety visits are in place led by the deputy Chief Nursing Officer and board members retain an open invitation to these.

Recommendation

The Board is asked to note the activity that has taken place in 2024/25 and adopt the change in approach to the Board visibility safety and experience programme.

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

1. Introduction

The purpose of the report is to review the Board visibility safety and experience programme for 2024/25. In 2024/25 visits took place prior to each board workshop where divisional teams and department leaders were engaged in conversation and present within departments. The report outlines the aims of the visits and the areas visited and a refreshed approach to 2025/26.

2. Background

The aim of the Board visibility safety and experience programme is to:

- Demonstrate meaningful attention and visibility within the organisation balancing the value, appreciation and understanding of clinical and non-clinical areas.
- Engage and listen to patients and service users experiences.
- Allow the Board to explore topics presented for information and/or assurance in Committees and at Board and triangulate the written information with seeing this in practice.
- Respond to staff survey feedback, encourage and support the development of a positive safety culture within the organisation with Board members participating in leading conversations through an appreciative enquiry approach.
- Be effortlessly inclusive and hold conversations as senior leaders that provide a demonstrative commitment to inclusivity in all areas of our organisation.
- Observe in practice the impact of improvement methodology across the organisation, recognise this and celebrate with teams promoting cultures of improvement.
- Promote our values driven culture.
- Ensure colleagues know the Board, feel able to contact them should they wish to raise concerns and share good practice.
- Enable the Board to consider feedback, observations in the context of strategic development at Board level.

How this programme fit with our strategic aims and ambitions

Safety and Experience fundamentally underpins each of the 5 ambitions. Partnership, People, Patients, Productivity and Performance. Visibility of the Board is a fundamental part of connecting with front line staff, role modelling the values of the organisation, understanding the services delivered and identifying strategic opportunities that exist. In line with our culture counts, Board members advocate, and role model the behaviours that underpin creating a culture that enables teams to flourish.

Summary of Board visits 2024/25 – Impact and effectiveness

21 November 2024 – Neurosurgery/Maternity/Medical Engineering/Acute Medical Unit

7 January 2025 – Blood Science Team/Physical Therapy/Pharmacy

4 March – Ward 8 (Children's ward)/Neonates

In additional to these formal visits NEDs undertook informal visits organised on an ad hoc basis. In particular the Maternity Champion (Tim Ballard)

When undertaking the review of the impact and effectiveness for 2024/25 it was agreed that, whilst a formal arranged visit should allow for a more structured and equitable oversight, it had proved difficult in practice for NEDs to manage with other conflicting priorities.

In contrast the more informal approach adopted by Tim Ballard has worked well, with measurable impact delivered through his ability to triangulate evidence and provide assurance on maternity services to the Safety and Quality Committee.

The 2025/26 approach

Using the example of the informal approach detailed above, the programme has been refreshed for 2025/26 to ensure the new Non-Executive Board members can understand the organisation, build relationships with divisional leaders, understand the business of the division and the experiences of patients, families and colleagues and use this to triangulate against assurance reports received through the committees of the Board, albeit that this would be in the area and functions they were allocated to.

Table 1 – NED alignment

Area	NED	Divisional Contacts
Division: Surgery Education and Research	Stjohn Crean Tim Wheeler	Divisional Director - Kate Hudson Divisional Nurse Director - Lisa Elliot Divisional Medical Director- Steve Canty Deputy Director of Education- Lauren O'Brien Deputy Director of Research - Paul Brown
Division: Medicine Urgent Care	Karen Deany Adrian Leather	Divisional Director - Michael Brown Divisional Nurse Director - Amy Booth Divisional Medical Director- Mark Brady
Division: Womens & Children Maternity, Children, Neonatal services, Estates including health and safety	Tim Ballard	Divisional Director – Laura Wilkinson Divisional Nurse Director – Jo Connolly Divisional Midwifery & Nursing Director – Emma Ashton Divisional Medical Director- Nick Wood
Division: Diagnostics Rehabilitation Pharmacy	Uzair Patel John Schorah	Divisional Director – Russell Dineley Divisional Nurse Director – Debbie O'Mahoney Chief Pharmacist- Gareth Price Chief Allied Health Profession – Claire Granato Divisional Medical Director – absent
Corporate Services Safety & Quality, People, facilities	Mike Thomas	Deputy Chief People Officer- Louisa Graham Deputy Chief Nursing Officer- Catherine Gregory Divisional Director Estates- Cliff Howell

Each executive team member is paired with a division through a division buddy/oversight arrangement. It is expected they will spend time in areas that are of increased focus to help support divisional leadership teams find solutions to risks and recognise, celebrate and learn from areas that are performing well.

In addition to this there are monthly safety visits scheduled that are open to the Board as a whole that focus on specific areas and provide a flexible approach to visiting departments and listening to colleagues and teams across the organisation. The outcomes of these are reported in the NMAHP group and will in future be included in the Always Safety First strategy updates.

Table 2 – Executive alignment

Medicine	Sarah Morrison/Ailsa Brotherton
Surgery	Gerry Skailes/Katie Foster Greenwood
Womens and children	Craig Carter/Jennifer Foote
Diagnostic and Clinical Services	Naomi Duggan/Neil Pease
Estates	Ailsa Brotherton/Katie Foster-Greenwood

3. Conclusion

The Board visibility safety and experience programme has facilitated visits to 9 teams and areas across the organisation during 2024/25. It is recommended the changes described within the report are adopted, leading to increased connection with the divisional teams and services across the organisation.

Recommendation

The Board is asked to note the activity that has taken place in 2024/25 and adopt the change in approach to the Board visibility safety and experience programme.

13. ITEMS FOR INFORMATION

13.1 FIT AND PROPER PERSONS' TEST/COMPLETION OF DIRECTOR APPRAISALS ? ANNUAL REPORT

Information Item

REFERENCES

Only PDFs are attached

13.1 - FPPT Annual Assessment 2024-25.pdf

Board of Directors Report

Annual Assessment of Fit and Proper Persons 2024-25			
Report to:	Board of Directors	**Date:**	3 June 2025
Report of:	Director of Corporate Affairs	**Prepared by:**	J Wiseman
Part I	✓	**Part II**	

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

Executive Summary:

In line with NHS England's Fit and Proper Persons Test (FPPT) Framework for Board Members, the annual FPPT assessment was undertaken covering the period 1 April 2024 up to and including 27 May 2025. The assessment involved a review of the Chair, Non-Executive and Executive Directors, including starters and leavers during the reporting period, to ensure that very senior Directors of the Trust were fit and proper to serve as Board members.

The annual assessment involved completion of a range of documents including declarations, self-attestations, and checks completed on central registers, such as Companies House, the Insolvency Register, professional governing bodies, and social media platforms. Confirmation of the satisfactory completion on an annual appraisal is also required.

The annual FPPT assessment has been submitted to NHS England in line with reporting deadlines.

The Board is asked to note the successful outcome of the Fit and Proper Persons Annual Assessment for 2024-25.

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

13.2 *MATERNITY AND NEONATAL SERVICES UPDATE

Information Item

*Full report in ancillary pack

13.3 DATE, TIME AND VENUE OF NEXT MEETING:

Information Item | M Thomas | 12.25pm

7 August 2025, 9:15am, Lecture Room 1, EC1, Royal Preston Hospital